U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

DEC - 8 2006

The Honorable Margaret Keliher
Presiding Officer
Dallas County Commissioners Court
411 Elm Street, 2nd Floor
Dallas, TX 75202

Re: Investigation of the Dallas County Jail, Dallas, Texas

Dear Judge Keliher:

On November 28, 2005, we notified you of our intent to investigate conditions at the Dallas County Jail ("DCJ" or "the Jail"), in Dallas, Texas, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Consistent with our statutory requirements, we write to report the findings of our investigation and to recommend remedial measures to ensure that DCJ meets federal constitutional requirements. See 42 U.S.C. § 1997b.

From February 20-24, 2006, and from March 20-23, 2006, we conducted on-site inspections of DCJ with consultants in the fields of correctional medical care, correctional mental health care, and environmental health and safety. While on-site, we interviewed administrative and security staff, medical and mental health care providers, and inmates. Before, during, and after our on-site inspections, we received and reviewed a large number of documents, including policies and procedures, incident reports, grievances, medical and mental health records, and other records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided extensive debriefings at the conclusion of our inspections, during which our consultants expressed their initial impressions and concerns.

In July 2006, we received updated information regarding the efforts the Jail is undertaking to address many of the problems cited by our consultants during the two exit interviews and that are discussed herein. We are encouraged by the County's prompt efforts to address deficient conditions at DCJ.

We appreciate the full cooperation we received from County and DCJ officials throughout our investigation. We also wish to extend our appreciation to the Sheriff and the staff and administration at the Jail for their professional conduct and timely responses to our requests.

Having completed the fact-finding portion of our investigation of the Jail, we conclude that certain conditions at DCJ violate the constitutional rights of inmates confined there. As detailed below, we find that DCJ fails to provide inmates with: (1) adequate medical care; (2) adequate mental health care;[1] and (3) safe and sanitary environmental conditions.

I. BACKGROUND

A. DESCRIPTION OF DCJ

The Dallas County Jail is operated by the Dallas County Sheriff's Office ("Sheriff's Office") and is the seventh largest detention facility complex in the country. DCJ receives 90,000-100,000 admissions per year, 57% of which are released within three days, and 68% within seven days. As of February 20, 2006, the Jail housed approximately 7,770 inmates, both pre-trial and sentenced, in five separate adult facilities: the Suzanne Kays Detention Facility; the Decker Detention Facility; the George Allen Courts Building; and the adjoining Lew Sterrett Center Tower Facilities ("Lew Sterrett").

Most of the inmate population is housed in Lew Sterrett which includes: an intake area for all of DCJ; a medical infirmary; the majority of the Jail's behavior observation cells for inmates with mental illnesses; housing for female inmates, including female observation cells; a male geriatric unit; a unit for juveniles; and a large general population. The George Allen facility has a female infirmary and houses both men and women of all classification levels. The Decker Detention facility is a

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[1] We note that in late 2004, the Dallas County Commissioner's Court commissioned a study of medical and mental health care, the results of which became public in February 2005, and are consistent with the findings contained herein.

minimum-security facility which houses both male and female inmates. Lastly, the Suzanne Kays facility is a minimum-security facility that houses both male and female inmates.

The Sheriff's Office is responsible for all operations of the Jail, including classification, physical plant and services, security, escort, and transportation for inmates. From October 2002 through February 2006, medical and mental health care services at the Jail were provided by the University of Texas Medical Branch at Galveston ("UTMB") through a contract monitored by Parkland Health and Hospital System ("Parkland"). Parkland began providing medical and mental health care effective March 1, 2006.

II. LEGAL FRAMEWORK

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of jail detainees and inmates subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997. Pre-trial detainees, individuals who have not been convicted of the criminal offenses with which they have been charged, comprise the majority of inmates at the DCJ. The rights of pre-trial detainees are protected under the Fourteenth Amendment which ensures that these inmates "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979) (applying the Fourteenth Amendment standard to a facility for adult pre-trial detainees); Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996) (finding that a municipality assumed a Constitutional obligation under the Fourteenth Amendment to provide pre-trial detainees with minimal levels of safety and security); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir. 1996) (en banc), rev'd on other grounds, 135 F.3d 320, 326 (5th Cir. 1998) (recognizing a "pretrial detainee's constitutional right to be secure in his basic human needs, such as medical care and safety...").

In Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996), the Fifth Circuit has held that the protection of pre-trial detainees' rights under the due process clause of the Fourteenth Amendment is "at least as great as the Eighth Amendment protections available to a convicted prisoner." Id. (quoting City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983)). Under the Eighth Amendment, prison officials have an affirmative duty to ensure that inmates receive adequate food, clothing, shelter, and medical care. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell, 441 U.S. at 535-36, 537 n.16; Scott, 85 F.3d at 235; Hare, 74 F.3d at 639. The Eighth Amendment

protects prisoners not only from present and continuing harm, but also from future harm. Helling v. McKinney, 509 U.S. 25, 33 (1993).

Detainees have a constitutional right to adequate medical and mental health care, including psychological and psychiatric services. Farmer, 511 U.S. at 832; Gates v. Cook, 376 F.3d 323, 332 (5th Cir. 2004). Inmates' Eighth Amendment rights are violated when prison officials exhibit deliberate indifference to their serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 102 (1976). The standard for adequate medical and mental health care requires a showing of both the subjective and objective components of "deliberate indifference." Gates, 376 F.3d at 333. Deliberate indifference may be inferred when a prison official "knows of and disregards an excessive risk of inmate health." Farmer, 511 U.S. at 837. Prison personnel exhibit "deliberate indifference" to an inmate's health when they refuse to treat him, ignore his complaints, intentionally treat him incorrectly or "engage in any similar conduct that would clearly evince a wanton disregard for any serious medical needs." Domino v. Texas Dep't Of Criminal Justice, 239 F.3d 752, 756 (5th Cir. 2001).

III. FINDINGS

A. MEDICAL CARE

DCJ fails to provide inmates with adequate medical care that complies with constitutional requirements. We found the following serious deficiencies: (1) inadequate intake screening; (2) inadequate acute care; (3) inadequate chronic care; (4) inadequate treatment and management of communicable disease; (5) inadequate access to health care; (6) inadequate follow-up care; (7) inadequate record keeping; (8) inadequate medication administration; (9) inadequate medical facilities; (10) inadequate speciality care; (11) inadequate staffing, training, and supervision; (12) inadequate quality assurance; and (13) inadequate dental care.

1. Inadequate Intake Screening

DCJ fails to adequately identify inmates' health needs through appropriate intake screening, thereby preventing inmates from receiving adequate care for acute or chronic needs. Generally accepted correctional medical standards require that incoming inmates be screened by staff trained to identify and triage serious inmate medical needs, including drug and alcohol withdrawal, communicable diseases, acute or chronic needs, mental

illness, and potential suicide risks. DCJ's intake screening process fails to identify such needs and places inmates at risk of serious harm.

Prior to March 1, 2006, detention officers, who lacked adequate training and medical supervision, were responsible for conducting intake screenings. On March 1, 2006, DCJ began using paramedics to perform intake screenings. While this staffing change is an improvement, the intake screening process remains deficient because there are no medical policies governing the intake process and signs and symptoms of serious illness or contagious disease go unrecorded. Further, the screening form used by DCJ lacks sufficiently specific questions regarding acute and chronic illness, including drug and alcohol withdrawal. Moreover, screening interviews are conducted with a total lack of privacy, further compromising the quality of information received. These practices contravene generally accepted correctional medical standards and place inmates at significant risk of harm. The following examples illustrate the intake screening deficiencies.

- Inmate P.C.[2] was booked into DCJ on February 21, 2006. Although he was diagnosed with alcohol withdrawal, the screening process failed to identify that he was suffering from delirium tremens, a potentially life-threatening complication of alcohol withdrawal. As a result, P.C. did not receive appropriate medical care. Two days after intake, our medical consultant examined P.C. and found that he was acutely psychotic with tremors, delusions, and hallucinations. It was only after we brought his conditions to DCJ's attention that P.C. was transferred to the hospital for necessary care.

- Inmate A.L. died in October 2005, two days after being booked into DCJ, of diabetic ketoacidosis, a life-threatening complication of diabetes. At intake, A.L.'s blood sugar level was recorded at a dangerously high level yet he received no physician care while at DCJ. We note that while this incident occurred prior

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[2] Throughout this letter, when referring to a specific inmate, we use pseudonymous initials to protect the identity of the inmate. We are providing to the County a key to the identity of inmates referenced in this letter under separate cover.

to the March 1, 2006 change, this type of deficiency can recur given that DCJ lacks policies and procedures to govern its intake process.

