March 6, 2003

Mr. Jack Sullivan
County Commission Chairman
102 Grant Avenue
Santa Fe, NM 87501

Re: Santa Fe County Adult Detention Center
(Formerly the Santa Fe County Correctional Facility)

Dear Mr. Sullivan:

We write to report the findings of our investigation of conditions at the Santa Fe County Adult Detention Center ("Detention Center," formerly the Santa Fe County Correctional Facility). On March 20, 2002, we notified you of our intent to investigate the Detention Center pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.

On May 7-10 and 29-31, 2002, we conducted on-site inspections of the facility with expert consultants in corrections, medical care, mental health care, and sexual misconduct/gender issues. While at the Detention Center, we interviewed correctional and administrative staff, inmates, medical and mental health care providers, and programming, training, safety, food service and sanitation personnel. Before, during and after our visit we reviewed an extensive number of documents, including policies and procedures, incident reports, medical and mental health records, inmate grievances, use of force records, and investigative reports.

We commend the staff of the facility and the County for their helpful and professional conduct throughout the course of the investigation. The staff have cooperated fully with our investigation and have provided us with substantial assistance.

Consistent with the statutory requirements of CRIPA, we write to advise you of the results of this investigation. As described more fully below, we conclude that certain conditions at the Detention Center violate the constitutional rights of inmates. We find that persons confined suffer harm or the risk

of serious harm from deficiencies in the facility's provision of medical and mental health care, suicide prevention, protection of inmates from harm, fire safety, and sanitation. In addition, the facility fails to provide inmates sufficient access to the courts and opportunity to seek redress of grievances.

I. BACKGROUND

A. FACILITY DESCRIPTION

Santa Fe County opened the Detention Center in 1998. Management and Training Corporation ("MTC"), a private corporation, has managed and operated the facility by contract with the County since October 2001. The facility has a housing capacity of approximately 672 inmates. On the first day of our visits to the facility, the total inmate population was 598. There were 532 adult male and 66 adult female inmates. At the time of our visits, the Detention Center housed inmates from nineteen jurisdictions, including federal inmates by agreement with the Bureau of Indian Affairs and the United States Marshals Service. Since that time, the facility has entered into a contract to house a large number of inmates from the State of New Mexico Department of Corrections, as well.

Inmate housing includes double cells and dormitories. Some inmates are singly housed in double cells. Housing is divided into four housing unit pods of six areas each, centrally managed by a unit control center. The Detention Center also has administrative areas, classrooms, a booking and intake area, four outdoor recreation yards, food service, laundry and medical facilities. Physicians Network Associates ("PNA") provides the medical care at the facility by subcontract with MTC.

B. LEGAL BACKGROUND

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights of inmates in jails and prisons. 42 U.S.C. § 1997.

With regard to sentenced inmates, the Eighth Amendment's ban on cruel and unusual punishment "imposes duties on [prison] officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care." Farmer v. Brennan, 511

U.S. 825, 832 (1994). Prison officials have a further duty "to protect prisoners from violence at the hands of other prisoners." Id. at 833. The Eighth Amendment protects prisoners not only from present and continuing harm, but from the possibility of future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993). It also forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1 (1992). Medical needs which must be met include not only physical health needs, but mental health needs as well. Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977); Young v. City of Augusta ex rel Devaney, 59 F.3d 1160 (11th Cir. 1995).

With regard to pre-trial detainees, the Fourteenth Amendment prohibits imposing conditions or practices on detainees not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. 520 (1979). The Fourteenth Amendment also requires that inmates have access to the courts, sufficient to challenge their sentences and the conditions of their confinement. Bounds v. Smith, 430 U.S. 817 (1977); Lewis v. Casey, 518 U.S. 343 (1996).

II. FINDINGS

A. MEDICAL CARE

The Detention Center provides medical services through a subcontract between MTC and Physicians Network Associates ("PNA"). The Detention Center, through PNA, provides inadequate medical services in the following areas: intake, screening, and referral; acute care; emergent care; chronic and prenatal care; and medication administration and management. As a result, inmates at the Detention Center with serious medical needs are at risk for harm.

1. Intake, Screening, and Referral

PNA's intake medical screening, assessment, and referral process is insufficient to ensure that inmates receive necessary medical care during their incarceration.

According to PNA policy and in keeping with the standard of care in jails, all arrestees should receive an initial health screening at the time of booking. At the Detention Center, screenings are completed by a Licensed Practical Nurse ("LPN") following a three-page form, and include a physical, mental, and

dental health screen. The intake process is intended to ensure that inmates who suffer from chronic conditions or otherwise need prompt medical attention are referred to the Health Services Unit for needed follow-up care and given appropriate housing.

Review of a random sample of medical records of inmates admitted during the month of April 2002, revealed that 20 percent did not have the documented initial health screening described above. Without this screening, incoming inmates suffering from chronic and/or contagious disease may not be referred for follow-up care, which heightens the risk that their illnesses will continue and their conditions will deteriorate. Furthermore, incoming inmates whose illnesses go undiscovered and untreated may be housed with the general population, placing other inmates and staff at risk for disease.

Moreover, even when PNA staff identify inmates with serious medical needs during the intake process, they fail to refer them for appropriate care. Chart review revealed that of those inmates in our sample who did receive the initial health screening, none were referred to the Health Services Unit for the medical attention they needed. For example, inmates reporting histories of hypertension and depression who claimed to be on prescription medication at the time of their incarceration should have been promptly referred to the Health Services Unit for assessment, decisions about continuity of medication(s), and appropriate medical care. Interruption of hypertension medication can lead to heart ailments and strokes, and interruption of antidepressant medication can lead to mental health crisis as well as resulting in physical withdrawal symptoms such as headache, disturbed sleep and loss of appetite. Failure to refer for medical follow-up inmates who have chronic or acute conditions may result in the interruption of treatment and medication, which may in turn lead to deterioration or loss of function.

Subject to reasonable security needs, screening interviews must be conducted privately, to ensure that the inmate feels comfortable enough to disclose any physical or mental health problems she or he may be experiencing. During our visit, we observed breaches of confidentiality of inmate medical and mental health information. Two different male corrections officers, on

separate occasions, entered the room where a newly admitted female inmate was completing the initial health screening and observed parts of the process. One of the male officers handcuffed the inmate. The officers' presence and the imposition of unneeded restraints on a cooperating inmate decreases the likelihood that the inmate will provide reliable information during the screening. Accurate medical history is critical to the provision of appropriate care and protection of other residents and staff from communicable diseases.

To provide for inmates' serious medical needs, facilities must identify inmates with chronic, acute or contagious conditions or other serious needs so that appropriate care may be provided. Accordingly, inmates who stay more than a few days at a facility must have a detailed assessment of their health histories and current conditions beyond the limited information provided in the intake health screening. Such steps are necessary so that plans for inmates' ongoing care may be established. The facility fails to conduct timely histories and physicals to ensure that medical providers have adequate information to meet inmates' serious medical needs.

