DEPARTMENT OF CORRECTIONS

VIA EMAIL ONLY

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CONDITIONAL LICENSE ORDER

Pursuant to Minnesota Statutes, section 241.021, subdivision 1a(a), the Minnesota Department of Corrections (DOC) hereby places the Hennepin County Adult Detention Center's (Hennepin County ADC) license to provide adult detention facility services at 401 South Fourth Avenue and 350 South Fifth Street, Minneapolis, MN 55415 on conditional status as of the date of this order. One of the terms of this conditional license is the capacity reduction for the Hennepin County ADC.

This order is based on Hennepin County ADC's failure to substantially conform to the minimum standards required under Minnesota Rules Chapter 2911, and its failure to make satisfactory progress toward substantial conformance with those standards.

Hennepin County ADC's failure to comply with these legal requirements has contributed to conditions that have the potential to pose an imminent risk of life-threatening harm or serious physical injury to individuals confined or incarcerated in the facility if left uncorrected. The capacity reduction and other terms imposed by this conditional license order are necessary to ensure Hennepin County ADC promptly corrects these deficiencies. The terms imposed by this order are designed to ensure the safety and well-being of the individuals in the care and custody of Hennepin County ADC, and to promote the remediation of deficiencies within a reasonable period of time as outlined below.

MINIMUM STANDARDS VIOLATED

Minnesota Rule 2911.0900, subp. 15(B) – Ratio of custody staff to inmates

Minnesota Rule 2911.3700, subp. 4 – Emergencies and unusual occurrences

Minnesota Rule 2911.5000, subp. 5 – Well-being checks

BACKGROUND OF HENNEPIN COUNTY ADC

Hennepin County ADC is physically located in two separate buildings, one located in the Minneapolis City Hall Building, and the other in the Hennepin County Public Safety Facility building. Bed capacity at Hennepin County ADC is:

Area	Bed Capacity
City Hall 4th Floor	275 beds
City Hall 5th Floor	234 beds
Public Safety Facility	330 beds
TOTAL	839 beds

In the City Hall portion of the Hennepin County ADC, there is a pipe alley, or plumbing chase, behind the cells, which staff sometimes utilize to conduct well-being checks of inmates. These are long, narrow hallways behind the cells that contain plumbing fixtures. Staff are unable to personally observe all inmates using the windows in the pipe alley. Each area contains obstructed views of the cell unless the inmate is standing directly in front of the window.

FINDINGS OF VIOLATIONS OF MINIMUM STANDARDS

Deaths of Hennepin County ADC Inmates

The DOC's Inspection and Enforcement (I&E) unit inspects and licenses adult correctional facilities such as Hennepin County ADC. This includes reviewing deaths that occur at the facility or after a person is transferred from the facility for medical care and subsequently dies. *See* Minn. Stat. § 241.021, subd. 1. Since a biennial inspection on September 7, 2022, seven inmates have died either at Hennepin County ADC or while receiving care at a medical facility after being transported from Hennepin County ADC for treatment.

Further, on September 4, 2024, while investigating the August 22 death of an inmate, an I&E inspector learned that another inmate had been transported from the facility for emergency medical care on August 25 and subsequently died on August 28.

Though the circumstances of each death differ, after each death review, the DOC found that Hennepin County ADC had violated the rule governing well-being checks, which states:

> A written policy and procedure shall provide that all inmates are personally observed by a custody staff person[1] at least once every 30 minutes. Thirty-minute checks should be staggered. If a well-being check does not occur due to an emergency, it must be documented in the jail log and have supervisory review and approval.
>
> More frequent observation is required for those inmates of a special need classification who may be harmful to themselves. Examples of inmates of a special need classification include those classified as potentially suicidal, or as mentally ill, or those experiencing withdrawal from drugs or alcohol.

Minn. R. 2911.5000, subp. 5.

Further, in reviewing the two most recent deaths, Hennepin County ADC was found in violation of the rule prescribing minimum staffing levels. *See* Minn. R. 2911.0900, subp. 15(B) (outlining minimum staffing ratios between *custody staff* and inmates).

