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Hurricanes Katrina and Rita and the Louisiana Dept. of Public Safety and Corrections:

A Chronicle and Critical Incident Review

An NIC Technical Assistance Report
Technical Assistance No. 06P1035

Jeffrey A. Schwartz
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DISCLAIMER

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The resource persons who provided the on-site technical assistance did so through a technical assistance agreement, at the request of the Louisiana Department of Public Safety and Corrections, and through the coordination of the National Institute of Corrections. The direct on-site assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Jeffrey A. Schwartz and David Webb. The contents do not necessarily reflect the official views or policies of the National Institute of corrections.

Hurricanes Katrina and Rita and the Louisianan Dept. of Public Safety and Corrections: A Chronicle and Critical Incident Review

NIC Technical Assistance Report (TA No. 06P1035); May 6, 2006
Jeffrey A. Schwartz and David Webb

Executive Summary

The morning of August 29, 2005, Hurricane Katrina made landfall on Louisiana's Gulf Coast, with catastrophic results. One month later, on September 24, 2005, Hurricane Rita came ashore in southwestern Louisiana, with several small communities almost totally destroyed and extensive damage throughout that part of the state and in southeaster Texas. One of Louisiana's state prisons received substantial direct damage from Katrina and several probation and parole offices in the New Orleans area were shut down with flooding and severe damage, or were totally destroyed.

The flooding and widespread destruction of New Orleans, all of St. Bernard Parish, along with parts of Jefferson Parish, St. Tammany Parish and Plaquemines Parish ultimately caused the LA DPSC to engage in activities unprecedented in the history of American corrections. The evening of August 29, 2006, some 14 hours after Katrina struck, LA DPSC received calls from the Jefferson Parish Prison (JPP) asking the department to evacuate over 1100 prisoners from its jail, and then, a few minutes later, from the Orleans Parish Prison (OPP), asking LA DPSC to evacuate over 6500 prisoners from their facilities.

While the evacuation of JPP was accomplished in 24 hours, the OPP complex was in five to eight feet of flood waters and buses and vans could not drive there. Instead, the 6500 prisoners had to be evacuated in small boats, two to six individuals at a time, to a nearby freeway overpass. From there, evacuees climbed a department erected scaffolding to the freeway and were loaded into vehicles and transported to the Louisiana State Penitentiary (LSP) or to the Elayn Hunt Correctional Institute (EHCI). At one point on the overpass, some three thousand prisoners were being guarded by approximately 30 Probation and Parole (P&P) officers, and the situation was complicated by angry and emotional New Orleans residents wanting the Department to transport them to safety rather than taking the parish prison evacuees. That evacuation was completed in three days and, ultimately, LA DPS&C evacuated over 10,000 prisoners and new arrestees with no loss of life, serious injuries or escapes.

With no operating jails in the greater New Orleans area, LA DPS&C was tasked with locating, developing and operating a makeshift jail so that law enforcement agencies would have a place to take arrestees. LA DPS&C Secretary Richard Stalder and Orleans Parish Sheriff Marlin Gusman chose a Greyhound station adjoining a railroad station and "Camp Amtrak" was launched as the makeshift and temporary New Orleans jail. It operated for over a month and more than 1200 arrestees were booked there, and many temporarily housed there, without serious incident.

Sending evacuees and arrestees to multiple locations proved impractical and EHCI was designated as the sole processing center for male evacuees (and the Louisiana Correctional Institute for Women, LCIW, served that purpose for female evacuees and arrestees.) EHCI grew from a normal population of 2,100 to over 5,000, with 3,000 evacuees and arrestees on their main yard under gun coverage for a few days. Identification of the evacuees was difficult and often impossible, as they were transported with no records of any sort. Eventually, convoys transported evacuees from EHCI to other state prisons and the population was reduced to a level that could be maintained inside the living units, with many individuals sleeping on floors.

Probation and Parole staff were assigned to ride on fire trucks in the New Orleans area in order to provide security for the fire fighters, who had been fired upon on numerous occasions. P&P staff also accompanied police officers in areas where there were not enough available police, and in at least one area P&P staff provided the sole working law enforcement services. The flood damage to homes, the evacuation of the city and the loss of communication with immediate family members had a very dramatic effect on the P&P staff. In the days after the flood, everyone worked with staff who could not locate parents or spouses or children. Large numbers of P&P staff were unaccounted for and no one knew whether they had evacuated, or were sick or injured or worse. It took three weeks for the Department to locate all of the missing P&P staff.

Washington Correctional Institute (WCI) was the only prison in Louisiana to take a direct hit from Katrina. At WCI, some interior fences were down. One perimeter fence had a section broken. All communications were down as was water and power. Some HVAC systems were blown off building roofs. That produced very dangerous gas leaks, and WCI staff had to find the appropriate utility shut-offs and cut off the natural gas even before the storm had passed. Some of the prison buildings had serious roof damage. Trees were down everywhere and the road into the prison was impassable because of fallen trees. Approximately twelve WCI employees lost their houses entirely. Approximately fifty percent of the staff, or about 150 employees, had significant damage to their houses. In the immediate aftermath of the storm, WCI sent crews out to clear the major roads in the parish. Warden James Miller offered to move the FEMA distribution center from the town of Varner to the prison and the offer was quickly accepted. Water, MREs and ice, among other supplies, were distributed as the prison set up a drive through system. Between the prison's perimeter security and the presence of numbers of uniform staff, there were no problems with theft, assault or the like. The prison also served as the Red Cross distribution center for debit cards for residents entitled to financial assistance.

The Department accepted a number of other missions, all unusual but all related directly to public safety, and all were successfully accomplished.

Many states and some individual counties and individual correctional facilities sent supplies to Louisiana. In addition, cash donations were received from a wide range of correctional sources, with most earmarked for assistance to staff members in need in Louisiana. Over one half million dollars was donated. There were several states and the

Federal Bureau of Prisons (FBOP) which, in addition to sending supplies and monetary contributions to Louisiana, also sent correctional staff. These included the Kentucky Department of Corrections, both the New York State of DOC and the New York City Department of Corrections, and the Pennsylvania Department of Corrections. Most states sent correctional officers, but Pennsylvania also sent specially trained mental health staff and maintenance staff, and the Arkansas Department of Corrections sent nursing staff. While hurricane Katrina produced the largest natural disaster in the history of the country, the national response from the American corrections community was also without parallel.

LA DPS&C faced challenges unprecedented in the history of American corrections. The staff of LA DPS&C exhibited the highest standards of professionalism, commitment, courage and dedication to their communities. The extent to which staff members within LA DPS&C were and are themselves victims of the hurricanes may never be fully recognized or appreciated. That is particularly true for Probation and Parole staff. The Department's leadership must also be accorded very high marks. Leadership in the Department was clear, strong and focused.

The staff of LA DPS&C were able to accomplish what they did largely because of their experience, ability, judgment and values. However, the Department's planning and preparations for emergency situations was not strong and is not one of the major factors accounting for the Department's success. In most cases, staff ignored existing emergency plans and preparations (which were generally not practical, user friendly, comprehensive or current.)

Communications was almost universally regarded as the most dysfunctional aspect of the Department's response. Phone service was down in most areas for weeks. Cell phone service was almost eliminated because of the number of transmission and repeater towers that were destroyed. With power outages and phone outages, internet services were also out. The Department had anticipated that much of the problem and had purchased expensive satellite phones that were supposed to be the answer to that situation. In the actual event, the satellite phones worked only infrequently.

Over the course of the disaster, the Department's working relationships with FEMA were frustrating and generally not helpful. That was certainly not true in all cases and there were specific issues that went well and a number of FEMA staff who were excellent to work with.

The Department does not have a comprehensive emergency system. Some parts of such a system are in place but other parts are missing and there are elements of emergency preparation that do not complement one another. That general assessment holds true whether one looks at Departmental level emergency readiness or one looks at individual institutions. The Department does not use any emergency organizational structure nor any emergency command structure, relying instead on the organizational structure and chain of command that operate on a day-to-day basis. Prior to the hurricanes, LA DPS&C had not provided enough training on emergency preparedness to its staff, and the training that

had been provided was too superficial and not particularly effective. However, emergency services for staff and staff families were accorded high priority by LA DPS&C management and the area is one of many strengths exhibited by the Department. The assistance sent to LA DPS&C by other correctional agencies was not a token show of support, it was a massive and it was critically important, from emergency generators, to drinking water, to nursing staff. to cots and blankets, to correctional officers, to money for staff that had lost their homes. The American correctional community has never before been mobilized to this extent or in this manner. In this regard, the Louisiana experience provides a model for the future.

Hurricanes Katrina and Rita and the Louisianan Dept. of Public Safety and Corrections: A Chronicle and Critical Incident Review

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II. Introduction and Background

A. The morning of August 29, 2005, Hurricane Katrina made landfall on Louisiana's Gulf Coast, with catastrophic results. One month later, on September 24, 2005, Hurricane Rita came ashore in southwestern Louisiana, with several small communities almost totally destroyed and extensive damage throughout that part of the state and in southeastern Texas. The storm surge from Hurricane Rita further compromised some of the levies originally breached by Katrina and contributed to additional flooding in the city of New Orleans.

B. The Louisiana Department of Public Safety and Corrections ("LA DPS&C" in this report, although the Department is sometimes referred to as the "Louisiana DOC") activated its emergency plans to prepare for and then respond to both hurricanes. One of Louisiana's state prisons received substantial direct damage from Katrina and several probation and parole offices in the New Orleans area were shut down with flooding and severe damage, or were totally destroyed. While the direct impact of the two hurricanes on the Department's facilities, staff and offenders was severe, it was not unprecedented for a state with high hurricane risk.

C. Rather, it was the flooding and widespread destruction of New Orleans, all of St. Bernard Parish, along with parts of Jefferson Parish, St. Tammany Parish and Plaquemines Parish that ultimately caused the LA DPS&C to engage in activities unprecedented in the history of American corrections. For example, on the day that Katrina hit, the LA DPS&C received separate phone calls from the Orleans Parish Sheriff's Office and the Jefferson Parish Sheriff's Office just after 10 pm, indicating that neither Sheriff's Office was able to evacuate their parish prison (equivalent to a county jail in most states) and requesting that the state DOC evacuate 6,500 inmates and 1,000 inmates from the two parish prisons, respectively. The evacuation took three full days and could be the subject of a documentary or a novel. With all the parish prisons in the New Orleans area closed, the LA DPS&C was also forced to improvise to locate, develop and operate a jail facility that would serve the city of New Orleans as police and National Guard troops struggled to regain the rule of law.

Several months after the two hurricanes, the LA DPS&C was continuing to deal with extraordinary situations directly attributable to the hurricanes. Significant

numbers of evacuees from parish prisons remained in various state facilities, as did a number of arrestees, processed through the makeshift jail that the Department had established in New Orleans. Some facility damage had not yet been repaired. Some probation and parole staff had been moved into temporary office accommodations and some probation officers had not returned to work. Arrangements were continuing to be made for supervision of offenders evacuated to other states, and high priority had been placed on locating and supervising sex offenders.

With all of this going on, Richard Stalder, the Secretary of Corrections for Louisiana, became increasing concerned that much of what the Department had accomplished during and after the two hurricanes, would be lost if it was not documented while the people involved were available and the facts were fresh. At the same time, Secretary Stalder wanted an independently conducted critical incident review to rigorously examine strengths and weaknesses of the Department's hurricane planning and response, with particular attention to lessons learned and other implications for future emergency planning.

Secretary Stalder approached Morris Thigpen, Director of the National Institute of Corrections (NIC) and requested technical assistance, outlining his objectives. NIC quickly agreed to provide the requested help to LA DPS&C and Jason Heaton, of NIC's Community Corrections and Prisons Division, was designated as the program specialist for the technical assistance effort. Mr. Heaton contacted Jeffrey A. Schwartz of LETRA, Inc., in Campbell, California and David Webb of Sam Houston State University in Huntsville, Texas as potential consultants for this project. After discussions among the two consultants, Mr. Heaton and Cathy Fontenot, the appointed Storm Recovery Director for LA DPS&C, it was decided that Dr. Schwartz and Mr. Webb would provide the technical assistance and that onsite work would begin in January, 2006.

Jeffrey A. Schwartz has worked with prisons and jails across the U.S. and Canada on emergency preparedness for more than twenty-five years. His work with law enforcement and corrections spans more than thirty years. In addition to his work on emergency systems for correctional institutions, he has been widely recognized for innovative work on crises intervention and conflict resolution, on use of force policy formulation and training, and on management and leadership development. Mr. Webb is the Deputy Director of LEMIT (Law Enforcement Management Institute of Texas) at Sam Houston Sate University. Mr. Webb develops and presents management training programs to law enforcement officials across Texas, and also consults in other states. He has managed law enforcement projects internationally in countries ranging from Poland to Thailand. Prior to coming to the United States, Mr. Webb rose through the ranks and became chief of a metropolitan police force in England of some 3,000 members. Mr. Webb played a

key role in the investigation of the terrorist bombing of Pan Am flight 103 that went down over Lockerbie, Scotland.

III. Method

A. Following initial discussions among Jeffrey Schwartz, David Webb, Jason Heaton and Cathy Fontenot, it was agreed that the consultants would begin their work on site the week of January 23, 2006. In preparation for that week, the consultants asked for and quickly received summary information on key activities within the Department during the hurricane situations. The consultants also reviewed more general information having to do with the Department's emergency plans and policies.

B. Dr. Schwartz flew to Baton Rouge on Sunday, January 22. On Monday morning he had an initial meeting with Secretary Stalder. David Webb flew from Houston to Baton Rouge that same morning and met Jeffrey Schwartz mid morning. The consultants spent the rest of that day meeting with headquarters' administrators. On Tuesday, the consultants drove to Elayn Hunt Correctional Center (EHCI), the facility that had processed most of the evacuees from the parish prisons and processed the arrestees from "Camp Amtrak". In addition to interviewing key staff at EHCI, and touring the facility, the consultants were able to talk at length with a group of women offenders who had been at EHCI since being evacuated from the Orleans Parish prison. Male inmates, including evacuees and arrestees, were also interviewed.

On Thursday, the consultants traveled to New Orleans and interviewed front line, supervisory and management staff within Probation and Parole. They also drove to the Orleans Parish Prison and briefly looked through the only jail building that had been reopened. Following that, they were able to interview a few staff members from the Orleans Parish Sheriff's Office and then spend time with Orleans Criminal Sheriff Marlin Gusman. The consultants spent the remainder of the week with additional interviews and document review.

C. Following the week on site in Baton Rouge in January, the consultants discussed their progress with Jason Heaton, NIC's program specialist. The consultants were aware they had a great deal of work that had not yet been done and they were concerned whether it would be realistic to attempt to finish the technical assistance with one additional week on site. It was decided to schedule another week in the hope the work could be completed, or that any remaining interviews might be completed by phone. Due to a variety of scheduling conflicts, the consultants chose February 22nd – 25th for their second round of work. Both consultants were to fly to Baton Rouge on Tuesday February 21st, 2006. Dr. Schwartz ended up trapped at the Dallas - Ft. Worth airport for almost a full day because of a cancelled flight followed by bad weather in Baton Rouge the next morning. David Webb

began work on Wednesday, February 22nd in Baton Rouge and was joined by Jeffrey Schwartz that evening. On Thursday, the consultants drove to LSP and toured several of the camps there and had the opportunity to interview staff and inmates about hurricane related issues. Like EHCI, LSP continued to house both evacuees and arrestees. Importantly Warden Burl Cain had gone to New Orleans immediately after the hurricane hit to evaluate and help plan the parish prison evacuations and he had remained in New Orleans to organize a jail operation run by the Department of Corrections ("Camp Amtrak"). It was important for Dr. Schwartz and Mr. Webb to be able to spend time with Warden Cain, due to his central role in these crucial events. On Friday of the week, the consultants met with a wide variety of individuals including a FEMA representative, Susan Lindsey from Probation and Parole, Colonel Mary B. Kennedy of the Orleans Parish Sheriff's Office, and others. On Saturday, Dr. Schwartz drove to Washington Correctional Institution (WCI) because it had sustained more direct hurricane damage than any other state prison, and it had been essentially out of all communication with the Department for three days immediately following Katrina's landfall. James Miller had been Warden at WCI during and immediately after the hurricanes, but has recently retired. Warden Miller was contacted and graciously agreed to meet with Dr. Schwartz at WCI on that Saturday. Warden Miller's memory of events and perspective proved invaluable. The consultant was also able to spend time with Acting Deputy Warden Kathleen McGinnis, tour portions of the institution and talk informally with inmates and staff.

D. The second week on site did allow the consultants to complete the bulk of the work that had remained. There were a number of individuals that were not available during the week for a variety of reasons, but it was decided to reach as many of those individuals as possible by phone rather than attempting to return to Louisiana for a third trip.

IV. Caveats and Limitations

A. The most important limitation of this report is that it is not a complete record of what transpired within the LA DPS&C during and after the hurricanes. The reasons for this are many; most are obvious.

The consultants had two weeks on site and four person weeks, while far more than is usually allocated for an NIC technical assistance effort, did not begin to allow a detailed or comprehensive examination of all events and issues. In fact, a truly detailed report on the establishment of a jail ("Camp Amtrak") in New Orleans or the story of the evacuations of the Jefferson and Orleans Parish Prisons, would themselves require months of work.

There was no part of the Louisiana Department of Corrections that was untouched by these events. Every institution and every Parole and Probation office faced

significant impacts. A complete analysis would have involved visiting every Departmental site in the state, a practical impossibility within the constraints of this TA effort. Further, the consultants were not able to give as much attention to events or locations related to Hurricane Rita as they had afforded to Katrina-related issues, again because of the press of time.

Some key people were relocated or were otherwise unavailable at the time of the consultants' visits. While phone interviews were used to supplement face-to-face meetings, the potential cast of interviewees was in the hundreds and some people could not be reached.

In the end, the defining parameter was time and this report is as comprehensive as possible given that constraint. However, the reader should be aware as the consultants are, that many events transpired in the Department – some dramatic, some heroic even – of which there is no mention in this report.

B. This report is specific to the LA DPS&C. It does not attempt to review key events or draw conclusions about the operation of other agencies, local, state or federal. Many elements of the preparation for, and response to, Katrina and Rita have been the subject of national controversy and extended political debate. However, the events within the direct control of LA DPS&C were not the subject of those debates and controversies; as such, this report provides neither additional information nor recommendations about those difficult issues because they were outside the scope of the consultants' mandate.

C. The consultants' findings and observations are based on several different kinds of information. Many documents were reviewed, but there were also institutional tours and many informal interviews with staff and inmates. Thus, while some information could be verified or corroborated against written records, that was not true for a substantial amount of the information gathered by the consultants. There was not enough time to corroborate all information against source data, to collect original data, to monitor processes or events or otherwise verify all information. This report attempts to provide as many details, observations and recommendations as possible, but some of the information the consultants received may have been inaccurate and may have led to recommendations or observations that are simply wrong. The reader should regard this report as an overview in summary of events of historic proportions, but not as the product of empirical research.

D. The scope of this report is obviously quite broad and no attempt has been made to prioritize observations, findings or recommendations within the various sections of the report.

E. This report and its observations, findings and recommendations are entirely the responsibility of the two authors and this report does not necessarily reflect the views of either LA DPS&C or of NIC.

F. The body of this report is divided into two separate and quite distinct sections. The first chronicles the various tasks that LA DPS&C was assigned or performed prior to, during and after the hurricanes. That first section of the report is intended to document the Department's efforts and is not evaluative in nature. (It is also true that everything is at some level and in some part subjective. In that sense the views of the consultants have not been purged from the first section of the report, and there is certainly an effort to identify key issues in that section as well.) However, the section is meant to be documentary rather than evaluative.

The second substantive portion of this report is a traditional critical incident review (also referred to as an "after action report" by some agencies). That portion of the report does present an assessment of the Department's planning for and response to the two hurricanes. The consultants looked at a number of factors, including the quality of the Department's pre-planning, the degree to which what was done during and after the hurricanes matched what had been planned, areas that might have been planned and were not, operational mistakes, creative responses and successes, lessons learned and implications. With regard to lessons learned and implications, it is important to recognize that some portions of that section will relate primarily to LA DPS&C and to their future emergency preparedness efforts, but that much of what transpired in the Department has broad implications for other state and local correctional agencies across the United States

G. Finally, the portion of the report that constitutes a critical incident review, is not balanced. The consultants tried to identify areas of strength, creativity and success and to also mention areas that functioned well or as intended. However, it is inevitable that more attention is focused on problems and deficiencies. That is the case with almost any critical incident review and it is fitting in some ways because it is the problem areas that need detailed analysis and attention if they are to be improved or corrected. For the reader to maintain perspective, it is important to remember that the critical incident review within this report contains a bias toward locating and identifying problems.

V. Acknowledgments

A. Both consultants received exceptional cooperation and assistance from the staff of the Louisiana Department of Corrections. When Dr. Schwartz first arrived on site in Baton Rouge, Secretary Stalder arranged time to meet informally and review his hopes and expectations for this technical assistance effort. (David Webb was unable to arrive until later that same day.) When the technical

assistance was first arranged by phone, the Department immediately assigned a manager as liaison with the two consultants. Cathy Fontenot is normally an Assistant Warden at the Louisiana State Penitentiary at LSP, but her temporary assignment to the Department's headquarters in order to coordinate recovery efforts made her a natural choice to work with the consultants. Ms. Fontenot's long history in the Department meant that it was relatively easy for her to arrange information, trips, resources and interviews at the convenience of the consultants.

B. Colonel Eric Sivula is a retired Louisiana state police manager hired by the Department of corrections several years ago to head internal affairs, among other job responsibilities. In light of Colonel Sivula's background in crisis management, one of his other assigned duties for the Department is managing emergency preparedness. When Katrina hit Louisiana, Colonel Sivula was in the Incident Management Center (IMC) in headquarters for most of the next several days, alternating with one or two other management staff, and he was the manager making decisions when higher ranking officials were unavailable because of the severe communication problems during the hurricane. Colonel Sivula graciously spent a large amount of time with the consultants, reviewing the operation of the Incident Management Center and recounting some of the critical issues and decisions from the perspective of the incident commander.

