November 25, 2003

The Honorable Mike Huckabee
Governor of Arkansas
State Capitol
Little Rock, Arkansas 72201

Re: McPherson and Grimes Correctional Units, Newport, Arkansas

Dear Governor Huckabee:

On May 8, 2002, we notified you of our intent to investigate conditions at the McPherson and Grimes Correctional Units (the "Units") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. We write to report the findings of our investigation and to recommend remedial measures to ensure that the Units meet federal constitutional requirements.

On July 23-26, August 20-23, and September 25-27, 2002, we conducted on-site inspections of each Unit with consultants in the fields of correctional medical and mental health care, penology, sexual misconduct prevention, and environmental health and safety. While on-site, we interviewed administrative and security staff, medical and mental health care providers, and inmates. We also reviewed a large number of documents, including policies and procedures, incident reports, grievances, medical records, and use of force records. We appreciate the full cooperation we received from state officials throughout our investigation. We also wish to extend our appreciation to the staff and administrations of both Units for their professional conduct and timely response to our document requests.

Having completed our investigation of McPherson and Grimes, we conclude that certain conditions at these facilities violate the constitutional rights of the inmates confined there. As detailed below, we find that: (1) inmates at McPherson and, to a lesser extent at Grimes, experience deliberate indifference towards their serious medical needs; (2) inmates at both Units

receive inadequate protection from physical harm and sexual misconduct; and (3) inmates at both Units are exposed to unsanitary and unsafe environmental conditions. These deficiencies expose inmates to serious harm and have, in some cases, resulted in actual injury.

I. BACKGROUND

A. DESCRIPTION OF THE UNITS

McPherson and Grimes opened in January 1998 as private prisons built and operated by Wackenhut Corrections Corporation ("Wackenhut") on behalf of Arkansas. The State resumed control in July 2001 after Wackenhut failed to renew its contract.[1]

McPherson, the State's only prison for female inmates, was initially designed to hold approximately 600 women in single and double occupancy cells. At the time of our inspection, the inmate census for McPherson was approximately 700. Plans to expand McPherson to accommodate an additional 200 inmates are on hold. Grimes is predominantly a medium security prison, and is designed to house approximately 600 young adult males (ages 16 to 24). The Grimes inmate census during our inspections was 599. No inmates under 18 years of age were housed at either Unit during our inspection. Grimes currently is expanding to accommodate an additional 400 inmates; officials expect construction to be completed before the end of 2003. We understand from the administration that most of the additional inmates will be over the age of 24.

McPherson and Grimes are located in the same complex, approximately a quarter of a mile apart, and have the same physical design. Each Unit has two primary housing areas (Housing A and B) located at opposite ends of the facility. The housing areas contain seven large barracks -- four "open," dormitory-style barracks and three "closed" barracks with

[1] Wackenhut's decision to terminate its oversight of the Units reportedly followed the State's refusal to pay for increased operating costs.

double-bunk cells on two levels. Each Unit has single cells in its isolation barracks.[2] Housing A and B are monitored from elevated control rooms located over the barracks. In addition to the general population housing and isolation barracks, both Units have a six-bed infirmary. McPherson also has a Special Programs Unit ("SPU") for inmates with serious mental illness.

B. LEGAL FRAMEWORK

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of inmates. 42 U.S.C. § 1997a. The Eighth Amendment places an affirmative duty on prison officials to provide humane conditions of confinement and to ensure that inmates receive adequate food, clothing, and shelter. Farmer v. Brennan, 511 U.S. 825, 832 (1994). Inmates must also receive access to medical and mental health care. Ruark v. Drury, 21 F.3d 213, 216 (8th Cir. 1997) (intentional delay or denials of medical care may constitute deliberate indifference). Moreover, cost cannot justify a complete denial of constitutionally-mandated services. Monmouth Cty. Correctional Institutional Inmates v. Lanzaro, 834 F.2d 326, 337 (3d Cir. 1987) (citing Bounds v. Smith, 430 U.S. 817, 825 (1977)); cf. McAlphin v. Toney, 281 F.3d 709, 710 (8th Cir. 2001) (failure to provide dental care may constitute sufficiently serious injury to violate constitution).

The Eighth Amendment likewise forbids the excessive use of physical force against prisoners, see Hudson v. McMillian, 503 U.S. 1 (1992), and imposes a duty on prison officials "to protect prisoners from violence at the hands of other prisoners." Farmer, 511 U.S. at 833. Similarly, inmates have the right to be protected from constant threats of violence and sexual assault. Ware v. Jackson County, 150 F.3d 873, 882 (8th Cir. 1998). Finally, a prison may, in some circumstances, violate the Fourth Amendment if it fails to protect a prisoner's right to reasonable privacy in an exaggerated response to security concerns. Hill v. McKinley, 311 F.3d 899, 903-904 (8th Cir. 2001) (citing Franklin v. Lockhart, 883 F.2d 654, 656 (8th Cir. 1989)).

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[2] Single cells are used to house inmates on administrative and "punitive" segregation status, close custody classification, and pre-hearing disciplinary status.

As discussed below, the State frequently acts at odds with these legal standards and with other generally accepted standards that are not themselves constitutional violations, but that may be relevant to determining whether the State has engaged in unconstitutional conduct.

II. FINDINGS

A. MEDICAL CARE

McPherson and Grimes provide medical care through a contract with Correctional Medical Services ("CMS"), a private corporation. At McPherson, medical services fall short of constitutional standards in the following areas: emergent, chronic and acute care; intake physicals; referrals and consults; and dental services. As explained below, these deficiencies primarily result from inadequate staffing, lack of proper supervision, and the failure to implement consistently the generally adequate written medical policies and protocols.

Although the medical services at Grimes raise fewer constitutional issues than the services at McPherson, Grimes still falls short of constitutional requirements in the areas of emergent, chronic, and dental care.

1. Emergent Care

McPherson and Grimes inmates with emergent care needs are at significant risk of harm because they frequently do not receive appropriate referrals, medical treatment, or follow-up care.

Consistent with generally accepted practices, nurses may review and triage sick call requests so long as they refer inmates to advance-level care providers when necessary. At McPherson and Grimes, these referrals often are not made. For example, in July 2002, a Grimes inmate who complained of nausea, vomiting, and right lower quadrant tenderness was not referred to a physician even though his symptoms were consistent with appendicitis. A month earlier, another Grimes inmate who recently had undergone open heart surgery was given Tylenol and sent back to his barracks by a nurse after he complained of chest pains. In light of this inmate’s serious symptoms and recent medical history, accepted standards of care would require that he be referred to a physician the same day he visited the infirmary

with such serious complaints. During the same time frame -- June through July 2002 -- still another Grimes inmate who complained of chest pains three times during a two-week period also was not referred to a doctor. This failure violated the CMS protocol requiring inmates who are seen more than twice for the same complaint to be referred to a physician. The same protocol was ignored in the case of an asthmatic inmate at McPherson who never saw a doctor even though she reported to the clinic three times between July 11 and July 20, 2002 for asthma-related breathing problems.