Our review indicated that only 37 percent of the inmates received a full health appraisal within 14 days of arrival at the facility. Only 50 percent of the records in our sample contained documentation that the health appraisal or the skin test for tuberculosis were completed within 18 days of admission. In some files in which a health appraisal was recorded, documentation was incomplete, and failed to include information on the inmate's history, a review of symptoms and/or a record of the physical examination. In some cases we reviewed, PNA staff failed to respond appropriately to information received from inmates during the 14-day evaluation, including information which indicated a serious medical need. The nurses conducting these examinations have no formal training in physical assessment.

For example, one inmate reported during his 14-day physical that he had tested positive for glaucoma at the facility from which he was being transferred. Although a note was placed in his chart to procure the records of this test, PNA failed to follow through and staff never obtained the records. The inmate complained about his condition again nearly two months later, but still did not receive an eye examination. Another four months passed between the inmate's second request and our site visit to the Detention Center, at which point our expert reviewed this

inmate's medical record and reported his concern to the staff. Nearly one month after our visit, the patient finally received an eye examination. However, there was still no report of an ocular pressure determination or any other test to detect glaucoma. If this inmate has glaucoma, he may become blind unless he receives treatment. As of our last review of his chart, it had been eight months since he originally reported this condition during the initial health screening, and his record still did not reflect an appropriate assessment to determine what care he needed.

PNA does not test for sexually transmitted diseases ("STDs"). STDs are prevalent in jail populations. Left untreated, STDs can cause brain and organ damage and damage to fetuses. PNA's failure to screen for STDs places the inmates and the community at risk.

2. Acute Care

PNA fails to provide timely access to appropriate medical care for inmates when they develop acute medical needs. Medical care is unreasonably and unnecessarily delayed and, even when provided, often inadequate.

Inmates access medical care by completing sick call forms, which are filed in boxes on the housing pods. A designated member of the Health Services Unit staff retrieves the sick call forms daily. PNA policy provides that the requests will be "triaged," and inmates will receive medical care according to the urgency of their medical needs. The Health Services Unit calls for the inmate if a visit to the Unit is deemed necessary.

Our review of inmate sick call requests revealed that inmates experience delays in responses to their requests for care, putting them at risk for worsening conditions. For example, one inmate filed a sick call request stating that he was suffering from alcohol and narcotic withdrawal symptoms, including cold sweats and vomiting. PNA policy states that an inmate exhibiting symptoms of withdrawal such as sweating and vomiting will be evaluated by a Health Services staff person as soon as possible. This inmate was not seen for four days, even though withdrawal from alcohol can be life-threatening.

Even once inmates succeed in getting to the Health Services Unit, they frequently receive substandard care. We reviewed the medical records of ten inmates seen for primary care by the nurse practitioner within a one-month period. Six of the ten inmates received substandard care. For example, two inmates had abnormal

skin tests for tuberculosis, one of whom was recently infected, but neither was offered treatment. The consequences of failing to treat new latent tuberculosis infection can be severe, as recently infected individuals are at a high risk of developing contagious tuberculosis. This risk can be significantly reduced with prophylactic treatment. The nurse failed to recognize abnormal heart rhythm in one inmate, and in a second inmate, identified abnormal heart rhythm but failed to refer that inmate to a specialist for appropriate examination.

Additional chart reviews confirmed PNA's failure to respond to inmates' acute medical needs. For example, one inmate reported breast lumps and lumps in her armpit, chest pain, and swelling in her legs and feet. Although a mammogram was ordered in October 2001, it had not been done by the time of our visit to the Detention Center seven months later. In addition, by that time the swelling in this inmate's legs was so severe that when pressed, her tissue stayed depressed, resembling "silly putty." This condition is known as "pitting edema" and, as our expert reported to the PNA staff, requires urgent medical care. Pursuant to our recommendation, this inmate was subsequently seen by a physician. However, the physician did an incomplete evaluation of her swollen legs and did not document whether he conducted an evaluation of her breast or armpit lumps.

Another inmate who had heart disease and a history of positive skin testing for tuberculosis complained of chest pain. The nurse practitioner treated him with nitroglycerin. After two months, the inmate was sent to the emergency room, where the physician recommended a chest x-ray, a stress test, and treatment with long-acting pain medication, none of which the inmate received. Three months later, the inmate developed fever, chills and an elevated respiratory rate. The nurse practitioner did not examine the inmate or order a chest x-ray, which would be the standard of care for a patient with a positive skin test for tuberculosis complaining of these symptoms. Instead, the nurse practitioner diagnosed the inmate with pneumonia and prescribed antibiotics through a telephone call with health services staff, which is inconsistent with accepted standards of care. She did not see the inmate until three days later. The failure to diagnose and treat this inmate in an appropriate manner on a timely basis, despite the fact that he could have had tuberculosis, placed the inmate at serious risk. Furthermore, the failure to place this inmate in respiratory isolation based

on the possibility that he was infected with tuberculosis placed the inmates and staff at risk for contracting the disease.

The grievance system does not provide an avenue for resolving problems of access to health services. The grievances we reviewed included a complaint from one inmate who was supposed to have an x-ray, but had received no response from the Health Services Unit despite having filed two grievances in three weeks. This complaint was not reviewed for eight days after it was filed, and no resolution to the grievance is documented. Another inmate filed a grievance complaining that he had not received his medication and that his condition was worsening. According to the response record, the matter was not resolved for eight days.

The nurse practitioner's personnel file included a memo from the Vice President of Operations of PNA instructing her to see one patient for each five minutes of scheduled clinical time. Many inmates, particularly those with acute or chronic conditions, require significantly more clinical attention to ensure that their needs are adequately addressed. This arbitrary time limit places extreme pressure on the nurse practitioner and necessarily affects the care she is able to provide. It also increases the likelihood that the nurse practitioner will fail to diagnose, will incorrectly diagnose, and/or will fail to provide appropriate treatment and prescribe correct medications to inmates with medical needs.

At the time of our visit, the only physician providing supervision or care at the Detention Center was the doctor who is the Chief Executive Officer (CEO) of PNA and is based in Lubbock, Texas. As the CEO of PNA, this doctor has numerous responsibilities, including supervising the medical care at each of the facilities at which PNA provides care throughout the south and southwestern United States. This physician was visiting the Detention Center an average of once every six weeks, and saw only a few patients during each visit. While he is available by telephone for consultation, he does not visit the Detention Center frequently enough to provide adequate supervision. Given the deficiencies in care and other problems identified in this letter, additional physician supervision at the Detention Center is necessary.

3. Emergent Care

PNA fails to provide appropriate and timely care to inmates

with emergent medical needs.

One case we reviewed involved an inmate who was referred to the Health Services Unit because he had bleeding from the ear following trauma. Bleeding from the ear typically indicates either a perforated ear drum or a basilar skull fracture. The nurse never provided or referred the inmate for a full ear examination or a neurological examination, and instead prescribed an addictive narcotic pain reliever which is an inappropriate treatment for these symptoms.

