U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

SEP 11 2009

Marlin N. Gusman
Orleans Parish Criminal Sheriff
2800 Gravier Street
New Orleans, LA 70119

Re: Orleans Parish Prison System
New Orleans, Louisiana

Dear Sheriff Gusman:

I am writing to report the findings of the Civil Rights Division's investigation of conditions of confinement at the Orleans Parish Prison ("OPP"). On February 12, 2008, we notified you of our intent to conduct an investigation of conditions at OPP pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On June 23-27, 2008, August 18-20, 2008, and November 17-20, 2008, we conducted on-site inspections at OPP with expert consultants in corrections, use of force, custodial medical and mental health care, and sanitation.[1] We interviewed administrative staff, security staff, medical and mental health staff, facilities management staff, training staff, and inmates. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, use of force reports, investigative reports, inmate grievances, disciplinary reports, unit logs, orientation materials, medical records, and staff training materials. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary impressions to OPP officials and legal counsel for the Sheriff's Office at the close of each of our site visits.

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[1] Our corrections expert was the only expert who accompanied us on the August on-site visit, and our medical health care expert was the only expert who accompanied us on the November on-site visit.

We remain sensitive to the fact that OPP is still recovering from the devastating effects of Hurricane Katrina and commend the Sheriff and his staff for their extraordinary efforts to structurally rebuild the facilities. We also note the tremendous strides and improvements that the Sheriff and his staff have made in light of the scope and depth of destruction caused by Hurricane Katrina.

We commend the OPP staff for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation with our investigation and appreciate the receptiveness to our consultants' on-site recommendations. Accordingly, we have every reason to believe that the Sheriff, his office, and the City are committed to remedying all known deficiencies at OPP. We hope to be able to work cooperatively to such a resolution.

Prior to our investigation, many media reports, allegations, and even rumors circulated regarding conditions at the Jail following the Hurricane. Our review of documents, investigative files, and interviews of staff and inmates has been to ascertain if the Constitution has been violated in a systemic manner. Again, commendably, we recognize the Sheriff's efforts in safely and efficiently evacuating the inmates and his efforts to secure the necessary funding to rebuild.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at OPP violate the constitutional rights of inmates. In particular, we find that inmates confined at OPP are not adequately protected from harm, including physical harm from excessive use of force by staff and inmate-on-inmate violence. In addition, we find that inmates do not receive adequate mental health care, including proper suicide prevention. While OPP meets constitutionally required standards of medical care in many areas; however, we found specific deficiencies in medication management. OPP inmates also face serious risks posed by inadequate environmental and sanitation conditions.

I. BACKGROUND

Located in downtown New Orleans, OPP is one of the largest correctional facilities in Louisiana. Despite its name, OPP operates like a county jail (Louisiana's parishes are equivalent to other states' counties). Like most county jails, OPP houses a large number of pre-trial detainees and inmates serving short misdemeanor sentences. Currently, OPP is able to accommodate 2,545 inmates and serves as overflow for the Louisiana Department of Corrections and the federal prison system.

Prior to its loss of physical plant space, due to damages sustained in Hurricane Katrina, OPP's capacity was 8,000 and the facility housed an average of 6,500 inmates daily. Again, it currently can house 2,545 inmates. OPP currently operates six of the original 12 jail buildings and is staffed by approximately 450 security officers. At the time of our visits, OPP housed inmates in the House of Detention ("HOD"), South White Street, Templeman V, Conchetta,

eight windowless tents constructed with FEMA financial assistance ("The Tents"), and the Broad Street work-release facility.

Recently, the Orleans Law Enforcement District ("LED") was statutorily created to provide financing to the Criminal Sheriff's Office. Further the LED is authorized to issue bonds for equipping and furnishing facilities for the Criminal Sheriff and for agencies where there is a use or benefit to the LED and the Sheriff. Of the $63,225,000 in bonds issued for the LED, $40,890,000 have been designated to the Sheriff for the jail and other facilities, which should impact the constructing, improving, renovating, and repairing of various facilities at OPP.

In making our findings, we acknowledge that there have been ongoing improvements at OPP during the course of our investigation. The damaged Intake Processing Center ("IPC") was demolished and a new IPC opened in June 2008. In addition, we are aware that the 80-year-old original Orleans Parish Prison Jail re-opened in February 2009. The refurbished jail is designed to hold more than 800 inmates. We understand that the Sheriff plans to occupy the jail with inmates currently housed in temporary facilities or facilities in need of work. Despite these commendable improvements, we believe there are serious constitutional deficiencies at OPP, as will be discussed in detail below.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to investigate and, when necessary, initiate civil action to obtain appropriate relief from egregious jail conditions that subject inmates to a pattern or practice of deprivation of their constitutionally protected rights. 42 U.S.C. § 1997. In defining the scope of jail inmates' Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell v. Wolfish, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment); Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996) (finding that a municipality assumed a constitutional obligation under the Fourteenth Amendment to provide pre-trial detainees with minimal levels of safety and security); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir. 1996) (en banc), rev'd on other grounds, 135 F.3d 320, 324 (5th Cir. 1998) ("[T]he State owes a duty to both [detainees and convicted prisoners] that effectively confers upon them a set of constitutional rights that fall under the Court's rubric of 'basic human needs.'"). The Fifth Circuit has held that the protection of pretrial detainees' rights under the due process clause of the Fourteenth Amendment is "at least as great as the Eighth Amendment protections available to a convicted prisoner." Id. (quoting City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983)).

A jurisdiction's constitutional obligation to provide adequate medical care to inmates includes the duty to provide adequate psychological and psychiatric mental health care. Farmer, 511 U.S. at 832; Gates v. Cook, 376 F.3d 323, 332 (5th Cir. 2004) (finding that "mental health needs are no less serious than physical needs"); Woodall v. Foti, 648 F.2d 268, 272 (5th Cir.

1981) (finding that an inmate stated a claim of deliberate indifference where prison officials refused to treat him and knew that he had been diagnosed as a pedophile and as a manic depressive with suicidal tendencies). Consequently, a prison's failure to take any steps to save a suicidal detainee from self harm may constitute a constitutional violation. Partridge v. Two Unknown Police Officers of the City of Houston, 791 F.2d 1182, 1187 (5th Cir. 1986).

The standard for adequate mental health care follows the standard for medical care, requiring a showing of both the subjective and objective components of "deliberate indifference." Gates v. Cook, 376 F.3d at 333. The jail officer's subjective knowledge must be determined by the finder of fact through circumstantial evidence or the obviousness of the risk. Id. The Fifth Circuit emphasized "that the essential test is one of medical necessity and not one simply of desirability." Woodall v. Foti, 648 F.2d 268, 272 (5th Cir. 1981). In determining the adequacy of mental health care, the Court makes a holistic assessment of the prisoner's conditions of confinement. Gates v. Cook, 376 F.3d at 343 (acknowledging that "the isolation and idleness of Death Row combined with the squalor, poor hygiene, temperature, and noise of extremely psychotic prisoners create an environment 'toxic' to the prisoners' mental health.").