As detailed below in Section II.A.5, our chart review also revealed that even when inmates receive an appropriate referral, they often do not get an appointment with the physician because, in part, there is inadequate staff oversight and no review system in place to ensure that referrals are being carried out.

2. Chronic Care

Chronic care clinics at both McPherson and Grimes fail to meet the needs of inmates with chronic illnesses such as diabetes, HIV, asthma, and seizure disorders. Inmates who suffer from such medical conditions require ongoing, coordinated care and training to prevent the progression of their illnesses. Although CMS has a comprehensive chronic care policy that establishes adequate protocols for testing and monitoring, we found that the staff at McPherson and Grimes fail to adhere consistently to these written standards.

For example, neither facility regularly administers a standard blood test to monitor the status of diabetic inmates. These inmates also do not receive the testing and treatment necessary to prevent possible medical complications resulting from their disease. For instance, although diabetes often causes retinal disease, which left untreated may result in preventable vision loss, diabetic inmates are not given annual eye examinations. Diabetic inmates also do not consistently receive routine urine tests that are critical to the detection of kidney disease. Moreover, the medical staff at both facilities often are unresponsive to changes in diabetic inmates' medical status. By way of example, although the blood work of one Grimes inmate indicated that his disease was worsening, medical staff did not change his medication or take other steps to address his deteriorating health status.

The care of inmates with HIV is also deficient. Indeed, medical staff at McPherson and Grimes informed us that they are "uncomfortable" with their level of skill and training to monitor and treat this disease effectively. At the time of our July tour, an HIV-positive inmate who was admitted to McPherson in March 2002 had received no chronic care visits and no tests to evaluate her immune state. Another HIV-positive inmate admitted to McPherson in March 2001 had received three chronic care visits, but, as of July 2002, had yet to receive the blood tests necessary to monitor her condition. This lack of oversight is dangerous because inmates may need additional medications to prevent opportunistic infections -- a major cause of illness and death in HIV-positive patients. In addition to these issues, critical treatment decisions are often made for HIV-positive inmates without appropriate medical guidance. For example, the facility doctor -- who admitted she lacked the skill necessary to treat and monitor HIV-positive patients -- terminated a Grimes inmate's HIV medication on the basis of a memorandum from the Regional Medical Director asking physicians to consider stopping such regimens under certain conditions. When we visited Grimes four months later, the inmate had an increased viral load and decreased T-cell count -- both indicators of a weakened immune system. We found no evidence that the doctor considered re-starting the medication or referring the inmate to a specialist. In another recent case, a nurse practitioner restarted medications for an HIV-positive inmate at McPherson. Because there are a limited number of drugs available to treat HIV and because effective treatment often depends on complicated drug regimens, decisions to stop or start medication should be handled by specialists.

With regard to asthmatic inmates, we are concerned about a recent CMS policy change which unduly impedes access to chronic care. The new policy prohibits medical staff from ordering inhalers and instead requires inmates who experience shortness of breath to report to the chronic care clinic each time they experience an episode. However, many asthmatic inmates told us that security staff often do not allow them to access the clinic -- a practice that places inmates at risk and could result in avoidable risk of fatalities.

Inmates with other chronic illnesses such as seizure disorder, blood clotting conditions, and hepatitis also receive inadequate chronic care because they are not provided with routine tests or appropriate follow-up. For example, in July

2002, we reviewed the record of a McPherson inmate with seizure disorder whose anticonvulsant drug level had not been checked since December 2001, at which time it was too low. Although this inmate had a seizure on May 29, 2002, she received no follow-up care, her medication was not changed, and she was not scheduled for a chronic care visit. Another McPherson inmate takes a blood clotting medication that requires her blood to be tested at least once a month to ensure the drug is working effectively. Between July 2001 and July 2002, this inmate's blood was checked only four times. Moreover, her records indicate that two of the four readings were not in the proper range, indicating a potentially serious problem. The staff's failure to monitor this inmate on a consistent basis places her at risk for blood clot formation and sudden death.[3]

Finally, we were advised by inmates and medical staff alike that neither facility provides treatment for Hepatitis C -- an illness that left untreated can result in potentially fatal liver damage. We were told by medical staff that the decision not to treat this disease was based on fiscal efficacy. Although it is appropriate for health care providers to seek cost effective means and alternatives for providing care, cost cannot be the only consideration. Treatment decisions must also be based upon thorough medical assessments.

3. Acute Care

We found that McPherson often fails to provide inmates who develop acute medical needs with timely, appropriate medical care. Inmates access acute medical services by completing a sick call request form and placing it in a locked box inside the housing units. Each day, nursing staff retrieve and review all request forms. Consistent with national standards, the policies of the Arkansas Department of Corrections ("ADC") and CMS require that inmates who submit requests be seen at the next sick call (i.e., within 24 hours). In practice, however, the delay is much longer.

During our inspection, nursing staff at McPherson readily admitted that they rarely meet the 24-hour requirement. They

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[3] We addressed the failure to monitor this inmate (as well as other situations presenting immediate risk of harm) during both our tour and our exit interview.

maintained, however, that sick call requests usually are processed within 72 hours. Upon reviewing medical records and speaking with inmates, we discovered that virtually no one is seen within a 72-hour window. Indeed, during our chart review, we found several examples where inmates waited two to three weeks to attend sick call. Many inmates also reported submitting multiple sick call requests before being seen. Based on our review, it appears that staff do not prioritize sick call requests consistently and appropriately. Such prioritization is necessary to ensure that inmates with serious medical needs are seen more quickly than those with more minor complaints.

Access to acute care is further limited by the time at which sick call is held -- namely, 11:00 p.m. to 4:00/5:00 a.m. Some inmates who begin work at 5:00 a.m. simply forego sick call in order to be awake and alert for their job detail. To be sure, there is nothing per se unreasonable about conducting sick call during these hours. However, holding sick call exclusively at these hours may require inmates to choose between medical attention and sleep, thus potentially creating an unacceptable and unnecessary barrier to medical care.

Even if inmates successfully navigate the sick call system, they risk disciplinary action if medical staff conclude that they are not sick, or if medically untrained correctional officers determine that they left work without a valid medical complaint. Although McPherson has a security interest in preventing malingering, a neutral third party such as the grievance officer should be tasked with disciplining inmates who unnecessarily report to sick call. We spoke with a number of inmates who received disciplinary reports because their symptoms diminished between the time they submitted their requests and the time they ultimately saw a nurse. There is a risk that allowing medical and correctional staff to write disciplinary reports in instances in which an inmate's health in fact seriously improved during this period improperly discourages inmates who may be legitimately ill from seeking medical services. We emphasize, of course, that we have no way of determining whether or not this type of situation has actually occurred, and merely flag the issue for training purposes.

