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U.S. Department of Justice

Civil Rights Division

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

July 11, 2008

Todd H. Stroger
Cook County Board President
118 N. Clark Street
Room 537
Chicago, IL 60602

Thomas Dart
Cook County Sheriff
Richard J. Daley Center
50 W. Washington Street
Room 704
Chicago, IL 60602

Re: Cook County Jail
Chicago, Illinois

Dear President Stroger and Sheriff Dart:

We write to report the findings of the investigation of the Civil Rights Division and the United States Attorney's Office into conditions at the Cook County Jail ("CCJ"). On February 16, 2007, we notified the Cook County Board of Commissioners ("County") of our intent to conduct an investigation of CCJ pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On June 18-22, 2007, and July 23-27, 2007, we conducted on-site inspections at CCJ with expert consultants in corrections, use of force, custodial medical and mental health care, fire safety, and sanitation.[1] We interviewed administrative staff, security staff, medical and mental health

[1] Our fire safety and sanitation experts accompanied us only on the July on-site visit.

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staff, facilities management staff, training staff, and inmates. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, use of force reports, investigative reports, inmate grievances, disciplinary reports, unit logs, orientation materials, medical records, and staff training materials. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to CCJ officials and legal counsel for the County and Sheriff's Office at the close of our July 2007 site visit.

During our July 27, 2007 exit meeting, and by letter dated August 3, 2007, we notified CCJ officials of life-threatening deficiencies in sanitation and safety measures at CCJ. In particular, we indicated that inadequate emergency key precautions and grossly unsanitary conditions in certain tiers resulted in a serious and immediate risk of harm to inmates. On August 6, 2007, counsel for the Sheriff's Office promptly responded by indicating that a number of corrective measures were being implemented to address our concerns.[2]

We commend the staff at CCJ for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation with our investigation, which is particularly appreciated given that CCJ is the country's largest single-site jail. CCJ provided us with unfettered access to records and personnel, and responded to our requests, both before and during our on-site visits, in a transparent and forthcoming manner. We also appreciate the County's and the Sheriff's Office's receptiveness to our consultants' on-site recommendations. Accordingly, we have every reason to believe that the County and the Sheriff's Office are committed to remedying all known deficiencies at CCJ.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at CCJ violate the constitutional rights

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[2] Counsel for the Sheriff's Office provided additional information regarding corrective measures in a letter and attachments on October 5, 2007. We commend the Sheriff's Office on these reported advances and view them as progress toward improved conditions at CCJ. We look forward to the opportunity to verify the improvements.

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of inmates. In particular, we find that inmates confined at CCJ are not adequately protected from harm, including physical harm from excessive use of force by staff and inmate-on-inmate violence due to inadequate supervision. In addition, we find that inmates do not receive adequate medical and mental health care, including proper suicide prevention. CCJ inmates also face serious risks posed by inadequate fire safety precautions. Finally, we find that environmental and sanitation deficiencies at CCJ result in unconstitutional living conditions for inmates.

As discussed in this letter, these conditions have resulted in serious harm to CCJ inmates. Three inmates committed suicide at CCJ in the first four months of 2008. During our investigation, we identified multiple preventable inmate deaths and a preventable amputation, due to inadequate medical care. In 2006, separate incidents of unchecked inmate violence resulted in two inmate deaths. In a one-week period during March 2007, CCJ documented 35 inmate fights, required 27 uses of force, and found 46 weapons within the facility. The myriad of serious incidents summarized here, and others discussed herein, indicates that CCJ is not adequately providing for the safety and well-being of the inmates.

I. BACKGROUND

Located on approximately 96 acres in Chicago, Illinois, CCJ is the largest single-site county jail in the United States.[3] CCJ has a daily population of approximately 9,800 adult male and female inmates, most of whom are awaiting trial in the criminal court system. In 2006, CCJ admitted 99,663 inmates. CCJ is staffed by approximately 3,800 sworn law enforcement officers and civilian employees.

CCJ is separated into 11 semi-autonomous divisions,[4] each with its own superintendent and standard operating procedures. The majority of the male inmates are housed in three maximum-security divisions (Divisions I, IX, and X), three medium-security male divisions (Divisions V, VI, and XI), and one medium and minimum-security dormitory division (Division II). Female inmates of mixed security classifications are housed on

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[3] http://www.cookcountysheriff.org/doc/html/facility.html

[4] The divisions are designated by number, one through eleven. There is no Division VII. The Receiving Classification Diagnostic Center essentially functions as a separate division, with its own superintendent.

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Division III, which also contains male and female medical and mental health tiers, and Division IV. Division VIII contains Cermak Health Services and the Residential Treatment Unit. The Receiving, Classification, and Diagnostics Center ("RCDC") is located in the lower level of Division V and handles reception, classification, and discharge for all CCJ inmates. Division I is the oldest building, dating from 1929, and Division XI is the newest, opened in 1995. The divisions range in rated capacity[5] from 353 inmates in Division III to 1,536 in Division XI.

All corrections and security functions at CCJ are administered by the Cook County Department of Corrections ("CCDOC") under the Cook County Sheriff. Health care services at CCJ are provided by Cermak Health Services of Cook County ("Cermak"), which is part of the Cook County Bureau of Health. While the health services staff are County employees who are responsible for the health care of all CCJ inmates, they are not employed by, or responsible to, the Cook County Sheriff or CCDOC. Although health care and security issues require a degree of separation in all correctional facilities, as discussed in more detail below, the complete division between corrections and health care operations at CCJ results in serious administrative problems, including increased frustration, communication breakdowns, and finger-pointing. Regardless of the administrative division, Cook County and the Cook County Sheriff's Office are responsible for the well-being of CCJ inmates, including providing adequate care for inmates' serious medical and mental health care needs.

In 1982, the County entered into a consent decree in Duran v. Dart, No. 74-C-2949 (N.D. Ill. Apr. 9, 1982) ("Duran Consent Decree") to resolve a class action lawsuit filed by pre-trial detainees, pursuant to 42 U.S.C. § 1983, regarding overcrowding of CCJ. The Duran Consent Decree, as amended, is still under the jurisdiction of the United States District Court for the Northern District of Illinois. The decree focuses on overcrowding, but does contain some provisions governing staffing, food service, personal hygiene, the law library, visitation, physical exercise, classification, environmental health, and emergencies. CCJ's compliance with the Duran Consent Decree is monitored by the John Howard Association. CCJ is also governed by multiple other agreements and orders, such as Harrington v. DeVito, No. 74-C-3290 (N.D. Ill. Oct. 19, 1978) (mental health care) and Jackson

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[5] Actual capacity is often much lower than the rated capacity due to cells that are inoperable as a result of maintenance problems.

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v. Sheriff of Cook County, No. 06-CV-493 (N.D. Ill. July 16, 2007) (STD testing). Despite the existence of these court orders, a myriad of unconstitutional practices remain at CCJ. The current court orders applicable to CCJ either do not include specific provisions governing the constitutional concerns raised below regarding protection from harm, inadequate medical and mental health care, fire safety, and sanitation, or have not resulted in lasting or effective corrective measures.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to seek injunctive relief to enforce the constitutional rights of inmates subject to a pattern or practice of unconstitutional conditions in jails and prisons. 42 U.S.C. § 1997. In defining the scope of jail inmates' Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell v. Wolfish, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment); Cavalieri v. Shepard, 321 F.3d 616, 620 (7th Cir. 2003). Providing "humane conditions" requires that a corrections system must "take reasonable measures to guarantee the safety of the inmates" and satisfy inmates' basic needs, such as their need for medical care, food, clothing, and shelter. Farmer at 832. The protection of pre-trial detainees' rights under the due process clause of the Fourteenth Amendment is "at least as great as the Eighth Amendment protections available to a convicted prisoner." City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983).

When a jurisdiction takes a person into custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189, 199-200 (1989)).

The duties imposed and rights conferred by the Eighth Amendment apply to the unreasonable risk of serious harm, even if such harm has not yet occurred:

> We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year . . . . That the Eighth Amendment

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> protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is reasonable safety.

Helling v. McKinney, 509 U.S. 25, 33 (1993) (internal citations and quotations omitted); Woodward v. Correctional Medical Services of Illinois, Inc., 368 F.3d 917, 927 (7th Cir. 2004) (citing Farmer, 511 U.S. at 842).