The chart below provides a summary of the seven deaths of Hennepin County ADC inmates from the facility's biennial inspection in September 2022 through its biennial inspection in September 2024:

Date	Summary	Well-Being Check Violations (Minn. R. 2911.5000, subp. 5)	Minimum Staffing Violations (Minn. R. 2911.0900, subp. 15(B))
12/31/2022	Inmate died at the facility following a medical emergency at the facility.	X	
2/17/2023	Inmate died at Hennepin County Medical Center following a suicide attempt at the facility.	X	
3/14/2023	Inmate died at the facility after being found unconscious during a facility roll call following a medical emergency.	X	
9/18/2023	Inmate, who had been seen exhibiting severe symptoms of withdrawal, died at	X	

[1] "Custody personnel" is defined by the rules as "staff whose primary duty is supervision of inmates." Minn. R. 2911.0200, subp. 26.

	the Hennepin County Medical Center following a medical emergency.		
9/26/2023	Inmate died at the facility following a medical emergency at the facility.	X	
8/22/2024	Inmate died at the Hennepin County Medical Center after being transported for further medical care for suspected pneumonia.	X	X[2]
8/28/2024	Inmate, who had been seen exhibiting severe symptoms of withdrawal, died at the Hennepin County Medical Center after being found unresponsive following a medical emergency.	X	X

Pattern of Failure to Conduct Timely and Appropriate Well-Being Checks

As illustrated in the above chart, in reviewing each of these seven deaths, the DOC found Hennepin County ADC failed to meet the requirements of the well-being check rule. In the past two years, staff have failed to conduct well-being checks within the mandatory 30-minute period, have inaccurately logged that they have completed checks when no checks actually occurred, have completed checks in a manner that would not actually ensure the health and safety of inmates,[3] and have failed to put special-needs-classified inmates on more frequent observation. Investigators found the following after each death:

12/31/2022

Hours before the inmate's death, a staff member logged a well-being check within that inmate's unit, but one did not actually occur.

2/17/2023

Staff logged but did not actually conduct a well-being check and failed to conduct well-being checks at least every 30 minutes as required by the rule.

3/14/2023

Though the DOC's death review notes the violation did not directly contribute to the inmate's death, it nevertheless noted that "video review showed that some well-being checks [during the 16 hours preceding the inmate's death] were not completed in a manner that ensured staff were able to determine [whether] the inmate was [] experiencing visible or audible distress." This was a dorm style housing

[2] The DOC notes that the inmate in question was not housed in the units where there were staffing violations.

[3] When reviewing well-being checks, the I&E unit ensures that staff complete them in a manner that allows them to personally observe the inmate visually for signs of life and/or distress. This would include the staff member stopping and looking into a cell at a pace that ensures the inmate's well-being is observed.

unit, and the I&E inspector found that multiple inmates did not receive well-being checks sufficient to meet these personal observation requirements of the rule.

9/18/2023

Hennepin County ADC staff failed to put the inmate, who was exhibiting active withdrawal symptoms, on more frequent observation as required by the rule.

9/26/2023

In the death review letter, the I&E inspector noted that Hennepin County ADC staff conducted ten consecutive well-being checks "in a manner that did not allow for staff to observe the well-being of all inmates," including the inmate that died.

8/22/2024

In the hours preceding the inmate's transfer to Hennepin County Medical Center, Hennepin County ADC staff conducted ten well-being checks that were not sufficient to meet the personal observation requirements of the rule, including two purported well-being checks where the custody staff did not look into the cells to personally observe the inmates.

8/28/2024

On the date this inmate was found unresponsive, the inspector noted: (1) video showed 26 total well-being checks that were completed at too fast a pace to determine the well-being of the inmates; (2) that five well-being checks were completed via the pipe alley behind the cells, which do not allow for full view of inmates; and (3) four violations of the 30-minute time frame for well-being checks.

Hennepin County ADC, therefore, has failed to substantially conform to the rule requiring mandatory well-being checks of inmates in its custody and is not making satisfactory progress toward substantial compliance. Consistently not meeting this minimum standard could seriously affect the health and safety of the inmates confined at the facility.

In addition, the 2024 inspection and subsequent report, further discussed below, outlines that inspectors have found Hennepin County ADC to be in violation of the minimum standards for well-being checks during their review of additional unusual occurrences[4] that are separate and in addition to the deaths discussed in this order. This continues to be a persistent and concerning issue: on October 28, 2024, an I&E inspector reviewed two unusual occurrences at Hennepin County ADC that had occurred on October 5 and October 15, 2024. In reviewing video and records from the two hours preceding each occurrence, the inspector found:

- A late well-being check;
- Staff logging well-being checks when no officers were observed in the housing unit; and

[4] "Unusual occurrences" are sometimes informally referred to as "special incidents."