C. Susan Lindsey is the area manager for Probation and Parole in New Orleans. She arranged for the consultants to be driven through the lower Ninth Ward in New Orleans, so that they could get a first hand view of the devastation left by Katrina, even six months later. On the consultants' second trip to Louisiana, Ms. Lindsey drove to Baton Rouge and spent most of a morning briefing the consultants on a wide range of issues involving Probation and Parole staff during and immediately after the hurricane.

D. Like large members of staff in the Department, some of the individuals the consultants worked most closely with had themselves had relatives displaced, had their own homes lost or badly damaged, and had other personal crises caused by the hurricanes. These problems were in many cases not resolved at the time of the consultants' visits. Nevertheless, the staff were remarkably objective in reviewing events and the actions of the Department and the consultants very much appreciated their professionalism. The consultants were given unfettered access to people, facilities, documents and other information and this report would not have been possible without that kind of help and cooperation. The consultants are indebted to the large number of staff with whom they worked, in Headquarters, at the institutions and in the Probation and Parole, almost all of whom were open, candid and gracious.

E. Jason Heaton was the program manager for NIC on this project. Mr. Heaton stayed in close touch with the consultants throughout this work, and he was supportive, flexible, and patient as this report was developed. Mr. Heaton's experiences in managing correctional institutions was a distinct asset to the consultants and the project.

VI. Hurricanes Katrina and Rita

A. Tropical storm Katrina became a hurricane on the morning of August 24th, 2005 and made landfall that evening near Aventura, Florida. As is typical, Katrina weakened as it passed over Florida, but then achieved hurricane status again almost immediately after entering the Gulf of Mexico. By August 28th, Katrina exhibited sustained winds exceeding 175 miles per hour with hurricane force winds extending approximately 100 miles from the eye of the storm, making Katrina one of the largest hurricanes on record. On the night of August 29th, Katrina showed a disruption of its eye wall which diminished the intensity of the storm, but further increased its size. When Katrina made landfall the next morning it was as a category 3 hurricane with sustained winds of 125 miles an hour, but with hurricane force winds extending outward 120 miles from the storm's center. Katrina produced record storm surges along the Gulf Coast, peaking at 34 feet in Mississippi. The record storm surge was the result of several factors including the extraordinary size of the hurricane, and the fact that it had weakened only shortly before it made landfall, so that many of the waves that were generated had been produced when Katrina was still a category 5 storm.

With over three-fourths of the New Orleans area below sea level, and with the forecast showing the possibility of a direct hit on New Orleans from Katrina, there was discussion of a potential catastrophe in New Orleans as early as August 26th. It should be emphasized that most of the discussion was about direct damage from a category 5 hurricane. Mayor Ray Nagin ordered the first mandatory evacuation in the history of New Orleans, at 10 am on August 28th. For a wide range of reasons, the evacuation did not succeed in getting all people out of the city, and hundreds of thousands of residents and tourists were still in New Orleans when Katrina hit.

Katrina produced over 1,400 deaths in seven states. In New Orleans, three levees failed, putting over three fourths of the city under water. The flood waters were twenty to twenty-five feet deep in some parts of the city. A week later, on September 6th, sixty percent of New Orleans remained flooded.

B. Hurricane Rita was the tenth hurricane of the 2005 season and the second most powerful (after Hurricane Wilma). Rita hit Florida and then intensified over the Gulf of Mexico before making landfall near the Texas-Louisiana border. Rita had intensified to level 5 and exhibited wind gusts measured at 235 miles an hour. It was generally one of the most intense hurricanes ever recorded.

Fortunately the damage caused by Rita was not as monumental as had been expected. The storm dissipated rather quickly once it made landfall and the storm surge was much lower than predicted. On the other hand, the rural area where the eye of the hurricane hit, and particularly Cameron Parish, Louisiana were very heavily damaged and the storm surge the day before Rita made landfall did reopen some of the levee breaks in New Orleans, leading to re-flooding of some portions of the city. Damage from Rita was estimated at over nine billion dollars, a sharp contrast to the more than seventy-five billion dollars of damages attributed to Katrina, the costliest natural disaster in U.S. history.

VII. The Louisiana Department of Public Safety and Corrections (LA DPS&C): An Overview

A. The LA DPS&C is responsible for all adult correctional services at the state level. The Secretary of Public Safety and Corrections is appointed by the Governor and is at cabinet level. Until recently, the Department included state youth correctional services but juvenile corrections is now a separate state agency. The Deputy Secretary, Under Secretary and Assistant Secretary of the Office of Adult Services are also appointed positions and report directly to the Secretary. The Office of Management and Finance is headed by the Under Secretary and provides administrative services to all areas of the Department. The Office of Adult Services, under the Assistant Secretary, is responsible for offender services Department-wide. The Chief of Operations is a Secretary-level appointment and functions as a second in command on most operational issues. The Division of Probation and Parole (P&P) includes 21 district offices across the state. In addition to traditional community supervision, the Division operates residential community rehabilitation center (CRC's) and two alternative centers that provide short term intensive residential treatment for parole violators. The Division of Prison Enterprises operates at all of the Department's major institutions and includes a wide range of farming operations as well as traditional industrial manufacturing ranging from license plates and furniture to clothing. There are 13 major institutions and two of those are operated by private corporations. There is also a five member Board of Pardons, appointed by the Governor, and a separate seven member of Board of Parole whose members are also gubernatorial appointees.

B. Louisiana is unusual in that almost half the offenders sentenced to state time are incarcerated in local jails. At the time of the consultants' first visit, state inmates in custody in Department facilities totaled about 19,000 and state inmates in local facilities totaled just under 16,000. With almost 300 prisoners housed in the Federal Bureau of Prisons, the Department's total population of inmates was 35,273 as of January 26, 2006. Those numbers are somewhat skewed by the two hurricanes, as the population in state prisons included 1,133 evacuees and arrestees who would have been housed in parish prisons, or perhaps released, were it not for

the hurricanes. Additionally, the Department typically has a very small number of inmates housed in Federal Bureau of Prisons facilities and the almost 300 inmates reflected in these numbers are a result of emergency housing provided to the Department by the Federal Bureau of Prisons in the aftermath of Katrina. Nevertheless, the mix of inmates in state and local facilities is not atypical for the Department. A year earlier, at the end of the first quarter of 2005 and prior to both hurricanes, the Department had 53% of all state inmates housed in state prisons and the other 47% were housed in local jails. Many states have a statutory limitation on the length of sentence an offender may be serving if that offender is to be housed in local rather than state custody. In many states, a sentence of over a year automatically remands an inmate to state custody, while in a smaller number of states that limit may be 2 or 3 years. Louisiana has no statutory limit but it stands to reason that the offenders with longer sentences and more serious crimes will generally be housed in state facilities, and that is the case. Approximately 53% of the inmates in state facilities are serving maximum sentences that exceed 16 years while less than 7% of the state inmates in local jails are serving maximum sentences of 17 years or longer.

The state prisons range from a small substance abuse treatment facility with 260 beds to the Louisiana State Prison, LSP, with a population of approximately 5200 inmates. The majority of the prisons range from just over 1,000 to approximately 1,600 beds. There are two prisons larger than that and four facilities are smaller than that range.

Inmates within LA DPS&C are approximately 72% black and 27.5% white with "other" accounting for less than one half % of the prison population. Approximately 93% of the state inmate population is male and 7% is female.

C. The Department has approximately 7000 staff and of those positions, approximately 750 are within P&P and 4500 are security positions within the institutions.

Turnover of correctional officers is quite high and that is primarily due to staff leaving before the end of their first year of employment. In the first quarter of 2005, 56% of newly hired correctional officers resigned or were terminated prior to the end of their first year of service, and that figure is relatively constant for the prior year and one half. Turnover of Probation and Parole staff is quite low, averaging well under 10% and as a result the P&P workforce is a veteran group, with 32% of the staff having more than 10 years experience and an additional 30% of the staff having 5-10 year tenure.

D. The Department's costs on a per inmate basis are among the lowest in the nation, at approximately $35 per inmate per day. While most of Louisiana's state prisons reflect per inmate per day cost exceeding $50, those higher rates are balanced by

two important factors. The two privately operated prisons are approximately $31 per inmate per day, and the cost to the state for housing inmates in local jails is just over $22 per day. Since that latter figure accounts for almost half of the state's inmate population, the average state cost over all inmates is very low.

E. In addition to extremely low cost of operation, LA DPS&C is most impressive when measured against major indicators of institutional effectiveness. The Department tracks both inmate-on-inmate assaults and inmate-on-staff assaults and categorizes assaults into class "A", "B", and "C" events. A "class A" assault is one that results in an injury serious enough that it threatens life or limb. A "class B" assault results in a serious injury but not life or limb threatening, and "class C" assaults are those that produce non-serious injuries or no injury at all. Reviewing 6 quarters of records from late 2003 to early 2005 showed a total of 2 class A assaults in the entire Department which were offender-on-offender, and no class A assaults that were offender on staff. During that same year and one half, there were 6 class B inmate on inmate assaults for the entire Department and 2 class B assaults that were offender on staff. In general, the Department's institutions show a very low level of offender violence and compare very favorably to most other state departments of corrections in this regard.

   During the same six quarters, the Department had a total of one escape from a secure state facility. The Department is proud of its record that since January 2001 the apprehension rate for escapes from secure state facilities has been 100%. The Department has also achieved an extremely low rate of suicides. For the 18 months ending in March, 2005 there was one suicide within the Department.

   In summary, the Department manages a large population of very serious offenders and does so with an extremely low incidence of violence, suicide, or escape.

F. A three year study of recidivism rates for prisoners released in 2000 reflected an average return-to-prison-rate of 42.8% with 23.8% of released offenders returned for parole violations and the other 19% returned for new charges. The average time from release to new offense was approximately 11 months.

G. Probation and Parole supervises over 60,000 offenders in the community. Approximately 60% of those offenders are on probation with the remaining 40% on parole. Interestingly, while the gender demographics for parolees is close to the institutional breakdown at 90% male and 10% female, the probation breakdown is dramatically different, with just over 75% male offenders and almost 25% female offenders. An analysis by race reflects essentially the same picture. The parole supervised case load is approximately 70% black and 30% white while the probation caseload is closer to statewide population averages with 53% black offenders and 47% white offenders.

Electronic monitoring is used widely throughout community corrections in LA and drug screening is also commonly required as part of supervision. By early 2005, the percentage of offenders testing positive on drug screens had risen to almost 35%, up from just 25% in late 2003. From 1994 until 2004, the percentage of total commitments attributable to revocations rose steadily from just under 50% to just over 60%. Conversely, commitments attributable to new felonies fell steadily during that same period from approximately 51% to just under 40%.

VII. A Partial Chronicle of the LA DPS&C Before and After Hurricanes Katrina and Rita

A. The Evacuation of the Southernmost Parishes

1. Hurricane Katrina passed over Florida and entered the Gulf of Mexico on Friday, August 26, 2005. The Department continued to monitor the storm forecasts as Katrina built quickly from a tropical storm to a category two and then category three hurricane by Saturday morning, August 27. Landfall was predicted in Eastern Louisiana. At 7:00 AM that Saturday the Department's command staff met in the Incident Management Center, IMC, and began activation. All divisions of the Department were notified.

2. That same morning, evacuations were begun at Plaquemines Parish Prison and St. Tammany Work Release. It is important to note that the southern-most parishes in LA, Plaquemine and St. John, are the most vulnerable to hurricanes. Because of their location, they have a long history of evacuating early to more northern state prisons. These evacuations are conducted jointly by parish prison staff and LA DPS&C staff and are seldom problematic.

3. The Plaquemines Parish Prison evacuation to Washington Correctional Institution involved 179 prisoners and was completed in less than eight hours, as was the St. Tammany work release evacuation of 71 prisoners. Later that same Saturday afternoon, St. John initiated its inmate evacuation and three community correctional centers contacted the IMC to arrange evacuations beginning the following morning. Early Sunday, August 28, the St. John evacuation to Dixon Correctional Institute (DCI) was completed, with 239 prisoners transferred. That morning evacuations were begun at Lafayette Community Correctional Center and Lafourche Work Release. St. Martin then canceled its request for evacuation assistance and the Lafayette Community Correctional Center finished evacuating 87 prisoners by early afternoon.

4. By 4:00 PM on that Sunday, Katrina had strengthened to a category five hurricane and strong winds had begun to hit the southeastern Louisiana coast. The state command center had notified IMC that they were activating the plan for mass feeding.

B. Katrina Hits Louisiana

1. Katrina came ashore at 3:00 AM Monday, August 29. The storm had weakened to a category three just before landfall. The storm track had veered as well and New Orleans did not receive a direct hit.

2. The IMC attempted to maintain communication with all divisions and facilities and to get damage assessment from the early hours of Monday morning on. Communication problems and power outages throughout the region made this task difficult. Media reports about damage in the New Orleans area were sometimes contradictory but it appeared that the greater New Orleans area had suffered extensive damage.

3. Secretary Stalder ordered the Department's response teams to activate and report to their home facilities or districts wherever possible. Colonel Eric Sivula, in charge of the IMC, notified P&P Director Genie Powers to place all certified (sworn) P&P staff on standby.

4. By late afternoon Monday, August 29, some damage assessments were being received by IMC. In particular, Washington Correctional Institution (WCI) reported substantial damage to buildings, roofs, perimeter fencing, etc. WCI had lost all communication systems and was only able to contact IMC when they were successful in calling by satellite phone, which was infrequently.

C. Contra Flow Evacuations

1. Southeastern Louisiana had a hurricane mass evacuation plan in place when Katrina hit. The plan was called contra flow. The basic concept of the plan was that state police and local law enforcement would take control of the major roads two to three days before a hurricane made landfall. Prisons, hospitals, and other public facilities would be evacuated during specific windows of time, but much earlier than the general population evacuation. The general evacuation itself would be organized geographically with the southernmost areas evacuating earliest. A similar plan had been used the year before during Hurricane Ivan and found to have significant flaws. The contra flow plan was re-designed in light of the lessons learned during Ivan. As a result, the evacuation from southeastern Louisiana actually worked remarkably well, with at least two obvious exceptions.

   First, the plan did not contemplate the large number of people who did not have cars and would not have access to busses or other means of public transportation as a way to evacuate. Second, large numbers of residents simply ignored or refused the order to evacuate.

D. Communications

1. Without exception, every facility, division or key decision maker in the Department interviewed for this report identified communication as the biggest problem during and after the two hurricanes.

2. Phone service was down in most areas for weeks. Cell phone service was almost eliminated because of the number of transmission and repeater towers that were destroyed. With power outages and phone outages, internet services were also out. The Department had anticipated that much of the problem and had purchased expensive satellite phones that were supposed to be the answer to that situation. In the actual event, the satellite phones worked only infrequently. They had not been well-tested and even after the crisis was over, the Department was not certain how much of the problem was overloading of the satellite communication system because of the crisis and how much was attributable to inherent unreliability in the technology.

3. Because calls would occasionally get through on a cell phone, and because at any moment one cell phone service provider might work while several others might not, Secretary Stalder would carry 3 or 4 cell phones plus the larger satellite phone, hoping that one might get through or allow people to reach him. The majority of the time, none worked. Of the various cell phones, Verizon seemed to be marginally better than the other carriers, but none were good.

4. After reporting serious damage to its facilities and perimeter fencing, WCI was unable to get further calls through to IMC by any means and was essentially out of communication for the next three days. Eric Sivula and other staff in the IMC reported that the inability to know the status of the situation at WCI was a major source of stress and anxiety.

5. The communication problems were exacerbated by the Department's need to have command level staff traveling to critical sites outside of Baton Rouge. For example, Secretary Stalder and Warden Cain from LSP spent most of the week following the hurricane's landfall directing evacuation activities in the New Orleans area and then locating and developing a jail in that same area. Thus, the person in command of the agency was not in the IMC and was frequently mobile in the New Orleans area. As a result, Secretary Stalder was out of contact with the IMC much of the time, adding to the frustration and tension of the situation.

6. The Probation and Parole staff, far more decentralized by nature than the institution staff, were in most cases working on tasks in the community and

away from probation offices. If anything, their communication capacity was even more compromised than the rest of the Department's.

7. The Department uses both high band and low band portable radios but neither of these systems were effective during the hurricane. With many base stations inoperable and repeaters damaged or destroyed by the storms, the high band radios were out of service. The low band radios were occasionally effective for short distance, unit-to-unit communication, but were generally unreliable.

E. The Evacuation of the Jefferson and Orleans Parish Prisons

1. In the early summer of 2005, the LA DPS&C had contacted the Jefferson Parish Sheriff's Office and the Orleans Parish Sheriff's Office to schedule a meeting to discuss evacuation plans for the two parish prisons. Because of scheduling conflicts, that meeting never transpired.

2. On Saturday, August 27, St. Bernard Parish had notified IMC that they were going to evacuate their inmate population to the Orleans Parish Prison (OPP).

3. Initial indications from both Jefferson Parish and Orleans Parish were that they did not plan to evacuate inmates. Orleans Sheriff Gusman had also been on television indicating that the parish prison would "defend in place" and ride out the hurricane without evacuating. By Monday evening, with more information about the extend of flooding in New Orleans available, staff in the IMC were increasingly concerned about the viability of the OPP "vertical evacuation" plan.

4. At 11:45 PM on that Monday night, the IMC received a call from the Jefferson Parish Prison (JPP) asking that LA DPS&C evacuate all inmates from the parish prison. Within ten minutes, the IMC received a cal from the Orleans Sheriff's Office similarly asking LA DPS&C to evacuate OPP.

5. The IMC made an immediate decision to use all available resources to evacuate JPP first and then, after completing that first evacuation, to evacuate OPP. That was a crucial decision and an excellent call. JPP had approximately 1,100 inmates while OPP was over 6,000. Also, with the lack of communications and the chaotic, often unknown conditions in the greater New Orleans area, both evacuations would be difficult and high risk. It made good sense to avoid splintering resources or further confusing communications.

6. The evacuation of JPP began immediately. The IMC located buses throughout the Department and they were staged at Elayn Hunt Correctional Institute, (EHCI), so that they could drive to JPP in convoys. The area around JPP was

not flooded. Thus, the buses and vans were able to drive to the JPP doors and inmates were moved in reasonably orderly groups onto the evacuation vehicles.

7. While the evacuation of JPP went remarkably quickly and without major incident, a number of serious issues began to surface. The Department did not have enough buses to transport the required number of inmates. With some buses already working to transport inmates back to work release centers, community correctional centers and parish prisons in the southernmost Parishes, the Department had neither the internal resources nor the external emergency contacts to provide the seats needed. Parole and Probation offices had a relatively large number of vans that could be used for transport and they were pressed into action. A Baton Rouge school district provided a few buses, and after some time, the Federal Bureau of Prisons (FBOP) provided additional buses with bus drivers.

   There were other problems associated with the buses. The Department did not have enough fully qualified bus drivers and in some cases there were no lists of emergency contacts for the qualified drivers. The Department used other staff with different commercial license qualifications, but without bus certifications.

   Perhaps the most serious issue was fuel. Both gasoline and diesel fuel became all but impossible to purchase in the immediate aftermath of Katrina. In fact, both fuel trucks and water trucks were being hijacked and when a tanker could be arranged, it needed to be transported under armed guard. EHCI did have a substantial supply of diesel fuel but with the power out there was no way to activate the fuel pumps. Portable fuel pumps were not available and there were no other back up plans. FEMA had taken control of most of the available fuel but had not decided how or where it would be dispersed. Fortunately, Colonel Sivula had a personal contact in the state department of agriculture and he was able to arrange fuel for the Department on an informal and personal basis.

   The remaining problem with the buses as well as with other vehicles that were used for transporting prisoners and civilians was the lack of identifying characteristics. Vehicles were not numbered or uniquely identified in any clear manner. As a result, when a bus broke down, it was not certain what kind of bus the police or the correctional staff should look for with assistance. Institutions receiving inmates were not sure how many buses were due to arrive, or which buses. Eventually, IMC staff went to an office supply store and simply purchased materials to put numbers on the vehicles and, once each vehicle was identified with a distinct number, the evacuation became easier to track.

8. As the evacuation of JPP progressed, the original plan to transport the evacuees to a number of different prisons around the state was revised. The first group

of inmates brought from JPP were taken to LSP, to EHCI, and to the Louisiana Correctional Institute for Women (LCIW). The situation with buses and vans leaving JPP for different locations and then returning to JPP meant that vehicles were everywhere. Processing the inmates at the receiving institutions, with little in the way of records or identification, was also proving very difficult. The strategy was changed and EHCI was identified as the single staging area where inmates would be received, processed and then held until such time as the Department could move them to other institutions. That held true for male inmates, and female inmates were sent directly to LCIW.

9. Miraculously, the JPP evacuation of 992 male inmates and 120 female inmates was completed by 10:00 PM on Tuesday, August 30, less than 24 hours after the phone call asking for assistance had been made. The evacuation produced no escapes and no serious injuries to staff or prisoners.

10. The inmates evacuated from JPP were complaining of thirst and hunger and they were generally scared. The vast majority of inmates were extremely grateful for the evacuation and were cooperative. In turn, the Department tried to arrange water on all transport vehicles.

11. During the time that JPP was being evacuated, the Department was conducting other smaller evacuations. At 7:15 PM that same Tuesday night, a convoy of 49 P&P and Headquarter vehicles were sent to pick up approximately 300 civilian walking wounded from a triage center in New Orleans. These individuals had been triaged and found to need medical care but not ambulance transport. The triage center had no way to transport them to Baton Rouge for treatment and so the task fell to Probation and Parole. The motley convoy included some P&P transport vans and some state sedans but it also included employees' personal cars; all of the drivers in this convoy were P&P staff. By 10:00 PM (Tuesday, August 30), the convoy had loaded the 300 injured civilians and was in route back to Baton Rouge. P&P Director Genie Powers called the IMC to have them contact the Pete Maraveich Assembly Center and convey the New Orleans Police Department request to accept the injured civilians. The second part of the medical convoy was in route to the Pete Maraveich Center when, just after midnight, the IMC was notified that one van had run out of gas and was stranded at the side of the road. It took a few more hours to locate and get assistance to the disabled van but eventually al of the injured civilians were successfully delivered to the Pete Maraveich Center.