Finally, neither facility provides sick call request boxes in its segregation unit. Instead, segregated inmates rely on correctional staff to convey sick call requests to medical staff. This practice, which is contrary to generally accepted practices,

potentially compromises timely access to medical care by allowing staff with no medical training to serve as gatekeepers for medical services.

4. Intake Physicals

Although inmates receive physicals soon after they arrive at McPherson, these examinations often do not include pap smears for each new inmate or mammograms, where indicated. The medical staff at McPherson initially advised us that, consistent with "generally accepted standards," all incoming inmates receive pap smears. Our records review, however, demonstrated that virtually none of the women had initial pap smears. When confronted with this inconsistency, staff reported they had run out of vaginal specula a month earlier and had not conducted any pap smears since. We understand that the staff has begun to clear up the backlog from the month of our visit. Nonetheless, while the temporary unavailability of equipment explains the staff's failure to conduct pap smears for June 2002, it does not address the staff's failure to provide pap smears consistently in the months preceding our visit.

Unlike pap smears, mammograms are not clinically indicated for all incoming inmates. However, while the provision of mammograms for all incoming inmates may not be required as a matter of constitutional law, generally accepted standards require that women of a certain age and medical history receive this test. And our records review identified multiple McPherson inmates who, by reason of age, should have received mammograms under these generally accepted standards but did not. It also verified the reports of many inmates that they are unable to obtain mammograms, even upon request. The failure to provide pap smears and mammograms may deprive inmates of the benefits of early cervical and breast cancer detection and may result in avoidable illness and death.

Another shortcoming in the intake process is the staff's failure to communicate laboratory results to inmates. The inmates we spoke with were particularly concerned about the lack of information regarding their HIV tests. The failure to convey test results and document this communication not only violates generally accepted standards, but it prevents inmates from learning about potentially serious medical conditions.

5. Referrals and Consults

In addition to the systemic failures noted above, we discovered many cases where inmates were tested and evaluated properly, but did not receive appropriate follow-up treatment for their serious health conditions. For instance, one of the few McPherson inmates who received a pap smear during her intake physical tested positive for the presence of abnormal cells. Although this inmate was recommended for a biopsy in January 2002 to rule out cancer, when we visited the facility in July 2002, she had received no further evaluation. If this inmate has cancer, early diagnosis and treatment are critical to her survival. Another inmate who entered McPherson in April 2002 with a diagnosis of cervical cancer repeatedly requested a pap smear to evaluate the status of her condition. Despite a file note from her former doctor recommending additional testing, she had not received it as of July 2002.[4]

We also found that inmates with serious medical conditions often are not referred to a doctor or a hospital in a timely manner. These lapses occur even though CMS' own nursing protocols require, consistent with generally accepted professional standards, that inmates who report to the infirmary with the same complaint more than twice are to be seen by a doctor, and inmates with a history of chest pain complaints get priority physician referrals. In addition, although the infirmaries at McPherson and Grimes do not have appropriate equipment to treat patients with cardiac and pulmonary instability, a Grimes inmate who complained of severe chest pain three times in a two-week period was treated by the nurse in the infirmary, but never was referred to the doctor or taken to a hospital. Similarly, a McPherson inmate who sought treatment for chest pains and was found to have elevated blood pressure was sent back to her dorm by the nurse without the site doctor's input or referral. An asthmatic, HIV-positive inmate who placed a sick call request complaining of chest pains and shortness of breath was not seen by medical staff for two days. When the inmate finally was seen, she presented with abnormal vital signs. The nurse, however, did not immediately notify the doctor. Twelve hours later, the inmate was sent to the hospital with a diagnosis of pneumonia. She later was found to have a potentially fatal opportunistic infection commonly associated

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[4] We informed McPherson officials about both of these inmates during our exit interview.

with HIV infection. In view of the inmate's HIV status and her serious symptoms, she should have received appropriate care much earlier.

Regarding speciality care services, there is no mechanism at either Unit to ensure that needed consults are requested and that consultation reports are reviewed and acted upon by the staff. For example, as discussed above, HIV-positive inmates are not referred to an infectious disease specialist. Diabetic inmates are not routinely referred to an eye specialist. And, inmates with heart conditions do not receive cardiology evaluations. Even when specialists are consulted, the facilities do not consistently follow their recommendations. For example, we interviewed and reviewed the records of a McPherson inmate who had an off-site visit with an eye specialist in December 2001. The doctor recommended that she return for a follow-up visit because of possible retinal problems related to diabetes. At the time of our visit, over seven months after the consultation, this inmate had not returned to the specialist and the medical chart contained no explanation why the specialist's recommendation for a return visit was not followed. Similarly, in February 2002, an infectious disease specialist recommended that McPherson give an HIV-positive inmate a pap smear and test her viral load before further evaluation. As of July 2002, the inmate had not received either of these tests, nor had she had the follow-up visit.[5]

6. Staffing and Adherence to Policies and Procedures

The above-noted deficiencies in emergent care, chronic care, sick call and intake services are aggravated by inadequate medical staffing. The Units share one staff physician to meet the needs of 1,300 inmates (the doctor spends 30 hours a week at McPherson and ten hours at Grimes). As we learned in interviews with the medical staff, the physician spends most of her time attending to sick call complaints at McPherson. In addition to her clinical responsibilities, the doctor is the medical director

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[5] When we asked why these recommendations had not been followed, staff advised that the facilities do not have enough staff to track them. Indeed, during our tour of McPherson, we discovered a stack of recommendations that needed to be filed. Because the recommendations had not been placed in the inmates' medical charts, the medical staff could not track and implement them.

for both Units and devotes a significant amount of time to administrative matters. Consequently, she often cannot perform important tasks such as providing clinical guidance and oversight to lower level practitioners. The doctor advised that she rarely is able to see chronically ill inmates at Grimes, has little time to review records, and has difficulty seeing sick call patients who are referred to her. As a result, the care available to inmates at both Units is compromised. Although the doctor receives some assistance from a nurse practitioner, nursing staff at both facilities operate without appropriate physician oversight and perform functions outside the scope of their training and licensor. Although the Director of Nursing conducts chart review at both sites, this practice is an inadequate substitute for physician review.

7. Dental Care

Access to basic dental care at both Units does not comply with CMS standards because it is limited, as a matter of practice, to extractions. "Generally accepted standards" require that prisons provide surface restorations, prophylaxis, and preventative care. Although CMS policies are consistent with such standards, our review indicated that the policies are not followed.