Another inmate entered the Detention Center with high blood pressure and diabetes. He reported sudden loss of vision on February 20, 2002. Diabetics are at an increased risk for disease of the retina and bleeding into the retina. Sudden loss of vision, particularly in the case of a known diabetic, constitutes a medical emergency, and the inmate should have been immediately referred for emergency care. He was referred to an optometrist, who measures eyes for eyeglasses, as opposed to an ophthalmologist, who specializes in diseases of the eye. The inmate was finally seen by an ophthalmologist on April 1, 2002, nearly six weeks after he lost his vision. Although the ophthalmologist immediately referred him to a retina surgeon, the Detention Center did not transport him to the retina surgeon for nearly two more weeks. After examining the inmate, the surgeon identified the inmate's condition as a medical emergency and called the Detention Center for permission to operate immediately. Nonetheless, the inmate did not receive the surgery for another ten days. Although this inmate's blindness could have been prevented had he received appropriate care, the delay in treatment caused him to lose his vision permanently.

Another inmate, also with severe symptoms, was similarly unable to access appropriate care when he experienced a medical emergency. This inmate, who reported a history of head trauma at intake, became disoriented on his third day at the Detention Center. Three days later he experienced bowel and bladder dysfunction, exhibited abnormal movement in his extremities, and had difficulty balancing. After another three days, he became incontinent, was disoriented and experienced weakness in his left side. The facility finally sent him to the emergency room at this point. Head trauma can cause serious seizure disorders. Despite this inmate's history of head trauma and his serious symptoms, neither the nurse practitioner nor the physician at the Detention Center ever examined him. This denial of treatment

resulted in the worsening of the inmate's condition.

4. Chronic Illness and Prenatal Care

Individuals suffering from chronic illnesses such as diabetes, hypertension, asthma, and HIV must be regularly monitored by medical professionals to ensure that their symptoms are under control and their medications are appropriate. PNA's policies recognize its obligation to provide appropriate medical care for inmates with chronic diseases. Nevertheless, our review of the medical records of fourteen inmates known to have one of the four chronic diseases mentioned above revealed that PNA fails to provide adequate medical care to inmates with chronic diseases.

For example, appropriate care for individuals with hypertension requires that the individual's blood pressure be brought under control by diet and prescribed medication. The medical records we reviewed, however, indicated that only 50 percent of the inmates with hypertension received such care at the Detention Center. The standard of care for individuals suffering from asthma requires the performance of a baseline peak flow measurement and, for those with persistent asthma, treatment with inhaled control medication and the provision of rescue medication. We reviewed medical records for four inmates with moderate persistent asthma. Of these four, only one had a documented measurement of peak flow. None of the inmates had appropriate medication with inhaled steroids. Without this care, these inmates are at risk for persistent wheezing, bronchopneumonia, and life-threatening health crises. Of the five diabetic inmates whose charts we reviewed, none had documented measurements of A1C hemoglobin. This measurement is the only way to assess long term control of the disease. Furthermore, none of the diabetics had documented retinal examinations, which should be done annually. Such an examination might have prevented the loss of vision experienced by the diabetic inmate discussed in the preceding section.

The Detention Center fails to provide a medically appropriate diet for inmates with conditions that require the inmates to receive special diets. For example, the "heart healthy diet" provided to diabetics at the Detention Center contains approximately 30 percent more calories and fat than recommended for diabetics.

PNA fails to provide adequate prenatal care for pregnant inmates. Of the four pregnant women at the Detention Center at the time of our visit, none had any prenatal visit with an OB/GYN during their incarceration documented, despite the fact that two of the women were in their third trimester of pregnancy and near term. While the pregnant inmates may have been seen by the nurse practitioner, they were not screened for diseases that can severely impact maternal and fetal health.

We reviewed the chart of one inmate who was within days of delivery at the time of our visit. This inmate reported a history of spontaneous miscarriages. She was within six weeks of delivery when she arrived at the Detention Center, and the nurse practitioner advised that she should be transferred to another facility better equipped to handle inmates with high risk pregnancies. This transfer never took place. Despite the nurse practitioner's recognition of this inmate's serious medical needs, the inmate was not scheduled for a prenatal visit with an OB/GYN until our expert reviewed her chart and advised the Detention Center staff that she needed additional prenatal care immediately. She was scheduled for a visit with an OB/GYN that week, and delivered one week later. This delay of care was deficient and placed the woman and her child at risk for serious harm.

5. Special Needs Care by Outside Providers

As discussed in the chronic care section above, Section A(4), the Detention Center fails to ensure that inmates receive timely referral to outside care providers when specialized care is medically necessary. In addition, our review indicates that approximately one in three outside care appointments that are arranged by medical staff are postponed or cancelled because of lack of available transportation officers.

Furthermore, the Detention Center fails to ensure that the recommendations of outside specialists, once consulted, are carried out upon the inmate's return to the facility. We reviewed the charts of several inmates sent for outside care, and found no indication that PNA staff sought written documentation of results of the referrals or the recommendations and findings

of the outside care providers. PNA does not employ any tracking method to follow the care received by inmates who are referred for outside specialty care. Without this information, the PNA providers cannot implement treatment recommendations made by the specialized care provider.

6. Medication Administration and Management

PNA fails to provide inmates with needed medications in a timely manner, and fails to monitor medication in inmates with serious medical needs.

The Detention Center fails to provide for continuity of medications for inmates upon arrival at the facility. Several files we reviewed revealed that the nurse practitioner does not continue the same medications for inmates that were prescribed for them prior to their incarceration. Sometimes the nurse practitioner simply discontinues the medication, and sometimes she changes the inmate's prescription to older, less expensive medications which are significantly less effective. For example, inmates who entered the Detention Center with credible histories of taking medication such as Prozac and Wellbutrin were disadvantageously changed to doxepin, amitryptilyne and nortriptyline, which are significantly less effective than Prozac and Wellbutrin and have significantly more adverse side effects.

One inmate arrived at the facility with Navane in her possession. She reported that she has "psychotic features," but had been stable for five years on low doses of Navane, an antipsychotic. Despite the fact that she arrived at the facility with her medication on her person, she did not receive the medication for her first five days in the facility. She was switched to Mellaril, a non-equivalent drug, which the Federal Drug Administration has determined is not a first line antipsychotic. Because Mellaril is known to cause potentially fatal heartbeat irregularities, it is usually prescribed only when other antipsychotics have been tried and failed. Her treatment was not being monitored by the nurse practitioner or the counselor. Her cellmates confirmed that she frequently seemed distraught, and would cry, scream, and talk to herself. Failure to provide this inmate with her prescribed medication and to monitor her treatment on a different medication placed her at risk for psychotic relapse.

PNA also fails to provide reliable access to medications that have been prescribed or continued by the nurse practitioner. Several inmates complained that they had not received prescribed medications despite repeated requests. Our chart reviews substantiated these complaints. For example, one HIV-positive inmate did not get his medication at the Detention Center for six weeks. The inconsistent use of medication contributes to the emergence of drug resistant diseases, which place both the individual and the community at risk.

Inmates also complained that they frequently missed their doses because they were not in their cells or did not hear the medication call. A review of the medication administration records revealed that approximately 25 percent of the entries were blank. PNA attributed these missed doses to inmate noncompliance. PNA policy requires that every refusal of medication will be documented in the inmate's medication administration record (MAR), and after three refusals or no/shows, the medical staff will discuss non-compliance consequences with the inmate and document this counseling in the health record. Based on the charts we reviewed, PNA does not appear to be following its policy.

