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Members of the Legislative Audit Commission:

The Department of Corrections is responsible for the safety of incarcerated prisoners and the staff who work at state correctional facilities.

We found that several conditions at the state prisons reduce safety, including persistent staffing shortages, heavy overtime use, suspensions of prisoner activities, unprofessional workplace relationships, limited oversight, and outdated infrastructure. We make several recommendations in this report to the department and the Legislature in order to improve safety for prisoners and staff.

Our evaluation was conducted by David Kirchner (project manager), Tavis Leighton, and Caitlin Zanoni, with assistance from Andrew Duncan. The Department of Corrections cooperated fully with our evaluation, and we thank them for their assistance.

Sincerely,

James Nobles
Legislative Auditor

Judy Randall
Deputy Legislative Auditor
Summary
Safety in State Correctional Facilities

Key Facts and Findings:

- The Department of Corrections (DOC) operates 11 state correctional facilities housing approximately 9,200 prisoners. DOC prisons employ about 3,700 staff. (pp. 1, 10)
- DOC cannot state how safe its correctional facilities are for staff and prisoners; its data on violent events are inconsistent and incomplete. (pp. 14-16)
- Violence between prisoners appears to have decreased slightly over the last four years. However, violent incidents between prisoners are underreported. (pp. 16-21)
- Reported assaults on prison staff spiked in 2018, then declined. (pp. 23-24)
- At some prisons, sexual offenses against female staff by prisoners occur frequently, but are often ignored or downplayed by supervisors and coworkers. (p. 25)
- One in three prison staff said that bullying and harassment among staff is a problem at their prison. (pp. 43-45)
- Chronic shortages of correctional officers and the increasing use of overtime at several prisons have affected the safety of prisoners and staff. (pp. 31-40)
- Staffing shortages have also led many prisons to curtail activities for prisoners, increasing tensions and reducing safety. (pp. 52-55)
- Outdated design features at the St. Cloud and Stillwater prisons create dangers for staff and prisoners. (pp. 63-66)
- Unlike county jails, which are inspected and licensed by the state, there is little external oversight of safety in DOC prisons. (pp. 77-82)

Key Recommendations:

- DOC should transform its data collection processes so it has better data about violent events, staffing shortages, overtime usage, and prisoner discipline. It should then use that data to improve safety. (pp. 17-18)
- DOC should ensure that supervisors take sexual offenses against female staff seriously and discipline prisoners when appropriate. (p. 26)
- DOC should develop additional strategies to reduce bullying and harassment among its staff. (pp. 45-46)
- DOC should continue its efforts to hire sufficient correctional officers to staff state prisons. (p. 37)
- DOC should present to the Legislature long-term plans for rehabilitating or replacing the residential units at St. Cloud and Stillwater. (p. 66)
- The Legislature should require regular external oversight of prison safety procedures, either through licensure or by putting into law and strengthening DOC’s existing “security audits.” (pp. 82-83)

The Department of Corrections should take additional steps to protect staff and prisoners.
Report Summary

The Department of Corrections (DOC) operates 11 state prisons confining prisoners convicted of serious crimes. The department is responsible for the safety of approximately 9,200 prisoners and 3,700 prison staff. The majority of staff working at prisons are security staff, such as corrections officers and lieutenants.

State prisons have four custody levels: Levels 2, 3, 4, and 5. Generally, prisoners at the lower custody levels live with fewer restrictions, while prisoners at higher custody levels have more. Level 4 prisons are located at Rush City, St. Cloud, and Stillwater. Oak Park Heights is the state's only Level 5 (maximum security) prison.

Violence between prisoners has slightly declined in recent years, but prisoner assaults on staff spiked in 2018.

Although data are limited, multiple sources indicate that prisoner violence against other prisoners slightly declined over the last four years. In a survey we conducted of prisoners in Level 3, 4, and 5 settings, most said they felt somewhat safe in DOC prisons, despite believing that violence among prisoners occurs frequently.

Violence between prisoners is far more common than violence against staff. However, prisoner assaults on staff increased dramatically during calendar year 2018, driven by sharp increases at Level 4 and Level 5 prisons. Convictions in DOC’s internal discipline system for assaults on staff increased from 112 in 2017 to 149 in 2018, before dropping again in 2019. Worker’s compensation claims for prison staff due to conflicts with prisoners also rose steeply and then fell.

DOC documented few cases of staff-against-prisoner physical violence or sexual assault during fiscal years 2016 through 2019. Further, prisoners we interviewed complained more about staff actions that affected their safety indirectly, rather than physical abuse. For example, prisoners said some staff label prisoners as informants, putting them at risk of assault from other prisoners. On the other hand, about one-third of prisoners responding to our survey said that officers or other staff physically harm prisoners “sometimes” or “very often.”

Prison administrators have not done enough to address sexual offenses by prisoners against staff.

In some state prisons, female staff endure repeated sexual offenses by some male prisoners, who catcall, verbally threaten them with sexual assault, or masturbate in front of them. Female staff said some supervisors and coworkers expect them to tolerate this behavior, and that prisoners frequently receive no disciplinary consequences.

Even if these offenses were routinely punished, DOC disciplinary charges do not distinguish sexual misconduct against staff from other infractions, so it would be very difficult to count them. DOC should create a separate disciplinary charge for sexual misconduct against staff and should ensure supervisors support staff that encounter such offenses.

Bullying and harassment between staff is a pervasive issue in DOC prisons.

In a survey we conducted of DOC staff working in prisons, one in three respondents described unprofessional work relationships as an ongoing problem in DOC prisons. Staff told us about different experiences depending on the prison or their role. For example, some staff described a top-down culture of bullying by supervisors, while others described sexual harassment.

Many staff do not believe that their coworkers or supervisors take harassment seriously. Some staff told us they had experienced retaliation from coworkers or supervisors for reporting wrongdoing by other staff members. For example, one staff person told us that officers refused to respond when that person was working alone in a prisoner living unit and called for assistance.

DOC should take strong action to address workplace culture issues. DOC has recently taken a good first step by establishing a new Office of Professional Accountability; it is
too soon to evaluate whether this initiative will be successful.

**Chronic shortages of correctional officers and increasing overtime usage have reduced safety for both staff and prisoners.**

High turnover rates have led several prisons to fall below their budgetary allocations of correctional officers. For example, during Fiscal Year 2019, Stillwater averaged a shortage of 25 officers under its allocated 314 correctional officers. Although DOC recruited a similar number of new officers in Fiscal Year 2019 as it had in previous years, those staff were not enough to fill the increased vacancies.

To address these shortages, DOC almost quadrupled its use of overtime for corrections officers between Fiscal Year 2013 and Fiscal Year 2019. When prisons lack enough volunteers to work overtime shifts, prison administrators often require staff to work overtime. DOC does not track how often it forces officers to work overtime. We estimated that roughly 15 to 20 percent of instances when officers worked overtime in the last year were forced.

Large majorities of DOC staff we surveyed said that staffing shortages and heavy overtime usage create safety challenges for staff and prisoners. For example, staff may not have enough time to perform routine security tasks, or may need to work alone or in small numbers in settings with many prisoners. Staff tired from working excessive overtime may be less alert, less responsive in emergency situations, or more short-tempered.

Prison administrators and staff told us that short-staffing also leads prisons to frequently suspend prisoner activities such as therapy, employment, education, and recreation. Yet research indicates that providing structured prisoner activities leads to reduced violence in prisons. DOC does not track how often its prisons suspend prisoner activities.

DOC should track the extent of its staffing shortages, use of forced overtime, and suspensions of prisoner activities. It should also continue its efforts to hire enough correctional officers to alleviate its staffing shortages.

**Line staff often do not trust decisions made by prison administrators.**

Most staff at Level 4 and Level 5 prisons doubted that prison leaders do all they can to reduce violence by prisoners against staff. Although staff responding to our survey agreed that structured activities for prisoners help reduce violence, many staff complained that prison administrators often prioritize such activities over measures that would protect safety. Staff told us that administrators often make decisions arbitrarily, without seeking staff input.

Our interviews with administrators suggest that they juggle many different priorities. However, a lack of transparency around decisions feeds distrust and lowers morale. Prison administrators should improve their communication and consultation with line staff.

**DOC does not systematically assess the level of safety at its prisons.**

Decisions made to improve safety are often implemented without any formal assessment of whether they make a difference. Prison and central office administrators instead make decisions by relying on informal impressions or reacting to major incidents.

Taking a more systematic approach to protecting safety is currently challenging because DOC’s data on violent events in prisons are inadequate. Much of the information DOC collects is narrative and difficult to aggregate. The aggregated data the department does collect is often incomplete. For example, DOC’s biennial reports to the Legislature include counts of prisoners administratively charged with “assault” but not prisoners that are charged with “fighting.” Either charge can reflect a violent conflict in which prisoners were hurt.

Additionally, violence among prisoners is likely underreported across all data sources. Staff acknowledged they may not observe some conflicts between prisoners.

**Persistent staffing shortages have threatened safety.**
DOC’s data on its disciplinary actions for prisoners who violate prison rules have flaws. DOC has faced particular challenges in providing accurate data about the number of prisoners in restrictive housing (isolation from the general prisoner population) and the length of time they spend there.

DOC should transform how it gathers and uses data. Rather than adding data-gathering tasks to the work it already does, the department should explore ways to restructure its processes so that data are gathered automatically. Once better data are available, prison leaders should use that data to make more evidence-based safety decisions.

There is limited external oversight of safety in state prisons.

Although DOC is subject to oversight from several external entities, each oversees individual components of safety rather than safety as a whole. For example, audits conducted for the federal Prison Rape Elimination Act focus on sexual assault and harassment of prisoners, while Minnesota’s Occupational Safety and Health Administration focuses mostly on occupational injuries.

State law requires that county jails be licensed and inspected, but DOC claims that its prisons are exempt from this requirement. DOC has voluntarily conducted “security audits,” or peer reviews of prisons’ security procedures. However, these audits occur infrequently—St. Cloud has not had a security audit since 2011—and there are no consequences should prisons fail to adopt security audit recommendations.

The Legislature should require that DOC regularly and systematically evaluate safety at state prisons according to defined security standards, either through licensure and inspection or by adding security audits to state law.

The prisons at St. Cloud and Stillwater—both built over 100 years ago—have design features that are outdated and unsafe.

The residential units in these prisons present security challenges, such as the danger of falling or being pushed over railings from several stories in the air. The layout of these residential units also makes it difficult for staff to monitor prisoners. Some key infrastructure elements, such as door locking mechanisms, are no longer manufactured and DOC must fabricate replacement parts as needed.

DOC should develop and present to the Legislature a long-term plan for rehabilitating or replacing the living units at the St. Cloud and Stillwater prisons. At some point, the state will have to substantially reinvest in these prisons if it is to keep using them.

Summary of Agency Response

In a letter dated February 21, 2020, Department of Corrections Commissioner Paul Schnell wrote that “we concur in whole” with the report’s findings and recommendations. He wrote that the department’s new leadership has spent the last year engaging with its staff and has heard much about “the deeply troubling realities pertaining to the safety of our facilities.” He stated that “we have already begun implementing a number of the recommendations highlighted in your report” and continued, “your comprehensive look back at the safety of our state’s correctional facilities confirms, supports, and underscores the significance of the work ahead of us.”

The full evaluation report, Safety in State Correctional Facilities, is available at 651-296-4708 or:
www.auditor.leg.state.mn.us/ped/2020/prisonsafety.htm
Table of Contents

1 Introduction

3 Chapter 1: Background
3 Correctional Facilities
6 Legal Framework
7 Prisoners
9 Staff
11 Finances

13 Chapter 2: Measuring Safety
13 Measurement
18 Performance Reports
19 Safety Outcomes

31 Chapter 3: Staff Management
31 Staffing Shortages
38 Overtime
41 Staffing Distribution
42 Workplace Culture
46 Training

49 Chapter 4: Prisoner Management
49 Programming and Recreation
56 Discipline for Prisoner Misconduct

63 Chapter 5: Infrastructure
63 Design
67 Crowding

71 Chapter 6: Decision Making and Oversight
71 Prison Leadership
77 Oversight

85 List of Recommendations

87 Appendix: Survey Methodology

91 Agency Response
Introduction

During 2018, a series of violent events at Minnesota correctional facilities managed by the Department of Corrections (DOC) drew the attention of legislators and the public.¹ Most tragically, two corrections officers died in the line of duty. Officer Joseph Gomm died on July 18 after being allegedly attacked at Stillwater; a prisoner was charged with homicide. On September 24, Officer Joseph Parise fell ill and died in the aftermath of responding to an assault on a staff person at Oak Park Heights.

In April 2019, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate safety in state correctional facilities. Our evaluation addressed the following questions:

- **How safe are Minnesota’s prisons, both for the staff who work there and the offenders who live there?**

- **To what extent has DOC taken reasonable steps to maintain and improve safety in state prisons?**

To answer these questions, we visited 9 of DOC’s 11 correctional facilities.² At Faribault, Lino Lakes, Moose Lake, Red Wing, and Shakopee, we interviewed the executive staff and toured the facility. At Oak Park Heights, Rush City, St. Cloud, and Stillwater, we toured the facilities during all three work shifts, interviewed executive staff, and met with groups of corrections officers, lieutenants, nonuniformed staff, union representatives, and prisoners.

We obtained access to DOC’s central prisoner database and analyzed data on prisoner populations, criminal histories, sentences, and disciplinary records (for offenses while in prison). We also analyzed data from a separate DOC database containing information on staff disciplinary actions. We examined data on staffing levels and overtime from the state’s payroll system and information on staff injuries from the worker’s compensation unit at the Department of Administration. We reviewed reports by DOC’s Office of Special Investigations on its investigations into violent incidents in prisons over a four-year period.

DOC prisons have been subject to several external reviews. We examined accreditation reviews conducted of each prison by the American Correctional Association, the independent audits of each prison required by the federal Prison Rape Elimination Act, and security audits conducted in the past ten years by DOC peer review teams.³ We also reviewed records of all investigations into workplace safety conducted at state

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¹ DOC generally refers to its prisons as “correctional facilities” or simply “facilities.” In this report, we use both “prisons” and “correctional facilities” to refer to state-run correctional facilities. We use “jails” to refer to county-run correctional facilities.

² We did not visit Willow River and Togo, the state’s two “boot camp” facilities.

prisons over a ten-year period by the Minnesota Occupational Safety and Health unit in the Department of Labor and Industry.

We reviewed numerous documents generated both by DOC prison staff and the central office and interviewed many staff about their work. We examined relevant sections of state and federal law, state rules, and DOC policies. We also reviewed the standards for prisons published by the American Correctional Association.

Finally, we conducted two surveys, one of prisoners housed in medium security or higher security settings, and another of all prison staff that routinely interact with prisoners. We provide details of our survey methodology in the Appendix.

We restricted the scope of our evaluation to safety from interpersonal interactions, such as assaults, fights, threats, extortion, and harassment. We did not assess how DOC attempts to prevent suicides or other self-injurious behavior among prisoners, nor did we assess DOC’s efforts to support prisoner or staff mental health. We also did not evaluate how DOC manages occupational safety hazards, such as ice on outdoor walkways or improperly maintained equipment.

As we note in several places in our evaluation, DOC has proposed or begun some new practices in recent months that would address prisoner and staff safety. We were unable to evaluate these efforts.
When individuals are convicted of committing crimes, judges commit individuals convicted of the most serious charges to the Department of Corrections (DOC) for placement in state prisons. Over 9,000 prisoners are in Minnesota state prisons on any given day. In this chapter, we provide an overall introduction to Minnesota’s prison system.

**Correctional Facilities**

DOC operates state prisons at 11 locations in Minnesota, as shown in the map on the next page. Four of the prisons are in the seven-county Twin Cities metropolitan area, and the other seven are in greater Minnesota.\(^1\) Two prisons serve specialized populations. Shakopee is the only state correctional facility housing female prisoners.\(^2\) Red Wing houses nearly all juvenile prisoners.\(^3\) (Red Wing also has a small minimum security building housing adults.)

Minnesota has four different custody levels (also called security levels) in its state prisons.

- **Level 2** (minimum custody) is the least restrictive custody setting. (There are Level 1 prisoners, but no Level 1 prison.) Prisoners in Level 2 settings are restricted more by rules than by physical barriers. Some minimum security buildings, for example, are not enclosed by fencing, and supervised prisoner crews often carry out work assignments in the community. Prisoners wear GPS tracking devices to hinder escape.

- **Level 3** (medium custody) prison settings are the lowest level of fully fenced-in settings. Though confined by fences and locked doors, prisoners in Level 3 settings have some freedom of movement. For example, cell doors are often unlocked and prisoners can go in and out of their cells as they choose (though building entrances and exits may be restricted). This limited freedom of movement is a necessity for many prisoners at Lino Lakes, Moose Lake, Shakopee, and Red Wing because prisoners use common restrooms. DOC...

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\(^1\) Moose Lake and Willow River, located eight miles apart, are managed by a single administrative team. DOC refers to the two locations as a single organizational entity for some purposes, and as two entities for others. We treat them as two separate correctional facilities throughout this report. The seven-county Twin Cities metropolitan area comprises Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.

\(^2\) The official name of each prison is “Minnesota Correctional Facility” followed by the location name, such as “Minnesota Correctional Facility – Shakopee.” However, the prisons are commonly referred to solely by their location names, and we have followed that practice throughout this report.

\(^3\) DOC does not have a facility housing female juveniles. On the rare occasions when courts place female juveniles in DOC’s care, DOC places them at correctional facilities outside of the state prison system. DOC houses a very small number of juvenile prisoners—those tried and convicted as adults—in a special unit at the Lino Lakes prison. When they are old enough, they transfer to the general prison population to serve their remaining time.
provides most treatment programs, such as chemical dependency treatment and sex offender treatment, in Level 3 settings. Although the women’s prison at Shakopee and the juvenile units at Red Wing have no level number, both environments are roughly similar to Level 3 prisons.

- **Level 4** (close custody) prison settings place further restrictions on prisoner movement. Prisoners in these settings are able to leave their cells only at scheduled times, and officers closely supervise them as they move from location to location in groups. Prisoners going somewhere individually (such as an in-prison medical appointment) need to obtain special permission. Unstructured free time outside the cells—when prisoners might use telephones or socialize with each other, for example—is limited.

- **Level 5** (maximum custody) is at only the Oak Park Heights correctional facility. To facilitate closer monitoring, there are fewer prisoners in each cell block (approximately 50 instead of over 100 in most Level 4 settings). Each individual cell block can be entirely sealed off from the rest of the prison to contain any major incident to a single cell block. Activities and unstructured free time are tightly controlled. Officers move prisoners from one location to another in groups of no more than seven people. There is no prisoner dining area; all meals are delivered to prisoners.

DOC places male adult prisoners at the different levels using a point system; the more points a prisoner has, the more secure the setting. DOC staff assign points when a prisoner enters the system based on a number of factors, including criminal history and disciplinary records during previous incarcerations. Over time, prisoners may reduce their points through good behavior or increase their points by committing infractions against prison rules. Such changes in points may make a prisoner eligible for transfer to a lower or higher custody setting. DOC may also transfer prisoners between settings so they can participate in specific programs or receive services that are only available at some prisons.

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4 DOC houses female adult prisoners at Shakopee regardless of individual custody level.

5 DOC is currently exploring a new method of classifying prisoners that would rank prisoners against one another. Thus, a prisoner’s custody classification could move up or down based not just on the prisoner’s own behavior, but also on whether other prisoners judged to be lower or higher risk have entered or left the prison system.
Correctional facilities consist of several buildings or building wings, referred to as “units,” each with different functions.

Living units contain the cells (rooms) where prisoners live. Most cells house more than one prisoner. Living units also have common areas where prisoners can socialize, use telephones, do laundry, or use other amenities specific to each unit and custody level. Most prisons have separate units containing kitchen and dining facilities where prisoners get their meals.

Every prison has a health care unit where prisoners can receive medical services. Most also have behavioral health units, where prisoners can receive mental health treatment and participate in specific programs intended to change behaviors, such as chemical dependency programs and sex offender treatment programs. All prisons also have education units, where prisoners can take basic education classes. Under DOC policy, prisoners that do not have a high school diploma or General Educational Development (GED) certification must earn one or the other before they can work in prison jobs. Several prisons also have vocational education programs where prisoners can learn specific trades, such as barbering, cabinet making, or stone masonry.

Many prisons also have “industry” units, where prisoners work at specific jobs through MINNCOR Industries, a division of DOC that employs prisoners in the production of various goods and services. These jobs range widely, depending on the specific facilities available at each prison. Some jobs are unskilled, such as assembling or packing premanufactured items. Others require prisoners to learn specific skills such as carpentry or sewing. Prisoners can also get non-MINNCOR jobs helping with internal prison operations, such as food preparation, janitorial work, or landscaping.

Lastly, all medium or higher security prisons have restrictive housing units. (Many DOC staff refer to them as segregation units.) These units contain spartanly furnished cells where DOC staff isolate prisoners from the general population and severely restrict their activities. Broadly speaking, there are two primary reasons DOC sends prisoners to restrictive housing: disciplinary segregation and administrative segregation. Disciplinary segregation is a penalty for misconduct, such as fighting, extortion, illicit possession of pharmaceuticals, or brewing homemade alcohol. Administrative segregation is used to isolate prisoners for reasons other than misconduct (for example, because prisoners fear for their own safety). Prisoners in administrative segregation may have more privileges than those in disciplinary segregation. Stays in disciplinary segregation are generally tied to a sentence of a certain number of days, while administrative segregation can end as soon as the

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6 As required by state law, the maximum security prison at Oak Park Heights has only one prisoner per cell (except for a few rooms in its medical unit). Minnesota Statutes 2019, 243.53. Some units elsewhere, particularly in minimum security prisons or special treatment programs, are “dormitory-style,” where sleeping rooms contain many bunk beds. We discuss the number of prisoners per cell in more detail in Chapter 5.

7 If educational programs are full, prisoners may be placed temporarily in prison jobs until they can begin classes.

8 MINNCOR is the name of the program, not an abbreviation. See Minnesota Statutes 2019, 241.27.

9 At some prisons, restrictive housing cells are also used as temporary overflow housing.
situation of concern is resolved. We discuss DOC’s use of restrictive housing in more detail in Chapter 4.

Legal Framework

Under state law, DOC is responsible for the “care, custody, and rehabilitation” of prisoners incarcerated in its facilities.\(^{10}\)

**Minnesota and federal laws place few constraints on how DOC should operate correctional facilities to protect safety.**

Beyond the broad statement above, state law contains no provisions directing DOC to protect prisoners from one another, and only a few specific provisions related to protecting prisoners from improper treatment by prison staff. For example, prisons must provide prisoners with necessary health care and mental health care.\(^{11}\) Statutes also specify the circumstances under which prisons may use physical force on prisoners.\(^{12}\)

Both the Eighth Amendment of the U.S. Constitution and the Minnesota Constitution prohibit the use of “cruel or unusual punishment.”\(^{13}\) These provisions broadly protect prisoners from abuse by prison employees. Federal courts have also found that prison officials have a duty under the Eighth Amendment to protect prisoners from one another. Correctional facilities must “take reasonable measures to protect prisoners from violence at the hands of other prisoners” because “being violently assaulted in prison is simply not part of the penalty that criminal offenders pay for their offense against society.”\(^{14}\) However, these rulings’ implications for practical day-to-day procedures that affect safety—such as how often to search cells or check on prisoners’ welfare—are open to interpretation.

Similarly, few provisions in federal or state law specifically govern the safety of corrections employees. Like nearly all Minnesota employers, DOC must comply with the federal Occupational Safety and Health Act and its state counterpart.\(^{15}\) Thus, DOC must “furnish to each of its employees conditions of employment and a place of employment free from recognized hazards that are causing or are likely to cause death or serious injury or harm to its employees.”\(^{16}\) It is difficult to say how this duty should be interpreted in a correctional facility context with inherent hazards that do not exist in other workplaces.

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\(^{10}\) Minnesota Statutes 2019, 241.01, subd. 3a(a).

\(^{11}\) Minnesota Statutes 2019, 241.021, subd. 4; and 241.69.

\(^{12}\) Minnesota Statutes 2019, 243.52.

\(^{13}\) U.S. Constitution, amend. VIII; Minnesota Constitution, art. I, sec. 5.