- Inmate A.N. suffered from HIV and died on October 5, 2005 of pneumocystis pneumonia, an opportunistic infection, which could have been prevented if he had continued to receive the antibiotic he was prescribed at the time he was admitted to DCJ. The Jail failed to provide A.N. with this prescription for 11 days following intake.

- In December 2004, DCJ transferred inmate Q.S. to the hospital where he died of alcohol withdrawal. Q.S. had been admitted to DCJ a week prior with a history of alcoholism and seizures during alcohol withdrawal. Within four days of intake, he became disoriented, developed a fever, and had an elevated blood pressure. Q.S. was kept in the facility with no physician or nursing care, and no monitoring of his vital signs. Q.S. soon became lethargic and was later discovered lying in his feces. After finding him in this state, it took an additional five hours before Q.S. was transferred to the hospital where he subsequently died.

DCJ's intake screening process also fails to identify the health needs of juveniles, notwithstanding this population's particular vulnerabilities to mental illness and suicide. On February 20, 2006, DCJ had 11 juveniles in custody. Only six had a medical screening, and none had been screened for suicide risk. On March 21, 2006, there were also 11 juveniles in custody, but only two had a medical screening. There were no medical evaluations for those juveniles with asthma or for a youth with a history of being on pyschotropic medications.

Finally, DCJ inmates do not receive a full health assessment within a reasonable period after admission. The generally accepted correctional medical standard is to conduct health assessments within two weeks of admission. Appropriate and timely health assessments reduce the risk of harm should screening procedures fail to identify an inmate's serious health needs and improves the facility's ability to provide efficient, adequate care. Typically, this assessment includes a review of the intake information, a complete medical and mental health history, a physical examination, and screening for TB and sexually transmitted diseases. Approximately one in four inmates are still at DCJ two weeks after intake and many do not receive a

health assessment. At DCJ, the need for a prompt assessment is compounded by the inadequacies in the intake screening process described above.

2. Inadequate Acute Care

DCJ fails to provide inmates adequate acute care, that is care for urgent and/or emergent medical conditions. Jail staff frequently mismanage inmates' acute medical needs, thereby significantly delaying appropriate medical care. Most seriously, we found numerous instances where DCJ's mismanagement contributed to preventable deaths, hospitalizations, and unnecessary harm.

Correctional facilities should provide adequate nursing and physician care for the treatment of serious and emergent conditions. Jail staff should be adequately trained and prepared to manage emergent situations in accordance with generally accepted correctional medical care standards. DCJ's failure to provide such care has subjected inmates to serious harm. The following examples highlight DCJ's deficiencies in providing acute care:

- In early 2006, inmate E.E. suffered a severe leg infection as a result of DCJ's failure to provide adequate acute care both prior and subsequent to his hospitalization for a severe leg wound. Notably, even after E.E. was discharged from the hospital, DCJ failed to treat him in accordance with the directions provided in his hospital discharge instructions. E.E. received inadequate care for an additional five months. In fact, his care was so deficient that he was released by court order so that he could obtain medical care outside of DCJ.

- On April 28, 2004, inmate C.D. sustained trauma to his left eye. Although Jail staff were aware of the injury, C.D. was not seen by a physician for seven days, until he was hospitalized. By this time, C.D.'s injury was inoperable and he is now blind in that eye.

- Inmate A.F. died on February 1, 2004 after not receiving adequate care for an emergent and life threatening condition. A.F., who suffered from HIV, was admitted to DCJ in October 2003. In late December, Jail staff ordered an x-ray after A.F. complained of chest pain. Over two weeks passed before his x-ray was taken. During the interim, he developed pneumocystis pneumonia, a life-threatening condition. The results

of A.F.'s x-ray were not reviewed until late January 2004. On January 31, 2004, a physician who had reviewed A.F.'s chart ordered that A.F. be brought to him the next day. A.F. died prior to seeing the physician.

3. Inadequate Chronic Care

DCJ fails to provide constitutionally adequate care to meet the serious medical needs of inmates with chronic medical conditions. See, e.g., Lawson v. Dallas County, 112 F. Supp. 2d 616, 637 (D. Tex. 2000) aff'd 286 F.3d 257 (5th Cir. 2002) (finding deliberate indifference where prison officials, aware of an inmate's deteriorating medical condition, failed to administer required medication and treatment). See also Domino v. Texas Dep't of Criminal Justice, 239 F.3d 752, 756 (5th Cir. 2001) (finding deliberate indifference where jail staff had refused to treat, ignored complaints of, or intentionally mis-treated an inmate despite serious medical need). Jail staff may not effectively deny, substantially delay, or refuse care for an inmates' serious medical needs. See Stewart v. Murphy, 174 F.3d 530, 537 (5th Cir. 1999) citing cf. Hudson v. McHugh, 148 F.3d 859, 863-64 (7th Cir. 1998) (noting deliberate indifference where jail officers and nurse refused to address an inmate's repeated requests for epilepsy medicine despite knowing of his serious medical need).

Inmates who suffer from chronic medical conditions require ongoing coordinated care and treatment to prevent the progression of their illnesses. DCJ has no clinical practice guidelines for chronic and communicable diseases, such as diabetes, asthma, hypertension, HIV and sexually transmitted diseases. In particular, DCJ's care for inmates with chronic medical conditions fails in two areas: (a) assessment of chronic conditions; and (b) timely and adequate follow-up medical treatment, including proper medication administration.

a. Failure to Assess for Chronic Conditions

Generally accepted standards of correctional medical care require that medical staff be able to identify inmates in need of chronic care and provide timely treatment or referrals for inmates' chronic conditions. DCJ fails to ensure that inmates receive thorough assessments and monitoring of their chronic illnesses. The Jail has no established policies and procedures for identifying and caring for inmates with chronic illnesses or

diseases. DCJ inmates with chronic conditions are not routinely identified and assessed at intake or shortly thereafter. As a result, no plan is made for their ongoing assessment and monitoring. Moreover, inmates with chronic conditions are not routinely seen by a physician to evaluate the status of their health and the effectiveness of the medication they are taking for their chronic conditions.

Additionally, DCJ intake nurses are not adequately trained to identify inmates with chronic conditions, and commonly fail to administer standard tests for treatment and prevention of medical complications, including blood tests for diabetics and peak air flow measurements for asthmatics. Without such routine tests, it is not possible to identify those who require urgent medical care and for medical staff to appropriately monitor inmates with these chronic illnesses.

b. Inadequate Follow Up Treatment and Medication Administration

Care for inmates with chronic conditions is plagued by delays in the treatment and administration of medication. Delays begin during the Jail's intake routing process and are exacerbated by overall inadequacies in the medical care system. Our review of inmate medical records revealed consistent significant delays for inmates receiving care for chronic conditions. Such delays increase the risk of harm to inmates and the likelihood that their chronic conditions may worsen. This deficiency was acknowledged by DCJ's medical director, who reported to us that inmates commonly wait two to three weeks before receiving medications following intake.

Inmates who are identified with chronic health conditions are often not scheduled for follow-up medical assessment. Rather, they are transferred to their housing unit, where they must avail themselves of the deficient processes described below, to seek further medical care. Consequently, inmates with chronic medical needs are routinely not seen timely by clinicians. During our investigation, we reviewed the medical charts of 18 inmates admitted to DCJ on February 13, 2006. Five of these inmates had a history of chronic disease yet, according to their medical records, one week later none had been seen by DCJ medical staff. Such delays are contrary to generally accepted standards of correctional medical care and expose inmates with chronic

conditions[3] to significant and unnecessary risk of harm. For example, Inmate Y.G. died of heart failure within 20 days of arriving at the Jail in October 2004, because he was unable to get care for his multiple chronic conditions and abdominal swelling (a symptom of heart failure). Despite efforts by both Y.G. and his sister to get the Jail to treat his diabetic and heart conditions, DCJ failed to administer Y.G.'s medication.