When certain medications are prescribed, such as anti-epileptic medications, it is necessary to check blood levels of these medications at regular intervals to ensure the inmate's health is not at risk from either too high or too low a dosage. We found several instances in which PNA failed to monitor inmates on these types of medications, even when inmates reported experiencing side effects.

Even when staff did monitor medication levels, they failed to respond to indications that an inmate's dosage was inappropriate. For example, an inmate had been prescribed a medication for his seizure disorder, in addition to several other

medications, and his blood levels of the seizure medication had been measured. Although the laboratory results showed that the amount of this drug in his system was not enough to achieve the intended therapeutic effect, there was no reference to this finding anywhere else in his medical record. Moreover, staff failed to respond appropriately, such as adjusting his medication. Seven days later, the inmate attempted suicide by cutting his wrists, then suffered a seizure. Even with all the attention from medical staff due to his suicide attempt, his seizure medication blood level was not measured until four days

after his suicide attempt, at which point it was still well below the therapeutic range. Even then, staff did not address this deficiency for another three days, when his medication was finally adjusted.

Our review revealed that the Detention Center uses protocols to guide nurses in the treatment of illnesses that include some standardized orders for prescription of medications. This includes a protocol for treatment of inmates experiencing substance abuse withdrawal. Allowing nurses administer the medications to inmates without review by the nurse practitioner or physician and without an evaluation of the inmate's particular medical needs is unsafe.

PNA's formulary does not contain effective medication for inmates with serious medical needs such as hypertension, heart failure and diabetes. In addition, the formulary includes many less expensive, less effective medications than are currently available for the treatment of some diseases.

The facility claims that there is a waiver process in place by which medical practitioners can prescribe medications off the formulary, but the medical staff was unable to provide us with policies or forms providing for such waiver. Approval from corporate headquarters is necessary to prescribe an off-formulary medication. This cumbersome and unstandardized process combined with the severe understaffing at the facility make it less likely that overburdened staff will make the effort to prescribe a drug off-formulary. Although we did note that some inmates were receiving off-formulary medications, they were few and far between. Some inmates at the Detention Center are currently provided with less effective medications with greater side effects than they had received prior to incarceration, which can lead to deterioration in inmates with mental illness and end-organ damage in inmates with diseases such as hypertension and diabetes.

At the time of our visit, all medications, including psychotropic medications, were prescribed by the nurse practitioner. As the only person on the medical staff with the ability to prescribe medication, the nurse practitioner is overburdened. She frequently prescribes, adjusts or terminates psychotropic medication on the recommendation of the mental health counselor, sometimes without examining or even seeing the

inmate. Neither the counselor nor the nurse practitioner is trained to manage medication of inmates with complex mental health diagnoses, such as schizophrenia and bipolar disorder. Furthermore, the counselor has made it widely known that he is personally opposed to the use of psychotropic medication. Several inmates with credible histories of stabilization on psychotropic medications reported that the counselor told them they did not need medications and that they should take control over their own problems. The counselor is not trained nor licensed to make medical prescription decisions. Allowing him to function in this capacity increases the risk that inmates with mental health needs will not receive needed medication. We understand that shortly after our visits, the facility retained the part-time services of a psychiatrist, which may have alleviated some of this problem.

B. MENTAL HEALTH CARE

The Detention Center fails to provide adequate mental health services to inmates who need this care. Specifically, the Detention Center fails to provide appropriate intake screening and referral and access to mental health care.

1. Intake Screening and Referral

PNA's initial health screening process, which is discussed in detail in section A(1) above, includes a brief mental health assessment. Nurses ask inmates questions concerning their mental health treatment history, medication, and mental health status. This assessment may result in a referral for either a routine mental health evaluation or an immediate evaluation by the mental health practitioner and determination whether the inmate will receive follow-up mental health care.

Our review indicates that PNA does not identify appropriately inmates who may need an immediate mental health evaluation and mental health services. For example, one inmate answered several of the initial mental health suicide screening questions in the affirmative, including that he had recently experienced a significant loss, that he felt that he had nothing to look forward to, and that he "just didn't care." He reported that he had been diagnosed with Post Traumatic Stress Disorder and that he was taking an antidepressant for this condition. He also stated that he felt that he needed to see a psychologist.

Despite these indicators, the screening nurse concluded that the inmate needed only a routine mental health referral, as opposed to an immediate mental health evaluation and determination whether mental health services were necessary. This inmate's suicide two weeks later is discussed in greater detail in the section on suicide prevention, below.

As this inmate's experience illustrates, PNA's failure to identify and refer appropriately inmates with immediate mental health needs may be partially attributed to the fact that the threshold for triggering such a referral is too high. The form used to guide the nurses requires too many indicators to be present before directing referral. Inmates reporting suicidal ideation, a history of recent suicide attempts, psychiatric hospitalization, and/or recent or current use of psychotropic medication should be referred for a mental health assessment when booking is completed. However, chart reviews indicate that inmates reporting these symptoms during the initial health screening are not consistently referred for immediate assessment by a mental health professional.

Moreover, some inmates reporting significant mental health histories do not receive referrals for mental health services at all. For example, one inmate arrived at the facility on a mood stabilizing medication and an antidepressant. These medications were verified at intake. During the initial health screening, the inmate reported a two-year history of mental health problems, including a suicide attempt. Despite her verified medications and her mental health history, the intake nurse did not refer this inmate for mental health services.

Other inmates who receive a routine mental health referral are not seen by a mental health practitioner in a timely manner. Inmates reported a significant time lag between the referral and their first visit with the mental health services provider. Chart review confirmed these reports. Inmates who received routine mental health referrals might wait two weeks or more to see a provider after the initial referral was made.

Some inmates may develop symptoms of mental illness following incarceration, but not seek care. The 14-day physical examination is an opportunity for nurses to detect inmate mental health needs that have arisen since the time of admission. However, nurses conduct no mental health assessment at the 14-day physical.

The mental health evaluations conducted at the facility do

not incorporate development of a diagnosis or treatment plan, and are therefore inadequate. The form which guides this evaluation fails to provide for an ultimate determination that an inmate has a mental disorder, and contains no reference to a diagnosis of the disorder. This information is important because it forms the basis for the provider's decision to place the inmate on the mental health roster for services. It also functions as the basis upon which a treatment plan may be developed for the inmate. In the absence of such documentation, it is difficult to assess whether some inmates referred for mental health care are receiving appropriate care. The facility does not engage in discharge planning for inmates receiving mental health services.

2. Access to Adequate Care

The mental health care provided at the Detention Center is inadequate to meet the needs of inmates with serious mental health conditions. At the time of our visit, mental health services at the facility were provided by a master's level counselor, who is not trained to diagnose psychiatric illness nor licensed to prescribe medication. The facility's problems with medication management are outlined above in section A(5).