    By this time the Department had also completed an evacuation of one of the state's juvenile facilities. That also was conducted successfully and without incident.

12. As buses and vans became available with the completion of the JPP evacuation, they were diverted to OPP. The situation at OPP was nothing like the straightforward evacuation at JPP. The OPP complex was flooded, with water up to five to eight feet deep around the buildings. It took several hours for Department officials to find a route by which they could bring buses and vans close to OPP without driving through flooded areas. The situation was further complicated because staff families who lived in flooded areas of New Orleans had come to the jail for safety. They were in the first floor in administrative areas of at least one of the buildings. (OPP is a large complex including several different buildings that house prisoners). Some civilians that were not associated with the jail but saw the area as a possible refuge from the flood waters or from violence, had also assembled in or around the jail.

    The situation inside the jail was very bad. Inmates on first floors had been in rising badly polluted flood waters until they were moved to higher floors. The fuel tanks for the emergency generators were in the basement so that when the floodwaters first reached the jail complex, the main power and the emergency power both went off. That meant no lights and no running water, no operable toilets, etc. Additionally, the buildings did not have opening windows and were dependent on the HVAC system for fresh air. With no power and no emergency power, the HVAC system was inoperable.

    There is a great deal of controversy about how bad conditions were within OPP from Monday, when Katrina hit, until Thursday, when the evacuation was complete. The questions of conditions within OPP and what the OPP staff did or didn't do are outside the scope of the consultants' charter and this report has no light to shed on those questions.

    Not withstanding that controversy, there is no question but that some of the OPP population was frightened or terrified, and that some prisoners were desperate and angry.

    After the fact, there were concerns raised about whether Sheriff Gusman had left OPP prior to the evacuation. He not only was present and assisting with the evacuation, he personally waded and swam in the polluted flood waters in order to help get OPP prisoners into the small boats.

13. There were two immediate challenges to evacuating. The first was getting the prisoners out of the jail buildings and the second was transporting them through the floodwaters to an overpass that was directly above a portion of the highway which was itself accessible to buses and vans and without flood waters. For the first part of the task, a cutting torch had to be used to cut the bars off an upstairs window and female inmates were brought out through that window and then climbed down to ground level and the boats. An impromptu

scaffolding was also erected to allowing inmates to climb more safely down from an upper level of the prison. For the second problem, the solution was to transport inmates four to six at a time from OPP to the highway overpass in small boats. The State Department of Fish and Wildlife arranged for a few boats but for much of the evacuation, the Department purchased three flat bottom boats with sixty horsepower outboard engines. Each boat was capable of transporting four to six inmates per trip. The Department tried to rent or lease a "party barge" which would have made much shorter work of the evacuation but those arrangements did not work. Two private individuals later offered the Department air boats but the transport from OPP to the highway overpass remained painstakingly slow. The OPP evacuation was substantially aided by the tactical teams brought to New Orleans from LSP by Warden Cain. They performed a wide range of security functions.

14. At OPP, the general procedure where possible was for tactical teams to go into the OPP buildings and frisk inmates and then send them out to the boats. At one point, the IMC received a call that the state police were reporting that inmates had taken over the armory on the 10th floor of OPP and that there was a firefight in progress. That information evidently reached Washington, D.C., because there was a second call from Washington saying that 3,000 prisoners were holding hostages and had the armory and controlled OPP. Those reports turned out to be totally without foundation. However, they were not the only misinformation conveyed during this emergency and they were rather typical of the kind of alarming but wildly inaccurate reports that may come in with the same certitude as good information. Sometimes bad information just "feels" wrong but it is not always possible in the midst of a crisis to distinguish the accurate from the inaccurate.

15. At 11 p.m. on Tuesday, the IMC decided to stand down the convoys overnight because of fatigue on the part of the bus drivers and continuing security concerns in the area of OPP. Buses, vans and other vehicles were told to complete their current trip and then stop and that the transportation would resume at 5 a.m. Wednesday morning. Some of the buses and vans that had been making medical trips were able to bring civilians back to Baton Rouge with that last trip.

16. With the long delays in waiting for the JPP evacuation to be completed and then finding a route for buses and vans to approach as close as possible to OPP, the evacuation out of the OPP buildings had gotten substantially ahead of the transportation of those inmates to EHCI. The overpass was being controlled by probation and parole staff and one of the officers called the IMC to report that there were 3,000 inmates on the overpass being contained by 30 officers. There were also large numbers of civilians in the area that presented additional problems for the P&P staff. Some of the civilians were angry that the

Department was evacuating inmates and refusing to evacuate civilians. Some of the civilians were sick, thirsty or otherwise in need of attention or medical care. It was an extremely emotional scene. One mother approached officers with her daughter and said that her daughter had been repeatedly raped the night before and asked that they take her out of the area to Baton Rouge. Another woman approached officers with small children and a baby in her arms and said that her baby was dying. That family was put in a vehicle and transported to New Orleans but the baby did in fact die in route. In addition to these kinds of extraordinary and traumatic experiences, many of the staff who worked in New Orleans in the days after the hurricane saw dead bodies lying untouched on the ground or floating in the flood waters where they themselves had to wade. The flood waters were also fouled with human feces, dead animals, and a variety of other pollutants. It was an altogether hellish scene.

The officer calling in from the overpass requested food, water and MRE's (military emergency meals). At one point on the overpass, a man who may have been mentally disturbed, angry or distraught walked straight towards P&P officers who were holding shotguns. He ignored their verbal commands to stop. No one fired and he eventually walked through the group of staff and kept walking. It ended up as simply one more strange and disturbing incident but could easily have resulted in a fatality.

17. The evacuation was greatly assisted when Warden Leblanc had the creative idea to bring scaffolding from one of the institutions and erect the scaffolding from the first lane of the freeway below up to the overpass above. That idea worked remarkably well and the prisoners were able to climb from the overpass to the highway and the waiting evacuation vehicles. By Wednesday morning, there was a continuous cycle of about 5 hours duration which would move 450 to 500 inmates per convoy from the overpass to EHCI.

18. As the evacuee population at EHCI grew toward 3, 000, the institution began to have serious trouble and the Department redoubled its efforts to move evacuees out of EHCI into other facilities as the same rate as they were being processed into EHCI. For the next two days, there was a relatively continuous cycle of conveys from OPP to EHCI and then back to OPP for more evacuees and a second continuous cycle of convoys from EHCI to other prisons across the state.

19. Warden Cain requested portable night lighting and additional tactical teams to support the OPP evacuations. Both proved important.

20. It is well beyond the scope of this review to describe the OPP evacuation fully or in complete detail. Challenges, problems, individual and group acts of heroism, and life threatening situations are not recounted here – some because

of lack of knowledge of the incidents on the part of the authors and some because of time and space constraints. For example, at one of the OPP buildings, inmates were in control of the second floor and above and had come down a stairwell to the first floor. They were separated by a single door from an administrative first floor area where staff families had taken refuge. LA DPS&C staff opened the stairwell door, fired a warning shot to force the inmates back to the second floor and were able to establish a relatively safe evacuation procedure for the building. How close was that situation to an incident that would still be featured national news had it occurred? Very close. The most amazing thing about the JPP and OPP evacuations remains the bottom line: over 7500 prisoners were evacuated in three days out of nightmare conditions to multiple locations more than 60 miles away, with no loss of life serious injuries or escapes.

F. Processing Evacuees and Arrestees at Elayn Hunt Correctional Center Correctional Institution (EHCI)

1. On Saturday and Sunday EHCI had prepared for the hurricane in the usual ways, taping glass throughout the institution, picking up objects outside and sanitizing the yards, filling sandbags, etc. They already had some inmates from Plaquemines Parish, but not so many as to present a problem. On August 29, EHCI came through the hurricane in reasonably good shape. They were on emergency power but they thought the crisis was over. It was actually just beginning. They were informed that they would receive 400 to 600 of the JPP prisoners. As they reached 1,000 evacuees, the OPP evacuation began in earnest and EHCI rose to 3,000 evacuees at the institution in addition to approximately 2,100 of their own permanent population. In the next few weeks, a total 8,000 prisoners were processed through EHCI, with the vast majority of those in the first several days. In general, EHCI was unable to identify most inmates during processing and was unable to conduct counts. Even with two complete kitchens, they were pressed to feed evacuees one hot meal per day keeping both kitchens going 24/7.

2. Initially, all of the evacuees were kept outside under a canopy and the staff used the roofs of buildings for armed posts. Evacuees were given one blanket each but no mattresses. The canopies had been obtained from the National Guard and porta potties were also placed in the outside compounds.

3. EHCI tried to move the evacuees into groups on individual outside yard areas between the living units. Inmates in the permanent population were kept well informed and were extremely cooperative throughout the crisis. The staff put TV's outside so that the evacuees could see news reports and perhaps allay their

fears about their families. Tactical teams were dressed and deployed on site 24/7 for several days.

4. The EHCI administration did not realize that they were going to become the staging area for all the evacuees nor did they recognize that large number of evacuees would be staying there for a long period of time. As that information began to sink in, they reorganized and moved their own inmate population almost completely for the second time. By Thursday evening the evacuees were clearly growing more restless and the individual yard holding areas were difficult to control. In essence, a serious disturbance in one outside area could have compromised the security of the entire institution. A decision was made to put all evacuees together on the large yard. At first that was attempted with the rented large tents and porta potties. Both had to be removed because prisoners were dumping the porta potties and tearing up the tents and some of the tent material and tent stakes were potential weapons. Officers with weapons reinforced the perimeter around the yard and the evacuees were fed twice a day. EHCI worked to move as many inmates into living units as possible and by Saturday morning, between buses moving evacuees to other institutions and movement of evacuees off the yard and into the living units, the yard was reduced to approximately 700 inmates. Eventually, all inmates were moved off the yard and into the units but at a cost of very serious overcrowding, with inmates sleeping on the floor in many locations.

5. The existing emergency plan at EHCI had been to accommodate 264 inmates if evacuations were necessary from other locations. They tried to work from that plan but it quickly went "out the window". There had been no consideration of using EHCI as the staging area for the entire state.

6. EHCI was informed they were going to be receiving inmates from JPP well before anyone at the institution realized New Orleans had flooded. Poor communication, bad information and lack of the "big picture" continued to plague the institution through the next few weeks.

7. As the first evacuees reached EHCI, the staff tried some minimal classification as the evacuees came off the buses. That quickly produced a back-up that was impractical. Also, the classification efforts were not worthwhile because the staff had no way to verify the identity of the inmates. OPP uses a color coated plastic bracelet system for identifying inmates by security level, but most inmates who were awaiting trial on felonies or who were sentenced state inmates simply tore off their bracelets during the bus ride and were able to be anonymous at EHCI. It was not possible to run each inmate through an APHIS machine for fingerprint identification nor was EHCI prepared to take Polaroid or digital pictures for later identification. Staff did continue to use a one and one-half page classification questionnaire throughout the several weeks,

and staff paid particular attention to trying to identify inmates who seemed to pose suicide risk. There were, in fact, no suicides and no close calls at EHCI, which were perhaps a testament to staff's training and commitment.

Medical issues were also vexing. In general, the staff were relegated to asking inmates about their medical condition and medications and simply taking their word. No medical records had been transferred and no medications had been transported. EHCI staff knew they could face consequences that could include inmate deaths if individuals on insulin, heart medication, etc. were without prescriptions for extended periods. Evacuees decompensating due to discontinuances of psychiatric medications was a similar concern. Staff also asked inmates for names, addresses and status in the jail, but knew full well that they could not rely on the answers. Nurses and classification staff walked the yard pulling out juveniles or other cases that obviously needed medical help or other special attention.

8. Conditions on the yard were not good. It was 95 to 100 degrees in the daytime and cold at night. The staff were well aware that if serious unrest developed, three thousand inmates could easily take down the perimeter fence and there would then be nothing between them and the community. That did not happen. One inmate did suffer a stroke on the compound. There was no way to know immediately whether he had a history of hypertension or prior strokes. The only other serious incidents were that a warning shot was fired and an attack dog used to get to an inmate and extract him from the yard after he had been beaten, and another inmate was shot with rubber bullets when he ran towards the perimeter fence. There were no complaints or allegations of stabbings, rape or other serious assaultive behavior. At one point staff did get rumors of knives and other weapons on the yard and they organized as much of a shake down of the yard inmates as was practical under the circumstances. No serious contraband was discovered.

9. At the height of the evacuation there was a line of buses, vans and other vehicles one mile long waiting to drop inmates off at EHCI. Not all of the evacuees turned out to be prisoners. People from the community got off vehicles because they had managed to get on the buses along with the prisoners in a rather bold attempt to escape New Orleans. EHCI also had officers from St. Bernard Parish bivouacked at the institution because they had gone to OPP with their own inmates and then come with the OPP inmate evacuation out to EHCI. Most of them had nowhere to go and almost all of St. Bernard Parish was deeply submerged in flood waters. EHCI also had babies staying at the institution and the facility was effectively functioning as a shelter as well. Staff initially worked until they began to burn out and then generally settled into twelve hour shifts. Since gasoline and transportation were major problems and

since many staff had had their homes seriously damaged or destroyed, EHCI also had staff sleeping at the facility.

10. Inevitably, some of the prisoners transported to EHCI would have been released almost immediately on recognizance or on bail had JPP and OPP continued to operate. An Australian on vacation in the French Quarter had been arrested for a misdemeanor. His wallet was stolen or lost when the jail property room flooded and he had no way to identify himself or prove that his charges were minor. The Australian Consulate became involved, the newspapers picked up the story and that prisoner became very high profile. There were many similar cases of evacuees who spent months at EHCI or other prisons because police and jail records were lost, the courts were closed and there was no good way to distinguish the minor offenders from the most serious. The situation with OPP evacuees was most difficult because the parish had used an offender information system that was not compatible with the state system or that of other parishes. With no remote hot site that could be activated and no back up data that could be run on other computers, huge numbers of prisoner records were lost or destroyed by flood waters.

11. EHCI received important help from Kentucky in the form of volunteer correctional officers sent by Commissioner John Rees to work alongside the EHCI staff. Jeff Beard, the Commissioner of Corrections in Pennsylvania, arranged to send social workers and other mental health staff and they worked at EHCI providing critical incident debriefing and other post-trauma care to both staff and inmates. These staff from other states provided a much needed morale boost for the EHCI staff who were exhausted, overwhelmed and frequently frustrated. One staff member from EHCI had been in the community escorting a sick inmate. When they were trapped by flood waters, they ended up in the Superdome and they were then taken out to a plane with other evacuees and ended up in Georgia. EHCI had to send a van with an officer to Georgia to bring them back. Other officers from EHCI on escort duty at Charity Hospital were isolated in New Orleans for days. When street thugs began to loot the hospital looking for drugs, those escort staff and the inmates they were guarding had to be rescued from the hospital. Once the flooding began, staff from EHCI who were sent to New Orleans had to be given hepatitis and tetanus vaccinations.

12. EHCI's Tactical Team might have been overwhelmed by the situation, but they were not. At one point, they worked twenty-one hours straight. It is noteworthy that early in the situation they were given the green light to use lethal force if necessary without further consultation or review. In spite of some precarious situations they did not find that necessary and no lethal force was used.

13. Much of the frustration at EHCI was clearly attributable to communication problems. They were intermittently unable to reach the IMC and when they did they could not always reach someone with decision making authority. Further, they were being contacted by a number of top administrators in the Department and sometimes receiving conflicting or contradictory explanation or direction. In retrospect, EHCI recognized that some of the problem was their own lack of preparation for an extended major emergency. Although they set up a physical command post early on, it was not a real command post and no one was identified as in command of the situation for the first few days. After four or five days, the top managers started meeting every morning to compare notes and assess the situation and all agreed that helped greatly. As the fulcrum for both the evacuation cycles (into EHCI and out of EHCI) arrivals and departures were crucial. It was an inordinate amount of help once the buses and vans were numbered and could be clearly identified.

14. While EHCI received direction from the IMC and top administrators, there were no formal briefings and staff at EHCI had difficulty understanding the scope of the situation and the Department's overall strategy. After initial information that EHCI would receive 400 or 500 JPP inmates, the institution was over 1000 evacuees and beginning to understand that large numbers of OPP evacuees were being sent there, but there had still been no communication to that effect, or even verification. They had originally understood they would be receiving trustees but quickly realized that was not the case and they were receiving many very serious inmates.

    The institution was asked to come up with a cemetery for emergency burials and given twenty-four hours notice to develop the cemetery. That plan was later scrapped. One hundred female evacuees arrived at EHCI that were intended for LCIW. All of these changes in direction and missteps are common, even inevitable, under the kinds of conditions the Department was facing. The lack of consistent communication magnified these issues for staff at EHCI until they created a question of trust with Headquarters. On Friday, the fourth day of the evacuation, the Department held a press conference outside the fence at EHCI and in front of the large recreation yard. EHCI staff were unhappy that their own top managers were not briefed or consulted prior to or after the press conference and, in general, felt that there should have been more top administrative staff presence from headquarters at EHCI in the weeks following Katrina. Again, it appears that much of this might have been alleviated if EHCI had a better sense of the scope of the Department's missions and if there had been a system of regular briefings.

15. EHCI staff, even at high levels, had had no training in command post operations and no significant training on emergency preparedness. As was true for the rest of the Department, no one at EHCI referred to the institution's or

the Department's emergency plans during the crisis. That was true for a few reasons. Since the staff were not familiar with the emergency plans, they would have had to start reading thick documents, a task for which they had neither time nor inclination. Second, most staff assumed that the emergency plans would not be realistic or helpful.

16. With hindsight, the EHCI management staff recognized that they would have been in a better position if they had at least understood command post operations and the manner in which command needs to operate in a crisis. Those lessons were self-taught over the first several days of the situation and by day five, EHCI had moved the command post to a larger and more appropriate location and insured that one person was in charge of the command post at all times and that other staff knew who it was that was in command. Those were exactly the right decisions, but with effective training and/or realistic and user friendly emergency plans, those decisions could have been put in place at the outset. Instead, the EHCI managers were candid that they had been extremely lucky that nothing untoward happened in the first few days of the emergency when no one was in charge of the command post and decisions were made by whoever happened to answer the phone.

G. Housing Arrestees and Evacuees at the Louisiana Correctional Institution for Women (LCIW)

1. As the only women's institution in the state, LCIW was the natural place to move female evacuees and arrestees. Fortunately, LCIW is located close to EHCI, which made the transfer of female prisoners processed through EHCI relatively easy.

2. Like EHCI, LCIW staff felt overwhelmed by the sudden influx of additional offenders and, also like EHCI, the staff still felt somewhat overwhelmed at the time of the consultants' visit some five months after Katrina.

3. Unlike EHCI, the scale of the movement of evacuees and arrestees to LCIW was nothing like what occurred at EHCI. With a rated capacity of 1100 inmates, LCIW had been operating between 1000 and 1100 average daily population (ADPL). At its peak the resident population of evacuees and arrestees reached 340, or just under one-third of the regular population, compared to Elayn Hunt Correctional Center, which at one point housed a group that equaled 150% of their resident population. The LCIW staff were much too busy and tired to feel lucky by comparison.

4. The general strategy at LCIW was to move resident inmates out of the segregation unit and one other dorm and put evacuees, and later arrestees, in those two areas. When those two locations became badly overcrowded, the

institution was forced to mix evacuees and arrestees with resident inmates in some units, a move that they had hoped to avoid. In retrospect, the management staff thought they would have been better off using a tent city on the yard rather than overcrowding all of their living units. They were unaware that at EHCI that approach had proved unworkable in a number of ways.

5. The institution's infrastructure was challenged at many different levels. It was very difficult to provide sufficient medical services. As was true everywhere else in the Department, LCIW staff found that the new prisoners arrived in very bad condition and needed clothes, food, water, showering and de-licing. Yeast infections and rashes were very common, whether from the polluted flood waters or from lack of recent hygiene. Staff expressed concerns about communicable diseases, but there was little that could be done with regard to screening or prevention. Feeding and exercise took much longer than normal and with seventy-five percent of the population on medication, the "pill passes" were themselves a lengthy operation.

6. From the outset, staff recognized that they could not conduct "business as usual". Most managers were at the institution 24/7 and front-line and security staff responded wonderfully, with no absentee issues in spite of the many hardships individual staff members were experiencing. The resident inmate population was extremely cooperative, which made the whole operation much easier, and for their part, staff went out of their way to keep the population informed frequently and in detail. The staff involved inmates in preparing emergency food rations to be sent to New Orleans, and that was a morale booster for the inmate population. Staff also set up systems to allow new detainees phone calls and to get messages to them. As was the case at EHCI, the Department's emphasis on suicide recognition, prevention and training paid dividends as the institution made a conscious decision to keep social workers on the floors and walking through the living units, and in general to make staff presence as visible as possible. Not surprisingly, the single most frustrating aspect of the situation for staff was the inability to identify prisoners as they came off the buses and the lack of knowledge about personal, medical or criminal histories.

7. In general, the institution's infra-structure held up to the challenge quite well. The facility was on emergency power for several days but that did not produce any particular new crisis. The food supply was good and was not severely challenged. The management staff established a command post at the outset and ensured that it was staffed by a person empowered to make decisions at all times. Unlike EHCI, management staff described communication with the IMC, which was primarily by phone or email, as exceptionally good. Gasoline was in critically short supply for about two days, both for institutional needs and for staff personal vehicles so they could drive to work and back. After two

days, the Department was able to provide an adequate supply of gasoline. All staff interviewed were extremely pleased with the internal emergency response of the institution and identified that as the best thing that happened in the situation.

8. When the consultants visited LCIW at the end of January, 2006, managers there said, "The most difficult time is now." They meant that with the height of the crisis passed and with approximately 150 evacuees and arrestees remaining in the institution, they were continuing to face over-crowding and some negative staff morale at line levels due to the months of pressure and overtime. With budget cuts, positions were being left unfilled and managers were doing supervisors work. For inmates, cutting back on programs has similarly had a negative effect on morale.