B. MENTAL HEALTH CARE

We believe that mental health services at McPherson are constitutionally deficient. The facility provides insufficient access to care and falls short of the "generally accepted standards" that often are relevant to determining whether the State has engaged in unconstitutional conduct. As explained below, these deficiencies result in large part from the lack of appropriately qualified staff and serious gaps in several of the mental health policies.

Although Grimes has similar problems with its mental health care, they are less pronounced. This appears to be because most male inmates who are seriously mentally ill are not sent to Grimes. Moreover, if Grimes identifies a seriously mentally ill inmate, that inmate generally will be transferred to a facility that is better equipped to provide mental health care.

1. Policies and Procedures

In general, with the exceptions noted below, CMS and ADC have adequate written policies to govern mental health services. However, staffing shortages and the lack of supervisory oversight make it difficult for either Unit to implement these policies consistently. During one of our tours, for example, an inmate in McPherson's Special Programs Unit ("SPU") -- an 11-bed unit that serves seriously mentally ill inmates -- was placed in the restraint chair for more than 45 hours without properly documented justification. The inmate reportedly was restrained after threatening to "run her head into the wall and kill herself." Notwithstanding Policy No. 1136, which requires a psychiatric consult after an inmate has been restrained for 24 hours, there is no evidence that such a consult occurred in this case.[6] Moreover, the inmate was restrained in the SPU instead of in the infirmary or another medically appropriate venue. Finally, although it appears that this inmate was allowed to walk every two hours, the manufacturer's instructions warn that the chair should not be used for more than eight to ten hours, and directs that any longer use should take place "under direct medical supervision." This did not occur.

Two of the existing policies regarding the use of medical restraints present health and safety risks. Policy No. 1136, which addresses treatment precautions during crisis management, allows an inmate to be placed in restraints without a face-to-face physician exam. A related policy, No. 66.01, describes the use of medical restraints, but does not give sufficient guidance on how to provide restrained patients with appropriate range of motion exercises to minimize the risk of blood clot formation.

The absence of certain types of policies, and gaps in others, also present life-threatening risks to inmates. Of particular concern is the lack of a written policy and procedure for inmates who take certain psychotropic medications and work in hot outdoor temperatures. For instance, a number of McPherson inmates who participate in extended daily field duties (outside

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[6] In addition to requiring a consult with a psychiatrist, Policy No. 1136 mandates that inmates be seen by mental health staff within 12 hours of being restrained. It is unclear whether this requirement was satisfied.

grounds maintenance) receive psychotropics.[7] Without specific medical interventions, these inmates are at increased risk of heat stroke.

2. Access

The mental health staff does not routinely canvass the general population units or the segregation units of either facility to identify evolving mental health concerns. Indeed, at both Units, inmates' primary access to mental health services is self-referral. Because there is little attempt to identify inmates in need of mental health services who have not self-identified, a number of McPherson inmates receive little or no mental health care.[8] Further, reliance on inmate self-referral shifts the burden of requesting mental health services to inmates and, in so doing, ignores the fact that many mentally ill inmates are unable to recognize their need for such services. Although perhaps not unconstitutional, this is contrary to generally accepted standards. Moreover, our review of the mental health services request logs indicated that staff generally take two to four weeks to respond to inmates' requests for general mental health services. This delay is too long, particularly when inmates are experiencing a mental health crisis. Without adequate access to mental health care, serious mental health needs may go undiagnosed and mentally ill inmates who present a risk of harm to themselves and others may be left untreated.

At Grimes, staff conduct mental health assessments and psychological testing for segregated inmates in front of the inmates' cells. Although, at times, legitimate security concerns may preclude the use of a confidential environment for mental health assessment and testing, the lack of privacy and significant noise level in the segregation unit may inhibit inmates from providing relevant, candid responses, may restrict the mental health provider's visual observations, and may result in incomplete or inadequate mental health assessments. We are aware that this environment would not violate the Constitution,

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[7] Six percent of the McPherson inmates were receiving psychotropic medications at the time of our visit; nearly 28 percent of these inmates work outside.

[8] The exception is the 11-bed SPU discussed below.

but flag the fact that it is inconsistent with "generally accepted standards" in the medical community.

3. Assessment, Diagnosis and Treatment

Appropriate, timely mental health treatment is critical to minimize decompensation, i.e., deterioration of mental health status, and regulate the symptoms of mental illness. Our investigation at McPherson uncovered constitutional violations throughout the mental health care delivery system -- from assessment and diagnosis to treatment planning and implementation of therapeutic and pharmacological interventions.

One of the most significant failures at McPherson is the under-diagnosing of serious mental illnesses. Without accurate diagnoses, mentally ill inmates risk inadequate or inappropriate medication and treatment. Our file review suggests that the problem of under-diagnosing is exacerbated by the mental health staff's tendency to discount both the symptoms and psychiatric histories described by inmates and the records from their former mental health providers. For example, prior to her incarceration, one McPherson inmate took Xanax for her bipolar disorder. The McPherson psychiatrist, however, concluded that this inmate suffered exclusively from substance dependence and discontinued the Xanax prescription. The doctor's notes indicate that he discounted the bipolar diagnosis simply because he did not trust the former provider. He did not use clinical testing protocols to determine whether the prior diagnosis was accurate. Whether this practice constitutes deliberate indifference -- i.e., a constitutional violation -- or mere negligence, it is contrary to generally accepted standards. At the time of our visit in July, the inmate reported that she experiences panic attacks at least once every three days and depressive episodes that last up to three weeks. In the case of another McPherson inmate, the psychiatrist overlooked a family history and prior diagnosis of bipolar disorder when he reportedly told the inmate that she did not have bipolar disorder and "was nothing but a crack head."

Because the psychiatrist does not consistently conduct proper assessments and because his diagnoses often appear arbitrary, we learned in staff interviews that mental health counselors occasionally decline to refer inmates to him. In certain cases, these counselors anticipate the futility of a psychiatric referral because they believe the psychiatrist will

identify the inmate in question as a malingerer. For example, one counselor refused to refer an inmate who presented with complaints of tactile hallucinations and who had twice been hospitalized for psychiatric problems, because the counselor believed the psychiatrist would view these symptoms as "thinking errors" and refuse to see the inmate.

An additional problem is the mental health staff's failure to schedule regular appointments for inmates when clinically indicated. For instance, we interviewed a McPherson inmate **[redacted to protect privacy]** with symptoms suggesting a depressive disorder. Although mental health staff appear to have been aware of this inmate's depression for several months, no care had been provided at the time of our July visit. Instead, after having the inmate sign a "no harm agreement" in which she promised not to commit suicide, the mental health staff allowed the inmate to return to the general population. The only reference to her mental status was a file note stating that she should return to see the mental health staff "as needed." Because mentally ill inmates often have impaired judgment, they may not recognize that they need treatment. Indeed, when we interviewed the suicidal inmate mentioned above, she acknowledged her symptoms but denied her depressed state.