\(^{15}\) Occupational Safety and Health Act (OSHA) of 1970, 29 U.S. Code, secs. 651-678; Minnesota Statutes 2019, Chapter 182.

\(^{16}\) Minnesota Statutes 2019, 182.653, subd. 2.
A specific set of state laws addresses the potential exposure of corrections employees to blood-borne pathogens, such as the hepatitis B virus, hepatitis C virus, and human immunodeficiency virus (HIV).\footnote{Minnesota Statutes 2019, 241.33-241.342.} As we discuss in Chapter 2, prisoners sometimes spit or throw bodily fluids at corrections staff. Intentionally transferring bodily fluids onto corrections staff can be prosecuted as a fourth-degree assault.\footnote{Minnesota Statutes 2019, 609.2231, subd. 3.} State law provides for a series of steps that DOC may take in such circumstances, including steps it can pursue to extract and test the blood of prisoners who have carried out such assaults.\footnote{Minnesota Statutes 2019, 241.331-241.336.}

Minnesota law requires DOC to report regularly to the Legislature on its goals, objectives, and performance.\footnote{Minnesota Statutes 2019, 241.01, subd. 3b; and 241.016.} However, there is no requirement that DOC present information pertaining to the safety of prisoners or staff when it reports to the Legislature on its overall performance.

State law does require DOC to provide two specific reports related to prisoner safety. First, DOC must report on its use of restrictive housing, including how frequently it is used for various infractions, the numbers of individuals placed in restrictive housing by prison, demographic information on restrictive housing residents, and lengths of restrictive housing terms.\footnote{Minnesota Statutes 2019, 243.521, subd. 9. The Legislature adopted this provision in 2019 and DOC submitted the first report in January 2020. See Laws of Minnesota 2019, First Special Session, chapter 5, art. 3, sec. 10; and Minnesota Department of Corrections, 2019 Administrative and Disciplinary Segregation Report (St. Paul, 2020).} Second, DOC must report on its use of restraints on pregnant women or women who have very recently given birth.\footnote{Minnesota Statutes 2019, 241.88, subd. 3.}

Minnesota law requires that adult and juvenile correctional facilities be licensed, and DOC has a special division that inspects and licenses county correctional facilities under a set of standards detailed in Minnesota Rules.\footnote{Minnesota Statutes 2019, 241.021, subd. 1(a); and Minnesota Rules, Chapter 2911, published electronically December 20, 2013; July 3, 2014; and December 15, 2017.} However, DOC has never licensed its own prisons, taking the position that state law does not require it to do so due to a clause in the Administrative Procedures Act.\footnote{DOC bases its claim on Minnesota Statutes 2019, 14.03, subd. 3(b)(1).} We discuss licensing in more detail in Chapter 6.

**Prisoners**

The total prisoner population has remained fairly stable over the last decade. In every fiscal year from 2012 through 2018, Minnesota’s prison population on July 1 was between 9,300 and 9,500 prisoners (counting only prisoners housed in DOC.
The population declined slightly to 9,248 on July 1, 2019. In part, the stable population is due to the fact that the prison system has stayed at or near DOC’s operational capacity. We discuss capacity issues further in Chapter 5.

In fiscal years 2016 through 2019, prisoners ranged in age from 13 (for a juvenile resident at Red Wing) to 92. The majority of prisoners fell between the ages of 26 and 45. During these years, about 52 percent of all prisoners in Minnesota correctional facilities on any given day were white, 35 percent were black, 10 percent were American Indian, and 3 percent were Asian. Approximately 6 percent of prisoners had Hispanic ethnicity.

Minnesota incarcerates fewer individuals than most other states, with its incarceration rate placing in the bottom five of U.S. states. In 2017, Minnesota prisons held 249 individuals for every 100,000 people in the state’s adult population. Nationally, state prisons held 503 individuals for every 100,000 people.26

Minnesota prisons tend to house prisoners convicted of serious and violent crimes.

Minnesota’s incarceration rate is low, in part, because it places many individuals convicted of less serious crimes in community settings. As a result, a high proportion of prisoners in state prisons are those convicted of more serious offenses. During fiscal years 2016 through 2019, three of every four prisoners at the state prisons were serving at least one sentence for a violent crime.

As of July 1, 2019, more than 70 percent of prisoners had at least one sentence of three years or longer. Many prisoners are serving multiple sentences for several criminal convictions. Around 9 percent of prisoners are serving life sentences. The amount of time that prisoners spend in custody at a state prison depends not only on their sentence lengths but a number of other factors, such as their behavior in the facility and completion of mandated treatment programs.

25 DOC places prisoners at other correctional facilities, such as county jails, when it does not have places for them in state prisons. The number of DOC prisoners housed in non-DOC facilities decreased from 766 prisoners in 2015 to 404 prisoners in 2019. We did not evaluate the safety of these prisoners.

26 Jennifer Bronson and E. Ann Carson, *Prisoners in 2017*, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Bulletin NCJ252156 (April 2019), 11-12. Statistics in this paragraph omit juvenile prisoners. Although Minnesota’s incarceration rates are low when compared with other states, they are high when compared with many other countries. For example, Council of Europe member countries had a median incarceration rate of 116 prisoners per 100,000 population in 2015. See Marcelo F. Aebi, Mélanie M. Tiago, and Christine Burkhardt, *SPACE I–Council of Europe Annual Penal Statistics: Prison Populations, Survey 2015* (Strasbourg: Council of Europe, 2016), 2.
Prisoner turnover within correctional facilities is high. During fiscal years 2016 through 2019, over half of all prisoners had spent less than one year in their current prison. The percentage of prisoners with short stays is particularly high at St. Cloud, which serves as the intake facility for prisoners newly admitted to DOC custody. Prisoners tend to have longer stays at higher custody level prisons (Oak Park Heights, Rush City, and Stillwater).

Courts ordinarily do not commit prisoners to DOC unless their sentence is at least a year and a day in length, and prisoners generally serve most of their sentences in prisons before being released into community supervision. However, DOC’s Hearings and Release Unit may return released prisoners to prison for short periods if they violate the terms of their release. Between 2,500 and 2,900 prisoners with releases revoked or rescinded were returned to DOC prisons each year of fiscal years 2016 through 2019.

**Staff**

DOC is a major employer in Minnesota state government; only the departments of Human Services and Transportation have more employees. About 3,700 of the department’s 4,400 employees work at 1 of its 11 correctional facilities. Staff at these facilities work in a variety of roles, as shown in the box on this page. By far, the largest category of staff is security staff.27

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>213</td>
</tr>
<tr>
<td>Case Management</td>
<td>151</td>
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<tr>
<td>Education</td>
<td>162</td>
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<td>Food Service</td>
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<tr>
<td>Management</td>
<td>96</td>
</tr>
<tr>
<td>Medical Health</td>
<td>231</td>
</tr>
<tr>
<td>MINNCOIR Industries</td>
<td>85</td>
</tr>
<tr>
<td>Office/Administrative</td>
<td>278</td>
</tr>
<tr>
<td>Physical Plant/Trades</td>
<td>210</td>
</tr>
<tr>
<td>Security</td>
<td>2,088</td>
</tr>
<tr>
<td>Other</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,664</td>
</tr>
</tbody>
</table>

As shown in the chart on the next page, the number of prisoners in Minnesota prisons increased substantially during the 2000s. In 2010, Minnesota prisons held 63 percent more prisoners than they had in 1998. The total number of prison staff increased only 13 percent during the same period. Since 2010, staffing has continued to increase gradually while prisoner numbers have leveled off. However, prisons still employ only 4 staff for every 10 prisoners, less than the 5.5 staff for every 10 prisoners that DOC employed in 1998.

Most prison-based DOC staff regularly work in close proximity to prisoners. DOC staff that spend at least 75 percent of their work time interacting with prisoners are eligible for a special Correctional Employees Retirement Plan.28 About 83 percent of prison-based staff are eligible for this retirement plan.

27 In this report, we sometimes follow the DOC practice of referring to security staff—corrections officers and their supervisors—as “uniformed” staff, in contrast to the “nonuniformed” staff that work in other positions.

28 See Minnesota Statutes 2019, 352.90-352.955. All security staff (corrections officers, lieutenants, and captains) are eligible for the plan, even if their specific responsibilities require less interaction with prisoners.
According to DOC administrators, the number of staff needed in a prison setting varies by a prison’s custody level, its physical layout, the activities available for prisoners, and the prisoner population. Different staffing levels are needed for different activities. For example, a correctional facility may use only a handful of corrections officers to oversee hundreds of prisoners recreating outside in a prison yard—well-positioned staff can see everyone at the same time and radio for backup if an emergency occurs. However, the same number of prisoners would require many more officers to oversee their activities when scattered in different buildings participating in educational classes, chemical dependency treatment groups, and industrial employment. In addition to watching individuals in these multiple locations, officers would also complete tasks that they would not perform when monitoring prisoners during outside recreation, such as tracking tool use and searching prisoners moving from one part of the complex to another.

DOC’s labor contract with AFSCME, which represents corrections officers, shapes the distribution of security staff at each facility. Officers “bid” to work in certain posts, and the contract requires DOC to grant those bids in order of seniority. Post assignments comprise both work locations and weekly schedules. Daytime posts with weekend days off are disproportionately filled by the most senior officers. Newly hired officers are more likely to work evening or overnight shifts with weekday days off. Posts considered undesirable for other reasons—for example, posts many staff consider especially challenging or stressful—may also be disproportionately filled by less experienced staff.

DOC monitors prisoners around the clock every day of the year. To ensure that there will always be security staff to meet minimum needs, DOC may require corrections officers to work overtime. We discuss DOC’s use of overtime in Chapter 3.

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29 AFSCME stands for the American Federation of State, County, and Municipal Employees.

30 Seniority can also affect when and where nonuniformed staff work. However, because there are fewer positions per prison and most work shifts occur during daytimes and weekdays, seniority affects the working conditions of nonuniformed staff much less than the working conditions of corrections officers.
Finances

DOC uses substantial state funding to meet its responsibility to house, feed, guard, and provide services to over 9,000 prisoners. As shown in the chart below, DOC spent $686 million in Fiscal Year 2019, of which $406 million went toward salaries, overtime, and other payroll expenses. Legislative appropriations for that year directed that 73 percent of allocated funds be spent at correctional facilities. Another 5 percent of funds were allocated to general operations that also support prison operations, such as communications and human resources.

In recent budget years, the Legislature has made broad appropriations to DOC with only a few specific programs or purposes singled out for specific funding. As a result, DOC has latitude in how it distributes funding among correctional facilities. Individual prison budgets tend to be fairly static from year to year, changing primarily to reflect expected salary changes and overtime costs.

However, many of the staff and services at prisons are not funded through individual prison budgets. DOC uses a “shared services” model to fund staff who provide services such as education and medical and behavioral health. Although these staff deliver services at prisons, they are funded by accounts managed at DOC’s central office in St. Paul; wardens do not control their prisons’ budgets for these activities. As a result, a warden cannot unilaterally decide, for example, to add a corrections officer position by eliminating a behavioral health position.
Chapter 2: Measuring Safety

Assessing safety in prisons is inherently difficult. Prisoners and staff we spoke with agreed that it is impossible to eliminate all violence from prisons. There are no thresholds at which a prison is considered “safe” or has reduced violence to an “acceptable” level. Further, safety cannot simply be measured by the absence of violence, because individuals may feel unsafe even in situations where no violence occurs. For example, if a group of prisoners extorts others by threatening violence, the victims will not feel safe, even if they make the payment and avoid violence.

This chapter provides an overview of what we know—and what we do not know—about safety in state prisons. First, we examine available sources of data from DOC relating to violence in Minnesota’s prisons and describe their limitations. Then, we discuss the data that the Department of Corrections (DOC) publishes regarding safety in prisons. Finally, we discuss what these data tell us about safety in prisons.

Key Findings in This Chapter

- The Department of Corrections does not collect the data needed to measure its overall performance in protecting the safety of prisoners and staff.
- The Department of Corrections’ biennial performance reports underreport the amount of violence between prisoners.
- Although data are incomplete, prisoner-against-prisoner violence appears to have gradually decreased from fiscal years 2016 through 2019.
- Assaults on staff in higher-security prisons spiked during calendar year 2018.
- In some state prisons, female staff endure repeated sexual offenses by male prisoners, often without appropriate support from supervisors and colleagues.

Measurement

Although safety cannot be measured solely by the presence or absence of violence, the frequency and severity of violent events is a fundamental starting point. In this section, we describe the data DOC collects about violent events in prisons and the limitations of these data.

Data Sources and Limitations

DOC collects large amounts of information about violent incidents that occur in its prisons. This information serves important purposes. For example, it allows supervisors to review staff actions and determine if staff acted appropriately, supports administration in determining the proper next steps, and provides documentation of DOC’s actions in case of litigation. While these data are useful for these purposes, they are generally inadequate for developing broader assessments of prisons’ levels of safety.
The Department of Corrections does not collect the data needed to measure its overall performance in protecting the safety of prisoners and staff.

DOC data sources are insufficient for assessing violence in prisons; they either exclude some incidents, lack important detail, or are difficult to aggregate into a bigger picture. These limitations affect DOC’s understanding of both conflicts between prisoners and conflicts involving staff. Despite these limitations, we use several of these sources of information throughout this report because no better data are available. Below, we describe many of these sources, as well as their limitations.

- **Incident Reports.** After any “incident,” each involved staff person writes an incident report recounting what happened. Incidents can include anything out of the ordinary—an assault, a sprained ankle from playing basketball, a search for contraband, or a prisoner learning of a death in the family. These reports are one of the most detailed sources of data DOC has on events that happen in its correctional facilities. However, these reports are entirely narrative, and would be prohibitively time-consuming to aggregate.

- **Incident Command System.** Whenever an emergency occurs—such as a fight, a medical emergency, or a burst pipe—staff activate the Incident Command System and follow specific protocols to resolve and contain the emergency as quickly as possible. Quarterly, staff at each prison create reports with summary information about Incident Command System activations by type.

However, Incident Command System summary reports do not include some incidents, and lack important detail. The reports omit any violence that DOC became aware of after it occurred. Additionally, Incident Command System summary reports do not distinguish violence from attempted violence, indicate how many people were involved, or indicate whether anyone was injured. Further, some prisons have not consistently submitted reports.¹

- **Office of Special Investigations (OSI).** OSI conducts investigations of potential criminal activity within DOC correctional facilities, among other

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¹ For instance, Oak Park Heights did not submit quarterly reports from April 2018 through March 2019.
responsibilities. To this end, OSI investigates and reports on prisoner-against-prisoner assaults that result in serious injury, and all prisoner-against-staff assaults. OSI reports usually identify how staff respond to violent incidents and any injuries that occur. However, OSI investigative files omit conflicts between prisoners that aren’t investigated. OSI reports are mostly narrative, making them time-consuming to aggregate.

- **Prisoner Discipline.** DOC maintains an internal database that tracks a wide range of information about prisoners, including convictions prisoners incur in DOC’s internal disciplinary process. Disciplinary charges include fighting or assaulting other prisoners and assaulting staff, as well as other violent and nonviolent offenses.

However, prisoner discipline data have not included information on severity of injuries or type of weapon used that can easily be aggregated. It is also impossible to use discipline data to count how many violent incidents occur. Several prisoners may receive discipline for a single incident, a prisoner may have more than one disciplinary charge for a single incident, and other incidents may result in no disciplinary charges at all. Further, information on staff response to incidents is included only in a narrative field, and is sometimes omitted altogether. DOC discipline data have additional limitations, which we discuss in Chapter 4.

- **Staff Discipline.** DOC tracks disciplinary investigations of staff in an internal database. This database categorizes infractions by type, and also provides narrative descriptions of infractions. However, similar infractions are categorized differently by different facilities. Additionally, certain key information, such as whether anyone was hurt, is inconsistently recorded.

- **Prisoner Medical Records.** Medical records contain detailed information on injuries prisoners sustain while in prison. Unlike other data sources in this list, medical records could show the severity of violent conflicts. However, these records are not linked to other types of data and are prohibitively time consuming to aggregate because they are paper files. Prisoner medical records also contain no information about injuries sustained by staff.

- **Workers’ Compensation.** The Department of Administration collects data on all work-related injuries for state employees, including DOC employees. These data are well-organized, providing useful information on the frequency and extent of injuries. However, workers’ compensation data exclude any incidents that did not result in staff injuries.

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2 Prisoner disciplinary convictions are not criminal convictions in a court of law.

3 For instance, a case one prison codes as “Horseplay/Rumors/Jokes” could be coded by a different prison as “Inappropriate Verbal (non-offender issue)” or “Gen Harass—Staff & Staff.”

4 We described other problems stemming from DOC’s lack of prisoner electronic health records in Office of the Legislative Auditor, Program Evaluation Division, *Health Services in State Correctional Facilities* (St. Paul, 2014), 104-105.
• **Safety Leadership Team Data.** Staff at each prison aggregate data on staff and prisoner injuries on a monthly basis. However, these data focus on occupational injuries, such as falls or kitchen accidents, and exclude injuries to prisoners that occur as a result of assaults, sexual abuse, self-injury, or staff restraint.\(^5\)

DOC is not alone in its weak measurement of safety-related events. A 2006 report from a national commission formed by the nonprofit Vera Institute identified “stunning gaps in the research and data about violence and abuse” in prisons and jails.\(^6\) This report stated that correctional institutions across the country have weaknesses collecting, creating consistent definitions for, and providing sufficient detail about their data.

### Unobserved Violence

When staff see a violent incident occurring—or the warning signs that one will likely occur—they activate the Incident Command System, and “A-Team” staff respond to the incident location to assist. Generally, both prisoners and staff told us that when staff intervene in physical conflicts between prisoners, they do so quickly. In surveys we conducted, 96 percent of staff, and 72 percent of prisoners said that when officers see fights or assaults, they step in to stop them “very quickly” or “somewhat quickly.”\(^7\) However, many staff and some prisoners told us that such conflicts frequently occur without any staff intervention.

**Staff do not witness many assaults and fights between prisoners.**

Both DOC data sources and anecdotal information from staff and prisoners suggest that staff do not see a significant proportion of the violence between prisoners. Our review of OSI reports suggest that staff often learn of assaults only after they have occurred. We reviewed all OSI investigation reports related to physical or sexual violence within state correctional facilities in fiscal years 2016 through 2019. In 34 percent of the cases involving substantiated violence between prisoners, there was no staff intervention. In interviews, staff told us they often become aware of conflicts only after they occur, usually because a prisoner later reports the conflict or has an unexplained injury.

Staff at multiple prisons told us that some violent incidents between prisoners are never discovered by staff, and that they regularly find prisoners with unexplained injuries, such as bruises or black eyes. One officer we interviewed guessed that officers miss half of the fights that happen inside of cells. Forty-one percent of respondents to our

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\(^5\) Safety Leadership Team data for the juvenile prison at Red Wing do include some of this information.


\(^7\) We surveyed staff working at all state correctional facilities who regularly interact with prisoners. We also surveyed adult prisoners in Level 3 or higher custody prison settings (including Shakopee). For details on both surveys, see the Appendix.
Staff and some prisoners we interviewed told us that prisoners often fear retaliation if they tell staff about violence between prisoners. Twenty-two percent of prisoners—and 32 percent of prisoners at Level 4 facilities—we surveyed said they had kept quiet about someone else being hurt in the past six months. Among prisoners surveyed who said that reporting violence was risky, the vast majority of prisoners said it was risky because of threats from other prisoners. In one of our interviews, a prisoner told of an assault he witnessed some years ago while he was on a jogging track. No prison staff observed the attack, and the prisoner dared not report it for fear of being targeted himself. He continued to circle the track, repeatedly passing the victim, who was lying incapacitated nearby.

**RECOMMENDATION**

The Department of Corrections should transform how it gathers and uses data to assess and improve safety in prisons.

Consistent, accurate measurement of outcomes is necessary for improving performance. But DOC data are insufficient for counting, categorizing, and analyzing safety outcomes. The most comprehensive sources of data cannot be easily aggregated. The sources that can be easily aggregated either omit incidents or lack important detail, or both. None of the sources can be readily linked to the others. As we discuss in other sections of this report, DOC data are also insufficient for analyzing staffing levels, the frequency of structured programming activities, or the use of disciplinary sanctions.

However, we do not simply recommend that DOC gather more data. As we discuss in the next chapter, DOC has serious staffing challenges. It is not feasible for the department to add many more data recording and reporting tasks to the work its staff are already doing. Instead, we recommend that the department transform what it already does so that it obtains more useful information with less effort.

For example, one small piece of a larger reorganization of DOC processes could be to assign each violent event a unique code number. That code number could then be used in all incident reports related to that incident, the Incident Command System record of the staff response, the Office of Special Investigations review of the incident, the disciplinary records of each prisoner involved in the event, the medical records related to injuries sustained in the event, and so forth. Such linking together of different data sources would allow DOC to address important questions that cannot currently be answered.

DOC should also seek to simplify or automate its internal reporting processes, many of which make little use of modern technology. For example, in Chapter 4, we describe the limitations of DOC data to show where prisoners have been—whether or not prisoners assigned to treatment programs or employment actually participated, or whether prisoners served their full disciplinary sentences in restrictive housing. DOC could investigate the possibility of having prisoners wear scannable badges, so that as prisoners move from unit to unit, a record of where they go and what they are doing is automatically created. DOC could also explore the possibility of staff using speech-to-
text technology to create incident reports. Using such technology could allow officers to compose reports while remaining at their posts and continuing to monitor prisoners, instead of writing reports later.

The ideas above are intended to be illustrative. Having focused primarily on safety issues in this evaluation, we do not have a comprehensive understanding of DOC’s data needs or its available technical resources. DOC is currently developing a department-wide strategic plan to address major areas of concern. We recommend that DOC add a component to this plan focused on understanding its long-term data needs and transforming its processes to produce better data with minimal additional effort by prison staff.

**Performance Reports**

State law requires DOC to publish performance reports every two years to provide information about state prisons to the Legislature.\(^8\) The 2018 report presented a wide range of information, including recidivism rates, affirmative action hiring performance, and per diem costs of housing an adult prisoner.\(^9\) As we noted in Chapter 1, the law does not explicitly require any specific safety information to be in these reports. DOC has included some information in these reports on violence levels in prisons, but that information is incomplete.

**The Department of Corrections’ biennial performance reports underreport the amount of violence between prisoners.**

DOC’s performance reports list prisoners’ disciplinary convictions for assaulting other prisoners and for assaulting staff. However, DOC does not report disciplinary convictions for physical fights between prisoners. By omitting fights between prisoners, these reports significantly underrepresent the true amount of violence that occurs between prisoners. In fiscal years 2016 through 2019, 3.1 times as many prisoners received disciplinary convictions for fighting other prisoners as for assaulting other prisoners.\(^10\)

The definitions of “fight” and “assault” in DOC’s disciplinary regulations overlap. The regulations define “fighting” as a prisoner engaging in a “physical struggle” with another prisoner, including “hitting, kicking, restraining or other wrongful physical contact.” “Assault” is defined as “harmful or offensive contact, and any act with intent to cause harmful or offensive contact.”\(^11\) Either charge can reflect a violent incident in

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\(^8\) Minnesota Statutes 2019, 241.016.


\(^10\) In DOC’s discipline data, a prisoner may have more than one disciplinary conviction listed in a single disciplinary report. Such data could indicate that multiple separate charges were addressed in a single process. But they could also indicate that two different penalties were given for the same conviction, and prison staff entered the same infraction twice in order to record both penalties. For the analyses in this chapter, we treat all convictions for the same prisoner from one disciplinary report to be a single disciplinary conviction.

\(^11\) Minnesota Department of Corrections, 2019 Offender Discipline Rules (St. Paul, 2019).
which prisoners were hurt. Which charge to use is a matter of judgment by DOC staff. For instance, a physical conflict with a clear winner and loser may lead to the winner being charged with assault. In a similar conflict without a clear winner or loser, both prisoners might be charged with fighting.

**RECOMMENDATION**

**Department of Corrections performance reports should include more complete data on violence in prisons.**

DOC’s biennial performance reports inform both the Legislature and the public about how safe state prisons are. Performance reports are the primary means by which DOC provides data on safety to the Legislature. In addition, media organizations have regularly used these same data to inform the public about the level of violence in prisons.

DOC performance reports should include disciplinary convictions for fights between prisoners. Including convictions for fights would reduce, but not fully eliminate, the underreporting of violence between prisoners.