9. The consultants were able to spend some time interviewing a group of inmates who had been evacuated from OPP (the group included one woman who was evacuated from JPP). Unlike the male evacuees, the women in OPP had been taken to the overpass bridge and then directly to the busses and had not spent any length of time waiting on the overpass. To a person, they did describe horrendous conditions at OPP and JPP prior to their evacuation. As had been true with male evacuees, the women described a variety of serious problems with the legal system, ranging from not knowing what offense they were charged with or why they were held, to being months beyond a scheduled jail release date. LA DPS&C staff confirmed that the gamut of legal problems described did apply to some of the evacuees still held within the prison system. It should be emphasized that these were criminal justice system problems, and almost exclusively problems at the parish level, and that LA DPS&C was working with the state Attorney General's Office (and the courts as the parish courts were reconstituted), to attempt to resolve problems of identity and charges.

10. The female evacuees were, as a group, angry and upset about conditions within LCIW. Many of the issues they described stemmed from being isolated and being accorded different treatment than the resident female inmate population. The female evacuees complained about being kept on 23 hour lock-down for months, the lack of availability of indigent packages for months, long delays in getting medication, no distribution of clothes given to the resident population, sleeping on the floor for the first three months and a continuing lack of access to phones and a continuing prohibition against family visiting. The consultants were not in a position to investigate individual inmate complaints or even to verify some of the group concerns expressed. LCIW staff did confirm that many of the situations involving mattresses, services, hygiene items and the like were essentially as described. The consultants discussed the situation with phone access and with access to family visiting with the administrative staff and

there was a decision that the evacuees should be given immediate access to family visits and phones.

H. Evacuees at LSP

1. The Louisiana State Penitentiary (LSP), often referred to as "Angola", is one of the legendary, old state prison work farms dating to the 1800s. Georgia had Reidsville, Mississippi had Parchment, Arkansas had Tucker and most southern states had a large prison work camp, usually named for the community in which it was located, where inmates worked the fields and were supervised and guarded by other inmates, all under the eye of a small number of staff "bosses" on horseback in the fields and in offices within the prison. LSP has a colorful and at times very violent history.

2. Today, LSP is a modern, large prison with a capacity of approximately 5800 inmates. There is one Warden, Burl Cain, over the entire operation, but the prison is subdivided into much smaller camps that have their own administrators and which are physically separated on the 18,000 acres that the prison still occupies. Under Warden Cain there are three Deputy Wardens and fourteen Assistant Wardens. There are approximately 1700 staff at LSP, with the majority correctional officers and supervisors. The inmate population is 80 to 85% African American and 10 to 15% white with no other significantly large ethnic population. The staff are approximately 50% White and 50% African American; security staff are approximately 60% male and 40% female. The prison has no major contract functions. Outside hospital assistance is provided primarily by LSU.

3. LSP is now a modern, low violence prison with a heavy emphasis on inmate agricultural work, other Prison Enterprises and inmate programming. There are few serious problems and the institution is often visited by correctional professionals from other states and other countries. There is a particularly broad emphasis on faith-based programming and the Warden believes that direction has been one of the reasons for the institution's success.

4. LSP has a long history with hurricanes and generally has not had great trouble. LSP is far enough inland that, historically, hurricanes have diminished in intensity sufficiently that they have passed over LSP without catastrophic impact. Still, the prison complex is well practiced at preparing for hurricanes and "riding them out".

5. LSP weathered Katrina's direct impact without serious problems. They did lose power, but one of the lessons the prison had learned over past hurricanes was the importance of emergency power and LSP had managed to acquire several large portable generators as well as the usual fixed emergency

generators. Running on emergency power was neither new for the prison nor was it particularly problematic. By Monday evening, the staff at LSP thought that except for the power outage, Katrina was behind them.

6. LSP staff and buses had assisted with the evacuation of the lower Louisiana parishes to Dixon CI and on Monday, Assistant Warden Cathy Fontenot was describing the evacuation of those lower parishes to media representatives as reports of the New Orleans flooding began to come in. When the requests to evacuate JPP and OPP were received, Assistant Warden Fontenot, like many other staff, made arrangements for child care and went into the prison Monday night prepared to stay many days, which she did. Assistant Warden Fontenot was responsible for classification at LSP and she quickly called her key staff and then got medical staff heading back to the prison and began to prepare for a massive intake of inmates.

7. Early on, LSP was sending buses to help return the Lafayette Parish inmates from DCI and also sending busses to EHCI so that JPP and OPP prisoners could be taken to EHCI.

8. The staff at LSP expected to get JPP inmates first, which they did. During the first night of the evacuation, prisoners from New Orleans were sent directly to LSP as well as directly to EHCI. The early processing went well and the evacuees from JPP generally seemed to be in somewhat better shape than the LSP staff had expected from media reports. Many of those media reports emanating from the New Orleans area were quite frightening.

9. As was true at EHCI, the LSP staff were not sure what to expect in the way of total evacuees and communication from the IMC in Baton Rouge was not good in this regard. There was communication about specific convoys, numbers of busses, drivers and fuel, but more general briefing and the "big picture" were missing. For his part, Warden Cain was on-site as LSP prepared to receive evacuees and then left to drive to New Orleans to work with Secretary Stalder in organizing the evacuation of JPP and OPP. Two Assistant Wardens from LSP were detailed to the state Emergency Operations Center and were involved 24/7 in receiving missions assigned to Corrections by FEMA or state government. In Warden Cain's absence, LSP was under the direct command of Deputy Warden Sheryl Ranatza.

10. As prisoners from OPP began to arrive at LSP in the middle of the night Tuesday, the situation at LSP became much more difficult. By then, EHCI had been designated as the initial processing location and evacuees were no longer being received directly from New Orleans. The initial OPP inmates were not in as good shape as the JPP inmates and were described by one staff member at LSP as looking as if they had arrived "directly from hell". LSP did not have

projections about which inmates they would receive or how many. At one point the Deputy Warden was on the phone to the IMC asking, "Can you just tell me whether the inmates coming are male or female?"

11. In fact, over the next several days LSP received approximately 2000 evacuees, some directly and some sent from EHCI. Included in that number were several hundred female inmates. (As the consultants toured LSP in February, 2006, there were still 98 female evacuees remaining there).

12. The female inmate issue was noteworthy for LSP because historically the last female inmates had been moved out of LSP in 1961. Thus, the prison had no hygiene supplies for women, no housing areas that had accommodated women, no programs or services designed for women, and no staff accustomed to working with female offenders.

13. In general, LSP handled the influx of evacuees by placing most male prisoners in unoccupied areas (gymnasiums, the educational center, etc.) and by moving approximately 400 male inmates out of a dormitory that was secure from the rest of the institution and moving the female inmates into that dorm. As the evacuation continued, prisoners who were troublemakers were typically identified during transportation and then off-loaded first upon arrival and sent directly to some form of restrictive housing. The general processing at LSP was that evacuees received medical and mental health screening first, then were fingerprinted, a mug shot was taken and a plastic ID bracelet used and then prisoners were showered, given clothing and a blanket and assigned to a permanent or temporary housing area. The problem with the lack of identification of evacuees, the lack of personal and medical records and medications was not different than at EHCI. LSP was less overwhelmed with the influx of evacuees in general, and the processing at LSP appears to have been somewhat more systematic and thorough.

14. Staff at LSP worked very long hours during the evacuation. No staff from the parish prisons accompanied the evacuees to LSP, which had also been the case at EHCI. While LSP staff did try to run inmates though NCIC, many inmates remained unidentified. Inevitably, a few very high profile cases appeared among the population of evacuees, as had been true at EHCI. A teacher from Ohio who was picked up drunk on Bourbon Street was incarcerated for months and there was an African American Ph.D. student from Tulane who continued to assert that she had no knowledge of why she was being held. With no contact with the state Prosecutor's Office from Baton Rouge, the situation with inmate identification was very frustrating for staff.

15. A total of 2100 parish prisoners passed through LSP including male and female evacuees. With the exception of fencing in two pavilion areas on the rodeo

grounds to make additional outside staging areas for the inmates, there were few structural changes that needed to be made. Interestingly, there were rumors, completely unfounded, that LSP was flooded, and it was necessary to work with media representatives to quell those rumors. Actually, direct storm damage at LSP had been limited to some roof damage in addition to the power outage.

16. Early in the situation, the communication with the headquarters IMC was sporadic and generally had to be conducted over the satellite phone; thus, the institution did not know when to expect inmates. As a result, it was not possible to release staff for rest periods and instead the institution attempted to keep most staff on site. In light of the problems with various communications systems, the institution generally regarded their ability to communicate with the Headquarters IMC as good to excellent throughout most of the period following the evacuation. Staff pointed out that it would have been useful to attempt to pause in some of the ongoing activities, fall back and re-group and re-prioritize objectives. These comments were in general similar to those from EHCI and reflected some lack of ability to find the "big picture" in the midst of considerable chaos, as well as underscoring the need for status reports.

17. LSP sent two tactical teams comprised of 40 staff members to New Orleans to help with the parish prisons' evacuations. Those teams then stayed to help provide security at Camp Amtrak. With their tactical team staff in New Orleans, LSP kept 20 field officers on stand-by at the prison as a precaution against a disturbance, mass escape or something similar. Field officers were the natural choice for this assignment since they work armed posts regularly.

18. Releases were a particular problem at LSP. With different parishes involved, there were many different kinds of release papers. If someone appeared at LSP with what looked like official release papers for one of the evacuees, there was no guarantee that the paperwork could be verified. For example, months after the initial evacuation, St. Bernard Parish still had no working phones or faxes that could be used to verify court or parish prison paperwork. As a result, some evacuees were released without any of the verification of orders that is fundamental under normal circumstances.

19. With shelter space at a premium and with a large number of offenders who could not locate families locally, the Department authorized out of state bus tickets for inmates who had available living arrangements with family in other states. Most often these arrangements involved states neighboring Louisiana, but at LSP, for example, some women were given bus tickets to Ohio or to New England states. There was little choice if the women were to be released to a location and situation that provided them a modicum of safety.

20. Small group and individual interviews with male and female evacuees at LSP produced the same kinds of stories and information that had been received from inmates at EHCI and LCIW. There were complaints about lack of court process and lack of review of individual cases, but most evacuees saw the staff and the living arrangements at LSP as reasonable to quite positive. Most of the bitterness, anger and detailed stories of horrendous situations had to do with conditions in the various parish prisons immediately prior to evacuation.

21. Warden Cain emphasized that LSP had extensive history in preparing for hurricanes and that they were well prepared for the storm impact if, in retrospect, a bit overly optimistic. Warden Cain had talked with Secretary Stalder as early as Saturday night, a day before the storm hit, discussing possible ways that LSP might provide assistance to other areas. The institution also had a history of community assistance and assistance to other parts of the criminal justice system during prior hurricanes.

22. By late Monday night, Warden Cain was en route to New Orleans to work with Secretary Stalder and the immediate objective was to arrange enough buses to effect the evacuation of Jefferson Parish. Tuesday he joined Secretary Stalder, Probation and Parole Director Genie Powers and Attorney General Charles Foti, Jr., who had formed an informal command group to begin to deal with the NOPP evacuation.

23. Warden Cain reported early decisions to get Departmental vehicles out of the area ahead of the rising waters (many of the state and local agencies did not get their vehicles out and lost them). With flood waters still rising at OPP, the Department bought three flat bottom aluminum skiffs with 60 horsepower outboard motors. The situation was deteriorating so rapidly that when the group left OPP Tuesday night, prior to buying the boats, they were unable to drive back on the same roads they had come in on.

24. Warden Cain described in some detail the situation at OPP and at the overpass that became the staging area for evacuees to be put on buses and vans. There was no police presence either at the OPP evacuation sight or at the overpass. It was LA DPS&C staff (and primarily P&P) that established traffic control on the freeway and above at the overpass. The 8 foot wide by 50 foot high scaffolding that the Department brought in and erected from the overpass down to the highway, allowing the movement of evacuees to the buses to proceed faster and more safely was the creative idea of Warden Leblanc.

25. As was the case with every other key individual, Warden Cain identified the lack of communication as the most incapacitating and consistent problem. Had there been adequate communication, Warden Cain remains convinced that the Department could have evacuated more nursing homes and would have had

adequate numbers of Parole and Probation staff to help suppress violence in the Superdome. Without communication, he and other Department officials were unaware of many of these severe problems until after the fact. The communications system failures also meant that there would have been no way to coordinate those kinds of efforts by the Department.

I. Camp Amtrak: LA DPS&C Develops a Jail

1. As New Orleans flooded, the whole country watched media coverage of violence in the Superdome, looting in New Orleans and other general lawlessness in southeastern Louisiana. In the days following Katrina's landfall, pressure mounted to re-establish the rule of law in southeastern Louisiana. However, the jails in Orleans, Jefferson and St. Bernard Parishes were closed and it was obvious that none were going to re-open any time soon. In order for the National Guard, the state police and remnants of local law enforcement agencies to begin to operate, there had to be some place to which arrestees could be transported, booked and safely detained. The most pressing need was for a jail within New Orleans, but the entire OPP complex was out of the question because of flooding.

2. Secretary Stalder and Sheriff Gusman jointly chose the location of the new jail. They chose the Greyhound Bus Station which adjoined the Amtrak train station. The location offered good road access and, when the two stations were taken together, adequate office space and inside areas as well as large outside areas with vehicle access that could be fenced off and used for law enforcement delivery of arrestees. An additional advantage was that many of the outside areas were already heavily fenced and reasonably secure, minimizing the amount of additional fencing that had to be constructed. Much of the necessary construction was done by LSP's tactical teams, and Camp Amtrak remained a work in progress after it opened. Amazingly, Camp Amtrak was open and fully operational as a jail by September 3, 2005.

3. In some ways the physical facility was the least of the challenges facing LA DPS&C staff. The Department had never run a jail and had none of the established protocols and procedures for handling new police detainees. Fortunately, officers from the New York City Department of Corrections arrived relatively early in the Camp Amtrak saga and they proved invaluable because jail operations is their business. They helped Louisiana staff develop appropriate emergency procedures for receiving, screening, processing and housing new prisoners.

4. New arrestees were entitled to a speedy court appearance. Thus a court had to be established on the second floor of Camp Amtrak. Offices were established on the second floor of Camp Amtrak for ATF, the State Attorney General's

office, the FBI, the U.S. Department of Justice, parish District Attorneys and more.

5. Most of the prisoners processed through Camp Amtrak were arrested for fairly serious offenses because law enforcement were too busy and the situation too dire to make arrests on minor charges. Those law enforcement officers working in the greater New Orleans area were well aware that Camp Amtrak had limited capacity. The make-shift jail with staff with little or no jail experience successfully completed the intake process and provided housing for over a thousand offenders including murders, rapists and other extremely serious offenders. As of February, 2006, well after Camp Amtrak had been closed, not a single law suit had been filed over any of the operations there.

6. With all of Warden Cain's experience at LSP, he reported seeing more media at Camp Amtrak than he had ever before seen in his career. His approach at Camp Amtrak with the media was simple: tell them the truth and give them complete access. As a result of that approach and because there were no severe incidents at the jail, the coverage of Camp Amtrak was high-profile but almost entirely positive.

7. Supplies and logistics at Camp Amtrak were a challenge. Warden Cain arranged for nine inmates from LSP to stay there and work as cooks. Amtrak had large quantities of food in a warehouse on site and they made that available to corrections staff, who fed up to 200 individuals a day. It should be noted that the LA DPS&C staff saved the Amtrak building, food and a substantial amount of money, because until the corrections staff arrived there, individuals had been looting the bus station and attempting to loot the train station. Water for Camp Amtrak was a more serious challenge. Eventually, the tactical team worked out a method for obtaining water. A local water company had water trucks and a water supply. The company was not operating; however, looters were going onto the company property and filling water trucks or taking filled trucks and driving off the property, presumably to sell the water in other communities. The LSP tactical teams would wait outside the property until the looters drove a water truck out and then stop the truck, repossess it and drive the truck to Camp Amtrak.

8. At one point, Camp Amtrak was taking fire from a nearby high rise garage. A tactical team was sent to the garage to move through the higher floors and clear out the shooters and take control. Warden Cain commented that at that point, "It just didn't seem like it was still America".

9. Warden Cain ran Camp Amtrak for approximately one month. Two Majors alternated shifts and ran jail operations for the Warden. They lived in a trailer

onsite so that one or both were constantly available.

10. Camp Amtrak had approximately sixteen fenced off areas which were each used as containment pens for offenders. There might be up to 30-40 prisoners in one pen and over 500 detainees were at Camp Amtrak at its maximum. Once they became reasonably well organized, they sent buses to EHCI and LCIW every day with prisoners in order to keep the population down at Camp Amtrak.

11. Many supplies and services had to be improvised. There were no showers and there was no supply of inmate garb. Instead they used old clothes when possible, and they had salvaged a few sets of inmate garb that originated at OPP. The primary source of food was MRE's from the National Guard and water, also from the Guard. The food and water was not supplied through FEMA but rather because of informal contacts that the correctional staff had with National Guard staff.

12. Camp Amtrak did not have safety cells, padded rooms or other safe areas to segregate violent or wild psychotic arrestees. They had little choice but to resort to handcuffing detainees to fixed objects when necessary (there was a large steel rail that buses pulled up to and prisoners could be handcuffed around that rail and would be secure for some time). Every so often one of the law enforcement agencies would call in or radio in saying that a prisoner was en route who was kicking the windows out of the police vehicle, and the jail staff were quite limited in their responses. There were no mental health staff on site to give medications. If the prisoner were floridly psychotic, he or she would be sent directly to Jefferson Hospital. At most times there were EMTs and/or paramedics and that was a substantial help to the jail staff.

13. Camp Amtrak used old-style Polaroid photos and similarly old style fingerprint cards for prisoner identification. In many cases, the jail developed its own documentation and forms. Once inmates had been booked and identified, the jail staff used the sixteen or so pens to try to separate prisoners by seriousness of offense.

14. Use of force incidents at Camp Amtrak were infrequent. One prisoner kicked a canine and was bitten. Another prisoner was shot by a bean bag round, but neither of these prisoner injuries were serious. Camp Amtrak tried to maintain three staff in booking and three or more staff in the lock-up areas, around the clock.

15. The two Majors in charge of the operation at Camp Amtrak were concerned that the facility was so visible and accessible from the street that there was a substantial risk of family, friends or gang members trying to break prisoners

out of the facility. As a preventative measure, National Guard troops were used to guard the perimeter and no outside assaults or major escape attempts occurred.

16. The work at Camp Amtrak was high stress and exhausting. Once the jail was up and running, the staff pattern was six hours on and six hours off, but all staff were just tired. There were inmate mattresses in some small rooms that staff used for sleeping, but one of the managers said that the best rest he got in the first several days was three hours at a time on a park bench.

17. While the public safety concerns with Camp Amtrak were serious, staff described excellent cooperation and a team effort among many staff members. There was an open expression of ideas and opinions among staff in trying to solve the many challenges, and the fact that most staff had worked together at LSP for many years and had a long history of close relationships was a valuable bonus.

18. By October 17, 2005, Camp Amtrak had been in operation for one and one half months. Twelve hundred and eighty-four prisoners had been processed including 132 females and 1052 male arrestees. Five hundred eighty-five individuals were booked into Camp Amtrak on misdemeanors and 699 were booked on state felony charges. About two-thirds of the prisoners with felony charges were subsequently transferred to state prisons included 414 male arrestees with felony charges who were sent to EHCI and 62 female arrestees on felonies who were sent to LCIW. All misdemeanants were discharged directly from Camp Amtrak. There were nineteen different arresting agencies that brought one or more prisoners to Camp Amtrak. The majority of these agencies accounted for less than ten arrests each. The New Orleans police accounted for 756 arrestees and the Jefferson Parish Sheriff's Office brought in 313 individuals. Three other law enforcement agencies, the Louisiana State Police, the Kenner Police and the St. Bernard Parish Sheriff's Office accounted for 76, 55, and 32 arrests, respectively.

    The most ironic arrest of the almost thirteen hundred, and the funniest, if any arrest can be deemed humorous, was the first person processed at Camp Amtrak. That individual drove into the jail the day it was opened, trying to buy a train ticket. He was driving a stolen car.

J. Katrina Hits Washington Correctional Institution (WCI)

1. WCI was the only prison in Louisiana to take a direct hit from Katrina. Twenty-four hours ahead of Katrina's landfall, WCI knew they were likely to be in Katrina's path.

2. WCI had no plans for a category 3 or 4 hurricane. However, Warden Miller pointed out that it was mentally helpful for the prison that they had thought through potential problems like train derailment. Staff attempted to take reasonable steps to prepare for the hurricane, although they afterwards realized that they had not been able to begin to contemplate the extent of the damage they would face. Most of the prison buildings have flat roofs covered with small rocks. All prison vehicles were moved away from the buildings to protect them from flying rocks during the hurricane. Trucks were preloaded with chain saws ready to foray out with inmate crews to clear roads. Windows were boarded or taped and most of the other traditional hurricane precautions were observed.

3. On Monday morning, WCI was hit with the brunt of Katrina for three to four hours. They did not attempt to feed breakfast that morning and instead fed inmates for the first time at 1:00 p.m. Staff described the damage to the institution and the area as looking like a forty mile wide tornado had come down, stayed down and moved through.

4. At WCI, some interior fences were down. One perimeter fence had a section broken. All communications were down as was water and power. Some HVAC systems were blown off building roofs. That produced very dangerous gas leaks, and WCI staff had to find the appropriate utility shut-offs and cut off the natural gas even before the storm had passed. Some of the prison buildings had serious roof damage. Trees were down everywhere and the road into the prison was impassable because of fallen trees.

5. Warden Miller said that throughout the crisis the employees were great and the inmate population was well behaved and cooperative. The staff that were on duty when the hurricane hit, worked approximately twenty-five hours straight. Then they were back at work within twenty-four hours.

6. Approximately twelve WCI employees lost their houses entirely. Approximately fifty percent of the staff, or about 150 employees, had significant damage to their houses. With no communication available, some staff members were two to three days before they were able to reach their families. No inmates in the population lost immediate family members during the hurricane, but some staff did. One correctional officer had a son and grandson who died during the storms in the Biloxi area.