One chart we reviewed contained a particularly severe example of the potential consequences of failing to provide access to adequately trained mental health staff and appropriate mental health care. This inmate arrived at the facility with a documented history of prior treatment at the Detention Center for bipolar disorder and depression. The facility's former staff psychiatrist had diagnosed the inmate with depression during a previous period of incarceration and treated her with medications. Review of her chart indicates that shortly after MTC/PNA took over management of the Detention Center, the inmate was taken off some of her medications based on the counselor's note that "she and I decided she didn't want to take the Paxil and vistorel." The counselor's written notes document that this inmate subsequently declined over a period of the next three months, including banging on the metal portion of her bed and singing along aloud; destroying her mattress with a razor blade; and flooding her cell with water. She was placed in administrative segregation several times during this period. Both the counselor's notes and the inmate's sick call requests document that throughout this period, the inmate repeatedly requested a return to her previous medications, but the counselor denied her requests. The inmate's decline ultimately resulted in a suicide attempt.

During subsequent periods of incarceration the counselor noted that this inmate "attempted to convince [him]" that she needed medication for her "alleged" bipolar disorder but "unfortunately she wasn't able to convince [him]." He denied her repeated requests for medication without consulting with any practitioner trained and licensed to make such decisions. Thus, this inmate who had been treated by a psychiatrist with psychotropic medications for many months was forced to attempt to conform her behavior in a jail environment without any aid from medication. She experienced continued headaches, anxiety, depression, and sleep disturbance, and frequently found herself in segregation.

Other inmates reported that this counselor instructed them to "Go smoke dope and you will be O.K." and made other inappropriate comments in the course of counseling sessions. Such comments alienated some inmates, who had nowhere else to turn for counseling services. Furthermore, the facility had no mental health professional trained and skilled to provide services to victims of sexual assault. When we raised this issue during our exit conference, the County took immediate action and reports that inmates will now be transported to the Rape Crisis Center for services as needed.

C. SUICIDE PREVENTION

The Detention Center suicide prevention policies and practices are seriously deficient and suicidal inmates are at grave risk of harming themselves as a result. As of the time of our visit, during the seven months since MTC assumed management of the facility, there had been one completed suicide and seven attempted suicides. A review of these incidents reveals that the Detention Center staff fail to respond appropriately to inmates' indications of mental health crises and possible suicidality.

The standard of care for suicide prevention requires timely identification of risk; adequate assessment of risk; monitoring high risk inmates, in special housing units if indicated; and referral to appropriate providers for needed care. Because identification and assessment are addressed in preceding sections of this letter, this section will focus primarily on the Detention Center's provision of monitoring and appropriate housing to suicidal inmates, and referral for crisis mental health care.

Our review indicates that the Detention Center fails to provide adequate monitoring for inmates who have been identified as suicidal. An illustrative example is the completed suicide that occurred at the facility in January 2002. Upon arrival at the facility, this inmate expressed feelings that there was nothing to look forward to in the future as well as other signs of suicidality. He asked to see a mental health professional, but was given only a routine referral and not put on any type of suicide precautions. Two days later, while the inmate awaited his first visit with a mental health professional, staff learned that he had written a last will and testament in his cell, and placed him on suicide watch. While he saw a counselor during his time on suicide watch, once he was released from the watch three days later, he received no mental health services for nine days, until he attempted to cut himself with a razor. He was seen by medical and mental health staff and placed on a suicide watch in the booking area. Orders were for a five-minute watch, but staff only checked the inmate every 15 minutes.

While on watch, the inmate made explicit statements and other indicators that he continued to have active plans to end his life. Statements and observations included: observation that the inmate attempted to hang himself with a sock (appropriately, staff did remove his clothes after this attempt); a statement to a crisis response counselor that he would hurt himself on an exposed nail in his cell in the booking area; threats to the nurse practitioner that he would "pull out his jugular;" observations by a nurse that he attempted to remove sutures to the cut he had inflicted on his neck; a staff member note that the inmate's food tray contained chunks of padding from the foam wall (he ultimately created a foothold for himself to climb up to hang himself); observations that he was tearing up his suicide blanket; and a statement that he was "very claustrophobic. I'll lose my mind in this cell." Despite these indicators, the facility did not adjust either the frequency of or the location of the watch, or take other security measures to address the situation presented. Furthermore, the crisis response counselor who saw the inmate the day before his suicide determined that the booking area was not an appropriate location for this inmate and recommended that he be moved, but the facility did not follow this recommendation.

The watch log ended at 18:45 the night before the inmate's

death, and did not resume until the following day at 6:00 a.m., nearly twelve hours later. That entry was followed by a second entry at 6:15 a.m., and the log ended again, until a 9:40 entry in which the inmate is quoted as saying to staff, "if I find something I will do myself in." The inmate committed suicide by hanging himself from a sprinkler head with a strip of his suicide blanket at approximately 9:50 a.m.

Another inmate attempted to communicate to a supervising officer his intention to kill himself by holding a note up to his segregation cell door. Despite this clear manifestation of his need for intervention, the officer did not respond and the inmate was later found trying to hang himself with a sheet. These incidents as well as staff interviews at the facility indicate that staff are insufficiently prepared to identify the signs of suicidality and respond appropriately.

The Detention Center lacks an appropriate location for housing high risk suicidal inmates. The inmate who completed his suicide was being held in an isolation room in the facility's booking area at the time of his death. These cells are inappropriate for inmates in mental health crisis because it is impossible to provide sufficient supervision of such inmates. The cells have solid doors with small windows. There are no panic buttons or intercoms and no video surveillance in any of the cells. Furthermore, the padded room was not designed to deter inmate suicide. As noted above, an inmate was able to pull large chunks of foam from the padded wall, and an exposed sprinkler head provided a hanging opportunity.

The medical area, with its current staffing, is equally insufficient. An inmate placed on watch status in a medical unit cell for his own safety due to mental illness and seizure disorder was able to cut both of his wrists with a razor blade within 5 minutes of his arrival in that cell. The only way that staff knew that the event had occurred was when blood began running down the floor from his cell. This example also illustrates that staff lacked the skills to search the inmate adequately and make appropriate decisions about what he should have in his possession prior to placing him in that cell.

Some suicide attempts by cutting occurred in the housing units. Staff learned of these incidents only through inmates reporting the emergencies on the intercom. At the time of our visit, several of the intercoms from the housing units to staff in the control room were broken. If inmates are unable to get the attention of staff quickly in an emergency, the response of

rescue personnel could be delayed.

Staff have not been provided with the training or resources to respond properly to suicide attempts. In the booking area, where newly arrived inmates are housed, there was no tool to cut down a hanging inmate, despite the fact that the completed suicide had occurred in this area. In addition, only 27 staff members had received training in CPR and First Aid at the time of our visit. As the likely first responders to suicide attempts and other health crises, all staff should be trained and provided with appropriate equipment to respond to such emergencies while awaiting medical staff.