The lack of coordinated care for chronic conditions is particularly dangerous for diabetic inmates. As part of our review, we randomly selected 12 inmates from those designated as diabetics by DCJ. In a gross departure from generally accepted medical standards, none of the 12 inmates had been tested for two standard indicators of their diabetic condition and potential complications. Additionally, only nine of the 12 inmates had blood sugar measurements taken during intake; six did not receive their first dose of medication for a period ranging from six days to two months after intake; and two never received medication. These failings were typified by our interactions with inmate A.R. who had been in medical housing at the facility for three weeks as of our February 21, 2006 tour. A.R. had received no insulin and Jail staff had failed to measure his blood sugar level. At our request, DCJ checked A.R.'s blood sugar and discovered that it was extremely high. A.R. was unnecessarily exposed to potentially life-threatening harm due to DCJ's failure to monitor his condition.

We found numerous additional instances of deficient chronic care that put inmates' health and lives at serious risk:

- Inmate B.P. has HIV, asthma, and a drug-resistant skin infection. Although B.P. reported during our February 2006 tour that he has prescriptions for three HIV medications, his medical record reveals that Jail staff were administering only one of these medications. The failure to administer all three of the prescribed medications may cause B.P. to develop resistance to HIV medication. Moreover, without his HIV medications, B.P. becomes more susceptible to potentially fatal skin infections.

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- Inmate N.T. has a seizure disorder. Although she suffered seizures on both October 10, and November 28, 2005, DCJ staff failed to order her seizure medication for several weeks, until February 16, 2006.

- Inmate B.Q. was admitted to the Jail in July 2005 but in February 2006 he reported to us that he was not receiving his HIV medication. A review of his medical record reveals that B.Q. had neither received his medication nor been evaluated by a physician during his seven months in custody.

- Inmate I.S. had five seizures at DCJ over a period of 12 days in December 2005. As of February 2006, she had not been seen by a physician for her condition. Our medical consultant reviewed her chart and found that I.S. had been prescribed a sub-therapeutic dosage of medication for her seizure disorders. I.S. remains at risk for repeated seizures.

- In July 2005, inmate L.E., who is bipolar and is HIV-positive, suffered repeated delays in receiving his medication each time he was transferred to a new cell. An examination of his medical record reveals that, with each of his four transfers, the Jail failed to administer his medication for periods ranging from four days to seven weeks.

4. Inadequate Treatment and Management of Communicable Disease

DCJ fails to adequately treat and manage communicable diseases. DCJ's management of tuberculosis ("TB"), Methicillin Resistant *Staphylococcus aureus* ("MRSA"),[4] and other infectious diseases deviates significantly from generally accepted

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[4] MRSA ("methicillin-resistant staphylococcus aureus") is a bacteria resistant to certain antibiotics, including methicillin, oxacillin, penicillin, and amoxicillin. Centers for Disease Control and Prevention, at http://www.cdc.gov/ncidod/hip/Aresist/ca_mrsa_public.htm. MRSA manifests itself as a boil or sore on the skin and is spread through contact with an infected person or a surface the person has touched. Id. In some cases, MRSA can have serious medical consequences, for example, by causing surgical wound infections, bloodstream infections, and pneumonia. Id.

correctional medical practices. Inmates with communicable diseases are not appropriately screened, treated, or isolated. Further, the crowded conditions at DCJ exacerbate the serious risk of spreading communicable disease among inmates and staff. We note that DCJ's inadequate practices pose a serious risk to DCJ inmates, staff, and even the Dallas community at large when the facility's high turnover is taken into account. Similar to the deficiencies in chronic care, DCJ lacks practice guidelines, based on generally accepted correctional medical standards, for managing and treating communicable diseases in a correctional setting.

a. Tuberculosis

Pulmonary Tuberculosis ("TB") is a potentially life-threatening disease commonly found in correctional facilities. The transmittal of TB can be prevented or controlled with an appropriate TB control plan. A TB control plan provides guidelines for identification, treatment, and prevention of transmission of TB to staff and other inmates. The Jail has acknowledged the necessity of developing and implementing a TB control plan that is consistent with generally accepted correctional medical standards, however, such a plan is not currently in place.[5] Consequently, we found deficiencies in: (1) screening; (2) containing; and (3) treating inmates for TB.

(1) Insufficient Screening

DCJ fails to adequately identify potential TB cases during intake screening, and fails to conduct timely and consistent clinical evaluations and diagnostic x-rays. These deficiencies expose inmates, staff, and the Dallas County community to an unnecessarily high risk of transmission.

Inmates who display symptoms of TB should be assessed and screened for exposure in a timely manner to facilitate the provision of any needed care. Screening tools include skin-

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[5] On April 3, 2006, we notified the County of specific instances of emergent medical concerns that required immediate attention, including the creation and implementation of an effective TB control plan. The County responded on April 10, 2006, and stated that there was a TB screening team and program in place at the Jail. However, our review of the documents indicated a continued lack of appropriate planning to screen and treat inmates, and to contain TB transmission in accordance with general standards of care.

testing (for exposure) and chest x-rays, as needed. TB screening programs are intended to identify inmates who require treatment as well as to determine if certain inmates require isolation to limit the risk of transmission.

TB-suspect inmates at DCJ must contend also with the deficiencies in care noted previously. There is a lack of necessary policies and procedures; inadequate follow-up care and assessment; and significant lags in inmates' receiving appropriate diagnosis and medication. Tests are not consistently performed on inmates who display symptoms of TB, contrary to generally accepted correctional medical care standards. For example, on January 15, 2006, inmate J.M. was coughing up blood, a symptom of possible TB. Yet, by late March 2006, over two months later, J.M. had not received a chest x-ray to identify or rule out TB.

Overall, our review of DCJ's screening program yielded disconcerting results. Nationwide, 15 to 25% of inmates have latent tuberculosis. Yet, at DCJ, only 2% of the 11,668 TB skin tests read between December 1, 2005 - February 28, 2006 were read as positive. Such a low percentage identified, compared to the national average, suggests that Jail staff are either not conducting or interpreting tests properly.

Additionally, we found a several week backlog for x-rays of inmates suspected of having TB. Our review of the Jail's computer system revealed that on March 21, 2006 the unanswered backlog for x-rays reached 891. As a result, inmates who are TB-suspect are inappropriately housed with the general inmate population, while they wait weeks for chest x-rays.

(2) Insufficient Containment

DCJ fails to ensure the adequate containment of TB. Inmates with suspected TB should be placed in specialized respiratory isolation ("negative pressure") rooms to reduce the risk of transmission through airborne particles. When properly used, these rooms are effective in preventing contagion. In addition, staff who are potentially exposed to the risk should wear and be trained in the use of specialized respirators. However, DCJ does not comply with these generally accepted standards of care.

The risk of TB transmission is heightened by DCJ's practices and inattention to precautionary measures. DCJ's negative pressure isolation cells in the Jail are sufficient and capable

of creating negative pressure when properly utilized and maintained. However, we observed both inmate and staff conduct that defeat the negative pressure systems by leaving open cell doors and feeding ports (slots in cell doors through which inmate meals can be delivered). We also observed an inmate diagnosed with active tuberculosis defeating the system by covering the HVAC return vent with newspaper without effective staff intervention. Additionally, DCJ staff fail to take appropriate precautions in isolating inmates with active TB because such inmates are not consistently identified. DCJ uses its respiratory isolation cells to house inmates with active TB and also for overflow housing of general population inmates. Nonetheless, DCJ does not consistently identify those inmates who are placed in respiratory isolation cells for medical reasons.

(3) Inadequate Treatment

DCJ fails to ensure that inmates with TB receive complete treatments to decrease the risk for the emergence and transmission of multidrug-resistant TB.[6] Treatment for TB requires at least a six-month course of antibiotics. Interruptions in an inmate's antibiotic treatment can lead to the development of multidrug-resistant TB.

DCJ's failures to adequately treat and manage communicable diseases has potentially resulted in inmates and staff being exposed to active TB. The following examples are illustrative:

- Inmate C.C. waited over two months to have an x-ray for suspected TB. Despite a medical order on January 9, 2006, the x-ray was not taken until two months later, on March 18, 2006. As a result of the x-ray, C.C. was then put into medical isolation.

- Inmate C.T. complained of coughing up blood and night sweats (both symptoms of active TB) seven days after admission to DCJ on March 14, 2006. Our review of his medical chart revealed that C.T. had not had an intake examination, chest x-ray, or evaluation by medical staff.

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[6] Multidrug-resistant tuberculosis is a variant of the tuberculosis bacteria that resists treatment with several anti-tuberculosis drugs. If the wrong medications are used, this condition is fatal in 25% of cases and can be transmitted to others who come into close contact with the patient in a confined space.

