



**U.S. Department of Justice**

**Civil Rights Division**

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*Assistant Attorney General  
950 Pennsylvania Avenue, NW - RFK  
Washington, DC 20530*

April 29, 2008

The Honorable Deval Patrick  
Massachusetts State House  
Office of the Governor  
Room 360  
Boston, MA 02133

Re: Investigation of the Worcester County Jail and House of Correction, West Boylston, Massachusetts

Dear Governor Patrick:

On November 17, 2006, we notified then-Governor Mitt Romney of our intent to investigate conditions at the Worcester County Jail and House of Correction (the "Jail"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. In accordance with statutory requirements, we write to report the findings of our investigation and to recommend remedial measures that will ensure the Jail's compliance with federal constitutional requirements. See 42 U.S.C. § 1997b.

On February 13-15 and May 9-11, 2007, we conducted on-site inspections at the Jail with consultants in the fields of protection from harm and mental health care. While on-site, we interviewed administrative staff, corrections staff, mental health care providers, nursing staff, pre-trial detainees, and sentenced inmates. Additionally, before, during, and after our on-site inspections, we reviewed a large number of documents, including policies and procedures, incident reports, and mental health records. Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we concluded our tours with extensive debriefings at which our consultants expressed their initial impressions and concerns.

We appreciate the full cooperation we received from the Commonwealth of Massachusetts and the Worcester County Sheriff's Office. We especially wish to thank Sheriff Guy Glodis, Deputy Sheriff Jeffrey Turco and the administration and staff at the Jail for their professional conduct, their timely responses to our information requests, and the extensive assistance they provided during our tours. Additionally, we value the immediate

attention given to address some of our concerns and appreciate that the Sheriff continues to update us on changes to policy and procedures in response to our on-site observations. While we have not had the opportunity to assess the implementation of these measures, we commend such leadership and commitment to reform.

Having completed the fact-finding stage of our investigation, we conclude that certain conditions at the Jail violate the constitutional rights of persons confined there. As detailed below, we find that the Jail fails to: (1) protect pre-trial detainees and sentenced inmates (collectively, "inmates") from harm; (2) protect inmates from exposure to unsanitary and unsafe environmental conditions; and (3) provide inmates with adequate mental health care to address their serious mental health needs.

## I. BACKGROUND

### A. Facility Description

The Jail is located in West Boylston, Massachusetts, approximately 50 miles west of Boston, and is operated by the Worcester County Sheriff's Office.<sup>1</sup> The Jail houses adult males who are pre-trial detainees or have been sentenced to a maximum of two and a half years. Although the Jail was designed to house approximately 800 inmates, it is significantly overcrowded; the average census in 2006 was 1,400. When we first visited the Jail in February 2007, the inmate population was approximately 1,427. During our second tour in May, it was approximately 1,380.

The Jail is comprised of several buildings that provide housing for inmates with various security classifications. Opened in 1973, the Main Jail houses maximum and medium security inmates. It has five housing units -- A-1, A-2, Maximum B, Maximum C, and Medium C. Inmates are also housed in the gymnasium when there are not enough cells in the regular housing units. The upper tier of A-1 has 16 single-bunked cells that are used for inmates on suicide watch.

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<sup>1</sup> In 1998, the Worcester County government was abolished and the Sheriff's Office became an independent agency of the State. Auditor of the Commonwealth, Independent State Auditor's Report on Certain Activities of the Worcester County Sheriff's Office, at 1 (June 9, 2005).

The lower tier of A-1 and both tiers of A-2 have 16 cells that can be single-bunked or double-bunked and are used for disciplinary and administrative segregation.

The Modular Complex houses medium security inmates in five housing units with double-bunked cells. The Minimum Security Facility houses minimum security inmates in a dormitory style setting. The Annex provides dormitory-style housing for inmates who are on work release. Clinic health service areas are located in the Main Jail and the Modular Complex.<sup>2</sup>

#### B. General Legal Framework

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of pre-trial detainees and sentenced inmates. 42 U.S.C. § 1997. In defining the scope of 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) (pre-trial detainees are protected by the Fourteenth Amendment). The "humane conditions" standard is satisfied when a corrections system provides for inmates' basic needs for safety, medical care, food, clothing, and shelter. Id.; Giroux v. Somerset County, 178 F.3d 28, 31 (1st Cir. 1999). As discussed below, the conditions at the Jail do not comport with these legal standards.

## II. FINDINGS

#### A. Failure to Protect Inmates from Harm

The Eighth Amendment requires that inmates be protected from the unnecessary and wanton infliction of pain by corrections officers. Whitley v. Albers, 475 U.S. 312, 319 (1986). Corrections officers may use reasonable force in a good faith effort to maintain or restore discipline, but force is not to be used maliciously and sadistically to cause harm. Hudson v. McMillan, 503 U.S. 1, 6 (1992). The Eighth Amendment also imposes a duty on prison officials "to protect prisoners from violence at the hands of other prisoners." Farmer, 511 U.S. at 833; see also Calderon-Ortiz v. Laboy-Alvarado, 300 F.3d 60, 63-

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<sup>2</sup> Health services office space also is available in the Minimum Security Facility and the Annex. The Jail contracts with an outside provider, Advocates, Inc., to provide mental health care at the facility.

64 (1st Cir. 2002). Being violently assaulted while incarcerated simply is not "part of the penalty that criminal offenders pay for their offenses against society." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). Punitive treatment amounting to gratuitous infliction of "wanton and unnecessary" pain is prohibited under the Eighth Amendment. Hope v. Pelzer, 536 U.S. 730, 738 (2002). Moreover, when applied to pre-trial detainees, a sanction that is disproportionate to the infraction may constitute punishment in violation of the Fourteenth Amendment. Suprenant v. Rivas, 424 F.3d 5, 13 (1st Cir. 2005).

Notwithstanding these legal requirements, inmates at the Jail are subjected to serious harm and the risk of harm from: (1) the excessive use of restraint; (2) inmate-on-inmate violence; (3) inadequate supervision; (4) inadequate classification; (5) deficient internal investigations; and (6) an inadequate system for filing grievances.

1. Excessive Use of Restraint

a. Physical Restraint

Although there is no constitutional prohibition regarding the use of physical restraints, courts review their use with great care to ensure it does not amount to punishment or inflict wanton and unnecessary pain in violation of the Eighth Amendment. Ferola v. Moran, 622 F.Supp. 814, 820-21 (D.R.I. 1985); see also Bell v. Wolfish, 441 U.S. at 535-36 (restrictions on conditions of confinement for pre-trial detainees should not amount to punishment).

Our investigation revealed that, in a significant number of instances, Jail staff inappropriately restrain inmates, specifically via four, five, and six-point restraints.<sup>3</sup> Between April 2006 and March 2007, Jail staff performed 155 cell extractions and used the restraint chair/restraint bed 161 times. In many of these instances, Jail staff used restraints after the need for restraint had passed and/or used restraints for excessive periods of time.<sup>4</sup> On December 13, 2007, however, the

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<sup>3</sup> The use of restraints in this context is the simultaneous restraint of all four limbs, usually at the ankles

<sup>4</sup> At the conclusion of our May 2007 on-site tour, we notified officials of our immediate concerns regarding the restraint usage practices. We then memorialized our concerns in

County sent us a letter providing that it has revised its policies and conducted a self-audit regarding the Jail's use of restraints. The County has noted a decrease in the use of restraints particularly between the period of May 1 and January 31, 2008.<sup>5</sup> They also noted a significant drop in the time inmates were held in restraints. We commend the County for promptly reviewing and changing its practices, policies, and procedures, and we look forward to assessing whether the changes made are consistent with constitutional and generally accepted professional standards.

Notwithstanding these positive developments, we found restraint practices during our tours that substantially departed from generally accepted practices and that inmates were not adequately protected from serious harm. Jail staff routinely use restraints after a Special Operations Group ("SOG") performs a cell extraction -- a procedure in which an allegedly noncompliant inmate is forcibly removed from his cell.<sup>6</sup> Because these incidents generally are videotaped, we were able to observe the inmate's behavior as he was extracted, escorted to a restraint area, and placed in restraints.<sup>7</sup>

During our May 2007 tour, we reviewed nine randomly-selected videotapes of SOG teams extracting inmates from their cells and

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writing. Letter from Shanetta Y. Cutlar, Chief of the Special Litigation Section to Deputy Superintendent Jeffrey Turco, Esquire (May 18, 2007).

<sup>5</sup> Letters from Deputy Superintendent Jeffrey Turco, Esquire to Shanetta Y. Cutlar, Chief of the Special Litigation Section (December 13, 2007 and March 7, 2008).