Our review also indicates that inmates on suicide watch are not consistently seen by the mental health provider in a timely manner and are sometimes released from suicide watch without any evaluation or mental health clearance. For example, one inmate reported that he had cut himself. Staff placed him in the Health Services Unit for treatment of his lacerations and kept him there on suicide watch. He stayed in the Health Services Unit, on suicide watch, for nine days without once being seen by the mental health provider. On the tenth day, he was released back to administrative segregation, still without having seen a mental health provider or receiving mental health clearance to return to administrative segregation. The failure to respond to this inmate's mental health crisis, and the subsequent release of this inmate from suicide watch without a mental health evaluation, placed the inmate at risk for continued crisis and/or another suicide attempt.

Another incident involved an inmate who cut her wrists with a razor and was placed on a 15-minute suicide watch in the medical unit. According to the subsequent investigation of the incident, the inmate was upset because her medications were stopped. Although she had been seeing the mental health provider every two weeks for counseling, the counselor's records contained no notes or information concerning her attempted suicide. The inmate was treated for lacerations to her wrists and released from suicide watch without ever receiving a mental health evaluation or mental health clearance. Absent appropriate evaluation and intervention, this inmate remained a risk to herself.

The Detention Center has the ability to refuse admission to inmates who present at booking in a severe mental health crisis,

and also has a protocol for referring inmates with emergent mental health needs to the local hospital for appropriate care when the inmate's needs exceed the facility's capabilities. Our review indicates that the Detention Center underutilizes these options and fails to refer inmates to outside care when necessary.

Completed suicides and incidents of attempted suicide should be thoroughly reviewed to identify gaps and inadequacies in the provision of care. Information gained through morbidity and mortality reviews plays a critical role in preventing future incidents. PNA's policy is to initiate a mortality review following the death of an inmate. However, our review of the mortality review PNA conducted following the suicide of the inmate described above, revealed that PNA failed to assess critically the care and treatment of this inmate prior to his death. The mortality review provided a chronological history of the events leading up to his death but lacked a self-critical analysis of treatment failures.

D. PROTECTION FROM HARM

1. Booking Area

The booking area includes a small group of cells that are used to house inmates who have arrived recently, as well as some inmates on administrative or punitive segregation, some experiencing mental health or medical problems, or in protective custody. In this area there are 14 cells, one of which is padded and has no plumbing. Four of the larger cells ("the holding cells") are used to house inmates until staff screen and place them in the general population. Except for one of the cells designed for disabled inmates, none of the holding cells has beds or other furnishings other than the toilet and sink and some narrow movable benches.

The booking cells, and especially the holding cells, are hot, stuffy, have poor circulation, have a foul smell and are unsanitary. The holding cells at times have too many inmates to allow for their safety and health, particularly since inmates are kept in these cells for up to five days before they are placed in the general population. We saw some cells with inmates lying on mattresses on the floor from wall to wall, and occupying all available space on benches. Two of the holding cells and one of the smaller cells had no light at all, neither natural nor

artificial. Each cell has a narrow window that provides minimal light from the hallway. It was difficult to observe the inmates in those cells, creating an unsafe condition in which inmates could be victimized without staff being able to see anything through the doors. Because there is insufficient staff assigned to this area, staff cannot open doors frequently enough for proper surveillance, to compensate for the poor visibility through the windows. As an illustration of the difficulty staff have properly supervising these cells, on one occasion inmates got into a dispute which inmates were smoking in the cell, which is prohibited. The inmates eventually set off the sprinkler. The smoking, the dispute and the sprinkler tampering all occurred before an officer noticed and intervened.

Conditions in these cells lend themselves to inmate unrest. In one incident, two inmates were forcing others to move from where they were sleeping to give them the preferred spaces. An altercation broke out, and an inmate who refused to move from his spot sustained injuries. Furthermore, mixing sometimes agitated, intoxicated inmates with the rest of the newly arrived inmates is a recipe for conflict in these poorly ventilated, tight quarters, and sometimes leads to violence.

In another troubling incident, an older female inmate with a history of victimization was housed in a segregation cell in the booking area with another female inmate. Both women report that one of the male porters (an inmate with cleaning duties) repeatedly harassed her, making sexually explicit comments, threatening to find her in the shower and assault her. At one point he showed his exposed penis to her through the window of her cell. Several days after the incident, when we interviewed this woman, she was still traumatized by the experience. She reported that following these incidents she refused to shower during her five days in segregation because she believed that officers would not protect her.

In fact, there is insufficient staffing in the booking area to keep inmates safe. Only one officer is assigned to do rounds of the cells, admit and release inmates from the area, respond to other inmate needs and take inmates out for showers. The shower areas are around the corner, so an officer cannot provide supervision both in the showers and cells at the same time. Inmate porters move about the area without supervision. Use of this area for medical, protective, disciplinary and

administrative segregation is inappropriate. The area is busy with incoming and outgoing inmates, which leaves staff unable to respond to the needs of inmates on special status. As described above in the suicide prevention section (C), the staffing is so thin that an inmate in this area was able to complete a suicide in one of the booking cells before staff noticed.

The jail appears to have trouble processing inmates into general population with appropriate speed. One woman returned to the facility after a medical furlough for shoulder surgery. Despite her discomfort she was kept for three days in the holding cells without a bed or appropriate follow-up medical attention before being allowed back into general population.

Furthermore, the jail is responsible for detaining a number of offenders brought in under the New Mexico Detoxification Act following disorderly behavior, for the purpose of "protective custody" to detoxify from alcohol or drugs.[1/] The jail does not process these inmates into the general population, but rather leaves them in the booking area. Despite the high frequency with which inmates who have abused alcohol or drugs are received in the booking area, the staff in that area were unaware of signs and symptoms of withdrawal. Officers are insufficiently trained in the detection and handling of intoxicated inmates. This puts inmates at risk that serious and sometimes life-threatening withdrawal symptoms may not receive prompt response.

2. Sexual Misconduct and Privacy Concerns

As part of our investigation, we reviewed the circumstances for women housed at the Detention Center. Our review revealed serious concerns regarding past sexual misconduct under the previous management and insufficient prevention efforts under the new management. Staff provided anecdotal evidence of sexual relationships between staff and inmates under the previous management, as well as at least one incident in which male inmates were allowed into the female housing areas for several hours. Under the new management, one inmate became pregnant, although investigation did not reveal whether the father was an inmate or staff. The reporting and investigative system at the jail is flawed, which may have contributed to a lack of information available regarding this and other occurrences at the facility. While we did not determine that there is an ongoing

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[1]/See New Mexico Statutes Annotated 1978, §§43-2-2 through 43-2-22.

pattern or practice of sexual misconduct that violates the constitution under the new management, we do recommend that the new management make more concerted efforts to guide and train staff, avoid leaving female inmates isolated and vulnerable, and improve the system of reporting, investigation and accountability. We have provided technical assistance aimed at addressing our concerns. In addition, we also have provided technical assistance regarding ways to address the lack of privacy for women inmates during times when they are housed in the medical unit and are undressed.

E. LIFE SAFETY AND SANITATION

1. Fire Safety

Inadequate fire safety measures at the Detention Center compromise residents' safety. The facility does have sprinkler and alarm systems, self-contained breathing apparatus for staff to use in an emergency, and up-to-date fire extinguishers throughout the building. However, systems for fire drills, emergency evacuation and fire prevention are inadequate.