We suggested above that DOC reorganize how it gathers and records much of its data. After that process is completed, DOC should examine whether it can report new forms of data that will provide additional useful information to the Legislature and the public. For example, DOC does not currently have the capability to provide to the Legislature data on the severity of injuries from violent incidents.

**Safety Outcomes**

In the following sections, we present the evidence that we could gather about DOC’s performance in protecting the safety of prisoners and staff. We explored four possible directions of conflict: prisoner-against-prisoner, prisoner-against-staff, staff-against-prisoner, and staff-against-staff. Our sources of data are different for each type of conflict; further, as we have discussed above, many of these sources are inconsistent or include some incidents and not others. While we are able to make broad generalizations about some aspects of violence in DOC prisons, much remains unknown.

We begin by briefly noting that very few data exist that permit comparisons between states. Based on the data that are available, Minnesota state prisons have relatively low levels of violence leading to deaths. Only a single prisoner in a Minnesota state prison died by homicide from 2001 through 2016. The rate of prisoner death by homicide in Minnesota state prisons over this period was less than one-fifth of the nationwide rate.

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12 2016 is the most recent year for which nationwide data are available.

Prisoner-against-Prisoner Conflicts

Conflicts between prisoners can arise from many sources, including cellmate disputes, gang rivalries, events occurring outside of prison, extortion schemes, gambling or other debts, illicit trading of pharmaceuticals, and substance abuse.

Conflicts between prisoners can also vary widely in severity. Some violence between prisoners has resulted in life-threatening injuries. In 2018, a prisoner at Stillwater sustained a collapsed lung as a result of an assault. At Lino Lakes in 2016, a prisoner-against-prisoner assault caused nose and orbital bone fractures requiring corrective surgery. On the other extreme, many scuffles between prisoners result in no injuries at all, or only bruises. Some staff we interviewed commented that prisoners sometimes provoke fights directly in front of officers so that they will be separated quickly and avoid injury.

Incidents leading to serious injuries are more common at higher security level prisons. OSI conducted more investigations of prisoner-against-prisoner violence leading to the hospitalization of a prisoner at Level 4 (Rush City, St. Cloud, and Stillwater) and Level 5 (Oak Park Heights) correctional facilities than at lower level prisons (see table above).

Although data are incomplete, prisoner-against-prisoner violence appears to have gradually decreased from fiscal years 2016 through 2019.

Most of the available data show a slight downward trend in conflicts between prisoners from fiscal years 2016 through 2019. There were 547 prisoner disciplinary convictions for assaults of other prisoners in Fiscal Year 2016, and only 461 for assaults in Fiscal Year 2019, as shown in the chart on the next page. Within these, convictions for assaults causing “bodily harm” also decreased from 94 to 85. Convictions for fighting fell from 1,477 to 1,390.

14 Investigations that could not determine whether an alleged violent event occurred are omitted from the table. According to the OSI director, the higher number of investigations at the juvenile correctional facility at Red Wing is likely due to unique characteristics of that facility. For example, Red Wing has a higher staff-to-prisoner ratio than other DOC prisons, so staff are more likely to observe violence when it occurs. Additionally, Red Wing’s unique reporting requirements mean that OSI is more likely to investigate incidents that are observed.

15 Disciplinary convictions reflect an internal administrative disciplinary process. They are not convictions in a court of law. Disciplinary charges against juvenile prisoners are recorded in a separate system, and are omitted from our analysis of discipline data in this report.

16 Within DOC’s internal disciplinary system, “assault” and “assault with bodily harm” are distinct charges. DOC prisoner disciplinary regulations define “bodily harm” as “physical pain, injury, illness or any impairment of physical condition.”
The number of prisoner-against-prisoner conflicts investigated by the Office of Special Investigation, which tend to be cases involving more serious injury, also declined during the same period. OSI investigations of conflicts between prisoners dropped from 99 cases in Fiscal Year 2016 to 52 in Fiscal Year 2019.\footnote{17} The number of cases resulting in hospitalization also decreased, though at a slower rate.

On the other hand, prisoners’ convictions for nonviolent offenses that could affect safety showed mixed trends between fiscal years 2016 and 2019. Disorderly conduct convictions fell from 7,286 to 5,548, while convictions for threatening others increased from 519 to 763.\footnote{18}

Most allegations of sexual assault among prisoners have led to inconclusive findings.

The Office of Special Investigations reviewed 86 allegations of sexual assault between prisoners from fiscal years 2016 through 2019, but it usually did not have enough evidence to determine the allegations’ credibility. In 57 cases (66 percent), the investigations were inconclusive. In the cases where OSI could make a determination, it substantiated allegations in 19 cases and refuted them in 10. In the vast majority (78 percent) of sexual assault cases investigated by OSI, the assault was alleged to have occurred in a living unit.

According to national data reported to the Bureau of Justice Statistics, the 2012 publication of federal rules implementing the Prison Rape Elimination Act of 2003 coincided with a substantial increase in allegations of sexual victimization in prisons nationwide. Allegations nationwide nearly tripled from 2011 through 2015. Substantiated allegations also increased, though at a slower rate.\footnote{19}

\footnote{17} This statistic excludes cases where OSI could not determine whether an assault had occurred.
\footnote{18} Disciplinary data for disorderly conduct and threatening others do not distinguish between offenses against prisoners and offenses against staff.
Most prisoners feel somewhat safe in DOC prisons, despite believing that violence among prisoners occurs frequently.

In our survey of prisoners, 63 percent of prisoners reported that they generally felt “very safe” or “a little safe.” Only 33 percent felt “a little unsafe” or “very unsafe.” Generally, prisoners in Level 4 prison settings felt the most unsafe.\(^{20}\)

Even though most prisoners said they felt personally safe, many also believe that violence among prisoners occurs frequently. In our survey, 73 percent of prisoners reported that prisoners physically harm other prisoners either “sometimes” or “very often.” As with feelings of safety, these responses varied by prison. In Level 4 prisons, 83 percent of prisoners reported that prisoners physically harm other prisoners either “sometimes” or “very often.”

**Prisoner-against-Staff Conflicts**

Violence against staff is less common than violence among prisoners, but it can lead to tragedy. On July 18, 2018, Officer Joseph Gomm died after a prisoner allegedly attacked him with a hammer. A Washington County grand jury has indicted the prisoner on first-degree murder charges in the officer’s death.\(^{21}\) Prisoners have committed other severe assaults against DOC staff. In 2016, a Red Wing corrections officer sustained a head injury, including multiple broken bones, from a prisoner assault. In 2018, a prisoner at Stillwater attacked a staff person with a homemade shank, causing cuts to the chest, shoulder, and head.

**Physical Assault**

There were 489 prisoner disciplinary convictions for assaults on staff in fiscal years 2016 through 2019. These assaults varied widely in severity. Some assaults caused significant harm (such as those described above). But assault convictions can also reflect altercations that involve only minor contact such as pushing. Sometimes, prisoners assault staff by intentionally exposing them to prisoners’ bodily fluids. Most commonly, this exposure is via spitting, but there have also been cases of prisoners throwing urine and feces at staff.

Prisoners in two prisons—Oak Park Heights and Stillwater—accounted for more than half of the disciplinary convictions for assaults on staff in fiscal years 2016 through 2019. The number of convictions at Oak Park Heights was especially striking because it houses fewer prisoners than most DOC prisons. For all DOC adult prisons, there

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\(^{20}\) Minnesota prisons have designated security levels 2 through 5; several prisons house prisoners at more than one security level. For more on these levels, see Chapter 1.

were approximately 5 prisoner disciplinary convictions per 100 prisoners for assaults on staff during fiscal years 2016 through 2019. At Oak Park Heights, there were 38 convictions per 100 prisoners for assaults on staff over the same period.22

Attempting to count the number of assaults that resulted in significant staff injuries illustrates the lack of consistency among DOC’s data sources. For example, 85 of the 489 prisoner disciplinary convictions for assaults on staff in fiscal years 2016 through 2019 were for assaults causing “bodily harm.”23 Thirty-four (40 percent) of the convictions for assaults causing bodily harm occurred at Oak Park Heights, significantly more than any other prison. However OSI investigated 93 assaults on staff that caused injury in the same time period. Of these assaults, only 15 (16 percent) occurred at Oak Park Heights; 22 occurred at Stillwater.

Assaults on staff in higher security prisons spiked during calendar year 2018.

Although the recorded number of assaults on staff differs depending on the data source, all sources agree that there was a dramatic increase in assaults on staff in calendar year 2018.24 Prisoner disciplinary convictions for assaults on staff in 2018 were 33 percent higher than convictions for 2017 assaults (149, up from 112) due to steep increases at Level 4 and 5 facilities (shown in the chart at left).25 Convictions for assaults at Rush City and St. Cloud in 2018 were double those in 2017. Oak Park Heights and Stillwater increased 39 and 17 percent, respectively. By the first three months of calendar year 2019, convictions rates for assaults on staff had fallen to about half of the level they had reached at their peak.

Prisoner disciplinary convictions for assaults on staff causing bodily harm also increased. There were three disciplinary convictions for assaults on staff causing bodily harm in 2017 at Oak Park Heights. For the following calendar year, there were 25. Minnesota’s Level 4 prisons also recorded increases in convictions for assaults on staff causing bodily harm, though their increases were not as dramatic.

22 We calculated these rates using facilities’ prisoner populations as of July 1, 2018.

23 DOC disciplinary regulations define bodily harm as “physical pain, injury, illness, or any impairment of physical condition.” “Assault with bodily harm” is a separate disciplinary conviction from “assault,” with more severe penalties.

24 Although we analyze data by fiscal years throughout most of this report, we use calendar years in this section because the spike occurred both before and after July 1, 2018.

25 The quarters shown in the chart reflect the dates when the assaults occurred, not the dates when the disciplinary convictions were handed down.
Workers’ compensation and OSI data also show an increase in violence by prisoners against staff in calendar year 2018. More workers’ compensation claims were paid for staff involvement in violent altercations in the first and third quarters of 2018 than were paid in any other quarters from January 2017 through June 2019, as shown in the chart at left.\textsuperscript{26} OSI investigated more cases of assaults on staff, assaults on staff causing injury, and assaults on staff requiring hospitalization in 2018 than in 2017.

**Violence against prisoners occurs more often than violence against staff.**

Comparisons between assaults on staff and assaults on prisoners are problematic because of reporting differences. For example, shoving any DOC staff person will almost certainly result in an Incident Command System activation and disciplinary sentence. However, staff may not even see a prisoner push another prisoner.

Even given these reporting discrepancies, both Incident Command System and prisoner discipline data show significantly more prisoner-against-prisoner violence than prisoner-against-staff violence. In fiscal years 2016 through 2019, only 7 percent of Incident Command System activations for violent incidents were for violence against staff. Over the same period, 5 percent of prisoner disciplinary convictions for fights and assaults were for violence against staff.

**Sexual Offenses**

Available data indicates that sexual assault of staff by prisoners is rare. The Office of Special Investigations reviewed only five cases of prisoners sexually assaulting staff in fiscal years 2016 through 2019. All five of these cases were for male prisoners inappropriately touching female staff. However, while sexual assault may be rare, sexual offenses are not.

\textsuperscript{26} As with the previous chart, the quarters shown reflect the dates of the incidents.
In some prisons, female staff endure repeated sexual offenses by male prisoners, often without appropriate support from supervisors and colleagues.

During our site visits, staff at Oak Park Heights, Rush City, and Stillwater told us that female staff are regularly the targets of sexual offenses by prisoners. Some prisoners “constantly” catcall at female staff, verbally threaten them with sexual assault, or masturbate in front of them. Prisoners especially target new female officers for this abuse, though experienced officers and nonuniformed staff also reported encountering such behavior. A lieutenant told us that the sexual offenses new female officers endure are “just horrible.”

In our site visit interviews, we were told that female staff often do not receive support from their supervisors or fellow staff when prisoners verbally harass them or masturbate in front of them. One staff person told us that staff will sometimes be blamed for prisoner misconduct based on what they wear to work. At one correctional facility, a staff person told us that female staff are simply expected to deal with masturbating prisoners. At another prison, a staff person told us that masturbation is not “taken as seriously as it should be” at their prison. Another staff person related that a fellow officer was asked to “prove” that a prisoner had been masturbating in front of her by describing his private parts. Staff also told us that prisoners that participate in this behavior frequently receive no formal disciplinary consequences.

Department of Corrections discipline data do not distinguish sexual misconduct against staff from other infractions.

It is difficult to tell how often prisoners are charged with sexual offenses against staff, because these offenses are categorized together with other offenses in discipline data. DOC charges sexual harassment against staff as “Abuse/Harassment.” This charge also includes convictions for nonsexual verbal abuse—such as name-calling or cursing—against staff or other prisoners. DOC charges masturbating in front of staff and indecent exposure as “Sexual Behavior.” This charge also includes consensual sexual activity between prisoners. “Abuse/Harassment” and “Sexual Behavior” are both Level 1 violations—the least severe of DOC’s five levels of prisoner misconduct.

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27 It is possible that these offenses occur at other prisons as well. We conducted detailed interviews with multiple staff groups at only four DOC prisons: Oak Park Heights, Rush City, St. Cloud, and Stillwater. We did not ask specifically about this issue at St. Cloud, which was the first of these four prisons we visited.
RECOMMENDATIONS

The Department of Corrections should:

- Ensure supervisors take action when prisoners commit sexual misconduct against staff.
- Distinguish disciplinary charges for prisoners’ sexual misconduct against staff from other infractions.

DOC should ensure that supervisors take sexual offenses against staff seriously. Expecting staff to simply tolerate such offenses is unacceptable. When these offenses occur, staff should feel empowered to report prisoners’ actions with the knowledge that they will receive support from their supervisors for pressing disciplinary charges or taking other appropriate action. To this end, DOC should strengthen its protocols and policies regarding response to allegations of sexual offenses against staff, and consider training supervisors in responding to such sexual offenses.

DOC should also update its disciplinary regulations to categorize sexual offenses against staff—especially indecent exposure and masturbation—separately from other types of offenses. Doing so will allow DOC to track how often these offenses occur, which prisoners most frequently commit them, and how prison disciplinary units respond. Having data on these offenses will allow DOC to better address them and better support staff who experience them.

Perceptions of Safety

Staff’s perceptions of safety vary widely across DOC’s prisons, according to our survey results.

Staff at higher custody level prisons reported feeling less safe than staff at lower custody levels.

Based on our survey, feelings of safety among staff decrease as custody level increases. At the highest custody level, a majority of staff felt at least a little unsafe (see box on the next page).

At all custody levels, nonuniformed staff were more likely to say they felt safe than uniformed staff. Seventy-five percent of nonuniformed staff surveyed said they felt “Very safe,” “Safe,” or “A little safe,” compared with only 56 percent of uniformed staff.

Although available data indicate that violence against staff has decreased since the spike in assaults on staff in 2018, many staff believe that safety has continued to get

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28 In some instances, sexually offensive behavior may be a manifestation of mental illness; if so, DOC should pursue a therapeutic response rather than a disciplinary one. But it should respond.

29 As was noted in Chapter 1, “uniformed staff” refers to security staff—corrections officers, lieutenants, and captains. All other prison staff are considered nonuniformed staff.
worse. In our survey of DOC prison staff, one in three respondents said that staff were
less safe than they were a year earlier, while only one in six said staff were safer.
Thirty-nine percent of staff at Level 4 prisons, and 55 percent of staff at Level 5 (Oak
Park Heights), said they were less safe than they were a year earlier.

Staff-against-Prisoner Conflicts

Physical assault of prisoners by staff seems to be uncommon. However, other forms of
staff misconduct against prisoners can adversely affect safety of both prisoners and staff.

Incidents of staff assaulting prisoners have occurred, but appear to be far
less prevalent than other types of violence.

DOC had few documented cases of staff-against-prisoner physical assault. Staff
discipline data showed that DOC substantiated 157 cases of hostile staff misconduct
against prisoners in fiscal years 2016 through 2019. The majority of these cases
involved staff calling prisoners names or making other inappropriate verbal comments.
Only 27 of these cases involved physical mistreatment of prisoners. Forms of
mistreatment included, for example, leaving prisoners in restraints too long,
inappropriate physical searches, and improper use of force when intervening in an
ongoing conflict. Over the same period, OSI investigation records show 12
substantiated instances of inappropriate staff-against-prisoner violence.

30 We conducted our survey in October 2019.
31 These cases reflect 21 different incidents; some instances led to disciplinary actions against multiple
staff.
32 In addition, OSI investigated two cases of staff-against-prisoner violence for which we could not
determine whether DOC considered the use of force appropriate.
DOC also identified a small but significant number of cases where staff had inappropriate sexual interactions with prisoners. Staff discipline data included 18 substantiated cases of either intimate communication or sexual contact between staff members and prisoners in fiscal years 2016 through 2019. State law protects prisoners as a vulnerable population, so any physical sexual contact between a prisoner and DOC staff is criminal sexual conduct, regardless of consent.\(^{33}\) Over the same period, OSI investigated 40 allegations of sexual contact between staff and prisoners within state prisons. Of these, OSI found 12 to be credible.\(^{34}\)

Prisoners alleged some physical abuse by staff. In our survey, 37 percent of prisoners said that officers or other staff physically harm prisoners “sometimes” or “very often.” Prisoners at Level 4 and 5 prisons were more likely to allege that staff physically harm prisoners (see box below).

![Prisoner survey results:](image)

However, physical harm by staff does not seem to be one of prisoners’ most important safety concerns. In our survey of prisoners, 217 prisoners responded to the open-ended question, “What would you change to make prisoners safer?” Of these, only one response included concerns about staff assaulting prisoners. Far more prisoners offered suggestions aimed at reducing violence instigated by prisoners, such as separating incompatible prisoners or providing more activities.

In our interviews, prisoners were more likely to complain about staff actions that indirectly affected prisoners’ safety than about direct physical abuse. For example, some prisoners told us that some staff will label prisoners as informants. This label, whether accurate or not, puts a prisoner at risk of assault from other prisoners. Prisoners also told us that some staff provoke prisoners in various ways.\(^{35}\) The provoked prisoners may take their frustration out by assaulting staff or other prisoners.

\(^{33}\) *Minnesota Statutes* 2019, 609.345.

\(^{34}\) Among the other cases, 19 were determined to be unfounded and 9 had inconclusive findings.

\(^{35}\) Some DOC staff members also expressed this concern, saying they felt less safe working with corrections officers who were bad communicators.
Staff-against-Staff Conflicts

We found little evidence of physical or sexual assault between staff occurring at prisons. In fiscal years 2016 through 2019, the Office of Special Investigations reviewed only one case of staff-against-staff violence inside a state prison, a case in which one staff person punched another staff person. We did, however, find concerning trends of bullying and harassment between staff, which we talk about in more detail in Chapter 3.
Chapter 3: Staff Management

In this chapter, we examine the challenges that prison administrators face in managing staff to address safety and security needs. We begin by discussing the difficulties some prisons have faced in maintaining sufficient staffing levels and their heavy use of overtime to address understaffing. We then raise some concerns about how prisons distribute officers to posts within correctional facilities. We discuss concerning levels of bullying and harassment among Department of Corrections (DOC) staff. Lastly, we examine the frequency of staff training.

The chapter’s first three sections focus mostly on corrections officers, the staff primarily responsible for protecting the safety of prison residents, employees, and visitors. As we noted in Chapter 1, security staff make up over half of all prison employees, dwarfing the numbers in other employee categories.

DOC organizes its security staff hierarchically, by ranks. New officers hold the position of “Correction Officer 1” until they can advance to “Correction Officer 2,” which is the rank held by most officers. DOC promotes some officers to the rank of sergeant (“Correction Officer 3”), a senior officer position entrusted with greater responsibility and leadership. A relatively small number of lieutenants supervise officers, and one or two captains at each prison manage the entire security staff.

Key Findings in This Chapter

- Several prisons have experienced chronic shortages of corrections officers.
- The use of overtime by corrections officers almost quadrupled between Fiscal Year 2013 and Fiscal Year 2019.
- Although the Department of Corrections considers understaffing and the use of forced overtime to be crucial problems, it does not track the extent to which they occur.
- Although fights and assaults occur disproportionately in living units, prisons limit the number of officers working in them.
- Bullying and harassment between staff is a pervasive issue in Department of Corrections prisons.

Staffing Shortages

As we discussed briefly in Chapter 1, the amount of security staffing required to operate a correctional facility varies from one facility to another due to many factors, including the facility layout and infrastructure, the custody level of the prisoners, and the services and programming provided at each prison. Further, ensuring safety is an almost limitless task; even doubling the number of security staff at state prisons might not be

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1 In addition to security staff, each prison also has a safety coordinator whose mission is to limit occupational injuries to staff and prisoners, such as injuries from falls or misuse of tools. However, our evaluation focused on safety related to interpersonal conflicts, which is an area more directly addressed by security staff.

2 When first hired, officers hold the position of “Trainee” while they are completing their initial training.
sufficient to eliminate all interpersonal violence. Nonetheless, the available evidence suggests that many prisons have not had enough security staff.

Several prisons have experienced chronic shortages of corrections officers.

Prison leaders use two key types of corrections officer staffing targets: a broad budgetary target set by the DOC central office, and specific daily shift targets set by each prison. Some prisons consistently fell below both targets in Fiscal Year 2019.

The different targets are related, but have different purposes. The central office target is the total number of corrections officers budgetarily allocated to a facility. For example, the budgetary allocation to the Stillwater correctional facility for Fiscal Year 2019 was 314 corrections officers. The facility was expected to use that total number of employees to staff the facility during all shifts, taking into account expected vacation, sick, and other leaves, as well as other reasons an officer might be away from the facility (for example, to participate in training).

As can be seen in the table at right, several prisons averaged corrections officer numbers well below their targets during Fiscal Year 2019. Stillwater averaged more than 25 fewer full-time equivalent (FTE) corrections officers than the 314 FTEs it was budgeted for during Fiscal Year 2019. Averaging across the entire year masks the severe difficulties Stillwater faced late in Fiscal Year 2019; its staffing deficit dropped to more than 30 full-time equivalents below its budgetary target in May, and more than 40 below the target in June.

Although each prison has its own unique circumstances, staffing challenges at several prisons grew during Fiscal Year 2019 due to an increase in staff departures. DOC recruited a similar number of new officers in Fiscal Year 2019 as it had in previous years, but those staff were not enough to fill the increased vacancies. A few prisons had particularly large increases in staff departures. According to DOC human resources reports, after averaging an annual turnover rate of 11.2 percent among all staff in fiscal years 2014 through 2018, Oak Park Heights lost 17.7 percent of its staff in Fiscal Year 2019. Similarly, Stillwater

<table>
<thead>
<tr>
<th>Correctional Facility</th>
<th>Budgetary Target</th>
<th>Average Compared to Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillwater</td>
<td>314.0</td>
<td>-25.4</td>
</tr>
<tr>
<td>Faribault</td>
<td>331.0</td>
<td>-20.0</td>
</tr>
<tr>
<td>Oak Park Heights</td>
<td>213.0</td>
<td>-13.2</td>
</tr>
<tr>
<td>Lino Lakes</td>
<td>241.0</td>
<td>-8.9</td>
</tr>
<tr>
<td>Rush City</td>
<td>197.0</td>
<td>-8.4</td>
</tr>
<tr>
<td>Moose Lake</td>
<td>208.0</td>
<td>-7.6</td>
</tr>
<tr>
<td>Shakopee</td>
<td>130.0</td>
<td>-4.2</td>
</tr>
<tr>
<td>Willow River</td>
<td>30.0</td>
<td>-2.9</td>
</tr>
<tr>
<td>St. Cloud</td>
<td>228.0</td>
<td>-2.6</td>
</tr>
<tr>
<td>Tojo</td>
<td>27.5</td>
<td>-0.0</td>
</tr>
<tr>
<td>Red Wing</td>
<td>94.0</td>
<td>+0.2</td>
</tr>
</tbody>
</table>

The table, which is drawn from state payroll data, counts all regular work and regular leave hours but excludes overtime and compensatory time worked. We assumed that 1 FTE = 80 hours of work in a two-week pay period.
jumped to 15.1 percent turnover in Fiscal Year 2019 after averaging 9.9 percent per year over the previous five years.\textsuperscript{4}

Beyond a prison’s overall budgetary target, each prison sets specific corrections officer staffing targets for each shift.\textsuperscript{5} These staffing targets specify how many officers should be \textit{on duty} in the facility during that shift. For example, in November 2019, Stillwater had a minimum target of 60 corrections officers on duty during the afternoon/evening shift on Mondays and 66 on Thursdays.\textsuperscript{6}

A prison may be at its overall budgetary target but still fall below its staffing target for an individual shift; conversely, a prison below its overall budgetary target could still have a full complement of officers report for an individual shift. (However, the farther a prison falls below its budgetary target for corrections officers, the more likely it is to have shift shortages.)