The Eighth and Fourteenth Amendments forbid prison officials from using excessive physical force against inmates and pre-trial detainees. See Hudson v. McMillian, 503 U.S. 1 (1992), Farmer, 511 U.S. at 832; see also United States v. Walsh, 194 F.3d 37, 48 (2d Cir. 1999) ("the right of pre-trial detainees to be free from excessive force amounting to punishment is protected by the Due Process Clause of the Fourteenth Amendment.") (citing Bell, 441 U.S. at 535 [citations omitted] [emphases in the original]). The Fifth Circuit has held that this is true even when the use of force does not result in significant injury. Gomez v. Chandler, 163 F.3d 921, 924 (5th Cir. 1999) (concluding that there is no categorical requirement for an Eighth Amendment excessive force claim to be supported by a prisoner's significant, serious, or more than minor physical injury).

The standard for measuring the appropriateness of the force used is "whether force was applied in a good-faith effort to maintain or restore discipline or maliciously and sadistically for the very purpose of causing harm." Hudson, 503 U.S. at 6 (quoting Johnson v. Glick, 481 F.2d 1028, 1033 (2d Cir. 1973)). In determining whether force was used in good faith or in excess, courts examine a variety of factors, including:

> "[T]he need for the application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response."

Id. at 7-8.

Prison officials have a duty, under the Eighth Amendment, to protect prisoners from violence at the hands of other inmates. Farmer, 511 U.S. at 832-833; Longoria v. Texas, 473 F.3d 586, 592 (5th Cir. 2006). The standard for adequate protection from inmate violence is the

same as the standard for medical and mental health care, laid out in Farmer and discussed above, requiring a showing of "deliberate indifference." Id. at 837-839. The Fifth Circuit has determined that prison officials can be held liable for their failure to protect an inmate if they are deliberately indifferent to a risk of serious harm posed by another inmate's violent acts. Cantu v. Jones, 293 F.3d 839, 843-844 (5th Cir. 2002) (affirming verdict against prison-guard defendants found to have manifested the requisite deliberate indifference when they left the door to inmate's cell open, allowing him to escape and assault another inmate).

Prison officials must minimize inmate exposure to unhygienic conditions. Palmer v. Johnson, 193 F.3d 346, 352-353 (5th Cir. 1999) (finding that deprivation of toilet privileges for 17 hours forcing prisoners to urinate and defecate in a confined area with 48 other inmates constituted cruel and unusual punishment); Gates, 376 F.3d at 338 (holding that filthy cell conditions constituted an Eighth Amendment violation). Prisoners must be protected from both present and continuing exposure to harm caused by unsafe conditions, including mingling with inmates with contagious diseases. Helling v. McKinney, 509 U.S. 25, 33-34 (1993)(asserting that the Eighth Amendment protects against sufficiently imminent dangers as well as current unnecessary and wanton inflictions of pain and suffering).

The Fifth Circuit has held that both objective and subjective components are needed to establish an Eighth Amendment violation caused by unhygienic conditions. Harper v. Showers, 174 F.3d 716, 720 (5th Cir. 1999). First, there must be an objective showing of conditions "so serious as to deprive prisoners of the minimal measure of life's necessities." Id. (quoting Woods v. Edwards, 51 F.3d 577, 581 (5th Cir. 1995)). Second, there must be a subjective showing that the prison official was deliberately indifferent to such serious conditions. Id.

III. FINDINGS

We find that OPP fails to adequately protect inmates from harm and serious risk of harm from staff and other inmates; fails to provide inmates with adequate mental health care; fails to provide adequate suicide prevention; fails to provide adequate medication management; fails to provide safe and sanitary environmental conditions; and fails to provide adequate fire safety precautions.

A. INADEQUATE PROTECTION FROM HARM

Corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer, 511 U.S. at 832. Providing humane conditions requires that a corrections system must satisfy inmates' basic needs, such as their need for safety. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse.

To reasonably ensure safe conditions, officials must take measures to prevent the use of unnecessary and inappropriate force by staff. Officials must also take reasonable steps to protect

inmates from violence at the hands of staff and other inmates. In addition, officials must provide adequate systems to investigate incidents of harm, including staff misconduct and alleged physical abuse of inmates. Finally, a jail has an obligation to protect vulnerable inmates from harm, such as those who are at risk from other inmates. For the reasons set forth below, OPP fails to meet constitutional standards in all of these regards.

1. Unnecessary and Inappropriate Uses of Force

Although the violence present in a correctional setting necessarily permits the appropriate use of force, the Constitution forbids excessive physical force against inmates. A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Generally accepted correctional practices provide that appropriate uses of force in a given circumstance should include a continuum of interventions, and that the amount of force used should not be disproportionate to the threat posed by the inmate. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

Our investigation included an intensive examination of documents provided by OPP concerning the incidents listed below and various others occurring between January 2007 and August 2008. We also conducted a great many staff and inmate interviews. In many cases, our findings of inappropriate or excessive uses of force are in accord with OPP's own conclusions.

We believe that there is a pattern and practice of unnecessary and inappropriate uses of force by OPP correctional officers. Indeed, we found several examples where OPP officers openly engaged in abusive and retaliatory conduct, which resulted in serious injuries to inmates. According to our expert, in some instances, the officers' conduct was so flagrant it clearly constituted calculated abuse.

The following examples, derived from OPP's own internal documents, reflect disturbing evidence of officers openly engaging in retaliatory and abusive conduct:

- In July 2008, A.A. and B.B. were ordered into an empty holding cell on the OPP receiving docks.[2] Once in the cell, an officer entered the cell and began hitting and repeatedly beating both inmates. A.A. was beaten in the face, chest, and stomach. After knocking A.A. to the ground, the officer continued to beat and drag A.A. on the floor before finally choking and threatening to kill him. The officer then began beating B.B. in the arm, chest, and stomach area. After beating B.B., the officer placed his fist against B.B.'s jaw and stated, "I should break your

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[2] To protect inmates' privacy, we have used initials other than their own.

f------ jaw." Notably, this incident lasted for more than 10 minutes while several other officers observed the beatings without intervening or reporting the abuse. It was later determined that the officer beat the inmates because he believed that one of the inmates had robbed him several weeks earlier on the street. Defense attorneys for both A.A. and B.B. filed a formal complaint. OPP's Special Operations Division ("SOD") sustained allegations of abuse and recommended that the officer be suspended. After the officer's initial suspension, the Sheriff terminated the officer involved in the battery along with the four other officers who observed the beatings.

- In September 2007, C.C. was beaten in the Tents. While lying on his bunk smoking a cigarette, an officer ordered C.C. to go outside to the security area. Once in the security area, the officer then ordered C.C. to "tie his shoes" (a code we learned at OPP is an invitation to fight). At which point, C.C. refused to fight the officer. The officer then slapped C.C. in the face, knocked him to the ground, and continued to punch him several times in his back. The officer then took C.C. into a bathroom and continued to beat him. According to OPP reports, this incident was witnessed by another officer, yet the incident was never reported. C.C.'s grandfather filed a complaint on his behalf. OPP's Internal Affairs Division ("IAD") reviewed the incident and found that an assault did occur, but only charged the officer with untruthfulness (for not reporting that he pushed C.C. to the ground several times) and failure to keep the commanding officer informed (for not reporting C.C.'s alleged smoking violation). The Sheriff placed the officer on 90 days probation as a result of this incident.