<sup>6</sup> The SOG is a specialized unit that is responsible for, among other things, conducting cell extractions. They routinely videotape these extractions. In the videotaped cell extractions we reviewed, SOG teams were comprised of at least five officers wearing dark uniforms, riot helmets, body gear, combat coots, and elbow and knee pads. SOG officers carry handcuffs, leg irons, flex cuffs, oleoresin capsicum ("OC") spray, and non-lethal weapons known as FN 303s, which look like rifles and shoot pellets of OC.

<sup>7</sup> SOG team members are not the only corrections officers who place inmates in restraints. It is our understanding, however, that SOG team members are the only officers who videotape the application of restraints.

placing them in restraints. Although the Jail's policies state that restraints should only be used as a last resort to control inmates who exhibit violent behavior, threaten staff, or are out of control, none of the inmates in the tapes we reviewed appeared to be appropriate candidates for this highly restrictive measure.<sup>8</sup> The following examples are illustrative.

- In a videotaped incident from March 28, 2007, a SOG team removed four inmates from their cells because they reportedly had broken the glass from their television sets, were in possession of bleach, and were threatening staff. After deploying a distraction device (a device that creates billows of smoke making it difficult to see), two of the inmates were taken to the rear isolation cells in the Maximum B housing unit and placed in four-point restraints on metal beds.<sup>9</sup> The other two inmates were sent to the A-2 housing unit where they were placed in four- or six-point restraints.<sup>10</sup> At the time the inmates were restrained, none appeared to be a threat to themselves or staff. Indeed, the videotape and accompanying written documentation we reviewed indicated that the inmates were immediately compliant once they were removed from their cells. Notably, only one of the four inmates received a disciplinary write-up.<sup>11</sup>

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<sup>8</sup> In each case, we had ample opportunity to observe the inmate's behavior because the videotapes lasted between 15 and 30 minutes. Again, we commend the Jail for its policies and procedures to videotape. It provides managerial accountability and is consistent with generally accepted professional standards.

<sup>9</sup> It is worth noting that the isolation cells in the Maximum B and Maximum C housing units are inappropriate places to restrain inmates. Dungeon-like in appearance, because these cells are dank and dark, officers have no direct line of sight through which to observe restrained inmates. After we expressed our concern about conditions in these units, the Jail revised its policy to prohibit the use of restraints in these locations. We commend Jail officials for their swift action to address this concern.

<sup>10</sup> The documentation provided to us was inconsistent regarding the types of restraints used.

<sup>11</sup> We do not dispute the very serious actions taken by the inmates and disciplinary action was likely in order.

- Another videotaped incident from February 2, 2007 showed the SOG team removing inmate S.C.<sup>12</sup> from his cell, taking him to the A-2 housing unit, and placing him in six-point restraints. According to the videotaped explanation provided by a SOG team member, S.C. was removed from his cell because he was threatening staff, kicking his cell door, and refusing to be placed in handcuffs. From the moment the SOG team opened S.C.'s cell door, however, the inmate complied with the team's instructions. He did not resist handcuffs or leg irons, did not resist being escorted to the restraint bed in the A-2 housing unit, and actually assisted the SOG team as they applied the restraints.
- On February 2, 2007, the SOG team was called after inmate J.R. refused to move to a different cell in his housing unit. J.R. allowed the SOG team to handcuff him and place him in leg irons, but refused to be strip searched. Following this refusal, the SOG team escorted J.R. to the restraint area in the A-2 housing unit. Upon arrival in the restraint area, J.R. can be heard on the videotape agreeing to be searched. The SOG officer responded by saying "Now you're going to strip? It's too late now; you had an opportunity." Despite the inmate's express statement that he would comply with the search, the SOG team placed him in six-point restraints. Once the restraints were applied, the SOG team cut off J.R.'s clothing, leaving him to lie exposed in his boxer shorts in the middle of winter.<sup>13</sup>

Almost immediately after being restrained, J.R. started convulsing. In the videotape, J.R. can be heard telling a nurse in the restraint area that he thought he was having an anxiety attack. The nurse responded, "I think you are too," but left without intervening. J.R. continued to convulse for a period of time without

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<sup>12</sup> To protect inmates' privacy, throughout the document we identify inmates by initials other than their own. We will separately transmit to the County a list that cross references the initials with inmate names.

<sup>13</sup> We found a number of instances where, while being restrained, inmates were stripped to their underwear for no apparent reason.

receiving any assistance from mental health, medical, or custody personnel. There is no record of how long J.R. was restrained.

- On January 16, 2007, the SOG team was called because inmate P.Q. flooded his cell, was allegedly throwing items at officers, and refused to be placed in handcuffs. The SOG team asked P.Q. to lie down in his cell and place his hands behind his back. At that point, P.Q. began to cut his wrist with a sharp instrument. P.Q. was then taken to the medical unit and, thereafter, transported to the emergency room where he received stitches. The videotape showed that upon P.Q.'s return to the Jail several hours later, he appeared in control of his behavior and informed the officers that he was in pain. He also told the officers that he understood that he had broken the rules and stated that he would comply with their instructions. Nevertheless, the officers placed P.Q. in six-point restraints. When P.Q. asked why he was restrained, staff responded that he had attempted suicide and was in an agitated state.<sup>14</sup>

Given that the inmates described above exhibited no loss of control or threatening behavior during these lengthy incidents, the use of restraints cannot be justified.<sup>15</sup> Absent a sound penological or therapeutic rationale for using restraints, we are left to conclude that staff at the Jail used restraints in these cases for punitive purposes -- in violation of constitutional standards, Jail policy and generally accepted professional standards. When inmates violate Jail rules, the Jail should appropriately address the infractions through a fair and objective disciplinary process, but not by placing inmates on a bed or chair that restrains their arms, legs and torsos.

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<sup>14</sup> The propriety of using restraints for mental health purposes is addressed in Section III(C)(3) of this letter.

<sup>15</sup> We recognize the deterrent effect that the very presence of the SOG has on inmates -- they likely will comply once the SOG is dispatched (which is a good thing) -- but the policy/practice should provide for next steps when there is compliance, as well as when there is not. Otherwise, the Jail is not fully utilizing this team and, inadvertently, failing to encourage compliance from the inmates, and arguably inflicting restraints as a form of punishment rather than a compliance tool.



In addition to finding that inmates are inappropriately restrained, our investigation also revealed that even when the initial use of restraints is justified, in many cases the length of time inmates are restrained makes the practice punitive. We reviewed reports documenting 12 instances of restraint use between April 1 and 30, 2007. Nine of the inmates were restrained for four or more hours; one was restrained for 23 hours. We also found that inmates oftentimes are restrained without consultation with medical or mental health staff. In fact, as discussed in Section III(C)(3) below, mental health staff rarely are involved in the decision to restrain inmates on the mental health caseload (who may be suicidal or mentally ill). In a departure from generally accepted professional standards, this decision is made by solely security staff.

According to Jail policy, a supervisor or administrator must review the use of restraints. We discovered, however, that this review, if it occurs at all, often takes days, weeks, or even months. In light of these extensive delays, it is impossible for an inmate who is inappropriately restrained to receive timely relief. We note that the Jail reportedly has made some changes in this regard. At the end of our May 2007 tour, the Jail issued a directive requiring that an Assistant Deputy Superintendent or Operations Captain personally interview and observe an inmate who is subject to restraint longer than two hours. Because this practice was scheduled to be implemented after our departure, we were not able to assess its efficacy.

b. Chemical Agents

In addition to the unlawful use of restraints, we found that the Jail does not comply with generally accepted professional standards or its own policy regarding the use of the chemical agent oleoresin capsicum ("OC"). Specifically, we found only one instance in the videotapes we reviewed where the Jail decontaminated an inmate who was sprayed with OC. Moreover, despite a policy requiring staff to review inmates' medical records for contraindications before using OC, we found no evidence that such a review actually occurs.

For example, on January 10, 2007, a SOG team was called to remove inmates D.W. and T.G. from their cell because they reportedly were threatening to assault officers, disrupting the cellblock, and destroying their cell. The SOG team fired OC projectiles into the cell, striking both inmates. Thereafter, both D.W. and T.G. were handcuffed, placed in leg irons, escorted

to A-2, and placed on adjacent restraint beds.<sup>16</sup> No one attempted to ascertain whether the use of OC was contraindicated, and neither inmate was allowed to shower after being exposed to this chemical.

## 2. Inadequate Incident Review and Investigation

Management's failure to adequately review and investigate incidents contributes to the high number of excessive restraint incidents at the Jail. The principal purposes of management incident review are to ensure that no criminal conduct has occurred, that facility procedures have been followed, that no remedial training is necessary, and that no review or change in policies is required. Because the Jail's policies fail to set forth a time frame for supervisory review, the process varies in length from days to weeks to, in some instances, months. In addition, because supervisors are not required to sign the incident reports they review, it is impossible to determine whether a supervisory review has taken place. This gap in the system allows for improper uses of force to go unaddressed.