The mental health staff also fail to monitor adequately inmates who take psychotropic medications. We were told that ADC intends to require such inmates to have regular contact with a mental health worker in addition to medication management contact with a psychiatrist. If implemented, this policy will be a significant improvement over existing mental health care.

With regard to medication management, our review of the drug formulary revealed that it does not contain any SSRI (selective serotonin reuptake inhibitor) medications, which are used for anti-anxiety, or any atypical anti-psychotic medications (i.e., newer anti-psychotic drugs that often are more expensive than older generation medications, but have fewer side-effects and work more quickly). Although ADC's contract with CMS reportedly does not have formulary restrictions, we are concerned that, in practice, such inappropriate restrictions exist.

4. Special Programs Unit

The stated mission of the 11-bed SPU at McPherson is to provide specialized mental health treatment and intervention for

seriously mentally ill inmates. In practice, however, the inmates in the SPU do not receive meaningful treatment.

The SPU has only one full-time mental health worker -- a bachelor's-level social worker who also manages the SPU. Although the mental health worker is dedicated, he is not qualified to provide, or capable of providing, all of the necessary mental health services. For example, the mental health worker prepares treatment plans without interdisciplinary input or review by the psychiatrist or psychologist. Without such collaboration, treatment plans are virtually meaningless and SPU inmates fail to receive adequate treatment.

For example, an SPU inmate with a history of multiple suicide attempts, severe personality disorder and post-traumatic stress disorder attempted suicide shortly before one of our visits. Testing later revealed that she suffered from bipolar disorder, major depressive disorder, and schizophrenia. However, there was no evidence that the inmate's treatment plan was modified to address the new diagnoses, and it is unclear whether she is receiving appropriate treatment for each of her serious mental health conditions.

The SPU also provides little meaningful therapeutic activity. The SPU inmates and the correctional staff reported that inmates generally receive one hour of group therapy every one to two weeks. Our review of SPU inmate records confirmed the scarcity of group therapy. Although some individual therapy sessions also occur, they are insufficient to treat the conditions at issue. Moreover, following recent incidents and allegations of sexual misconduct (discussed below), the confidentiality of individual therapy sessions has been compromised. Individual counseling sessions are now conducted with an open office door, and inmates report that because others can hear their discussions, they are less comfortable sharing private information. Where consistent with security concerns, the facility should attempt to provide a confidential environment for counseling sessions.

5. Suicide Prevention

The Units fail to provide adequate monitoring and housing for inmates on suicide precaution. Between January and July 2002, there were five suicide attempts at McPherson and five attempts at Grimes. Additionally, a McPherson inmate attempted

to hang herself in May 2002, although McPherson did not classify this incident as a suicide attempt. In most cases, inmates identified as suicidal are transferred to the isolation unit and housed in a designated "suicide cell." Without adequate mental health treatment services, however, this cell becomes a punishment and can exacerbate the underlying issues.

Additionally, the physical attributes of the suicide cells in both Units present dangers to suicidal inmates. Specifically, the beds in the cells are not anchored to the floor, the panic buttons are inoperable, and there are no intercoms or video surveillance. Moreover, it is difficult for correctional staff to supervise inmates inside these cells because the cell doors have only a small window. Accordingly, the only way staff can directly and constantly supervise suicidal inmates is to stand at the cell door. Finally, neither Unit maintains a cut-down or 911 kit for quick rescue in the event of a hanging.

6. Staffing

The absence of sufficiently qualified mental health staff at McPherson and Grimes contributes to the inadequacy of mental health care. For instance, at the time of our visit, there were 45 inmates at McPherson receiving psychotropic medications and approximately 13 at Grimes. At present, the psychiatrist spends four to five hours a week at McPherson and one to two hours a week at Grimes. The part-time psychologist divides 16 hours, three days a week, between both Units. It appears that the amount of mental health care provided by these professionals is insufficient to address the needs of McPherson and Grimes inmates. Although four full-time bachelor-level mental health counselors provide some additional support, one of these counselors primarily works with pregnant inmates and the other is assigned as the coordinator and counselor for the SPU. While we found these counselors to be dedicated, they are unqualified to provide diagnostic assessments or mental health therapy. Yet, because the psychiatrist and part-time psychologist do not have the time to provide such care, the counselors are left to perform these types of services.

7. Oversight

McPherson lacks an oversight system to ensure that mental health staff provide appropriate services. As a result, staff often are unaware of the problems described above or simply fail

to implement appropriate remedies. For example, McPherson fails to collect and maintain statistical information about the number of mental health screenings performed each month, and does not track and monitor screenings that result in referrals for further mental health evaluation.

C. SECURITY, SUPERVISION AND PROTECTION FROM HARM

Neither Unit adequately supervises its inmates. The supervisory failures facilitate the introduction of contraband and promote violence, placing both inmates and staff at risk of serious harm.

1. Supervision

The physical layout of both Units combined with the current placement of security staff prevent direct supervision of the housing units, thereby increasing the risk of harm to inmates and staff. **[redacted for safety and security]**

At Grimes, the failure to supervise inmates during work details presents additional security risks. During one visit, we discovered a number of inmates hiding behind clothes dryers in the laundry area with the lights turned off. Although approximately 15 inmates work in the laundry, there was no correctional officer supervision in the laundry at that time, and it took more than 15 minutes for an officer to arrive. Additionally, Grimes inmates who work with tools have keys to various tool cabinets and are able to check out tools and maintain tool inventories without supervision. These practices place both inmates and staff at risk.

2. Control of Contraband

Staff and inmates reported that both facilities have a significant problem with contraband, including shanks (i.e., homemade knives) and tobacco. Our review of documents confirmed these reports. If tobacco products are smuggled into the facility, other more dangerous contraband can be introduced as well thereby potentially compromising the safety of inmates and staff. And the concern is obviously even greater with contraband weapons. At Grimes, for example, staff have recovered a large number of shanks, mostly from the housing units. During June 2002, staff confiscated 14 shanks, one ice pick, and one box cutter. The failure to control such contraband and the lack of sufficient oversight by security staff allowed a Grimes inmate to stab another inmate with a shank on April 4, 2002. The assault occurred in one of the open, dormitory-style barracks. No staff were in the barracks at the time; staff reported to the scene after being notified by the control room officer that the stabbing had taken place.

Many of the shanks we viewed appeared to have been constructed from and with materials in the area under construction -- underscoring the need for proper supervision.

Not only do inmates who work in the construction area have access to tools and materials that can easily be fashioned into weapons, but the security measures used to address this risk are inadequate. **[redacted for safety and security]**

The documented involvement of staff in the introduction and trafficking of contraband creates a significant security and safety risk. Staff who commit such acts become vulnerable to potential acts of aggression and/or manipulation by inmates, and innocent staff members may be exposed to illegal transactions that place them in dangerous or compromising situations. As noted, tobacco trafficking also can indicate the trafficking of more serious items such as weapons or illegal or prescription drugs. Finally, having banned items within the prison creates a situation ripe for conflict and extortion.