The "Eighth Amendment prohibition against cruel and unusual punishment has been expanded under the Due Process Clause of the Fourteenth Amendment to impose upon both federal and state correctional officers and officials the obligation to take reasonable steps to protect inmates from violence at the hands of other inmates." Goka v. Bobbitt, 862 F.2d 646, 649-50 (7th Cir. 1988); see also Hudson v. Palmer, 468 U.S. 517, 526-27 (1984); Swofford v. Mandrell, 969 F.2d 547, 549 (7th Cir. 1992); Anderson v. Gutschenritter, 836 F.2d 346, 349 (7th Cir. 1988); Archie v. City of Racine, 847 F.2d 1211, 1222-23 (7th Cir. 1988) (en banc).

The Eighth Amendment forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1, 9 (1992). This is true even when the use of force does not result in significant injury. Id. A jail or prison official who inflicts force maliciously and sadistically to cause an inmate harm violates the Eighth Amendment. Id.

Inmates also have the right to be free from retaliation for engaging in constitutionally protected conduct, such as complaining about conditions of confinement. Walker v. Thompson, 288 F.3d 1005 (7th Cir. 2002); DeWalt v. Carter, 224 F.3d 607, 618 (7th Cir. 2000) ("An act taken in retaliation for the exercise of a constitutionally protected right violates the Constitution").

While low staffing levels do not, by themselves, constitute due process violations, they provide support for a conclusion that the inmates are treated "recklessly or with deliberate indifference" to their safety. Swofford, 969 F.2d at 549. Similarly, although overcrowding is not a per se constitutional violation, overcrowding resulting in bunking multiple inmates in a single cell without adequate safety, space, sanitation, bedding, or opportunities for activities outside the cells can amount to unconstitutional conditions of confinement. French v. Owens, 777 F.2d 1250, 1252-53 (7th Cir. 1985) (holding that overcrowding was unconstitutional where it led to unsafe and unsanitary conditions); Wellman v. Faulkner, 715 F.2d 269 (7th

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Cir. 1983) (holding that prison was unconstitutionally overcrowded); see also Nami v. Fauver, 82 F.3d 63, 67 (3d Cir. 1996) (holding that double-bunking coupled with extended in-cell periods despite safety hazards could constitute a constitutional violation).

A jailer's deliberate indifference to an inmate's serious medical needs violates the Eighth Amendment. Estelle v. Gamble, 429 U.S. 97, 102 (1976); Maggert v. Hanks, 131 F.3d 670, 671 (7th Cir. 1997). "Deliberate indifference" involves both an objective and a subjective component. The objective component is met if the deprivation is "sufficiently serious." Farmer, 511 U.S. at 834. Prison officials may not refuse, unreasonably delay, or intentionally interfere with medical treatment for incarcerated individuals. Hudson v. McHugh, 148 F.3d 859 (7th Cir. 1998) ("[T]his is the prototypical case of deliberate indifference, an inmate with a potentially serious problem repeatedly requesting medical aid, receiving none, and then suffering a serious injury."); Zentmyer v. Kendall County, 220 F.3d 805 (7th Cir. 2000). "Deliberate indifference can be evidenced by 'repeated examples of negligent acts which disclose a pattern of conduct by the prison medical staff' or it can be demonstrated by 'proving there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care.'" Wellman, 715 F.2d at 271 (citing Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980), cert. denied, 450 U.S. 1041 (1981)). Jail officials also may not provide an easier but less efficacious course of treatment nor may they offer only cursory medical care when the need for more serious treatment is obvious. See Estelle, 429 U.S. at 104-05. Failure to provide medication can violate the duty to provide adequate medical care to address serious medical needs. See, e.g., Zentmyer, 200 F.3d at 811.

The County's obligation to provide adequate medical care includes a duty to provide adequate mental health care. Farmer, 511 U.S. at 832; Sanville v. McCaughtry, 266 F.3d 724, 734 (7th Cir. 2001) (noting that a mentally ill inmate's condition was "objectively, sufficiently serious" such that incarcerating him under conditions that posed a substantial risk that he would commit suicide subjected him to cruel and unusual punishment). In addressing the constitutionally minimal standards for mental health care in a jail or prison, the Seventh Circuit notes: "When a claim is based upon the failure to prevent harm, in order to satisfy the first element the plaintiff must show that the inmate was 'incarcerated under conditions posing a substantial risk of serious harm.'" Id. (citing Farmer, 511 U.S. at 832); see also Estate of Novack v. County of Wood, 226 F.3d 525, 529

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(7th Cir. 2000); Estate of Cole v. Fromm, 94 F.3d 254, 261 (7th Cir. 1996). Where a jail's "actual practice" towards treatment of mentally ill inmates in general is clearly inadequate, the facility may be held to be "on notice" at the time of an inmate's incarceration that there is a substantial risk of deprivation of necessary care. Woodward, 368 F.3d at 927 (practice of inadequate employee training, incomplete intake screening, and inadequate suicide watch constituted deliberate indifference).

The risk of suicide is an "objectively serious harm" from which inmates have a right to protection, under the deliberate indifference standard. Matos v. O'Sullivan, 335 F.3d 553, 557 (7th Cir. 2003). Inadequate suicide prevention may constitute deliberate indifference. Hall v. Ryan, 957 F.2d 402, 406 (7th Cir. 1992) (noting that prisoners have a constitutional right "to be protected from self-destructive tendencies," including suicide); Woodward, 368 F.3d at 929 (fact that no previous suicides occurred in jail did not negate possibility of a practice of deliberate indifference toward suicidal detainees); Cavalieri, 321 F.3d at 620 (holding that the right to be free from deliberate indifference to suicide was clearly established).

Inmates are constitutionally entitled to environmental conditions that do not pose serious risks to health and safety, including deficient sanitation, inadequate fire safety, inadequate ventilation, and pest infestation. Vinning-El v. Long, 482 F.3d 923, 924-25 (7th Cir. 2007) (holding that deliberate indifference could be established by inference from conditions, including floor covered with water, broken toilet, blood and feces smeared along wall, no mattress to sleep on); Gillis v. Litscher, 468 F.3d 488, 568 (7th Cir. 2006) ("[A] state must provide . . . reasonably adequate ventilation, sanitation, bedding, hygienic materials, and utilities (i.e., hot and cold water, light, heat, plumbing)."); Board v. Farnham, 394 F.3d 469 (7th Cir. 2005) (requiring adequate ventilation); Isby v. Clark, 100 F.3d 502, 506 (7th Cir. 1996) ("*Sanitation*, we assume, includes things like odors and general cleanliness around the cell.") (emphasis in original); French, 777 F.2d at 1257 (holding that fire safety is a "legitimate" concern under the Eighth Amendment); Antonelli v. Sheahan, 81 F.3d 1422, 1432 (7th Cir. 1995) (requiring adequate pest control).

In addition, detainees have a right to be free of bodily restraints, such as shackles or a restraint chair, unless the facility demonstrates a legitimate penological or medical reason for the restraint. Murphy v. Walker, 51 F.3d 714, 718 (7th Cir. 1995). Where restraints are used, the inmate should be properly monitored and the length of restraint-time should be limited to

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ensure the inmate's safety. French, 777 F.2d at 1253-54. Restraints imposed by correctional officers that are medically unjustifiable and have no adequate security rationale infringe on an inmate's due process rights. Wells v. Franzen, 777 F.2d 1258, 1263 (7th Cir. 1985) (restraint of a suicidal inmate).

III. FINDINGS

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

A. INADEQUATE PROTECTION FROM HARM

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

To ensure reasonably safe conditions, officials must take measures to prevent the use of unnecessary and inappropriate force by staff. Officials must also take reasonable steps to protect inmates from violence at the hands of other inmates. In addition, officials must provide adequate systems to investigate incidents of harm, including staff misconduct and alleged physical abuse of inmates. Finally, a jail has an obligation to protect vulnerable inmates from harm, such as those who are at risk of suicide or at risk from other inmates. For the reasons set forth below, CCJ fails to meet constitutional standards in all of these regards.