Compounding this problem is the fact that the computer system used to track use of force incidents lacks reliability. A functional system should allow supervisors to easily review all reports relating to a particular use of force incident and should include documentation of witness statements from staff and inmates. At the Jail, however, corrections officers and supervisors enter incident information into the computer located at their posts or work areas. Each entry generates a number in sequential order. Thus, if one incident results in multiple incident reports from multiple participants and witnesses, each individual report will have a different number. This makes it difficult for supervisors to track all of the reports related to a particular incident to ensure that all relevant information is considered. A further complication is that the system includes entries about routine daily activities on the unit such as the distribution of meals and sick call. The fact that staff can make entries using each others' passwords further undermines the integrity of the system. The officers we interviewed were uniformly frustrated with the system's cumbersome nature. Given the deficiencies outlined above, the computer system cannot be relied upon to generate accurate statistics, patterns, or trends.

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<sup>16</sup> As discussed in Section III(C)(3), below, after we expressed our concern about restraining more than one person in the same area, the Jail changed its policy to forbid this practice.

### 3. Inmate-On-Inmate Violence

The lack of adequate inmate supervision has contributed to a number of inmates being assaulted by other inmates at the Jail. The Jail's "Significant Incident Summary" reports that 233 inmate-on-inmate assaults occurred between April 2006 and March 2007. For jails of similar size (with inmate populations 1,000 to 1,999), a reliably reported average is 108 inmate-on-inmate assaults,<sup>17</sup> less than half the number of assaults reported at the Jail.

Further, many of the Jail's inmates suffered serious injuries. During this same time period (April 2006 and March 2007), there were 155 medical referrals for inmate injuries sustained during such assaults. The injuries included head wounds, bleeding, lacerations, and bruises. In 2005, a pre-trial detainee at the Jail died from injuries he sustained after allegedly being beaten by his cell mate who was a sentenced inmate. A high incidence of inmate-on-inmate assaults is compelling evidence of the Jail's inability to keep its inmates safe.

### 4. Inadequate Investigations

A functional investigation process should be governed by policies and procedures that address file management, tracking procedures, authorization protocols for initiating investigations, training requirements for investigators, time frames for conducting investigations, interview processes of staff and inmates, polygraph requirements (if applicable), reporting requirements regarding allegations of staff misconduct, and final disposition procedures. The Jail conducted 39 investigations in 2006, and 21 investigations during the first five months of 2007. We reviewed a random sample of these investigations which revealed that the Jail's policies and procedures do not provide investigators with adequate guidance to conduct appropriate investigations.

For example, there is no requirement that investigations involving allegations of excessive force include medical evidence (or an affirmative statement that medical evidence was not available). Information regarding the extent of an inmate's injuries following a use of force incident is important to the investigation. Such information allows the investigator to

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<sup>17</sup> The Criminal Justice Institute, Inc., The 2000 Corrections Yearbook: Jails, at 85 (2000) .

determine whether the injury is consistent with what has been reported or alleged. The investigations we reviewed did not consistently include medical evidence.

The Jail's policies and procedures also do not adequately address when staff are required to report allegations and incidents, nor do they provide guidance as to who should be interviewed as part of an investigation. The policies and procedures also fail to require that investigation reports include the final disposition of staff sanctions when staff misconduct is sustained or there was a recommendation for disciplinary action. The effect of the deficiencies in the Jail's policies and procedures is reflected in the following examples:

- In October 2006, inmate A.C. informed a sergeant that two officers had used excessive force on him. The sergeant contacted Internal Affairs who sent two officers to speak with A.C. When A.C. stated that he did not wish to make a formal complaint, the matter was dropped. The investigation was reopened after inmate A.C. filed a formal grievance. According to A.C., an officer shook him, choked him, and slammed him into a wall, after A.C. asked the officer to stop banging on the P.A. system microphone. Another officer reportedly was involved as well. The investigators interviewed both officers, but their investigative report did not outline the discrepancies between the officers' versions of events and A.C.'s version. Moreover, some of the officers who witnessed the incident failed to write up a report and others did so weeks after the incident took place. There were also allegations that one of the officers involved in the incident prepared two conflicting incident reports. In the first, he wrote that a "jugular clamp"<sup>18</sup> was used on the inmate. In the second, he used different terminology to describe the incident. Although A.C. identified several inmates who witnessed the event, investigators did not speak to any of these individuals. Ultimately, the Assistant Deputy of Special Services found both officers to have violated the Jail's codes of conduct, and recommended that the case be referred to the local

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<sup>18</sup> A jugular clamp is similar to a chokehold; the technique involves restricting blood flow and oxygen to the brain. Generally accepted professional standards prohibit such

district attorney for possible criminal prosecution. Although the Assistant Deputy appears to have taken appropriate action, this incident would not have been pursued, even though a third party initially tried to report it, if the inmate victim had not filed a grievance.

- Another inmate, who has two prosthetic legs and uses a wheelchair, complained that on March 21, 2007, he was transported to court in a van that was not wheelchair accessible. The inmate alleged that during the drive, he was bounced around for four hours and ended the ride bruised and ill. He also claimed that he was not allowed to use the bathroom during trip. In addition to these allegations, the inmate stated that his legs were chafing and cracking because of the "freezing" cold air in his cell. The investigator who reviewed these allegations never interviewed the inmate or looked into whether any of the claims were true. Instead, he simply concluded that the allegations were unfounded.
- Internal Affairs reviewed allegations that on August 24, 2006, an officer had grabbed an inmate in the neck and chest area. Based on information received from another sheriff's department, the assigned investigator reported that the inmate is "animated and sort of a pain in the neck." Although the investigative report states that the inmate had no visible injuries, the investigator did not interview the inmate or search for injuries until a month after the incident. The investigator did not interview the officer involved in the incident nor did he interview any witnesses who could corroborate or repudiate inmate's story. Finally, the investigative report made no mention of the fact that there was no incident report regarding the alleged use of force.
- Another investigation was opened after an inmate's mother complained that her son had been abused while in four-point restraints. The investigative report notes that the investigator spoke with the inmate and his mother, but it does not reference or include the incident report associated with the incident.<sup>19</sup> It

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<sup>19</sup> Because the incident resulted in a disciplinary report, an incident report should have been generated.

also is not clear from the report whether the inmate was, in fact, ever placed in restraints.

In addition to the flawed investigatory process and the reports it generates, we are concerned that the Assistant Deputy of Special Services, who supervises the internal affairs officers, also supervises communications/dispatch, perimeter security, inmate grievances, K-9 operations, the range supervisor, the armorer, inmate rules and regulations, the SOG, fleet maintenance, transportation, and serves as the criminal justice liaison. In order to avoid impropriety or the appearance of impropriety, the special services deputy should not oversee both tactical operations and inmate grievances.

As currently structured, the special services deputy is responsible for reviewing incident reports and videotapes from a tactical operation, such as a cell extraction, that he authorizes or supervises. Moreover, if the tactical operation results in a grievance, the deputy is responsible for supervising the grievance officer who reviews the incident, and he would hear any appeal of the grievance officer's finding. Accordingly, the very person who authorized the underlying activity is charged with reviewing it for any impropriety. It is highly inappropriate for one person to have responsibilities that create such a clear conflict of interest.

##### 5. Inadequate Staffing and Inmate Supervision

Staffing levels at the Jail are inadequate to protect inmates from harm. As of December 15, 2006, the Jail had 710 employees. Only about 438 (60% percent) of these employees had custody-related duties. Although the serious overcrowding at the Jail makes staffing an issue throughout the facility, we are particularly concerned with the staffing in the A-1 and A-2 housing units, which provide disciplinary and administrative segregation housing as well as housing for inmates on suicide watch. Because these inmates present unique risks to themselves and others, they require more monitoring and supervision than inmates in the general population.

Notwithstanding the risks of leaving the inmates on A-1 and A-2 unattended, the Daily Roll Call Assignment rosters document that the security posts in A-1 and A-2 often are unmanned.<sup>20</sup>

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<sup>20</sup> It is worth noting that the Daily Roll Call Assignment roster also shows unmanned security posts in the Main Jail's Maximum B and C housing units.

Furthermore, although Jail policies and procedures require that corrections officers make frequent and regular security checks on these units, many of the security checks we observed involved little more than quick walks up and down the unit. Although the purpose of a security check is to ensure that inmates are safe, the officers we observed failed to stop at each cell door to view and/or interact with the inmates. This failure places inmates at serious risk of harm. The Jail plans to install video surveillance equipment in inmate living areas, importantly, however, such surveillance is not an adequate substitute for frequent, in-person visual checks of each inmate.