- In August 2007, D.D. was beaten by an officer in HOD. According to OPP reports, D.D. was transferred to HOD after he exposed himself to a female officer. An HOD sergeant reported the incident to the female officer's boyfriend, an OPP corrections officer. The sergeant gave the boyfriend/officer the "green light" to physically abuse the inmate. The officer went into D.D.'s cell and began repeatedly punching and kicking him. The officer knocked D.D. to the floor then he dragged D.D. out of the cell and continued to beat him on the tier. The officer finally stopped beating him after D.D. started bleeding under his eye. D.D. sustained bruising under both eyes and bruising to his body. This assault, witnessed by at least one other officer, was unreported. D.D.'s injuries were eventually observed by an uninvolved officer, who made a report of them. OPP's SOD sustained allegations of abuse. The officer involved in the beating, the sergeant, and the officer witness were all suspended for 14 days.

- In August 2007, E.E. was beaten by two officers in his cell. While lying asleep in his bed, two officers entered E.E.'s cell and beat him for nearly 10 minutes, before leaving the cell. E.E. sustained two black eyes and bruises on his upper, middle, and lower back. Several inmates witnessed the beating. The officers failed to

document the incident. Again, it was only after an uninvolved officer observed E.E.'s injuries that any report was made. When questioned by SOD investigators on why they failed to notify the Watch Commander of the incident with E.E., one of the involved officers replied, "the rank (referring to supervisors) does not like to be bothered." OPP's SOD sustained allegations of abuse and recommended that both officers be suspended for 14 days.

- In April 2007, F.F. was severely beaten by two officers in IPC. While in IPC, two officers placed F.F. in an empty cell and began beating him in his face and head area. Even after F.F. requested medical attention, the officers returned to the cell and continued to beat and kick him in his face and head area. F.F. received serious trauma to his head and face. This incident was not reported by either OPP officer. As soon as he was released from OPP, F.F. was taken to the emergency room where he was treated for injuries sustained as a result of the beating. F.F.'s brother reported the injuries to OPP's Internal Affairs Division ("IAD").[3] After its internal investigation, IAD sustained the allegations of abuse against both officers involved. Despite IAD's findings, it was not until our expert consultant made repeated inquiries related to the beating and the outcome that the Sheriff's office took disciplinary action (the officers were terminated).

a. Inadequate Policies and Procedures

Adequate policies and procedures regarding the appropriate use of force are essential to ensuring that inmates are not abused by security staff. The policies should be comprehensive, clear, up-to-date, and reflect currently acceptable practices. OPP's policies and procedures are lacking in all respects.

OPP's current Use of Force policy requires that each officer and witness to a use of force file a report, however, the policy fails to define what constitutes a use of force. Without a definition, staff are left to their own subjective interpretations, which results in inconsistent use and reporting on the use of force. Furthermore, the policy does not provide guidance on levels of resistance versus levels of response - e.g., passive resistance versus active aggression and empty hands controls versus impact strikes. In addition, the policy fails to identify approved self-defense tactics, approved less lethal weaponry, and fails to list general prohibitions - e.g., to punish, to retaliate, or to restrict respiration. Moreover, the policy does not contain any requirement to employ verbal strategies when appropriate and fails to require video of anticipated or calculated force. Further troubling on a systemic level, the current use of force policy does not require or have an established criteria for administrative review of investigations.

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[3] This incident was reported by F.F.'s brother, an Orleans Parish Sheriff's Office Lieutenant.

b. Inadequate Use of Force Reporting

Although OPP's current Use of Force policy requires that each officer and witness to a use of force file a report, we found that the policy is not consistently followed. In our review of hundreds of use of force incident reports, it was clear that officers routinely fail to adequately document incidents. In many instances, use of force reports prepared by officers lacked sufficient detail necessary to determine what type of force was used and whether the force used was justified. Also, we reviewed several reports which mention several officers, but that contain only one officer-filed report. This is a stark contrast from what the reporting policy requires. Compounding the reporting problem, we found that OPP does not have a standardized use of force form or format, resulting in a system in which the reporting officer has wide discretion in determining what details to include in the report. As a result, administrative review is limited and officer conduct is not effectively evaluated. We found that OPP's deficient reporting practices likely accounted for the dearth of incidents referred to IAD for investigation.

OPP's deficient reporting practices are best illustrated by the examples noted below:

- In the July 2008 incident involving A.A. and B.B., there is no indication that the incident occurred, no indication of the inmates' injuries, and no indication that any officer reported the incident;

- In the August 2007 case of E.E., there is no indication of any injury in the OPP reports, no witness statements gathered, and no indication that the officers reported the incident; and

- In the August 2007 case of D.D., there is no indication of any injuries D.D. sustained, no indication that any officers reported the incident, and no indication that any statements were taken.

These incidents were not reported, indicating either a recognition of officer wrongdoing or a failure to recognize and report officer conduct believed to be within policy. In all of the above-mentioned examples, the incidents were not reviewed until a third party reported the officers' conduct. An effective reporting system would provide more detailed use of force and incident reports and ensure sufficient supervisory and administrative review.

c. Inadequate Management Review of Use of Force

The principal purpose of administrative review and investigation of each use of force is to ensure that no criminal activity has occurred, that facility procedures have been followed, that no remedial training is necessary, and that no review or change in policies is required. OPP's current use of force policy does not include a provision for administrative review. Therefore, there is an apparent gap in the review process where officer misconduct is not captured and

reviewed. Incidents that typically should be referred to IAD and SOD for further review are not forwarded. This lapse of review does not comport with generally accepted correctional standards.

On the rare occasion where we found that an incident was referred for management review, it was apparent that reviewers were not adequately trained to review officer conduct and the reviewers operated without any criteria for determining whether the level of force used was appropriate. Again, appropriate referrals to IAD or SOD were not made. Moreover, we spoke to various OPP officials about self-initiated reviews and we were unable to determine what division, if any, was qualified or assigned the duty to review use of force incident reports other than IAD. We find this system inadequate.

d. Lack of Investigative Policies and Procedures

Generally accepted correctional practices require clear and comprehensive policies and procedures governing the investigation of staff use of force and misconduct. Adequate policies and procedures include, at a minimum, screening of all use of force and incident reports, specific criteria for initiating investigations based upon the report screening, specific criteria for initiating investigations based upon allegations from any source, timelines for the completion of internal investigations, and an organized structure and format for recording and maintaining information in the investigatory file. OPP's investigatory practices fail to comport with these generally accepted correctional standards.

OPP does not have an IAD standard operations manual for use of force investigations. In fact, the only guidance that investigators have is a two-page draft memo (dated January 3, 2007) that offers vague descriptions of procedure, which include: "[i]f a complaint appears to be worthy of an investigation it is assigned to one of the IAD investigators." The memo fails to offer any guidance as to what constitutes a "worthy" complaint and fails to require IAD to gather essential documentation from use of force and incident reports. Virtually all of the investigations that we reviewed contained significant investigatory flaws. The deficiencies in OPP's practice is reflected in the following examples:

- An IAD case file we reviewed indicates that in March 2007, an officer observed another officer deliver a series of multiple closed fist strikes to G.G. in a holding cell. The eyewitness officer observed the assaulting officer strike G.G. in the face, knocking him to the floor. While on the floor, the officer continued to strike G.G. even though the eyewitness officer yelled at the assaulting officer to "stop." The eyewitness officer filed a report with IAD the next day detailing her observations. The investigator concluded that only necessary force was used. The investigator, however, failed to interview or attempt to interview G.G., failed to locate and question additional witnesses, failed to collect incident reports, and failed to determine if the officer filed a contemporaneous report. The investigator

based his findings on the absence of injury and G.G. not seeking medical treatment.