1. Inappropriate and Excessive Use of Force

Although the violence present in a correctional setting necessarily permits the appropriate use of force, the Constitution forbids excessive physical force against inmates. A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Generally accepted correctional practices provide that appropriate uses of force in a given circumstance

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should include a continuum of interventions, and that the amount of force used should not be disproportionate to the threat posed by the inmate. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

We found that inmates at CCJ are regularly subjected to inappropriate and excessive uses of physical force. CCJ officers too often respond to inmates' verbal insults or failure to follow instructions by physically striking inmates, most often with the active assistance of other officers, even when the inmate presents no threat to anyone's safety or the security of the facility. Moreover, even in cases in which the initial use of force is reasonable, officers sometimes continue to engage in physical force after the inmate has been brought under control or is effectively restrained.

A top security administrator frankly acknowledged to us the existence of "a culture of abusing inmates" when he came to CCJ in October 2006. While senior management has taken steps to reduce the use of force, such as requiring Use of Force Reports and by subjecting these documents to greater scrutiny, the excessive and inappropriate use of force has not been brought under control. We believe that, despite management's efforts, a culture still exists at CCJ in which the excessive and inappropriate use of physical force is too often tolerated.

Our investigation included an intensive examination of documents provided by CCJ concerning the incidents listed below and a host of others occurring between January 2006 and July 2007. We also conducted a great many staff and inmate interviews. In some cases, our findings of inappropriate or excessive uses of force are in accord with CCJ's own conclusions.

a. Use of Force in Response to Verbal Altercations

The use of force, while sometimes necessary in a corrections setting, must be appropriate to the given circumstances and proportionate to the threat posed. A verbal taunt from an inmate to an officer is a rule violation and may appropriately result in disciplinary action, but it should not require a physical response. As the examples below demonstrate, verbal altercations with inmates too often provoke physical responses from CCJ officers:

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1. In July 2007, following his hour of exercise, Alberto P.[6] refused to return to his cell and a female officer locked the cell doors while Alberto remained outside. He called the officer a "b----." When Alberto came out with his property to be moved to disciplinary segregation for insulting the officer, he was beaten by a number of officers. One officer later told Alberto that he had tried to stop the beating, but he just "didn't have enough juice" (apparently explaining his inability to control the other officers). CCJ records confirm that Alberto was transferred to segregation and taken to Cermak for his injuries.

2. In June 2007, Dennis L. returned to his cellblock after a psychological evaluation. An officer refused to give Dennis a dinner tray. Dennis got into a verbal altercation with the officer and threw a cup of liquid at him. A number of officers attacked Dennis in his cell. Emergency Room records indicate that Dennis suffered blunt trauma to his head and body, three teeth knocked loose, and a laceration to his lower lip from this incident.

3. In April 2007, Billy D. wanted to exit his cell and was accused of pushing his way out. He had a "heated" verbal altercation with the officer. One officer struck Billy in the face and other officers joined in. Medical records show that Billy required internal and external stitches to close a one-inch laceration that punctured his lip.

4. In September 2006, an officer was handing out extra lunches to inmates. Malcolm W. asked for one, but was refused. Malcolm and the officer exchanged verbal insults. A mental health staff member and another inmate witnessed the officer slap Malcolm's face and drag him from the dorm. CCJ's Internal Affairs Division ("IAD") sustained allegations of abuse, and recommended that the officer be suspended for 29 days. The officer was "dedeputized" and prohibited from carrying a firearm or effecting arrests.

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[6] To protect privacy, we have used pseudonyms to identify inmates and officers listed in this letter. Upon request, we will provide the County with a schedule that cross-references the pseudonyms with the proper names, where appropriate.

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5. In March 2006, Danny P., who according to CCJ records was a slight man of 5'1" and 110 pounds, was on his way to the law library. He got into a shouting match with the female officer escorting him, which resulted in him being taken back to his housing unit. Near the secure staff station, the officer lunged at Danny and began to slap him. Two other officers grabbed his arms and pushed him into a dayroom. As he was being handcuffed, several other officers continued to punch and kick him. He was hit in the mouth after being handcuffed. CCJ records show that a sergeant found Danny standing outside the security office handcuffed and bleeding about the face. The female officer was disciplined for failing to report the incident in a timely manner and also for failing to obtain medical treatment for Danny. Danny filed a lawsuit against CCJ regarding this incident, and the parties agreed to settle the case in March 2008.

b. Use of Force for Failure to Follow Instructions

It is inappropriate and excessive to use force for rule violations which do not present a threat to safety or security. At CCJ, inmates' failure to follow orders too often lead to physical abuse, even where no security risk is present:

1. In June 2007, there was a fight on Thomas K.'s unit, in which he did not participate. A group of officers came to the unit, strip-searched the inmates, and sent them back to their cells. As Thomas started to go up the stairs to his top tier cell, his hands were on his neck holding his shirt, instead of on top of his head, as he had been directed. An officer grabbed Thomas by the neck, which choked him, and Thomas reacted by grabbing the officer's arm. The officer immediately swung and hit Thomas in the eye with a walkie-talkie, causing a wound that required five stitches to close. Cermak medical records confirm Thomas's injuries and that he was hit with an "unknown object." The officer continued hitting Thomas after the first blow, although Thomas offered no resistance. We observed Thomas's injuries during our on-site visit.

2. In February 2007, Matthew S. was ordered to leave the barber shop for standing up before his turn. When he tried to explain why he stood up, an officer grabbed him by the collar and told him to leave the barber shop. Matthew argued with the officer. Outside the

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barber shop, officers shoved his head into the concrete after he had been handcuffed. CCJ records confirmed that Matthew needed stitches to his face and a tetanus shot following this incident, but he refused treatment.

3. In April 2006, Terrence M. was being processed in his division when an officer noticed that Terrence had an unauthorized shirt. The officer asked for the shirt, but Terrence refused to give it to him. After Terrence was restrained, the officers punched and kicked him. As a result of the beating, Terrence suffered a broken jaw that required surgery at an outside hospital. CCJ found abuse by one officer, and the officer was terminated.

4. In April 2006, Darnell J. refused to go to recreation when he was told he could not first use the bathroom. Several officers shoved Darnell into the hallway where they beat and kicked him. A sergeant watched and then joined in the beating. Two other inmates in the hallway were also beaten. Darnell was hospitalized for neck injuries. CCJ found abuse by the sergeant and seven officers and also that the sergeant and several officers had filed false reports. IAD recommended termination for the sergeant and three officers.

5. In March 2006, John S. was being strip-searched prior to going to recreation. He was tapping on the wall. An officer ordered him to stop and hit him on top of the head. John continued to tap. After John was searched, the officer said: “You’re f------ guilty” and slammed him on top of a cart and against the wall. John was pulled into the hallway where other officers started to beat him. He was hit in the face, dragged by his hair, choked, and beaten. Photographs of John in the CCJ files show injuries to his face and body. IAD found that the officers used excessive force and recommended that two officers be terminated.

6. In March 2006, Jacob D. objected to a tier change and insisted on speaking with an officer. Three officers extracted him from his cell. He was handcuffed behind his back and, while they were taking him to the segregation unit, the officers pushed his head into the wall. He was hit in the face, thrown down stairs, kicked, and punched repeatedly. Photographs of Jacob from the following day show that his face was badly bruised and his eye was swollen shut. IAD found that

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three officers used excessive force and recommended that they be suspended for 29 days.

7. In January 2006, Byron S. was cleaning the dayroom with other inmate workers when a group of officers accused Byron and another inmate of planting contraband in the visiting area, and took both inmates into the hallway. Byron was beaten by multiple officers. After he was handcuffed and lying on the floor, Byron received a blow that broke his jaw. Medical records confirm that his jaw was fractured. Byron's jaw was wired shut at an outside hospital, which required him to eat with a straw. Three months later, Byron required additional surgery and his jaw was wired shut for a second time. Byron filed a lawsuit against CCJ regarding this incident, and the parties agreed to settle the case in September 2007.

8. In January 2006, Michael A. was resisting going to disciplinary segregation because he believed he had already served his time for the infraction in question. He asked to talk to a sergeant, who said that nothing could be done. When he continued to resist, stating that he wanted to talk to a captain, a correctional officer said: "No," and struck him in the face. Other officers were called and joined in beating him. He was sent by ambulance to an outside hospital. Medical records show he suffered a fractured nose and two black eyes.

c. Use of Force as Punishment or Retribution

We found that inappropriate and excessive use of force also occurs when officers are angry and upset about inmate violence against staff. Physical force is also sometimes inappropriately used at CCJ even after an active dispute between an inmate and officer has ended, apparently to punish the inmate. Retaliatory force even occurs when officers are dealing with mentally ill inmates with limited impulse control, although the inmates do not present a threat to themselves or others.[7] The use of force is

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[7] According to a division superintendent, a number of officers assigned to the tiers for inmates with mental illness have not received training on working with the mentally ill. The excessive use of force with mentally ill inmates is likely attributable to lack of, or ineffective, officer training.