The lack of staffing also makes it difficult for inmates on suicide watch to receive sufficient out-of-cell time. For example, some A-1 inmates are only allowed out of their cells for one hour, three days per week. This is also their only opportunity to shower and use the telephone. As discussed in Section III(C), below, inadequate staffing results in inmates on suicide watch being locked down at least 23 hours each day. Additionally, the lack of adequate assessments and interventions available to these inmates from the mental health staff may contribute to their length of stay on A-1 and exacerbate their mental illness.

Overcrowded conditions at the Jail magnify the staffing deficiencies in A-1 and A-2. Many, if not most, of the inmates housed in these units should be placed in single-bunked cells for security reasons. Instead, a number of them are required to share their cell with other special management inmates -- a management practice that is extremely unsafe.

Finally, we also are concerned about the Jail's practice of housing inmates in the gymnasium. Inmates housed in this location are at particular risk of harm because officers do not have a direct line of sight into the shower areas and bathrooms. Accordingly, inmates can harm each other in these locations without fear of detection.

#### 6. Inadequate Classification System

Generally accepted professional standards require that correctional facilities classify inmates in a timely fashion and in a manner that maximizes security and safety. An effective system classifies inmates based on, among other things, their medical and mental health needs, their gang affiliation (if any), their past behavior, the nature of their offense, and/or their need for protective or administrative segregation. The system also should track inmates throughout their incarceration and

provide quality control information so that inmates can be reclassified, if necessary.

At the Jail, however, the location of available cell space seems to be a primary factor in the classification process. For instance, because there are not enough segregation cells, inmates who commit disciplinary infractions often are put on a waiting list to serve their disciplinary time, or may simply serve that time locked in their general population cells with a cell mate. Our understanding is that the cell mate is not locked down with the inmate on disciplinary confinement. During our tour, the classification supervisor estimated that as many as 45 inmates were restricted to their cells in general population housing awaiting a segregation cell or serving their disciplinary sentence.

We understand that the Jail's population is well over its capacity and that the severe overcrowding complicates the classification process. This situation does not, however, obviate the need for the Jail to comply with generally accepted professional standards regarding the classification of inmates. The Jail's poor classification system can be linked to the murder of at least one pre-trial detainee. In February 2005, a pre-trial detainee, housed in the same cell as a sentenced inmate, was allegedly violently kicked and beaten to death by his cell mate. The Jail must immediately implement a system that is built on appropriate penological principles and that, to the extent possible, ensures the safety and security of the inmates.

#### 7. Inadequate Grievance Process

An adequate grievance process is an integral part of generally accepted professional standards and should be designed to ensure that there is an administrative means for the expression and resolution of inmate concerns. The process can also help management identify problems inside the facility thereby increasing safety and security for inmates and staff. To comply with generally accepted professional standards, a grievance system should include a written form that is completed by the inmate, provide an opportunity for staff to investigate and resolve the inmate complaint, and set forth an appeal process that must be completed within a specific time frame. The Jail's grievance system does not comply with these requirements.

The Jail attempts to circumvent the formal grievance system by encouraging inmates to "informally communicate" their problems to the senior corrections staff in their housing areas. Until recently, these informal communications were not entered into the



Jail's management system and thus could not be tracked. Perhaps more significantly, this informal process breaks down if an inmate's grievance concerns the senior corrections staff.

The Jail's grievance process is difficult for inmates to access. As an initial matter, inmates do not have direct access to grievance forms and must obtain them from the housing unit captain. Once a form is completed, inmates must "complete and forward the form in an envelope, with postage, addressed to the ('Facility Inmate Grievance Coordinator') by way of the outgoing facility mail." Pursuant to the Jail's policy, inmates must file a grievance form within ten days of the incident at issue, although the grievance officer told us that he does not enforce this rule. Inmates are subject to these same rigorous requirements if they wish to appeal the grievance officer's decision.

The inaccessibility of this system is reflected in the low number of grievances that are filed. For instance, when we asked about grievances filed during a three-month period in late 2006, we discovered that only 18 grievances were processed during that time frame. Given the Jail's population and the volume of grievances filed in other correctional facilities, our expert consultant found this number to be extremely low. Moreover, many of the inmates we interviewed expressed frustration with the Jail's grievance system. Those inmates found it particularly difficult to obtain grievance forms and/or postage for mailing the forms to the grievance officer.

Upon the completion of our initial tour in February 2007, the Jail made some changes in its grievance system. At present, unit lieutenants (as well as captains) are permitted to provide inmates with grievance forms. The Jail also issued a memorandum to inmates indicating that they could use the in-house mail system to file grievance forms. However, during our second tour, the grievance officer stated that he was not aware of either change. Additionally, the inmate handbook had not been revised to reflect the reported changes. Most importantly, the changes the Jail has made are insufficient. Inmates still complain about the difficulty of obtaining forms and the overall process is extremely prohibitive to inmates who need to be able to express serious concerns regarding jail operations.<sup>21</sup>

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<sup>21</sup> In the December 13, 2007 letter referenced previously, the County reports an increase in the number of grievances since the changes in practice and we agree that this may be a positive indicator that inmates find the grievance process more accessible

B. Environmental Health Deficiencies

Prison officials must ensure that inmates are protected from harm and receive adequate food, clothing, and shelter, Farmer, 511 U.S. at 832. Officials must also ensure that prisoners are not "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes, 452 U.S. at 347. The conditions at the Jail fall short of these constitutional requirements.

1. Physical Plant, Sanitation, and Hygiene

The Jail has severe problems with its physical plant that directly affect the health and safety of inmates housed there. In a February 2007 report, the Massachusetts Department of Health and Human Services identified many of these deficiencies, including the poor structural condition of the physical plant, overcrowding, unsanitary showers, too few showers, low hot water temperatures throughout the facility, and inmate exposure to extensive dust in areas that were being renovated.

During our tour, many of the showers we saw were covered with soap scum and mold, suggesting that the showers are not routinely cleaned. When combined with water temperatures that are not hot enough to kill bacteria, these unsanitary conditions can create serious health hazards and encourage the spread of disease. These risks are magnified in a correctional setting where numerous people share toilet and shower facilities in small, confined spaces.

Additionally, during the February 2007 tour, inmates complained that several of the housing units in the Main Jail were extremely cold. At the direction of our expert consultant, the Jail took random temperature readings in the A-2 housing unit and the temperatures confirmed the inmates' complaints. We also observed cells where inmates covered their vents and windows with plastic bags in an effort to keep cold air out.

We also are concerned about unsanitary conditions that may arise during lockdowns, which occur frequently at the Jail. Inmates reported that they do not receive clothing or linen changes while their housing units are locked down for days at a time, or even a few weeks. The failure to provide clean clothing

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and fair. We look forward to evaluating the County's changes to its grievance process. See Letter from Deputy Superintendent Jeffrey Turco, Esquire to Shanetta Y. Cutlar, Chief of the Special Litigation Section (December 13, 2007).

and linens can lead to the development and spread of infectious diseases.

## 2. Emergency Preparedness and Key Control

In the event of a fire or other emergency, inmates at the Jail are at serious risk of harm, including death, because of deficiencies in emergency preparedness and key control which prevent staff from quickly unlocking cell doors. During our February 2007 tour, we also found that emergency keys and locks could not be identified by sight and touch, which is essential in the event that smoke from a fire obscures officers' ability to visually distinguish keys.<sup>22</sup>

At the time of our February 2007 tour, we also found that Jail staff did not have the means to manually release cell doors in the A-1 and A-2 housing units on an individual basis. Because these units house special management inmates, including those placed on suicide watch, it is critical that staff be able to open a particular door quickly in the event of an emergency such as a suicide attempt. During our second visit in May 2007, we were pleased to find that the maintenance staff created a special tool that was capable of opening individual cell doors. However, because this tool is kept in the maintenance department, it is not readily available to security staff on the A-1 and A-2 housing units. We were told that more tools were being manufactured and would be kept in the units themselves. Once this occurs, the Jail should implement a testing program in which staff practice opening cells doors with the tool.

## 3. Risk of Food-Borne Illness

The kitchen at the Jail is unsanitary and the food service practices are deficient, which places inmates (and staff who also eat meals prepared at the Jail) at risk of food-borne illness. The Massachusetts Department of Health and Human Services reported in February 2007 that the Jail's "food service is in the worst condition that [we have] seen in over 30 years of inspecting the facility."

Approximately 5,000 meals are prepared daily in the Jail's kitchen. During our February 2007 tour, we observed remarkable health code violations that place inmates and staff at risk such as no soap or paper towels in the inmate bathroom or kitchen

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<sup>22</sup> We note that some progress had been made by the time of our second tour in May 2007.

serving area hand washing sink.<sup>23</sup> We also observed, among other things, debris and dirt build up in the floor drains and grease build-up on the overhead vents. More examples of lack of sanitation of the food service area are found in our expert consultant's report.