- Another, IAD case file indicates that in January 2007, an inmate was beaten by several officers in IPC. The investigation only contained the inmate's statement and an undated memo from one of the officers involved. The officer acknowledged during the investigation that he and three other officers had to "restrain" the inmate. The officer also states they escorted the inmate to "medical with no injuries found." The IAD investigation failed to contain any incident reports or interviews with the other officers, failed to contain medical reports, and failed to determine if this was an unreported use of force.

2. Inadequate Classification System

An adequate classification system is a fundamental management tool to aid in providing a reasonably safe environment in a correctional institution. The primary goal of a classification system is to determine the degree of supervision required to control each inmate and to maintain the safety and security of the institution and the community. The classification system at OPP contributes to its deficiencies in safety and security. Generally accepted correctional practices for classification systems utilize a variety of objective, behavior-based factors to determine the appropriate level of custody. Factors considered include: severity of offense, prior convictions, prior incarcerations, and personal characteristics such as age, residence, and employment. Typically, inmates are divided into high, medium, and low security classifications, and thereafter receive the appropriate level of freedom and staff supervision for that classification level.

In contrast to generally accepted practices, OPP relies on an antiquated charge-based classification scheme that uses the amount of an inmate's bond as the primary classification factor for general population inmates (aside from the obvious separation factors such as male or female). For example, inmates with bonds of $100,000 and over were housed in the HOD; federal inmates and bonds of $100,000 and less were housed in Templeman V; bonds of $75,000 and over were housed in the Tents; all females were housed at South White Street; and all work-release inmates were housed at Broad Street.

The current classification system does not consider an inmate's prior convictions, prior assaultive behavior, or true potential for violence. Even after inmates are classified, we learned from various OPP officials that housing assignments were predicated on space availability. As a result, we found instances where inmates with differing classification levels were assigned to ten-person cells at HOD. Under this system, there is very little to safeguard against housing predatory inmates with vulnerable inmates. Not surprisingly, we found a disturbingly high number of assaultive incidents in the multiple-occupancy cells at HOD.

Although we identified incidents throughout the facility, we are particularly concerned with the seriousness and frequency of incidents in the HOD and the Tents. We reviewed the

emergency route tracking log for July thru August 2008, which documents the referrals from OPP to the emergency room, and found a litany of serious injuries normally associated with assaultive behaviors including: blunt head trauma, facial fractures, jaw fractures, stab wounds, lip lacerations, and eye socket fractures. The majority of these injuries resulted from inmate-on-inmate assaults.

3. Inmate-on-Inmate Assaults

The high incidence of inmate-on-inmate violence at the HOD and the Tents demonstrates OPP's inability to keep its inmates reasonably safe. The following examples, derived from our review of OPP's own incident reports, illustrate our concerns:

- In August 2008, an 18-year-old inmate housed in a ten-person cell with 10-13 other inmates, all of whom were older, was attacked and beaten. At least four inmates assaulted him before officers arrived. The inmate sustained a fractured jaw and loosened teeth from the beating. The inmate had to be transferred to the medical floor as a result of the injuries he sustained.

- In June 2008, a 50-year-old inmate, who was recently arrested for public intoxication, was housed in a cell with 15-17 other inmates in the HOD. While in the cell, he was jumped by three inmates and sustained an eye injury and a head wound that required sutures.

- In June 2008, an inmate who was recently charged with a misdemeanor domestic violence offense was beaten in the Tents by another inmate. The inmate sustained a broken jaw and had to be taken to the emergency room for medical care.

- In May 2008, an inmate charged with aggravated rape was attacked by multiple inmates in a stairwell between the third and fourth floors of the HOD. The inmate was later moved to protective custody.

- In April 2008, another sex offender housed in HOD was beaten by several inmates after they learned of his offense. The inmate sustained two black eyes and injuries to his forehead and temple. After the beating, the inmate was moved to protective custody.

- In April 2008, an inmate was attacked by another inmate with a knife in the Tents because of an argument over the television. We learned from a tier representative (inmate trustee) that the inmate with the knife was a "known trouble maker" and had a history of assaultive behavior at the facility.

- In April 2008, an inmate was seriously injured after a fight over cigarettes. An officer observed the injured inmate washing blood from his face. The inmate was

immediately taken to the emergency room where he was treated for a fractured nose and injuries to his jaw, head, and back.

- In March 2008, an inmate suffered injuries to his eye, shoulder, elbow, and knee after multiple inmates jumped and beat him in a bathroom in the Tents.

- In February 2008, while in the Tents, an inmate was beaten by another inmate. We learned through OPP documents that the same two inmates were involved in a prior altercation in which one inmate was stabbed. It was only after the second incident that OPP placed the inmates in separate tents.

- In May 2007, a sex offender housed in the HOD in a 10- person cell was attacked and beaten by several other inmates and sustained a stab wound to his eye and a fractured jaw.

The frequency and serious nature of injuries sustained by OPP inmates represent a systemic level of violence that poses a serious risk of harm to both inmates and correctional staff at the jail.

4. Inadequate Staffing and Inmate Supervision

Staffing levels at OPP are inadequate to protect inmates from harm. Correctional facilities must protect inmates from harm by providing adequate staff supervision. Because of the jail's size and the physical configuration of its most densely populated facility (HOD), we found instances where officers failed to conduct scheduled rounds and were required to supervise an entire floor because of staff shortages. We also noted instances at other jail facilities (The Tents) where officers were required to supervise an entire pod (more than 80 inmates) during shifts. In both examples, it appears that OPP failed to adequately staff the buildings with this highest frequency and nature of injuries by inmates.

Exacerbating the staffing shortages, we found that OPP operates its facility without a staffing plan or analysis to establish the minimum number of security staff needed to safely manage OPP's population. Generally accepted professional standards provide that a staffing plan or analysis is vital in determining supervision posts, the span of control for each post, and what posts are essential to adequately staff OPP. Although we found staffing shortages throughout the facility, we are particularly concerned with the staffing levels at the HOD and the Tents - the two facilities where we found unacceptably high levels of serious inmate-on-inmate violence

We reviewed HOD's monthly squad status report for June 2008 and found that the total number of security staffing assigned to HOD for the month was 68 officers. During this same period, the average daily population was 868. In our expert's opinion, this 1:13 officer-to-inmate ratio per month is clearly deficient for the largest facility in OPP. We also found several instances during January 2007 and June 2008 where the HOD average daily population was 900

and only 12 officers were on shift, a 1:75 officer-to-inmate ratio. On these occasions, the majority of the multiple occupancy cells housed more than 10 inmates and four of the eight floors had only one officer responsible for over 140 inmates. We found several instances where staff failed to conduct daily rounds in the HOD and one officer had to monitor and supervise an entire floor for extended periods. During our review, we found the most densely populated facility (HOD) at OPP also was the most understaffed, which likely explains the high incidence of violence.

Similarly, we found deficient staffing levels at the Tents, the second largest facility in OPP. This facility comprises eight separate tent-like structures with metal framing and a polyester membrane covering. Each housing unit, known as a "pod," has a bed capacity for 88 inmates (44 double bunk beds). Each pod is equipped with an elevated officer station situated mid-way between the 44 beds. During our review of the June 2008 monthly squad staffing report, we found the total security staff was 33 officers, while the average daily population was 528. Again, we found several instances during February 2007 thru May 2008 where the inmate average daily population was more than 580 and the facility only had seven officers on shift, allowing only one officer to each pod during the shift. This deficient staffing places both inmates and staff at risk.

