Mr. L. Russell Molnar
President
Wicomico County Council
P.O. Box 870
Salisbury, MD 21803-0870

Re: Wicomico County Detention Center
September 9, 2002

Dear Mr. Molnar:

On October 5, 2000, we notified you of our intent to investigate the Wicomico County Detention Center ("WCDC" or "the Detention Center") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. On January 26-28, 2001, we conducted an on-site inspection of the Detention Center with expert consultants in correctional medical and mental health care, penology and environmental health and safety. While at WCDC, we interviewed correctional and administrative staff, inmates and medical and mental health care providers. In addition, we have reviewed an extensive number of documents, including policies and procedures, incident reports, medical records, use of force records and staff disciplinary records. At the end of our on-site inspection, we and our consultants discussed with County officials and the Detention Center staff our preliminary concerns regarding the conditions at WCDC. Consistent with the statutory requirements of CRIPA, we write to advise you of the results of our investigation.

As an initial matter, we commend the staff of the Detention Center for their helpful and professional conduct throughout the course of the investigation. The staff have cooperated fully with our investigation and have provided us with substantial assistance.

WCDC opened for operation in 1988, and is the largest detention center on the Eastern Shore of Maryland. The Wicomico County Department of Corrections operates WCDC. The facility houses both men and women, including pre-trial detainees, inmates serving sentences of 18 months or less and Immigration and Naturalization Service ("INS") detainees. Although both male and female INS detainees were housed at WCDC at the time of our tour, we understand that currently it only houses male INS detainees. According to Detention Center officials, WCDC has a rated capacity of 535 inmates and detainees.

The Detention Center has seven primary housing areas: 1) Central Booking, containing male and female holding cells and suicide-watch cells; 2) A-Block for INS female detainees and general population female inmates; 3) B-Block for general population male inmates; 4) C-Block for general population male inmates and INS male detainees; 5) Special Housing, containing five disciplinary segregation cells; four administrative segregation cells; and four cells for detainees with mental health designations; 6) Work Release Dormitory for male inmates; and 7) Work Release Dormitory for female inmates.

Our investigation revealed that WCDC provides adequate non-emergency medical care to the general population and implemented an appropriate mental health screening program, beginning in July 2000. As described more fully below, we also conclude that certain conditions at WCDC violate the constitutional rights of inmates and detainees housed at the Detention Center. We find deficiencies at WCDC in medical care, specifically in the areas of chronic care, access to medical care for inmates and detainees in segregation, and tuberculosis screening; mental health care, specifically in the areas of mental health treatment and medication distribution; inmate and detainee safety; and environmental

health and safety. In addition, overcrowding in the facility exacerbates many of these deficiencies.

I. Legal Framework

CRIPA authorizes the Department of Justice to investigate and take appropriate action to enforce the constitutional rights of inmates and detainees. 42 U.S.C. § 1997a. With regard to sentenced inmates, the Eighth Amendment's ban on cruel and unusual punishment "imposes duties on [prison] officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care." Farmer v. Brennan, 511 U.S. 825, 832 (1994). Prison officials have a further duty "to protect prisoners from violence at the hands of other prisoners." Id. at 833. The Eighth Amendment protects prisoners not only from present and continuing harm, but from the possibility of future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993). It also forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1 (1992). Medical needs include not only physical health needs, but mental health needs as well. Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977); Young v. City of Augusta ex rel Devaney, 59 F.3d 1160 (11th Cir. 1995). With regard to pre-trial detainees, the Fourteenth Amendment prohibits imposing conditions or practices on detainees that are not reasonably related to the legitimate governmental objectives of safety, order and security. Bell v. Wolfish, 441 U.S. 520 (1979).

II. Medical Care

WCDC provides inadequate medical services in the following areas: chronic care; access to medical care; and tuberculosis screening. As a result of these deficiencies, inmates and detainees do not receive adequate evaluation or treatment for their illnesses, particularly individuals with chronic conditions. The deficiencies in WCDC's medical care are largely a result of inadequate staffing and a lack of policies and procedures. These failings increase the risk of serious harm or death to the population at the Detention Center.