Additionally, the staff and inmates who work in the kitchen do not handle food properly. The inmate kitchen workers we interviewed had not been trained on how to properly sanitize pots, pans, and utensils. Further, we observed unsafe food handling practices, such as thawing frozen chicken in hot water and storing undated leftover food in the refrigerator.

We also observed serious physical plant problems in the kitchen area such as: (1) exposed electrical wiring on food service equipment and walls; (2) holes in walls;<sup>24</sup> (3) floor surfaces that were peeling, porous and dirty and thus could not be effectively cleaned; and (4) paint that was peeling off walls and the ceiling.

#### C. Failure to Provide Adequate Mental Health Care

Corrections officials have an obligation under the Eighth Amendment to provide medical and mental health care to incarcerated individuals. Estelle, 429 U.S. at 104-05. The "deliberate indifference" to [inmates'] serious medical needs constitutes "unnecessary and wanton infliction of pain." Id. Serious medical needs include the mental health needs of suicidal inmates. A suicidal inmate can demonstrate a jail's "deliberate indifference" to his/her serious medical needs by showing: "(1) an unusually serious risk of harm (self-inflicted harm, in a suicide case), (2) defendant's actual knowledge of (or, at least, willful blindness to) that elevated risk, and (3) defendant's failure to take obvious steps to address that known, serious risk." Manarite v. City of Springfield, 957 F.2d 953, 956 (1st Cir. 1992); see also Pelletier v. Magnusson, 201 F. Supp.2d 148, 164 (D. Me. 2002); Stewart v. Robinson, 115 F. Supp.2d 188, 193 (D.N.H. 2000); Elliott v. Cheshire County, New Hampshire, 940 F.2d 7, 10-11 (1st Cir. 1991) (deliberate indifference is

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<sup>23</sup> Like many other correctional facilities, the Jail relies heavily on inmates for its food preparation.

<sup>24</sup> The holes were immediately sealed once we brought them to the Jail's attention.

determined by whether the corrections officials, "knew, or reasonably should have known, of the detainee's suicidal tendencies.").

The deliberate indifference on the part of corrections officials to the "serious medical needs" of inmates constitutes "unnecessary and wanton infliction of pain." Estelle v. Gamble, 429 U.S. 97, 104-05 (1976). The Eighth Amendment also protects against deliberate indifference to an inmate's serious mental health and safety needs. Torraco v. Maloney, 923 F.2d 231, 234 (1st Cir. 1991); Cortes-Quinones v. Jimenez-Nettleship, 842 F.2d 556, 559-60 (1st Cir. 1988) (finding sufficient evidence that a jury could conclude corrections officials were deliberately indifferent to the health and safety needs of a psychiatrically disturbed inmate held in an overcrowded jail). "Deliberate indifference may be found where the attention received is so clearly inadequate as to amount to a refusal to provide essential care." Torraco, 923 F.2d at 234 (internal citation and quotations omitted).

We find that the Jail violates inmates' constitutional rights by failing to provide for their serious mental health needs. Specifically, the Jail: (1) fails to provide an adequate array of mental health services; (2) fails to respond appropriately to the needs of suicidal inmates; (3) fails to use restraints in a manner consistent with generally accepted professional standards; (4) fails to ensure proper management of psychotropic medications; (5) fails to keep complete and accurate medical records; and (6) fails to ensure that an adequate quality assurance/quality improvement system is in place.

1. Failure to Provide an Appropriate Array of Mental Health Services

At the time of our May 2007 visit, 21% of the total inmate population and 31% of the inmates on lockdown were part of the mental health caseload. The mental health staff we interviewed indicated that these percentages are typical for the Jail. Mental health staffing at the Jail is insufficient to assess, treat, and monitor this population. The only psychiatrist serving the facility is on-site for just 13 hours each week, and only one person on the day shift is a licensed mental health clinician.<sup>25</sup> Additionally, a lack of escort officers has made it

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<sup>25</sup> The Jail informs us that the hours for mental health clinicians has increased. However, the psychiatrist's hours remains unchanged. Letter from Deputy Superintendent Jeffrey

difficult for mental health staff to interview inmates in a setting that allows for adequate sound privacy. As a result of these staffing issues, inmates with serious mental illness suffer from delays in, or lack of, adequate treatment, and are continually placed at risk of becoming a danger to themselves and others.

Generally accepted professional standards require correctional mental health systems to provide the following types of treatment programs: (1) crisis intervention, including access to beds in a healthcare setting for short-term treatment (usually less than ten days); (2) acute care (an inpatient level of psychiatric care); (3) chronic care and/or special needs unit (housing for inmates with chronic mental illness who cannot function in the general population); (4) outpatient treatment (provided to inmates in the general population); and (5) discharge/transfer planning (including services for inmates in need of further treatment at the time of transfer to another institution or discharge to the community). The Jail falls far short of providing these required services.

a. Crisis Intervention Provided under Non-Therapeutic Conditions

The Jail attempts to provide crisis intervention by moving suicidal inmates to the upper tier of Unit A-1, or, when those cells are full, placing suicidal inmates in the "restraint areas" located in the A-1 and A-2 dayrooms.<sup>26</sup> Both of these settings are grossly inadequate locations in which to house and treat inmates in need of crisis intervention. Both closely resemble a segregation unit because inmates remain in their cells for at least 23 hours each day. Although Medical Services Policy #932.05 requires that certain inmates on suicide watch be offered one hour of tier time each day, the Jail follows the more restrictive Custody Policy #926, which has no such requirement. Indeed, consistent with Custody Policy #926, inmates on suicide watch are allowed out of their cells just three times each week for the purpose of taking a shower, and receive no therapeutic treatment. For all practical purposes, suicidal inmates are treated as if they were high security inmates, not inmates in

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Turco, Esquire to Shanetta Y. Cutlar, Chief of the Special Litigation Section (March 7, 2008).

<sup>26</sup> These restraint areas are larger than regular cells, but resemble cages because the walls, doors, and ceilings are made out of open, expanded metal.

need of mental health treatment. The current policy and procedures governing suicide watch are equivalent to the use of seclusion for mental health purposes. The infrequent clinical contacts with mental health staff, combined with the conditions on the upper tier of A-1, violate generally accepted standards of care and are likely to exacerbate the inmates' mental health problems.

The harsh conditions on the upper tier of A-1 are likely to exacerbate the mental health symptoms of inmates housed on this unit. Yet, as discussed in Section III(C)(3), below, these inmates rarely are assessed or treated by the psychiatrist. Moreover, because of staffing issues, inmates housed on the upper tier of A-1 do not receive daily visits from mental health staff.

Many of the general population inmates we interviewed had previously been housed on the upper tier of A-1. Several of these inmates indicated that they had been placed on suicide watch because of a past history of suicide attempts as opposed to current suicidal thinking. They were fairly unanimous in their descriptions that the property restrictions and lockdown nature of A-1 were draconian.

b. Acute Care

The Jail does not provide acute mental health care on-site. Instead, inmates who require such services are transferred to either a state hospital or the Emergency Services Unit at the Hamden County Jail. We find this practice to be an adequate solution; it is worth noting, however, that during 2006, only 35 inmates were transferred out of the Jail to one of these facilities. This number seems surprisingly small given the large inmate population and suggests that inmates with serious mental illness do not have appropriate access to acute mental health services.

c. Chronic Care

Inmates whose chronic mental illnesses prevent them from functioning in the general population should be housed in a special needs unit ("SNU"). Consistent with generally accepted professional standards, SNU inmates should receive at least ten hours of out-of-cell, structured, therapeutic activity and at least ten hours of unstructured recreational time each week.

The Jail does not purport to have anything approximating an SNU to assist inmates who require this level of care. Consequently, treatment for inmates with chronic mental illnesses

primarily consists of medication and includes little or no counseling. Because there is no chronic care program and seemingly limited access to an acute care program, inmates who are the most symptomatic and impaired from their mental illnesses often are labeled "suicidal" and sent to the upper tier of A-1 or are placed in segregation housing. Indeed, inmates with mental illness are over represented in both units. As noted above, 21% of the total inmate population is on the mental health caseload. In segregation housing, 31% of the inmates are mental health patients. When the upper tier of A-1 is included with segregation housing, the percentage of mental health patients on these units jumps to 38%.