- Instances where staff entered a housing unit to purportedly conduct well-being checks but did not personally observe inmates (including instances where staff stood at the door and did not walk through the unit).

In fact, 10 of the 11 reviewed well-being checks were not sufficient to meet the personal observation requirements of the rule. In the review of the October 5 occurrence, the inspector noted that in the two hours preceding the occurrence there was no well-being check conducted according to the requirements set forth in the rule.[5]

Persistent Violation of Minimum Staffing Requirements

Hennepin County ADC has also failed to substantially conform to minimum staffing ratios and is not making satisfactory progress toward substantial compliance, which has the potential to seriously affect the health and safety of individuals confined at the facility. For example, during the review of the August 22, 2024 death, the inspector found that based on the then-population in the City Hall Building at Hennepin County ADC, the 4th floor would be required to have nine custody staff present to supervise inmates, and the 5th floor would be required to have eight custody staff assigned. The 4th floor, however, only had between four and six staff present at any given time, and the 5th floor only had between five and seven staff present.

In another recent example, during the review of the August 28, 2024 death, an inspector found a number of minimum staffing violations in the area where the inmate was housed. The inspector found:

- The inmate was housed on the 5th floor of the City Hall Building prior to being transported to the Hennepin County Medical Center, where the inmate never regained consciousness and died;
- On August 24, 2024 (the day before the inmate was found unresponsive), there were between five and six custody staff assigned to that floor of the building, despite a need for eight assigned staff;
- On August 24, 2024, there were four custody staff assigned to the 4th floor of the City Hall Building, despite a need for seven assigned staff;
- On August 25, 2024 (the day the inmate was found unresponsive), there were, again, only between five and six custody staff assigned to the 5th floor of the City Hall Building, despite a need for eight assigned staff;
- On August 25, 2024, there were only four custody staff assigned to the 4th floor of the City Hall Building, despite a need for eight assigned staff;
- During times when there were appropriate staff ratios, when custody staff assigned to this area took breaks for lunch, there was not enough coverage to ensure required staffing; and

[5] The inspector has requested video of additional time preceding these incidents due to concerns that the issue of not personally observing inmates is even more pervasive.

- According to the schedule provided to the inspector, there were no escort/rovers[6] scheduled for these areas, and during break times the total staff in these areas decreased from their already low numbers.

The 2024 inspection and subsequent report, addressed in more detail below, also specifies a number of chronic concerns with Hennepin County ADC's staffing levels.

In addition, on October 2, 2024, an inspector noted the following during a site visit to the City Hall Building:

- Inspectors were on the 4th floor of the building from 12:00 – 3:00 p.m., and though an appropriate number of custody staff were assigned (nine), inspectors did not observe nine staff members on the floor. Several staff were on break causing staffing ratios to fall below the minimum required; and
- Inspectors were also on the 5th floor of the building from 12:00 – 3:00 p.m., and though an appropriate number of custody staff were assigned (eight), inspectors did not observe eight staff members on the floor. Several staff were on break causing staffing ratios to fall below the minimum required.

As of the date of this order, Hennepin County ADC does not have an approved staffing plan, and thus continues to lack compliance with a minimum standard that directly impacts the safety, health, and well-being of inmates at the facility. By failing to meet minimum staffing requirements, Hennepin County ADC is unable to adequately supervise inmates, respond to emergencies, care for the well-being of all inmates, and conduct well-being checks that comply with the rule.

Pattern of Failing to Timely Report Emergency or Unusual Occurrences to the DOC

As a licensed adult correctional facility, Hennepin County ADC is required to report all deaths of individuals who died while committed to the custody of the facility "regardless of whether the death occurred at the facility or after removal from the facility for medical care stemming from an incident or need for medical care at the correctional facility." Minn. Stat. § 241.021, subd. 1. This report must be made to DOC "as soon as practicable, but no later than 24 hours of receiving knowledge of the death." *Id.* Further, Hennepin County ADC must also report "[i]ncidents of an unusual or serious nature" to the DOC within ten days of the occurrence. Minn. R. 2911.3700, subp. 4; *see also* Minn. Stat. § 241.021, subd. 1. The rule sets forth a non-exhaustive list of the types of unusual occurrences that require reporting to the DOC, including assaults of staff or inmates that result in criminal charges or outside medical attention and serious injury or illness subsequent to detention, including but not limited to incidents resulting in hospitalization for medical care. *Id.*, subp. 4.E, .J & .K.