- Inmate C.V. was admitted to DCJ on January 6, 2006, with a history of treatment for active TB during the preceding two months. His diagnosis was confirmed to be multidrug-resistant TB on January 13, 2006, yet C.V. was not seen by a physician for 11 days, nor did he receive any treatment in the interim.

- Inmate C.X. had been on TB medication for five weeks prior to admission to DCJ on February 14, 2006. C.X., however, was not put on medication necessary to complete his treatment and was thus exposed to developing multi-drug resistant TB.

b. Skin Infection

DCJ fails to adequately manage contagious skin infection. Generally accepted correctional medical care standards dictate that a jail adopt a skin infection control plan to guide the prevention of transmission of skin infections, including drug-resistant infections such as MRSA. An effective control plan would delineate a course of care to prevent the spread of infection. DCJ lacks such a plan.

Although DCJ reports approximately 250 newly-identified skin infections each month, it has not developed or implemented a plan to address this serious issue. Without an adequate control plan, inmates are not properly treated and the risk of transmitting skin infection among the inmate population increases significantly. DCJ staff do not have specific training in treating skin infections or managing related wounds. As a result, inmates receive inappropriate wound care and, thus, are more likely to develop complications such as deep tissue infections, which may lead to hospitalization or death. For example, in October 2005, both inmate L.B. and inmate R.O. had to be hospitalized to treat deep tissue infections after Jail nursing staff failed to treat them with the proper antibiotics for their respective wounds. Despite his hospitalization, R.O. still had not been evaluated by a DCJ physician by February 2006.

DCJ's inadequate care for skin infections is compounded by inadequacies in other areas of care, including the failure to respond to inmate requests for care; properly assess and treat inmates to identify and contain the spread of infections; and maintain adequate medical documentation. Indeed, we noted numerous instances where multiple requests for care for skin infections had gone unanswered.

5. Inadequate Access to Health Care

The process by which inmates at DCJ are permitted to request medical care is inadequate and presents a significant barrier to receiving adequate medical care. Specifically, there are no protocols for collecting, processing, distributing, logging, and triaging medical requests. Additionally, the current process deprives inmates of any professional medical privacy.

Generally accepted correctional medical care standards dictate that facilities like DCJ have a logging system to track requests for care, to evaluate whether inmates are seen in response to their requests, and to identify those still in need of care. Moreover, facilities must provide appropriate policies and procedures to guide nursing staff on how to conduct sick calls, and when to refer requests to higher levels of care. The failure of DCJ's medical requests system to meet these essential standards hinders the ability for inmates to seek, and for clinicians to provide, appropriate medical care.

At DCJ, medical and mental health requests are initiated by the submission of a sick call slip. Inmates complete a slip stating their reason for requesting care. While there are locked boxes for the slips to be placed, these boxes are located outside of inmate housing units. Thus, inmates must give the slips to detention officers, who then are expected to put them in the locked box. In many units, inmates utilize cardboard cookie and cracker boxes to collect completed slips within their unit for pick-up by an officer. In others, detention officers sort the slips and deliver them to either nursing or mental health staff. This process offers inmates no confidentiality and, as discussed below, can create a barrier to needed care.

Our investigation revealed several instances where inmate medical requests were either lost or unanswered, resulting in the denial of care for serious medical conditions. For example, inmate A.H. was admitted to DCJ on December 15, 2005, with an ulcerating vascular tumor on his leg. Although A.H. requested care, he did not receive treatment for his tumor for over a month, even after our consultant directed Jail staff to his condition. With this kind of ulceration, A.H. is at risk of serious deep tissue and possible blood infection. Similarly, inmate A.A. was admitted to DCJ on December 18, 2005, three weeks pregnant and bleeding, as reflected on her intake form. On January 13, 2006, she submitted a sick call complaining of continued bleeding. At the time of our February 2006 tour, she had not been evaluated by the Jail's medical staff, despite her requests.

Even when DCJ does respond to medical requests, inmates are often not directed to the appropriate level of care:

- Inmate F.A. filled out a request for care on February 9, 2006, noting chest pain with left arm numbness (both symptoms of a possible heart attack). Although DCJ nursing staff reviewed the slip, F.A. was not referred to a physician for evaluation.

- Prior to our first tour in February 2006, inmate L.E. submitted a slip complaining of a swollen testicle. At the time of our March 2006 tour one month later, L.E. had still not been evaluated by the appropriate medical staff.

- Inmate A.G. had seven nurse visits before he was sent to see a physician in response to his complaint of a skin infection. As a result of this delay, A.G. had to be hospitalized in November 2005 for dehydration and an abscess (an infected collection of pus which may require surgical removal).

DCJ lacks an effective system for triaging medical requests. Contrary to generally accepted professional standards of medical care, all requests are given equal treatment regardless of the seriousness of the medical issue because there are no nursing protocols for triaging medical requests. This results in a significant backlog of potentially urgent requests.

We found that nursing staff respond to sick call requests on the housing unit rather than in the medical clinic. Cell-side responses provide inmates with no privacy or opportunity for appropriate examination. At the Decker facility, for example, the nurse conducting sick call does not carry the basic medical equipment essential for appropriate clinical evaluation such as a stethoscope.

The deficiencies in the medical requests system are also aggravated by the failures in DCJ's grievance system. Inmates consistently reported that the grievance system at the Jail is not effective when inmates seek relief for inadequacies in medical care. In this respect, both systems fail to address inmates' medical needs. For example, inmate A.K. was hospitalized with bacterial endocarditis, a potentially lethal infection of a heart valve. On December 14, 2005, he had his aortic valve replaced with the insertion of a pacemaker at Parkland. However, when he returned to the Jail, DCJ health care staff did not follow up on A.K.'s medical needs, including a

failure to administer his prescribed medication. A.K. attempted to use the grievance process to address this significant lack of care and, perhaps most importantly, to receive the needed medication. However, despite sick calls, hospitalization, and filing a grievance, A.K. never received his prescribed medication.

6. Inadequate Follow-up Care

DCJ fails to provide appropriate follow-up care for inmates after discharge from the hospital. See, e.g., Lawson, 112 F. Supp. 2d at 634-637 (finding conscious disregard where jail staff observed the progression of an inmate's medical condition, failed to comply with hospital discharge orders, and failed to render appropriate follow-up care and administer regular medications). Inmates who receive specialty care or return from hospitalization should be evaluated upon their return to the facility to ensure, at a minimum, that discharge instructions are noted and appropriate care is provided.

The Jail fails to provide timely follow-up care after inmates have received hospital care, including the failure to adequately document and execute relevant medical and discharge orders. For example:

- On March 10, 2006, inmate C.Z. was admitted to Parkland and was treated for severe bowel obstruction, a life-threatening condition associated with the use of her prescribed pyschotropic medication, Seroquel. The hospital discharge instructions recommended decreasing her dose of Seroquel. This note was never acknowledged by DCJ staff. When C.Z. returned to the facility on March 14, 2006, her Seroquel dose was actually increased by 300% further putting C.Z. at increased risk of developing additional bowel obstructions.

- Inmate A.Q. suffers from rhabdomyolysis, a serious medical condition which, if left untreated, can result in kidney failure. He was hospitalized for this condition on October 13, 2005, but was not seen for follow-up by DCJ medical staff when he returned to the facility. There were also no hospital notes in A.Q.'s chart when we reviewed it in February 2006.

- Inmate A.P. was hospitalized for an overdose of anti-seizure medication on October 11, 2005. DCJ never checked A.P.'s blood levels for this medication either before or after his hospitalization. Thus, A.P. may

still be receiving a dangerous dosage and could suffer additional harm.

- Inmate D.A. has not received his prescribed asthma medication following his discharge from the hospital on February 24, 2006. His medical record includes a discharge summary that clearly indicates that he was to be given asthma medication. D.A. is at risk of an exacerbation of his condition and another hospitalization.

- Inmate A.M. was admitted to DCJ with a wound on September 6, 2005 but did not receive medical care until October 4, 2005. Moreover, the treatment he received was inadequate; as a consequence, A.M. developed cellulitis (an infection of the skin and underlying tissues that can affect any area of the body), and had to be hospitalized ten days later. Following A.M.'s hospitalization, he was not seen by DCJ medical staff and by February 2006 still had not received his prescribed medication.