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never appropriate as retribution for previous bad acts and is inappropriate when an inmate is not a present threat:

1. In July 2007, Robert T., who suffers from mental illness, exposed himself to a female officer. In response, he was taken to a clothing room where a group of officers handcuffed him and then proceeded to hit and kick him after he was restrained. CCJ records confirm that Robert was sent to an outside hospital with severe head trauma.

2. In June 2007, Russell G.'s cellmate opened the cell door and Russell got out of his cell. In response, an officer locked all the inmates in their cells. After Russell was back in his cell, officers sent his cellmate downstairs and entered Russell's cell. The officers handcuffed Russell, then stomped on his back and hit him. His eye became swollen and his teeth were chipped. Before taking him to the dispensary, the officers threatened to beat Russell again and charge him with battery unless he told medical staff that he had hurt himself falling off his bunk. Russell was sent from the dispensary to Cermak Hospital for medical treatment.

3. In August 2006, an inmate stabbed an officer. Because Martin S. had argued with the officer earlier in the day, officers erroneously believed he had committed the stabbing.[8] As a result, officers responded to an "all available" call and began to beat Martin in the mistaken belief that he was the inmate who had assaulted the officer. Besides being punched and stomped, he was also hit with a radio and kicked in the groin.

4. Inmate Andrew B. was also housed in the unit where the August 2006 attack on the officer occurred. Andrew had nothing to do with the attack. A large number of officers came onto the unit and proceeded to beat the inmates indiscriminately. Andrew was ordered to lie down and, while he promptly obeyed, he was stomped and kicked by the officers.

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[8] CCJ records confirm that another inmate was charged with the crime.

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5. In April 2006, Damien H. pushed out of his cell. An officer escorted him back to his cell. At the door of his cell, Damien turned and hit the officer, for which he was charged with aggravated battery. All available officers were called and, while restraining Damien, several officers punched, kicked, and stomped him. IAD found that three officers had used excessive force and recommended 29-day suspensions for all of them.

6. In January 2006, an officer wanted Jerry M. to return to his cell, which Jerry resisted, and the officer rolled the door over Jerry's foot. Jerry called the officer a "b----." The officer then beat Jerry with handcuffs wrapped around his hand like brass knuckles. A CCJ internal investigation of this incident found that excessive force had been used and recommended that the officer be terminated. The Sheriff's Merit Board, which hears CCJ termination cases, ruled against CCJ and reinstated the officer to duty.

d. Use of Force at Intake

The pattern of inappropriate and excessive use of force is distributed throughout the CCJ divisions, and not confined to the areas where the use of force is most likely to occur in a correctional setting: the maximum security units and intake area. However, an especially high number of abuse of force allegations do emerge from CCJ's RCDC intake unit.

There is unanimity of opinion among those familiar with CCJ, including administrators and staff, the County, the Sheriff's Office, and the court monitors, that conditions in RCDC are unacceptable and must be changed. As discussed in more detail below, the RCDC is chronically overcrowded, cramped, chaotic, and insufficiently staffed. The impact of these conditions on the use of force is considerable. In the RCDC, inmates who request attention for various needs run the risk of becoming victims of physical abuse. Inmates are especially vulnerable to abuse when they are taken in large groups to be strip searched in an isolated area out of the view of non-security intake staff. Many inmates report that those who are old, mentally ill, or do not understand English, are struck by officers for undressing or dressing too slowly. Finally, inmates may also be targeted for physical abuse because of the charges for which they were arrested.

1. In September 2006, Pedro S. was arrested on a sex charge brought by his niece. While in the intake area,

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three officers who had read his charge began taunting him, yelling threats in Spanish, and asking if he knew what was about to happen to him. The officers struck him many times and called him a “f------ Mexican.” The other inmates were ordered to turn and face the wall “or else.” Because the officers threatened to kill Pedro if he said anything about the incident, he did not seek medical attention. Pedro was released four days later and immediately saw a doctor and reported the incident to the Chicago Police Department. The Police Department contacted CCJ. Medical records confirm that Pedro’s injuries included a broken rib and damage to his jaw and knee.

2. In July 2006, Lonnie L., 59-years-old, was leaving the medical area of intake and heading to the bullpen. When he turned around to get more medication, an officer told him not to return to the medical area. Lonnie did not obey the order. The officer came into the medical area and hit Lonnie on the mouth. When Lonnie fell to the ground, the officer kicked him and again struck him in the mouth, knocking out a tooth. The officer dragged Lonnie by the pants out of the medical area. During Lonnie’s intake strip search, the same officer hit him in the back with a cane. Three inmates testified that they witnessed the incident. Medical records indicated injury to Lonnie’s ribs and lung. CCJ found abuse and recommended that the officer be terminated.

3. While being processed into CCJ in May 2006, Antonio R. was wandering around the intake area asking for his methadone. An officer told him to return to his holding pen. Antonio apparently did not obey quickly enough, as the original officer and others proceeded to beat him, first in the main open area and then in an adjoining tunnel. They hit Antonio with a radio, knocked out his dentures and smashed them under a boot. As a result of this incident, Antonio suffered multiple fractures and a collapsed lung. After being returned from one outside hospital, he was sent to another in acute respiratory distress. He was transferred to a Level 1 trauma center, where he needed to be placed on a ventilator. Medical records confirm Antonio’s severe injuries.

4. In February 2006, while being processed into the CCJ for driving on a suspended license, James W. would not

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(and could not) remove jewelry embedded in a piercing because it was permanently soldered. The officer conducting the strip search attempted to strike James, who blocked the blow. The officer then called over other officers, who hit James in the face multiple times. One officer hit him repeatedly with a handcuff wrapped around his hand. James later stated that the officers had used his head as a "bongo drum." Medical records confirm that James was diagnosed with a perforated ear drum and blood in his right ear at Cermak Hospital the next day. Additional records show that the incident resulted in diminished hearing in one of James's ears. James filed a lawsuit against CCJ concerning this incident and the parties agreed to settle the case in March 2008.

e. Inadequate Oversight of Use of Force

Effective measures to prevent excessive and inappropriate uses of force start with the adequate reporting of information to permit the identification of potential problem cases and effective internal investigations. We find that CCJ fails to elicit adequate information about use of force incidents, making management review ineffective. We also find that, in most cases, internal affairs investigations of use of force are undertaken only when a lawsuit is filed, rather than when a serious incident occurs.

i. Management Review

In order for CCJ to provide adequate oversight of officers' use of force, management must have adequate information to review incidents and reach a conclusion as to the propriety of a use of force. While all officers involved in a use of force incident fill out a Use of Force Report, in most cases these reports provide very little information because they are written in generalities. For example, numerous Use of Force reports fail to describe, in factual terms, the type and amount of force that officers used. Many Use of Force Reports merely describe the force used with phrases such as, "used the least amount of force necessary to gain control of the inmate" or "faced inmate to the floor." Although most shift commanders review Use of Force and Incident Reports to ensure that reports are completed, some commanders reported that they do not review the reports for substantive content. Although copies of Incident Reports are forwarded to CCJ's Executive Director, Assistant Executive Directors, Superintendents, and the official file, it is unclear

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if the administration routinely conducts any additional review of these reports.

Moreover, while in most cases there are both Incident Reports and Use of Force Reports, the reports generally do not indicate the nature or extent of an inmate's injuries, arguably the most telling indication that there *may* have been an inappropriate use of force. The reports usually conclude with an inmate being taken for "medical attention," but with no indication of why medical attention was required. The reports also fail to capture the time the inmate received medical attention, which makes it difficult to assess whether medical attention was promptly provided. In the May 2006 case of Jacob D., there is no indication of any injury in the CCJ reports, but when Jacob was transferred the next day to the Illinois Department of Corrections ("IDOC"), his facial bruising and swelling was so severe that the IDOC contacted CCJ immediately to report the physical condition of the incoming prisoner. In the case of John S., there is also no indication of injury in the CCJ reports about a March 2006 incident. The reports simply state that John was taken for medical attention and released from the dispensary, with no mention of any injuries. In fact, as photos taken later show, John suffered two black eyes and a swollen lip, among other injuries. In both of these cases, CCJ eventually found excessive use of force by the officers, but the reports themselves were devoid of helpful information.[9]

Because the information contained in Use of Force and Incident Reports is insufficient for management to determine whether the incident raises suspicions concerning use of force, review by management, when it occurs, usually does not result in identifying cases for investigation. There can be no effective oversight if necessary information is not put forth when the incident happens. For example, a report indicating that an inmate sustained a black eye after an inmate-officer altercation should raise concern, but management will never know about the black eye under the current system.