At the time of our second tour, inmate C.T. had been on the upper tier of A-1 for approximately 22 days. This was the third time C.T. had been placed on suicide watch during the 77 days he had spent at the Jail. When we spoke with C.T., he stated that he was not suicidal and did not understand why he had been placed on suicide watch. A review of his mental health record indicated that he has a serious mental disorder associated with psychotic features. Although there was little in the record to justify suicide precautions, it is clear that C.T. needed specialized housing and treatment for his serious mental illness. The Jail, however, offered only medications, infrequent clinical contacts and segregated housing. This care was inadequate.

When we spoke with M.B., another inmate housed on the upper tier of A-1, he had been on the unit for five days. He was placed on suicide watch because he had been hearing voices telling him to harm himself. During the three weeks before his transfer to the upper tier of A-1, M.B. had refused to take his medications. Nursing staff was aware of these refusals, yet the psychiatrist had not met with M.B. during this time period. Like C.T., M.B. had been placed on suicide watch a number of times during his stay at the Jail. His serious mental illness, however, required intensive treatment, not seclusion. By placing M.B. on the upper tier of A-1 for prolonged periods of time, giving him little access to the psychiatrist, and offering nothing in the way of out-of-cell structured activities, the Jail neglected to address this inmate's serious mental illness.

Another inmate in need of treatment for his chronic mental illness is C.P. He preferred the upper tier of A-1 to general population housing, notwithstanding the restrictions on the A-1 unit. C.P.'s mental health assessment noted that he presented a chronic risk of self-harm and harm to others. A review of C.P.'s mental health record suggests that he needed more structured housing than what is available in the general population.



Continuing him on suicide precautions with lockdown restrictions, however, likely exacerbated his clinical condition.

Suicide watch in this context appears to have been a "ticket of admission" to this unit or was used as a rationale for continuing to stay on this unit because the inmates have difficulty functioning in the general population due to their mental health problems. These inmates have either a serious mental illness and/or a personality disorder associated with significant functional impairments that require mental health intervention. Such inmates are in need of an intermediate level of care that is not being provided by the Jail.

As discussed above, the upper tier of A-1 is far from a therapeutic milieu. Inmates housed on this unit receive few visits from mental health professionals and are locked down in single cells for more than 23 hours each day. Segregation housing has similar conditions of confinement. Neither area provides appropriate care for inmates with chronic mental illness. Instead, many of the mentally ill inmates housed on these units exhibit increased symptoms of their underlying psychiatric disorder or fail to show any improvement in their current symptoms. The lack of adequate treatment actually increases the risk that these inmates will harm themselves or others.

d. Outpatient Treatment

The Jail attempts to provide outpatient treatment services, but staffing shortages, vacancies, absences and allocation issues make timely, effective treatment difficult to achieve. There are insufficient mental health staff to provide regular, consistent therapy and counseling for general population inmates who are on the mental health caseload. Instead, the treatment of choice at the Jail appears to be medication. The only psychiatrist for the facility is on-site just three mornings and spends a total of 13 hours each week at the Jail. In general, the psychiatrist sees patients on a "block schedule," meaning that, for the most part, he only sees inmates when he is scheduled to be in their building. The psychiatrist's schedule allows him to visit each building once every two to three weeks. Only about 10-15 percent of the psychiatrist's appointments are based on the immediate clinical needs of the inmates. Although inmates can "self-refer" to mental health, it usually takes between two and four weeks to see the psychiatrist. Our document review revealed that the number of inmates on the mental health waiting list ranged from 31 to 69 patients.

During our May 2007 tour, we interviewed 12 mental health caseload inmates in a group setting at the Annex. About half of these inmates had been in the Jail for over six months. All but one of them took psychotropic medications. The inmates generally met with a mental health counselor about once every two months. Only one inmate reported meeting with a mental health counselor on a regular basis. Several inmates reported meeting with different counselors in response to self-referrals. All others reported that they only met with the psychiatrist and did not have access to a mental health counselor. This information was confirmed by mental health staff who reported that the mental health clinician assigned to the Annex had been on sick leave for the first three months of 2007. The Jail does not offer any group psychotherapy.

Inmates often were not interviewed in a setting that allowed for adequate sound privacy, consistent with generally accepted professional standards, because there were insufficient escort officers to move them to a sound-proof location. The mental health team has recognized and documented this problem since at least June 2006, yet the problem has not been addressed and it is unclear what steps, if any, have been taken to rectify the problem.

e. Discharge/transfer Planning

Generally accepted professional standards require that case management services be a part of discharge/transfer planning. These services include (1) arranging an appointment with mental health agencies for all mentally ill inmates; (2) providing referrals for inmates with a variety of mental health problems; (3) notifying reception centers at state prisons when mentally ill inmates are going to arrive; and (4) arranging with hometown pharmacies to have inmates' prescriptions renewed. The Jail falls short of providing these services.

Staffing allocation issues and logistical problems such as not being able to adequately identify discharge dates have prevented the Jail from developing a formal discharge planning process. For the very small percentage of inmates who are Department of Mental Health ("DMH") clients, the Jail contacts the appropriate DMH clinician when the inmate leaves the facility. Other inmates receive informal discharge planning in the context of receiving information about community mental health resources. Although mental health staff told us that inmates can receive a 30-day supply of discharge medications, none of the inmates we met with who had been discharged from the Jail in the year before their current incarceration had received

discharge planning or prescriptions for discharge medications. These inmates seemed surprised that prescriptions for discharge medications were available to them.

## 2. Failure to Provide Adequate Suicide Prevention

The Jail's process for identifying, housing, and treating suicidal inmates does not comply with generally accepted professional standards.<sup>27</sup>

### a. Screening and Assessment

As an initial matter, the Jail needs to improve the screening and assessment tools it uses to identify potentially suicidal inmates when they arrive at the facility. At present, the initial screening and assessment process consists of: (1) a "suicide potential screening form" which has 17 questions and is completed by an intake officer; (2) a "Q-5 form" which is filled out by records personnel after they consult the statewide Criminal Justice Information System to determine whether the inmate has a prior history of suicidal behavior while incarcerated in the state system; and (3) a "medical entrance exam form" which contains a limited inquiry regarding suicide risk and is completed by medical staff.

In addition to these three screening tools, mental health staff are required to assess all inmates within 14 days of confinement. About 88% of these assessments were completed within the two-week time frame specified in policies and procedures. Also, each inmate is assessed by the classification department and assigned to a housing unit based upon this classification. Although it would not be difficult to do so, classification personnel do not consult the Sheriff's Information and Reporting System ("SIRS") to determine whether the inmate was identified and housed as a suicide risk during a previous confinement at the facility.

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<sup>27</sup> We note that, following an alarming number of suicides in the first six months of 2005, the Jail retained Lindsay Hayes, a nationally-recognized expert on suicide prevention in jails and prisons who is also a consultant to DOJ in other matters, to provide short-term technical assistance in the area of suicide prevention. Mr. Hayes' services were of limited duration and he did not oversee the Jail's implementation of his recommendations.

One problem with the Q-5 form is that there was confusion in the records department as to what types of information should be included. Although the form should report suicide attempts and threats, many records department personnel were only including actual attempts on the Q-5 form. Another problem is that the various departments do not review the forms filled out by other departments at the Jail. For example, the suicide potential screening form and the Q-5 form are placed in the inmate's jail file. The medical staff never see this form because they only review the inmate's healthcare file. Additionally, the medical staff does not attempt to find out whether an inmate exhibited any suicidal behavior or mental illness during previous confinement in the facility.

Another problem with the Jail's screening and assessment process is that it often is untimely and incomplete. For instance, inmate G.J. had been admitted to the upper tier of A-1 one day before our May visit. He had attempted suicide 18 months earlier and was on Prozac (an anti-depressant) before his incarceration. G.J. told us he was a single father of four children, and he described significant distress about his current incarceration. The disposition section on both the medical entrance exam form and the suicide potential screening form was blank, when there should have been some indication in that section of both forms that a referral to mental health was recommended. Staff decided to renew G.J.'s suicide watch status and have him evaluated by the treatment team. The initial mental health evaluation, however, provided little information relevant to the dynamics and/or precipitating factors related to this inmate's apparent depression. In addition, despite G.J. having been assessed as having an illness severe enough to place him on suicide precautions, he had not been seen by a psychiatrist or the treatment team.

b. Rationale for Placing Inmates on Suicide Watch

Related to the issue of poor screening and assessments is the lack of adequate documentation of the rationale for placing an inmate on suicide precautions. Indeed, it appears that some of the inmates housed on the upper tier of A-1 did not need to be on suicide watch. The practice of placing a person on suicide precautions when such precautions are not clinically indicated is problematic. Suicide precautions often include close or constant observation, denial of all or nearly all personal effects, and entail a near total denial of privacy. While appropriate to safeguard persons who are at risk of suicide, this level of precaution may adversely effect the mental health of persons not at risk.