- Inmate A.O. was hospitalized with cellulitis on October 25, 2005 after having complained of a wound over a three-month period beginning July 7, 2005. A.O. was never seen by medical staff at the Jail and received no follow-up care following his hospitalization.

- Inmate C.F. was hospitalized on April 5, 2005 for pneumonia. C.F. returned to the Jail a month later with a prescription for an antibiotic. Our review of his medical records indicated that C.F. received neither his prescribed medication nor a follow-up clinical examination.

- On November 7, 2005, inmate A.I. was hospitalized for cellulitis. On returning from his four-day hospitalization, he was neither seen by medical staff at DCJ nor received his prescribed medication.

- Inmate A.J. was hospitalized for infected orthopedic hardware on November 11, 2005. There are no clinical notes documented in his medical record. Moreover, there is no indication that A.J. received any follow-up care after his hospitalization.

- Inmate O.H., a juvenile, was sent to the emergency room at Parkland on June 5, 2005, to receive sutures. Upon his return to DCJ, no one evaluated his wound or provided the appropriate follow-up care. As a result, O.H. had to cut his own sutures and later remove them himself.

7. Inadequate Record Keeping

DCJ fails to keep complete, accurate, readily accessible, and systematically organized medical records. A complete and adequate medical records system for a facility like DCJ is critical to ensure that medical staff is able to provide adequate care.

DCJ's electronic medical record system ("EMR") maintains records for some inmates. However, there is no central data repository to manage critical functions such as scheduling, locating patients, performance measurements, and registries of inmates with chronic or specialty needs. As a result, DCJ continues to lose track of such inmates and fails to provide adequate treatment for their conditions.

Our investigation revealed innumerable gaps and inconsistencies in DCJ's medical documentation. For example, when an intake screening is recorded on paper it is rarely entered into the EMR. Due to a limited number of computer work stations, health care staff must record notes by hand and, if they have time, later enter such into the EMR. This duplicative system greatly increases the risk of omission or error. Furthermore, most EMR entries consist of scanned images of handwritten pages, which often are illegible. Without accurate medical records, DCJ cannot meet constitutional standards to provide adequate medical care.

Finally, DCJ's EMR lacks any sort of backup system to protect against computer system downtime. For example, the EMR system was down for two weeks in early February 2006 and again for part of the day on February 24, 2006. During this time, staff could not access medical records or enter pertinent clinical information. The result was a serious lapse in continuity and coordination of care.

8. Inadequate Medication Administration

Medication administration at DCJ suffers significant delays, errors, and lapses, all of which are typically caused by inaccurate or inadequate documentation. We found that DCJ

frequently fails to do the following: (1) administer medication in accordance with prescriptions; (2) maintain inmate medication administration records ("MAR") concurrently with distribution; and (3) follow general standards of care to monitor and adjust inmates' prescribed medication regimens.

Generally accepted correctional medical standards require that facilities administer medication and maintain adequate medication records to meet the medical needs of the inmates and to prevent medication errors and other risks of harm. Regular and systematic reviews of medication usage is also required to ensure that each inmate's prescribed medication regimen continues to be appropriate and effective for his or her condition.

At DCJ, inmates routinely miss doses of life-sustaining medications, such as Coumadin, a blood thinner used to prevent blood clots in the deep veins of the legs, heart, and brain. According to the MARs we reviewed, inmates D.D. and D.E. each missed two successive days of their Coumadin in March 2006. Additionally, medication is often not distributed as appropriate. For example, a significant portion of the Jail failed to receive their medication on the morning of February 20, 2006, the first day of our tour. DCJ medical personnel acknowledged this failure in medication administration.

In one particularly egregious example of missed medication, Jail staff failed to provide inmate D.G. with prescribed medication that may have prevented his death. D.G. was admitted to DCJ on April 3, 2004 and had congestive heart failure, with symptoms that included swelling of his face and of his scrotum. The Jail transferred him to the hospital on April 10, 2004, but when he returned, DCJ failed to administer his prescribed medication. Two weeks later, on April 24, 2004, D.G died of congestive heart failure.

DCJ also fails to maintain MARs contemporaneously with medication administration. Contemporaneous documentation is a generally accepted standard of care necessary to ensure that errors do not occur. DCJ medical staff often leave records blank or fail to log critical clinical information contemporaneously with the distribution of medication to inmates. During our tour, we observed a medication technician serially initial a log of medication records after she had delivered medication to housing units. Such retrospective documentation is inconsistent with generally accepted professional standards of medical care and greatly increases the risk for error.

Our review of DCJ medication records revealed numerous instances of blank MARs. For example, on two floors of Lew Sterrett, approximately 15-20% of the boxes on the MARs were blank; on another floor in Lew Sterrett, more than 10% of the medication administration record boxes were blank; and on February 17 and 18, 2006, most of the afternoon shifts' boxes were blank. Blank MARs are indicative of inadequate training, supervision, and staffing.

Additionally, blank MARs and otherwise poor record keeping greatly limit DCJ's ability to manage and account for items such as narcotics and syringes. Generally accepted professional standards of medical care require correctional facilities to maintain regular counts on the inventories of items such as narcotics and syringes. DCJ has no system in place for reliable, periodic counts for these items. Together, the failure to maintain adequate MARs and maintain counts on inventories makes it almost impossible for DCJ to control and account for these items in a correctional jail setting.

MARs at the Jail do not adequately contain standard prescription information for each medication, including start date, stop date, prescribing practitioner, and nurses/technicians signatures to match to their initials. General standards dictate that each DCJ inmate on chronic medications should have a medication review, as part of a face-to-face encounter with the prescriber every three months, or sooner if medically appropriate. This allows for timely follow-up on the inmate's condition and ensures the appropriateness of the continued medication, a practice which is lacking at DCJ. For instance, while reviewing data on the use of appropriate antibiotics, we found that seven of the 12 records reviewed had no documentation of any examination or diagnosis despite the receipt of medication.

DCJ also fails to ensure that medication distribution is hygienic. Medication rooms we inspected were cluttered, with medication on the floor, and with no soap or towels for hand washing. In the main infirmary area, we observed insulin being drawn in advance for more than 20 inmates. This is a dangerous practice that can cause serious medication errors. Giving a person with diabetes the incorrect dose of insulin can result in serious illness or death.

9. Inadequate Medical Facilities

Medical facilities at DCJ lack adequate space, privacy, lighting, and sanitation to provide inmates with medical care consistent with generally accepted standards. In a facility the size of DCJ, approximately 700 inmates per day require face-to-face medical care. Inadequate space is an especially significant problem because it limits DCJ's ability to provide medical services such as intake screenings, sick calls, and health assessments as well as care for inmates with specialty, chronic, and acute needs.

Generally accepted professional standards of medical care require that for a proper clinical evaluation inmates be examined in a clean and private setting with sufficient lighting and access to necessary diagnostic tools. Medical examination rooms at DCJ do not have sufficient lighting and are not adequately clean. Likewise, some of these rooms lack accessible hand-washing sinks, towels to dry hands, and contain unsecured syringes and dental tools. Notably, hazardous waste was observed on the floors of several medication areas.

10. Inadequate Specialty Care

Specialty care generally refers to care provided in various medical specialties, including orthopedics, gynecology, cardiology, and geriatric medicine. Access to speciality care at DCJ is severely lacking. For instance, between January 1 and February 20, 2006, Jail staff made 316 referrals for specialty care. However, by late March 2006, the Jail had not scheduled appointments for any of these referrals. Such a large backlog for specialty care is grossly inconsistent with generally accepted standards of care.

Additionally, geriatric care and facilities at DCJ are inadequate. Given DCJ's large population, dozens of older inmates will require nursing care on a daily basis for their specialized needs. However, DCJ is not providing such care. For example, in February 2006, we observed inmate E.A. who has severe multiple sclerosis, Parkinson's, atrial fibrillation, and dementia. Although he was incontinent of urine and feces, he was housed in the general population without nursing care. If not for the care volunteered and provided by another inmate, E.A. would likely have died.

The geriatric housing area located in George Allen is ill-equipped, overcrowded, and generally inadequate. The area is equipped with double bunk beds. Because falls and injuries often

result from the use of such beds, elevated bunks pose a significant risk to elderly inmates. Also, due to overcrowding, many bunks are placed very close together, resulting in these medically vulnerable inmates sleeping face-to-face. This greatly increases the risk that respiratory infections may spread among this more susceptible population.