A. Chronic Care

The most problematic and potentially dangerous component of WCDC's medical care is its screening, monitoring and follow-up care of inmates and detainees with chronic medical conditions, such as hypertension, diabetes, asthma and AIDS. Individuals with chronic medical conditions require ongoing, routinized care to prevent progression or complications of their illnesses. The Detention Center does not have a functioning system for managing chronic illnesses, largely due to the physician's lack of time to manage chronic illnesses and the lack of chronic care policies and procedures. These deficiencies create a risk that inmates and detainees will suffer serious and preventable medical harm.

Our review of medical records of patients with chronic illnesses revealed a significant number of inmates and detainees who received inadequate monitoring and treatment, including a failure to provide important routine tests. For example, the Detention Center did not check the blood sugar level of an insulin dependent diabetic inmate until five months after his admission to WCDC. Medical providers should check blood sugar levels in insulin dependent diabetics no less than weekly and, depending on the patient, as frequently as several times a day. Moreover, despite complaints of blurred vision from the same inmate, WCDC did not refer him to an eye doctor until four months after his complaints. Diabetics may lose significant vision if not evaluated regularly by an eye doctor and immediately when symptoms of visual impairment occur.

In another case, a 54 year-old inmate with a history of chest pain and possible hyperthyroidism entered WCDC in June 2000. Intake notes indicated that the Detention Center should obtain and

evaluate the patient's medical records from a previous facility concerning the history of possible hyperthyroidism. WCDC failed to do so and did not conduct any further evaluation of his possible thyroid disease. In November 2000, the inmate complained of chest pain and WCDC ordered an electrocardiogram ("EKG"). But the patient did not receive the EKG until January 2001. The test disclosed serious heart problems. It is medically inappropriate and potentially life-threatening to wait over a month to conduct an EKG following complaints of chest pain in a 54 year-old man with possible thyroid disease.

The Detention Center also did not provide the necessary follow-up monitoring of hypertensive inmates to determine the efficacy of their therapies and the current state of their blood pressures. Chronic uncontrolled high blood pressure may damage the heart, kidneys and brain.

For another patient, a detainee with a history of hepatitis C, medical staff ordered blood tests to determine the status of the hepatitis. WCDC, however, failed to provide the tests or to conduct any follow-up evaluation. These failures may contribute to a very serious liver infection.

B. Access to Medical Care

Our review of medical records indicated that WCDC ordinarily provides timely access to non-emergency medical services for its general population. Inmates and detainees in the general population gain access to non-emergency medical care by completing sick call forms. An evening nurse picks up these forms during medical rounds five days a week, which are triaged the following morning.

WCDC provides an unacceptably lower level of sick call access to inmates and detainees in the Behavioral Adjustment Unit ("BAU"). Due to medical staffing deficiencies and a lack of written policies, WCDC does not have a systematic method for inmates and detainees in the BAU to speak directly with medical staff, such as conducting formal medical rounds. Instead, inmates and detainees in this unit must rely primarily upon correctional staff to communicate their sick call requests to medical staff. This practice compromises the quality and timeliness of treatment since individuals do not have an opportunity to speak privately and directly with medical staff.

Additionally, our review of medical records revealed instances in which WCDC failed to provide indigent inmates with adequate medical treatment. In particular, the Detention Center refused to provide medically indicated eyeglasses to inmates unable to pay for them. Treatment decisions must be based upon appropriate medical assessments of the need for treatment, not on an individual's ability to pay for the treatment.

C. Tuberculosis Screening

Our review of medical records revealed numerous instances where WCDC did not perform tuberculosis skin tests ("PPDs") on inmates and detainees at intake because they stated that they had tested negative in the community or in other facilities. WCDC does not require any documentation of the purported negative tests, relying instead solely on individuals' self-reports. Self-reported PPD results are frequently inaccurate because many individuals wish to avoid injections. Tuberculosis screening of all new intakes is an important part of correctional health care because inmates and detainees are frequently from populations at high risk of tuberculosis. Moreover, the disease is easily transmitted to other inmates and staff in congested correctional facilities like WCDC.