Absence of a reliable fire drill program risks harm to inmates. During our on-site visit, we asked the facility to conduct a fire drill. Administrative staff determined which unit to drill and which staff to use. Even under these controlled circumstances, security staff only evacuated one of the six sections of the housing unit. Staff were reluctant to evacuate the entire unit because they did not believe that they had safe evacuation routes and holding areas to do so. This demonstrates that facility staff do not have faith in their emergency evacuation procedures and are unprepared for evacuation should the need arise. Furthermore, most staff we questioned, many of whom had been working at the facility for seven months or longer, had never participated in a fire drill.

During a test of emergency keys, the Key Control Manager had a difficult time identifying keys needed to exit the facility. Keys were grouped with as many as 16 on a ring, and it was necessary to cross match them against numbers on a clipboard to find the right key for every door. In the case of a fire or other evacuation emergency, such a system would be too slow and cumbersome to evacuate inmates and staff safely. In addition, the facility's fire plan has not been approved by the State Fire Marshal, and the facility is not conducting fire safety

inspection rounds.

2. Food Service

The food service operation at The Detention Center does not meet sanitation requirements and puts residents at risk of developing food borne illness. We encountered food service and preparation equipment that was not properly cleaned. Some foods were stored in unsanitary containers or locations. In addition, several practices suggest a lack of sufficient concern for maintaining food at safe temperatures. We encountered bulk foods that required refrigeration sitting in a hallway next to a dry storage area following a delivery, with no staff attempting to refrigerate them. Furthermore, one of the facility's refrigerators had been showing temperatures well above an acceptable safe temperature for some time without being repaired. In addition, foods, once prepared, were not maintained at safe temperatures until service.

Food service workers were not screened properly for health problems before being permitted to prepare food. Only half of the food service workers had been cleared by Health Services staff to ensure they were healthy enough to work in the kitchen. Furthermore, the supervisor was conducting daily visual health checks of workers only after they had begun working with food for the day, and without asking them any questions about their health. We noticed an inmate with visible open wounds on his wrists slicing watermelon with bare hands, instead of plastic gloves. The supervisor had not noticed this condition, determined whether the inmate should be working, or provided close enough supervision to ensure that he was using proper protective practices.

3. Clothing and Mattresses

Laundry at the Detention Center is conducted with insufficient frequency to maintain proper hygiene. In addition, insufficient underwear is provided to inmates. We encountered inmates who had been at the facility for two or three weeks without being given a pair of underwear. Some had one pair of their own, and others were forced to wear the uniforms without underwear. Furthermore, the facility launders inmates' clothing with insufficient frequency for adequate personal hygiene.

Many of the facility's mattresses were old and cracked, and some were torn, exposing the inner stuffing. Mattresses in this

condition cannot be properly sanitized. By the time of our second visit, the facility had purchased 200 new mattresses, which should at least partially address the problem.

In the booking area, where inmates sometimes stay for up to five nights in rooms without beds with up to 17 people (see above, Section D(1)), we encountered some inmates who could not get sheets to use with the torn mattresses. As a result, inmates are forced to sleep directly on the mattresses, which they place either on the bare floor or on narrow benches. Some inmates staying overnight in booking had not even been provided with mattresses.

4. Infection Control, Hygiene and Public Health

The Detention Center fails to take reasonable steps to prevent the spread of airborne pathogens. For example, chart reviews revealed that it takes as long as one to three weeks for inmates with positive skin tests for tuberculosis to receive chest x-rays. The Detention Center has no respiratory protection program, and inmates with positive skin tests are not isolated, as they should be, until their chest x-rays are returned and confirmed to be negative for tuberculosis. Accordingly, inmates and staff are at risk for exposure and transmission of tuberculosis.

The Detention Center also fails to take reasonable steps to prevent the spread of blood borne pathogens. Staff and inmate workers are not consistently trained in universal precautions, and the Detention Center has no plan or training for how staff should handle high risk exposures to blood, such as needle stick injuries. One hazardous waste container we observed was not lined with a red plastic biohazard bag, and the container was half-filled with loose trash.

Staff at the Detention Center also fail to adhere to appropriate hygiene standards. For example, we found urine stored in a container in a medication refrigerator. In addition, several of the areas in which medical staff would be expected to wash their hands regularly lacked the proper plumbing fixtures or supplies to do so. Inmates reported having trouble getting toilet paper when they needed it.

F. ACCESS TO COURTS AND OPPORTUNITY TO REDRESS GRIEVANCES

The County has a responsibility to provide its inmates with reasonable access to the courts to challenge their sentences, directly or collaterally, and the conditions of their confinement. The County is not providing inmates the tools needed for such access through a law library, legal assistance, forms system or otherwise.

The grievance system at the Detention Center is not providing a meaningful path for redress of inmate complaints. While the facility has a grievance coordinator who processes grievances, the facility fails to document its actions in response to inmates' complaints and fails to let the inmate know how it has responded. The management frequently rejects inmate grievances that are formally incomplete, despite the fact that they include sufficient information to process them meaningfully.

Furthermore, the grievance system requires that inmates confront staff and attempt to resolve problems before filing a grievance. Given the power difference between inmates and staff, this requirement makes it even less likely that the grievance system will be a realistic avenue for reporting staff misconduct. In addition, when we were visiting the housing units, there were no grievance forms available in some units. Even after we brought this to the attention of staff, when we checked again there were still no forms available. No grievance forms were available in Spanish, despite the sizeable population at the facility that speaks and/or reads only Spanish.

III. REMEDIAL MEASURES

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

A. MEDICAL CARE

1) Provide for a more confidential environment in which to conduct medical and mental health booking screenings, recognizing legitimate security concerns.

2) Revise and implement policy, procedures and practices to ensure that all inmates receive the initial health screening in a timely fashion.

3) Revise and implement policy, procedures and practices to ensure that inmates reporting or exhibiting possible signs of serious medical or mental health needs at booking are referred promptly to the Health Services Unit and receive appropriate follow-up care.

4) Revise and implement policy, procedures and practices to ensure that inmates receive a comprehensive medical history and physical examination, performed by appropriately trained, licensed and, if appropriate, supervised personnel, within 14 days of their arrival at the facility.

5) Screen all incoming inmates for syphilis. Assess inmate risk for other sexually transmitted diseases, such as chlamydia and gonorrhea, and screen high risk inmates using modern laboratory methods.

6) Revise and implement policy, procedures and practices for addressing drug and alcohol withdrawal to ensure that all inmates are screened and/or treated appropriately if they report or exhibit signs of drug or alcohol withdrawal.

7) Develop and implement policy, procedures and practices to ensure timely referral for evaluation and treatment of inmates who exhibit signs and symptoms of mental illness.

8) Develop and implement policy, procedures and practices for validating and continuing, if appropriate, current prescriptions for medications of incoming inmates.

9) Ensure appropriate staffing for the Health Services Unit by retaining intermediate and advanced practitioners who are able to provide adequate treatment and monitoring of inmates with serious medical needs, in a timely fashion, without practicing beyond the scope of their licensure.

10) Establish policy, procedures and practices for evaluating and improving responsiveness to inmate sick call requests.