Prenatal care at DCJ is also inadequate. DCJ does not maintain a registry of pregnant inmates. Without such, it is very difficult for DCJ to provide and monitor the necessary specialized care, such as vaccinations. This is especially troubling in light of the preventable illnesses that can occur in correctional facilities. For example, if a pregnant inmate is found to be susceptible to viral hepatitis B and contracts it while at DCJ, this infection can be transmitted to the baby. DCJ fails to screen or immunize pregnant inmates against hepatitis B.

11. Inadequate Staffing, Training, and Supervision

DCJ maintains an insufficient number of medical and custody staff to provide adequate medical services. Delays in access to medical care are exacerbated by an insufficient number of staff trained to identify, respond, and provide the necessary medical treatment. Generally accepted standards of care require that facilities maintain adequate staffing to provide inmates with necessary medical care.

An example of the type of harm that arises from these failures is the death of inmate W.T. on November 13, 2005. W.T. had a history of schizophrenia and was receiving daily doses of Lithium (an anti-depressant) and Zyprexa (an anti-psychotic). On November 13, she fell from her top bunk as the result of an apparent seizure. Officers responded, but did not send W.T. for a medical evaluation. Instead, the officers reported to the nurses on duty that W.T. was dizzy. Based on the information provided by the officers, the nurses decided not to assess W.T.'s condition. Within three hours, W.T. was found dead. This death may have been prevented had the officers recognized that W.T.'s condition was critical and communicated this to the nursing staff.

Our investigation also revealed substantial nursing vacancies, including vacancies for five registered nurses and ten vocational nurses in February 2006. Some of these vacancies are being temporarily filled with agency nurses who are unfamiliar with jail policies and procedures. This staffing shortage has been acknowledged by representatives of Parkland.

Moreover, DCJ is currently operating with an interim medical director and an outside health services administrator to provide leadership for medical care at the Jail. Full-time, on-site administrators are needed to ensure appropriate medical treatment is provided. In addition, there is insufficient staff to support and provide the required medical care. A facility the size of DCJ should have staff dedicated to training, infection control, quality management, nursing direction, and utilization management to monitor under and over-utilization of on-site and outside services.

Finally, currently deficient medical services are hindered further by DCJ's shortage of correctional officers to escort inmates to medical units.

12. Inadequate Quality Assurance Review

DCJ fails to engage in consistent, effective quality assurance review in order to track and trend medical-related incidents at the facility. Investigative review, tracking, and trending of such incidents is a critical component to implement and monitor corrective action in order to avoid future incidents and to keep inmates safe of medical-related harm.

For example, DCJ failed to conduct a mortality review following the questionable death of C.G. who died five days after entering the Jail. Although he reported a history of congestive heart failure at intake in July 2004, C.G. received no clinical evaluation and no medication while at DCJ. This inmate's death may have been related to a lack of medical care at DCJ, however no autopsy or mortality review was conducted to ensure that proper policies and procedures are in place to correct any failures and ensure adequate care, prospectively.

13. Inadequate Dental Care

DCJ fails to provide adequate dental care to its inmates. Failure to treat inmates for dental-related conditions will expose them to risk of infection and significant pain. During our initial tour in February 2006, we found that no dental care was provided to inmates. DCJ's dentist started work on February 21, 2006, but lacked an adequate examination room to provide dental care - the dental chair had no water, no suction, no light, no clean instruments, and no dental x-ray equipment. These equipment deficiencies were still evident during our subsequent on-site tour.

Notably, at the time of our March tour, there was a backlog of 1,200 requests for dental care and inmates with serious dental needs, such as tooth abscesses, which can cause bone infection if not appropriately treated.

B. MENTAL HEALTH CARE

Jail officials violate the Eighth Amendment when they exhibit deliberate indifference to inmates' serious mental health needs. Gates, 376 F.3d at 333. Deliberate indifference may include intentionally denying or delaying access to medical care, or intentionally interfering with treatment or medication that has been prescribed. Id. See also Woodall v. Foti, 648 F.2d 268, 272 (5th Cir. 1981) (finding that an inmate stated a claim of "deliberate indifference" where prison officials knew of his diagnoses as a pedophile and a manic depressive with suicidal tendencies, but refused to treat him). Consequently, a prison's failure to take any steps to protect a suicidal detainee from self harm may constitute a constitutional violation. Partridge v. Two Unknown Police Officers of the City of Houston, 791 F.2d 1182, 1188 (5th Cir. 1986).

We find that DCJ fails to provide inmates with mental health care that complies with these constitutional standards. DCJ fails to address the specific needs of inmates with mental illness, including: (1) failure to timely and appropriately evaluate inmates for treatment; (2) inadequate assessment and treatment; (3) inadequate psychotherapeutic medication administration; and (4) inadequate suicide prevention.

1. Failure to Timely and Appropriately Evaluate Inmates for Treatment

DCJ fails to properly identify inmates with mental illness through adequate screening. Adequate screening of incoming detainees for mental health care needs is instrumental to a facility's ability to provide adequate mental health care to inmates, and to reduce potential harm to those whose conditions would otherwise go unrecognized at intake and throughout the initial medical screening. Mental health screening should comport with constitutional requirements and generally accepted standards of care to aid in classification, identification of emergent mental health care needs, provision of continuous care, and management of medication.

Follow-up of known or newly identified mental health problems is a key focus of intake screening. Mental health screening information should be incorporated into an inmate's

medical record. This ensures the prompt continuation of necessary medication for all inmates with chronic mental health conditions. Persons with potentially serious chronic mental health illness (i.e., active psychosis, suicidal) should be referred from screening for prompt mental health evaluations and examinations by a psychiatrist.

As discussed above, DCJ's medical screening and follow-up practices deny care to inmates. DCJ does not have policies and procedures to govern screening, including screening for mental health needs. Additionally, intake screening officers and intake nurses receive no training in detecting or querying inmates with mental illness. Screening is currently done by paramedics without policies or training on appropriate standards of care.

For mental health screening, DCJ staff utilize a self-report form entitled "Mental Disability/Suicide Intake Screening Form" that is not then incorporated into the medical record. Consequently, we found that less than 20 per cent of inmates referred for a mental health assessment were evaluated within seven days after intake. In addition, these mental health assessments are typically done by mental health liaisons who have no specialized training in mental health care and are inadequately supervised. We found that even for those inmates affirmatively identified with serious mental illness, the subsequent referral process to mental health is flawed.

2. Inadequate Assessment and Treatment

DCJ fails to appropriately assess and treat inmates with mental illnesses. Such failure is not in keeping with generally accepted professional standards of correctional mental health care and causes harm to inmates. The Jail's failure to provide adequate mental health assessment and treatment to inmates has resulted in inmates' mental health deterioration and unnecessary suffering.

In one case, despite several referrals for psychiatric care, an inmate's condition was allowed to deteriorate for almost two months before Jail staff administered any care; and then, only after he had been laying prostrate in his own excrement for three to four days. The inmate, D.C., was not receiving his prescribed anti-psychotic and anti-seizure medication while he was at the Jail in February 2004. After he was discovered, D.C. was hospitalized for dehydration and consequent kidney failure.

Our investigation revealed significant problems with mental health treatment records, specifically, the lack of adequate assessments. Mental health assessments frequently fail to account for inmates' psychiatric histories as a result of the inadequacy of medical documentation and general procedures detailed above. Currently, when a nurse believes that an inmate requires a mental health evaluation, the nurse notifies an individual mental health worker by e-mail. However, logs of these referrals are not kept. This type of referral system lends itself to losing track of inmates who may need urgent attention, thereby placing such inmates at risk of serious harm. Our consultant also found that treatment plans were infrequently done on a timely basis and treatment team meetings do not occur.

Consequently, the Jail fails to provide the essential components of adequate treatment programs in a correctional mental health system. The following programs fail to comply with generally accepted professional standards of correctional mental health care by lacking: crisis intervention, with beds available in a health care setting for short-term treatment; acute care (including inpatient level psychiatric care); and chronic care to include a special needs unit for inmates with chronic mental illness.

The crisis level of care lacks the capacity for necessary short-term treatment due to the lack of a licensed infirmary. There is simply no physical space for evaluating and treating inmates. DCJ does not have access to an acute care program that would provide appropriate access for inpatient hospitalization. Also, a chronic care program for inmates with serious mental illnesses does not exist. While the Jail does provide segregated housing units that are designated for inmates with serious mental illnesses, these housing units lack an adequate treatment program that is an essential component of chronic care programs. Accordingly, DCJ fails to provide the generally accepted necessary components of a correctional mental health system.