D. Medical Staffing, Policies and Procedures

The deficiencies in the Detention Center's chronic care and access to medical services are largely due to inadequate staffing and a lack of written policies and procedures. WCDC operates its medical department with very few written policies or procedures. The lack of routine procedures, for example, a policy governing follow-up appointments for individuals with chronic medical conditions, jeopardizes the care provided to inmates and detainees.

In addition, WCDC has inadequate medical staffing to meet the needs of its population of over 500 inmates and detainees. The facility provides only 16 hours of physician staffing per week and fails to utilize these hours in an optimal manner. In particular, the physician uses a large portion of his time performing routine clinical activities, such as sick call evaluations or treating individuals with less medically significant sick call complaints, that could be performed by nursing staff. However, WCDC's nurse practitioner spends much of her time answering phones and filing charts, instead of providing sick call evaluations, because WCDC does not employ any administrative staff for the medical unit. Because of these staffing shortages, medical records for inmates and detainees are extremely disorganized, jeopardizing the continuity of care.

III. Mental Health Care

The Detention Center's mental health treatment is deficient, resulting in a number of untimely mental health interventions. In addition, there are deficiencies in WCDC's medication distribution. These problems are largely caused by a lack of staffing, space and mental health policies and procedures, including a quality assurance system. While mental health screening was previously a problem at WCDC, the addition of two forensic screeners in July 2000, has remedied this problem.

A. Mental Health Treatment

WCDC does not provide adequate mental health treatment, which may exacerbate the condition of inmates and detainees with mental illnesses.

The Mental Health Unit, which houses 12 individuals, fails to provide any meaningful mental health treatment. Treatment plans are not developed for mentally ill inmates and detainees, although many have significant mental illnesses. Psychiatrist coverage is also insufficient to provide adequate evaluation and treatment. WCDC provided only two hours of psychiatric services per week for all inmates and detainees combined at the time of our tour. We understand that WCDC now provides four hours of psychiatric services per week, an amount that is still insufficient. Group therapy is not provided to inmates and detainees in the Mental Health Unit because of a lack of space and staff resource limitations. Inmates and detainees in this unit should have more than psychotropic medication and custodial care to address their severe and persistent mental health needs.

Further, mental health interventions often are untimely, posing the risk of further deterioration and harm to inmates and detainees. For example, an April 20, 2000, intake referral indicated an inmate was taking Zyprexa, which is used to treat schizophrenia and bipolar disorder, prior to arrival at WCDC. It appears, however, that this inmate first saw the psychiatrist two months later, and was only prescribed medication by WCDC on June 29, 2000.

Similarly, an inmate, whose presentation was consistent with schizophrenia, was placed in the Mental Health Unit in April 1999. A mental status examination in May 1999, concluded this inmate's medications should be adjusted. However, he was not seen by a psychiatrist between June and December 1999. This untimely intervention had been corrected for this individual inmate by the time of our tour and he appeared reasonably stable.

Finally, WCDC does not have sufficient housing designated for inmates and detainees with significant mental illnesses. While the Mental Health Unit can accommodate 12 individuals, the staff estimated that 25 to 30 male and five female inmates and detainees met the criteria for treatment in the Mental Health Unit. In addition to this lack of space, the cells in the Mental Health Unit were very dirty and malodorous.

B. Medication Distribution

WCDC's staff acknowledged a high rate of medication non-compliance among the mental health caseload of inmates and detainees. Improper administration of medications required by mentally ill inmates and detainees can exacerbate their mental illnesses or cause relapses. As noted above, medical records are very disorganized, which makes monitoring of medication compliance extremely difficult and increases the likelihood of non-compliance. The Detention Center's distribution of medication is also compromised by its use of off-duty correctional officers without adequate oversight and quality assurance. This practice increases the likelihood that mentally ill inmates and detainees will not receive timely and necessary interventions from mental health staff and may increase medication non-compliance.