Ninety-one percent of DOC prison staff responding to our survey said that staff shortages occurred frequently at the prisons where they work, including both prisons operating at and below their budgetary staffing targets.\textsuperscript{7} Administrators at several prisons told us that they frequently (at some prisons, almost daily) did not have enough corrections officers working to meet shift staffing targets without using overtime.

However, DOC does not track how often shift-level staff shortages occur in a consistent fashion across prisons. We were unable to use state payroll data to measure how frequently shift shortages occur, due to lack of information in the data about (1) which shift employees worked, and (2) whether employees worked off-site (for example, monitoring a prisoner during a hospital stay).

\textbf{The Department of Corrections analyzed its corrections officer needs in 2015, but the implications of the analysis for safety were unclear.}

Neither the overall budgetary targets nor the shift-level targets have been based on formal assessments of the number of officers needed to safely operate the state’s correctional facilities. Instead, they have reflected a series of broad judgments by DOC leadership over time about how best to distribute limited resources.

\textsuperscript{4} We show the impact of turnover using \textit{overall} staff departures rather than corrections officer departures because officers often transfer or are promoted to other positions. The number of corrections officers leaving DOC increased only slightly in 2019, but that figure omits those that stopped being officers because they accepted other positions within DOC.

\textsuperscript{5} All DOC prisons have three corrections officer staffing shifts: an overnight shift (called “first watch”), a morning/early afternoon shift (“second watch”), and an afternoon/evening shift (“third watch”). Some officers work special schedules that combine portions of two different shifts.

\textsuperscript{6} More officers are needed on Thursdays than Mondays because Stillwater allows visiting on Thursdays.

\textsuperscript{7} We surveyed staff working at all state correctional facilities who regularly interact with prisoners. For details, see the Appendix.
In 2015, DOC conducted an analysis of corrections officer staffing at its prisons, using a process based on recommendations from the National Institute of Corrections in the U.S. Department of Justice. 8 This effort was the first time the department had formally analyzed its staffing, and it has not repeated the process since. Looking at officer posts on a shift-by-shift basis, the project teams conducting the analysis identified 77 additional full-time positions that should be added, compared with only 13 existing full-time positions that could be eliminated. The teams further identified 36 locations where additional help was needed for part of a shift, and 17 locations where officers could be spared for part of a shift. 9 According to DOC senior leadership, the department was unable to add most of the additional positions recommended by the staffing analysis prior to Fiscal Year 2020 due to budgetary constraints. 10

Although the analysis took safety needs into account, protecting safety was not the only objective of the analysis. According to a key member of the DOC project team, the template the staffing analysis used to assess officer needs was based primarily on the tasks assigned to each post. In some instances, recommended changes were directly tied to providing additional safety in the analyzed prison location, but in other instances they were not. A recommendation to add an officer to a health services area, for example, could reflect that the security staff currently assigned to that area simply had more tasks to accomplish than time available. It did not necessarily indicate that the area was less safe than it should be. As a result, it is difficult to use the staffing analysis to draw a direct link between adding staff and increasing safety.

However, when officers can better meet their responsibilities in any location, a prison’s overall level of safety should increase. For example, one important task of officers in some prison health services areas is to ensure that prisoners immediately swallow any medication they receive so they are less able to smuggle it out and sell it to others. Reducing the amount of drugs illicitly traded among prisoners would increase the overall safety of the prison, even if adding an officer would have a minimal impact on the safety of the health services area itself.


9 The totals we present likely undercount the true totals. Two teams examined each prison’s staffing needs: a DOC-wide team that visited all prisons and a local team comprising staff from each prison. The DOC-wide team analyzed a limited number of posts in each prison, while the local team examined more. The teams sometimes had overlapping recommendations for the same posts. The totals presented in this paragraph assume that all recommendations overlapped. For example, at Shakopee, the local team recommended four additional officers and the DOC-wide team recommended one. The total could be five or four, depending on whether the recommendations overlapped. We used four in creating our total.

10 The Legislature increased funding for DOC in fiscal years 2020 and 2021 to hire additional corrections officers. Laws of Minnesota 2019, First Special Session, chapter 5, art. 1, sec. 15, subd. 2. However, due to recruitment and retention difficulties, the department was not able to immediately increase its staffing levels at the start of the 2020 fiscal year.
Staffing shortages have strained corrections officers’ efforts to ensure safety in state prisons.

Line staff, administrators, and some prisoners agreed that staffing shortages reduce the overall safety level for both staff and prisoners. Large majorities of staff said that staffing shortages created safety challenges for both staff and prisoners, as shown in the box at right. In our interviews at Level 4 and Level 5 correctional facilities, administrators and line staff described a variety of security concerns caused by understaffing. Examples included:

- Security officers working alone or in small numbers in settings with many prisoners.
- Lack of time to perform routine security-related tasks, such as searching cells for weapons, liquor, or drugs.
- Inability to effectively monitor prisoners to ensure they do not enter prohibited areas, especially other prisoners’ cells.
- Lack of time to write reports citing prisoners for infractions, meaning that DOC has no record of the infractions and prisoners receive no disciplinary sanctions.
- Reduced ability to build relationships and develop trust with prisoners that may forestall future conflicts.
- Increased tensions among prisoners caused by more frequent confinement to cells.

In interviews, several prisoners also suggested that prisons would be safer if there were more officers. When we asked one group of prisoners what changes could be made to increase safety at the prison, one prisoner immediately responded “you can’t go wrong with more staff.” He commented that staff are so overworked that they allow prisoners to commit infractions without consequences, and that tightening discipline would make the prison safer.

However, other prisoners were more doubtful that increases in staffing would lead to more safety. In our survey of prisoners, for example, opinions varied widely. Those responding to our survey were almost evenly divided between agreeing, disagreeing, and selecting “neither agree nor disagree” for the statements, “Adding more officers would make the prison safer for prisoners” and “Adding more officers would make the prison safer for officers and other staff.”

Staff Survey Results

“When staffing shortages occur, staff at this prison are less safe.”

- Strongly agree: 72%
- Agree: 18%

“When staffing shortages occur, prisoners at this prison are less safe.”

- Strongly agree: 59%
- Agree: 22%

11 We surveyed adult prisoners in medium custody or higher custody prison settings (including Shakopee). For details, see the Appendix.
Due to staffing shortages, some prisons frequently operate with the minimum number of staff that administrators believe they need to run the correctional facility. In other words, a facility will not replace every missing officer using overtime, but will instead ensure that the most critical posts are filled. However, operating at minimum levels creates safety concerns whenever unplanned events occur because prison administrators must reallocate staff to address the unforeseen event.

For example, one frequent challenge is escorting prisoners to outside medical appointments, which are often arranged with just a few days’ notice and require two corrections officers per prisoner. According to DOC records, Faribault, Shakopee, and Stillwater averaged more than one outside medical appointment per day during Fiscal Year 2019. Oak Park Heights averaged more than two and a half appointments per day. When a correctional facility already operating at minimum levels must devote two corrections officers to a medical escort, administrators must figure out how to operate with less staff than the minimum.

Another challenge is dealing with prisoner misbehavior. For example, if a prisoner is caught with drugs or alcohol, then corrections officers search the prisoner’s cell for additional contraband, pack up possessions (because the prisoner is usually sent immediately to restrictive housing), and write reports. No additional officers are assigned to a living unit while these tasks are done; instead, fewer officers are actively monitoring prisoners.

According to staff we interviewed, some prisons dealing with staffing shortages commonly use “A-Team” members, who are responsible for responding to emergencies, to cover other posts. Such staff are essentially working two positions at once, both monitoring prisoners at a specific location in the prison and responding to any crisis that might arise. When emergencies happen, these staff must either immediately leave their posts to respond, or delay responding until they can be relieved; either can create safety concerns. Most prisons average one to three A-Team activations per day.

In one of our interviews, an officer described the experience of staffing a dining area in a Level 4 prison when other officers working in the area were on the A-Team. She said that when an emergency alert occurred, all of the other staff left to respond, leaving her alone in the dining room with a large number of prisoners.

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12 Routine medical care is provided by prison health services staff. But prisoners needing to see specialists, such as oncologists or dermatologists, ordinarily travel outside the prison to do so. For some high-risk prisoners, prisons assign three officers for medical escorts.

13 DOC routinely transfers prisoners with serious medical conditions to Oak Park Heights because it has an infirmary unit designed to accommodate prisoners requiring extra medical care.

14 As we explained in Chapter 1, restrictive housing units are locations where prisons isolate prisoners away from the general prison population as discipline for misconduct or to increase safety.

15 This statistic refers to activations of the Incident Command System, which we described in Chapter 2. A-Team members ordinarily respond whenever the Incident Command System is activated, although other staff (such as health services staff or maintenance staff) might also participate in the response depending on the nature of the incident.
During our interviews at Level 4 and Level 5 prisons, a few officers noted that our visit itself strained staffing resources. One officer commented that in order for her to participate in the interview, she had been replaced in a restrictive housing unit by a trainee officer who had not yet been issued chemical irritant for controlling prisoners when needed. She said that assigning an officer with limited experience and insufficient equipment to work in that environment “should never happen.” A second officer in the interview session added that such substitutions were commonplace because of staffing shortages.

**RECOMMENDATION**

*Particularly at higher security prisons, the Department of Corrections should establish higher shift staffing targets for corrections officers to accommodate unplanned events.*

Prisons set minimum officer staffing targets that under ordinary circumstances provide enough staff to accomplish the tasks that must be done—counting and feeding prisoners, providing security for needed medical care, and allowing some time out of cells. However, these minimum levels leave no slack for unplanned events that pull officers away from their posts. Such unplanned events actually occur regularly, stretching officers in too many directions at once and leaving security gaps that create hazards for both prisoners and staff. Minimum shift staffing targets should be increased to ensure that there are sufficient officers to deal with such common “unplanned” events.

We make this recommendation with the understanding that some correctional facilities cannot meet even their current minimum targets for some shifts. Raising those minimum targets will not immediately increase the number of officers working for DOC. However, it is important that the minimum shift targets truly reflect the minimum staffing needs for each facility.

**RECOMMENDATION**

*The Department of Corrections should continue its efforts to hire more corrections officers.*

DOC has persistently been unable to hire enough officers to keep up with its turnover rates. We did not examine DOC’s recruitment and hiring processes, so we do not have recommendations for how the department might improve them. However, we are aware that DOC has recently taken a number of steps to increase recruitment and retention, including creating part-time officer positions and increasing the starting salary of corrections officers. Because we believe that sufficient staffing is directly related to safety for both staff and prisoners, we encourage the department to continue its efforts.
Overtime

Prisons that do not have enough available corrections officers for a shift must rely on staff to work overtime. In general, when a correctional facility needs officers to work overtime, it first solicits volunteers. If there are not enough volunteers, prison administrators have two choices: (1) they can operate with fewer staff, either by closing down some services or by providing services with lower numbers of staff; or (2) they can require (or “force”) some officers to work overtime even though they have not volunteered. When prisons are severely short-staffed, administrators may make both choices.

The use of overtime by corrections officers almost quadrupled between Fiscal Year 2013 and Fiscal Year 2019.

As can be seen in the table at right, prisons have been using increasing amounts of overtime—with a large increase in Fiscal Year 2019—even as the total number of hours worked has remained flat. All prisons have used overtime work to operate, but some use much more than others. At Oak Park Heights, Shakopee, and Stillwater, for example, approximately 10 percent of the total hours worked in Fiscal Year 2019 were overtime hours. Conversely, only 2 percent of the total hours worked were overtime at Red Wing and Togo.

Overtime work is also not evenly distributed among corrections officers. During the last quarter of Fiscal Year 2019, 28 percent of officers did not work any overtime hours, while 13 percent of officers worked at least 80 hours of overtime.

In our survey of staff, 76 percent of corrections officers who started work in the past three years reported that they had been forced to work overtime in the previous six months. Only 8 percent of officers with 15 or more years of experience said they had been forced in the same time period. Seniority heavily influences who works overtime hours. Officers with the most seniority have the first opportunity to volunteer for available overtime hours, regardless of how many hours they have worked recently. But if prison administrators force officers to work overtime, they contractually must force those with the least seniority first (except that an employee may not be forced more than once every five calendar days).

In Thousands

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Overtime Hours</th>
<th>Total Hours Worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>61</td>
<td>3,403</td>
</tr>
<tr>
<td>2014</td>
<td>74</td>
<td>3,448</td>
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<td>3,468</td>
</tr>
<tr>
<td>2019</td>
<td>236</td>
<td>3,483</td>
</tr>
</tbody>
</table>

16 The table represents the hours worked in all pay periods that ended during that fiscal year. Because pay periods are 14 days long, they do not exactly fit within a 365-day year. Fiscal Year 2015 had one more pay period than other years.
Administrators and staff agree that the constant use of overtime threatens staff and prisoner safety.

In our interviews with administrators, supervisors, and line staff, many stated that the increasing use of overtime has decreased safety in prisons both directly and indirectly. Officers who are tired may be less alert and more likely to miss warning signs of impending trouble or attempts to smuggle contraband. Staff told us that they do not have confidence that tired officers will be able to effectively support their coworkers in an emergency situation. Further, officers working overtime shifts can be more short-tempered than they would be otherwise, making them more likely to unnecessarily create or escalate conflicts. Constant overtime use can also affect safety indirectly by affecting employee stress levels, mental health, and morale.

Staff expressed particular concern about the heavy use of forced overtime. In our survey of prison staff, 59 percent of staff agreed or strongly agreed that “staff working a lot of voluntary overtime are less effective at their jobs than those working regular shifts.” When asked about staff working a lot of forced overtime, 89 percent thought that the overtime reduced job performance.

Although we did not find studies examining the relationship between overtime work and safety in corrections, there have been studies of the relationship in other fields, particularly health care. In general, many academic studies have found that excessive overtime can negatively affect work performance and safety outcomes.17

Although the Department of Corrections considers understaffing and the use of forced overtime to be crucial problems, it does not track the extent to which they occur.

Senior DOC leaders consider staffing challenges to be among the most important problems facing the department. In addition to the direct effects of understaffing and extensive overtime on safety, administrators believe that staffing shortages have long-

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term negative effects on employee morale, motivation, and job loyalty. The current
department leadership has taken a number of steps to address staffing shortages.

Despite the concerns DOC leaders have regarding staffing shortages and forced
overtime, they have taken no steps to measure their extent. DOC does not record how
short-staffed its prisons are on a day-to-day basis nor how prisons change their activities
when short on staff.

The state’s payroll system records overtime hours, but it makes no distinction between
voluntary overtime and forced overtime, and DOC makes no effort to record this
information consistently in any other format. As with staffing shortages, the only
information DOC has about the extent of forced overtime is anecdotal or scattered
across numerous documents, and the department has no way of measuring whether its
use is increasing or decreasing over time.

Most DOC prisons record some limited information about forced and voluntary
overtime on daily reports. We collected a sample of these reports from the fall of 2018
through the summer of 2019. Based on the information available in these reports—
which varied from prison to prison—we estimate that department-wide, roughly 15 to
20 percent of the instances when officers worked overtime from October 2018 to
September 2019 were forced. However, we could not determine how many hours of
overtime were worked per instance, nor were we able to determine how often prisons
repeatedly forced the same officers to work overtime.

**RECOMMENDATION**

The Department of Corrections should track the extent of its understaffing
and use of forced overtime.

Shortages of corrections officers have clearly caused problems for DOC. However, the
lack of information about the scope of the shortages makes it difficult for DOC to
determine whether it is making progress or falling behind. It is also difficult to analyze
how much understaffing and forced overtime have affected staff or prisoner safety. Our
discussion above about the impacts of short staffing and forced overtime is based
almost entirely on the opinions of administrators, staff, and prisoners. Because DOC
does not collect sufficient data to analyze its activities, we cannot analyze whether more
violent incidents occur—or whether they cause more injuries—when prisons are
dealing with staffing challenges. DOC should be collecting information that would
enable it to examine such connections.

Beyond direct effects on safety, frequently working in understaffed situations or
working overtime may also influence staff morale and mental health. Better tracking of
staffing shortages and forced overtime could enable DOC to measure the extent to
which specific staff (for example, those with low seniority) are disproportionately
affected by stressful staffing situations.
Staffing Distribution

Prisons must constantly juggle their available staff to meet their needs, which change throughout the day as various activities begin and end. Several times during our prison tours we reencountered corrections officers whom we had met earlier in the day but had since shifted to different posts with different job responsibilities. While some staffing distributions made sense—for example, when no prisoners are in classes, there is no reason to station officers in the education area—others raised safety concerns.

Although fights and assaults occur disproportionately in living units, prisons limit the number of officers working in them.

Living units are the buildings or building wings that include prisoner cells and indoor common spaces. Common spaces usually include recreation areas and telephones; depending on the custody level of the prison, they may also include other amenities such as laundry machines, ice machines, microwave ovens, large screen televisions, exercise equipment, and “JPay” terminals. Corrections officers working in living units are usually stationed centrally and monitor prisoner activities both by direct sight and sound and by using video cameras. Officers periodically conduct “rounds,” in which they walk through the unit and briefly check on the welfare of the prisoners in each individual cell.

All of the data that we were able to analyze indicate that violent incidents occur more often in living units than any other location within a prison. In fiscal years 2016 through 2019, 52 percent of all violent events investigated by DOC’s Office of Special Investigations (OSI) occurred within living units, as shown in the table at right. During the same time period, 50 percent of staff workers’ compensation claims related to violence resulted from incidents in living units. In both data sources, the locations with the next highest number of incidents—restrictive housing units—had less than half as many violent incidents as living units.

In our surveys, staff and prisoners also identified living units as particularly dangerous areas of a prison. We asked both groups what the most dangerous areas of the prison were for both prisoners and staff. About one in three prisoners selected living units or cells as the most dangerous place for prisoners, and nearly as many chose living units or cells as the most dangerous places for staff as well. Less than 10 percent of prisoners chose dining areas—the next most-chosen location—as most dangerous. Similarly, in

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18 JPay computer terminals provide prisoners with extremely limited internet functionality, such as sending and receiving e-mail and video messages. All prisoner communications are subject to monitoring.

19 See Chapter 2 for a description of the Office of Special Investigations records we examined. In general, OSI investigates all assaults on staff and violent conflicts between prisoners where serious injuries occur. The table excludes investigations where OSI could not substantiate that any violent incident had occurred.
the staff survey, more than three times as many staff identified living units and cells as their prison’s most dangerous location than identified any other area.\textsuperscript{20}

Despite the evidence that strongly suggests most violence takes place in living units, DOC has not taken aggressive steps to increase corrections officer staffing in those units. In fact, our interviews suggest that prisons sometimes reduce staffing in living units to cover shortages elsewhere. Based on our observations and interviews during our site visits, medium security prisons often have only one or two corrections officers stationed in units housing dozens of prisoners. In higher security facilities, six or fewer officers might be assigned to monitor hundreds of prisoners in large cell blocks.

**RECOMMENDATION**

**Prisons should assign more officers to locations with higher levels of repeated violence and prevent those officers from being redirected to other priorities.**

Nearly everyone we spoke with agreed on a simple fact—the presence of staff makes everyone safer. Therefore, DOC should increase staffing numbers in areas shown to have higher numbers of fights and assaults. Available data clearly show those areas are currently living units. More officers should be placed there, even if that means fewer officers are stationed in other locations. Further, when shortages occur elsewhere in the prison, officers should be taken out of living units only when other options are exhausted.

We make this recommendation with the awareness that some staff may object that violence among prisoners will simply migrate to other locations—if officer staffing is increased in the living units at the expense of hallways, dining areas, industry workshops, educational classrooms, or health services, those other locations will become correspondingly less safe. We cannot discount this possibility.

However, in our view, decisions about the best use of scarce resources should be made based on good quality data about what has occurred, rather than speculation about what may occur. Officers and prisoners have been injured in living units—not in one or two isolated occurrences, but repeatedly. DOC should be directing more of its available resources to address this current, ongoing threat.

**Workplace Culture**

Correctional environments contain threats to safety that are not present in other workplaces. However, prison administrators and supervisors must also address employee management challenges that can occur in any workplace environment.

\textsuperscript{20} Combining responses from all prisons together masks particular concerns at individual prisons. For example, both prisoners and staff identified restrooms at Moose Lake and dining areas at St. Cloud as particularly dangerous locations for prisoners.
Bullying and harassment between staff is a pervasive issue in Department of Corrections prisons.

Although not a majority, a disturbingly large number of staff described unprofessional work relationships as an ongoing problem in DOC prisons. Overall, 32 percent of staff responding to our survey said that bullying and harassment were problems in the prisons where they worked. This sentiment was shared by staff across nearly all job categories—behavioral health, case management, education, food service, industry, maintenance, and security staff—and all age groups. Around 40 percent of both African American staff and female staff identified bullying and harassment as problems.

Our site visit conversations at individual prisons identified the same concerns. However, we found that staff had different experiences depending on their locations or staff roles. Some staff described a “good old boys’ club,” where social networks inside and outside of prison influenced how staff treated one another. Those well-connected in the networks would be treated favorably and those outside would be treated unfavorably. In other instances, staff described a top-down culture of bullying, where senior prison administrators established a culture in which supervisors belittled those below them or experienced officers hazed new hires. Yet other staff described sexual harassment by other staff, sometimes accentuated by supervisors’ lack of interest in
addressing sexual offenses against female staff by prisoners. In recent years, DOC has had the highest rate of sexual harassment complaints among large state agencies.\textsuperscript{21}

Many staff do not believe that their coworkers or supervisors take harassment seriously. Among staff who responded to our survey, 30 percent of women and 22 percent of men disagreed or strongly disagreed that corrections officers do all they can to reduce bullying and harassment between staff. Even more staff—42 percent of women and 30 percent of men—disagreed or strongly disagreed that prison administrators do all they can to reduce bullying and harassment between staff. For their part, some administrators acknowledged that they have sometimes had to address improper staff behavior, but also expressed frustrations that staff concerns did not always reach them and they were sometimes unaware of festering issues until a crisis occurred.

Bullying and harassment between staff is an issue at all Minnesota prisons, but appears to be a particular concern at Oak Park Heights. In our survey, Oak Park Heights had the highest percentage among all prisons of staff who agreed or strongly agreed that staff-on-staff bullying and harassment is a problem in their prison (50 percent). They also had the highest percentage of staff who disagreed or strongly disagreed that prison administrators do all they can to reduce bullying and harassment between staff (51 percent), and the highest percentage of staff who disagreed or strongly disagreed that they trust other staff to assist them if they are bullied or threatened (34 percent).

Some staff fear retaliation if they report harassment by other staff members.

In our site visit conversations, both line staff and prison administrators told us that reporting other staff for misconduct can lead to retaliatory bullying and harassment. Staff at multiple prisons told us that there are “no secrets” in prison, and employees who report on another staff person are nearly always identified by coworkers in a matter of days. In some instances, staff told us that direct supervisors have retaliated against staff they supervised for complaints they made.

One staff person told us of being ostracized by coworkers and threatened with disciplinary action by a supervisor after reporting on an officer who was intimately involved with a prisoner. Another told us of being retaliated against by A-Team members, who refused to respond when this staff member was working alone in a

\textsuperscript{21} See Minnesota Management and Budget, Sexual Harassment Prevention Policy and Procedures Report: Review and Recommendations (St. Paul, 2018), 5-6, https://mn.gov/mmb-stat/reports/2018/sexual-harassment-prevention-policy-and-procedures-report.pdf, accessed November 15, 2019. This report lists total sexual harassment complaints for each cabinet agency; we calculated the rate per 100 employees. DOC had 1.7 complaints per 100 employees from 2012 through 2017. The departments of Public Safety and Veterans Affairs had 1.1 complaints per 100 employees during the same time period; all other agencies with at least 500 employees had fewer than 1 complaint per 100 employees.
prisoner living unit and requested assistance. The staff member did not report the lack of response because of the fear of further retaliation. In our site visit interviews, several staff told us that they did not report (or would be reluctant to report) staff misconduct due to concerns about retaliation.  