For example, at the time of our May 2007 visit, T.S. had been on the upper tier of A-1 for a few days. The medical entrance examination report was completed from a mental health perspective, but the disposition section on the form was not completed. The initial mental health evaluation indicated the presence of memory loss, a past history of hallucinations, and fleeting suicidal thinking. The clinical impression was alcohol abuse, depression, and that he exhibited symptoms of substance induced mood disorder. Although the rationale for placing T.S. on suicide watch appeared to be his past history of suicide attempts, the rationale was poorly documented, and without proper documentation it is impossible to determine whether the placement was clinically indicated.

The rationale for placing L.S. on suicide precautions was equally unclear. At the time of our May 2007 visit, L.S. had been on the upper tier of A-1 for four days. He told us that he was feeling depressed and wanted to talk to a psychiatrist, but claimed that he was not suicidal. L.S.'s initial mental health evaluation form indicated a provisional diagnosis of symptoms of bipolar disorder, psychotic disorder, and personality disorder. L.S.'s answers relevant to presence or absence of suicidal thinking were somewhat evasive, and the plan was to refer him to the mental health director for case review and treatment plan. Thus, the documented rationale for placing L.S. on suicide watch was very weak. There also was no clear treatment plan.

c. Contact with Mental Health Staff

Generally accepted professional standards require mental health staff to visit inmates on suicide watch every day. Because of staffing shortages, mental health staff at the Jail do not comply with this standard. Indeed, two of the inmates we interviewed had been on suicide precautions for two and six days, respectively, but reported that they had not yet seen a mental health clinician. Additionally, the psychiatrist told us he rarely was involved in the assessment and/or direct treatment of inmates on suicide watch.

Instead of complying with generally accepted professional standards, mental health staff at the Jail evaluate the inmates on "Suicide A Watch" -- the most restrictive suicide precaution -- every 2-3 days; inmates on "Suicide B Watch" are seen twice each week. The Jail justifies the lack of daily rounds by citing the open communication that exists between mental health and corrections staff, the implication being that if an inmate needs more frequent visits from mental health, corrections staff will identify that need and inform mental health personnel.

The Jail also cites the significant cost associated with providing for daily evaluation of every inmate on suicide watch.

It is not appropriate, however, to rely on security staff to assess an inmate's mental health needs. These staff have neither the training nor the expertise to evaluate whether an inmate requires contact with mental health personnel. Moreover, daily rounds provide much needed clinical contact for suicidal inmates and provide continuity of care for this vulnerable population.

d. Cut-down Tools

During our February 2007 tour, staff lacked access to emergency cut-down tools. As we discussed in our emergency letter of May 18, 2007, the absence of these tools placed inmates at significant risk of harm. Although corrections staff were allowed to carry their own knives for cut-down purposes, there was no policy that required corrections staff to carry knives nor was there a policy that specified an acceptable size of knife.

In any event, allowing staff to carry knives is an unsound correctional practice because there is no accountability in terms of how the knives will be used, their size, or their level of sharpness. An inmate can easily remove the knife from a corrections officer's person without the officer's knowledge. Moreover, knives are not the most effective tools to assist officers responding to an attempted hanging because many of the materials inmates use as ligatures cannot easily be cut with a knife.

When we raised this issue with Jail administrators, they responded promptly to our concerns. Indeed, by the time of our second tour, the Jail was in the process of placing cut-down tools in all housing units and providing them to each staff member. We recommend that the Jail develop and implement policies and procedures relating to the availability and use of these tools. We also recommend that staff receiving training on how to use them.

3. Improper Use of Restraints

A random sample of 26 inmates who were restrained suggests that inmates with mental illness are restrained more frequently than inmates who are not mentally ill. As a result, appropriate care is not being provided to these inmates in accordance with generally accepted professional standards. Although only 21% of the total inmate population is on the mental health caseload, over 60% of the inmates in our random sample of inmates who were

restrained were mental health patients. Although the Jail asserts that it does not use restraints for mental health purposes, the over-representation of inmates with mental illness among the restraint uses indicates that restraints often are required because the Jail provides inadequate mental health treatment or because some of these inmates have serious mental disorders that are not responsive to available treatment. In either case, the Jail is, *de facto*, using restraints for mental health purposes.

For example, on January 8, 2007, inmate V.N. (who was on the mental health caseload) cut his wrist and was bleeding heavily. The SOG team removed V.N. from his cell in A-1 and he was treated by medical personnel in the A-1 dayroom. The videotape of this incident shows that V.N. did not resist treatment nor did he threaten staff or himself during this time. Right after he was treated, the SOG team placed V.N. in six-point restraints. There is no documentation of why he was placed in restraints nor is there any evidence that the use of restraints was discussed with, or approved by, mental health personnel.

As discussed above, a SOG team also restrained inmate P.Q. after he cut himself so severely that he required treatment at the local emergency room.

Pursuant to generally accepted professional standards, whenever a mentally ill inmate is restrained, correctional facilities should assume that the restraint is for mental health purposes. This default assumption, in turn, means that custody and mental health staff should follow policies and procedures governing the use of restraints on the mentally ill. The Jail, however, does not have adequate policies addressing this issue. Contrary to generally accepted professional standards, the current policies permit inmates to be restrained for mental health purposes with little to no input from mental health staff. Additionally, in a departure from generally accepted professional standards, restraints are initiated and terminated by custody staff. Recently, the Jail changed its policy to require that mental health staff perform an assessment of an inmate after they are restrained. The purpose of this assessment, however, was not clear to staff.

In addition to having inadequate policies, the Jail does not enforce the policies that are in place. For instance, according to Jail policy, custody staff are tasked with performing range of motion exercises and observing restrained inmates. However, our document review and interviews made clear that this requirement is not being met. This is a serious problem that could have

life-threatening consequences such as blood clot formation.<sup>28</sup> Consistent with generally accepted professional standards, healthcare staff should monitor restrained inmates and perform range of motion exercises every two hours.

Finally, we are concerned that both of the Jail's restraint beds and the restraint chair are located in one area in the A-1/A-2 dayroom. One primary purpose of restraints is to help the restrained person regain acceptable control. This process is not facilitated by having more than one person restrained in the same room at the same time. We note that during our second tour, the Jail changed its policy to require that only one person could be restrained at one time in any designated area.

#### 4. Poor Medication Management

The Jail's formulary is adequate with respect to psychotropic medications. It appears, however, that inmates routinely do not receive the medications that have been prescribed for them. One reason for this failure is that medications may not go with the inmates when they are transferred between housing units. Indeed, the minutes from the March 2007 mental health meeting state that some inmates go days without receiving their psychotropic medications after they are transferred from one housing unit to another.

Another difficulty arises when prescriptions expire. Although the Jail has a system for tracking prescriptions that need to be renewed, the system is not computerized and relies on medication orders that are written for long periods of time -- some as long as six months. The practice of writing orders of lengthy duration may help avoid expiration issues, but it presents significant risks to the inmates, especially because the psychiatrist spends so little time on-site. Inmates receiving psychotropic medications need to be monitored carefully and seen regularly by the psychiatrist. Standing orders that are in place for months at a time make it easier for mental health staff to avoid these obligations.

The Jail has no formal policy to guide staff when inmates refuse to take their medication. Staff told us that non-adherence practices exist, but these appear to be ad hoc.

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<sup>28</sup> As previously indicated, we reviewed documentation reflecting that nine inmates were restrained for four or more hours, and we found that one inmate had been restrained for 23 hours without range of motion exercises being performed.



Some inmates reported that they have been threatened with or actually placed on the upper tier of A-1 for failing to take their medication. Pursuant to generally accepted professional standards, the Jail should develop a policy and procedure that defines medication non-compliance and tells staff how to respond. Among other things, there should be a reporting mechanism through which the nursing staff who administer medications can inform the psychiatrist of the refusal in a timely manner. It is worth noting that inmates reported that custody personnel sometimes dispense medications in the Annex. This is a violation of generally accepted professional standards. All medications should be dispensed by nursing staff. The psychiatrist in turn must meet with the inmate in a timely fashion. The psychiatrist can educate the inmate about the medication and can, if necessary, make adjustments in the inmate's medication regimen

Because, as discussed in Section III(C)(6), below, the Jail has no quality assurance/quality improvement process in place, it was difficult to accurately assess the extent of the Jail's medication management issues. Both staff and inmates, however, made it consistently clear that problems exist in this area. Because inmates who miss doses of psychotropic medication are at risk of serious harm, the Jail should address this issue immediately.

5. Failure to Keep Complete and Accurate Medical Records

The Jail fails to keep complete and accurate mental health records. As an initial matter, there is a significant backlog -- between one and four weeks -- of mental health records filing. In addition, a number of the records we reviewed had documents that were not in chronological order. Many records also were missing medication administration records. Others had assessments and other documentation that were incomplete.