As a result of not having access to an acute or chronic care program, inmates who are the most symptomatic and impaired from their mental health illnesses are generally inappropriately locked down in single cells for 23 hours per day. Many detainees with serious mental illness are harmed by the lack of adequate treatment as manifested by either increased symptoms of their underlying psychiatric disorder or lack of improvement regarding their current symptoms. The following examples are illustrative:

- Inmate T.W., admitted to DCJ on February 10, 2006, was housed on a mental health housing unit. His health care record had a notation at intake that he had been receiving pyschotropic medications and needed to be evaluated. However, at the time of our second tour in late March, more than one month later, T.W. had still not been assessed by mental health staff.

- Inmate D.B. was on a hunger strike as early as January 27, 2006, and had been diagnosed as being psychotic by a nurse practitioner on March 2, 2006. Yet, D.B. had no medical evaluation regarding her nutrition and state of hydration, and no psychiatric care for her psychosis until she had to be hospitalized for lethargy (an abnormal state of drowsiness or dullness) on March 11, 2006, nearly three months later.

- In September 2005, inmate J.P. was assessed at intake with a diagnosis of bipolar disorder. Over the next six months, J.P. suffered from a significant lack of continuity of care. During that time, four clinicians each made different diagnoses (from active psychosis to lacking a psychotic illness) and prescribed various medications to J.P. without apparent reference to notes in his medical file. Indeed, by March 12, 2006, J.P.'s mental health had deteriorated to the point that Jail staff repeatedly observed him eating his own feces.

3. Inadequate Psychotherapeutic Medication Administration

DCJ fails to timely and appropriately evaluate inmates for the administration of pyschotropic medications and to monitor their continued administration. Many DCJ inmates require pyschotropic medications to avoid the unnecessary suffering of acute episodes of mental illness. Moreover, inmates are prescribed pyschotropic medications during intake but do not receive timely evaluations to determine whether such administration is appropriate. Generally accepted correctional mental health care standards require that a physician see an inmate patient usually before, but clearly shortly after, a prescription for pyschotropic medication is written in order to evaluate whether the medication should be maintained and to evaluate the continued administration for proper dosage and effectiveness. Inmates who remain untreated, or who are treated without being seen by a physician, may suffer from a worsening of

their symptoms, including suicidal and homicidal thoughts, or from potentially lethal side effects of medication. DCJ consistently fails to comply with these standards.

We found significant problems at the Jail with regard to psychotherapeutic medication management, including: delays ranging from days to weeks, for inmates to begin receiving their pyschotropic medication; inappropriate breaks in medication administration due to housing changes and insufficient staffing; numerous medication errors; and medications routinely prescribed with 11 pre-approved refills, a dangerous practice resulting in inadequate medication monitoring.

Our review of Jail records revealed numerous inmates suffering from mental illness who did not receive their prescribed medications in a timely manner. This practice has resulted in serious harm to inmates. For example, despite a documented 20-year history of schizophrenia, inmate O.C. did not receive his prescribed pyschotropic medication for a five week period between December 25, 2005, and February 2, 2006. This overall lack of care and monitoring of pyschotropic medication at DCJ is not in keeping with constitutional requirements or standard practices of care.

4. Inadequate Suicide Prevention

The current suicide prevention practices at DCJ are grossly inadequate. Constitutional requirements and generally accepted professional standards of correctional mental health care mandate the development of suicide prevention standards. These standards require an appropriate policy and procedure; education and training for all staff members; appropriate screening to assess suicide risk; appropriate housing for those identified as at risk; appropriate supervision, observation, and monitoring of those inmates so identified; appropriate referrals to mental health providers and facilities; appropriate communication between correctional health care and correctional personnel; appropriate intervention addressing procedures of how to handle a suicide in progress; and appropriate notification, reporting, and review if a suicide does occur.

DCJ's current practice of suicide prevention does not comport with generally accepted professional standards of correctional mental health care. The Jail's written policy on suicide prevention fails to ensure appropriate management of suicidal inmates and lacks major components of an adequate

suicide prevention program. For example, DCJ's policy does not require that staff be trained on suicide recognition and intervention.

The current intake screening/assessment process fails to assess adequately the suicide risk factors of inmates. The process is not under the direction of trained mental health staff. As a result, correctional staff inappropriately have the authority to place any inmate who they deem to be suicidal into a "suicide cell," which is a closed observation cell in which the inmate is under continuous lock down. There are two housing tiers designated as suicide tiers with eight cells in each tier that are classified as suicide cells. These cells are reportedly visually checked by an officer at regular intervals. However, because this check is not formally logged, monitoring is haphazard and places inmates in potential danger.

Moreover, placement in a suicide cell appeared to be arbitrary. The assessment is seldom performed by a mental health staff member so placement in a suicide cell is often inappropriate and utilized as a form of punishment. Mental health staff repeatedly reported that it is their perception that few of the persons placed in these cells are actually suicidal. In addition, mental health staff reported that they disagreed clinically with existing suicide practices, especially the stripping of inmates of all clothing and granting them only a paper gown.

As stated above, intake officers received no training in suicide screening and the communication between mental health staff and correctional staff is informal. The significant communication problems between custody and mental health staff result in a fragmented, uncoordinated system. It is often unclear who initiated suicide precautions during the central intake process. In fact, our mental health consultant found that suicide precautions were often initiated under a DCJ clinician's name without his knowledge or approval.

Inmates placed on suicide watch are being observed by correctional officers who are ill-trained and who often have a myriad of other responsibilities in addition to the observation task. This is especially problematic at the George Allen facility where the physical layout does not allow for direct observation of the inmate on suicide watch. Additionally, the room in which inmates are placed on suicide watch contains a myriad of suicide hazards such as exercise equipment.

The current suicide prevention program also fails to contain different levels of supervision of the inmate based on the presenting risk factors for suicide. Moreover, due to a lack of training, correctional staff are ill-prepared to handle a suicide in progress, including how to cut down a hanging victim and employ other first-aid measures. Finally, contrary to generally accepted practice, there is no administrative review following a suicide or a suicide attempt to identify what could have been done to prevent the incident.

Our review of the records of several inmate suicides revealed significant problems. The following examples are illustrative:

- C.L., a 27-year-old inmate, died on October 10, 2005, of toxic effect of an overdose of nortriptyline, an antidepressant medication that had not been prescribed to him. His suicide intake screening assessment had never been completed. C.L.'s problem list in his medical record included "mental health issues." A nursing clinical note, dated February 15, 2005, indicated that his sister had called concerned that C.L. had voiced suicidal thoughts. Yet, C.L. never received a mental health evaluation while he was incarcerated at DCJ.

- While on suicide watch, inmate K.B. hung himself in July 2003. The physician assistant subsequently reported that he had not been able to interview the inmate due to the lack of an available detention officer escort. As a result, K.B.'s transfer to a closed behavioral observation tank was delayed. This case highlights issues related to inadequate supervision, poor communication between custody and mental health staff, and the lack of adequate numbers of detention officers for escort/transfer purposes.

- Inmate M.K. hung herself on January 5, 2003 after having been admitted on December 4, 2002. Her record contained the following inmate request form dated two days before her death on January 3, 2003. The note indicated the following:

  > I need to see the doctor to get my medicine straightened out. I am not getting my meds that my doctor faxed prior orders for me, and I

> brought in the medication myself and paid for it. I cannot afford to be treated this way! Please help me! I need my medicine.
>
> There is no indication that M.K. received her medication before her death. The case reflects inadequate screening for mental illness, inadequate screening for suicide prevention purposes, lack of timely access to needed medications, and the lack of timely response to an inmate request form.

C. SANITATION AND ENVIRONMENTAL CONDITIONS

Prison officials must ensure that inmates receive adequate food, clothing, and shelter, Farmer, 511 U.S. at 832, and that prisoners are not "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). Certain prison conditions are so base, inhuman and barbaric that they violate the Eighth Amendment. Palmer v. Johnson, 193 F.3d 346, 352 (5th Cir. 1999) (citation omitted). One such condition is the deprivation of basic elements of hygiene. Id. See also Gates, 376 F.3d at 338 (finding that filthy cell conditions constituted an Eighth Amendment violation). DCJ fails to ensure that sanitary and environmental conditions are in accordance with these constitutionally minimal standards.