RECOMMENDATION

The Department of Corrections should make greater efforts to address bullying, harassment, and retaliation among staff.

Large employers like DOC are likely to confront staff misconduct issues at least occasionally, simply due to the total number of staff they employ. However, the widespread nature of bullying and harassment problems within DOC is deeply concerning. Even at Red Wing—the prison where the fewest staff expressed concerns in our survey—one in five staff responding to our survey agreed or strongly agreed that staff-on-staff bullying and harassment was a problem.

Like all state agencies, DOC is responsible for implementing state policies to prevent harassment and promote respectful workplaces. DOC has developed its own policies to implement these statewide initiatives, delivered trainings to staff, and conducted investigations in response to complaints. But these steps appear to be insufficient. The department should explore additional strategies.

For example, the department could consider allowing anonymous reporting of bullying and harassment concerns. Under current departmental policies, any individual reporting harassing or discriminatory behavior must identify themselves. While it would be inappropriate to discipline an employee based solely on an anonymous report, such reports could prompt managers and supervisors to play closer attention to other signals that harassment is occurring.

The department could also consider taking steps to demonstrate that it does take action when it substantiates that bullying or harassment has occurred. The state’s Data

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22 This reluctance to report was not reflected in our staff survey; less than 10 percent of respondents agreed with the statement, “Sometimes, I do not report incidents of bullying or harassment between staff.” The discrepancy could be because the individuals we interviewed were not representative of all DOC staff. However, we think it is possible that we were better able to convey during interviews our office’s ability to protect the identity of respondents. (State law authorizes our office to protect the identity of any individual providing information to assist an audit or evaluation. Minnesota Statutes 2019, 3.979, subd. 3(c).) DOC can discipline staff for not reporting misconduct by other staff; if respondents believed that their survey responses might be shared with DOC, they may have been reluctant to mark “agree” or “strongly agree” for that statement. We received a few messages from staff telling us they would not complete our survey because they believed supervisors could discipline them for their responses.

Practices Act limits the information DOC can provide about any specific case.\textsuperscript{24} However, the department could report aggregate numbers to its employees on the number of investigations it conducted, the number of cases substantiated, and some information on the disciplinary sanctions it implemented.

Lastly, DOC could consider developing additional performance appraisal tools for those in management and supervisory positions that incorporate input from peers and from the staff they supervise. Various versions of such “360-degree assessments” are common in business and government sectors. Instituting such assessments may improve communication up and down the chain of command and provide additional incentives for supervisors to be responsive to the employees they supervise. DOC should explore whether successful models exist that have worked in correctional settings.

DOC has recently introduced several initiatives intended to address workplace culture concerns, most notably the creation of a new DOC Office of Professional Accountability. While this is a step in the right direction, it is too soon to evaluate the efficacy of these initiatives.

Training

Although we did not closely examine DOC’s staff training practices, we did ask staff and administrators about the quality and sufficiency of training during our site visits and in our survey.

DOC trains all new staff that will have regular contact with prisoners in an “academy” setting, where they undergo several weeks of full-day training sessions. After completion of the academy, they begin working at their job placements and receive additional training specific to the operations of that correctional facility. DOC requires all staff to repeat or update some training on an ongoing basis to refresh their skills or learn new procedures. Some training updates are “hands-on” training sessions that take place in a classroom (such as self-defense), while others are self-directed training modules delivered via computer (such as data privacy). Different positions have different training requirements.

During our site visits, some staff raised concerns about the quality of DOC’s academy training, but many more expressed dissatisfaction with ongoing training. These opinions were mirrored in our staff survey.

\textsuperscript{24} Minnesota Statutes 2019, 13.43, subds. 2(a)(4)-(5) and 4. In a 2018 report on preventing sexual harassment in state government, Minnesota Management and Budget suggested that the Legislature consider altering the Data Practices Act so that complainants could receive more information about the progress and outcome of an agency’s investigation. See Minnesota Management and Budget, Sexual Harassment Prevention Policy and Procedures Report: Review and Recommendations, 8-9 and 25.
Security staff at Level 4 and 5 prisons want more frequent training in how to handle violent situations.

Forty-four percent of corrections officers disagreed or strongly disagreed with the statement, “DOC has repeated the training I need frequently enough to keep my skills sharp.” At Oak Park Heights, Rush City, St. Cloud, and Stillwater, majorities of officers disagreed or strongly disagreed with the statement. In our site visit interviews, officers and some supervisors told us that DOC’s every-other-year schedule for providing the fundamental training sessions related to handling violent situations—“self-defense” and “control tactics”—is insufficient. Supervisors told us these training sessions are critical because they are officers’ only opportunities to practice techniques that they might need to protect themselves and their coworkers in an emergency. Since most officers do not use these techniques on a daily basis, such practice is important to ensure that they will be ready to use them when necessary.

Some staff we interviewed commented that staff who do not get training frequently enough may use force incorrectly against a prisoner due to the lack of practice. One officer also commented that techniques change periodically—if newer, safer techniques are introduced shortly after staff have completed a training session, it will be at least two years before they receive updated instruction.

In some prisons with staffing shortages, supervisors and line staff told us that hands-on training sessions are frequently cancelled or delayed due to understaffing, stretching the time between trainings even longer. Unlike computer-delivered training modules, which can be taken by a single staff person at a time, the “hands-on” training sessions are provided in a classroom setting with several officers taking part at once (including the instructor, who is usually a supervisor or experienced officer at the same prison). Finding times when enough staff can be spared to hold the training sessions has been challenging.

A large majority of staff believe that nonsecurity staff should receive ongoing self-defense training.

Currently, most nonsecurity staff (such as maintenance staff, food service workers, and educators) receive a single session of self-defense training as part of their academy training when they are first hired. After that, they are not required to receive self-defense training again, though some prisons have offered their staff the ability to take such courses optionally.

Most nonuniformed staff do not believe that the single day of training at the start of their employment is sufficient for them to protect their own safety in a crisis. In our survey of DOC staff, 79 percent of nonuniformed staff agreed or strongly agreed with the statement, “Nonuniformed staff that interact with prisoners should regularly receive self-defense training.” Officers and lieutenants—who are more
familiar with self-defense training because they have received it repeatedly—felt even more strongly.

In our site visit interviews, several nonuniformed staff commented that the training is important not only for day-to-day safety, but also because nonuniformed staff sometimes perform security functions. For example, when many officers are responding to a large fight, nonuniformed staff may participate in monitoring hallways or otherwise act as a physical presence to deter prisoners elsewhere in the prison from taking advantage of the tumult.

**RECOMMENDATION**

**The Department of Corrections should provide more “hands-on” training courses for existing staff.**

Staff training has a direct impact on the safety of both staff and prisoners. Staff that are well-trained should be better able to defend themselves and their fellow staff members from assaults and to more safely and effectively intervene in physical conflicts between prisoners. Regular training will also give both officers and nonuniformed staff greater confidence when dealing with stressful situations.

Increasing the frequency of training will place even greater stress on staffing resources. Given current officer staffing shortages, it may be difficult to implement more frequent training for officers immediately. We suggest that DOC start by providing periodic self-defense or similar training to nonuniformed staff, and gradually implement more frequent hands-on training for officers as staffing resources permit. Although available data suggest that nonuniformed staff are much less frequently injured than security staff in physical conflicts with prisoners, all staff that work with prisoners should be prepared to protect themselves in threatening or dangerous situations.
Prisons provide opportunities for prisoners, including education, vocational training, therapy, employment, and maintaining contact with family and friends. They also place limits on prisoners’ behavior, by controlling prisoner movement, monitoring activities, and disciplining prisoners who violate rules. Both of these functions have implications for the safety of prisoners and prison staff.

In this chapter, we first discuss the safety advantages of providing programming for prisoners, along with the challenges prisons face providing such programs. Then, we discuss the relationship between prisoner discipline and misconduct. Lastly, we examine the Department of Corrections’ (DOC) recent changes to its disciplinary practices, particularly its use of restrictive housing.

Programming and Recreation

Prisoners in Minnesota correctional facilities spend their days in a combination of structured programming, unstructured recreation time, and time in their living quarters. “Programming” describes structured activities provided or arranged by the Department of Corrections, such as sex offender treatment or chemical dependency treatment; adult basic education and vocational education; religious services and programs; visits with family and friends; and employment in a prison job.¹ Prisoners may spend unstructured recreation time in gymnasiums, outdoor yards, or common areas in living units.

DOC provides prisoner programming as part of its mission to rehabilitate prisoners. By providing programming, DOC hopes to reduce the number of prisoners who will commit a new offense and return to prison following their release from custody. The

¹ “Programming” is a term with a range of meanings depending on the individual using the word. In some DOC contexts, programming refers to both regularly scheduled, structured group activities and unstructured free time.

Key Findings in This Chapter

- Shortages of corrections officers have limited available programming at several prisons.
- Many staff do not believe that prison leaders appropriately balance security needs and prisoner programming.
- The Department of Corrections does not collect sufficient data on its disciplinary actions to determine whether they help prevent future violence.
- The Department of Corrections implemented reductions to restrictive housing sentences without having alternative procedures in place to manage the most violent prisoners.
department’s focus on programming is supported by a large body of research. In general, academic literature shows that prisoners that spend their time in prison productively are less likely to commit additional crimes after they return to the community.

**Programming and Safety**

In addition to programming’s role in changing prisoner behavior after their release from custody, DOC administrators consider programming to be an important factor in improving safety outcomes within prisons. The academic literature and experiences of staff and prisoners support this focus.

**Academic studies and the experience of Department of Corrections staff indicate that programming and recreation opportunities reduce the risk of violence in prisons.**

Academic literature suggests that offering programs for prisoners can reduce misconduct—including violent misconduct—in prisons. One review of the literature commented that a “proven strategy for reducing prison violence and disorder is to expand and improve our in-prison programming.” This review further noted that increased programming is the only antiviolence strategy among many that have been proposed (including reducing overcrowding, increasing staffing levels, and more), for which strong evidence exists. DOC has conducted a study on the link between

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5 *Ibid*, 59. The authors did not suggest that the other strategies were ineffective. Rather, they concluded that the evidence collected so far to support those strategies was weak.
participation in one form of programming—prison employment—and prisoner misconduct at DOC prisons; however, its results were mixed.\(^6\)

DOC prison administrators, staff, and prisoners we interviewed generally agreed that programming is an important way to reduce violence. Some administrators and staff told us that persistently idle prisoners will inevitably commit some misconduct, possibly violent misconduct. Staff consider prisoners unassigned to any programs to be more prone to violence than prisoners that have a daily routine. In our survey of prison staff, most responded that prisoner involvement in activities like programming and recreation make violence less likely, as shown in the box at left.\(^7\) Although all categories of staff agreed that programming and recreation make violence less likely, nonuniformed staff agreed most frequently.\(^8\) For example, 86 percent of nonuniformed staff agreed or strongly agreed that recreational activities make violence less likely, compared with 70 percent of security staff.

In interviews, prisoners commented that violence is more likely when prisons frequently confine them to their cells because there are no stress-relief activities. Staff and prisoners both told us that confinement to cells increases prisoners’ irritability, stating that when prisoners confined for long periods are finally given out-of-cell time, pent-up conflicts among prisoners are more likely to lead to violence.

Prisoners we spoke with agreed that programming suspensions affect safety at the prisons. During site visit interviews, some prisoners told us that programming suspensions throw off their daily routines and disrupt valued activities, such as visits with family and friends. Many prisoners responding to our survey volunteered that it would be safer for both prisoners and staff if prisons offered more programming or offered it more consistently.

About one in four prisoners responding to OLA’s

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\(^7\) We surveyed staff working at state correctional facilities who regularly interact with prisoners. For details, see the Appendix.

\(^8\) As we described in Chapter 1, “uniformed” staff refer to security staff—corrections officers and their supervisors—while “nonuniformed” staff includes other positions such as educators, case managers, behavioral health professionals, and MINNCOR staff.
survey said the threat of losing a prison job would make prisoners less likely to assault or fight other prisoners.\(^9\)

**Staffing Shortages and Programming**

Structured programming requires staff—both nonuniformed staff to offer the activities, and corrections officers to provide security. Increasing the number of programming settings increases the need for officers. As we explained in Chapter 1, corrections officer staffing needs are a function of the number of locations that need to be staffed simultaneously, not strictly the number of prisoners in those locations.

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**Shortages of corrections officers have limited available programming at several prisons.**

Officer shortages have led several prisons to repeatedly suspend recreation and programming. Prisons must prioritize basic functions—such as feeding and counting prisoners—so recreation and programming are frequently cancelled when prisons are short-staffed. Prison administrators, especially those in Level 4 and 5 correctional facilities, said their prisons regularly make decisions about whether to run programming based on the availability of security staff. One administrator described a frequent process of suspending one program on one day, then suspending a different program the next day, and yet another program the third day, so that programming suspensions would not affect one group disproportionately. Another administrator said his prison has cut down on the number of days it is open for visitors due to staffing shortages.

Most prison administrators we spoke with told us that their correctional facilities do not have sufficient staff to keep all programming open regularly. Some administrators also noted that they do not have sufficient programming space to provide activities for all prisoners. Staff responding to our survey had mixed opinions about whether their prison has enough resources to provide helpful programming to prisoners, though staff at higher custody level prisons were more likely to think that their prisons did not have enough resources for programming. (See chart on next page.)

Despite its stated emphasis on programming, DOC does not track how often prisons suspend programming or recreation due to staffing shortages, nor does it track how much time individual prisoners spend in programming. In 2018, DOC began tracking programming suspensions after ongoing security issues caused repeated programming cancellations in several prisons. However, the tracking initiative ended after most prisons resumed normal operations, and central office administrators had difficulty locating these data when we asked for them.

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\(^9\) We surveyed adult prisoners in Level 3, 4, and 5 prison settings (including Shakopee). For details, see the Appendix.
DOC broadly tracks whether or not prisoners enroll in programs such as chemical dependency treatment and sex offender treatment, but its data on whether prisoners actually attend programs daily is inconsistent or missing. DOC tracks statistics on idleness, or the percent of prisoners unassigned to any program even though they are available to participate in one. However, DOC’s idleness statistics appear to track only whether a prisoner is “assigned” or “idle,” and do not fluctuate based on whether the programs are consistently available. For example, prison administrators told us that the Stillwater facility stopped offering programming for weeks following the death of Officer Joseph Gomm in July 2018. However, in August 2018, Stillwater’s idleness rate was similar to that in months prior, and over half of the facility’s prisoners were still “assigned” to some program.

In some instances, administrators have chosen to run programming despite security staffing shortages.

When prisons continue offering programming despite officer shortages, they must either force officers to work overtime or run programs with low security staffing levels (or both). Running programs by bolstering staffing levels using forced overtime comes with its own security concerns, as we described in Chapter 3. On the other hand, operating with low staffing levels means that a staff member working alone may be unable to call for assistance in a crisis.

In our interviews, prison staff recounted instances in which they believed prison administrators ran programs even though staffing levels were too low to do so safely. For example, nonuniformed staff members from two different Level 4 correctional facilities stated that they were often left alone with groups of prisoners with little or no

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10 Monthly reports prepared by the correctional facilities showed that idleness in DOC’s prison population increased from about 18 percent in Fiscal Year 2016 to about 22 percent in Fiscal Year 2019. The idleness rate included prisoners assigned to activities for less than three hours of each day, but not those whose idleness was “authorized.” For example, prisoners who could not participate in programming because they were in restrictive housing or under medical care were not counted as idle.
security support. At a different prison, an associate warden described how a staff member working alone in a minimum-security programming setting collapsed with a medical emergency. Because no other staff were nearby, a prisoner had to use the staff member’s radio to request help.

Some prison staff blame the death of Stillwater Officer Joseph Gomm on a decision to keep prisoners working in an industrial program even though a staffing absence meant that only two staff members would be present to supervise prisoners in two large workshops. When Officer Gomm was allegedly assaulted by a prisoner, he was unable to call for assistance, and no other staff person was present to radio for help. Help was called only after another prisoner went to the neighboring workshop and alerted the staff member there.

Many staff do not believe that prison leaders appropriately balance security needs and prisoner programming.

Prison staff in our site visit interviews and survey often complained that administrators made decisions to provide or suspend programming arbitrarily. For example, union representatives at one prison told us that administrators would consider a given number of security staff sufficient to run programming on one day; on another day, the same number would not be enough and programming would be suspended. Some staff acknowledged the difficulty in balancing staffing needs with the need to run programming, but they still complained that administrators tended to run programming with insufficient staff.

Many staff participating in OLA’s survey and interviews believed that prison administrators often prioritize programming over security measures, leaving the prisons less safe than they otherwise might be. Some of these staff particularly distrust decisions to keep prison industry programs (MINNCOR) open when staffing is limited. While staff generally supported the value of employment programs, some staff believed that industry programs have been disproportionately prioritized over other programs, such as education classes or group therapy. Several staff claimed that MINNCOR administrators have inappropriate influence over administrative decisions related to prisoner and staff safety.

Some staff in our interviews suggested that DOC may actually create pressures to keep programming running despite staffing shortages. For example, DOC runs a “canteen,” through which prisoners from all state prisons may purchase items such as hygiene products and snack food. Prisoners order and pay for items, then pick up their orders on a regular schedule. The primary jobs available to Oak Park Heights prisoners are to work in a warehouse that receives the canteen goods in bulk and then prepares individual orders for distribution to all DOC prisons. Some Oak Park Heights staff complained that Oak Park Heights cannot always shut down this program when appropriate for security purposes; failure to distribute canteen orders can lead to prisoner unrest and security concerns at other correctional facilities.
Some prisoners expressed doubt that prisons make decisions to suspend programming for security reasons. In site visit interviews at one prison, prisoners said they believe administrators may suspend programming punitively. Several of these prisoners suggested that violent incidents do not occur during unstructured recreation activities such as gyms or yard time, and so the limitations frequently placed on these activities are unnecessary.

For their part, prison administrators explained that they juggle many factors when determining whether to run or suspend programs and recreation. Prison leaders often must decide between reducing activities for prisoners and forcing staff to work overtime. In either case, they will create dissatisfaction—prisoners will be upset if they cannot participate in activities, or staff will be upset if they are forced to work overtime. Other prison leaders explained that when they are determining which activities should be suspended, they consider how many prisoners will be affected by different choices and prisoners’ stated preferences regarding programs they prefer to remain open. One warden told us that budgetary concerns also influence decisions to run or suspend programming and recreation; administrators consider how much overtime pay they can afford within their budgets.

RECOMMENDATION

Department of Corrections administrators should strive to improve the transparency of decision making to run or suspend programming and recreation.

While prisons should offer programming and recreation when possible, it may not be feasible to provide them consistently at some prisons until officer shortages lessen. We cannot determine how many security staff are needed to offer these activities safely without better data, and therefore we do not provide specific recommendations on how frequently programming should run in a short-staffed environment.

However, the seeming arbitrariness of programming decisions creates uncertainty among staff and prisoners about administrative priorities. It also contributes to perceptions that administrators are not fully committed to promoting safety, a concern we discuss further in Chapter 6. Prison administrators should look for opportunities to make their decision-making processes more transparent so that staff and prisoners can reasonably expect that the prison will provide programming options when certain conditions are met, and will not provide them when they are not.
Discipline for Prisoner Misconduct

On the other end of the spectrum from providing programming and recreation opportunities, DOC manages prisoners’ behavior by controlling or restricting their actions. Examples include placing restrictions on the number of prisoners that may move between locations in the prison at any given time, conducting pat-down searches on prisoners or requiring prisoners to walk through metal detectors, and carefully controlling the use of certain tools in industrial settings. In this section, we will focus on only one form of control—prisoner discipline—acknowledging that there are a number of other control mechanisms important to safety at state prisons.

Prisoners that violate DOC rules are subject to informal or formal disciplinary sanctions. They may also be referred for prosecution if their actions violate criminal laws.

Discipline and Safety

DOC’s data limitations make it challenging to assess whether prisoner discipline has deterrent effects.

The Department of Corrections does not collect sufficient data on its disciplinary actions to determine whether they help prevent future violence.

Prisoners that commit infractions against prison rules can be subject to formal or informal discipline, as described in the box on the next page.

Data are not available on whether the use of informal discipline correlates with reductions in violent incidents. The use of informal discipline varies between correctional facilities, living units in prisons, and individual staff members. Prisons track informal discipline inconsistently, and some do not retain data on its use. For example, Lino Lakes maintains a temporary log of informal discipline given within the last 90 days. After 90 days, this information is discarded. On the other hand, Faribault uses a tracking system that allows administrators to review the amount of informal discipline assigned to individual prisoners over time.

As we described in Chapter 2, the department records prisoners’ formal disciplinary decisions and penalties in a database, the Correctional Operations Management System (COMS). However, the information in this database would be difficult to use to evaluate the effects of disciplinary actions. Staff enter disciplinary information into COMS differently from prison to prison and staff member to staff member. For example, if a prisoner successfully appeals a disciplinary finding, staff may either keep the guilty determination in the prisoner’s disciplinary record but remove the associated penalty or remove the original guilty determination entirely.
Another limitation of COMS is that it can only associate each rule violation with a single disciplinary sanction; prisoners might receive more than one disciplinary sanction for serious rule violations. In these cases, prison staff would need to duplicate charges in the system to capture all disciplinary sanctions. A key information technology manager that works with COMS acknowledged that the module containing discipline data is outdated and does not meet the department’s current needs.  

Nowhere is the inability to judge the impact of disciplinary sanctions more evident than in DOC’s use of restrictive housing. Tracking the lengths of stay in restrictive housing using COMS is challenging. Prisons vary in how they record the length of a disciplinary segregation sentence; a prison may record either the number of days sentenced to restrictive housing or the number of days served. These numbers are not necessarily the same. For example, prisoners may serve only part of their sentence because of overcrowding in the restrictive housing unit. In other cases, prisons move prisoners from restrictive housing to medical or mental health units before their disciplinary sentences end.

DOC has struggled to produce information about restrictive housing stays in response to legislative requests. Central office staff developed a method that compares prisoners’ disciplinary data, living assignment data, and work assignment data to assess whether a prisoner was in restrictive housing at a given point in time. However, there were often conflicts between the different sources of data and confounding information. For example, prisoners on administrative segregation (described in the box at left) might reside in a restrictive housing unit, but COMS discipline data omit these prisoners. Also, at least two prisons have used their restrictive housing units as overflow bed spaces for newly arriving prisoners until other beds become available. Although staying in restrictive housing units, these prisoners generally do not follow segregation restrictions. DOC

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**Types of Restrictive Housing**

**Disciplinary segregation** is a sentence to a number of days in restrictive housing following a guilty determination for a DOC rule violation.

**Administrative segregation** is the use of restrictive housing to separate certain prisoners from the rest of the inmate population if the prisoner’s presence in normal living quarters poses a risk to the safety or security of that prisoner or of other prisoners and staff.

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**Prisoner Discipline**

**Informal discipline** is incurred for less severe misconduct, such as failing to keep a cell or dormitory clean. Prison staff members may assign informal discipline. A common form of informal discipline is short-term loss of privileges, such as participating in recreation or using the phone.

**Formal discipline** is incurred for committing more severe misconduct—such as assaulting, fighting, or threatening others—or for accruing many informal disciplinary charges within a short period of time. DOC staff administer formal discipline through due process procedures that require formal notice, a hearing, and the right to appeal. Formal discipline results in a range of sanctions, such as placement in restrictive housing (isolation), extended incarceration (added time in prison), or restitution (payment for damage or theft of property).

**Criminal prosecution** may be pursued by DOC for severe misconduct. Local county attorneys decide whether to prosecute a case, juries evaluate guilt or innocence, and judges determine punishment. The process is mostly outside of DOC’s control.

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11 DOC is currently developing a replacement for its discipline data module in COMS that it expects to begin using in 2020.
has often resorted to manually counting prisoners in restrictive housing to generate these data.

Staff and prisoners have mixed opinions about whether discipline can prevent prisoner violence.

Informal discipline. DOC administrators, staff, and prisoners expressed a variety of opinions about whether informal discipline can prevent prisoner violence. Several prison administrators told us that informal discipline is an important part of prisoner management; one warden said it may deter minor rule violations. However, OLA’s surveys showed that neither staff nor prisoners have much faith in informal discipline as a means to prevent violent misconduct. Only one in five staff members responding to our survey said loss of privileges makes prisoners less likely to assault or fight other prisoners. Even fewer staff said they believed that loss of privileges make prisoners less likely to assault staff members. Very few prisoners responding to OLA’s survey said they believed that loss of privileges makes prisoners less likely to assault or fight other prisoners or to assault staff.