In addition to the lack of information contained in CCJ reports, we discovered that the Incident Reports did not contain a tracking number or source of issuance until a July 2007 initiative by the Executive Director. This initiative is consistent with generally accepted correctional practice. Previously, it was extremely cumbersome to track any one incident

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[9] In both of these cases, investigations were initiated as a result of external complaints.

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(for use of force and other serious incidents) and, in all likelihood, impossible to ascertain if all incidents were being reported and processed. Incident tracking numbers are now to be issued by External Operations staff. Serious incidents and uses of force should also be tracked by each division with a uniform logging system for recording serious incidents at all levels of CCJ.

Finally, CCJ has no tracking or early warning system to identify those officers who are the most frequent users of physical force and those whose actions have elicited the most complaints of excessive force, grievances, or injuries. An appropriate early warning system is an accountability tool that allows for early intervention by alerting a facility to a need for retraining, problematic policies, supervision lapses, or possible bad actors. In 2004, CCJ hired an external consulting firm to review its policies and procedures regarding the use of force after a special grand jury concluded that a 1999 incident, in which correctional officers beat and terrorized 49 inmates at CCJ, constituted “gross, if not criminal, misconduct.” The consulting report recommended that CCJ institute an early warning system “as soon as possible.” The 2004 recommendation was never implemented.

ii. Investigations

To ensure reasonably safe conditions for inmates, correctional facilities must develop and maintain adequate systems to investigate staff misconduct, including alleged physical abuse by staff. Beyond management review, the avenue for oversight at CCJ is the Internal Affairs Division (“IAD”). Generally accepted correctional practices require clear and comprehensive policies and practices governing the investigation of staff use of force and misconduct. Adequate policies and practices include, at a minimum, screening of all Use of Force and Incident Reports, specific criteria for initiating investigations based upon the report screening, specific criteria for initiating investigations based upon allegations from any source, timelines for the completion of internal investigations, and an organized structure and format for recording and maintaining information in the investigatory file. The investigation must also be and appear to be unbiased. CCJ’s investigatory practice fails on multiple levels.

To be effective, investigations must be undertaken promptly. A jail, by its nature, has a tremendously high turnover of inmates. An inmate whose incident is being investigated may well have left CCJ if the investigation does not occur soon after the

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incident, and the same is true for inmate witnesses. Because CCJ does not initiate many use of force investigations, most use of force investigations are not opened until long after an incident has taken place. Instead, investigations are undertaken because the inmate has filed a lawsuit, which can be up to two years after an incident occurs. For example, the investigation of Michael A.'s January 2006 beating did not begin until 16 months after the incident, despite the fact that Michael was treated at an outside hospital, suffered a fractured nose, and had, according to the medical records, "raccoon eyes." The investigation of the incident in which Byron S. suffered a broken jaw did not start until Byron filed suit seven months later, even though Byron's visible injuries required him to eat through a straw with his jaw wired shut. Because of the delay, inmate witnesses to the occurrence will likely have left CCJ by the time an investigation begins. IAD's only attempt to reach an inmate witness who has left CCJ is a form letter to a last known address, which rarely elicits any response. We found that many investigations are simply undertaken far too late to be effective.

Perhaps even more troubling is the fact that investigations are reactive and suffer from the appearance of bias. The vast majority of IAD files we reviewed stated that the investigation of use of force was opened at the request of CCJ's attorney in response to an inmate lawsuit CCJ is defending in court. It is almost impossible for IAD to appear fair and unbiased when the investigation is undertaken only because CCJ is defending an inmate lawsuit. All uses of force should be appropriately reviewed through the chain of command. Whenever Incident Reports, Use of Force Reports or other information raise the possibility that excessive force was used, such incidents should be thoroughly investigated by IAD. In particular, incidents involving suspicious inmate injuries, such as black eyes or blunt head trauma, and incidents requiring medical care at an outside hospital should be investigated by IAD. An appropriate evaluation of incidents for investigation will require more detailed Use of Force and Incident Reports and a more thorough management review than CCJ's current practice.

IAD also reported a backlog in resolving use of force cases and incidents involving inmate-on-inmate assaults because it is difficult to obtain medical releases from Cermak, CCJ's on-site health care provider, in a timely manner.[10] Obtaining medical

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[10] IAD is under the Sheriff's Office while Cermak is part of the Cook County Bureau of Health.

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records from Cermak can take anywhere from six to 12 months, which prevents IAD from bringing prompt closure to an investigation. This type of delay is totally unacceptable, and is devastating for any investigation.

We also found that there are attempts by officers or other staff to conceal the inappropriate or excessive use of force. CCJ officials found that the officer involved in the January 2006 beating of Jerry M. had attempted to persuade a sergeant on the tier to change his story as to what had happened. In another case, Russell G. reported that the officer who caused his injuries in June 2007 threatened him with worse treatment unless he told the medical staff that he had hurt himself by falling out of his bunk. We found two accounts of senior division staff attempting to dissuade inmates from complaining about the use of force, in one case by the offer of a favor and in the other by the threat of criminal charges. CCJ's administration and IAD must take action to ensure that inmates are not intimidated into concealing excessive use of force and that information received is accurate and credible.

Finally, we also found flawed investigatory techniques at CCJ. For example, investigators often do not give sufficient attention to the inmate injuries that are known. When investigators question officers accused of using excessive force, the officers are generally not even questioned as to how an inmate's particular injury might have occurred. For example, IAD opened an investigation of the March 2006 case of Antonio R. after a doctor at an outside hospital reported that Antonio was in serious condition with "blunt trauma all over his body." Although the investigator was aware of Antonio's injuries at the time he questioned both of the officers involved, he never asked the officers about the nature of Antonio's injuries or how they occurred. While there may sometimes be tactical reasons to avoid discussing inmate injuries when an officer is first questioned, the investigation is incomplete if the officers are never asked to address the inmate's resulting injuries.

We found other examples of investigatory techniques that are unlikely to result in complete or credible information. For example, on March 9, 2006, an investigator interviewed inmate Gabriel M. about a use of force incident involving another inmate in his tier. The investigator then attempted to interview Gabriel's cellmate about the same incident but, since the cellmate could not speak English, the investigator utilized Gabriel as the Spanish interpreter to provide his cellmate's statement. Relying on one inmate to translate for another inmate in an investigation involving both of them is a poor

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investigatory technique that calls into question the credibility of the information gathered by CCJ investigators.[11]

iii. Videocameras and Overhead Cameras

When properly utilized, cameras in a correctional setting can augment inmate safety and security and provide essential information for investigations. Certainly video surveillance should never be used to substitute for direct officer supervision of inmates, but it often is helpful to supplement supervision and for incident reconstruction. CCJ has limited and antiquated live feed overhead cameras in some divisions, but the cameras do not have the critical capability to record and replay, and most do not capture activities outside of the housing unit dayrooms. Moreover, while there are two small monitors in the RCDC intake area, we discovered that the officers in the Security Office were unaware that the monitors could view various parts of the intake area. The cameras, installed to monitor activity in a part of CCJ that had experienced among the highest number of allegations of excessive and inappropriate uses of force, were not being used.

Procedures at CCJ require that a handheld videocamera be brought to the scene of any use of force and that the use of force be recorded. While this policy is helpful for review of cell extractions and other planned uses of force, it is not surprising that the use of handheld videocameras has not been an effective means of oversight for unplanned uses of force. None of the numerous videotapes we reviewed captured an unplanned use of force in progress. Improvements and additions to CCJ's video surveillance system, including the ability to record for retrieval following an incident, would be a much more effective oversight mechanism.