C. Mental Health Staffing, Policies and Procedures

The deficiencies in WCDC's mental health care are largely due to a lack of staffing, mental health policies and procedures and a systematic quality improvement process.

Mental health staffing is a significant problem at WCDC. As noted above, the Detention Center's psychiatrist currently provides only four hours of coverage per week even though it houses approximately 60 to 80 individuals with serious mental illnesses, about 25 to 30 of whom meet the criteria for placement in the Mental Health Unit.

In addition to the four hours of psychiatric coverage, WCDC has 1.33 full time equivalent ("FTE") case manager positions. While the case workers are dedicated and hardworking, they lack sufficient credentials to provide diagnostic assessments or mental health therapy. Moreover, WCDC has failed to supervise the caseworkers adequately. These case workers used to report to the Program Manager for Forensic Services, but this position was abolished. These shortages contributed significantly to the untimely mental health interventions described above.

As with medical care, the lack of site-specific, written policies and procedures governing mental health services jeopardizes the care provided to inmates and detainees. Further, the overall quality of mental health care at WCDC is diminished by the lack of a quality improvement process. WCDC lacks a systematic method of identifying problems or designing solutions in order to improve the provision of care. The absence of a systematic process makes it extremely difficult to develop and implement the changes needed in mental health services at WCDC.

D. Mental Health Screening

Mental health screening must be performed in a timely manner to identify critical needs and prevent suicide and deterioration of an individual's mental health. Since July 2000, WCDC has utilized two FTE forensic screeners to conduct mental health screening examinations. The screeners examine all inmates and detainees admitted to WCDC who are not released from the Detention Center within 24 hours. This system appears to work well and it or a similar system is critical for identifying inmates and detainees with mental illnesses in a timely fashion. WCDC funds the screeners through a yearly grant. We

understand that the grant was renewed and is currently in effect. Continuation of this program is important as our review of medical records demonstrates that, prior to the implementation of the screening program, WCDC failed to conduct adequate mental health intake screening.

IV. Inmate and Detainee Safety

Inmates and detainees are constitutionally entitled to incarceration in an environment that offers reasonable protection from harm. WCDC's use of force and force reporting practices and policies are deficient. In addition, the Detention Center's security administration is deficient, posing a risk of injury to inmates and detainees.

Our investigation also examined the Detention Center's use of restraints, particularly the use of the restraint chair. The Detention Center appears to have used the restraint chair infrequently in the three years prior to our site visit and our review of those incidents did not reveal constitutional problems, although we noted a lack of sufficient detail in reporting its use. In addition, our consultants noted some problems in WCDC's restraint policies, such as the restraint chair policy does not set a limit on the maximum length of time an inmate or detainee may be restrained.

A. Use of Force

Our review of incident reports revealed a number of inappropriate and/or unnecessary uses of force by WCDC staff. For example, an inmate on suicide watch was punched in the eye by an officer because he "started to spit" on the officer again. Another inmate, who was locked in a medical cell, was sprayed with a chemical agent because he "tried to spit" at a passing officer. The officer later asked if the inmate wished to see a nurse, received no reply and so apparently took no further action. WCDC policy requires approval from the Warden or his/her designee before using chemical spray on an inmate in a cell and that individuals sprayed with chemical agents be given medical treatment immediately. Although the report indicated neither was done in this case, the Duty Supervisor concluded the use of force was appropriate.