Formal discipline. Staff and prisoners likewise had mixed opinions about whether formal discipline, such as restrictive housing, can prevent violence. Forty-five percent of the staff members responding to OLA’s survey said that restrictive housing makes prisoners less likely to assault or fight other prisoners, and 39 percent said it makes prisoners less likely to assault staff. But only one in four prisoners surveyed said restrictive housing makes prisoners less likely to assault or fight other prisoners. Even fewer said restrictive housing makes prisoners less likely to assault staff. In interviews, prison administrators, staff, and prisoners stated that the extent to which restrictive housing deters future violence depends on the individual. Some DOC staff and prisoners told us there are prisoners who do not care whether they will be placed in restrictive housing, so its use has a limited effect on reducing violence by those prisoners. Several staff and prisoners suggested that no form of discipline is truly effective at deterring prisoners from violent behavior.

Criminal prosecution. Though outside of DOC control, most staff believe that criminal prosecution is an effective deterrent to the most serious misconduct, such as assaults on staff. Over 50 percent of staff surveyed said they believe the possibility of criminal prosecution makes prisoners less likely to assault staff. Slightly less staff, 45 percent, said it makes prisoners less likely to assault or fight other prisoners.¹²

¹² Our prisoner survey did not directly ask prisoners about the effectiveness of criminal prosecution in deterring violence. Several prisoners volunteered in written comments that criminal prosecution is a deterrent.
Changes to DOC’s Restrictive Housing Policies

In 2015, DOC embarked on a multiyear process to reduce the use of restrictive housing amid growing national concern about the negative effects on prisoners of long-term isolation. Among other goals, DOC sought to reduce the amount of time individuals spend in restrictive housing and to increase programming for prisoners in restrictive housing. DOC officials told us that it has been challenging to balance external calls to reduce the use of restrictive housing with the need for state prisons to continue holding prisoners accountable for misconduct. Below, we discuss DOC’s initial changes to restrictive housing sentences in 2016, its implementation of a new “Step-Down Management Program” for certain offenders in restrictive housing in 2018, and DOC’s partial reversal of the 2016 sentencing changes in 2019.

2016 Changes

DOC altered its disciplinary segregation sentences for prisoners in September 2016. It reduced segregation lengths across all infractions and set a maximum disciplinary segregation penalty of 90 days for a single incident. Further, DOC decided that disciplinary penalties for multiple rule violations would be served concurrently, rather than consecutively.

The new limits dramatically reduced the potential time a prisoner might spend in restrictive housing for the most serious offenses. As shown in the hypothetical example in the box on this page, a prisoner who cursed at and assaulted a staff member could spend far less time in restrictive housing under the new sentences than the old ones.

When introducing the changes, DOC provided guidance for how prisons could continue to hold prisoners accountable for serious misconduct. For example, prisoners who broke rules while in restrictive housing could receive an additional disciplinary sentence. Also, prisoners with serious misconduct—such as assaulting and injuring another prisoner or staff—would not necessarily return to normal living units after completing 90 days in restrictive housing. A prisoner assessed as a continued risk to safety and security might instead be placed on administrative segregation status (thus staying in restrictive housing, but with more privileges than disciplinary segregation) and be considered for a “special management plan” that would prepare them for gradual reentry into a normal living unit.

<table>
<thead>
<tr>
<th>Violation</th>
<th>Before September 2016</th>
<th>September 2016 to June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse/harassment</td>
<td>Up to 45 days</td>
<td>Up to 15 days</td>
</tr>
<tr>
<td>Disorderly conduct</td>
<td>Up to 45 days</td>
<td>Up to 15 days</td>
</tr>
<tr>
<td>Assault of Staff</td>
<td>Up to 360 days</td>
<td>Up to 60 days</td>
</tr>
<tr>
<td>Total</td>
<td>Up to 450 days</td>
<td>Up to 60 days</td>
</tr>
</tbody>
</table>


14 Prisons could make exceptions to concurrent sentencing in some circumstances, but DOC limited such consecutive sentences to 180 days.
The Department of Corrections implemented the 2016 reductions to restrictive housing sentences without having alternative procedures in place to manage the most violent prisoners.

DOC implemented the 2016 changes to disciplinary segregation sentences before developing the “special management plans” for prisoners posing a continued risk to safety and security. It took 18 months after the reduction of disciplinary segregation sentences for DOC to introduce its Step-Down Management Program for these high-risk prisoners. In the interim, prisons had to improvise their management of potentially violent prisoners who were released after shorter stays in restrictive housing. DOC officials said these efforts were inconsistent and unfunded. A few security staff at Oak Park Heights (where many high-risk prisoners are located) commented that the disciplinary changes were rolled out before programming was well developed.

Step-Down Management Program in 2018

DOC introduced its program for high-risk prisoners in restrictive housing in the form of the Step-Down Management Program in March 2018. The Legislature passed a law supporting the program in 2019. Under the program, described in the box on this page, DOC staff develop individualized case plans that set expectations for development of behavioral, cognitive, and other skills. Case plans might also contain requirements for mental health, educational, or other programming, as appropriate.

DOC case managers are now tracking data intended to show whether the program is an effective intervention. These data include not only information about misconduct and length of stay in restrictive housing before and after the intervention, but also assessments of thinking patterns related to recidivism. To date, not enough time has passed since the beginning of this program to show whether it is achieving its goals.


16 DOC must release a report to the Legislature by April 1, 2020, detailing “outcomes, measures, and challenges to implementation of a step-down management program.” *Minnesota Statutes* 2019, 243.521, subd. 9(b). We did not evaluate the data DOC is collecting to meet this requirement.
2019 Changes

In June 2019, after much criticism by staff of the 2016 changes, DOC retracted the 2016 guidelines and instituted new, longer disciplinary segregation sentences. DOC now divides rule violations into five levels according to the severity of the violation. For example, gambling is a low-level violation (Level 1), and assault of staff causing significant bodily harm is a high-level violation (Level 5). Each level has a range of minimum to maximum disciplinary sentences associated with the disciplinary charge, as shown in the box at right. Prisons may also extend prisoners’ period of incarceration for committing high-level violations.\(^{17}\)

<table>
<thead>
<tr>
<th>Violation Level</th>
<th>Violation Examples</th>
<th>Disciplinary Segregation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gambling, Lying, Disorderly Conduct, or Tattooing</td>
<td>0 to 30 days</td>
</tr>
<tr>
<td>2</td>
<td>Fighting, Extortion, or Use of Alcohol</td>
<td>0 to 60 days</td>
</tr>
<tr>
<td>3</td>
<td>Assault or Arson</td>
<td>0 to 90 days</td>
</tr>
<tr>
<td>4</td>
<td>Assault Causing Bodily Harm</td>
<td>90 to 180 days</td>
</tr>
<tr>
<td>5</td>
<td>Homicide, Assault Causing Significant Bodily Harm, or Sexual Abuse</td>
<td>270 to 360 days</td>
</tr>
</tbody>
</table>

Restrictive Housing Changes and Safety

Although staff have mixed opinions on the overall effectiveness of discipline at reducing violence in prisons, many staff told us that the 2016 changes to restrictive housing made prisons less safe.

Many staff believe that the 2016 changes to restrictive housing caused an increase in staff assaults, but the evidence is inconclusive.

As we described in Chapter 2, DOC experienced a spike in assaults on staff in calendar year 2018. During our site visit interviews, several staff said this increase was the result of the lowered restrictive housing sentences. Labor union representatives commented in multiple news articles in 2018 and 2019 that changes to restrictive housing penalties were part of the reason for increased assaults, and that penalties should be increased to improve staff safety. Even after the June 2019 changes, many staff responding to our survey in September 2019 still commented that staff safety would improve if DOC increased restrictive housing sentences.

However, evidence to support this assertion is unclear. The increase in assaults on staff did not occur until over a year after the introduction of the new restrictive housing limits in 2016. Further, the number of assaults on staff decreased months before DOC

\(^{17}\) DOC could also pursue criminal charges, but it would have no control over the sentence a court would assign.
reintroduced longer disciplinary segregation penalties in June 2019. In addition, available data indicates there was no increase in prisoner-against-prisoner violence during the same period.

**RECOMMENDATION**

The Department of Corrections should improve its data on prisoner discipline and the use of restrictive housing.

DOC needs to collect better data on prisoner discipline and restrictive housing to measure the effects of policy changes like those to restrictive housing in 2016. Without better data, the department cannot assess whether changes generated positive or negative consequences. DOC could not counter the narrative among staff that increased assaults were the result of the changes to restrictive housing sentence length because it did not have sufficient data. We also did not have the evidence to substantiate whether any changes to DOC policy resulted in the increase in assaults in 2018.

DOC is already developing a new discipline module in COMS to better track prisoner discipline at the correctional facilities. We support these efforts and believe it is an important first step towards better tracking of violent incidents. In contrast, administrators told us that plans to develop better data on the use of restrictive housing have stalled.

Not only would improving its restrictive housing data enable DOC to better measure the effect of restrictive housing on safety, it would help the department comply with new legislative reporting requirements. In 2019, the Legislature required that DOC report annually on its use of restrictive housing, including data such as the number of prisoners placed in restrictive housing, the length of time they serve in restrictive housing, and the number of prisoners transferred from restrictive housing to a mental health unit.\(^\text{19}\)

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\(^{18}\) It is possible to theorize a relationship between the policy changes and violence against staff consistent with these data. If only a small number of prisoners are likely to assault staff, those prisoners might be more likely to commit other infractions that would lead to placement in restrictive housing. If it took prisoners some time to cycle out of earlier disciplinary segregation sentences (assigned prior to the 2016 change) and then learn of the new policy, that might explain the lag time between the introduction of the new segregation sentencing limits and the assaults on staff. However, without much more information to support it, this theory is purely speculative.

\(^{19}\) *Laws of Minnesota* 2019, First Special Session, chapter 5, art. 3, sec. 10, codified as *Minnesota Statutes* 2019, 243.521, subd. 9(a).
Chapter 5: Infrastructure

In managing state prisons, the Department of Corrections (DOC) is constrained by the physical characteristics of the correctional facilities it administers. Some of these characteristics influence how effectively DOC staff can protect safety for both staff and prisoners.

In this chapter, we begin by addressing the design of some of the state’s prisons, particularly the old living units used at St. Cloud and Stillwater. We then discuss crowding and capacity issues, specifically the state’s practice of placing more than one prisoner in many cells.

Key Findings in This Chapter

- Some Department of Corrections prison facilities have design features that are outdated, creating conditions that increase danger for both prisoners and staff.
- Legislative requirements instituted in the 1990s increased crowding at Department of Corrections prisons.
- Administrators, staff, and prisoners said that housing more than one prisoner in the same cell increases risks for prisoners, particularly at higher custody levels.

Design

Minnesota’s prison system predates statehood, and several state prisons have histories stretching back over 100 years. Generally speaking, state correctional facilities can be divided by origin into four groups.

- **Built as prisons long ago: St. Cloud and Stillwater.** These prisons still rely heavily on infrastructure that is over 100 years old. St. Cloud accepted its first prisoners in 1889. The current Stillwater prison was built in 1914 to replace the original Stillwater prison, a territorial prison that opened in 1853.

- **Built as prisons more recently: Oak Park Heights, Red Wing, Rush City, and Shakopee.** Oak Park Heights, Rush City, and Shakopee were constructed in the 1980s and 1990s. Red Wing’s original building (constructed in 1889) still stands, but is now used solely for administrative offices; Red Wing’s residential units and programming spaces have mostly been built since the 1950s, though a few date back to the 1930s.

- **Built for other purposes, then repurposed as prisons: Faribault, Lino Lakes, and Moose Lake.** Lino Lakes was originally built in 1963 to house juvenile prisoners and youth with emotional and behavioral disorders. Faribault and Moose Lake were originally regional treatment centers for the developmentally disabled, mentally ill, and chemically dependent. They were founded in 1881 and 1938, respectively. DOC renovated these three facilities in the 1970s, 1980s, and 1990s to convert them to prisons.

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1 The women’s prison at Shakopee was originally founded in 1920, but DOC replaced the entire prison in 1986.
• **Built as outdoor-oriented camps for younger prisoners:** Togo and Willow River. These correctional facilities were established in the 1950s in an effort to teach trades in outdoor-oriented settings different from traditional penal institutions. Willow River had originally been a 1930s-era Works Progress Administration camp.

### Some Department of Corrections prison facilities have design features that are outdated, creating conditions that increase danger for both prisoners and staff.

Though both facilities contain units built or refurbished more recently, the primary residential units in St. Cloud and Stillwater were built to the standards of 100 years ago. The federal government and states mostly abandoned such designs for prisons built after the 1950s. The main living units in both prisons feature tiers of cells stacked on top of one another, four or five stories high. Narrow walkways (called “galleys”) run in front of the cells. Prisoners and staff can only reach cells above the ground floor by climbing flights of stairs at the end or middle of cell blocks and walking along the galleys. Some basic built-in infrastructure elements, such as cell locking mechanisms, are entirely mechanical and rely on parts that can no longer be purchased; DOC must fabricate replacement parts itself. In contrast, corrections officers in more modern facilities such as Oak Park Heights and Rush City have the ability to remotely lock and unlock cells at the touch of a button.

These older living unit designs create several challenges to protecting the safety of prisoners and staff. It is almost impossible for officers based in a central location to see or hear what is occurring in cells far out to the side or high over their heads. Without direct observation, officers may use video cameras located throughout the living units to monitor prisoners and cells. However, it is difficult for small numbers of officers to adequately monitor large numbers of video camera feeds. Officers told us that video footage is generally more useful for reviewing incidents after they have occurred than for stopping them in progress or preventing them from occurring. By necessity, officers have learned signals that may indicate that a fight or assault is occurring in a cell even though they cannot see the cell directly. For example, one Stillwater staff member described a characteristic squeaking sound that sneakers make on concrete floors as an important tell-tale sign that a fight may be occurring.
Fights and assaults that happen in cells above the ground floor or on the galleys also create the potential for fighting prisoners or intervening officers to fall to the concrete floors below. An administrator at Stillwater told us of one assault where video footage showed that the victim, lying prostrate on the galley floor, could have slid over the edge had not a nearby uninvolved prisoner pulled him back. In our view, given the narrowness of the galleys and the relatively wide gaps between railings (particularly at Stillwater), it is somewhat miraculous that such a fall has never occurred. Another concern is prisoners throwing items off of the galleys onto staff or prisoners walking below. When we visited the Stillwater living units, we were advised to walk underneath the galley overhangs to limit the danger from thrown or falling objects.

Another threat to safety in these older facilities is the lack of air conditioning in the living units. Administrators and staff told us that temperatures can rise to very uncomfortable levels on the top tiers during hot summer days, particularly in units where the sun shines directly into the large windows on the living unit walls. One warden said he thought the conditions on those days were “like an oven” for prisoners who are in their cells. He said that packing hundreds of prisoners together at such temperatures is practically a recipe for violence. Some officers who work in these living units told us that summer humidity can also lead to condensation on the galleys, making them slippery and even more dangerous than normal.

Another problem created by the older architecture at St. Cloud and Stillwater—and shared with the repurposed prison sites at Faribault, Lino Lakes, and Moose Lake—is the difficulty of placing video cameras. At these facilities, many buildings were not designed to ensure good sightlines for video cameras. As a result, there are many nooks, recesses, stairways, corners, and other spaces that require an inordinate number of cameras to provide full coverage or that are simply not monitored using video at all. Although the exact locations of such “blind spots” are secret, officers told us that prisoners can generally discover them through trial and error. For example, an officer in one correctional facility told us that officers often check a certain location in one living unit that is not visible on camera; they commonly find homemade liquor and other contraband that prisoners have stored there.
Making physical changes to either St. Cloud or Stillwater is complicated by the fact that both prisons are listed in the National Register of Historic Places. Under state law, DOC must consult with the State Historic Preservation Office before altering structures at either location.²

**RECOMMENDATION**

**The Department of Corrections should develop and present to the Legislature a long-term plan for rehabilitating or replacing the living units at the St. Cloud and Stillwater correctional facilities.**

The age of the living units at St. Cloud and Stillwater presents significant challenges to protecting the safety of prisoners and DOC employees. In our view, these safety risks would not be considered acceptable if they were found at highways, schools, courthouses, or other public structures in daily use. We do not think they should be acceptable for prisons.

We have not evaluated the extent to which relatively low-cost, short-term fixes might mitigate some of the safety hazards we described above. To the extent that such options exist, DOC should pursue them.³ However, without major structural changes, DOC will be trying to carry out its mission with infrastructure that will create more problems as it ages further. At some point, the state will have to substantially reinvest in these facilities if it is to keep using them.

DOC should develop long-term plans for ending the use of the multi-tiered St. Cloud and Stillwater living units in their current configuration. The plans should envision the costs of developing new structures and set target dates for rehabilitation or replacement. DOC should then present those plans to the Legislature for consideration.

We specify the living units in our recommendation because a prison cannot operate without living units. DOC administrators told us that St. Cloud, Stillwater, and other DOC prisons have other units that also need rehabilitation or replacement.⁴ But we are not in a position to assess whether prisons can do without those buildings or repurpose them to other uses until they can be renovated. That being said, we reiterate our finding from Chapter 4 that evidence supports a link between programming and safety. The Legislature should take into account the likely safety benefits of building improvements when evaluating DOC bonding requests for buildings used to provide programming.

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² *Minnesota Statutes* 2019, 138.665, subd. 2; and 138.666.

³ Although we did not gather any evidence to evaluate its merits, we are intrigued by a proposal DOC is considering to swap the prisoner populations of Faribault and Stillwater. Transferring higher-risk Level 4 prisoners to a facility with modern living units and moving lower-risk Level 3 prisoners to the older Stillwater facility might produce a net increase in safety.

Crowding

Many observers have associated overcrowding—too many prisoners in too little space—with increased violence among prisoners. A report from a national commission formed by the nonprofit Vera Institute bluntly stated, “Crowding, and the tremendous increase in the prisoner population that underlies it, fuels violence.” A recent report from the U.S. Department of Justice on Alabama state prisons found that “overcrowding combined with understaffing is driving prisoner-on-prisoner violence.”

However, academic researchers have reached mixed conclusions about the relationship between crowding and safety in prisons. Some researchers have found a causal relationship between increased crowding and violence. However, others have found no effect, or even, in a few instances, a negative effect (i.e., that overcrowded prisons have less violence and misconduct). Much earlier research on overcrowding has been criticized for ignoring other possible explanations for violence, such as gang activity, drug trafficking, or racial tensions.

Researchers have generally measured crowding by comparing the total number of prisoners to the size of the prison. Fewer academic studies focus specifically on the number of prisoners per cell. The U.S. Supreme Court has held that in the absence of other intolerable conditions, housing multiple prisoners in the same cell does not, by itself, violate the Eighth Amendment’s prohibition on “cruel and unusual punishment.”

DOC prisons routinely operate at close to their DOC-defined “operational capacity,” the number of prisoners a facility can house based on staffing and services. As we discussed in Chapter 1, DOC regularly places prisoners in county jails because it does

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8 Wooldredge and Steiner speculate that one possible explanation for negative effects is that overcrowding causes less reporting—staff in overcrowded prisons spend so much time on other tasks that they are less able to monitor prisoners and identify misconduct. Wooldredge and Steiner, “Comparing Methods for Examining Relationships Between Prison Crowding and Inmate Violence,” 814.


10 Studies specifically examining the number of prisoners per cell include Christine Tartaro, “The Impact of Density on Jail Violence,” Journal of Criminal Justice 30, no. 6 (2002): 499-510; and Bernadette Pelissier, “The Effects of a Rapid Increase in a Prison Population: A Pre-and Posttest Study,” Criminal Justice and Behavior 18, no. 4 (1991): 427-447. Neither found that more prisoners per cell were correlated with increases in misconduct or violence.

not have enough space for all the prisoners it takes into custody. However, several DOC prisons currently house more prisoners than they once held, due in part to legislative changes in the 1990s.¹²

**Legislative requirements instituted in the 1990s increased prisoner populations at Department of Corrections prisons.**

In 1858, Minnesota’s first Legislature mandated that “whenever there shall be cells sufficient” at the state prison, “each prisoner shall be confined in separate cells.”¹³ This law remained essentially unchanged until 1992, at which point the Legislature allowed multiple occupancy housing in minimum and medium security prisons.¹⁴ Five years later, the 1997 Legislature changed course; rather than merely enabling multiple occupancy, it required that most DOC prisons use multiple occupancy cells “to the greatest extent possible.”¹⁵

Following this change, DOC used “double-bunking” to increase capacity at many of its prisons, converting many single cells to double cells. As shown in the table at right, most prisoners in state prisons now share living spaces with others. Shakopee—which, as the only women’s prison, cannot easily transfer prisoners elsewhere—faced particular challenges as its population increased. It both used double-bunking and converted some prisoner common spaces to create cells housing four or six prisoners.

<table>
<thead>
<tr>
<th>Prison</th>
<th>Singles</th>
<th>Doubles</th>
<th>Multiples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faribault</td>
<td>65</td>
<td>1,812</td>
<td>126</td>
</tr>
<tr>
<td>Lino Lakes</td>
<td>51</td>
<td>1,230</td>
<td>12</td>
</tr>
<tr>
<td>Moose Lake</td>
<td>173</td>
<td>328</td>
<td>560</td>
</tr>
<tr>
<td>Oak Park Heights</td>
<td>379</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Red Wing</td>
<td>90</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Rush City</td>
<td>96</td>
<td>916</td>
<td>0</td>
</tr>
<tr>
<td>St. Cloud</td>
<td>448</td>
<td>536</td>
<td>77</td>
</tr>
<tr>
<td>Shakopee</td>
<td>74</td>
<td>398</td>
<td>166</td>
</tr>
<tr>
<td>Stillwater</td>
<td>1,281</td>
<td>150</td>
<td>105</td>
</tr>
<tr>
<td>Togo</td>
<td>0</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>Willow River</td>
<td>0</td>
<td>0</td>
<td>111</td>
</tr>
<tr>
<td>Totals</td>
<td>2,657</td>
<td>5,390</td>
<td>1,239</td>
</tr>
</tbody>
</table>

**NOTES:** Multiples include “dormitory-style” settings with many beds to a room but larger common spaces. Singles include prisoners in restrictive housing (isolation). Doubles at Oak Park Heights are only in the medical unit. All Red Wing juvenile prisoners are in singles. Data as of July 1, 2019.

¹² We narrowly focus the following discussion on legislative changes mandating how DOC should operate its prisons. A series of public policy changes beginning in the 1970s led to large increases in the per capita prison population both in Minnesota and throughout the United States. Detailing those changes and their effects is beyond the scope of this evaluation. For one discussion of these trends, see Jeremy Travis, Bruce Western, and Steve Redburn, eds., *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, DC: National Academies Press, 2014).

¹³ *Laws of Minnesota* 1858, chapter 34, sec. 34. The original Stillwater prison was the only state prison in 1858.

¹⁴ *Laws of Minnesota* 1992, chapter 571, art. 11, sec. 2.

¹⁵ *Laws of Minnesota* 1997, chapter 238, sec. 2. At the time, this provision applied to all adult facilities (including the planned new prison at Rush City) except St. Cloud and Stillwater (then classified as Level 5 in a six-level classification system) and Oak Park Heights (then classified as Level 6). The 2003 Legislature applied the multiple occupancy requirement to St. Cloud and Stillwater as well. *Laws of Minnesota* 2003, First Special Session, chapter 2, art. 5, sec. 4. The current law, which reflects the four-level classification system we described in Chapter 1, is codified in *Minnesota Statutes* 2019, 243.53.
Double-bunking means that many of DOC’s Level 3 and Level 4 facilities do not meet national standards for prisoner accommodations. Reviews of DOC facilities by the American Correctional Association (ACA) found that Shakopee, St. Cloud, and Stillwater did not provide many prisoners with the minimum of 25 square feet of unencumbered living space (space not occupied by furniture or fixtures) called for in its standards. ACA reviewers also found that Faribault, Lino Lakes, St. Cloud, and Stillwater did not have sufficient plumbing in some or all of their living units for the numbers of prisoners housed there. Additionally, Moose Lake and Stillwater did not have enough common space in living units to meet ACA standards.