[6] Escort, movement, and booking staff are counted separate and apart from custody staff when evaluating staffing ratios and approving staffing plans because they do not serve the same primary role of supervising inmates. *See* Minn. R. 2911.0900, subp. 17.

Since the last biennial inspection in September 2022, Hennepin County ADC has repeatedly failed to timely report unusual occurrences that occurred at the facility. In 2023, Hennepin County ADC submitted three late unusual occurrence reports. In 2024, Hennepin County ADC submitted five late reports of unusual occurrences. In addition, as outlined above, in the course of the September 2024 inspection, a DOC inspector learned of a death of an inmate recently incarcerated at Hennepin County ADC that had not been reported to the DOC despite the fact that the inmate was found unresponsive at the facility and was transported to the hospital for emergency medical care. Hennepin County ADC only reported this incident to the DOC upon prompting by the inspector.[7]

2024 Inspection and Inspection Report

Senior Detention Inspector Jen Pfeifer (senior detention inspector) inspected Hennepin County ADC on September 18, 2024 as part of the facility's biennial review. *See* Minn. Stat. § 241.021, subd. 1 (calling for review of correctional facilities at least once every two years to determine compliance with minimum standards). The resulting inspection report, which is being issued concurrently with this correction order, is attached as **Exhibit 1** and incorporated herein by reference.

While the inspection report outlines that Hennepin County ADC complies with most mandatory and essential rules, it also details the persistent issues the facility has with well-being checks and staffing levels.[8] The senior detention inspector outlined that well-being checks were out of compliance both in the 30-minute time frame of the rule, and also that inmates found to be experiencing withdrawal symptoms were not placed on more frequent observation as required. **Exhibit 1 at 2**; Minn. R. 2911.5000, subp. 5. The inspection report also outlines that Hennepin County ADC "is not operating at the 1:25 staffing levels required for linear style housing units on floor 4 and 5 of the city hall building;" "[d]uring staff break times, staffing falls below the required staffing ratios;" and "the facility is utilizing the housing unit staff to assist with internal movement and escorts which leaves the housing areas to fall below the required [staffing] levels." **Exhibit 1 at 2**; Minn. R. 2911.0900, subp. 15.

Violating these rules presents numerous health and safety concerns, especially in the context of the number of deaths and other unusual occurrences that have occurred at Hennepin County ADC since the September 2022 biennial inspection. The attached 2024 inspection report mandates corrective action, and also places Hennepin County ADC on an annual review as opposed to biennial review. **Exhibit 1 at 2-3**.

CORRECTIVE ACTION NEEDED

As detailed above, Hennepin County ADC's continued failure to substantially conform to all applicable minimum standards and lack of satisfactory progress towards substantial conformance, most notably its

[7] While Hennepin County ADC did report this incident as an unusual occurrence within 10 days, they failed to properly report it as a death. *See* Minn. Stat. § 241.021, subd. 1.

[8] The inspection report also highlights an additional violation and area of concern identified by the senior detention inspector. *See generally* **Exhibit 1.**

chronic and repeated failure to meet well-being check and staffing requirements, requires corrective action, including the reduction of the facility's operational capacity. *See* Minn. Stat. § 241.021, subd.1a(a). The DOC reserves the right to restore Hennepin County ADC's original approved capacity limits during the term of this conditional license, with such license being subject to additional conditions as detailed below. It is expected that Hennepin County ADC and its staff will immediately comply with the minimum standards outlined in Chapter 2911, particularly minimum staffing, and well-being check requirements. *See, e.g.*, Minn. R. 2911.0900, subp. 15(B); Minn. R. 2911.5000, subp. 5.

TERMS OF CONDITIONAL LICENSE

Hennepin County ADC is hereby required to comply with the following terms in order to maintain its license:

1. Hennepin County ADC's approved capacity is reduced to 600 inmates from November 14, 2024 until further ordered by the DOC.
    a. A maximum of 150 inmates may be housed per floor in the City Hall Building.
    b. Hennepin County must submit the following information for the City Hall Building to the senior detention inspector daily by 8:00 a.m.:
        i. Inmate counts – total and per floor; and
        ii. Staffing numbers – total and per floor.
    c. Staff must maintain a 1:25 ratio for linear style housing at all times. Escort/movement staff must be in addition to the 1:25 ratios for any internal movement and break relief. At any time the facility is unable to maintain the required staffing levels, inmate counts must be reduced below the approved 150 beds per floor to ensure the 1:25 staffing ratio is met.
    d. Hennepin County ADC must also maintain the required staffing ratios in Minnesota Rule 2911.0900 for all other areas of the jail, including intake/post booking.
2. Hennepin County ADC must submit to the DOC a capacity-reduction plan to reach the capacity limits imposed by this order by close of business on November 7, 2024. This plan must result in achieving the ordered capacity reduction no later than noon on November 14, 2024.
3. Hennepin County ADC must begin to immediately reduce facility population to comply with the capacity limits imposed by this order and provide daily written updates to the senior detention inspector on these capacity-reduction efforts until the facility population is reduced to the capacity limits imposed by this order.
4. Hennepin County ADC must report to the senior detention inspector any time the facility's population exceeds the capacity limits imposed by this order.