2. <u>Deficient Inmate Safety and Supervision</u>

CCJ does not provide adequate inmate supervision, which exposes inmates and staff to unsafe conditions. Lack of adequate

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[11] Title VI of the Civil Rights Acts requires that recipients of federal funds take reasonable steps to provide meaningful access to limited English proficient communities. Given Cook County's growing Hispanic population, CCJ should ensure that some investigators and correctional officers are familiar with rudimentary Spanish. In addition, CCJ staff would benefit from receiving diversity training. <u>See</u> Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d <u>et</u> <u>seq.</u>

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security staff, insufficient direct supervision in the majority of the housing units, a dilapidated physical plant, inadequate policies and procedures, and an overcrowded environment combine to result in an unsecure facility that is dangerous for everyone on the premises. On April 9, 2007, the John Howard Association found that the rates of injuries to CCJ inmates and staff have increased significantly in the past decade, despite a substantial decrease in inmate population.[12] In 2006, inmate injuries occurred at the highest rate since the John Howard Association began gathering data, and staff injuries reached the third highest rate since 1991.[13] Our review of CCJ documents revealed that between January 1, 2007 and June 19, 2007, IAD opened approximately 254 cases involving inmate assault and/or battery and five cases of sexual assault. In 2006, IAD opened approximately 357 cases involving inmate assault, battery, or sexual assault.

Insufficient inmate supervision has been a serious problem at CCJ for decades. Inmate supervision is seriously compromised by chronic overcrowding and under-staffing. The federal district court monitoring the Duran Consent Decree has repeatedly cited CCJ for failing to provide adequate security staff to ensure safe and secure conditions at the facility.[14] In September 2006, then-Sheriff Michael Sheahan admitted that the Jail is "severely understaffed."[15] The John Howard Association's April 9, 2007 report found that CCJ would require an additional 189 new correctional officers and suitable replacements for the 130 to

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[12] Court Monitoring Report, Duran v. Dart, No. 74-C-2949, at 115-16 (N.D. Ill. Apr. 9, 2007) ("2007 Court Monitoring Report"). Monthly averages for staff injuries have risen from 6.6 in 1996 to 28.3 staff injuries per month in 2006.

[13] Id. at 116. Monthly averages for inmate injuries increased from 14.7 injuries per 1000 inmates in 1996 to 27.8 injuries per 1000 inmates1 in 2006.

[14] Leonard N. Fleming, "Federal Judge Warns County to Fix Overcrowding at the Jail," Chicago Sun Times, Dec. 1, 2007; Jonathan Lipman, "Judge Blasts Staffing at Jail," Daily Southtown, Dec. 29, 2005.

[15] Joint Status Report, Duran v. Dart, No. 74-C-2949, at 8 (N.D. Ill. Sept. 29, 2006).

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152 correctional officers on inactive status[16] to comply with the Duran Consent Decree and "good correctional practices."[17] CCJ's Post Analysis Reports and Divisional Staffing Reports for April through June 2007 revealed that at least 172 correctional officer positions at CCJ were vacant or inactive. Although the External Operations Unit, which is responsible for the security of the CCJ perimeters, the Emergency Response Team, the Canine Unit, and the transportation of 800 to 1500 inmates to and from court daily, has an authorized security staffing complement of 420 positions, on May 1, 2007, the actual External Operations manpower availability comprised 352 positions. Our expert consultant found that the level of correctional staff available to supervise housing units at CCJ is woefully inadequate.

The lack of adequate staff is magnified by the fact that CCJ is chronically overcrowded. In fact, every day from June 2006 through April 2007, numerous inmates were required to sleep on the floor of two-person cells that housed three inmates.[18] Divisional reports for the period of February 26, 2007 through June 17, 2007 reflect that an average of 485 inmates were forced to sleep on the floor each night. During our site visit on July 23, 2007, Division VI held 1268 inmates in space with a rated capacity of 992 inmates.[19] Dormitory Four in Division II is operating at twice its design capacity.[20] However, we did not observe any increase in security staffing levels or enhanced supervision practices within the overcrowded divisions.

Overcrowding has an impact on security at CCJ. For example, the week of March 19, 2007, CCJ had more inmates sleeping on the floor (591) than any other week in the four-month period of March through June 2007. During that week, CCJ also had the most fights (35), the most uses of force (27), and found the third most "shanks" (homemade knives) (34) and second most weapons

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[16] Correctional officers on "inactive status" include persons on disability, suspension, leave of absence, military leave, or leave for a duty injury.

[17] 2007 Court Monitoring Report at 84.

[18] Id. at 12.

[19] The actual capacity of Division VI was much lower than 992 on July 23, 2007, due to numerous cell closures because of maintenance problems, which further exacerbated the overcrowding.

[20] 2007 Court Monitoring Report at 15.

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(12), of any other week during the same period.[21] On November 30, 2007, Judge Virginia Kendall for the United States District Court for the Northern District of Illinois apparently chastised the County and Sheriff's Office for failing to ease overcrowding at CCJ, stating: "This is no longer a budget problem. It is a constitutional violation."[22] Despite the fact that CCJ has been subject to the Duran Consent Decree for 25 years, the County and the Sheriff's Office have been unable to solve the problems of overcrowding and inadequate supervision at CCJ.

CCJ has taken some unusual steps to try to deal with the problems of overcrowding and inadequate staffing. The practice of cross watching, discussed below, is an unacceptable and dangerous approach. A recently instituted policy of extended lockdowns is similarly unacceptable. In the spring of 2007, CCJ implemented extended lockdown periods for all general population inmates. Under this system, only half of the inmates in each housing tier were allowed out of their cells during each shift. Generally, this meant that half of the inmates were allowed out of their cells for a period in the morning, half of the inmates were allowed out of their cells for a period in the afternoon and evening, and all of the inmates were locked in their cells during the night. Because the groups of inmates rotated on a shift by shift basis, the result was that every other day each group of inmates spent a continuous 26-hour period locked inside the cells. This practice was applied indiscriminately to all general population inmates, except those housed on the medical units. As discussed in further detail below, in addition to constituting an unjust restriction on pre-trial detainees, the extended lockdown practice interfered with medical and mental health care, programs, and the grievance system. Moreover, deficient maintenance in many cells (no lighting, plumbing failures, etc.) resulted in inhumane conditions for an extended lockdown. Therefore, as a result of CCJ's inadequate supervision, inmates are subjected to unjustified, prolonged periods of in-cell confinement. Following our July 2007 visit, the Sheriff's Office informed us that CCJ had revised the lockdown policy to decrease the length of the in-cell periods. This would be an improvement

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[21] Weekly averages for March through June 2007 were: 23.5 fights, 17 uses of force, 23.5 shanks, and 6.6 weapons.

[22] Staff Writer, "Judge Orders Cook County to Fix Jail Overcrowding," PR Newswire Europe, Nov. 30. 2007; Leonard N. Fleming, "Federal Judge Warns County to Fix Overcrowding at the Jail," Chicago Sun Times, Dec. 1, 2007; Notification of Docket Entry, Duran v. Dart, No. 74-C-2949 (N.D. Ill. Nov. 30, 2007).

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and a welcome change, and we look forward to assessing the new lockdown system.[23]

As discussed below, the result of CCJ's inadequate inmate supervision is that inmates and staff are exposed to unsafe conditions, an increased risk of violence and an abundance of dangerous and illegal contraband.

a. Assaults on Inmates and Staff

The severity and frequency of inmate-on-inmate assaults demonstrate that CCJ is not providing for the safety and well-being of the inmates. In a period of less than two months in the spring of 2006, inmates reportedly engaged in at least seven separate knife fights that resulted in serious injuries to at least 33 inmates and seven correctional officers, including one inmate death.[24]

Weekly Divisional Reports from February 26, 2007 through June 17, 2007 show an average of 23.5 inmate fights and 3 incidents of "battery to staff with injury" per week at CCJ. Many of these incidents occurred in CCJ's maximum security divisions, where inmates should be supervised at the highest level, and extra precautions should be taken to minimize access to, and creation of, shanks and other weapons. Clearly CCJ cannot be expected to prevent all altercations between inmates. Nevertheless, the Constitution requires correctional officers and Cook County officials to take "reasonable steps to protect

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[23] CCJ's latest attempt to deal with overcrowding involves a "hot bunking" pilot program whereby inmates volunteer to take turns using the same bed in eight-hour shifts. See Sheriff's Supplemental Report, Duran v. Dart, No. 74-C-2949, at 2 (N.D. Ill. Jan. 15, 2008). Although each inmate is reportedly using his or her own bedding, the hot bunking procedure could result in serious sanitation and infection control problems, as well as possible inmate-to-inmate intimidation regarding potential volunteers.