Similar issues were raised when the staff performed a cell extraction of an inmate who refused to return his food tray and apparently threatened to throw bodily fluids at officers. One officer reported that the inmate had stabbed another officer on a previous occasion, so extra precautions were taken. During the course of the extraction, which was supervised by a high-ranking official, the officers used both pepper spray and the stun shield. The staff then wrapped a towel around the inmate's head, apparently to prevent spitting. Several problems with the force used in this incident should have prompted further review by WCDC administrators, including the use of chemical agents in conjunction with the stun shield, the use of a towel to wrap the inmate's head after use of the chemical agent and stun shield and the failure to check for contra-indications. However, the only documented review of this incident was performed by officers directly involved in the use of force.

As evidenced by these incidents, the problems with the use of force at WCDC are perpetuated by deficiencies in its policies and practices on reporting and reviewing the use of non-deadly force. While the policy requires a report be prepared, it only requires minimal information regarding the incident. In addition, the policy does not require an independent investigation of use of force by the staff. Finally, the policy does not address videotaping cell extractions, or photographing injuries resulting from a use of force.

Although there was no final policy on the use of electronic restraints, we were provided with a draft policy. The draft does not identify conditions where it should not be used, such as when water is present

or when aerosol chemical agents are used. Moreover, it does not require a check for medical contra-indications. These gaps in policy expose inmates and detainees to an increased risk of physical harm.

B. Security Administration and Protection from Harm

WCDC does not adequately protect inmates and detainees from harm. This is due to problems in the classification and housing of inmates and detainees, understaffing, inadequate training and surveillance problems.

A system of inmate housing based upon objective, behaviorally-based criteria is critical to providing a reasonably safe environment. Based on our investigation, WCDC utilizes an objective classification system (dividing inmates and detainees into minimum, medium and maximum security) and classifies inmates and detainees in a timely fashion. However, WCDC does not have the flexibility in housing space required to separate the population by classification because it is so crowded.

New inmates and detainees are randomly assigned a bed, based on availability. While some mixing of classifications is not unusual, such as minimum with medium security, mixing minimum security inmates with maximum security inmates increases the risk of inmate violence against other inmates. WCDC does not have protocols for what classifications should be mixed, for how long or with what precautions. For example, it is inappropriate to mix minimum security inmates or detainees with maximum security individuals who have recently engaged in assaultive behaviors.

The Detention Center's ability to protect inmates and detainees from harm is also compromised by understaffing. WCDC had approximately 90 line officers available for assignment in the general population areas at the time of our visit. There were several indications of this shortage. For example, there are often only one or two movement officers per shift in the entire facility to fulfill a wide range of duties, from supervising inmates and detainees participating in programs to assisting in inmate and detainee meal distribution. Similarly, there were no officers with fixed-post assignments in Special Housing. This staffing shortage compromises the delivery of basic services and security functions, such as rounding and escorting inmates and detainees. These sorts of lapses in security increase the likelihood of inmate violence, escapes, and suicides. The problems arising from the staffing shortage at WCDC are aggravated by the lack of a centralized staffing roster to evaluate shortages and inadequate training, particularly a lack of training on use of force tactics and the use of restraints.

Currently, WCDC requires its staff to conduct three rounds of inmate-occupied areas per shift. We noted several problems with WCDC's inmate surveillance equipment and procedures that increase the risk of physical harm to inmates and detainees and, therefore, increase the importance of rounding by the staff of these areas. For example, the one-way glass in the control centers for B and C Blocks impairs sight lines into the individual pods of these cellblocks. The view of some areas of these pods are also obstructed, such as the areas where inmates and detainees are housed under the stairwells. Rounds of areas out of direct sight of the control center should be performed more frequently than three times per eight-hour shift.

V. Environmental Health and Safety

WCDC's environmental health and safety practices and procedures are deficient in the following areas: sanitation; food service; inmate clothing, bedding and supplies; and physical plant.

WCDC is significantly overcrowded, exacerbating the unconstitutional conditions we identified at the facility. Specifically, overcrowding at WCDC increases the risk of the spread of infection and, as

discussed above, the difficulty ensuring inmate and detainee security. For example, space in the Male Work Release Unit and the Kitchen Trustee dormitory is less than one-fourth that recommended by public health standards to minimize the spread of secondary infections and provide safe egress during an emergency. Problems with overcrowding are magnified on weekends, because the Detention Center must house a number of weekend detainees. During our visit, five female weekenders were housed in one cell in the booking area. These inmates had no out-of-cell time, no shower access and limited hygiene opportunities for three days.