Contributing to the contraband problem is **[redacted for safety and security]**

3. Inmate-on-Inmate Violence

Grimes fails to supervise properly its inmates and control inmate movement. The result, as the incidents described below demonstrate, is a serious problem of inmate-on-inmate violence. Not only do such incidents create risks of harm to inmates, they also place staff -- who are responsible for intervening in inmate altercations -- at risk.

A recent fight between inmates illustrates problems caused by lax supervision. On July 19, 2002, two Grimes inmates on food

service detail had a fight in the dining area. One of the inmates sustained a broken jaw during the incident. Although the incident report does not describe the location of staff at the time of the fight, it is clear that the inmates were unsupervised. According to the injured inmate, staff had left the dining area to store supplies, leaving the inmates unattended for a significant period of time. An ADC employee informed us that it took approximately 45 minutes for security staff to respond to this incident.

Another fight took place on August 22, 2002 in a shower area at Grimes. Again, one of the inmates sustained a broken jaw. We heard conflicting reports regarding the whereabouts of vestibule staff during the incident. One report maintained that correctional staff were nowhere to be found and became aware of the incident only after security staff observed visible injuries. Another report, however, maintained that correctional staff were present, but ignored warnings that a fight was starting. The injured inmate stated that he could not obtain staff assistance because, among other things, the barracks call button was inoperable.

In addition to the incidents described above, other inmate violence results from uncontrolled inmate movement. For example, on April 6, 2002, a Grimes inmate attacked another inmate in a barracks. The inmate who initiated the attack was not housed in that barracks and should not have been there.

Similarly, on June 7, 2002, a McPherson inmate attacked another inmate in the pill call line for housing unit 2. Although the assault appears to have been stopped quickly by security staff, the inmate who instigated the violence should not have been in the line because she was assigned to housing unit 1, which has a separate pill call.

[redacted for safety and security]

4. Classification of Inmates

The classification system at Grimes contributes to the safety and security deficiencies at the facility. Generally accepted classification systems separate problematic inmates from those who cause fewer problems or who are vulnerable to violence or abuse. Grimes' failure to do so makes supervision more difficult and increases the risk of harm to both staff and inmates.

D. SEXUAL MISCONDUCT, SUPERVISION AND PRIVACY VIOLATIONS

Under former management, there were numerous sexual misconduct incidents at the Units.[9] The number of allegations and incidents appears to have decreased since ADC assumed operational control in July 2001 and instituted policies and training to address staff/inmate sexual misconduct. Yet despite the Units' attempt to respond to sexual misconduct, our records review and staff and inmate interviews indicate that the following serious problems continue to exist: (1) lapses in supervision of staff and inmates; (2) privacy violations; and (3) substandard investigations. Because of these failings, we conclude that McPherson and Grimes fail to protect adequately their inmates from harm. In addition, the privacy violations we observed and the substandard misconduct investigations we reviewed create an atmosphere conducive to misconduct and abuse.

During the 13 months following the State's resumption of control of the Units (from July 2001 to August 2002), there were at least 13 reported incidents of sexual misconduct or abuse. Each occurred in areas that, during the night and early morning, are poorly monitored and/or isolated. For instance, on June 13, 2002, a male nursing assistant sexually assaulted a

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[9] These incidents were confirmed by staff and inmates.

McPherson inmate who reported for a minor medical procedure. The assault took place in an unmonitored examination room and lasted between five and six minutes. After the inmate reported the incident, the nursing assistant confessed and was terminated. A few days later, at 12:30 a.m., an officer and inmate were found in the programs area broom closet. The officer's pants were open, and the couple later admitted they intended to engage in sexual intercourse. The subsequent investigation, which resulted in the officer's termination, revealed that the officer and inmate had been sexually involved for a month. Around the time the officer and the inmate initiated the relationship, ADC warned the officer that he "appeared to be spending too much time with inmates," and yet no corrective actions were reportedly taken.

Similar problems exist at Grimes. In the Spring of 2002, a female sergeant was terminated for making phone calls to a former inmate. According to supervisory staff, the sergeant and the former inmate had been in a sexual relationship while the inmate was incarcerated. Another female officer was terminated on May 8, 2002 after she and an inmate were seen in a compromising position. Although this officer was accused of sexual misconduct, she ultimately was terminated for lying about a relationship with another officer.

In addition to these examples, there appear to be additional cases of sexual misconduct that were never investigated. For instance, our review of one investigative file referenced a female officer who was terminated for sexual misconduct. The file did not indicate whether ADC Internal Affairs or Grimes staff ever investigated the allegations. We also were told of two other recent incidents, one of which management verified, for which we received no paperwork. In addition, uninvestigated grievances and allegations (discussed below in Section II.D.3) both heighten the risk of sexual misconduct and suggest that sexual misconduct and abuse occur more frequently than is reported.

1. Security, Oversight, and Supervision

As discussed in Section II.C.3, inmates at McPherson and Grimes often violate the policies that limit unsupervised inmate movement. Incident reports and inmate interviews provide further evidence of unauthorized inmate movement. Not only have multiple inmates been written up for being in restricted areas, inmates themselves told us how, during shift changes, they can move

undetected into isolated areas to have sex with other inmates and with staff. These events reportedly occur in poorly monitored locations. Certain areas at both Units appear to be the most likely places for sexual misconduct to occur. **[redacted for safety and security]** According to an inmate and a member of the staff, the medical area is used for sexual misconduct during shift change, particularly in the early morning hours. We were told that sexual misconduct often takes place at night in the program areas. Other isolated venues we found to be inconsistently locked and monitored include the maintenance area and the training/muster room.

2. Privacy Violations

In some instances, it appears that McPherson may not provide reasonable privacy for its inmates. The shower curtains in the barracks are transparent, and inmates report that male officers gratuitously observe them during their showers. For instance, the inmates allege that instead of watching the shower area to assess security issues, male officers stand and watch them without a security purpose whatsoever throughout the duration of their showers. We obviously cannot know whether these inmate accounts are in fact true, but the allegations are troubling. To be sure, McPherson has a legitimate security interest in monitoring all areas of the prison, including the inmates' showers. Indeed, the safety and security of inmates and officers require such supervision. However, while opposite-sex surveillance of female inmates is not unconstitutional, such surveillance must further the goal of prison security. See Timm v. Gunter, 917 F.2d 1093, 1102 (8th Cir. 2002). There is no penological interest in prurient observation of naked inmates.