[24] See e.g., William Lee, "Two Cook County Jail Inmates Were Stabbed During a Fracas in a Maximum-security Division Monday Night," Daily Southtown, May 2, 2006; Lori Rackl, "2 Inmates in Hospital After Jail Brawl," Chicago-Sun Times, Apr. 24, 2006; William Lee, "Seven Inmates at Division 11 are Injured by Homemade Knives in a Gang-Related Fight," Daily Southtown, Apr. 24, 2006; Staff Writer, "Knife Fights in Cook County Jail Injure 17," Chicago Tribune, Mar. 13, 2006.

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inmates from violence at the hands of other inmates." Goka v. Bobbitt, 862 F.2d 646, 649-50 (7th Cir. 1988). The level of inmate-on-inmate and inmate-on-staff violence that is occurring within CCJ is so unacceptably high that it is clear that inmates are not adequately supervised, in accordance with generally accepted correctional standards. Notably, just as the Court and CCJ staff have recognized the shortage of staff supervision, inmates are also aware that they could engage in violence with little to no supervision. Much of the violence at CCJ involves group attacks, which reflect some degree of planning and coordination by the inmates, without the staff's knowledge or intervention.

As the following examples demonstrate, CCJ is not meeting its constitutional obligations to provide for the safety and well-being of its inmates:

1. On December 29, 2007, multiple inmates suffered stab wounds during a fight in a Division IX dayroom. Six inmates required treatment from outside hospitals and two inmates were admitted to the hospital with multiple stab wounds and other serious injuries. Officers were required to use Oleoresin Capsicum spray ("OC spray") to break up the fight. CCJ recovered four shanks, some of which measured six inches in length, and another weapon in the tier. Despite the severity of this incident, IAD did not open an investigation file.

2. On June 26, 2007, an officer delivering breakfast trays found inmate Louis J. unconscious on the floor of his cell in Division IX. Louis J. was admitted to the hospital for trauma and died on July 8, 2007, as a result of his injuries. Hospital records showed a hematoma with fractures and wounds to the face and head. Although the Incident Report related to this incident states that Louis J. may have suffered a seizure, Louis J.'s cellmate was promptly transferred to CCJ's highest level of disciplinary segregation, the Level IV Special Incarceration Unit in Division IX. However, CCJ could not produce a disciplinary citation, hearing record, or investigation documentation on the incident.[25] Louis J.'s cellmate was still in the

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[25] We requested all documentation related to this incident on multiple occasions. We never received any disciplinary or investigation records. CCJ did not complete a mortality review for Louis J., allegedly because he was no longer in custody at

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Special Incarceration Unit a month after the incident, during our July 2007 site visit.

3. On June 26, 2007, officers noticed that several inmates from Tier 4B were running as they returned from the Division X gymnasium. Officers found several inmates with stab wounds and other injuries in the corner of the gymnasium. One inmate was hospitalized with a stab wound to the neck and another inmate had a broken jaw. The fight was apparently the result of different gang affiliations mixed within the tier. Upon investigating, officers recovered three shanks. CCJ placed the entire 48-inmate tier on extended lockdown from June 26 through July 8, 2007, wherein each inmate was allowed out of his cell for only one hour per day, and only one inmate was allowed out at a time. No other obvious precautions were taken to address the gang problem on the tier. When the lockdown ended on July 8, another fight broke out involving some of the same inmates and the same gangs as the June 26 incident. One inmate was stabbed and officers recovered another shank.

4. On June 20, 2007, inmates Auben J. and Sam D. suffered injuries to their heads and faces following a fight in the outdoor area of Tier A-H in Division IX. Because no officers witnessed or responded to stop the fight, it was eventually broken up by another inmate, Roger R. Officers only learned of the fight after observing Auben J. bleeding from the head when he returned from exercise. Because Roger R. admitted that he helped separate the fighting inmates and injured Auben J. in doing so, he was transferred to disciplinary segregation along with Auben J. and Sam D.

5. On May 10, 2007, seven inmates were treated for stab wounds after a gang-related fight involving approximately 25 inmates in the Division IX, Tier 3C, dayroom. Inmates Mark V., Alex W., and Arthur A. had to be transferred to outside hospitals for medical treatment. CCJ staff found a shank in the dayroom.

6. On December 5, 2006, 31-year-old Marcus K. was found dead in his cell. His cellmate was charged with first-degree murder for allegedly strangling Marcus K.

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the time of his death.

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after the two were heard arguing. The two men were locked in their cell at the time, and other inmates in the common area alerted a correctional officer that an inmate needed help during the altercation.

7. On April 22, 2006, inmate Izzy J. suffered a fatal stab wound to the head during a gang-related fight involving approximately 20 inmates in Division XI. Six other inmates were hospitalized after the brawl; five of the inmates were stabbed with shanks.

8. On April 2, 2006, inmates Tyson D. and Freddy R. were seriously injured during a gang-related fight involving at least six other inmates in Division XI. Both Tyson D. and Freddy R. were admitted to the hospital with multiple stab wounds to the back.

In addition to the inmate-on-inmate violence, CCJ's security failings put staff in danger as well:

1. On March 22, 2007, maximum security inmate Reed W. stabbed a correctional officer, a nurse, a hospital patient, and a bus driver during an unsuccessful escape attempt at Stroger Hospital, where he had been taken for a doctor's appointment. CCJ officials reported that Reed W. may have smuggled a shank out of CCJ Division IX in his rectum.

2. On August 16, 2006, correctional officer Ben W. was hospitalized for five days and required 30 stitches after being attacked by inmate Daniel M. in Division V. The inmate was able to run from the scene before any other officers could come to Officer W.'s aid.

3. On April 15, 2006, six officers received medical treatment, and at least four inmates were hospitalized for stab wounds, after a multiple-inmate fight broke out in a Division XI dayroom. Officers recovered several wooden sticks and at least one metal shank following the fight.

b. Inadequate Security Staffing

As a result of insufficient security staffing, CCJ is not providing adequate supervision of the inmate housing areas. As discussed above, a major concern surrounding inmate supervision is the practice of "cross watching." Cross watching refers to the practice of having one correctional officer simultaneously

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supervise two tiers of cells as opposed to one.[26] The correctional officer monitors the second tier on camera while stationed in the first tier's control center. By policy, the officer supervising a housing unit is supposed to conduct security rounds inside the unit every 30 minutes, which allows him to check on inmates in their cells and in the shower and bathroom areas. These areas are not visible on the security monitors or from the officer's standard post inside unit's control center. However, if or when the officer conducts a security check inside the first housing unit, the second housing unit is unsupervised. If the officer leaves the control center of the first housing unit to conduct a check of the second housing unit, the inmates in the first housing unit can see that there is no officer supervising their actions.[27] Although we recognize that CCJ has made efforts to increase staffing levels in housing units and decrease cross watching, we observed numerous instances of cross watching during our June and July 2007 visits to CCJ. The practice is highly utilized during lunch periods, but we also observed cross watching throughout the day.

As noted earlier, because inmates are aware when there is not an officer in the housing unit, there is a higher risk for illicit inmate behavior, including inmate assaults, production of weapons, and gang and drug activity. For example:

1. On May 15, 2007, an officer was cross watching two tiers in Division IX, a maximum security division. Inmate Carson T. was assaulted by five or six inmates in the tier dayroom. He received multiple wounds to his shoulders, back, face, and was admitted to the hospital. The cross watching officer did not notice anything amiss until he saw inmate Carson T. pacing by the tier door. CCJ documents noted that Carson T. had "injuries resulting from being attacked with a homemade knife" and that a "small piece of metal was sticking out [his] back." During the subsequent investigation, security staff found two shanks in the tier. No officer observed the dayroom assault.

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[26] Cross watching is prohibited by the Duran Consent Decree and the John Howard Association has cited CCJ for the practice, but it continues to occur. See 2007 Court Monitoring Report at 86.

[27] The number of inmates per housing unit varies across divisions, but it is not unusual for one cross watching officer to be responsible for more than 90 inmates in two units.

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2. On May 10, 2007, also in Division IX, an officer was cross watching two tiers when a disturbance involving 25 inmates occurred. Seven inmates received injuries including multiple lacerations and puncture wounds.