Administrators, staff, and prisoners said that housing more than one prisoner in the same cell increases risks for prisoners, particularly at higher custody levels.

Regardless of the amount of space available, many who live and work in DOC prisons pointed out the safety challenges created by double-bunking. Administrators, staff, and some prisoners at Level 4 prisons said that requiring prisoners to live together in small spaces creates interpersonal conflicts and makes it more difficult to protect vulnerable prisoners from abuse or extortion. One warden suggested that the practice of double-bunking increases gang participation because prisoners feel more vulnerable and will join gangs as a means of self-protection. A prisoner at a facility with double-bunking commented that the practice creates a perverse incentive for prisoners to assault others, because then they will be placed in

[After double-bunking was introduced in the early 2000s,] that population in B West was over 400 in a cell block, and that didn’t work. That was a lesson learned. … We had fights upon fights upon fights upon fights. We’d be locked down for weeks at a time.

— Administrator, Stillwater

16 American Correctional Association, Commission on Accreditation for Corrections, Standards Compliance Initial Audit, Minnesota Department of Corrections, MCF—St. Cloud, April 23-25, 2018 [not-public document]; American Correctional Association, Commission on Accreditation for Corrections, Accreditation Report, Minnesota Department of Corrections, MCF—Stillwater, February 25, 2019 [not-public document]; and American Correctional Association, Commission on Accreditation for Corrections, Accreditation Report, Minnesota Department of Corrections, MCF—Shakopee, October 10, 2017 [not-public document]. We discuss ACA accreditation in more detail in Chapter 6. Oak Park Heights was also cited for insufficient living space, but only for cells in its mental health unit, which were slightly smaller than the 80-square-foot ACA standard for prisoners with special needs. American Correctional Association, Commission on Accreditation for Corrections, Accreditation Report, Minnesota Department of Corrections, MCF—Oak Park Heights, February 25, 2019 [not-public document].

17 American Correctional Association, Commission on Accreditation for Corrections, Accreditation Report, Minnesota Department of Corrections, MCF—Faribault, March 1, 2017 [not-public document]; American Correctional Association, Commission on Accreditation for Corrections, Standards Compliance Initial Audit, Minnesota Department of Corrections, MCF—Lino Lakes, April 25-27, 2018 [not-public document]; Standards Compliance Initial Audit, Minnesota Department of Corrections, MCF—St. Cloud; and Accreditation Report, Minnesota Department of Corrections, MCF—Stillwater.

18 American Correctional Association, Commission on Accreditation for Corrections, Accreditation Report, Minnesota Department of Corrections, MCF—Moose Lake, October 10, 2017 [not-public document]; and Accreditation Report, Minnesota Department of Corrections, MCF—Stillwater. In all instances, DOC applied for waivers from the ACA requirements, stating that the department would have to essentially rebuild the living units to provide additional space or plumbing, and it did not have the funding to do so. ACA approved the waiver requests.
restrictive housing and have a cell to themselves. Some staff suggested that prisoners have committed assaults on staff or self-injurious behavior in order to be transferred to Oak Park Heights, where all prisoners are in single cells.\textsuperscript{19}

Facility administrators and corrections officers also told us that double-bunking can create prisoner management challenges because of the need to allow more than one prisoner in and out of the same cell. For example, it is more difficult to enforce the confinement of a prisoner to a cell for misbehavior when the prisoner’s cellmate is allowed to come and go during unstructured recreation times.

**RECOMMENDATION**

*The Legislature should repeal the requirement that the Department of Corrections use multiple occupancy cells “to the greatest extent possible.”*

As with many of the other factors contributing to violence cited by DOC administrators and staff, it is difficult to draw firm conclusions about the relationship between double-bunking and violence due to the data limitations we described in Chapter 2. Further, the academic literature on the effects of crowding in prisons is not conclusive. However, we think that requiring DOC to use multiple occupancy cells is unnecessary and micromanages the department’s actions. Repealing the requirement would likely have no immediate effect; DOC would have just as many prisoners to house as before and no additional prisons to do so. However, it could give DOC greater flexibility to manage its prisoner population in the future. If, for example, DOC dramatically improves its data collection efforts and is able to show that double-bunking is correlated with increased violence—as its leaders suspect—it would be better positioned to take steps to improve safety.

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\textsuperscript{19} A very small number of prisoners in Oak Park Heights’ medical unit are in double-occupancy rooms.
Chapter 6: Decision Making and Oversight

Leadership teams at each individual prison make key decisions regarding staff duties, distribution of staff, and use of the prison’s budget. These teams are responsible for the safety of prisoners and staff, and make decisions about how to react when security incidents occur. The Department of Corrections (DOC) central office sets policies, manages certain prison operations, and provides oversight to the prisons.

In this chapter, we first discuss prison leaders’ decision making and how staff perceive their decisions. Then, we describe the oversight provided by DOC’s central office and external bodies.

Prison Leadership

Administrative teams that manage Minnesota correctional facilities include a warden, associate wardens, security captains, and program directors, among other leadership roles. Prison administrators follow department-wide policies, but they may adapt some policies to the unique context of their prison. The box on the next page shows the central office and prison leaders responsible for many security-related decisions at the prisons.

Security Decisions

Prison leaders make decisions every day that influence the safety and security of their prison. These decisions include determining how to control prisoner movement within the correctional facility and deciding on necessary follow-up actions to reported incidents. In this section, we discuss the information on which they base security decisions.

Key Findings in This Chapter

- Prison administrators often rely on subjective, informal impressions to assess safety in their prison.
- Many staff, particularly at Level 4 and 5 prisons, do not trust administrators to make appropriate decisions regarding safety for staff.
- The central office’s oversight of prisons’ safety performance is limited.
- The Department of Corrections does not license the facilities it operates—unlike other correctional facilities in the state—but the legal basis for the department’s position is questionable.
- The Department of Corrections’ “security audits” could provide valuable oversight, but the department’s implementation of these audits limits their usefulness.

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1 Some Department of Corrections officials based at the central office share management of prison staff with the prison leadership team. For example, teachers at the prisons report to both the central office Director of Education and the warden of their prison.

2 DOC changed its leadership structure in January 2020. During most of the period of our evaluation, the Assistant Commissioner for Facilities reported to a Deputy Commissioner for Facilities, who then reported to the Commissioner.
Prison administrators often rely on subjective, informal impressions to assess safety in their prison.

Prison administrators’ methods of assessing safety are not systematic, vary among prisons, and often rely on administrators’ own preferences. In our site visit interviews, leaders at all prisons mentioned statistics that could be used to evaluate prison safety, such as the number of violent incidents or physical harm to staff and prisoners, but the statistics reviewed and the importance placed on them varied. Administrators from a majority of prisons also said they considered perceptions of safety within the prison. However, some administrators noted that they simply form impressions of staff and prisoner perceptions through informal means; they do not systematically solicit opinions. Several administrators also commented that they assess safety by how well staff follow policies and procedures.

Most administrators told us they did not formally assess whether changes they had made to improve safety actually made a difference, relying almost entirely on personal observations or those of staff. A few wardens said they might monitor whether additional incidents occur after a change is made. However, monitoring is often informal. One warden acknowledged that administrators have no way of knowing whether specific changes lead to increased or decreased violence.

Documentation of the reasoning behind decisions is frequently informal or nonexistent. DOC generates a large number of reports, but those reports generally are about “what,” not “why,” such as what happened in an incident, how many prisoners officers counted in specific locations, or which staff worked at which posts. Decisions made to improve safety often do not have written justification or plans for measuring their impact. More commonly, administrators and experienced staff tell stories about past events that shape current practices. We found that the reasons for current practices often lay not in written documents, but in the memories of senior staff. For example, a staff member at one prison explained that the prison no longer uses a certain recreational area due to an assault that occurred there long ago. It is often difficult to determine at a later point in time why a decision was made or whether it achieved its intended objective.
Many staff stated that DOC’s reactive decision making perpetuates safety risks.

In our interviews, we were often told that DOC makes changes only as a reaction to major incidents. Corrections officers—and some administrators—told us repeatedly about potential safety risks inside prisons, but claimed that nothing would change unless a serious incident happened. For example, multiple prison staff and even an administrator shared stories about instances at the Stillwater prison in which staff or inmates nearly fell or were pushed off the narrow walkways in front of cells (called “galleys”) to the floor several stories below. Office of Special Investigations reports also described cases in which staff or inmates were close to falling over the galleys. However, little has been done to address these risks because no severe incidents related to the galleys have occurred so far.

We were also told about many instances where a single noteworthy event led to changes affecting many staff and prisoners. For example:

- Rush City removed staplers from officer desks in the living units after a prisoner assaulted an officer using a stapler.
- Oak Park Heights removed razors from prisoners’ property after a prisoner assaulted an officer with a razor.
- DOC changed its policies for officer security rounds systemwide after an investigation into a 2015 prisoner suicide revealed that officers had not conducted security rounds properly. Prisons began conducting “security round reviews,” in which supervisors viewed video footage to verify that officers were conducting rounds appropriately.

Reactive decision making tends to emphasize high-profile incidents and de-emphasize ongoing background concerns. For example, administrators at one prison told us that gangs often controlled access to phone or laundry machines through extortion. Extortion creates ongoing security concern for prisoners, who might become involved in other illicit activities to pay the extortion and avoid violence. However, prison staff largely handled extortion on a case-by-case basis, treating each report as an individual issue affecting the prisoner being extorted rather than a systemic issue affecting the entire prisoner population. Administrators have only recently introduced a new way of distributing items amongst prisoners that they hope will reduce extortion activities.

A few prison leaders acknowledged that security decisions are often reactive, but commented that prisons must adapt out of necessity as prisoners change their actions and behaviors. If prisoners notice a weakness in security and act upon it, the prison responds by shoring up that deficiency—only for prisoners to find the next weakness to exploit.
In some instances, reactions to major events have led to systematic assessments that produced broader policy changes. For example, following the death of Stillwater Officer Joseph Gomm in 2018, the department began working to review its “tool control” policy—that is, its procedures for tracking prisoner tool usage and ensuring secure tool storage when tools are not in use. DOC asked each facility to inventory their tools, assess whether tools were needed, and eliminate any unnecessary tools. On several of our prison visits, staff told us that their prison’s tool controls had improved as a result of this systematic review.

**RECOMMENDATION**

**Prison administrators should more systematically assess the impact of changes intended to improve safety.**

Security changes made in reaction to high-profile events—and implemented without a formal way to assess the impact of those changes—make it challenging to determine what actually works to improve safety and security. While it is appropriate to make changes as prisons identify new risks, we recommend that administrators shift towards systematic evaluations of security needs as a whole. When prisons make specific changes intended to improve safety, leaders should identify the expected outcomes and then measure the extent to which they are achieved. For example, if the intended outcome is to reduce violence in a certain area, administrators should actively track the number of violent incidents in that location before and after a given change.

Prison administrators’ reliance on informal impressions is likely due in large part to DOC’s inability to provide them with high-quality data. This recommendation is closely tied to our Chapter 2 recommendation that DOC reorganize its data gathering efforts. If that recommendation is not implemented, it will be much more challenging for prison leaders to follow this information and use more evidence-based decision making to address safety concerns.

**Trust in Leadership**

DOC’s commissioner told us that lack of trust is a serious ongoing issue in the department, saying that staff lack trust both in leadership and in other staff members. Our surveys and interviews supported his assessment.

**Many staff, particularly at Level 4 and 5 prisons, do not trust administrators to make appropriate decisions regarding safety for staff.**

In our survey of DOC staff, one-third of respondents either disagreed or strongly disagreed that “prison administrators do all they can to reduce violence by prisoners against staff.”\(^3\) As shown in the box on the next page, around 60 percent of staff at Oak Park Heights and Rush City and about 50 percent of staff at Stillwater said they disagreed or strongly disagreed with this statement.

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\(^3\) We surveyed staff working at all state correctional facilities who regularly interact with prisoners. For details, see the Appendix.
Our findings are consistent with an internal survey DOC administered in 2018. About 40 percent of staff responding to that survey disagreed or strongly disagreed with the statement “I trust my Executive Team members.” Almost 75 percent of responses from Stillwater disagreed or strongly disagreed with this statement, although it is important to note that DOC administered the survey following the death of Stillwater Officer Joseph Gomm. More than 45 percent of staff responding to DOC’s survey from Lino Lakes, Oak Park Heights, Rush City, and St. Cloud expressed a lack of trust in their executive teams.

In our site visit interviews and survey, staff cited multiple reasons for distrusting administrative decisions. Sometimes staff tied their distrust to the perception that administrators do not understand the day-to-day experience of the “line staff” who have direct contact with prisoners on a daily basis. Many staff complained that administrators made decisions without taking staff input into account.

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4 The survey defined “executive team” as “facility or field services leadership.”

5 To protect respondents’ confidentiality, DOC administered its staff survey without taking steps to prevent individuals from completing the survey multiple times (or to ensure that all respondents were actually current staff). As a result, although the DOC survey findings are similar to ours, their results should be interpreted cautiously.
Some staff also said that when leaders do request staff input, the effort is inadequate or insincere. One staff member said he believed decisions had already been made prior to requesting staff input. Others believed staff are penalized for expressing their opinions.

Many staff said there is an overall lack of transparency from administrators, which they believed affects safety in the prisons. For example, staff at one prison described a decision made to change the seating arrangement in the prisoner dining hall. Leaders communicated the decision to staff in one memorandum, but provided a different memorandum with different information to prisoners. The different memoranda led to some confusion, and prisoners reacted to the change and the lack of communication with hostility. After staff de-escalated the potential conflict, staff said they wished they had had access to both documents prior to implementing the seating change to better address prisoners’ concerns.

**RECOMMENDATION**

_The Department of Corrections prison administrators should improve communication and consultation with prison staff._

Rebuilding trust in the department begins with communication. Many of the criticisms from staff were that administrators do not empathize with their situation, and furthermore, do not care to learn about what they do or about their concerns. Others criticized the lack of transparency from administrators. All of these complaints are rooted in communication, and administrators at prisons with high levels of distrust should look first at their communication with staff.

As we stated at the beginning of this section, DOC has recognized its challenges with lack of trust, and the department has taken steps to address them by increasing staff engagement. During 2019, staff from the commissioner’s office conducted listening sessions at each correctional facility. DOC also embarked on a strategic planning process and opened opportunities for staff to participate in planning work groups. Members of the work groups included staff from all prisons, including administrators and line staff with a range of different responsibilities. We could not evaluate the efficacy of these steps, but we agree that such steps are important and believe even more should be done to improve engagement at the correctional facility level.
Oversight

The commissioner’s office oversees the 11 state correctional facilities by gathering reports, reviewing performance measures, and approving certain prison decisions. Additionally, central office administrators and prison leaders coordinate with external bodies that provide oversight over specific aspects of the correctional facilities.

Oversight by DOC’s Central Office

As we described in Chapter 2, DOC’s data inhibit the department’s ability to measure its performance in protecting the safety of prisoners and staff.

The central office’s oversight of prisons’ safety performance is limited.

Senior central office administrators told us they have no formal way to evaluate safety at DOC correctional facilities on an ongoing basis. Central office leadership may review statistics, such as the number of assaults on staff, the number of injuries at the facilities, or other figures that appear in prisons’ required quarterly reports, but they do not assess them systematically or develop an overall performance score for each prison. Rather, senior central office administrators rely on their personal observations and narrative reports from prison leaders. They also draw information from other offices, such as the Office of Special Investigations and the Safety Department.

Wardens have discretion to determine which information to share with central office administrators. Senior central office administrators listed several types of security incidents they would expect to be notified about immediately, such as significant assaults on staff and prisoner suicide attempts. However, DOC policies require notification only for certain events. For example, DOC policy requires that prisons notify the Assistant Commissioner of Facilities regarding prisoner deaths. Central office administrators rely on the judgment of wardens to understand what the central office needs to know.

Central office administrators routinely review certain types of decisions made by prison leaders. For example, central office administrators review any cases in which an inappropriate use of force against a prisoner might result in leaders disciplining prison staff.

External Oversight

Beyond the direct supervision of the central office, prisons are subject to external oversight from a number of entities. These entities may be entirely external to DOC or may be located within the department, using auditors or reviewers from outside of the prison in question. Below, we briefly summarize several forms of external oversight that address safety. We then discuss two of these forms—licensing and security audits—in greater detail.
No single external form of review provides comprehensive oversight of safety in Minnesota state prisons.

Reviews generally provide oversight for select components of safety at the prisons, rather than safety as a whole.

- **DOC Inspection and Enforcement.** DOC’s Inspection and Enforcement unit provides oversight to select programs within the correctional facilities. The Red Wing juvenile program, as a juvenile residential out-of-home placement, must be licensed and inspected under the Children’s Residential Facility Licensing Standards.\(^6\) DOC Inspection and Enforcement conducts these inspections every two years. Adult and juvenile sex offender treatment programs at the prisons are also certified by the Inspection and Enforcement unit.\(^7\)

- **DOC Security Audits.** DOC coordinates peer-review-style “security audits” of its prisons, in which senior staff from other DOC prisons spend several days reviewing a prison’s security procedures. Security audits assess prisons’ compliance with a broad array of security measures, such as tool and key control, staff training on incident response, and monitoring prisoner movement. These audits do not review data on past security incidents except to check whether the prison is maintaining the appropriate records. Audit standards derive from DOC policies, so security audits are a way to measure prisons’ adherence to department policy.

- **Prison Rape Elimination Act (PREA) audits.** State prisons undergo federally required PREA audits that review the existence of controls and procedures to reduce sexual abuse and harassment against prisoners.\(^8\) PREA oversight is limited; it does not address violence that is not sexual, nor does it address sexual offenses against staff. Minnesota correctional facilities have been audited for compliance with PREA twice since 2014, in accordance with the PREA requirement that facilities undergo one audit every three years. All DOC prisons have either met or exceeded all applicable PREA standards.

- **Minnesota Occupational Safety and Health Administration (MNOSHA) inspections.** MNOSHA promulgates rules related to occupational safety and health for working conditions in Minnesota, and may inspect workplaces to ensure compliance with health and safety standards. MNOSHA may also launch investigations after serious employee injuries or employee deaths. After the July 2018 death of Officer Joseph Gomm at Stillwater, MNOSHA conducted a comprehensive investigation, found the prison’s procedures for protecting the safety of its employees insufficient, and fined DOC $25,000. DOC is currently contesting the fine. MNOSHA also investigated the death of

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Officer Joseph Parise at Oak Park Heights and issued no citations. However, aside from the two death investigations in 2019, MNOSHA has not conducted any other on-site investigations related to physical conflicts at DOC prisons in the past ten years.

- **Ombudsperson for the Department of Corrections.** The Office of the Ombudsman for Corrections was first established in 1973 and operated for 30 years until the Legislature abolished the office in 2003. The corrections ombudsman responded to information requests, provided assistance with and investigated complaints, and made formal recommendations to DOC about systemic issues discovered in its investigations. The Legislature re-established the Office of Ombudsperson for the Department of Corrections in 2019, and the governor appointed the new ombudsperson in December 2019.

- **American Correctional Association (ACA) accreditation.** DOC began seeking accreditation for state correctional facilities from the American Correctional Association in 2014. ACA is a professional organization that produces standards for correctional entities.

DOC staff told us that ACA accreditation reviews have focused heavily on documentation, such as whether DOC has appropriate policies in place or whether staff documented actions in the appropriate logs. ACA inspectors do not verify that practices are being carried out as reported. ACA audited nine DOC correctional facilities from 2016 through 2019 to ensure that the facilities complied with ACA standards; all facilities successfully received accreditation.

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9 MNOSHA does not publicly disclose the identities of injured employees when it conducts investigations into workplace injuries (*Minnesota Statutes* 2019, 182.663, subd. 4). We concluded that publicly accessible MNOSHA investigation data referred to the deaths of Officers Gomm and Parise based on the listed dates and locations of the incidents.

10 MNOSHA has conducted investigations related to non-conflict hazards at DOC prisons, such as inadequate ventilation and asbestos. MNOSHA conducted a routine full inspection of Shakopee in 2013 and issued one citation related to the safety shielding on a hydraulic press.


12 The corrections ombudsman was particularly authorized to investigate actions that might be “(1) contrary to law or rule; (2) unreasonable, unfair, oppressive, or inconsistent with any policy or judgment of an administrative agency; (3) mistaken in law or arbitrary in the ascertainment of facts; (4) unclear or inadequately explained when reasons should have been revealed; (5) inefficiently performed.” *Minnesota Statutes* 2002, 241.44, subd. 2(a). However, the ombudsman could investigate “any action” by the department. *Minnesota Statutes* 2002, 241.44, subd. 3.


14 ACA had previously accredited DOC correctional facilities, but the department discontinued accreditation approximately ten years before seeking it again in 2014.

15 Togo and Willow River will undergo their initial ACA reviews in April 2020.
Many DOC staff found the ACA accreditation process burdensome and unhelpful, and the department decided to discontinue accrediting its facilities. After reviewing the correctional facilities’ audit reports from 2016 to 2019, we agreed with DOC that while preparing for the audits may have been a helpful exercise for DOC facilities, the ACA audits were not rigorous as an accountability mechanism. In particular, we were unimpressed with ACA’s review of the safety outcomes reported by individual prisons, as shown in the box at right.

Licensing

State law directs the commissioner of Corrections to create rules for the operation of correctional facilities and then inspect and license “all correctional facilities throughout the state” based on their adherence to those rules. DOC’s Inspection and Enforcement unit inspects and licenses county jails every two years under this requirement and issues citations when it finds violations.

The Department of Corrections does not license the facilities it operates— unlike other correctional facilities in the state—but the legal basis for the department's position is questionable.

DOC officials have said over time that state prisons are exempt from the inspection and licensure requirement in state law. The department has based its position on the fact that state law exempts the department from the rule-making requirements of the Administrative Procedure Act for rules related to the internal operations of its correctional facilities. However, the language of the correctional facilities licensing law is clear. It says, “…the commissioner of corrections shall inspect and license all correctional facilities

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16 Minnesota Statutes 2019, 241.021, subd. 1(a).

17 The Department of Corrections does not have to follow the Administrative Procedure Act’s rule-making process for rules “relating to the release, placement, term, and supervision of inmates serving a supervised release or conditional release term, the internal management of institutions under the commissioner’s control, and rules…governing the inmates of those institutions.” Minnesota Statutes 2019, 14.03, subd. 3(b)(1).
throughout the state...”\textsuperscript{18} None of the exceptions in the law exempt Department of Corrections’ facilities from being inspected and licensed.\textsuperscript{19} Since the correctional facilities licensing law and the Administrative Procedure Act are separate and distinct laws with separate and distinct purposes and requirements, we do not see how the second law negates the first.

Licensure provides accountability for correctional facilities. For example, county jails face serious consequences if they receive repeated citations for failure to comply with state rules and correct cited deficiencies—the commissioner of Corrections may even condemn a jail if it is insecure or otherwise unfit for use.\textsuperscript{20} Currently, Minnesota state prisons do not face the same consequences. Instead, state prisons need only meet DOC’s policies, and the consequences for failing to do so may vary. For example, both jails (under state rules) and prisons (under DOC policy) require correctional staff to perform regular security rounds or well-being checks on prisoners at defined intervals.\textsuperscript{21} Jails can receive progressive sanctions for failing to implement this requirement. Meanwhile, prisons would not be sanctioned if prisoner checks do not occur.

**Security Audits**

Although DOC prisons are not licensed, DOC’s Inspection and Enforcement unit does participate in a form of external oversight by serving as the coordinator of DOC’s security audits. However, these audits are not as frequent as county jail licensing inspections and their findings do not take the form of formal citations.

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**The Department of Corrections’ “security audits” could provide valuable oversight, but the department’s implementation of these audits limits their usefulness.**

Security audits are a DOC initiative; there is no statutory requirement that DOC perform them. Under DOC policy, the department should conduct security compliance audits at least once every four years at each prison. However, audits have generally occurred less frequently.\textsuperscript{22} St. Cloud has not had a security audit since 2011 and Rush City not since 2013.

In our review of the most recent security audit for each correctional facility, we noted several benefits of the security audits. Final audit reports highlighted auditors’ major

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\textsuperscript{18} *Minnesota Statutes* 2019, 241.021, subd. 1(a).