C. INADEQUATE MENTAL HEALTH AND MEDICAL CARE

1. Mental Health Care

OPP fails to provide inmates with adequate mental health care that complies with constitutional standards. Specifically, we found the following deficiencies: (a) inadequate suicide prevention; (b) inadequate intake and referral process; (c) inadequate staffing; (d) inadequate assessment and treatment; and (e) inadequate quality assurance review.

a. Inadequate Suicide Prevention

Suicide prevention practices at OPP are grossly inadequate. Generally accepted professional standards of correctional mental health care mandate the development of suicide prevention measures, including evaluation by a psychiatrist and development of a management plan. While OPP's suicide prevention policy requires that all inmates with suicidal ideation be directly observed by staff immediately and at all times, our investigation revealed practices inconsistent with generally accepted standards and OPP's own policy.

OPP inmates with suicidal ideation are transferred to HOD-10 and placed in five-point restraints before they are evaluated by a psychiatrist. The practice of initiating restraints, the most restrictive of suicide precautions, without medical or mental health review is inconsistent with generally accepted professional standards. Furthermore, we found that restraints are used as the first response to inmates with suicidal ideation and are seemingly used in a punitive fashion.

Moreover, we found that OPP fails to protect inmates from harm while in restraints. The following examples are illustrative:

- On January 6, 2009, H.H., a 43-year-old woman, stopped breathing while in restraints at OPP. H.H. was sent to HOD-10 hours after intake because she was considered hostile and suicidal. While in HOD-10, H.H. was placed in five-point restraints even after she repeatedly complained of asthma and breathing distress. H.H. did not receive physician or psychiatric care to determine if medication was appropriate or if placing an asthmatic individual in a five-point restraint was acceptable. Although she was under direct observation, H.H. was reportedly seen attempting to get out of the restraints. As OPP staff intervened and placed her in the restraints, H.H.'s body went limp. OPP medical staff responded to assess her condition. She was sent to the emergency room, where she was later pronounced dead.

- In June 2008, I.I. was placed in five-point restraints for more than 24 hours after he reported suicidal ideation. I.I. had a history of mental illness and taking psychotropic medications. Even though OPP staff received medical orders prescribing a nine hour time-frame for restraints, OPP placed him in restraints for over 24 hours without appropriate observation. OPP did not follow its own suicidal ideation policy, failed to provide I.I. with one-to-one observation, and went beyond the medical orders for restraint usage.

- On March 27, 2008, J.J. was placed in five-point restraints for more than 35 hours after he reported suicide ideation. The restraints were intermittently maintained by three consecutive orders from March 27, 2008 at 11:20 a.m. to March 29, 2008 at 5:00 a.m. Records showed that J.J. was neither agitated nor disruptive and OPP did not follow its own suicidal ideation policy and provide J.J. with one-to-one observation. We found that J.J.'s care and treatment was inconsistent with generally accepted professional standards of care and, indeed, inhumane.

Compounding the risks inherent in these practices, OPP has neither a restraint chair nor a safe cell. Inmates are restrained to metal beds affixed to a cell wall. The positioning of the bed prohibits 360 degree access to the inmate and, ironically, is itself a suicide hazard as even restrained individuals can strangle themselves by affixing clothing or sheets to this type of bed.

b. Inadequate Intake and Referral Process for Inmates with Mental Illness

OPP fails to properly identify inmates with mental illness through adequate intake screening and referral. The identification and follow-up of known mental illness should be a key focus of intake screening. In addition, mental health screening information should be incorporated into an inmate's medical record. This ensures the prompt continuation of necessary

medication for all inmates with chronic mental health conditions. Persons with potentially serious chronic mental illness (i.e., active psychosis, suicidal) should be referred from screening for prompt mental health evaluation and examination by a psychiatrist. We found the systems for intake and referral at OPP to vary markedly from generally accepted correctional mental health standards.

The average percentage of inmates receiving mental health services in city jails ranges from 18 to 30 percent. OPP's staff reported that 150 inmates were on the mental health caseload, approximately 6% of OPP's total inmate population, indicative of the failure to adequately identify and refer inmates with mental illness. This indicator was confirmed by our expert consultants' review of OPP medical records and inmate interviews which indicated that the numbers of OPP inmates referred for mental health services should be significantly higher.

We found OPP's intake and referral services inadequate and delayed. As a result, an alarmingly high number of inmates with mental health issues, including past mental health treatment, history of suicidal behavior or attempts, and/or being on psychotropic medications fail to consistently be referred to mental health service providers. In addition, we found that OPP does not have a formal referral process. As a result, inmates are not seen, as a matter of practice, on an emergent (immediate), urgent (within 24 hours), or routine basis (within five days) by the psychiatrist. Therefore, inmates who either received mental health services prior to incarceration or present with significant mental health concerns, typically have substantial delays before being referred to a mental health provider. Inmates who are not timely referred remain untreated and have suffered from a worsening of their symptoms, including suicidal and homicidal ideation. The deficient intake and referral process is illustrated in the following examples:

- In April 2008, during intake, K.K. reported that he attempted suicide five times in the last nine months. Even with this self-report, OPP staff failed to note his prior history and failed to refer K.K. to a psychiatrist. Due to this failure, K.K was not assessed for six weeks. When he was finally assessed, he was diagnosed with Chronic Schizophrenia and was on a hunger strike. OPP's failure to properly note his mental health status and history at intake, contributed to his delayed treatment and degenerative mental health state.

- In May 2007, L.L., a 57-year-old man, was sent to general population, even though he suffered from a brain disease affecting his mental capabilities. While in general population, L.L. showed signs of memory loss but did not receive any mental health care or services. Five months after intake, L.L. was finally seen by mental health staff and diagnosed with probable dementia. OPP's deficient intake process failed to give L.L. adequate care and agitated his mental condition.

c. Inadequate Staffing

We found that OPP fails to employ sufficient mental health staff to ensure that inmates receive adequate services. The HOD-10 unit, which serves as the House of Detention crisis unit for all mental health inmates, has only one full-time psychiatrist and one part-time psychiatrist. HOD-10 also has four licensed practical nurses, supervised by one registered nurse. During our site visits, we noted that there were no licensed drug counselors or social workers on staff. We found inadequate mental health staffing resulting in delays in inmates being assessed and treated.

In the South White Street Facility, we found that female inmates were not receiving necessary and adequate mental health care because of inadequate staffing. Even though some of these inmates received previous community mental health treatment, psychotropic medications, or been placed on suicide watch, they received deficient mental health care. Without adequate mental health staffing, including social workers and drug counselors, many of these women will not receive needed mental health services, such as: group or individual therapy, substance or physical abuse counseling, and other services to address their underlying mental disorders. The following examples are illustrative of OPP's failure to provide adequate mental health care because of inadequate staffing:

- On May 20, 2008, M.M. was screened and sent to the segregation unit of the women's facility. Despite reporting that she had been taking psychotropic medication for depression and anxiety, the psychiatrist did not evaluate her for three weeks. Like other inmates in OPP, M.M. was given her medication via the "Keep on Person" program. This program allows inmates to keep medications in their possession and self-administer these medications. Inmates are not given appropriate instruction on use of the medications, nor are they adequately monitored. M.M. reported that no one monitored her medication and that she took it when she thought she needed it.