3. Investigations

Our review of 13 investigative records from July 2001 to August 2002 reveals that investigations -- whether performed by ADC Internal Affairs staff or by staff who work at the Units -- often are ineffective and unprofessional. Specifically, we observed a consistent over-reliance on the use of leading questions, a failure to ask critical follow-up questions, and missed lines of questioning about significant information. Any one of these shortcomings could compromise investigations. In one recent sexual misconduct investigation, the investigator provided a detailed account of the allegation and stated his opinion that the officer's actions did not amount to misconduct

before taking the officer's statement. The officer then asserted a defense based on information provided by the investigator. In this same investigation, the investigator responded to an inmate's formal complaint about improper behavior by commenting that when male officers see so many women they think "they are there for stud service only." In another investigation, the investigator made several inappropriate statements while questioning a witness about the officer's involvement with the inmate in question. Among other things, the investigator opined that the officer did not "look like he would have probably dealt with a black girl."

Investigators also occasionally appear to fail to investigate misconduct discovered during unrelated investigations. For instance, while investigating an alleged relationship between two officers, an internal affairs investigator uncovered allegations of unrelated sexual misconduct by an officer at McPherson. The allegations, contained in 15 grievance reports, included: (1) privacy rights violations; (2) male inmates being left alone with female inmates; (3) the practice of officers, who had no formal role whatsoever in intake or adjacent areas, "watching" strip searches in intake; and (4) retaliation towards inmates who report inappropriate conduct. No investigation was conducted of these allegations.[10]

4. Policies

ADC's sexual misconduct policies are generally sufficient. However, certain policies fail to meet "generally accepted standards." For instance, while ADC policies appropriately prohibit sexual contact between inmates and ADC employees, they fail to prohibit sexual misconduct by all persons who have or might have contact with inmates (e.g., volunteers, contractors or agents). Other policies obstruct the process of reporting sexual misconduct. For example, ADC policy directs inmates to report

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[10] Although the officer eventually was terminated for an unrelated sexual misconduct incident, the 15 grievances were ignored after an assistant warden told the investigator that "the women were angry with the officer because he had been responsible for tobacco and drug busts." Given the number of complaints filed against this officer over an extended period, the assistant warden's opinion should not have prevented an objective investigation.

sexual misconduct through the grievance process. This reporting mechanism is improper because grievances are not confidential. Additionally, implementation of sexual misconduct policies is inconsistent. For instance, although several polices require that all sexual misconduct investigations be completed and, in certain cases, forwarded to the state police, some investigations we reviewed ended prematurely when an accused officer resigned or was terminated. For example, an investigation into a female sergeant's alleged sexual relationship with a Grimes inmate was closed when the sergeant resigned for an unrelated reason. The investigation into alleged sexual misconduct between another female officer and a male inmate ended after the officer was terminated for lying about an unrelated matter.

E. LIFE SAFETY AND SANITATION

The environmental health and safety conditions at McPherson and Grimes fail to meet "generally accepted standards" in the areas of fire safety and prevention; food service; plumbing; and general sanitation and safety. We are aware that some of these failures to comply with generally accepted standards may not rise to a constitutional deficiency, and to the extent they do not, we merely flag those issues for training purposes.

1. Fire Safety and Prevention

In the event of a fire or other emergency, the evacuation of inmates depends, in part, on doors that must be manually unlocked and opened. Neither facility maintains emergency keys in a readily-accessible location, and the identification of emergency keys is a cumbersome process. At both McPherson and Grimes, officers must use four separate rings of emergency keys (each with numerous keys) to access all areas of the facility.[11] Finding the correct key is especially difficult at McPherson because most keys are not color-coded or notched to permit identification in the dark or in a smoke-filled room. Moreover, the back-up sets of emergency keys at both facilities do not match the primary sets. In addition to these shortcomings, at the time of our tour, eight of the 22 emergency doors at Grimes

[11] Although we recognize the security interest in maintaining keys on different rings, both facilities must provide for prompt and quick evacuation in the event of a fire or other emergency.

would not open. Two of these doors appeared to have been sabotaged by inmates who jammed the locking mechanisms; the remainder had electrical, mechanical, or maintenance problems. The deficiencies in emergency key and door operations present safety and security risks for both inmates and staff.

Both McPherson and Grimes use standpipes to provide high-pressure water to fight fires. During our tour, we observed that fire hoses were missing from the standpipes at McPherson and that the wheels used to turn on the water were missing from the standpipes at both facilities. Hoses should be available and standpipe wheels should be in place at all times. Valuable time would be wasted if these items had to be located, retrieved, and mounted before water was available to contain and fight a fire. During an inspection that preceded our visit by more than five months, the local fire marshal cited both McPherson and Grimes for missing standpipe wheels and required corrective action.

2. Food Service

The food service programs at McPherson and Grimes raise a number of health and safety issues.

a. McPherson

Many aspects of the food service program at McPherson present unacceptably high risks of food contamination, food-borne illness, and injury to inmates working in the food service area.

Throughout our inspection, it was evident that inmate workers receive no food safety training. Dishes and food trays are not properly cleaned or sanitized because the water in the dishwashing machines does not reach the temperature necessary to achieve sterilization. Further, pots and pans are cleaned improperly as it appears from our observations and inmate reports that a sanitizing agent is never used in the sink. Compounding these health hazards is the fact that food trays are not consistently air-dried, and the fact that McPherson reuses single-service plastic utensils that cannot be cleaned adequately after the first use.

McPherson has no procedure for feeding inmates when the kitchen cannot operate safely. For instance, during one of our visits, there was no hot water in the kitchen. Instead of taking appropriate measures, the kitchen continued to operate as usual.

Several weeks before we arrived, the kitchen experienced a sewage backup. Although the backup reportedly took several days to fix, the kitchen operated normally throughout that time. Both the lack of hot water and the sewage backup had the potential to cause serious life-threatening illnesses to staff and inmates.

Contributing to inadequate sanitation is the lack of adequate hand washing facilities. At the time of our tour, one of three hand washing sinks in the kitchen area was missing and one had an inoperable hot water handle. Moreover, trash cans were not provided at any of the hand washing locations. These deficiencies discourage proper hygiene practices and render inmates and staff subject to disease.

At the time of inspection, the walk-in coolers at McPherson were dirty. One contained run-off from a clogged floor drain, another was filled with dirt and debris, and another contained pools of blood from thawed meat. The walk-in freezer also was dirty and had significant ice build-up. Finally, the gas fryer was improperly wired. To light it, workers had to get down on a wet floor and wiggle the wires.

b. Grimes

The Grimes kitchen was under construction during our visits. All meals served at Grimes were prepared at McPherson and transported to Grimes. Nonetheless, we found Grimes to have serious problems with food handling practices and sanitation.

At the time of our first visit, the food transportation truck was undergoing renovation and meals were being transported in a van. The van was fly infested, had food spilled on its floor and sides, and emitted a stench so strong that some staff refused to get near it. The van was replaced by the regular truck the day before our second visit. Although this replacement vehicle was suitable for food delivery purposes, the containers used to transport the food were dirty and had ill-fitting lids.