7. In the immediate aftermath of the storm, WCI sent crews out to clear the major roads in the parish. First priority was given to the access road to the prison itself and to the road leading to the local hospital. Major highways in the parish were the other top priority. Crews of inmates supervised by staff worked around the clock until the next day, when there was no gas left for the

chainsaws and there were no replacement chains left. Some 200 inmate trustees worked in the community on clean up tasks, many along side community volunteers. There were no problems with any of the inmates.

8. Two of the most persistent and serious problems in the days following the storm were fuel and water. WCI had ordered fuel prior to the storm but it had not been delivered. There was no gasoline available within the parish for employee vehicles. The Warden had clearance from Secretary Stalder to give gasoline to employees (ten gallons per shift), but the problem quickly became the overall availability of gasoline at WCI. Warden Miller had every state vehicle parked and gave orders that none of those vehicles were to be used without his specific permission because of the fuel shortage. Eventually fuel trucks were sent from other parts of the state. The first fuel truck was being sent from the greater New Orleans area and WCI sent five armed staff to escort the truck to the institution. The staff sent on this trip wore ballistic vests and took an extra for the truck driver. The trip which would normally be a two and one-half hour drive each way, took fourteen hours.

9. WCI was without water for two to three days and the situation became critical. Staff took water out of ditches and poured it into toilets to see which toilets would flush if there were poured water available. Initially, bottled water was used to provide drinking water for inmates. After a few days they were able to arrange a potable water container from the National Guard. While drinking water had been a potential crisis, the institution ended up isolated for weeks, and water for flushing toilets and water for showers quickly became very serious issues. In one of the more creative initiatives during the whole crisis, Warden Miller went to a truck stop and found a trucker with a tractor trailer rig. The Warden offered the trucker twenty gallons of diesel fuel in return for hooking up to an old milk tank trailer and pulling it into the prison compound. Warden Miller got non-potable water and a water storage truck from a fire department and used that water for flushing toilets and the milk storage trailer for water for showers. Finally, staff and inmate work crews were sent to cut through fallen trees so that there was vehicle access to wells for the community water system.

10. The staff worked hard to keep the inmate population well informed. Warden Miller told both groups that the institution was going back to normal programming as much possible, as soon as possible. He felt it was helpful for both groups to try to normalize. The inmate population saw that staff were devastated and understood that some staff had lost immediate family members, their homes, etc. Staff inmate relations actually improved in the aftermath of the hurricane. With the TV cable system down, there was no television in the inmate dormitories. Warden Miller took to taping CNN at his home each day and then staff would take a VCR into every dormitory and play two hours of

news each day for the inmates. Once phone service was restored, mental health staff talked to every inmate. Staff also got phone numbers for family from inmates and made contact where possible and then provided that information to the inmates. Warden Miller met almost daily with the Inmate Welfare Council and large numbers of inmates volunteered to help in the prison and/or in the community. On Wednesday, two days after Katrina hit, WCI sent eleven inmates out to other prisons because of medical conditions. The local hospital was not operational and the prison wisely decided not to risk an inmate with a serious medical condition needing urgent case.

11. The FEMA distribution center for the community was located in Varner. There were a number of problems with that distribution center, including road access and security for the emergency supplies. Warden Miller offered to move the distribution center to the prison and the offer was quickly accepted. Water, MREs and ice, among other supplies, were distributed as the prison set up a drive through system. Between the prison's perimeter security and the presence of numbers of uniform staff, there were no problems with theft, assault or the like. The prison also served as the Red Cross distribution center for debit cards for residents entitled to financial assistance. The arrangement worked so well, and the community reaction was so positive that Warden Miller told other Wardens prior to hurricane Rita's landfall that they should consider working with state officials to establish community distribution centers at the prisons.

12. WCI employees not only helped staff the FEMA distribution center, they also hauled supplies to local churches and other community locations in need. It was clear to the consultants that in the aftermath of Katrina, the local community regarded Warden Miller as a hero, and the WCI staff interviewed used the same term repeatedly.

13. The lack of communication was, of course, identified by Warden Miller and the WCI staff as the biggest barrier during and after the storm. For the first several days, the only communication possible was with the IMC by satellite phone and that would be successful once in perhaps thirty calls. WCI was able to let the IMC know quite early that they had extensive damage, but no serious injuries. After that, there was almost no communication for the next several days. With the lack of communication, WCI staff were surprised that no one from headquarters drove to the prison. WCI had no knowledge of the massive evacuation of OPP and JPP, and no awareness of how other prisons in the state had fared during Katrina. It was a matter of weeks before WCI became aware of the scope of the Department's activities.

14. WCI was fortunate to receive extraordinary assistance from other agencies. The Pennsylvania State Department of Corrections, in an arrangement worked

out between Pennsylvania Corrections Commissioner, Jeff Beard and Secretary Stalder, sent twenty-one correctional officers and mental health staff to WCI. They worked along side WCI staff in dormitories, took inmate work crews out and were available day and night. They slept in barracks set up in the training academy. All were volunteers, and it is worth noting that Pennsylvania had far more volunteers than could be sent. When they were not on duty at the institution, many of the Pennsylvania staff helped WCI staff fix their own houses. The mental health staff were trained in critical incident debriefing and worked initially with WCI staff, but were then also made available to the inmate population for debriefing and other mental health needs. The Pennsylvania staff stayed approximately two weeks and then cycled home and a group of Pennsylvania DOC maintenance staff employees came to the institution for the next two weeks.

15. Donations arrived at the institution from Kentucky, Tennessee, Maryland and more jurisdictions. In almost all cases, the donations were from corrections staff in those states. The Norfolk County Sheriff's Office in Massachusetts "adopted" WCI, collected money and sent a check for $21,000 for WCI staff.

16. At the time one of the consultants visited WCI, most staff seemed to be doing well except that many were continuing to deal with substantial house damage and extraordinary storm related expenses. Warden Miller suggested that the impact of Katrina will be felt for ten to twenty-five years in the parish, and perhaps forever, because of the number of displaced New Orleans residents who may stay in what was a quiet rural community.

K. Katrina and Probation and Parole (P&P)

1. The impact of hurricane Katrina on the Louisiana Parole and Probation (P&P) staff was more profound and in many cases categorically different than that experienced by other areas of the department. There are a number of reasons for this and some are obvious. While the institution staff are spread across the state with few in the greater New Orleans area, P&P staff are heavily concentrated in southeastern Louisiana with a large number working in greater New Orleans. Thus, the flood damage to homes, the evacuation of the city and the loss of communication with immediate family members had a very dramatic effect on the P&P staff. If you lived in southeastern Louisiana and did not lose your own home, it was almost certain that you worked closely with staff who did. In the days after the flood, everyone worked with staff who could not locate parents or spouses or children. Large numbers of P&P staff were unaccounted for and no one knew whether they had evacuated, or were sick or injured or worse. It took three weeks for the Department to locate all of the missing P&P staff.

Of the four P&P offices within the New Orleans area, two were completely destroyed by the flood waters. A third office just across the river in a high rise building in Jefferson Parish had been expected to re-open, but had not some four months after the hurricane. P&P staff were frustrated because they could not get any information from the state about when that office building might re-open, or if it would re-open. As of the end January, 2006, that left the staff from four different offices crammed together and working out of a single location.

Another reason for the devastating impact on P&P staff was the nature of the tasks they were assigned in the days and weeks following Katrina's landfall. It fell on the P&P staff to do the bulk of the work moving and then transporting parish jail inmates, evacuating civilians, evacuating nursing home patients and working essentially as armed security personnel with fire trucks and local law enforcement. Those assignments kept the P&P staff in and around the flooded areas of New Orleans, kept them in danger and kept them face to face with living and dead victims of the hurricane and with the lawlessness that followed.

Another factor was that P&P staff were assigned emergency functions that were far from their usual duties and, in many cases, well outside their comfort zones.

Finally, many of the offenders under P&P supervision seemed to have scattered to the four winds. Some evacuated from the greater New Orleans area ahead of Katrina, others ended up in the Superdome or trapped elsewhere and were ultimately air lifted to Texas, Florida or other states. Few offenders remained in the area and with communications down and with no agreed upon procedures for reporting from remote locations, P&P staff felt great pressure to locate sex offenders and other parolees who might pose serious danger to the communities in which they were currently residing.

2. A brief overview of Probation and Parole in Louisiana may be helpful. The Division handles adult offenders only. There are roughly 800 P&P staff in the state, of whom about 500 are field officers. These staff supervise a total population of approximately 62,000 offenders. An officer supervising sex offenders or supervising high-violence parolees may have a case load in the 50's, although regular case loads are much larger. All probation officers are peace officers, carry firearms and have arrest powers.

   The Division has its own POST certified training academy which is ten weeks long. In-service training is a minimum of 40 hours per year per staff member and most staff feel the in-service training has been excellent. The Division is ACA accredited. A probation officer starts at approximately $2000 per month, substantially lower than either the Baton Rouge police or the Louisiana State

Police. The Division has strong ties with local enforcement agencies and they frequently assist police with various law enforcement tasks. On the other hand, the Division also tries to be community oriented with strong re-entry efforts and with a program that allows P&P staff to track offenders within institutions. Staff suggest there is little pressure to avoid revocations although the Division is emphasizing alternatives to quick revocation.

3. As Katrina approached, P&P staff assumed a "normal" storm situation in which they might assist local police for a few days and then, as people returned to their homes after the storm passed, P&P expected to move back to normal operations. They did some specific planning around security equipment, vehicles, phone trees and what to do with the most violent offenders and sex offenders. Much of this planning was ad hoc and informal and few of the P&P plans were committed to paper. Perhaps more importantly, the Division did not have existing plans that staff could rely upon.

4. When the storm turned directly towards New Orleans on late Friday night and early Saturday morning, it was then so late that P&P staff were trying to get themselves and their families out of the area. In almost all cases, the P&P staff were able to move the state cars, and move equipment to higher locations. The Division identified a Regional Director in Shreveport to be the phone contact in case there were problems reaching the Headquarters in Baton Rouge.

5. Monday, when Katrina hit, things want generally well for P&P staff, although the storm's direct impact was much greater than they had planned for. By early Monday evening, there was some spotty information about levees breaking. The Division Director was called at close to midnight by Eric Sivula, in the IMC, requesting help from the P&P staff. Director Powers had already called for volunteers and each P&P district in the state had identified volunteers prior to the request from the IMC. On Monday night and Tuesday the volunteers were contacted and other staff were ordered in, communications allowing, and directed to drive to Southeastern Louisiana shortly thereafter, all P&P staff were ordered to report to duty. Staff from the northern part of the state were told to bring extra clothes, food and other supplies they could keep in their car trunk. Staff from the closer parts of the state were not asked to bring clothes or supplies, but should have been. Again, even on Tuesday, August 30, the expectation throughout P&P was that they would be a resource and help informally. That did not turn out to be close to the way in which P&P was used.

6. On Tuesday morning a group of P&P staff went to New Orleans in buses and vans. They were unable to communicate with the IMC by cell phone, satellite phone or radio. P&P staff identified the same long term and pervasive communications problems that others in the department had noted, as a

problem of the first magnitude. Also, with most P&P staff working semi-autonomously and in the field on a day to day basis, P&P is far more decentralized than the department's institutions. P&P managers and supervisors struggled in the aftermath of the hurricane with the lack of a command structure within P&P and the lack of infrastructure within the Division.

7. Early on, the department offered to provide P&P staff to the Louisiana State Police for assistance. They could not get an answer from the State Police quickly and after a while the offer was declined. Later, as the scope of the catastrophe became more obvious, the State Police asked for as many P&P staff as possible to reinforce their own numbers. That request could not be honored because the P&P staff were by then fully engaged in a number of other critical missions.

8. The breadth of missions assigned to Probation and Parole remains one of the more extraordinary facets of the department's response to the two hurricanes. In addition to assisting with the evacuation of prisoners from the two parish prisons (OPP and JPP) P&P staff took primary responsibility for evacuating employees and employee families from those two locations. Probation officers used state vehicles or their own personal cars to escort buses and vans and the vehicles being used for evacuation were often driven by P&P staff. P&P provided the major staffing at the overpass where OPP prisoners were awaiting transportation and large numbers of civilians had gathered. That was one of the most difficult assignments for P&P staff as they had no training for that kind of emergency situation and no practical framework or training for dealing with large scale crowd control situations. One manager described it as simply "flying by the seat of their pants".

   On the overpass, the P&P staff were severely out numbered and under great pressure from the prisoner population that was hungry, thirsty, terrified and angry, and a civilian population that was also distraught, angry and extremely emotional. In general, P&P staff had excellent people skills, well honed by training and experience, and those skills proved invaluable.

   A large percentage of the prisoner population and the civilian crowd on the overpass was African American and the P&P staff trying to control the scene was disproportionately white, adding an additional element of conflict to the situation. Some African-American P&P staff effectively defused that issue by stepping up and taking the lead in dealing with the crowds. On the other hand, some staff found they were ill suited to working with crowds in general and that situation in particular. Some individual probation officers were frustrated and upset with their inability to explain and reason with individuals and groups who neither wanted nor heard reason or explanation. For many of the staff,

perhaps most, it was a deeply frightening experience. Many probation officers talked about dealing with family groups that attempted to stay with the P&P staff for personal safety, and about dealing with mothers with small children who had no food or water while the probation officers had no supplies with which to help. In retrospect, staff knew that there were helicopters flying in the area and that food and water could have been helicoptered to that overpass. Lack of communication and lack of coordination among responding agencies prevented that kind of assistance.

9. P&P staff took the lead role for the department in medical evacuations. They evacuated one nursing home in its entirety, evacuated over 300 "walking wounded" from a medical triage area in New Orleans to Baton Rouge, and during the several days after Katrina hit, transported civilian medical cases and other special needs individuals to hospitals in Baton Rouge primarily in staff personal vehicles. Fire and police personnel had taken over one nursing home in New Orleans and were using that as a staging area. That nursing home became a bivouac area for P&P staff. Some staff attempted to work a schedule of 48 hours on followed by 24 or 48 hours off. Almost no staff were able to go home during off duty hours.

10. Early on, P&P was asked to assign staff to accompany fire trucks in the New Orleans area. With no running water, and with other infrastructure disabled, the threat of major fires in the immediate aftermath of the hurricane was very high, but in some areas of the city, fire trucks were being shot at. It was one of the earliest of a number of different requests for P&P staff because they were armed and certified as peace officers. Most of these tasks were fundamentally law enforcement roles and had little to do with the central mission of probation and parole. However, as with so many other crucial but unusual missions the Department was assigned, the response from the Department was "can do".

    Approximately thirty staff from across the state rotated through the fire truck protection assignment. It was particularly difficult the first week because of the tension of waiting to find out whether the fire trucks would continue to be shot at even with armed staff aboard, and because those P&P staff were bivouacked at a college that was not ready for occupancy and where conditions were quite primitive. The cooperation between P&P staff, fire department personnel, local police and EMS was excellent. P&P staff commented that the Fire Department appeared to be the only agency with realistic and effective emergency plans.

11. P&P staff provided a wide variety of other direct and support functions and they are not all summarized within this report. Some probation officers staffed the phones near the IMC, helping to coordinate trips to and from New

Orleans. Probation officers also provided a substantial amount of the security at Camp Amtrak.

12. When hurricane Rita hit, one quarter of the P&P staff state wide remained unaccounted for. That is a difficult statistic to comprehend. There was some shift of missions and roles for probation staff in the aftermath of hurricane Rita. While some probation officers continued with inmate transportation, smaller law enforcement agencies in southwestern Louisiana were desperate for assistance and probation staff were detailed to work with them. In many cases probation officers paired with police officers or deputies in small communities and provided law enforcement services for days or weeks. In one area, there was no police presence and probation and parole staff performed basic police work until law enforcement patrols were re-established. P&P staff were also used to provide security at shelters and a group of staff provided security at the Lake Charles Hospital. In rural areas, probation officers would drive their cars with lights flashing in an effort to show a police presence.

13. Even in the days and weeks following hurricane Rita, communication and coordination within P&P remained a major challenge. When Rita struck, there was still no P&P office that had been re-opened in the New Orleans area. When probation officers could not contact headquarters or contact their own regional managers, they would most often assign themselves to police assistance tasks until they were able to communicate or report.

14. As hurricane Katrina approached southeastern Louisiana, St. Bernard Parish had contacted the Regional Manager for Probation and Parole and requested that all minor violators be released prior to the hurricane's arrival. That was an excellent decision, but it was limited to offenders from St. Bernard Parish. In New Orleans, P&P had opened a residential "Alternatives Center" that housed approximately 200 offenders. The Alternatives Center was the culmination of years of planning and a great deal of work, and the Division had high hopes for it as a new service model. Immediately after Katrina, all those offenders were released and placed on community supervision, such as it was, and as of March, 2006, it was not clear when or whether the Alternatives Center would re-open.

    After Katrina hit, P&P began receiving a stream of release orders for individual offenders. The same Regional Director who had coordinated the release of minor offenders from St. Bernard was put in charge of organizing offender release efforts. It was, in itself, a daunting task. Each probationer released had to have his or her own release number and the releases had to be coordinated with lists of prisoners in the various parish prisons. One manager commented, "thank God all our case records were automated".

15. By the Friday following Katrina, P&P was attempting to take stock of its situation with serious offenders. Even a superficial analysis showed the situation to be overwhelming. In southeastern Louisiana, case loads simply didn't exist. Probation officers were assigned to other emergency tasks and large numbers of staff were unaccounted for. Offenders were not in their homes and could not be reached by phone. Some offenders had left the city with the voluntary evacuation preceding Katrina's landfall; others had been trapped in the city and later evacuated by government agencies. Large numbers of offenders were known to be in Houston with the Superdome evacuees, in other parts of Texas, in Florida and Mississippi and Alabama. However, the Department had no idea which offenders were where and no established procedures for them to contact the Department or vice versa. The Department established a form that was used when individual offenders would call in (a parallel form was developed for use when an unaccounted for staff member made contact with the Department). An 800 number was set up for parolees and probationers to use in contacting the Department and that 800 phone number was publicized as widely as possible.

16. P&P was particularly anxious to locate the serious sex offenders under supervision. There were almost 500 sex offenders under supervision at the time of the hurricanes. When prostitution and other less serious sex crimes were excluded, 261 serious sex offenders remained unaccounted for. P&P staff worked with the U.S. Marshall's Office, the FBI, FEMA, the Red Cross and other sources of evacuee data bases to try to locate those serious sex offenders. Department personnel appeared on TV stressing the need for offenders to report to the Department. All P&P offices in the state tried to work closely with shelters in their area, checking rosters for offenders who might have been relocated there. An emergency transfer form was developed and then an emergency transfer procedure, bypassing the typical but much more lengthy process. Eventually most of the serious sex offenders did call in on their own and provide the Department with their location. In October, the Department began to get warrants for those offenders who had not called in. In many cases, those warrants could not be served because the Department had no idea where those offenders were living. Several unanticipated dilemmas developed. Some states would not accept the Louisiana offenders and found reasons to reject them as interstate compact cases even though the offenders had been re-located or evacuated to their jurisdiction. In particular, in Houston and in some other Texas areas there was a strong community reaction against allowing offenders to settle there semi-permanently or permanently. Also, the Department had no budget for the extraordinary number of long trips involved in picking up these offenders and returning them to Louisiana. Finally, P&P staff struggled with the question of why they should require offenders to return to New Orleans

when there was nowhere for the offenders to live and they would have been contributing to the general chaos in the area.

17. At the time of the consultants' visit in late January, 2006, it was possible to begin to assess the impact of the hurricanes on the P&P staff. The impact was obviously greatest in southeastern Louisiana. All staff had been accounted for and, thankfully, none had died or been seriously injured as a direct result of the hurricane. One probation officer's mother had drowned and in late January a supervisor who had been evacuated to Texas and had returned and was living in temporary quarters on a cruise ship in the river, died of a heart attack. Many P&P staff lost their homes entirely as the adrenalin of the days and weeks immediately following the hurricanes faded, a substantial amount of frustration and despair was evident; however, staff professionalism was even more in evidence, and individuals who had every reason to be off work on stress or to be submerged with personal problems were instead working long hours and attempting to restore some semblance of normalcy and accountability to the Probation and Parole operation.

18. The Division took extraordinary measures to try to assist it's own staff in dealing with personal crises and with the catastrophic situation in the community. An employee assistance program was used to provide critical incident debriefing to all staff members, finishing in December. Group counseling sessions were also held. The Division also worked closely with worker's compensation and with a company that specializes in "fitness for duty" evaluations. In addition to those efforts, much of the staff recovery was due to staff helping staff.

    The situation was not mitigated quickly. With two districts in New Orleans collapsed into one and four physical offices operating out of one location, stress levels remained high for many obvious reasons. One of the P&P offices that was lost had been sitting in 8-10 feet of flood waters and there and in one other office, almost all equipment and paper records were a complete loss. The Division did not have a fugitive apprehension unit (or warrant unit) and individual officers were generally responsible for following absconders on their own caseloads. After the two hurricanes, with many probation officers fully occupied with emergency assignments and other staff members off duty or unaccounted for, the Division's traditional method of following and tracking absconders with the case carrying officer was not practical, and in some cases would not have been reasonable from an officer safety perspective. However, there were no contingency plans for forming specialized units to re-locate offenders or track absconders.

19. The consultants found the Probation and Parole staff to be unusually thoughtful and perceptive about the hurricane situation. They were blunt in

their assessment that they were dramatically unprepared for the hurricane events. There was strong consensus not only about the communication problems but about the lack of an identified command structure and coordination, the lack of emergency training and the lack of emergency contact numbers and emergency procedures. As had been true with institutions staff, P&P front line staff, supervisors and managers recognized that there had been no point early on where staff could sit down, evaluate and re-assess and try to align staffing and assignments with available manpower, risks and other situational factors. A number of P&P staff felt strongly about the lack of planning, assessment and overall strategy. Some staff noted that much of what the Division was engaged in during the aftermath of the two hurricanes was law enforcement work, and commented that it was time for the Division to revisit it's role and mission and clarify that the Parole and Probation function is very different from the police role in the community.

20. To a person, all of the Probation and Parole staff the consultants talked with were proud and somewhat amazed at what they and their colleagues had accomplished in the response to two hurricanes.