- On April 6, 2008, N.N. reported at intake that she had a history of depression and that she had been taking antidepressants before incarceration. The psychiatrist ordered an antidepressant via telephone but did not assess N.N. until over a month after the initial medication order. During the psychiatric assessment, N.N.'s antidepressant dosage was increased. In our expert's opinion, the psychiatrist should have interviewed and assessed N.N. in person before prescribing the initial medication. Further, N.N.'s second visit with the psychiatrist was more than two months after her initial assessment. This is insufficient since she received an increased dose of antidepressants during the psychiatric assessment.

d. Inadequate Assessment and Treatment

OPP fails to appropriately and timely assess and treat inmates with mental illnesses. Our investigation revealed a lack of attention to past mental health information and a failure to

provide timely psychiatric assessment and treatment. These failures are inconsistent with generally accepted professional standards and have resulted in mental health deterioration and unnecessary suffering The following examples are illustrative of OPP's failure to adequately assess and treat mental health inmates resulting in mental health deterioration and unnecessary suffering:

- On December 14, 2007, O.O. was screened with a history of heroin use and past psychiatric treatment. It took more than four months before he received a psychiatric assessment. When O.O. was finally assessed, he was suffering from heroin dependence, cocaine and alcohol abuse, and symptoms of seasonal affective disorder. He received treatment four months after intake.

- On August 29, 2007, P.P., a 43-year-old man, hung himself with a telephone handset cord in OPP's HOD-4 unit. P.P. was referred to a psychiatrist at OPP, but was never assessed. P.P. complained of insomnia and informed OPP that he had been on psychotropic medications. His complaints were not addressed by a psychiatrist and he committed suicide at OPP by hanging himself 22 days after the psychiatric referral. While P.P.'s suicide does not appear foreseeable, the delay of 22 days is unacceptable even for a non-emergency referral within the correctional system.

- On August 17, 2006, Q.Q. was sent to the psychiatric unit after complaints of homicidal ideation. It took OPP staff more than seven and a half months before Q.Q. received an initial psychiatric assessment. When he finally began treatment on March 3, 2007, he had a number of mental health illnesses and disorders. OPP should provide adequate mental health assessment and treatment in accordance with generally accepted professional standards of mental health care. The delay in Q.Q.'s initial psychiatric assessment is unacceptable.

Exacerbating the problem with assessment and treatment, we found that OPP lacks multi-disciplinary treatment teams where other staff, with the exception of the nurses on HOD-10, participate in the care of inmates. Effective mental health treatment of inmates often involves services provided by a multi-disciplinary treatment team that includes psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, drug counselors, and correctional officers. Under OPP's procedures, the psychiatrist writes a plan as part of the initial psychiatric evaluation, and discussions are later held with a nurse. By not having social workers as part of the treatment team, for example, inmates do not receive the benefit of group therapy. And, without the input of correctional officers, who experience daily contact with inmates, the mental health service providers will not have the benefit of the correctional officers' ongoing observations.

e. Inadequate Quality Assurance Review

Generally accepted correctional mental health standards call for adequate quality assurance review. Such review is necessary to examine the effectiveness of the mental health care delivered and to implement corrective action so that the quality of care is improved.

We found that OPP fails to engage in consistent, effective quality assurance review in order to monitor and assess the quality of mental health offered at the facility. During our site visits, we found that despite the existence of OPP's Medical Quality Improvement Committee, there is no formalized review and evaluation process for mental health services. It is essential that a consistent and effective quality assurance process exists to track and trend mental health related deficiencies at the facility. OPP fails to conduct formal quality reviews of (1) effectiveness of the intake and referral process; (2) management of psychotropic medications; (3) suicide prevention including assessment of suicide risk; (4) review and tracking of suicide attempts; (5) monitoring of inmates on suicide observation; (6) treatment planning and treatment interventions for inmates in the mental health program; (7) appropriate use of restraints and monitoring of inmates in restraints; (8) discharge planning for the effective management and continuity of care for inmates released from custody; and (9) review and audits of medical records for quality and appropriateness of documentation of services provided.

2. Medical Care

Jail officials are responsible for providing adequate medical care to inmates. Our investigation revealed that medical care provided at OPP meets constitutionally required standards of medical care in many areas; however, we found specific deficiencies in OPP's medication management.

a. Inadequate Medication Management

Generally accepted correctional medical standards require that facilities administer medication and maintain adequate medication records to meet the medical needs of the inmates and to prevent medication errors and other risks of harm. We found that OPP's practices were inconsistent with generally accepted professional standards of care.

In particular, OPP's "Keep on Person" ("KOP") medications program is deficient. The KOP program allows inmates to keep medications in their possession and self-administer these medications. Both general population and mental health inmates are provided small, unmarked envelopes with four days of medications twice per week. This distribution process is deficient because it fails to consistently provide inmates with adequate instruction on how to take the medications, fails to monitor inmates' medication intake, and fails to give the name of the prescribed medications. This lack of basic information and supervision in the KOP program fails

to protect inmates from improper use and harm. The following examples in which inmates obtained dangerous quantities of medication and overdosed are illustrative of this concern:

- On August 21, 2008, R.R. overdosed on his medication. He was rushed to the emergency room after OPP staff discovered that R.R. had ingested six antidepressant and four antipsychotic pills. We found that OPP failed to monitor R.R.'s medication intake, and did not provide him with adequate instruction regarding his medication, including informing him of the harm in ingesting high amounts. When asked about overdosing on his medication, R.R. stated he missed his earlier doses, so decided to take all of his pills at one time to "catch-up."

- On January 20, 2008, S.S. was neither screened as a mental health patient nor prescribed an antipsychotic, yet he was rushed to the emergency room after he ingested a dangerous amount of antipsychotic medication. Even though S.S. survived, we found that OPP staff was unaware of the dosage S.S. ingested, or how S.S. had obtained the medication.

- On January 8, 2007, T.T. overdosed on 40 to 50 doses of psychotropic medication. T.T. was rushed to the emergency room after OPP discovered that she swallowed large quantities of medication. We found that OPP staff failed to monitor T.T. and failed to provide adequate medication management.

In addition, we found many instances where OPP failed to maintain documentation contemporaneously with medication administration. Contemporaneous documentation of medication is the practice of maintaining records at the same time that medication is administered to inmates to ensure that errors do not occur. It provides a more accurate accounting of the time, date, and type of medication received.

We also found that OPP's system for obtaining informed consent for medications substantially departed from generally accepted standards. During intake, inmates are required to sign a form that gives blanket consent for medications. This practice is not an informed consent because OPP is not also providing inmates with sufficient information about the medication and necessary treatment throughout an inmate's incarceration. Once a diagnosis is made and an inmate is prescribed medication, there is responsibility on the part of the medical staff to address an inmate's treatment at appropriate intervals during incarceration. Furthermore such blanket inmate consent can deter the medical staff from appropriately monitoring chronic or life-saving medications.

D. INADEQUATE ENVIRONMENTAL HEALTH and SANITATION

Although several areas in the OPP have undergone recent renovations, OPP has serious environmental health and sanitation problems.

1. Inadequate Pest Control

OPP has a visible pest problem. Although mice and cockroaches are nocturnal by nature, we observed both during our daytime visit, indicating there is a widespread presence. We also found other evidence of their presence in several of the buildings housing inmates, as well as in the food warehouse. Additionally, inmates complained about rodents and roaches in the facilities, and several work orders noted the presence of rodents in cells. Despite the obvious extent of these infestations, OPP was unable to produce a list of services or chemicals used for pest control. When asked about how often OPP sprayed or treated for pests, staff gave inconsistent responses, ranging from weekly to every three months.