Food safety training at Grimes also is inadequate. During our inspection, cold food and beverages were not refrigerated or placed in ice pans once they reached the gym, increasing the risk of food-borne illnesses. For instance, although cold foods should be served at no more than 40 degrees, the milk we tested registered 63 degrees.

3. Plumbing

[redacted for safety and security]

4. General Sanitation and Safety

Several of the housing units at McPherson have too few sinks, showers and toilets to meet the needs of the inmates. Moreover, we observed inoperable showers and toilets; showers with mold, mildew and peeling paint; and missing shower nozzles in the segregation unit. At Grimes, we observed inoperable showers and toilets, clogged drains, and plumbing leaks. In addition, several mop sinks had no backflow prevention device to prevent possible contamination of the potable water system.

III. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of inmates, ADC should implement, at a minimum, the following measures at both Units:

A. MEDICAL CARE

1. Provide pap smears to each incoming inmate and annually thereafter, and provide mammograms as clinically indicated. Inform inmates of these and all other test results.

2. Increase on-site physician coverage to ensure adequate supervision of nursing staff and adequate primary and chronic care.

3. Provide sufficient staffing to ensure that inmates who make sick call requests are seen in a timely manner.

4. Develop and implement a quality improvement system that monitors the quality of medical care services and access to such care.

5. Implement a system to ensure that the existing chronic care program and protocols are implemented consistently. Allow asthmatic inmates to access their inhalers, and educate security staff on the need for such inmates to receive breathing treatments. Develop and implement policies and procedures regarding treatment of Hepatitis C.

6. Develop and implement a policy to discipline inmates who abuse the sick call system.

7. Ensure that inmates with special medical needs are promptly scheduled for and transported to outside care appointments. Ensure that the findings and recommendations of outside care providers are tracked and documented in inmates' medical charts, and follow outside treatment recommendations when appropriate.

8. Enforce existing dental care policy to provide full array of dental services, including surface restorations, prophylaxis, and preventative dental care.

B. MENTAL HEALTH CARE

1. Implement a policy that requires mental health staff to make regular rounds in the segregation units. Modify the comprehensive mental health evaluation to ensure that mental health practitioners provide accurate diagnoses and timely implement treatment plans.

2. Develop and implement policies, procedures and practices to ensure that staff triage and respond to mental health requests in a timely manner, and that they provide adequate ongoing mental health care. Provide, where consistent with legitimate security concerns, an appropriate confidential environment for psychological testing and counseling.

3. Ensure adequate on-site psychiatrist supervision of mental health staff and sufficient staff to provide appropriate mental health care.

4. Improve monitoring and treatment of inmates who are seriously mentally ill through regularly scheduled visits with mental health professionals. Develop and implement a policy requiring inmates who take psychotropic medications to have regular contact with mental health staff.

5. Revise the drug formulary to include at least one SSRI or atypical anti-psychotic medication. Alternatively, revise, if necessary, the CMS contract to specify that practitioners may request non-formulary medications.

6. Remove suicide hazards from all suicide precaution cells, provide appropriate housing for suicidal inmates, and enhance existing policies, procedures and practices to ensure proper supervision of suicidal inmates and the availability of cut-down tools.

7. Conduct training for security and SPU staff on how to understand symptoms of mental illness and respond appropriately.

8. Develop and implement policies, procedures, and practices to ensure: (1) that a mental health caseload roster is developed and regularly updated to reflect intakes and discharges; and (2) that the provision of mental health services is tracked through an effective management information system.

9. Develop and implement a quality improvement system that monitors the quality of mental health services and access to such care.

10. Ensure appropriate use of the restraint chair by restricting its use to appropriate circumstances.

C. SECURITY, SUPERVISION AND PROTECTION FROM HARM

1. Provide adequate correctional officer staffing and supervision to ensure inmate safety. Ensure that inmate work areas are supervised whenever inmates are present.

2. **[redacted for safety and security]**

3. Install security cameras in the intake, kitchen, laundry, muster room, program, and mess areas.

4. Implement an objective classification system at Grimes that separates inmates in housing units by classification levels.

5. Develop and implement a policy for effective tool control. Establish a procedure to ensure that inmates do not possess or have access to contraband.

D. SEXUAL MISCONDUCT, SUPERVISION AND PRIVACY VIOLATIONS

1. Review and revise selection criteria and training for investigators. The training should provide investigative templates to assist in gathering evidence, conducting witness interviews, and preparing investigative reports.

2. Review and revise the overall investigative process to ensure that administrative and criminal investigations are handled appropriately. Ensure that sexual misconduct investigations do not terminate when a staff member is fired or resigns. Ensure that if during the course of an investigation, the investigator discovers evidence of other misconduct, the investigator also should investigate the secondary misconduct to its logical conclusion.

3. Ensure that established protocols for reporting and investigating sexual misconduct allegations are followed consistently. Establish policy for confidential reporting of sexual misconduct.

4. Regularly review grievances for allegations of sexual misconduct or harassment, and conduct full-scale investigations where appropriate.

5. Vigorously restrict unsupervised inmate movement and ensure that isolated areas are adequately staffed, monitored and, when not in use, secured and locked.

6. Where consistent with legitimate security concerns, develop and implement policies and procedures to provide for privacy in inmate showers.

E. LIFE SAFETY AND SANITATION

1. Develop and implement a key procedure that permits identification of cell block keys in emergency situations.

2. Develop and implement emergency door inspections.

3. Permanently mount standpipe control wheels and provide and maintain fire hoses for use in both facilities.

4. Provide training for kitchen workers in the areas of food

safety and food handling to reduce the risk of food contamination and food-borne illness.

5. Ensure that dishes and utensils, food preparation and storage areas, and vehicles and containers used to transport food are properly cleaned and sanitized. Ensure that foods are served and maintained at proper temperatures.

6. **[redacted for safety and security]** Monitor ambient air temperatures to ensure that housing area temperatures are appropriate for the particular population.

7. Equip all threaded hose bibs with approved backflow prevention devices.

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We understand that officials recognize many of the problems discussed in this letter. In anticipation of continuing cooperation toward a shared goal of achieving compliance with constitutional requirements, we will forward our consultants' reports under separate cover. Although the reports are the consultants' work and do not necessarily reflect the official conclusions of the Department of Justice, the observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that 49 days after receipt of this letter, the Attorney General may institute a lawsuit pursuant to CRIPA to correct the noted deficiencies. 42 U.S.C. § 1997b(a)(1). Accordingly, we will soon contact state officials to discuss in more detail the measures that must be taken to address the deficiencies identified herein.

Sincerely,

/s/ R. Alexander Acosta

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