A. Sanitation

We found several problems with WCDC's sanitation practices that pose significant health risks. The most significant deficiency was that the trays used for food service are not properly sanitized between uses posing a risk of spreading food-borne illnesses. The dishwasher used for cleaning the trays cannot handle the volume of trays processed at the facility, did not reach the necessary pasteurization temperature of 160 and the spray from the dishwasher does not adequately clean the food contact surface. Because of these problems, inmate workers use unsanitary rags to remove food from the trays after they are taken from the dishwasher.

Inmate staff in the kitchen do not practice basic hand-washing techniques. For example, we observed an inmate portioning food without gloves or washing his hands. Even with proper instruction, there was no soap at the hand-washing sink in the kitchen and it was used for utensil storage during food preparation. We also noted problems in the infirmary, where the sinks are not elbow or foot operable, allowing cross contamination.

We observed a number of other sanitary problems during our tour. In the kitchen, several areas were not adequately sanitized, such as the can opener and a baker's table used for food preparation, and the food-tray preparation area was too close to the tray scrapping and rinsing area. In the dental clinic, we observed what appeared to be mucus on the handles of the examination light and there was also no biological monitoring device to ensure the autoclave was providing proper sterilization. Many cells and sleeping areas were very dirty, increasing the risk of illness spreading. Cleaning supplies and implements are not readily available, especially in the medical and specialty housing areas, and inmates do not have scheduled access to cleaning supplies.

B. Food Service

We observed deficiencies in food preparation and storage at WCDC. The Detention Center fails to heat foods sufficiently during cooking or maintain them at temperatures high or low enough to minimize microbial growth, which may result in the spread of food-borne illnesses. For example, during our visit, we found the temperature of three hotel pans of recently reconstituted mashed potatoes significantly below the temperature level necessary to prevent microbial growth. In addition, we observed trays of prepared food sitting out for over one hour. After this amount of time, foods were no longer hot or cold enough to minimize the risk of spreading food-borne illnesses.

Similarly, there were deficiencies in temperature control in the walk-in refrigerator. During our visit, the temperature measured was too high to minimize microbial growth, increasing the risk of spreading food-borne illnesses.

C. Inmate Clothing and Supplies

There are deficiencies in WCDC's issuance and maintenance of clothing and bedding that result in

unsanitary conditions, facilitating the spread of disease. While the INS detainees at the Detention Center appear to receive the full allotment of clothing and bedding, most of the other detainees and inmates are issued only one set of each. Moreover, the supplies that are issued are not properly maintained.

Most of the mattresses observed in WCDC were in extremely poor condition, including those in the infirmary. The plastic covers were cracked, soiled and flaking off, making them impossible to sanitize between inmates and detainees.

During our tour, we observed numerous prisoners wearing extremely soiled underwear and jump suits and most of the sheets we observed were extremely soiled. As noted above, most inmates are issued one set of clothing and bedding. In order for inmates to get their clothing cleaned, they must turn in their one set for several hours. As a result, many inmates do not surrender their clothing for laundry. Similarly, inmates complained that sheets and pillowcases were in short supply and, therefore, it was uncertain whether bedding sent to the laundry would be returned. The supply shortage at WCDC is exacerbated by problems with the laundry facility, including a lack of capacity and equipment failures. This poses a significant hygiene problem that facilitates the spread of disease.

D. Physical Plant

Our inspection revealed several health and safety concerns related to the facility's ventilation and plumbing systems. A detailed inspection of the ventilation system revealed that poor design, installation, and maintenance causes wide disparities in temperature and ventilation throughout the facility, and even between cells in the same cell block.