2. Physical Plant and Housekeeping

With the challenges OPP faced after Hurricane Katrina, it is not surprising that the maintenance of the facilities presents an ongoing struggle. We are well aware that Hurricane Katrina rendered parts of OPP inhabitable and left others severely flood damaged. In a correctional setting where inmates and staff depend on maintenance staff for water, heat, lighting, and ventilation, however, these issues must be addressed in a timely manner in order to reduce the risks of illness and injury to inmates and staff.

We found that areas of OPP that housed inmates remain in a state of disrepair. The correctional staff generate work orders to the Facilities Department, which tracks the completed tasks. During our site visit, we observed hundreds of maintenance and repair needs, including approximately 60 broken or non-operational toilets, sinks, and drains in the HOD alone. We also observed a high number of broken, missing, or hazardous tiling, vents, and flooring in need of repair or replacement. Broken tiling and flooring is significant because these materials can be fashioned into weapons. We observed The work orders from 2007 and 2008 confirmed the problems we observed, including those of numerous work orders for broken toilets, sinks, and showers, as well as for water leaks.

Ventilation in many parts of OPP is extremely poor. Air quality measurements within HOD indicated that the temperature exceeded 85 degrees for many of the cells. We observed ventilation fans covered with visible layers of dust and debris, which can contain toxic chemicals, rodent waste and insect parts. The thick layer of dust and debris obstructs proper ventilation and the circulation of these substances in the air increases the risk of transmitting and contracting airborne diseases to both inmates and staff.

During our visits, we also observed obvious electrical hazards throughout the facilities. Electrical panels were not locked in the kitchen or in the rooms adjacent to housing areas. The panels often were located in rooms scattered with litter.
Many of the panels needed repair, and other panel door covers were missing altogether. These conditions pose a safety hazard to inmates and staff.

In addition, OPP does not properly store and control chemicals, cleaning agents, and other hazardous materials. Although several chemicals were stored in the appropriately labeled boxes, these chemicals were never opened or used. Our consultant noted other unlabeled chemicals stored in cells and other housing areas throughout the facilities. These chemicals are harmful if used in wrong concentrations or on the wrong surfaces. Furthermore, many inmates had unsupervised access to these chemicals, which if used improperly could cause serious harm or be used as a weapon.

While the lighting in common areas at OPP is adequate, inmates had covered many lighting fixtures with paper, cardboard and other materials in 30 percent of the individual cells. The covering of light fixtures not only presents a fire and health hazard, but also compromises the security of those housed in the cells, especially in light of the problems with supervision and inmate violence at OPP.

Finally, the conditions in the OPP housing areas are generally unsanitary. Dirt, dust, and debris covered many parts of the facilities, including the floor, windows, and corners. The shower and toilet areas had problems with mold. In HOD, the floor drains in these areas had no covers, and the shower vents were blocked with paper and other debris. The amount of refuse led our expert to recommend that all units in HOD "should be cleaned thoroughly."

3. Food Service

Food service practices at OPP place inmates at risk of harm. Approximately 7,200 meals are prepared in the food service area daily. Although a new kitchen had opened just days prior to our May 2008 tour, we observed improperly stored food, unattended cleaning materials and chemicals on the floor, and insects in the food preparation area. Furthermore, the kitchen had litter on the floors, and all kitchen employees did not have access to hand-washing facilities.

Food delivery at OPP is also inadequate. The facility delivers food to the housing areas by placing food in insulated containers for delivery. Generally accepted professional standards require that hot food be served at 140 degrees. Although when originally put in the insulated transportation containers, the food temperature measured well in excess of 140 degrees, it took as long as *four hours* for food prepared in the kitchen to reach some of the housing units. For those housing units, food temperatures were well below 140 degrees when served. In some cases we measured the temperature at 88 degrees for some hot food. The range of temperature between 41 degrees and 140 degrees is typically called the food danger zone. Bacteria that causes food-borne illness multiply and grow at this temperature range.

Once the food arrives at the housing units, handling and service did not comport with generally accepted professional standards. As in many other correctional facilities, OPP relies primarily on inmates to serve food. During meal times, inmate workers placed food containers on dirty tables and did not wash their hands before serving food. We also observed instances where gloves were inconsistently used. For example, we observed a food handler at the facility

using his bare hands to serve noodles on the individual plates. These practices are unsanitary, can result in cross contamination, and greatly increase the risk of food-borne disease.

4. Fire Safety

While it appears that OPP has taken steps to protect inmates and staff in the event of fire or an emergency, they remain at serious risk of harm because of certain deficiencies in emergency preparedness in terms of accessibility of fire equipment and consistency of conducting fire drills.

OPP has an adequate number of fire extinguishers, and emergency exit procedures were posted in each facility. Fire extinguishers were inspected regularly, but often were housed in locked compartments. When asked to locate fire extinguishers, some staff took an inordinate amount of time to find the keys to unlock the compartments. In the new kitchen and intake areas, it took the staff an unacceptable length of time to locate any of the three available fire extinguishers and find a key to unlock the compartment containing the fire extinguisher.

Although OPP appears to perform fire drills, they are not conducted in a manner consistent with generally accepted correctional standards, which require monthly fire drills. Monthly drills should rotate so that they are conducted quarterly on each shift. Drills should be conducted at differing times and under differing conditions, such as using different egress routes to confirm that officers have the necessary keys and know how to use them. Records of each drill should be maintained for at least one year. While staff reported that OPP conducts monthly fire drills, it remained impossible to discern when these drills actually occurred because OPP did not document any of these drills. Some inmates claimed that the drills occurred weekly, others stated that drills took place every two months.

IV. REMEDIAL MEASURES

In order to address the identified deficiencies and protect the constitutional rights of inmates confined at OPP, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice:

A. Protection from Harm

1. Use of Force

   a. Develop and maintain comprehensive and contemporary policies and procedures regarding permissible use of force.

      (1) Prohibit the use of force as a response to verbal insults or inmate threats.

(2) Prohibit the use of force as a response to inmates' failure to follow instructions where there is no immediate threat to the safety of the institution, inmates, or staff, unless OPP has attempted a hierarchy of nonphysical alternatives which are documented.

(3) Prohibit the use of force as punishment.

b. Establish effective oversight of the use of force.

(1) Develop and implement a policy to ensure that staff adequately and promptly report all uses of force.

(2) Ensure prompt management review of use of force reports. The review should include:

i. case-by-case review of individual incidents of use of force; and

ii. systemic review in order to identify patterns of incidents.

(3) Ensure that incident reports, use of force reports and inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, that it is referred for investigation.

(4) Develop and maintain comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.

(5) Develop and implement a process to track all incidents of use of force that at a minimum includes the following information: the inmate(s) name, housing assignment, date and type of incident, injuries (if applicable), if medical care is provided, primary and secondary staff directly involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.

c. Develop an effective and comprehensive training program in the appropriate use of force.

(1) Ensure that staff receive adequate competency-based training in OPP's use of force policies and procedures.

(2) Ensure that staff receive adequate competency-based training in use of force and defensive tactics.

(3) Ensure that SOD and IAD management and staff receive adequate competency-based training in conducting investigations of use of force allegations.