L. Shelters

1. The Department made a crucial decision that evacuees and, later, arrestees would not be released into the community without a safe destination. With southeastern Louisiana still in chaos, and with community supervision disrupted and in some areas not operational, it was considered unsafe for the offenders and for the community to simply open the institution gates and release individuals onto the street.

2. As a result of this decision, most evacuees and arrestees were released to shelters. Some offenders were released to families, but so many areas had been evacuated and so many other areas were without communication, that a large percentage of offenders to be released could not contact family members, even though they did have immediate family they would normally have rejoined.

3. The shelter situation grew to be a major problem throughout the months after Katrina. Some FEMA shelters and Red Cross shelters did not want to accept ex-offenders. There were instances in which the Department staff was told that shelters were full and other instances in which Department employees were told more directly that shelters did not want jail evacuees or jail inmates dropped at the shelters. This situation was extremely frustrating for Department staff both because they believed that legally released evacuees had a right to shelter space and because of the extraordinary pressure they were under to reduce the population at the artificially but severely over-crowded prisons.

4. Whalen Gibbs, the Assistant Secretary for Adult Services, was formally in charge of shelter services. Day to day, Mr. Gibbs is in charge of re-entry for the Department, but he was also designated as the Department's designee for mass feeding, one of the FEMA identified disaster functions. He received that assignment in early July but had no formal training and his awareness was limited to some informal discussions with Eric Sivula. Mr. Gibbs was on standby prior to Katrina's landfall, but he did not become involved until Monday, August 29. On Monday he met with representatives of the State Police, the Department of Social Services and the Red Cross with mass feeding as the primary focus of the meeting. Although Mr. Gibbs attended daily meetings about mass feeding, other agencies had taken over the brunt of the responsibility for feeding at shelters and elsewhere in the community. By the end of the first week after Katrina, Mr. Gibbs focus had shifted so that it was primarily shelters and shelter beds.

5. At one point, Mr. Gibbs was told directly by the Red Cross not to bring more inmates to their shelters in Department vehicles or by staff in uniform. He discussed the problem with Secretary Stalder and later with the Secretary of DSS. They thought about setting up a special shelter for ex-offenders but the faith based shelters and some other limited resources alleviated the pressure and made special shelters unnecessary.

6. In general, the heroes in this saga were the faith-based shelters, many of which were located in smaller or rural communities. The faith based shelters not only welcomed the evacuees and former offenders, many of them worked actively with the Department or with individual institutions to make transportation and housing of the evacuees as easy as possible.

7. Many releasees wanted to go to shelters in New Orleans, but there were no shelters in that area. Shelters in the Baton Rouge area were over capacity so it was necessary to disperse releasees around the rest of the state.

8. The work with shelters was cyclic. After arrangements seemed to be operating well, some of the emergency shelters began to close down, re-creating the problem with total bed capacity. Some smaller parishes drove releases to shelters in poor black neighborhoods and simply left the individual there and drove off. Some northern parishes bypassed probation and parole, knowing that the offenders would be placed in local shelters by probation and parole staff.

9. When parishes could provide lists of releasee names, Whalen Gibbs would send those on to P&P staff who would contact the offenders and make arrangements with shelters for their release. Fortunately, there were no serious incidents with ex-offenders at any of the shelters around the state. Mr. Gibbs stressed

that he felt that he would have been far more effective in his emergency roles had he received some training on those assignments or on the Department's emergency response plans.

M. Emergency Management Assistance Compacts (EMACs), and Assistance from other Correctional Agencies

1. Within a matter of days after Katrina struck the New Orleans area, offers of assistance from police and correctional agencies around the country began to flow into Louisiana corrections. The extent of the assistance subsequently provided was so monumental that it remains hard to fathom. While hurricane Katrina produced the largest natural disaster in the history of the country, the national response from the American corrections community was also without parallel.

2. Many states and some individual counties and individual correctional facilities sent supplies to Louisiana. For example, the Pine Hills Youth Facility in Montana sent supplies to Louisiana corrections including items such as socks and foot powder. A correctional facility in Hopewell, Virginia sent thirteen boxes of clothing. Indiana's Department of Corrections sent an eighteen-wheeler loaded with drinking water and other emergency supplies. The South Carolina Department of Correction sent four eighteen wheel trucks with supplies ranging from food and water to emergency generators and clothing. The Maryland's Department of Public Safety sent three eighteen wheel trucks including a large supply of diapers. Many individual locations within the Federal Bureau of Prisons sent supplies or trucks. Almost all the way across the country, Utah's Department of Corrections sent two trucks including camping gear and toys for children. Kentucky sent trucks with small TVs, gloves and medical supplies, while the New York State DOC sent three trucks with cots and shoes. Pennsylvania sent an eighteen wheeler and North Carolina also sent a large truck. The Correctional Peace Officer's Association sent a truck with hats, shirts and other clothing and the American Correctional Association sent batteries, survival gear and first-aid. It must be emphasized that this is not a complete list but rather a representative sample.

3. Most of the supplies sent by various correctional facilities and departments were generated by employee donations of goods or money. In addition, cash donations were received from a wide range of correctional sources, with most earmarked for assistance to staff members in need in Louisiana. Over one half million dollars was donated and it was a major task for the Department to set up criteria and procedures for distributing financial assistance to staff members.

4. The Federal Bureau of Prisons provided assistance in a number of ways. In addition to donating supplies, the Bureau stepped in at the height of evacuation

of inmates from OPP and JPP and agreed to help alleviate the overcrowding at EHCI and other prisons around the state by taking 920 inmates to a federal facility in Coleman, Florida. The Bureau also took responsibility for transportation of those inmates to Florida. Further, once accepted by the Bureau as a "mission assignment", all of the Bureau's assistance was without charge to Louisiana. The FBOP also provided nine buses and bus drivers to assist with the evacuation of OPP and JPP and the subsequent movement of those prisoners to other correctional facilities within the state. Most of the assistance from FBOP was provided under the direction of John Vanyur, Ph.D., Senior Deputy Assistance Director for Correctional Operations, following a decision by the FBOP Director Harley Lapin to expedite and maximize assistance to Louisiana corrections.

5. There were several states which, in addition to sending supplies and monetary contributions to Louisiana, also sent correctional staff. These included the Kentucky Department of Corrections, both the New York State of DOC and the New York City Department of Corrections and the Pennsylvania Department of Corrections. Most states sent correctional officers, but Pennsylvania also sent specially trained mental health staff and maintenance staff, and the Arkansas Department of Corrections sent nursing staff.

   All of these arrangements were, to some degree, a result of personal relationships between the heads of corrections in these various jurisdictions and Richard Stalder. Secretary Stalder is a past president of ASCA (the Association of State Correctional Administrators) and is one of the longest tenured and best known correctional administrators in the United States.

   Interestingly, the arrangements with other states ranged from extremely informal to highly formalized. Richard Stalder contacted Larry Norris, Director of Corrections in Arkansas, directly. When Director Norris asked what Louisiana needed, Secretary Stalder requested nurses. Director Norris sent seven or eight nursing staff members of the Department to Louisiana where they worked for between one and two weeks. There were no barriers encountered and there was no discussion about potential liability or about cost reimbursement. It was, at its heart, an arrangement between professional colleagues who were also good friends. Larry Norris told one of the consultants in a phone interview that he hoped he would never see such a situation again, but that if he did, he would not hesitate to provide assistance on the same basis.

   In Pennsylvania, the Commissioner of the state Department of Corrections, Jeff Beard, contacted Richard Stalder and quickly agreed to send correctional officers and mental health staff to help at the prisons in Louisiana. Commissioner Beard cleared the arrangement with his Governor's office and

then worked with the Pennsylvania Emergency Management Agency to get an EMAC (Emergency Management Assistance Compact) approved. That process was slower and more frustrating than Commissioner Beard had anticipated. In general, the assistance had to be specified in some detail, costed out, then approved in Pennsylvania and sent to Louisiana for approval there. Finally, the EMAC had to be signed off by a General on behalf of FEMA and he would only come in once a day to sign agreements. Jeff Beard had volunteer staff packed and ready to go to Louisiana and then had to wait and overnight them at a hotel in Pennsylvania waiting for final approval of the EMAC. Commissioner Beard talked with every staff member before they went to Louisiana and the met not only with individual staff members but with spouses or other family members upon their return to let their families know how important a contribution the staff member had made during the catastrophe. Commissioner Beard commented that all of his staff found the experience professionally challenging but personally gratifying.

In Kentucky, Commissioner of Corrections John Rees called Richard Stalder on Wednesday, two days after Katrina's landfall and reached Secretary Stalder's assistant. Commissioner Rees had already contacted his Governor's office and had permission for any assistance necessary. Kentucky sent two bob-tail trucks and two tractor trailers loaded with supplies. Along with the trucks were twenty-five staff. The trucks were unloaded and sent back to Kentucky reloaded with more supplies and sent back. The staff stayed to assist in Louisiana. Commissioner Rees sent a cross section of staff ranging from correctional officers to a deputy warden and including case workers and others. Approximately every eight days, the staff from Kentucky would return home and another group of staff would take their place. That was repeated three times. Commissioner Rees kept his Governor and Lt. Governor closely apprised of the situation and they were extremely supportive. Afterwards, the Lt. Governor gave staff who participated in the assistance an award at a staff picnic. Kentucky had far more volunteers than they were able to send as was true with other states sending staff assistance.

Originally, Commissioner Rees was not going to send staff armed, but Louisiana corrections called him back and said that he needed to send them with guns, which he did. The Kentucky staff worked primarily at Camp Amtrak, EHCI and LSP. The first group of staff to return to Kentucky showed some psychological reactions to what they had been dealing with and Commissioner Rees arranged for mental health teams to meet with those staff. Commissioner Rees described a phenomenally positive reaction both from the staff who went to Louisiana and those staff who did not go but were proud of the Department's assistance. The Kentucky arrangement was somewhat informal and now, six months afterwards, FEMA is attempting to document the assistance in detail, which is proving difficult. About six hundred thousand dollars of staff assistance was sent and it appears Kentucky will be reimbursed

in that amount. At the state level, Commissioner Rees arranged for each staff member traveling to Louisiana to take a "procard" (essentially a government version of a credit card). The Kentucky state auditor's office is now questioning that arrangement, but Commissioner Rees remains convinced that the over-arching need was to get the necessary assistance to Louisiana and to get it there quickly. John Rees also wrote personally to the spouse or significant other of every staff member who had gone to Louisiana, thanking them for allowing the staff member to go and for the help that the staff member was able to provide.

6. The EMAC process was not only frustrating for the Department's attempting to send assistance, it was also frustrating for LA DPS&C. The process was inherently bureaucratic and it was particularly difficult for corrections managers to take an EMAC to the state emergency operations center in Baton Rouge and to the EMAC desk, only to be told that it was too late to get the papers signed that day and they would have to wait until the General came in to sign papers the next day. Also, the EMAC's were always quite short term and some of the arrangements for assistance had to be renewed one or more times. Neither FEMA nor Louisiana corrections was particularly good about anticipating EMAC renewal dates in the midst of the crisis that was ongoing. Thus, either corrections would run to the EMAC desk at the last minute asking for a renewal, only to be told there would be a gap in assistance because the agreement could not be approved immediately, or FEMA would contact the IMC notifying them that a particular EMAC was due for renewal that day, but too late to achieve it seamlessly. Corrections managers also reported significant differences in the approval process depending on who happened to be staffing the EMAC desk. One person might go far out of his or her way to expedite approvals and assume that if the Department were asking for a particular type of assistance, it was a clear and serious need. The next person staffing the EMAC desk might have little understanding of corrections, but pose a number of questions about "why is this necessary"? and then say, "No" or "The storm is over". At the end of the day, the EMAC approval process was one of the areas that the executive staff in corrections hope to understand better, streamline or otherwise improve.

N. Dixon Correctional Institute (DCI) and the Evacuation of Pets from New Orleans

1. At one point, while Secretary Stalder was organizing the evacuation of OPP, he rescued a dog from the flood waters. That was the beginning of what turned into a very positive and high profile operation by LA DPS&C. Many animals, particularly family pets, were trapped in New Orleans by the flood waters. It is important to remember that most families leaving New Orleans though they were leaving their houses or apartments for a few days and that they would return almost immediately after the storm passed. Thus, they left all

belongings and many put out extra water and pet food and left their pets. Most of these pets perished as most of these houses and apartments flooded and remained flooded. However, a large number of pets and some other animals made it to islands of high ground or were in the flood waters themselves. Many animals could be rescued, but there was nowhere to take them and nothing to do with them.

2. While the life of a pet is not comparable to, and can not be considered in the ways in which the lives of residents are considered, pets do have a great importance symbolically and emotionally. The Department recognized this and set up an animal shelter at DCI. The Warden, James LeBlanc, contacted the U.S. Humane Society and offered to operate an animal shelter in a barn on the prison property. The operation proved to be an outstanding success in many ways. Humane Society volunteers worked with inmates, staff and other volunteers to care for injured animals and feed and maintain the healthy animals. In addition to its inmate population, DCI grew to an animal population of 150 dogs, 50 cats, 25 chickens, 15 ducks and 12 geese. (The consultants assumed the pet ADPL was verified by four to six standing counts per day). As the flood waters in New Orleans began to recede, DCI publicized descriptions of the pets and other animals that were housed there and owners came forward to claim their pets. The institution worked with the Humane Society to place the animals up for adoption if they were not claimed. The DCI story of pet evacuation and shelter was then featured on the Oprah Winfrey show in late November.

O. Financial Implications

1. Even a moderately detailed analysis of the financial impact of the two hurricanes on LA DPS&C is well beyond the scope of this review.

2. The year the hurricanes struck, fiscal year 05-06, Louisiana corrections had received a major budget reduction. For example, Parole and Probation lost 65 positions.

3. The total financial impact of the hurricane on the state may not be known for a few years. Some factors seem obvious. Revenue from tourism will be sharply reduced for at least a few years and may be near zero for fiscal year 05-06. Government revenue from the refineries and oil taxes may be down sharply because many refineries along the coastal areas will be closed for months or longer with hurricane damage. Some of that loss may be offset by sharply rising gasoline prices. Agriculture in central and northern Louisiana was affected by the hurricanes and agricultural production for the state will likely be down for the year. On the positive side, there is a huge influx of contractors

and construction related industries and rehabilitation and new construction will provide significant state revenue.

4. The situation in corrections is even less sanguine. The state pays the parishes $22.39 per inmate per day if the parish houses a state inmate. In the case of OPP, there is an additional $2.00 payment because of OPP higher costs and a $7.00 per inmate per day premium if the inmate is a mental health case. Most of the OPP state inmates have been housed either in state faculties or in other parishes since shortly after the evacuations. Thus, state corrections is owed approximately eight million dollars from Orleans Parish for housing inmates from August-December. (As of February, there were still 3700 inmates evacuated from parish prisons residing in DOC facilities. The state has little hope of actually collecting that eight million dollar bill and it continues to rise sharply from January, 06 on, as OPP inmates remain in state prisons and other parish facilities.)

   While the established cost for a state inmate in a parish prison is $22.39 per day, the cost to house that same inmate in a state prison is two or three times as much in most cases. While FEMA is paying the base cost of $22.39 per day for parish prisoners residing in the state's prisons, the state can bill the various parishes but is unlikely to collect. Assuming that most of the parish prisoners evacuated to state prisons are either released or returned to their original parish prisons by mid-summer, the loss to state corrections could easily be in the ten to twenty million dollar range for prisoner housing costs alone. In addition to that, the Department must find a way to accommodate huge staff overtime costs, facility reconstruction costs and replacement costs for lost or damaged equipment. All of this must be done in the face of an austere state budget picture and while trying to address lessons learned during the response to the two hurricanes.

P. Public Information and Press Relations.

1. Pam Laborde is corrections' first full time Communications Director. She was formerly a TV reporter in Baton Rouge and has excellent local media ties. Prior to joining corrections she spent five and one-half years as the Assistant Communications Director in the Attorney General's Office. Governor Blanco has stressed the importance of the public relations function and having professional Communications Directors in all state agencies in Louisiana. Communications representatives from all state agencies meet bi-monthly as a Communications Council and that has proved positive in many ways. Communications Directors from different agencies establish solid working relationships, there is a chance to discuss and compare notes on major stories

that cut across state agency lines and information can be shared about specific stories, media outlets or other current topics.

2. The Department is working to become proactive with the media although its history was much more reactive.

3. Pam Laborde received most of her updates about the hurricane response from the IMC and in turn she stayed in touch with the Governor's Communications Director. The press concentrated on the state Office of Emergency Planning, in part because all state agencies were represented there. Ms. Laborde was back and forth between that location and Department headquarters.

4. On Tuesday, August 30, there was intense media attention on corrections because of a variety of negative rumors about the situation in New Orleans. It was difficult to respond to or quell rumors of hostage situations or mass escapes at OPP because it was very difficult to reach Sheriff Gusman.

5. Since Secretary Stalder was "on the ground" in New Orleans, he was particularly credible with the media when he returned to Baton Rouge.

6. There were many media questions about why offenders were being evacuated from the parish prisons ahead of regular residents still trapped in New Orleans. The simple answer was "public safety" and that seemed to satisfy the media.

7. The second week after Katrina, an 800 line was set up for probationers and parolees to call in to the Department. Even with inmates calling in, the identification process was quite slow. The Department staffed seven or eight phone lines from 7 a.m. to 10 p.m., seven days a week.

8. During that second week, media attention turned to the evacuees at EHCI and at LSP. One of the most difficult issues in the media operation was conflicts with defense attorneys who went directly to the press with complaints. The Department did try to include defense attorneys from the outset in public information releases, and the 800 line was an out growth of the Department's early work with the criminal defense.

9. It would have been useful to establish an inter-active website for offenders to use in reporting in to the Department, but that was not done. However, information on sex offenders was put up on the Department's website within several days and that proved most helpful with the media and the general public. The Department then put pictures of violent offenders and sex offenders up on the website as well. The media saw the sex offender issue, in

particular, as quite high profile, but the Department's proactive steps kept most of the coverage positive.

10. WCI, the only institution to suffer a direct hit from Katrina, initially had no media coverage because they are somewhat isolated and in a rural area and because the media had so many other big stories to cover. However, WCI responded to the crisis so positively and Warden James Miller was so proactive with the surrounding community that the Department ended up "pitching" the story to a Wall Street Journal reporter with whom they had an excellent relationship and the result was an extremely positive front page story in the Journal.

11. In attempting to evaluate the Department's hurricane response, Ms. Laborde identified several positive and negative aspects. She echoed everyone else's frustration with the failure of the communication systems, which in her case took her back to old fashioned face to face contact, and the absence of email and the internet.

12. The Department was able to maintain the well established principle of "one channel out" for public information during a crisis. Information release were cleared by Secretary Stalder and then released directly by the Secretary or by Pam Laborde. While the Department does have one person at each institution who deals with media issues, some of those individuals are much more experienced than others and most have had no formal training. The Department has no back up for Ms. Laborde and had she been on annual leave or otherwise unavailable, the Department's public information function might have encountered serious difficulty.

13. The Department began to issue informational releases titled "Message Points" on a daily basis, beginning one week after Katrina hit. The message point documents were carefully crafted and concise. They were typically less than one page, with two to eight bulleted items in large type. Some media outlets reprinted individual message point releases in their entirety and verbatim, a sure sign of success for governmental communications.

14. At the end of September, 2005, the message point releases were prepared weekly instead of daily and continued on that basis for another five or six weeks.

VIII. Critical Incident Review

A. This section of the report presents key observations, conclusions, lessons learned and recommendations. In the interests of avoiding unnecessary repetitiveness, these findings and suggestions are mixed rather than presented as separate sections

of the report. That is, with regard to a particular subject, there may be a conclusion followed by a "lesson learned" followed by two or three recommendations. Areas covered and individual items within this section are not prioritized.

B. The Department's experience with Katrina and Rita may have more to offer other departments of corrections around the country, in terms of lessons learned and informing future planning, than any prior event in the history of American corrections.

C. Predictability

1. Hurricane Katrina produced the largest natural disaster in American history. The extraordinary problems caused by Katrina were exacerbated when hurricane Rita struck weeks later.

2. The events of last fall in Louisiana were not predictable. A direct hit on New Orleans by a major hurricane was within the realm of possibility, as was the failure of the levees around New Orleans; however, the confluence of events and the nature and scope of the catastrophe were so unlikely as to make the term "predictable" seriously misleading.

3. In any geographic area, there are a multitude of crises and natural disasters that are conceivable. If any one of these potential events is taken to a "worst case scenario", then the planning and resources available to contend with the situation will be almost hopelessly inadequate; it is not possible to realistically plan for a wide variety of worst case scenarios. In general, preparations for serious crises will have to suffice and those preparations will never be as specific as desirable for a given catastrophe or natural disaster.

D. Planning for the Last Emergency

1. In emergency planning circles, it is axiomatic that organizations plan for the last crisis. That is, a crisis like Katrina (and Rita) is so overwhelming and exposes so many things that might have been done differently and better, that the natural reaction is to carefully analyze the organization's preparation and response and then set out fixing it so that the organization will be well prepared when the same event happens again.

2. In corrections, that principle holds as true for major riots and serious hostage situations as it does for fires and natural disasters.

3. The problem with the proposition is that the last crisis never happens again. Even if the same type of crisis occurs, it is always substantially different in

many important ways. Often, however, the next emergency has little in common with the last emergency, and is a different kind of situation altogether.

4. While this point may not be obvious at first blush, it is a major dilemma that the Department now faces. Shall the Department now prepare for the next hurricane (and there will be other deadly hurricanes along the gulf coast)? As an alternative, should the Department put much of its effort into improving emergency preparedness more generically? The analysis presented below attempts to address both questions.

E. General Assessment

1. LA DPS&C faced challenges unprecedented in the history of American corrections. In fact, no prior situation comes close to what Louisiana corrections was forced to contend with last fall. To evacuate over ten thousand inmates from imminently life threatening situations in the midst of a community disaster; on almost no notice to evacuate over 6500 prisoners by small boat from the Orleans Parish Prison and then to immediately transport them to other parts of the state, process them and house them for months; to evacuate nursing homes and move hundreds of seriously injured and sick civilians from a flooded New Orleans to Baton Rouge; to use Probation and Parole staff to provide armed escorts for fire department personnel and to provide law enforcement services to small communities; to develop and operate a jail under chaotic conditions in a New Orleans still flooded and to process over 1200 arrestees through that jail; to accept and complete a myriad of other missions and tasks, many of which were smaller in scope but were also matters of life and death; to provide emergency supplies, shelter and security to local communities throughout the southern part of the state; and to accomplish all of this with no loss of life and no inmate or prisoner escapes, is close to miraculous. That is what Louisiana corrections did.