5. Hennepin County ADC must submit to the DOC for approval a staffing analysis and updated staffing plan for the facility's reduced capacity by November 22, 2024. Once approved, Hennepin County ADC may not deviate from the staffing plan without prior DOC approval.

6. Hennepin County ADC must conduct weekly audits of well-being checks on no less than 20 staff and submit the findings of those audits to the senior detention inspector no later than 3:00 p.m. every Friday.

7. In consultation with the health authority, Hennepin County ADC must report the count of inmates experiencing signs/symptoms of withdrawal to the senior detention inspector daily by 8:00 a.m. beginning on November 5, 2024.

8. Hennepin County ADC must report staff schedules for the entire facility to the senior detention inspector upon request.

9. No later than December 2, 2024, Hennepin County ADC shall create a training plan and timeline to ensure all custody staff are given refresher/remedial training on the following topics:

    a. Well-being checks; and

    b. Signs/symptoms of withdrawal.[9]

    This training plan and timeline must be approved by the senior detention inspector. All training must be documented for the DOC's review. All training must be completed within 15 days of the senior detention inspector's approval of the training plan and timeline.

10. Hennepin County ADC must follow the withdrawal protocol approved by the DOC, which will include more frequent well-being checks of those inmates experiencing signs and symptoms of withdrawal.

11. Hennepin County ADC must address and correct the violations found by the senior detention inspector in the 2024 biennial inspection report, including by completing all corrective action ordered by the dates outlined in that report. *See* **Exhibit 1.**

While Hennepin County ADC is operating under this order, the DOC shall conduct random facility visits to ensure the facility's ongoing compliance with Minnesota Rules Chapter 2911 and applicable statutes and shall monitor the facility's compliance with this order.

In the event the DOC approves the subsequent reinstatement of Hennepin County ADC's original approved capacity limits, which may be dependent on DOC's inspection of the facility, such license will remain on conditional status and subject to the following conditions:

[9] This shall be provided in consultation with the health authority. *See* Minn. R. 2911.1350 (requiring the facility administrator to cooperate with the health authority to provide medical training to staff).

1. Hennepin County ADC must maintain staffing ratios in all areas of the facility as approved by the DOC to include the required number of escort/internal movement staff (including rovers).

In the event Hennepin County ADC falls below staffing levels approved by the DOC, the DOC shall reinstate the capacity limits outlined above.

2. Hennepin County ADC must complete well-being checks that comply with Minnesota Rule 2911.5000, subpart 5.

In the event Hennepin County ADC fails to complete well-being checks that comply with the rule, the DOC shall reinstate the capacity limits outlined above.

This conditional license order will remain in effect at least until May 30, 2025, contingent upon the completion of an inspection deemed satisfactory by the senior detention inspector, or further order of the DOC.

RIGHT TO REQUEST RECONSIDERATION

Hennepin County ADC has the right to request reconsideration of this conditional license order. Under Minnesota Statutes, section 241.021, subdivision 1e, any request for reconsideration does not stay any provision of this order. A request for reconsideration must:

- Be in writing.
- Be sent by certified mail to the Commissioner and postmarked no later than 30 calendar days after receipt of this order.
- Specify the parts of the order that are alleged to be in error.
- Explain why the order is in error.
- Include any supporting documentation to show why the order is in error.

Failure to follow these requirements will result in the loss of the right to request reconsideration. The timeline to seek reconsideration begins upon receipt of this order. Please send any request for reconsideration to:

Commissioner, Department of Corrections
ATTN: Inspection and Enforcement Unit
1450 Energy Park Drive, Suite 200
St. Paul, MN 55108

So ordered,

Date: __10/31/2024_____

Kristi Strang
Kristi Strang
Acting Inspector General
Minnesota Department of Corrections