Because the psychiatrist and other mental health staff rely on inmates' mental health records when prescribing medication, changing medication dosages, and determining suicide risk, the errors and omissions described above can jeopardize inmates' mental health treatment and lead to serious consequences.

6. Lack of a Quality Assurance/Quality Improvement Program

Quality assurance/quality improvement programs are critical components of correctional mental health systems. Such programs allow a facility to identify individual and systemic issues that need to be addressed. Without a quality assurance program, a facility might focus its efforts and resources on problems that

are not critical or compelling. A quality assurance system is especially necessary for the Jail, because its insufficient mental health resources are stretched thin. A quality assurance system would help the Jail distribute its limited resources in the most efficient manner possible.

Despite the importance of a quality assurance system, however, we found very few, if any, practices designed to address quality assurance with respect to the delivery of mental health services at the Jail. Indeed, we are not aware of a single quality assurance study that has been completed. Indeed, during a six-month period in 2005, three inmates committed suicide. In response, the Jail hired a suicide prevention expert to review its system management of suicidal inmates. Among other things, the expert recommended that the Jail conduct mortality reviews.

Mortality reviews are a form of quality assurance. Their purpose is to determine whether an inmate who dies in custody (under any circumstances) exhibited symptoms that could have led to earlier diagnosis and intervention. Citing attorney-client privilege, the Jail has repeatedly refused to give our expert consultants access to the facility's mortality reviews. Consequently, we are unable to determine whether the Jail is conducting a meaningful analysis of its in-custody deaths and detecting patterns of operational or security problems that place inmates at risk of harm. Because we have not seen the mortality reviews, and in light of the Jail's woefully deficient quality assurance, we must infer serious concerns regarding the adequacy of its process.

We note that the Jail has developed a mental health quality improvement process. As of the date of our last tour, however, this process had not been implemented. In order to rectify the mental health care deficiencies described above, the Jail must develop and implement a quality assurance/quality improvement program. Without such a program, the Jail will have difficulty identifying areas that need improvement, prioritizing its efforts and developing appropriate remedies.

### III. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional rights of the pre-trial detainees and sentenced inmates at the Jail, the Worcester County Sheriff's Office should promptly implement the minimum remedial measures set forth below:

A. Protection from Harm

1. Cease the use of four, five, and six-point restraints on inmates as punishment; revise and implement the use of restraints policy to ensure that it meets generally accepted practice; and ensure that medical and mental health staff are involved in the decision to use restraints on an inmate according to generally accepted practice.
2. Cease the use of the Maximum B and C isolation cells for restraining inmates.
3. Ensure that all staff, and particularly the SOG, are regularly trained regarding the facility's use of force policy.
4. Ensure that all staff, and particularly the SOG, are regularly trained regarding the restraints policy and policy on decontamination after the use of chemical agents.
5. Develop and implement policies and procedures requiring all staff involved in a use of force to write a timely report regarding the incident.
6. Develop and implement policies and procedures, and provide training to ensure prompt supervisory and/or management review and investigation for all uses of force (there will be variances regarding the level of investigation required based upon the severity of the force), to determine whether force was appropriately used, whether remedial training is necessary, or whether facility policies should be revisited.
7. Develop and implement an incident and use of force tracking system that ensures integrity, reliably captures all relevant information, and is efficient.
8. Develop and implement policies and procedures regarding investigations, including but not limited to, time frame for conducting investigations, file management, documenting medical and other physical evidence, tracking processes, protocols for initiation, training requirements, interview processes for staff and inmates, allegations of staff misconduct, and final disposition procedures.

9. Develop and implement policies and procedures to ensure that the Assistant Deputy of Special Services does not oversee both tactical operations and inmate grievances.
10. Ensure that staffing levels are appropriate to adequately supervise inmates.
11. Develop and implement policies and procedures for an objective classification system that separates inmates in housing units by classification levels.
12. Revise and implement policies and procedures to ensure inmates have access to an adequate grievance process.

B. Environmental Health and Safety

1. Develop and implement an emergency key operation, by sight and touch, that is readily available and includes identical back-up sets of emergency keys.
2. Develop and implement a regular program of testing and inspecting all cell doors and emergency doors as soon as possible.
3. Ensure inmates are provided access to adequate and sanitary showering facilities.
4. Adjust water temperatures in all housing areas to appropriate levels. Monitor and adjust air are appropriate.
5. Ensure inmates receive adequate clothing and linen development of infectious diseases.
6. Develop and implement policies and procedures and provide training to all kitchen staff in the areas of food safety, proper food handling, proper sanitation, and proper hygiene practices to reduce the risk of food contamination and food-borne illness.
7. Develop and implement policies, procedures, and practices to ensure that physical plant deficiencies in the kitchen, including exposed electrical wiring, are immediately rectified and repaired.

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

C. Mental Health Care

1. Provide sufficient on-site psychiatrist coverage to ensure that inmates with serious mental illness receive care that is timely and consistent with generally accepted professional standards.
2. Ensure that there are sufficient corrections staff to escort inmates to settings that allow them to meet with mental health staff in an appropriate, confidential environment.
3. Consistent with generally accepted professional standards, provide (or continue to provide) the following types of mental health treatment:
  - a. Crisis intervention, including access to beds in a healthcare setting for short-term treatment (usually less than ten days);
  - b. An inpatient level of psychiatric care that is available to all inmates who need it;
  - c. Outpatient treatment, including regular, consistent therapy and counseling, to general population inmates who are on the mental health caseload.
4. Consistent with generally accepted professional standards, provide discharge/transfer planning, including services for inmates in need of further treatment at the time of transfer to another institution or discharge to the community. These services should include the following:
  - a. Arranging an appointment with mental health agencies for all inmates with serious mental illness;
  - b. Providing referrals for inmates with a variety of mental health problems;

- c. Arranging with hometown pharmacies to have inmates' prescriptions for necessary mental health
5. Provide appropriate housing and treatment for inmates who need to be on suicide precautions. Consistent with generally accepted professional standards, this housing and treatment should include:
  - a. Timely and complete assessment of an inmate's suicide risk, that is shared between departments and includes information about suicide threats;
  - b. Consideration of whether an inmate was identified and housed as a suicide risk during a previous confinement at the Jail;
  - c. Document the rationale for placing an inmate on suicide precautions;
  - d. Provide inmates on suicide precautions with daily visits from mental health staff;
  - e. Sufficient out-of-cell time;
  - f. Ensure that inmates on suicide precautions receive proper supervision; and
  - g. Continue to ensure the availability of cut-down tools that is consistent with generally accepted professional standards.
6. Follow generally accepted standards when using restraints, and ensure that staff, at a minimum, perform range of motion exercise on all restrained inmates on a schedule that is consistent with generally accepted professional standards; and continue to implement the policy requiring that no more than one inmate be restrained in the same area at the same time.
7. Follow generally accepted standards in the area of medication management, and ensure that:
  - a. Inmates receive their medication within a reasonable time when they are moved within the facility;

- b. Institute an adequate medication management system that tracks prescriptions that need to be renewed;
  - c. Psychiatrists write medication orders in accordance with generally accepted professional standards;
  - d. Inmates who receive psychotropic medications are monitored carefully and seen regularly by the psychiatrist;
  - e. Policies and procedures governing medication refusals are developed and implemented; and
  - f. All medications are dispensed by nursing staff.
8. Ensure that all medical records are up-to-date, complete, and accurate.
9. Develop and implement a quality assurance/quality improvement program to assist the Jail in identifying areas that need improvement, prioritizing its efforts at reform, and developing appropriate remedies.

#### IV. CONCLUSION

Please note that this letter is a public document and will be posted on the Civil Rights Division's website ten calendar days after we send it to you. The letter will be immediately available, however, to any individual or entity upon request.

We hope to continue working with the Commonwealth and the Worcester County Sheriff's Office in an amicable and cooperative fashion to resolve our outstanding concerns regarding the Jail. Assuming there is a spirit of cooperation from the Commonwealth and the Sheriff's Office, we are willing to send our consultants' written evaluations -- which are not public documents -- under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obligated by statute to advise you that, in the unexpected 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 the Commonwealth and the Sheriff's Office and are confident that we will be able to do so. The lawyers assigned to this investigation will be contacting the Sheriff's general counsel 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,

/s/ Grace Chung Becker  
Grace Chung Becker  
Acting Assistant Attorney General

cc: The Honorable Tom Reilly  
Attorney General  
Commonwealth of Massachusetts

Sheriff Guy Glodis  
Administrator  
Worcester County Jail and House of Correction

The Honorable Michael J. Sullivan  
United States Attorney  
District of Massachusetts