For example, 37 percent of the cells sampled had little to no air movement. In addition, the air in the female dormitory was stale, humid and malodorous, and we detected no air movement. Poor air circulation increases the risk of contracting respiratory infections and may exacerbate existing respiratory illnesses, particularly given the crowding at WCDC.

The hot water system supplies water at too high a temperature, apparently in an attempt to compensate for a lack of capacity. During off-peak periods, the hot water is significantly above scalding temperature. For example, the water supplied to the infirmary cells was measured at 152, 32 above scalding temperature. This poses a significant risk of physical injury to inmates and detainees.

VI. Recommended Remedial Measures

In order to rectify the identified deficiencies and to protect the constitutional rights of the facility's inmates and detainees, the Detention Center should implement, at a minimum, the following measures:

A. Medical Care

1. Develop site-specific written policies and procedures governing the provision of health care, including medication distribution.

2. Arrange for sufficient nursing staff to provide sick-call evaluations, supervise intake medical screenings, supervise the distribution of medication and provide back-up nursing coverage in case of illness or vacations.

3. Provide physician staffing sufficient to ensure access to medical care, particularly for inmates and detainees with chronic conditions.

4. Provide sufficient and appropriate staffing to ensure that medical records are complete and accurate to maintain continuity of care.

5. Develop and implement a policy that ensures access to sick call for inmates and detainees in the BAU.

6. Provide all necessary medical care to indigent inmates and detainees, particularly medically indicated eyeglasses.

7. Begin a chronic care program that includes appropriate screening, monitoring and follow-up care.

8. Require tuberculosis testing of all inmates and detainees, unless there is documentation that the individual tested negative within the preceding three months or previously tested positive for tuberculosis.

B. Mental Health Care

1. Develop comprehensive site-specific mental health care policies and procedures, including medication distribution.

2. Ensure that mental health care records are complete and accurate to maintain continuity of care, particularly regarding the administration of medications.

3. Obtain additional mental health care staffing, including additional licensed mental health clinicians and psychiatric services sufficient to ensure adequate diagnostic assessments, mental health treatment and therapy, timely mental health intervention and adequate record keeping.

4. Develop and implement enhanced mental health programming in the Mental Health Unit.

C. Security and Protection from Harm

1. Develop and implement a protocol for housing inmates and detainees based on their classification. This protocol should address what classification levels may be mixed, under what circumstances and establish time limits on how long they may be mixed. It should also address identifying and acting to separate individuals within a classification who should not be mixed.

2. Hire sufficient staff to supervise inmates and detainees and ensure the safety and security of inmates, detainees and staff.

3. Design and implement a system for tracking security staffing throughout the institution.

4. Provide security staff with sufficient training, particularly in-service training regarding use of force, restraints and chemical agents.

5. Ensure frequent and documented rounds are made by staff for inmate areas that are not observable from the control centers.

6. Develop and implement a policy that requires adequate reporting and independent review of use of force by the staff.

7. Change the policy on the use of chemical agents to require decontamination procedures and a check for medical contra-indications before use, if time permits.

8. Develop and implement policies regarding the use of restraints.

D. Environmental Health and Safety

1. Repair the ventilation system to operate properly and then maintain its proper operation.

2. Ensure food is stored, prepared, and served in a sanitary manner.

3. Provide appropriate access to cleaning supplies to inmates and detainees in the housing areas.

4. Provide mattresses that can be properly sanitized between inmates or detainees.

5. Provide adequate laundry facilities for the demand at the Detention Center and issue all inmates two full sets of clothing and bedding so that they may be properly laundered.

6. Adjust the temperature of the hot water supplied to inmate areas to below the scalding temperature of 120.

7. Implement proper sanitation practices in the dental clinic.

We will forward our expert consultants' reports under separate cover. Although the experts' reports and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

Pursuant to CRIPA, the Attorney General may institute a lawsuit to correct deficiencies of the kind identified in this letter forty-nine days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you, and we have every confidence that we will be able to do so.

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General

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