2. The staff of LA DPS&C exhibited the highest standards of professionalism, commitment, courage and dedication to their communities.

3. The extent to which staff members within LA DPS&C were and are themselves victims of the hurricanes may never be fully recognized or appreciated. That is particularly true for Probation and Parole staff.

4. The Department's leadership must be accorded very high marks. Leadership in the Department was clear, strong and focused. The leadership was also positive and in many situations unusually creative. One Warden provided an evocative description of Secretary Richard Stalder during the crisis, as "strong, consistent,

predictable and focused but not a micro manager." The Department's results bear out those kinds of observations of its leader.

5. The media coverage of the two hurricanes was lengthy, intense and detailed. The public agency response to the natural disaster was scrutinized by the entire country. The situation quickly became highly politicized as well. While most of the local, state and federal agencies involved in the response to the two hurricanes have received strong criticism and in some cases scathing reactions, LA DPS&C stands out as one of the very few public agencies that is widely acknowledged to have performed successfully and above and beyond the call of duty. (LA DPS&C was not alone in this regard. For example, the consultants consistently heard the LA Department of Wildlife and Fisheries and the Department of Environmental Quality singled out for their courageous and effective work, particularly with regard to search and rescue operations.)

6. The staff of LA DPS&C were able to accomplish what they did largely because of their experience, ability, judgment and values. Certainly mistakes were made: that is inevitable in a situation of this size and complexity, but none proved fatal or disabling. It also must be noted that there was more than a modicum of good luck involved. There were many incidents and issues that could have "gone south", but none did.

7. The Department's planning and preparations for emergency situations was not strong and is not one of the major factors accounting for the Department's success. In most cases, staff ignored existing emergency plans and preparations and simply fell back on their considerable experience, ability and common sense. Those decisions to forge into new territory and deal with problems on an ad hoc basis rather then attempting to conform to existing emergency plans were well founded, as many as the emergency plans were not practical, user friendly, comprehensive or current.

F. Communications

1. Communications was almost universally regarded as the most dysfunctional aspect of the Department's response.

2. Reliance on cell phones, email and the internet is now so universal that it is a challenge to contemplate situations in which none of those communications avenues may be available.

3. The Department should maintain its satellite phones, at least until an alternate emergency communications system is well tested. Even then, the satellite phones may be an appropriate "back up". While the satellite phones worked

infrequently and performed far below expectation, they were in many cases the only thing that worked at all, albeit poorly.

4. Early in the crisis, Secretary Stalder made note that it would be worthwhile exploring the possibility of increasing the height of the radio transmission towers. The consultants are not communications experts and cannot evaluate the potential operational benefits of that change, or its cost.

5. The Department should consider installing a ham radio station in the IMC . In disaster after disaster, ham radio operators have been able to communicate into and out of devastated areas, even when all other forms of communications were down. It is possible, perhaps probable, that there are ham radio operators in the Department. If that is the case, lists of those staff should be included in the Departmental emergency plans.

6. The Department should aggressively explore satellite internet service providers. While satellite phones became difficult to impossible to use during the disaster, primarily because the satellite phone system was overloaded, the opposite phenomenon is likely to occur with satellite internet service. Most subscribers would not be using the service during an emergency because, with power out, they will not have use of their computers. The inherit capacity for satellite internet service is much greater than the capacity for satellite phone service because of bandwidth issues. If satellite internet service appears promising as an emergency communication system, it would offer a relatively inexpensive solution that could be installed at every institution and every probation and parole office. An additional advantage is that the system would allow the Department to continue communications with lotus notes or with any other email system or software the Department was accustomed to. Communication is then logged and archived almost automatically, another distinct advantage in an emergency. However, all of this would require battery powered laptops or available emergency power.

7. The Department should consider purchasing groups of battery operated, short range two-way radios ("Walkie Talkies"). While these radios offer no help with communication across the state, they can be invaluable for teams or work groups in a relatively small geographic area. For example, they would have allowed radio contact for the staff working at Camp Amtrak and they could have been issued to bus drivers or other staff on the evacuation convoys to help keep the convoys together, communicate vehicle failures or other problems etc. This equipment is battery powered, relatively inexpensive and applicable to a broad range of situations.

8. Connecticut and Massachusetts each have a statewide emergency communication system specifically designed to withstand hurricanes. The

special, wind resistant towers are throughout the state and the system is controlled by the state police. (Both states evidently purchased the quite expensive systems with Homeland Security funds). In an emergency, the state police are called on this system by another state or local emergency services agency, including corrections, and then the state police will assign a tactical frequency to that agency. LA DPS&C should explore the feasibility of a similar statewide communications system for Louisiana.

9. In a disaster as broad and long lasting as Katrina and Rita, the Department should plan for and rely more heavily on face-to-face communication, runners and messengers, and the like. While most everyone has the mindset that the next call will go through or that some other electronic solution will appear, there were situations in retrospect that could have been dealt with more quickly and more satisfactorily by simply dispatching individuals to travel and carry messages and discuss information.

10. The Department must avoid the "silver bullet" approach to the communication problems. There was too much reliance on the satellite phones and too little attention to back up and alternate systems. Even if the Department finds an emergency communications approach that appears to be what is needed, back up plans should be thoughtful and realistic.

G. The Incident Management Center ("IMC")

1. The Incident Management Center did not have enough staff.

2. The Department should consider recording what transpires in the IMC during an emergency. An inexpensive audio recorder will capture much of the communication and key decision making in the IMC, and if a staff member knows to occasionally voice the correct time the audio recording will be a time synced record that should not vary more than seconds. An inexpensive camcorder with a wide angle lens can sit in the IMC and be turned on at the onset of an emergency. All that is further required is to intermittently change and label the cassette video tapes.

3. Documentation in the IMC was not good. In the weeks of following Katrina, many of the logs and other records called for in the Department emergency plans were ignored or not completed. Thus, the IMC activation log, the SITREP log and the IMC stand by alerts were not used or were not kept. Similarly, the resource inventories called for as part of the IMC in the emergency plans were not in place at the time of Katrina and the notifications that were required to be updated every six months were either not current or absent. The overall IMC Log that was available to the consultants appeared to

be reconstructed rather then a "raw" contemporaneous business record of entries as they were made.

4. IMC documentation does not show who was in the IMC at what times, who was in command at various times and while most decisions were attributed to a specific individual, some were not.

5. The IMC staffing should include a command-level manager from P&P, on a 24/7 basis.

6. The IMC did not have a formal process for follow up, or "closing the loop". A message might come in from the field describing a dire situation, but if a number of other communications were being received and transmitted at the same time, there might not be a follow up to the message. In short, follow up occurred if the person in charge in the IMC remembered to do it. There was no protocol for highlighting or segregating messages that needed follow up and no one reviewed the IMC log on a regular bases to find situations that potentially needed further attention. It should be noted that the IMC log makes it clear that the IMC was extremely busy at times but that is an argument underscoring the need for some safeguard so that crucial messages are not lost.

7. Several areas of the Department and several individuals interviewed identified the need for more frequent briefing. There was consternation expressed in the field because the institutions and Probation and Parole did not have access to "the big picture" and were unable to put events, plans, problems and information in any context or perspective. While the situation was admittedly chaotic and while the IMC staff had neither crystal ball nor good methods to communicate frequently, they did have a general understanding of what was happening around the state, and particularly within the Department, and that would have been helpful and reassuring in the field if it had been transmitted even occasionally. Similarly there was a need for more strategy and planning with the various elements of the Department. While the initial situation in New Orleans was so overwhelming that the Department was forced to be reactive for days, there may have been opportunities to plan and strategize that were lost due to lack of communication and the ongoing assumption that the Department had no choice but to be completely reactive. This observation is as true for some of the individual institutions and for Probation and Parole as it is for the IMC.

8. In the early days of the disaster, the IMC was the only life line for many of the Department's staff and institutions. It was the only place they could contact. The IMC was widely seen as helpful and responsive. When decisions did not need to be escalated to the level of Secretary or Chief of Operations, the IMC

was quick and decisive and they were generally able to get decisions from the Department's top administrators relatively quickly. It should be noted that was not always the case, and the consultants did hear complaints about times when decisions were not forthcoming from the IMC, or where they conflicted with decisions from administrators in the field.

9. Colonel Eric Sivula's background with the state police and his personal relationships with the state emergency management agency and with other state and national agencies, were invaluable during the crisis.

H. FEMA

1. Over the course of the disaster, the Department's working relationships with FEMA were frustrating and generally not helpful. That was certainly not true in all cases and there were specific issues that went well and a number of FEMA staff who were excellent to work with.

2. FEMA has come in for perhaps more criticism nationally then any other agency involved in the hurricane response and relief efforts. The comments in this report are largely about much smaller and or specific day to day working issues. However, there were also some of the high profile, larger issues that impacted the Department negatively. In the most heavily affected areas of the state, FEMA was quick to exert jurisdiction over (commandeer) water trucks, gasoline and diesel trucks and other emergency supplies. Then, it appeared to Department personnel, FEMA could not or would not decide how to use those resources and they simply sat, providing no help to anyone. A similar situation existed with buses and vehicles that could have been put to excellent emergency use.

3. On day to day issues, FEMA was typically slow and their emergency responses were entirely based upon NIMS (National Incident Management System), which is itself overly large, complex and sprawling. These problems were magnified by contrast with LA DPS&C, which was quick, pragmatic, willing to forego beauracracy if necessary, and relentlessly results-oriented. The two organizational cultures would be destined to clash, with or without hurricanes.

4. There were situations with FEMA which were, in large part, of the Department's own making. For example, the crisis with last minute approvals of EMAC renewals could have been avoided with better planning and adequate time. Even in instances in which corrections bore a substantial responsibility for these problems, it was difficult for corrections staff to deal with FEMA personnel that were unaware of the missions corrections was trying to fulfill, and in some cases also seemed unaware of the realities on the ground in New

Orleans.

5. The consultants have little to offer the Department in terms of improving future working relationships with FEMA. In a disaster situation, many of the FEMA staff are brought in from other regions of the country or hired on contract. Thus, there is no chance to establish solid personal working relationships with those staff in advance of a disaster. The Department can consider training its management staff, as part of a broader emergency training effort, about where and how the Department must interface with FEMA during a catastrophe or a national disaster. The consultants' short answer is that it is FEMA, and not LA DPS&C , that needs to become more responsive, pragmatic and customer oriented, among other major changes that seem necessary.

6. When some probation officer who has lost his or her house entirely, and whose family has been evacuated to another part of the state, is riding on a fire truck in New Orleans trying to prevent fire fighters from being shot at, "The General only comes in once a day to sign papers", is not an answer the Department should have to contend with.

I. Leadership

1. The performance of the Department's leadership was as impressive as the performance of the rest of the staff in the Department during this disaster.

2. If the motto for the Department's leaders was not "Can do", it should have been. The Department readily accepted missions that were so overwhelming or so far afield from staff experience and expertise, that in retrospect it is humorous. "Evacuate 10,000 prisoners out of county jails and figure out what to do with them"; "The jails in the New Orleans area are closed. Set one up and run it"; "Some communities are without law enforcement. Go provide police services"; "Evacuate a nursing home and 300 injured or sick individuals from a triage center"; and "Fire fighters are being shot at. Put your staff on fire trucks to provide security". That is not satire. Those are some of the missions that Louisiana corrections accepted and accomplished.

3. The leadership of the Department also distinguished itself because of values, although that is a more subtle issue then the Department's list of accomplishments. In a situation such as the hurricanes, there was a need for compassion not only for staff, but for inmates, inmate families and members of the general public. The leadership of LA DPS&C demonstrated compassion in their response to situation after situation. As the Department quickly realized the parish prison evacuees were hungry, thirsty, and in generally bad shape, they quickly arranged to have drinking water available on the buses and other

transportation vehicles. At LSP and EHCI, staff met evacuees coming off the buses and gave them water, sandwiches and blankets and then got them medical screening and showers as quickly as possible. Wardens and other Department leaders recognized that a disproportionate number of inmates and almost all the evacuees were from the greater New Orleans area and worried they had lost loved ones and families. The institutions went far out of their way to keep inmates and evacuees as well informed as possible and in many areas inmates were given the opportunity to assist in relief efforts. That involvement was extremely positive for the inmates and for staff alike.

4. Rather then regarding defense attorneys as the enemy, the department leadership set the tone early in the disaster by beginning to work with the defense bar in establishing data bases of evacuees and eventually an 800 number so that evacuees and families could reconnect. Keeping inmates well informed and involving inmates in disaster relief efforts are well established principles in corrections, but LA DPS&C has underscored their importance and the role they can play in emergency response.

5. There was at least one institution where the evacuees did not seem to be doing well and where management seemed unaware of the specific conditions imposed upon the evacuees. Also, while the Department expended substantial time and effort in trying to work with various parishes and the state Attorney General's Office to develop release procedures for some evacuees and to identify charges against others, the coordination of evacuees issues, once housed in the state's prisons, was neither as consistent nor as effective as might have been desired. Coordination of evacuees issue might have been assigned to a high level Headquarters administrator and that issue, too, is a leadership matter.

6. As Secretary Stalder has pointed out, the Department is fast approaching a "Changing of the Guard". Most of the individuals in top leadership positions in the Department now have 25 to 35 years of seniority and are expected to retire within the next few years. While the connection may not be linear, that circumstance has important implications for the Department's emergency planning. The group of senior managers retiring over the next few years came up together in the Department. They were part of the Department when it was a much smaller agency and they know each other well. Over their careers, all of these managers have been through riots, hostage incidents, natural disasters and other major emergencies. They may have learned by trial and error but they are seasoned with crisis management. Most will be replaced by younger managers who have not worked together in the same way as the older generation. Many of these newer managers have not been through insurrections, hostage incidents and more, which is a testament to the Department's progress, but it is also a problem. The new managers will not be

able to fall back upon their experience or react to crises instinctively in the way that their predecessors would have. In short, these new managers will be far more dependent on good training, good emergency plans and thorough procedures than was the case with those they replace. That puts a burden on the Department to operate more formally and in a more planful manner than has been necessary until now.

J. Parole and Probation

1. All of the richly deserved high praise that has been given to the Department also applies to the Parole and Probation Division. There is a difference, however. The P&P staff were less prepared for what was needed from them than was true with most of the rest of the Department, and the personal devastation of individual probation officers was so widespread that it also became an organizational devastation. The accomplishments of the P&P staff in the aftermath of the hurricanes were achieved in the face of personal loss, tragedy and trauma on a scale that has not been seen before in a correctional work force.

2. The Division needs realistic plans for responding to large scale emergencies and disasters. These plans should be written rather then informal or "understood" and it is important that P&P staff be trained to those plans.

3. Emergency plans should include designated vehicle staging areas at some distance from probation offices. Those staging areas may be predetermined but may need to be changed because of the nature or location or the emergency. The purpose of the staging area is not only to get state vehicles to safety but to also provide an area where staff can assemble and start to use the vehicles.

4. Probation and Parole staff should carry a small kit of emergency supplies in the trunk of their cars. Those should include bottled water, emergency food, old clothes and rain gear, a change of shoes, a flashlight, a blanket and a vest or jacket stenciled with "Probation and Parole", or "Dept. of Corrections".

5. The Division should develop standing orders for staff for emergency situations. These orders should include how and when to report if phones or other communications are down, how to notify and or report if evacuating the area and what to do if injured or in some other crisis because of the emergency.

6. The Division should also consider developing standard release plans for misdemeanants or other low risk offenders, including when and how they should make contact and resume supervision. Those same plans should consider higher risk offenders as well. The Division may want to explore procedures that would require high risk offenders (high violence offenders and serious sex

offenders) to move to a different geographic area in advance of a potential natural disaster or to explore the legality of returning some offenders to custody for the duration of the emergency. In addition, a portion of the Department website should be devoted to parolees and probationers, so that offenders can check the website for updated messages. That portion of the website should be potentially interactive; offenders who cannot make contact by phone can check in with the Department and perhaps stay in contact by email. The Division can also consider maintaining an 800 number that can be accessed from any working phone and which can be automatically forwarded to an out of state location if phone service is out in the primary 800 number location. That 800 number can also be used for outgoing messages to offenders under supervision in the community.

7. The Division should evaluate the strengths and weaknesses of developing a fugitive apprehension unit that would have specialized expertise in locating absconders and returning them to custody. That might well offer advantages when contrasted with individual, case-caring officers bearing the responsibility for finding and apprehending absconders and other fugitives, because some officers are unavailable for that kind of duty if they are on other emergency assignments or if they are unable to work because of a community-wide disruption. It should be noted that the Division has tried this kind of unit in the past and found it unsuccessful because of elitism leading to divisiveness. That was before the experience with Katrina and the Division may want to revisit the application of specialized units, perhaps including a "special response" unit, in the light of lessons learned from Katrina. Some consideration must be given to staff who do not show aptitude or inclination for extraordinary emergency duties such as crowd control.

8. This may be an opportune time for the Division to reexamine its mission and role. To what extent shall probation officers become associate police officers? If the P&P role is going to morph into a predominately law enforcement role, do the P&P staff have the equipment and training that is required for those police functions or are these expanded missions and roles unreasonably jeopardizing staff safety? Is a probation officer as well equipped by training, procedure and experience as a typical police officer for building sweeps, drug interdiction situations or other high risk scenarios? The Division is well aware of the questions; it is the answers that can be vexing.

9. While the Division's mission and role are broad issues, there is a specific question that is related and which should be afforded close examination. That has to do with the rules of engagement. This is another area where no tragic incidents occurred and, to the best the consultants' knowledge, there were no particularly controversial situations that developed. However, that was fortunate and it might not have been the case. When probation officers are

engaged by themselves in what is essentially police patrol, or when they are serving as armed guards accompanying fire department staff or when they are participating in large scale crowd control operations as they were at the overpass, there is clear potential for a wide range of use of force incidents. That would include the potential for lethal force situations. While probation and parole staff are certified peace officers and do have extensive use of force training they were in a number of situations that were not contemplated by the Department's use of force policies, procedures, or training. That is equally true of numbers of the Department's institution staff working at Camp Amtrak and in a number of other community situations.

All of these staff were assigned without guidelines or restrictions, other than the Department's existing policies and procedures. It can be argued the Department was in the midst of an unprecedented emergency and there was no time to analyze policies or rewrite procedures. That argument has great merit; the Department did what needed to be done, and no one would wish otherwise. However, it is also true that there could have been controversial or tragic incidents and if that had been the case, these issues might been seen quite differently in retrospect. It would be worthwhile for the Department to consider whether under such extraordinary circumstances, rules of engagement, situational guidelines, restrictions or special directions should be issued, and if so, how and by whom.

This is also a relevant question for correctional agencies that may in the future send staff to assist another jurisdiction during a crises, as was done so effectively in this situation by several state DOC's, the New York City Department of Corrections and the FBOP. (The FBOP did provide detailed and specific guidelines for their staff that were sent to assist, and also conveyed those guidelines to LA DPS&C.)

K. Plans for Mass Evacuations

1. Each institution should be required to have plans not only for on site evacuations (for example, fire), but also for offsite evacuations of the entire population. Those plans need to be thoughtful, detailed and realistic. While that is a formidable planning task, it is a helpful exercise to staff in other aspects of emergency planning and emergency training

2. The Department should identify which records must accompany an inmate during an evacuation. Those will typically include criminal history, current sentencing and medical/mental health records. Since many inmates have voluminous records, the Department should explore creating summary sheets that contain the critical information that might produce life threatening circumstances in its absence. The inmate records required, whether in full form

or in summary form, should then be available in hard copy or electronically on short notice so that institution staff can quickly prepare inmates for evacuation and be able to send the records along with the inmate or transmit them electronically.

3. Evacuation plans must include plans for dealing with special populations (segregation, infirmary, special needs, mental health, protective custody, etc.).

4. Evacuation plans should include plans to identify inmate troublemakers during the evacuation and transportation process. The procedure the Department developed informally, removing those inmates from the buses and vans first and getting them to restricted housing prior to processing the rest of the evacuees, has much to recommend it.

5. All Department vehicles should be identified by large, easy to read, unique numbers on the sides of the vehicles and that same number should be painted on the vehicle's roof for identification from the air. The Department may choose to use a number system that identifies the vehicle as belonging to a particular element of the Department. ("3-1-22" may mean that the vehicle should be a van because of the "1" in the 2nd position; that it belongs to Dixon Correctional Institute because of the number "3" in the 1st position; and it is vehicle number 22 at Dixon). Within a given prison, all buildings should be identified with large numbers or letters painted toward the top of the sides of the buildings and the same number should be painted on the roof of the building. In that way, the building can be identified from the air and they are also easy to identify for mutual aid agencies that are within the compound for emergency purposes.

6. The Department should have the capacity at each institution to take digital photos of inmates or evacuees brought to the institution, and then to back up and/or send files of those photos to other Departmental locations by email.

7. The Department should determine whether there is any portable biometric identification system that is practical enough and inexpensive enough to be placed at each institution for quickly identifying large numbers of incoming or evacuating inmates. It would also be important to know whether the portable biometric identification system could be transported to a receiving institution or location, along with inmates being evacuated.

8. The Department should explore a color coded heavy plastic bracelet system for short term identification of large numbers of inmates being evacuated or received. Once inmates are identified, some form of picture ID should be attached to the bracelet or otherwise carried by the inmate.

9. When the Department is faced with evacuees at multiple locations or with large numbers of displaced inmates at more than one location, the Department should identify an administrator in Headquarters to coordinate the provision of services for those displaced individuals and to ensure that reasonable steps are being taken to identify individuals, move them through the court system, maintain contact with their families, etc.