11) Establish a chronic care system that includes gathering information and establishing medication upon intake into the facility, establishing a system of care of inmates with chronic diseases at established intervals, standardizing the information gathered at treatment

visits, devoting sufficient attention to inmates whose uncontrolled conditions must be stabilized, and ensuring that inmates with chronic medications have access to those medications when appropriate.

12) Improve morbidity and mortality review process to ensure that deaths are thoroughly and effectively evaluated and any problems with care or access to care that are revealed through that process are resolved.

13) Revise and implement policies, procedures and practices to ensure that diabetics and other inmates who need medically appropriate nutrition receive an appropriate diet.

14) Develop and implement policy, procedure and practices to ensure that pregnant inmates receive prenatal care from appropriately trained and experienced medical professionals on a timely basis.

15) Develop and implement policies, procedures and practices to ensure that inmates whose medical needs require specialized care are promptly scheduled for and transported to outside care appointments.

16) Develop and implement policies, procedures and practices to ensure that the findings and recommendations of outside care providers are documented in the medical chart of each inmate referred for outside care, and that treatment recommendations are followed once the inmate returns to the facility.

17) Eliminate the practice of using protocols with medication orders except for life-threatening emergencies.

18) Develop and implement policy, practices and procedures to ensure that inmates are prescribed medications only after a physical examination by the prescribing clinician.

19) Institute a medication management program which ensures continuity for ordered medication, and includes a requirement that the reason for every missed dosage of medication will be documented and a nurse will confer with any inmate who misses three or more doses for any reason. Revise the formulary to include at least one

medication for elevated blood lipids, a proton pump inhibitor, an ACE inhibitor, an SSRI antidepressant, and birth control pills, and develop and implement a simple and efficient waiver protocol for use when off-formulary medications are needed.

20) Implement a schedule for measuring blood levels of medication for medications which require such monitoring.

21) Revise and implement procedures to document the reason for every missed dosage of prescribed medication. Adhere to stated PNA policy of conferring with any inmate who misses three or more doses for any reason.

22) Develop and implement a quality improvement system that monitors and improves deficiencies in medical care and access, including but not limited to reviewing medication prescribing patterns and monitoring medication usage to assure appropriateness and continuity, and physician review and supervision of nursing.

B. MENTAL HEALTH CARE

23) Provide sufficient mental health professional staffing to meet the serious mental health needs of the jail's population, including staff qualified and trained to diagnosis and treat the seriously mentally ill.

24) Develop and implement policies, procedures and practices to ensure that every inmate receives an initial mental health screening upon arrival at the facility and a mental status assessment within fourteen days of arrival.

25) Modify the comprehensive mental health evaluation to ensure that mental health practitioners diagnose their patients and create treatment plans.

26) Develop and implement policies, procedures, and practices to ensure that a mental health caseload roster is developed and regularly updated to reflect intakes and discharges, and that the provision of mental health services to inmates is tracked by the facility through an effective management information system.

27) Develop and implement policies, procedures and practices to ensure that staff respond to sick call mental health requests in a timely manner and provide adequate ongoing care to inmates determined to need such care.

28) Institute a more thorough quality improvement system that covers all mental health professionals.

C. SUICIDE PREVENTION

29) Develop and implement appropriate suicide prevention policies, procedures and practices, including but not limited to reducing the threshold required to trigger an immediate mental health evaluation.

30) Develop appropriate housing for inmates on suicide watch, and ensure that cells in the booking area are not used for this purpose.

31) Develop and implement policies, procedures and practices to ensure that inmates initially placed on suicide watch are placed on continuous watch, and that the watch is reduced only upon the recommendation of a mental health professional following a suicide risk assessment.

32) Revise and implement effective policy, procedures and practices to ensure proper supervision of suicidal inmates, logging of supervision, and availability of cut-down tools for hangings.

33) Ensure that inmates have means to communicate with staff when necessary, through working intercoms or other effective means of communication.

34) Train staff to understand the signs, symptoms and appropriate responses to potentially suicidal inmates, including when and how to seek mental health follow-up.

35) Develop and implement policies, procedures and practices to ensure that inmates whose level of suicidality cannot be properly handled at the facility are promptly transferred elsewhere for appropriate care.

36) Revise and implement policies, procedures and practices to ensure that high risk inmates are placed in areas that lessen the likelihood of completed suicide, by requiring

that all inmates are thoroughly searched before they are placed on watch, and that admission medical/mental health orders are written in the inmate's chart and document allowable clothing, property, utensils, and diet.

37) Develop and implement appropriate policies, procedures and practices to ensure that inmates on suicide watch are monitored sufficiently by mental health professionals and are not released from suicide watch without clearance from a mental health professional, and that appropriate discharge orders are written upon release, including treatment recommendations and required follow-up care.

38) Develop and implement policies, procedures and practices to ensure that thorough, self-critical mortality reviews are conducted following the suicide or attempted suicide of an inmate, and integrate knowledge gained from such reviews into suicide prevention protocols.

D. PROTECTION FROM HARM

39) Staff the booking area sufficiently to provide reasonable safety to inmates.

40) Cease using the booking area for inmates on segregation, protective, medical, mental health or other special status.

41) Develop and implement policies, procedures and practices to ensure the safe and proper housing of inmates experiencing withdrawal from drugs or alcohol. Properly train staff to identify signs and symptoms of withdrawal and respond appropriately.

42) House inmates in the booking area for only brief periods of time.

E. LIFE SAFETY AND SANITATION

43) Develop and implement policies, procedures and practices to ensure that staff conduct adequate fire drills for all shifts, covering all institutional areas.

44) Develop and implement policies, procedures and practices

to ensure that staff conduct adequate fire safety inspections.

45) Revise the emergency key system to ensure that keys are readily identifiable and available to those who need them.

46) Develop and implement policy, procedures and practices to ensure that the facility's fire safety systems are maintained in order and operable.

47) Develop and implement policies, procedures and practices to ensure that food storage, preparation and service systems are maintained in a sanitary manner.

48) Develop and implement policies, procedures and practices to ensure that inmates and staff who work in food service are in proper health to do so.

49) Provide all inmates with properly cleaned and adequate bedding and clothing. Ensure access to needed hygiene supplies.

50) Develop and implement policies, procedures and practices to ensure that the facility follows nationally accepted standards for infection control and hygiene.

E. ACCESS TO COURTS AND OPPORTUNITY TO REDRESS GRIEVANCES

51) Develop and implement policies, practices and procedures to ensure that inmates have adequate access to the courts.

52) Reform the grievance system so that grievances are processed and legitimate grievances addressed and remedied in a timely manner, responses are documented and communicated to inmates, inmates need not confront staff prior to filing grievances about them, inmates may file grievances confidentially, and grievance forms are available on all units. Ensure that grievance forms are available in Spanish.

53) Develop and implement a quality assurance plan to address all deficiencies identified in this letter.

* * * *

In light of the County's cooperation in this matter, under separate cover we will send you our experts' reports. Although the experts' reports and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

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

Sincerely,

/s/ Ralph F. Boyd, Jr.

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