2. Safety and Supervision

a. Ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise inmates.

b. Ensure that inmate work and housing areas are adequately supervised whenever inmates are present.

c. Ensure frequent, irregularly timed, and documented security rounds by correctional officers inside each housing unit.

d. Ensure that staff adequately and promptly report incidents.

e. Develop a process to track all serious incidents that captures all relevant information, including: location of incident, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.

f. Establish a procedure to ensure that inmates do not possess or have access to contraband. Conduct regular inspections of cells and common areas of the housing units for contraband.

g. Conduct regular inspections of cells and common areas of the housing units to identify and prevent rule violations by inmates.

h. Review, and revise as applicable, all security policies and Standard Operating Procedures ("SOPs") on an annual basis.

i. Review, and revise as applicable, all security post orders regularly.

j. To the extent possible, taking into account the different security levels and different physical layouts in the various divisions, standardize security policies, procedures, staffing reports, and post analysis reports across the divisions.

k. Provide correctional officers transferred from one division to another formal training on division-specific post orders.

l. Implement specialized training for officers assigned to special management units, which include disciplinary segregation, and protective custody units. Officers assigned to these units should possess a higher level of experience and be regularly assigned to these units for stability purposes.

3. Classification

a. Develop and implement an objective classification system that separates inmates in housing units by classification levels.

b. Update facility communication practices to provide officers involved in the classification process with current information as to cell availability on each division.

c. Update the classification system to include information on each inmate's history.

d. Provide competency-based training and access to all supervisors on the full capabilities of the OPP classification and inmate tracking system (or any replacement system).

B. Mental Health Care

1. Use of Restraints

a. Develop and implement a policy for the use of restraints that is consistent with generally accepted professional standards, including the requirement of written approval by a qualified medical or mental health professional prior to the use of restraints.

b. Develop and implement a policy regarding monitoring restrained inmates that requires adequate checks of the physical condition of restrained inmates, and adequate documentation of the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained inmates.

c. Ensure that restraints are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.

2. Suicide Prevention

a. Develop policies and procedures to ensure appropriate management of suicidal inmates and the establishment of a suicide prevention program.

b. Ensure that OPP suicide prevention policies include an operational description of the requirements for both pre-service and annual in-service training.

c. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff who work directly with inmates have demonstrated competence in identifying and managing suicidal inmates.

d. Ensure that any staff who are exempt from suicide prevention training have limited inmate contact.

e. Ensure that intake staff are sufficiently experienced and qualified to identify inmates that pose a risk for suicide, and conduct appropriate follow-up evaluations by mental health professionals of new inmates within 14 days of intake.

f. Screen all inmates upon intake, including questioning to assess current and past suicide risk.

g. Document inmate suicide attempts at OPP in the inmate's correctional record in the classification system, in order to ensure that intake staff will be aware of past suicide attempts if an inmate with a history of suicide attempts is admitted to OPP again in the future.

h. Ensure that inmates on suicide precautions receive adequate mental status examinations by a mental health clinician.

i. Ensure that suicidal inmates are housed in an area that is safe for them with appropriate supervision and observation by staff.

j. Ensure that 15- and 30-minute checks of inmates under observation for risk of suicide are timely performed and appropriately documented.

k. Provide different levels of supervision of inmates based on the presenting risk factors for suicide.

l. Ensure that inmates placed on suicide watch are assessed adequately, monitored appropriately to ensure their health and safety, and released from suicide watch as their clinical condition indicates according to generally accepted standards of care.

m. Ensure a component of administrative review is implemented following a suicide or a suicide attempt to identify what could have been done to prevent the suicide.

3. Intake and Referral

a. Develop and implement an appropriate intake screening instrument that identifies mental health needs, and ensures timely access to a mental health professional when presenting symptoms require such care.

b. Ensure that inmates with potentially serious chronic mental health illness are referred for prompt mental health evaluations and examinations by a psychiatrist.

c. Ensure that OPP's intake evaluation process includes a mental health screening that is incorporated into an inmate's medical record.

4. Staffing

a. Provide staffing adequate for inmates' serious mental health needs.

b. Provide adequate on-site psychiatry coverage, including ensuring that psychiatrists see inmates in a timely manner.

5. Assessment and Treatment

a. Develop and implement policies and procedures for appropriate assessments of inmates with serious mental illness.

b. Provide adequate mental health assessment and treatment in accordance with generally accepted professional standards of mental health care.

c. Ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses and problems. Provide therapy services where necessary for inmates with serious mental health needs.

d. Ensure that mental health evaluations done as part of the disciplinary process include recommendations based on the inmate's mental health status.

e. Ensure that inmates receive psychotropic medications in a timely manner and that inmates have proper diagnoses for each psychotropic medication they receive.

d. Ensure that psychotropic medications are reviewed by a psychiatrist on a regular, timely basis and inmates are properly monitored.

6. Quality Assurance and Review

a. Develop and implement a quality assurance program to assist OPP in identifying and correcting serious deficiencies within the mental health system, prioritizing its efforts at reform, and developing appropriate remedies.

C. Medical Care

1. Medication Administration

a. Ensure that treatment and administration of medication to inmates is implemented in accordance with generally accepted professional standards of care.

b. Ensure that administration of medication is accurate and adequately documented. Develop policies and procedures for the accurate administration of medication and maintenance of medication records. Provide a systematic review of the use of medication to ensure that each inmate's prescribed regimen continues to be appropriate and effective for his condition.

c. Develop and implement an appropriate medication administration protocol that provides adequate direction on how to take medications, describes the name of prescribed medications, and identifies how inmates are monitored.

D. Sanitation and Environmental Conditions

1. Sanitation and Maintenance of Facilities

a. Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and

supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.

b. Ensure adequate pest control, including sufficient staffing for routine and follow-up pest control services.

c. Ensure proper ventilation and airflow in all cells and housing units.

d. Ensure adequate lighting in all housing units and prompt replacement and repair of malfunctioning lighting fixtures.

e. Ensure prompt and proper maintenance of shower, toilet, and sink units.

f. Develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials.

g. Use cleaning chemicals that sufficiently destroy the pathogens and organisms in biohazard spills.

2. Environmental Control

a. Repair electrical panels; develop and implement a system for maintenance and repair of electrical panels, devices, and exposed electrical wires.

3. Food Service

a. Provide training for kitchen workers in the areas of food safety, proper food handling, and proper hygiene to reduce the risk of food contamination and food-borne illnesses.

b. Ensure that dishes and utensils, food preparation and storage areas, and vehicles and containers used to transport food are properly cleaned and sanitized.

c. Ensure that foods are served and maintained at proper temperatures.

E. Fire and Life Safety

1. Ensure that all facilities have adequate fire and life safety equipment which is properly maintained and inspected.

2. Implement competency based testing for staff regarding fire/emergency procedures.

3. Develop and implement adequate policies and procedures regarding fire prevention including emergency planning and drills.

4. Ensure that emergency keys are appropriately marked, available, and consistently stored in a quickly accessible location.

5. Inventory and store all flammable, toxic, and caustic materials in a well ventilated, but locked, compartment.

6. Ensure that emergency drills are conducted on a regular basis.

* * * * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the City in an amicable and cooperative fashion to resolve our outstanding concerns regarding OPP. Assuming there is a continuing spirit of cooperation from the City, we also would be willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 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 are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney to discuss this matter in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

Loretta King

Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable C. Ray Nagin
Mayor
The City of New Orleans

T. Allen Usry, Esq.
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City Attorney
The City of New Orleans

The Honorable Jim Letten
United States Attorney
Eastern District of Louisiana