10. The decision to release evacuees and arrestees only to their own families and to shelters was an excellent decision that may have saved lives and may have averted some high profile incident in the community involving a former offender. Based on the Department's experience last fall, it would be worthwhile to try to establish guidelines with the Department of Social Services, the Red Cross and FEMA regarding the release of ex-offenders to their shelters. Responsibility for coordinating with shelters across the state or in a region of the state should be assigned earlier in the crisis, and, if possible, assigned to an individual involved in the planning and arrangements with the shelters and who has had an extensive amount of emergency preparedness training.

11. The state's contraflow plan for area wide evacuation worked surprisingly well. The problems in New Orleans with people who did not have cars or other access to transportation and with people who refused to evacuate, were not faults of the contraflow plan itself. Emergency training for Department managers should include familiarization with the contraflow plan.

L. Specific Hurricane Preparations

1. Many Department staff are very familiar with hurricane preparations. This section is not intended to list all necessary preparations, but rather to emphasize several issues that figured prominently in the preparation for Katrina or Rita.

2. Identifying inmate clean up crews in advance of the hurricane's projected landfall, and preloading trucks with chainsaws and supplies, proved effective steps for WCI.

3. At institutions, some provision should be made to connect washers and dryers to emergency power if an emergency lasts more than a few days.

4. Towers should be "de-manned" (that is, staff removed from the towers) very early. High velocity wind gusts can occur well before the center of the hurricane is close and the risk to staff in towers is substantial.

5. A relocation area for prison vehicles should be pre-determined. The location should not be close to buildings because, as happened at WCI, HVAC units can blow off roofs, and other heavy objects may be blown off of buildings. The location should obviously not be next to or under trees and it must not be a location that could be subject to flooding, or could be cut off by flooding or extensive road damage.

6. In parts of the country subject to hurricanes, just as in parts of the country subject to earthquakes, the rule of thumb has been that staff should be prepared to be isolated and self sufficient for a minimum of 72 hours. Experiences with Katrina and Rita suggest five to seven days might be a more conservative estimate. Staff on serious chronic medication should keep a three to five day supply at work in their desks or in some other agreed upon secure location. Staff with strong prescription lenses should keep a back-up pair of glasses or lenses at work as well.

7. Emergency generators powered by natural gas rather than diesel fuel or gasoline, have the potential to reduce the Department's dependence on gasoline and diesel fuel in an emergency. Some states have good history with natural gas emergency generators.

8. It is useful in advance of a hurricane (or other natural disaster) to have a list of inmates who have volunteered to assist with work in the community and are eligible by classification to do so.

M. Emergency Supplies

1. Food was not the most crucial commodity in the immediate aftermath of Katrina. Drinking water, gasoline and diesel fuel were all more crucial than food.

2. Warden Cain and LSP have the right idea about emergency generators; more are better. Also, while almost all institutions have emergency generators that are fixed, large portable emergency generators can be extremely valuable in an extended emergency.

3. Emergency generators should be tested on a regular schedule and run for a few minutes under load. Also, the institution and the Department should have readily available information on the rate of fuel that each emergency generator burns, how much storage of fuel is maintained with the generator and where the institution would get additional fuel if the emergency lasts longer than the supply that is with the generator.

4. In the immediate aftermath of Katrina, gasoline became difficult and in most cases impossible for civilians to purchase in the greater New Orleans area. Secretary Stalder's quick decision to furnish gas to employees so that they could drive to work and back, and perhaps get groceries and the like, was an extremely important decision that may have avoided a substantial amount of employee absenteeism. However, the Department then had its own problems in securing a supply of gasoline at many locations. Many years ago, it was common for state departments of corrections to have large supplies of gasoline and diesel fuel in tanks, whether for transportation, farm operations or other needs. In recent years, for environmental reasons, there has been a move directly away from large stored supplies of gasoline and diesel fuel. Above ground storage and double containment can be expensive and some departments have recently abandoned storage tanks and now rely on "on time" delivery and "as needed" inventory. Extended emergency situations provide strong motivation to reconsider the use of large storage tanks. Certainly, based on the Department's experience with Katrina and Rita, the Department should secure its own supply of gasoline and diesel fuel, as well as potable water. The Department's experience also demonstrated painfully that stored supplies of gasoline or diesel will not be helpful if the fuel pumps can not be connected to emergency power and there is no manual way to pump or siphon.

5. If the Department adopts a uniform system for identifying and numbering Departmental vehicles, as suggested earlier in this report, it will also be useful to have each vehicle number followed by the letter "G" or "D", with G indicating that it is a gasoline powered vehicle and D indicating diesel. The Departmental and institutional emergency plans, in their vehicle inventory, will then automatically include this information and it may also be helpful to record in the vehicle inventory the approximate mileage per gallon that the vehicle achieves and the gas tank capacity of the vehicle. In that way, someone arranging vehicles for an emergency mass evacuation of inmates will be able to quickly determine how far a convoy will be able to travel before the vehicle in the convoy with the least range needs refueling.

6. Each institution should have a minimum of five day's supply of potable drinking water for the inmate population and staff.

7. Batteries, flashlights and binoculars are among the most necessary emergency supplies in many kinds of crises. Each institution should know how many of those items it has on hand, and in what locations and that should be part of the institution's emergency equipment inventory, within its emergency plans, and that should also be on file at the Headquarters IMC.

8. Each institution should have four times as many flex cuffs as it does inmates in its total population. In mass evacuations, it is not possible to move all inmates

in steel restraints. Two sets of heavy-duty flex cuffs, chained together, will usually work as improvised leg restraints.

9. With larger and more expensive items, decisions are not as clear. Should the Department have its own porta potties? Should the Department purchase, store and maintain its own supply of large tents? Perhaps, but perhaps not. For example, large tents are quite expensive and they deteriorate over time. For some prison populations and some locations, a "tent city" may be counter-productive. It can be a security nightmare and it is staff intensive at best. EHCI found that rented tents offered too many opportunities for inmates to fabricate weapons.

10. With tents, port potties, and other items that are expensive but are likely to be needed only very rarely, the Department should consider a strategy know as "contingent contracting". There are two variations of this method. An agreement is made with a contractor or supplier that in the event of an emergency the Department will have first access to the supplies or services in question. In return for a guarantee of first access and first rights of refusal, the Department either pays a yearly retainer or agrees that if the contract is activated, the Department will pay a rate that is very substantially higher than the going market rate. That kind of arrangement can be made with things ranging from helicopter leasing to structural engineering services to supplies of bottled drinking water. Obviously, the arrangement will not work if the contractor or supplier has gone out of business or cannot be reached during the crisis.

11. Night lighting should be considered separately. In many institutional emergencies, additional night lighting or night lighting that can be powered by emergency generators, has been a crucial item. The Department can purchase portable night lighting and maintain it in a location that is relatively central so that it can be taken to an institution that is experiencing an emergency. It is also possible to install permanent enhanced night lighting at institutions and only activate that lighting when the need exists.

N. Public Information

1. The Department's communications strategy during the emergency was extremely successful. Information was released frequently and clearly and much of it found its way to the public. There were no questions raised about the accuracy of the Department's information and the Department was able to quickly quell rumors. The coverage was almost entirely positive.

2. Secretary Stalder's decision that individual staff members would not be highlighted because "There are no individual heroes. All of our staff performed

heroically," was a thoughtful and most unusual decision. It has worked very well. The public focus and the credit for the Department's actions have gone to individual institutions, probation and parole or to the entire Department. Staff actions have not been overshadowed by dramatic, individual stories.

3. The Department should consider an assistant or other backup to its Communications Director. That person can then be trained and given some media experience so that if the Communications Director is unavailable during an emergency, the Department will not lose direction or momentum in that area, which is crucial.

4. The Department should consider enhancing the role of the media liaison individuals at each institution. No matter what the Department has in Baton Rouge, the electronic media in particular will go directly to an institution that is in the midst of a major emergency. If the Department is to fully pursue its proactive strategy with media relations, there should be a person at each institution with formal training and increasing experience with media relations, and perhaps a back up person at each major institution.

O. Financial Issues

1. When the Department has a clear picture of the financial implications of housing parish prisoners in large numbers for many months, LA DPS&C should consider requesting clarifying legislation that would prevent the Department from being financially punished for accepting thousands of evacuees from parish prisons.

2. For the Department, one of many ironic results of the two hurricanes is financial. In addition to a multi-million dollar loss because of the mass housing of parish prisoners, the Department has also had to incur extraordinary emergency related expenses for transportation, supplies, staff overtime and more. After a prior year of substantial budget cut backs in the Department, the budget situation currently is dire, to say the least. The ironic part is now that the Department has come through the severe hurricane challenges with flying colors, the institutions find themselves cutting back programs and cutting back inmate work crews because they do not have the money to operate or supervise those activities. The loss of those activities, in turn, increases pressure on the inmate population and makes the institutions more difficult to operate. Some staff in the Department have no trouble reaching the conclusion that they are victims of their own success.

P. Operating A Jail

1. Seven of the fifty state departments of corrections in the U.S. are "unified systems". That term means that the state department of corrections handles all jail functions as well as prison functions. They receive offenders from police directly from the street, release people on bail and generally perform all jail functions in addition to the longer term incarceration of sentenced offenders that is typical of most prison operations. Outside of those seven "unified" systems, the rest of the state DOC's have little or no experience with jail operations. Like much of what happened after Katrina, the Camp Amtrak situation is unprecedented, but perhaps it should not have been completely unanticipated. In a severe natural disaster, a terrorist incident or some other major emergency that incapacitates a large metropolitan area and renders the existing jails unusable, someone will have to open and operate a jail. Without a jail to accept arrestees, law enforcement personnel are stymied in attempting to re-establish law and order (interestingly, by far the most frequent charges for arrestees processed through Camp Amtrak were looting or possession of stolen property). Without an operating jail, it becomes more difficult to combat lawlessness or even anarchy. Thus, as was the case in New Orleans, the need for an operating jail may not wait on the agency that is the rightful jail owner to get back in business. Under such circumstances, it stands to reason that a state department of corrections may be the natural choice to develop and run a jail on an interim basis.

2. The Department should work with the parish prisons to develop a detailed contingency plan for operating a jail. The parish prisons have the forms, the procedures and protocols and the experience to help the Department plan how it might operate a jail in any area of the state, without having to "re-invent the wheel", which was essentially the position the Department was in with Camp Amtrak.

Q. Other Inter-Agency Issues

1. The Department has no jurisdiction over parish prisons. Also, unlike many states, it is the criminal sheriff who is the chief law enforcement officer in Louisiana. Still, there are a number of inter-agency problems and issues which were apparent in the aftermath of the two hurricanes and which should not be allowed to re-occur. The Department should use its good offices and its considerable influence to work with the parishes in the greater New Orleans area to mitigate some of these potential problems.

2. It would be helpful if each parish prison had their criminal records and medical records available electronically and it would be more helpful if their software or data base systems were compatible with the state's systems. HIPAA

regulations should be reviewed to ensure procedures established do not contravene the HIPAA statutes.

3. The parish prisons should have back up systems for their records and data, and preferably back up that is out of the geographic area or otherwise protected from local disasters, and perhaps arrangements with a remote "hot site" so that data and records could be accessed seamlessly if the primary computer systems were inaccessible or inoperable.

4. The Department should work with the various parish jails to attempt to establish standing early release plans so that misdemeanants and other less serious offenders could be released from custody in anticipation of a natural disaster or a large scale crisis.

5. The Department should attempt to develop plans with the parish jails that would allow prisoner criminal records, medical records and medication to be sent with prisoners in the event of an emergency evacuation to state prison facilities.

6. The Department should attempt to coordinate its emergency operations with the emergency operations of the various parish jails so that in the event of another area wide disaster, the command staffs of the Departments can maximize communication between the agencies. The goal would be to have as few surprises as possible and to maximize lead time where cooperative operations are required.

7. If the Department moves towards more formalized inter-agency agreements, Memoranda of Understanding or the like, the Department could explore including specification of authority, jurisdiction and even financial arrangements in those agreements.

R. Emergency Plans and An Emergency Preparedness System

1. The Department does not have a comprehensive emergency system. Some parts of such a system are in place but other parts are missing and there are elements of emergency preparation that do not complement one another. That general assessment holds true whether one looks at Departmental level emergency readiness or one looks at individual institutions.

2. The Department's existing emergency plans could be substantially stronger and more useful. The Department uses a traditional approach to institutional emergency plans in which there are different plans for different kinds of emergencies. Further, plans differ markedly from institution to institution. There are a number of problems with this approach that have led most state

DOC's to move to a single, generic emergency plan with "offshoots," or appendices, for various kinds of emergencies. This "all hazard" or "all risk" approach is typically accompanied by standardizing the format of emergency plans so that all institutions use the same organization, format and style with different details, because the plans must ultimately be tailored to the individual institution. The consultants reviewed plans for the same type of emergency from two different institutions and found one plan to be substantially more detailed and realistic.

3. The emergency plans are not current in some cases and they are generally not as practical and user friendly as might be desired. The most user friendly emergency preparedness systems and institutional emergency plans are check-list driven; LA DPS&C plans rely primarily on text.

4. The most telling data about the existing emergency plans is that, almost without exception, staff responded to the hurricane situation without considering, using or other recourse to the emergency plans. At management levels, staff acknowledged that they had had little emergency training and remained unfamiliar with what might be in the plans. It might be argued that the situation the Department faced after Katrina was so monumental and so extraordinary that it is unrealistic to expect it would have been reflected in pre-existing emergency plans. While that is true in the most literal sense, no two emergencies are ever exactly alike and staff must always extrapolate from plans and training to the instant situation. Here, plans were not used as a foundation for staff actions.

5. The emergency plans do not include consideration of extended emergency situations, (those that go beyond twelve or fourteen hours.) The plans also do not include emergency staff services, except for mention of post-traumatic incident de-briefing. Documentation needs in an emergency are not well specified and there are a number of other elements of comprehensive emergency plans that were not fully covered. Deactivation, aftermath issues and "step-down" planning are not addressed.

6. The Department does not use any emergency organizational structure nor any emergency command structure, relying instead on the organizational structure and chain of command that operate on a day to day basis. That led to some pervasive problems during the emergency. While there was no question that Secretary Stalder was in charge of the Department, there were lengthy times when he could not be reached because of the many communications system failures. During some of those times, the Chief of Staff was in the IMC and was clearly the decision maker with the Secretary unreachable. At other times, it was not clear who was to exercise command authority if the Secretary and

the Chief of Operations were not in direct contact. Managers at institutions described receiving contradictory directions from the IMC and from an administrator calling the institution directly from the field. They also described having trouble getting a decision from the IMC depending on who answered the phone and who was available. Parole and Probation staff perhaps most frequently voiced frustration with lack of clarity of command and of organizational structure during the emergency. Fortunately, as far as the consultants were able to determine, these issues did not result in serious problems, a bad incident, etc. However, the potential for serious problems existed and it is recommended the Department closely review issues of continuity of command and organizational structure as they are expected to operate in an emergency.

7. The emergency plans are also more person-specific and position-specific than may be desirable. At a given institution, the emergency plans specify that a particular Assistant Warden will fulfill one role in an emergency and another top administrator will fill some other role, etc. If, during an actual emergency, several or more of the key top administrators are on leave, sick or at a great distance from the institution, the plans do not contemplate how those emergency roles shall be filled, or by whom. Further, if those key people are trained in those specified roles, then the institution will not have other individuals with the requisite training who can be used as back-up or relief in an extended situation. Finally, even the Departmental emergency plans have key staff working in the IMC when those same individuals have other emergency responsibilities that are incompatible with the IMC assignment.

8. If the Department had developed more detailed, more practical and more comprehensive institutional emergency plans, perhaps in the service of an overall system of emergency preparedness and emergency response, there are a number of issues which be-deviled the Department during the emergency, which almost certainly would have been covered and made easier by the emergency plans. For example, many department's emergency plans include a state-wide departmental vehicle inventory and institutional plans will include both the institution's vehicle inventory, the department's, and commercial and bus driver license holders at the institution. Each institutional emergency plan should include a complete and up to date list of emergency equipment with quantities and locations of various items within the institution specified. Up to date notification lists are basic to a departmental or institutional emergency plan and should be separated into command notifications, specialist notifications and external agency notifications. These notification lists were not available at some institutions or within P&P, and the IMC lists were not current or complete. The medical plan for major emergencies, within the institution's overall plan, should include primary and alternate locations for a triage center and procedures for dealing with mass casualties. Certainly there

are many things that occurred during the hurricane crisis that would not have been foreseen and for which almost no department would find direction or help in its existing emergency plans. For example, at one point in the crisis, EHCI was asked on very short notice to develop plans for a cemetery. The consultants are unaware of any department whose emergency plans include contingencies for establishing a cemetery.

9. Mississippi has a state statute allowing the Governor to suspend any state law or regulation that interferes with a necessary emergency response. Louisiana might consider the advantages of that kind of statute

S. Emergency Staff Services

1. Emergency staff services is a much broader concept than post-traumatic incident debriefing. It refers to the whole gamut of extraordinary services staff and staff families may need during and after an emergency.

2. Emergency services for staff and staff families were accorded high priority by LA DPS&C management and the area is one of many strengths exhibited by the Department.

3. The Department provided post trauma counseling (also called "critical incident stress debriefing", and a number of other names) to staff in many areas of the Department. The Department provided cash assistance to staff whose homes were seriously damaged or destroyed, using over one half million dollars received in contributions, largely from other correctional agencies and corrections staff around the country. The Department also gave staff gasoline, water and other emergency supplies in the days immediately following Katrina's landfall. Staff in many different locations spoke positively to the consultants about the Department's assistance to its own employees.

4. There are two changes that might enhance the Department's capacity with regard to addressing the emergency-related needs of staff and staff families during a crisis or disaster. There should be some centralized coordination of emergency services for staff and staff families, so that all areas of the Department are receiving attention in that regard, and so that situations needing Departmental assistance do not go unnoticed. Identifying a person in charge of emergency staff services should be an important element in the Department's emergency's plans and should be accomplished as early in the emergency as possible, in order to make the effort proactive to greatest degree practical.

5. It is worthwhile to consider a regulation providing the Department the authority to grant administrative leave to staff because of emergency conditions. In that way, staff who cannot report to work because of closed highways, or other emergency-related conditions beyond their control, can continue to receive paychecks uninterrupted, rather than having to remedy those situations after the fact.

6. Some administrative leave should be mandatory by policy for employees who have been traumatized. Psychological screening should be mandatory by policy for employees who may have been traumatized.

T. Emergency Preparedness Training

1. In general, prior to the hurricanes, LA DPS&C had not provided enough training on emergency preparedness to its staff, and the training that had been provided was too superficial and not particularly effective.

2. Staff at the level of Shift Commander and above need more in depth training on emergency preparation and emergency response than front line staff, first line supervisors, and civilian employees. The opposite seemed to be the case with LA DPS&C and the consultants encountered high level managers who had had essentially no formal training on the Department's emergency policies, plans, and procedures.

3. The single emergency training issue that appeared to be most glaring was command post operations. While this is a narrow subject, it is difficult to separate from closely related matters such as emergency organizational structure, command ascension, continuity of command and an organization's overall system of emergency response. Nevertheless, the Department's experience at EHCI and elsewhere indicates a clear need for at least some initial training on command post operations for all managers.

4. Effective emergency preparedness training would train staff to the Department's emergency's policies, the comprehensive system of emergency preparation and emergency response, the specific institutional or field service emergency plans and a number of other more detailed emergency topics. For example, in an area with high risk of natural disaster such as Louisiana, staff training should include procedures for updating staff family notification lists, encouragement to staff to talk with their families and agree on both an out-of-area phone contact that family members can use when local calls are not possible, and a family relocation area where family members should go if their homes or neighborhoods are damaged or unreachable.

5. The Department is under pressure to complete a substantial amount of NIMS training for all staff. That adds to an existing dilemma. The Department's budget situation is far from optimal and training time and training resources are limited. Unless the NIMS training is integrated with, and augmented by, a great deal of corrections-specific and Department-specific emergency training, it is unlikely to be particularly helpful for staff in the event of a hurricane or some other type of emergency. That question is closely related to two other decisions that may shape the Department's short term and medium range training strategy in the emergency preparedness area. First, will the Department train for hurricane preparation or will training address emergency preparedness and response more generally? Second, will the Department use its experience with last year's disaster to modify its emergency policies, plans and procedures or will the Department train to what remains in place currently?

6. Every staff member in LA DPS&C has questions, new ideas, and stories from last year's disaster. Thoughtful and effective training on emergency preparedness should be extremely well received by staff throughout the Department.

U. Assistance From Other Correctional Agencies

1. The assistance received was crucial for LA DPS&C. The Department has been deeply concerned that they had not documented everything received or all of the individuals and agencies who sent that help. In fact, the Department did a surprisingly thorough job of documenting the assistance they received, particularly considering the circumstances. If the Department is unable to specifically acknowledge a few of the sources of the assistance because of incomplete records, that is not a serious failing and the agency and individuals who sent assistance will certainly understand. What is important is that the help was needed, it was sent, it was received, and it was used. That last point must be emphasized. The assistance sent to LA DPS&C was not a token show of support, it was a massive effort and it was critically important, from emergency generators, to drinking water, to nursing staff. to cots and blankets, to correctional officers, to money for staff that had lost their homes.

2. The American correctional community has never before been mobilized to this extent or in this manner. In this regard, the Louisiana experience provides a model for the future. There is much for other correctional agencies to contemplate and learn. A number of state DOC's have major facilities that are geographically distant from any large source of correctional assistance within that state, but which are much closer to major correctional facilities in an adjoining state. The possibilities for crucial assistance in an emergency or disaster are readily apparent, but the consultants are aware of only a few states

that have explored those possibilities, and then only with quite informal understandings.

3. With Louisiana's experience with Katrina and Rita proving that a natural disaster may plunge several states or a region of the country into crisis, and with increasing awareness that a terrorist event could have multi-state implications, planning for interstate or regional assistance in emergency deserves careful examination. Encouragingly, as this report is being completed, the Maryland Department of Public Safety and the National Institute of Corrections are about to convene a group of administrators from the mid Atlantic and north east states to engage in just that sort of planning and analysis. That conference is one more direct, if unanticipated, result of LA DPS&C's experience with Katrina and Rita.

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