\textsuperscript{19} *Minnesota Statutes* 2019, 241.021, subd. 1(b).

\textsuperscript{20} *Minnesota Rules* 2911.0300, subp. 2, published electronically December 15, 2017; and *Minnesota Statutes* 2019, 241.021, subd. 1(e); and 641.26.


\textsuperscript{22} DOC may also conduct partial audits with a narrow focus, such as tool control. We did not include partial audits in our assessment of the length of time between security audits.
security concerns, often noting concerns that did not appear in other forms of oversight we reviewed. Additionally, because audit standards are divided into a number of topics, DOC can roughly compare how well different prisons perform in different areas (see box at right). Comparing prisons could help identify those with particularly positive practices that others can replicate. Prison and central office administrators agreed that they found the security audits helpful and that they provided more valuable information than other external reviews like the ACA audits.

DOC has no formal requirement that prisons address security audit recommendations, and there is little follow-through by central office administrators to ensure that prison leadership teams address issues identified in security audits. A few wardens told us they have rarely, if ever, received inquiries regarding whether the audit recommendations were implemented. Some recent security audits for prisons repeated noncompliance findings from a previous audit (which in some cases, might have occurred six or seven years earlier). DOC’s Inspection and Enforcement unit sometimes conducts a follow-up audit within about a year to review whether the prison has acted upon audit recommendations, but the only consequence for having failed to act on the recommendations is to be marked as “noncompliant” once more.

According to the director of DOC’s Inspection and Enforcement unit, DOC suspended its security audits in 2018 to update the standards used by auditors. However, the update process has languished, and no full security audits have occurred since May 2018.23

**RECOMMENDATION**

The Legislature should require that the Department of Corrections regularly inspect state prisons according to defined security standards.

In our view, correctional facilities benefit from undergoing regular inspections to ensure that they comply with practices that promote the safety of staff and prisoners. External reviewers may also be able to highlight security concerns to which those in the facility have grown accustomed.

We previously expressed concern that DOC had limited external review of its own facilities in the areas of health services in our 2014 evaluation of *Health Services in State Correctional Facilities*.24 At that time, OLA recommended that the Legislature improve oversight of the state prisons by doing one or more of the following: (1) requiring DOC to license and inspect its own prisons, (2) reestablishing a state

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23 The most recent partial security audit occurred in September 2019 for Stillwater’s industry operations.

ombudsman for corrections, or (3) requiring DOC to seek accreditation for its prisons. As we described above, DOC implemented ACA accreditation, but then decided to end the practice in 2019 with final audits occurring in 2020. While we did not assess how well ACA accreditation reviews provided oversight for health services (the topic of our earlier report), this form of oversight did not provide effective oversight with regard to safety. The state ombudsperson for corrections will soon begin operating once more, but if this office is similar to the previous iteration, the ombudsperson will largely focus on individual concerns and not broader oversight.

We therefore continue to recommend that state prisons be subject to ongoing, systematic external oversight. The Legislature, in consultation with DOC, should determine whether this recommendation is best addressed by: (1) requiring that DOC license and inspect its prisons, or (2) adding the security audit process to state law. A formal requirement that DOC regularly inspect its correctional facilities would prevent the department from either discontinuing regular security reviews or from falling behind its review schedule. The Legislature could also require more formal and consistent documentation from prison leaders regarding actions taken following reviews of the prisons’ security practices.

If the Legislature pursues licensing, there may need to be a transition period as the department addresses some of the challenges associated with licensing its own facilities. For example, the department would need to ensure that the staff who review and inspect the department’s prisons for licensure have adequate independence from department officials and prison administrators. However, the department’s Inspection and Enforcement unit is separate and independent from the prisons. As we described earlier in this chapter, this unit already licenses and inspects certain programs within DOC, such as the juvenile facility at Red Wing.

Additionally, if DOC licenses its own prisons, the department might need to establish new standards specific to state prisons or adapt existing rules to ensure the state’s facilities are subject to appropriate requirements. Some rules for jails might not be appropriate for prisons due to the differences in managing correctional facilities for short-term versus long-term confinement.

If the Legislature decides to require security audits, it should require DOC to regularly update and improve audit standards. We also believe DOC could improve its security audit process, which currently focuses heavily on procedures. We suggest that auditors pay additional attention to outcomes by reviewing available data and reports on past security incidents. Such outcome data could lead auditors to focus especially carefully on problem areas. For example, our review of Office of Special Investigations’ cases suggested that St. Cloud has had a greater proportion of violent incidents occur in its dining hall than other prisons. Security auditors might use this information to focus greater attention to that area during their review.
List of Recommendations

- The Department of Corrections (DOC) should transform how it gathers and uses data to assess and improve safety in prisons. (p. 17)
- DOC performance reports should include more complete data on violence in prisons. (p. 19)
- DOC should:
  - Ensure supervisors take action when prisoners commit sexual misconduct against staff.
  - Distinguish disciplinary charges for prisoners’ sexual misconduct against staff from other infractions. (p. 26)
- Particularly at higher security prisons, DOC should establish higher shift staffing targets for corrections officers to accommodate unplanned events. (p. 37)
- DOC should continue its efforts to hire more corrections officers. (p. 37)
- DOC should track the extent of its understaffing and use of forced overtime. (p. 40)
- Prisons should assign more officers to locations with higher levels of repeated violence and prevent those officers from being redirected to other priorities. (p. 42)
- DOC should make greater efforts to address bullying, harassment, and retaliation among staff. (p. 45)
- DOC should provide more “hands-on” training courses for existing staff. (p. 48)
- DOC administrators should strive to improve the transparency of decision making to run or suspend programming and recreation. (p. 55)
- DOC should improve its data on prisoner discipline and the use of restrictive housing. (p. 62)
- DOC should develop and present to the Legislature a long-term plan for rehabilitating or replacing the living units at the St. Cloud and Stillwater correctional facilities. (p. 66)
- The Legislature should repeal the requirement that DOC use multiple occupancy cells “to the greatest extent possible.” (p. 70)
- Prison administrators should more systematically assess the impact of changes intended to improve safety. (p. 74)
- DOC prison administrators should improve communication and consultation with prison staff. (p. 76)
- The Legislature should require that DOC regularly inspect state prisons according to defined security standards. (p. 82)
Survey Methodology

APPENDIX

We administered two surveys as part of this evaluation, one of prisoners and one of prison staff. In this appendix, we explain how we conducted the surveys and discuss the limitations of the survey data. In particular, our survey of prisoners presented several methodological and ethical challenges. The Department of Corrections (DOC) provided valuable assistance to enable us to complete the survey.

Prisoner Survey

Population. Using a DOC database, we compiled a list of all adult prisoners held by DOC in Level 3, 4, or 5 custody settings (including Shakopee, which combines all custody settings). We consulted with DOC administrators about the logistical challenges of administering surveys to prisoners and decided on a sample size of 50 prisoners per prison. We increased that amount to account for prisoners who might be unavailable due to placement in restrictive housing, transfer to other prisons, medical conditions, or other factors. After excluding prisoners that had been at their current facility less than 30 days, we drew a simple random sample at each of eight prisons: Faribault, Lino Lakes, Moose Lake, Oak Park Heights, Rush City, St. Cloud, Shakopee, and Stillwater.1 Our total sample was 439 prisoners.

Administration. We administered the questionnaire using an online survey tool, which prisoners accessed from computers in education classrooms or other locations chosen by prison staff. DOC information technology staff created special temporary computer configurations so that prisoners would be able to connect to our online survey without gaining inappropriate internet access. Although prison staff brought prisoners to classrooms and supervised them while they completed the survey, prison staff were not able to observe prisoners’ answers.

Due to the complexities of organizing prisoner movement and activities (and the ongoing staffing shortages we discuss in Chapter 3), we allowed prison administrators to decide how best to schedule when prisoners would complete the survey. We provided a three-week window during which prisons arranged for prisoners to take the survey, and then extended that window to provide additional time to some prisons with low response rates.

Ethical considerations. We consulted with DOC’s Institutional Research Board in developing our survey protocol; due to their incarceration, prisoners may feel coerced to respond to a survey or believe that their responses put them at risk. We emphasized to prison staff that survey participation was voluntary and prisoners could choose not to participate. Further, before prisoners began the survey, they were able to read additional information about the voluntary nature of the survey and about how we would protect the confidentiality of respondents. Because we were concerned that some

1 Red Wing, Togo, and Willow River have only Level 2 security units for adult prisoners.
respondents might have limited literacy skills, prisoners could also listen to an audio recording of this introductory information.

Response. We received 246 responses, for an overall response rate of 63 percent. However, response rates varied dramatically among prisons, as is shown in the box at right. Because we were not present during survey administration, it is difficult to know why response rates varied so much. Based on conversations with the individuals coordinating the surveys at several locations, we suspect that some prisoners might have been able to take the survey only at times when they would have had to give up other activities to participate and chose not to do so.

We examined whether there were factors that affected response rate across all prisons, such as race, age, or severity of crime. We did find that in nearly all prisons, prisoners without a high school diploma or General Educational Development (GED) certification were less likely to participate in the survey. However, the most important factor influencing survey participation appeared to be the prison where a respondent was housed.

Analysis. Our survey sample was not proportionate to the number of prisoners at each prison—we sampled approximately 50 prisoners both at Faribault, which holds nearly 2,000 prisoners, and at Oak Park Heights, which holds less than 400. As a result, prisoners had a different probability of being selected for the sample based on where they lived. To account for these differences, all prisoner survey results presented in the report are statistically adjusted (weighted) to account for these unequal probabilities.

The 95 percent confidence interval for our survey of prisoners is plus or minus 7 percentage points. When we refer to survey results for a subsample of prisoners (for example, just those at Level 3 prisons), the confidence intervals are larger. For the most part, we have avoided presenting survey results for individual prisons because they rely

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2 We calculated response rates by dividing the number of respondents by the number of prisoners in the sample able to take the survey. For example, of the 58 prisoners in our sample of St. Cloud prisoners, 37 completed the survey, 4 chose not to participate, and 17 were unable to take the survey. (St. Cloud is the intake facility for all DOC prisons, and several prisoners in our sample transferred to another prison before they could take the survey.) Thus, we calculated St. Cloud’s response rate by dividing the 37 prisoners that took the survey by the 41 who were able to take it. Rush City did not report how many prisoners in its sample were unavailable, so we assumed all prisoners were available. If we instead calculated response rates using the number in our original sample as the denominator, all of the percentages in the box (except Rush City) would be lower and our overall response rate would be 56 percent (246 ÷ 439).

3 We used additional weighting to account for the differences we observed in response rate by educational attainment.

4 A 95 percent confidence interval means that if random samples of the same size were drawn repeatedly from the same population of prisoners, the true result for the entire population would fall within the measured intervals 95 percent of the time.
on so few responses (and thus confidence intervals are large). However, we occasionally present results for Shakopee separately because its environment is quite different from the prisons housing men. The 95 percent confidence interval for our survey of Shakopee prisoners alone is plus or minus 17 percentage points.

Staff Survey

Population. DOC’s human resources office provided us a file of all DOC employees that work at state correctional facilities. To limit our survey population to staff that regularly interact with prisoners, we used information about enrollment in state retirement plans. Under state law, employees who interact with prisoners for at least 75 percent of their work time are eligible for the Correctional Employee Retirement Plan (CERP).\(^5\) We included in our survey population all positions where at least 91 percent of the individuals holding that position were in CERP, and excluded all positions where less than 9 percent of employees were in CERP.\(^6\) For positions in maintenance and the trades—which were more evenly divided—we included only individuals in CERP in our survey population.\(^7\) Our total survey population was 2,907 staff.

Administration. Surveys were conducted online. We contacted potential responders by e-mail, and they completed the surveys using an Internet survey tool. We assured responders that we would treat individual responses as private information.

Response. We received 1,469 responses, for an overall response rate of 51 percent. As shown in the boxes on this page and the next page, response rates varied both from prison to prison and by position. Unfortunately, during the time period when we were administering our survey, DOC experienced a serious cyberattack on its computer systems that affected some prisons more than others. The disruptions caused by the attack—and the accompanying warnings to staff to treat unexpected emails with caution—likely affected our response rates. Corrections officer staffing shortages may also have affected whether officers responded to the survey.

<table>
<thead>
<tr>
<th>Prison</th>
<th>Responses Received</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Wing</td>
<td>100</td>
<td>62%</td>
</tr>
<tr>
<td>Togo</td>
<td>30</td>
<td>58</td>
</tr>
<tr>
<td>Moose Lake</td>
<td>172</td>
<td>57</td>
</tr>
<tr>
<td>Shakopee</td>
<td>113</td>
<td>55</td>
</tr>
<tr>
<td>Stillwater</td>
<td>220</td>
<td>52</td>
</tr>
<tr>
<td>Willow River</td>
<td>29</td>
<td>52</td>
</tr>
<tr>
<td>Rush City</td>
<td>132</td>
<td>51</td>
</tr>
<tr>
<td>Faribault</td>
<td>247</td>
<td>50</td>
</tr>
<tr>
<td>Lino Lakes</td>
<td>186</td>
<td>49</td>
</tr>
<tr>
<td>St. Cloud</td>
<td>144</td>
<td>45</td>
</tr>
<tr>
<td>Oak Park Heights</td>
<td>96</td>
<td>38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,469</strong></td>
<td><strong>51%</strong></td>
</tr>
</tbody>
</table>

\(^5\) *Minnesota Statutes* 2019, 352.91. All correctional officers, lieutenants, and captains are automatically eligible for CERP, regardless of their specific job responsibilities.

\(^6\) For example, 59 of the 61 licensed practical nurses working in prisons were in CERP. Thus, we included all licensed practical nurses in our survey population.

\(^7\) For a handful of other positions, we made decisions based on information we learned on our site visits and by consulting DOC human resources staff (for example, we included all chaplains, although some are in CERP and some are not).
Analysis. Because we invited all staff in our survey population to take the survey, there was no need to extrapolate to a larger population from a sample; thus, there is no confidence interval to report. We chose not to weight responses based on prison and job type because we frequently provide information about the responses of subgroups, which would require different (or no) weighting.

<table>
<thead>
<tr>
<th>Staff Survey Response Rates by Job Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
<tr>
<td>Security (Lieutenants)</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>MINNCOR</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Medical Health</td>
</tr>
<tr>
<td>Physical Plant/Trades</td>
</tr>
<tr>
<td>Food Service</td>
</tr>
<tr>
<td>Security (Officers)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
February 21, 2020

James R. Nobles  
Office of the Legislative Auditor  
Room 140, Centennial Building  
658 Cedar Street  
Saint Paul, Minnesota 55155-1603  

Dear Mr. Nobles:

Thank you for the work you and your team did assessing safety in Minnesota’s correctional facilities over the last several months. We reviewed your findings and recommendations, and we concur in whole. This audit was born out of tragedy. Action on the recommendations you present, along with agency initiatives currently underway, is an opportunity to develop the Minnesota Department of Corrections into a national leader on data-driven safety and security practices that supports transformation of lives for a safer Minnesota.

The deaths of Officers Gomm and Parise stand out among our agency’s darkest hours. Having spent 30 years in law enforcement, including speaking at the funeral of a friend and colleague who was killed in the line of duty, I know that agencies that experience such tragedies are forever impacted. As a state, we must honor the service and sacrifice of these officers, but never should we accept loss of life as the acceptable risk of a career in public safety. As a state, we must take all reasonable and foreseeable steps to mitigate risk for our staff and the men and women serving sentences in our correctional facilities.

I was appointed to the role of commissioner just four months after Officer Parise’s death. From the start, members of the agency’s leadership team and I spent hundreds of hours in the state’s correctional facilities getting to know our new colleagues and learning about their concerns. During these conversations, we saw and heard a workforce understandably reeling from tragedy.

Still, much of what we heard from our staff gives us hope for the future. We heard deep commitment to serving the people of Minnesota. We heard passion for the work of transforming lives. And, we heard profoundly personal and proud stories about careers dedicated to public service.

These conversations also allowed us to hear the deeply troubling realities pertaining to the safety of our facilities. From the stories of staff and inmate assaults, we developed a better understanding of the growing challenge of realizing necessary staffing levels. We also observed with clarity how safety and staffing challenges impact the agency’s ability to deliver meaningful programming to transform the lives of those we serve. Adding to the range of issues were the reports of sexual harassment, bullying, and distrust that plague parts of the agency and make a career in correctional service that much more challenging.

Our recognition of these challenges informed our full-scale commitment to throwing open the doors to you and your staff when we learned of OLA’s assignment to assess safety in our prisons. We appreciate the opportunity to share our observations and concerns with you, and we are grateful for the time you spent obtaining the insights and perspectives of correctional facility staff at every level.
Even as you were engaged in your audit, we began the work of effecting change, reshaping culture, and initiating some new approaches to transforming lives for a safer Minnesota.

Now, 13 months into this administration, we have already begun implementing a number of the recommendations highlighted in your report. We are also actively engaged in implementing efforts that, while not specifically cited in your report, support the recommendation framework you offer.

In recognition of the reality that our prisons are publicly-funded entities entrusted to serve public safety and the public good, we’ve created unprecedented opportunity for the media to visit our prisons. We believe media access enables the people of Minnesota to gain a glimpse and understanding of the agency’s mission, the opportunities we have, and the challenges we face.

The Department of Corrections will identify agency staff to take lead roles on the recommendations advanced in your report. We will begin work on those recommendations that are within agency authority or resources as soon as practicable. Your comprehensive look back at the safety of our state’s correctional facilities confirms, supports, and underscores the significance of the work ahead of us. Your report establishes increased recognition of the immediate need for us to act.

We close by highlighting some of the initiatives we’ve been actively engaged in developing:

**Creation of a comprehensive agency Strategic Plan that will directly guide the agency’s work.**

We have been engaged in the strategic planning process for the past year. A new strategic plan that will guide the agency’s work, with clear goals and outcome metrics, is nearing completion. One core objective of our plan is the safety of agency staff, incarcerated people, and those under correctional supervision.

**Establishing the agency’s Office of Professional Accountability (OPA):**

The new Office of Professional Accountability moves the investigation of allegations of staff misconduct from supervisors to professionally-trained investigators, which allows supervisors to focus on employee development and performance. The OPA frees supervisors from time-consuming investigations to instead being directly engaged in the promotion of a positive culture. In addition to investigative expertise, the OPA will create a centralized allegation and outcome tracking process to better inform agency leadership on employee training and development needs to support professional accountability throughout the agency.

**Establishing the Office of Peer Support (OPS):**

This newly-created unit made up of existing agency personnel will develop new policies and protocols to support staff wellness and safety, provide immediate post-critical incident response, and identify pathways for agency staff to obtain trusted and professional mental health services. The office will also aid in resource navigation to support family members of staff impacted by traumatic events occurring in the workplace. OPS will also coordinate delivery of responsive support services for female staff who bear the inordinate and disparate impact of sexual harassment and sexual misconduct occurring in correctional facilities.

**Identification of data collection systems and processes to address the agency’s challenge of being “data rich, but information poor.”**

Strategic planning and information technology staff are planning for the systems and processes necessary to adequately track and evaluate critical incidents, staff assaults, inmate-on-inmate assaults, violent events, staff
deployment, shortages, and overtime usage – all in real-time. We also plan to develop systems to track inmate involvement in and completion of transformative programming options, along with corresponding outcome data, including inmate disciplinary interventions. When implemented, we will develop accessible data reporting dashboards to inform strategic decision-making across the agency.

**Overhaul of new employee onboarding, training academy, enculturation, and performance management.**

Built on a foundation of servant leadership devoted to our mission of transforming lives for a safer Minnesota, we are overhauling how we welcome, onboard, train, and develop a culture of service to the mission. Training will also include an emphasis on employee safety and wellness, along with the full complement of state-of-the-art training in the areas of tactical communications, de-escalation, and defense and control skills. We are also designing a new performance evaluation process that reflects the agency’s strategic priorities and recognizes every employee’s role in creating meaningful correctional outcomes.

**Evaluate a shift from a static “post” or location-based work assignment of staff to a dynamic deployment model.**

Wardens have been tasked with exploring the use of a dynamic model of staff deployment in our correctional facilities to ensure staff are deployed efficiently and effectively. To maximize safety and incident response, public safety agencies such as law enforcement, fire departments, and emergency medical services, began using a dynamic deployment model to put the right resources in “hot spots” or resource-depleted areas.

**Expanding tools to address inmate misconduct while minimizing the use of “lock downs” that negatively impact whole units within a facility.**

Long-term “lock down” of entire units within a facility reduces inmate involvement in transformative programming, increases idle time, and adversely affects the development and maintenance of prosocial relationships with family members. Research suggests that positive inmate activity reduces involvement in undesired behavior. When possible, we believe targeted interventions focused on those directly involved in prohibited conduct, rather than full-unit lock downs, advance a more communitarian response to wrongdoing.

**Limiting the use of restrictive housing as the primary disciplinary tool.**

The agency is continuing efforts to research and develop behavioral intervention options beyond restrictive housing, or “segregation.” Research studies have shown that the use of restrictive housing or “disciplinary segregation” can cause psychological harm to those subjected to it. As an agency, we believe restrictive housing as a disciplinary tool should be reserved for the most serious violations.

**Deployment of body-camera technology to aid in the creation of a safer environment for staff and inmates.**

Over the past eight months, a group of agency security staff and MN.IT employees have been exploring the launch of body worn camera technology. We believe this technology will improve facility safety, enhance supervision, and aid in documenting incidents of significance. Agency staff have been investigating costs, impact of the technology on internal operations, and development of policies applicable to a custodial setting.

Sincerely,

Paul Schnell
Commissioner
Forthcoming OLA Evaluations

Compensatory Education Revenue
Department of Human Rights: Complaint Resolution Process
Department of Human Services: Oversight of Personal Care Assistance
Pesticide Regulation
Public Utilities Commission’s Public Engagement Processes

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Agricultural Commodity Councils, March 2014
“Green Acres” and Agricultural Land Preservation Programs, February 2008

Criminal Justice
Safety in State Correctional Facilities, February 2020
Guardian ad Litem Program, March 2018
Mental Health Services in County Jails, March 2016
Health Services in State Correctional Facilities, February 2014
Law Enforcement’s Use of State Databases, February 2013

Economic Development
Minnesota Investment Fund, February 2018
Minnesota Research Tax Credit, February 2017
Iron Range Resources and Rehabilitation Board (IRRRB), March 2016

Education, K-12 and Preschool
Debt Service Equalization for School Facilities, March 2019
Early Childhood Programs, April 2018
Minnesota State High School League, April 2017
Standardized Student Testing, March 2017
Perpich Center for Arts Education, January 2017
Minnesota Teacher Licensure, March 2016

Economic Development and Housing Challenge Program, February 2019
Consolidation of Local Governments, April 2012

Government Operations
Office of Minnesota Information Technology Services (MNIT), February 2019
Mineral Taxation, April 2015
Minnesota Board of Nursing: Complaint Resolution Process, March 2015
Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014
Helping Communities Recover from Natural Disasters, March 2012

Health
Office of Health Facility Complaints, March 2018
Minnesota Department of Health Oversight of HMO Complaint Resolution, February 2016
Minnesota Health Insurance Exchange (MNsure), February 2015

Human Services
Home- and Community-Based Services: Financial Oversight, February 2017
Managed Care Organizations’ Administrative Expenses, March 2015
Medical Assistance Payment Rates for Dental Services, March 2013
State-Operated Human Services, February 2013
Child Protection Screening, February 2012
Civil Commitment of Sex Offenders, March 2011

Housing and Local Government
Economic Development and Housing Challenge Program, February 2019

Jobs, Training, and Labor
State Protections for Meatpacking Workers, 2015
State Employee Union Fair Share Fee Calculations, July 2013
Workforce Programs, February 2010
E-Verify, June 2009

Other

Oversight of Workers’ Compensation, February 2009

Miscellaneous
Minnesota State Arts Board Grant Administration, February 2019
Board of Animal Health’s Oversight of Deer and Elk Farms, April 2018
Voter Registration, March 2018
Minnesota Film and TV Board, April 2015
The Legacy Amendment, November 2011

Transportation
MnDOT Measures of Financial Effectiveness, March 2019
MnDOT Highway Project Selection, March 2016
MnDOT Selection of Pavement Surface for Road Preservation, March 2014
MnDOT Noise Barriers, October 2013

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Public Facilities Authority: Wastewater Infrastructure Programs

2018 EVALUATION REPORT