1. Inadequate Sanitation of Laundry

DCJ laundry procedures fail to protect inmates from the risk of contagious diseases and/or exposure to bodily fluids and excretions. DCJ lacks adequate procedures for distributing or requesting replacement uniforms. Likewise, inmate uniforms and linens are inadequately cleaned and ragged.

Equipment at the central laundry facility is outdated and inadequate to handle the volume of laundry that the Jail produces. Because inmate laundry is often returned from the laundry facility still soiled, many inmates resort to washing their laundry by hand in toilets, sinks, and mop buckets, using detergent available from the DCJ commissary. This practice is unhygienic and contributes to the spread of contagious diseases, such as MRSA. Moreover, as a result of these laundering practices, inmates hang their laundry in their cells to dry, limiting security staff's ability to observe inmates, creating a security and fire risk.

2. Inadequate Protection From Biohazards

Current Jail practices expose inmates and staff to infectious diseases and aerosolized pathogens through improper contact with blood and other body fluids. The Jail fails to adequately contain, secure, store, dispose, and quarantine biohazardous materials.

Inmates and staff do not receive adequate safety equipment, cleaning chemicals, or supervision when cleaning and disposing of biohazardous materials. Biohazard spill kits are not readily accessible in the housing areas and biohazardous waste is not properly disposed of. Biohazardous waste is stored with office supplies, potentially exposing staff to aerosolized pathogens. Pathogens generally include any organism such as bacteria and viruses that cause disease in human beings. Thus, inmates and staff may be exposed to increased risk of illness when exposed to such pathogens. Accordingly, biohazardous waste should be marked properly and appropriately disposed as such.

We also found that containers located in the medical areas for the disposal of sharp biohazardous tools are improperly installed, thereby compromising readily safe disposal. Further, sharp medical tools, such as needles and dental utensils, are left unsecured and in the open, creating a significant safety and security risk for both staff and inmates.

3. Lack of Environmental Control

The Jail lacks adequate control over razors and commissary items distributed to inmates. Hundreds of razors were observed throughout the Jail - virtually all with the blades missing. These ubiquitous razor blades create two problems. First, these blades pose a serious security hazard. There are countless razor blades in the hands of DCJ inmates and all are potential weapons. Second, the sharing of razors amongst inmates can lead to the spread of diseases such as MRSA, hepatitis, and AIDS.

Because the Jail fails to control inmate commissary, inmates stockpile commissary items, which indicates that there may be a significant underground market among the inmates. We saw several stockpiles of commissary items like food and razors amassed by inmates that were too large to be for individual consumption. This situation can lead to security and control problems such as inmate-on-inmate violence, as well as an increase in pest problems such as rodents.

Additionally, the Jail allows brooms and mops to remain in cells for extended periods of time. Such a practice ignores the fact that these items can be used as, or converted into, weapons.

4. Inadequate Sanitation of Facilities

It is the Jail's duty to ensure housing units and bathroom areas are adequately cleaned. Cleaning can be performed by inmates, but appropriate materials and supervision is required. The Jail's sanitation practices are grossly inadequate and vary widely among each facility. Cleaning was not uniform throughout the facilities, indicating that oversight by staff is better in some areas than in others. Parts of the Jail are filthy, subjecting inmates to increased risk of health problems. Bacteria like MRSA can survive in a dried state on various jail surfaces for significant lengths of time. DCJ's failure to keep the Jail adequately clean greatly increases the risk that inmates will be exposed to such dangerous bacteria.

There is inadequate cleaning and maintenance of toilet and shower areas throughout the Jail. Numerous showers and toilets were in need of repair, rendering them inoperable or difficult to use. Several combination sink and toilet units were seen leaking, causing the floor area to remain wet for extended periods of time. This situation promotes the growth of mold and bacteria that can lead to infections as well as creates a slip hazard, a critical risk to security if staff need to respond to an urgent matter. Moreover, floor and shower drains are in poor condition and need to be thoroughly cleaned. We observed drain flies and large concentrations of fly larvae in the bathroom areas, which is indicative of an unsanitary environment.

5. Inadequate Fire and Life Safety Systems

DCJ fails to ensure adequate fire and life safety systems throughout the Jail. It is critical that smoke detection systems are provided in all sleeping areas, especially where only a limited number of housing areas are equipped with smoke removal systems. Fire equipment, such as air tanks and fire extinguishers, must have up-to-date inspections and be properly maintained. Also, safety tools must be accessible and in good working condition. DCJ, however, does not meet these standard system requirements.

Some areas of the Jail are not equipped with smoke detection equipment. Also, DCJ does not ensure that all staff maintain a working knowledge of, and the ability to execute, the Jail's emergency evacuation procedures. Many staff members did not know

the location of emergency keys or of the markings that enable the keys to be identified by touch. Moreover, some emergency keys lacked these markings. This is a significant departure from generally accepted professional standards of care. Further, during our February tour, we identified the fire hazard of allowing inmates to keep excessive amounts of newspaper in their cells. We understand that DCJ has taken measures to address the presence of newspapers in inmate cells, however we have not had the opportunity to fully evaluate these measures.

IV. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of inmates, DCJ should implement, at a minimum, the following measures in accordance with generally accepted professional standards of corrections care:

A. Medical Care

1. Intake Screening

   a. Ensure that adequate intake screening and health assessments are provided. Develop and implement an appropriate medical intake screening instrument that identifies observable and non-observable medical needs, including infectious diseases, and ensure timely access to a physician when presenting symptoms require such care.

   b. Ensure that acute and chronic health needs of inmates are identified in order to provide adequate medical care.

   c. Ensure that medical screening information is reviewed in a timely manner by trained medical care providers.

   d. Provide adequate screening and health assessments for juveniles in accordance with generally accepted standards of care and ensure adequate evaluation for mental illness and suicide risk.

   e. Ensure that tuberculosis screening is conducted in a timely manner.

2. Acute care

   a. Provide timely medical appointments and follow-up medical treatment. Ensure that inmates receive treatments that adequately address their serious medical needs. Ensure that inmates receive acute care in a timely and appropriate manner.

   b. Provide adequate acute care for inmates with serious and life-threatening conditions.

   c. Ensure that staff are adequately trained and prepared to handle emergent situations in accordance generally accepted professional standards.

3. Chronic care

   a. Ensure that inmates receive thorough assessments for, and monitoring of, their chronic illness. Develop clinical practice guidelines for inmates with chronic and communicable diseases. Ensure that standard diagnostic tools are employed to administer the appropriate preventative care in a timely manner.

   b. Adopt and implement appropriate clinical guidelines for chronic diseases such as HIV, hypertension, diabetes, asthma, and elevated blood lipids, and policies and procedures on, inter alia, timeliness of access to medical care, continuity of medication, infection control, medicine dispensing, intoxication/detoxification, record-keeping, disease prevention, and special needs.

   c. Ensure that medical staff are adequately trained to identify inmates in need of immediate or chronic care, and provide timely treatment or referrals for such inmates.

   d. Ensure that inmates with chronic conditions are routinely seen by a physician to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.

   e. Ensure adequate follow-up treatment and medication administration concerning all inmates with chronic conditions.

4. Treatment and Management of Communicable Disease

   a. Provide adequate treatment and management of communicable diseases, including TB and MRSA.

   b. Ensure that inmates with communicable diseases are appropriately screened, isolated, and treated.

   c. Ensure that inmate and staff do not interfere with HVAC and negative pressure systems.

   d. Develop and implement an adequate TB control plan in accordance with generally accepted standards of care. Such should provide guidelines for identification, treatment, and containment to prevent transmission of TB to staff or inmates.

   e. Develop and implement policies that adequately manage contagious skin infections. Develop a skin infection control plan to set expectations and provide a work plan for the prevention of transmission of skin infections, including drug-resistant infections to staff and other inmates.

   f. Conduct a sufficient initial health assessment, including screening for TB and sexually transmitted disease, of all inmates in a timely fashion.

   g. Develop and implement adequate guidelines to ensure that inmates receive appropriate wound care.

5. Access to Health Care

   a. Ensure inmates have adequate access to health care.

   b. Ensure that the medical request process for inmates is adequate and provides inmates with adequate access to medical care. This process should include logging, tracking, and timely responses by medical staff.

   c. Develop and implement an effective system for triaging medical requests. Ensure that sick call requests are appropriately triaged based up the seriousness of the medical issue.