3. On December 24, 2006, the assigned officer was cross watching two tiers in Division VI when inmate George W. assaulted inmate Otis F., causing a head injury.

4. On July 25, 2006, inmate Andrew K. committed suicide in Division I while the assigned officer was cross watching two tiers. The Medical Examiner reported that inmates discovered Andrew hanging by the cell bars, alerted officers, untied his noose, and initiated chest compressions before staff intervened. Although staff reported that sight checks occurred in the tiers on a frequent basis, it is not clear if the officer actually saw Andrew in his cell at the times reported. Inexplicably, the CCJ investigation of the incident did not include the results of interviews of the other inmates who were present in the tier at the time of Andrew's death.

5. On March 19, 2006, inmate John M. was attacked by two other inmates in Tier D-B of Division XI, which at the time was a maximum security division. Because the officer assigned to Tier D-B was at lunch, and the two closest officers were cross watching Tiers D-B and D-C and Tiers D-A and D-D, the officers had to wait for back-up to arrive before anyone could enter Tier D-B to break up the fight. John M. suffered two puncture wounds to his neck and one puncture wound under his arm. After the fight, officers recovered two steel shanks, a broken cane, and three razors from the tier.

c. Contraband and Vandalism

Another indicator of inadequate supervision is the amount of dangerous contraband that is being recovered from the housing units and the ease by which inmates can fabricate homemade weapons. Due to the dilapidated condition of scores of cells, shower areas, and various dayroom features, inmates have ample material for fabricating weapons, including floor tiles, metal from light fixtures, metal from the ventilation system, glass from cell light bulbs, electrical wiring, and plumbing fixtures. It is virtually impossible for any correctional facility to completely deter inmates from obtaining materials for weapons due to the condition of the physical plant, but the problem at CCJ is

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further exacerbated by the lack of direct supervision in most of the divisions.

Even though the CCJ administration has recently made efforts to curtail the creation of shanks and other weapons through the establishment of a “Weapons Committee,” a severe contraband problem still exists. For example, IAD’s Contraband Log reveals that, between January 1, 2007 and June 19, 2007, security staff found approximately 484 weapons and shanks. Many of these weapons and shanks were found in inmate cells and dayrooms after a stabbing incident. The Weekly Divisional Reports from February 26, 2007 through June 17, 2007 show an average of 23.5 shanks and 6.6 weapons found each week at CCJ. In just one week, April 2-8, 2007, CCJ staff recovered 55 shanks and 12 weapons. In 2006, IAD opened approximately 590 cases involving shanks, 77 involving weapons, and 115 cases involving other contraband. The number of weapons and shanks is extremely high, even considering CCJ’s large inmate population.

During our site visits, we noticed scores of opportunities for inmates to fabricate shanks and other weapons. We found broken and jagged floor tiles laying exposed in dayrooms without raising the notice of staff. In some instances, inmates are using the absence of ventilation grates in their cells to rig a “dumbwaiter” system that allows them to transmit drinking water between the housing unit’s upper and lower tiers from within their locked cells. However, the inmates can also use these passageways to pass contraband. Shower and bathroom walls in the Residential Treatment Unit (“RTU”) that had been damaged by inmate vandalism provided ample opportunity for weapons production and concealment of contraband. We observed numerous vandalized cell lighting fixtures and missing and vandalized cell vents, which are commonly used to create shanks. Inmates’ access to the lighting fixtures can lead to additional dangers. For example, on June 14, 2007, an inmate attempted suicide by cutting himself with a broken light bulb.

In addition to the troubling, unchecked proliferation of weapons at CCJ, it is clear that there is a serious narcotics problem. Between January 1, 2007 and June 19, 2007, IAD opened approximately 110 cases related to narcotics/drugs. In 2006, IAD opened approximately 160 cases involving narcotics/drugs.

The lack of adequate supervision at CCJ is further highlighted by the frequent and flagrant rule violations that are evident in almost every tier throughout the facility, including special management units that should have a higher degree of supervision. For example:

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1. Scores of cells have been vandalized and are rife with gang and general graffiti.

2. Scores of cells contain homemade clothes lines. The hanging linens prevent adequate visibility into the cell. Also, the clothes lines can be used by inmates as potential weapons or suicide implements.

3. Small in-cell fires are common. Many inmates use the cell lighting fixtures as an ignition source for warming food and starting fires. Numerous inmates covered the cell light bulb with a milk carton that serves as a lamp shade and an ignition source. In scores of cells, the bottom bunk has evidence of having been heated. Inmates and staff reported that inmates use the bottom bunks as hot plates for warming food by setting a fire underneath them.

4. Scores of cells contain dozens of empty milk cartons and other stored debris that can be used by inmates for improper purposes and provide a potential fuel load in case of a fire.

5. Numerous shower areas have been vandalized, resulting in exposed ceilings and materials that can and are used to fabricate weapons.

6. Numerous inmates use extra blankets as carpets or room dividers for their cell, while other inmates claim a shortage of blankets.

7. Scores of cells, shower areas, bathrooms, and dayrooms have exposed electrical wiring.

8. Scores of vents, window sills, stairwells, and screens throughout the tiers are plugged and covered with debris.

9. As discussed below, many in-use cells are so unsanitary or have such severe maintenance problems that it is clear that adequate security checks are not occurring.

It is common for inmates to try to engage in vandalism or rule infractions, and CCJ could not be expected to prevent all such inmate activities. However, it is not generally accepted correctional practice to allow these violations to occur so flagrantly and with such prevalence throughout the facility.

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The sheer frequency of these issues demonstrates that inadequate supervision is common at CCJ.

d. Inadequate Visibility

Inmate supervision is further hampered by CCJ's physical layout, which does not allow for direct supervision in most divisions. With the exception of the Division II and RTU dormitory units, correctional officers are not stationed inside the housing units. In most divisions, the housing units are supervised by an officer from a tier control center or security entrance post that only allows for observation of the dayroom and some common areas of the housing unit. This is the case even in the special management units, such as disciplinary segregation and protective custody, which is a grossly atypical corrections practice. The officer cannot see into the individual cells while in the control center and is therefore required to conduct frequent physical checks of inmates in their cells. However, security check documentation at CCJ is spotty. For example, during our on-site visits we discovered pre-recorded security checks on housing unit logs and also security checks that were suspiciously logged at precise intervals throughout a shift without any deviation. In addition, numerous inmates throughout the facility reported that officers commonly only enter the housing unit during shift change or meal times, but not on regular rounds throughout the day. This is not surprising, as a single officer may be cross watching two housing units simultaneously from one control center.

Even if security rounds within the housing units are occurring as scheduled, lack of visibility into cells is a major safety concern. Scores of cells are dark due to inoperable lighting fixtures, missing light bulbs, or inmate vandalism of lighting fixtures. We also observed the results of rampant vandalism of the lighting system in the RTU dormitory units, despite the fact that an officer is purportedly posted inside each RTU dormitory at all times. In fact, one RTU dormitory had no working lights and another had only two or three working lights, out of 24 light fixtures. Lack of operable lights makes the entire unit dangerous both for inmates and officers. This problem is compounded by the fact that correctional officers cannot replace broken or burned out light bulbs, but must issue a work order and wait for Facilities Management to handle the request. In addition, we observed many cells and shower areas with "privacy curtains" and with the celldoor windows obscured by cardboard, paper, towels, and other materials. It is very difficult, if not impossible, for officers to provide adequate safety and security checks of inmates when they cannot see into

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the cells and shower areas. Compounding the lack of adequate inmate supervision within the housing units is the fact that cells are not equipped with intercoms or emergency call buttons, which are useful safety and security features designed to allow for a locked inmate to alert an officer in an emergency situation. Intercoms or emergency call buttons are especially important for special management units, where the inmates spend approximately 23 hours of the day locked inside their cells, often alone.

Of particular concern for inmate and officer safety is the lack of visibility in the Special Incarceration Unit of Division IX. As these cells house CCJ's highest risk offenders and inmates with demonstrated behavior problems, the celldoor windows have been modified to prevent inmates from throwing liquids or objects at officers. However, instead of installing a protective covering that would allow for observation, such as safety glass, CCJ welded a metal plate with small holes in it on to the cell windows in the Division IX Level 4 tier. As a result, it is virtually impossible to see into the cell, especially at night.

In addition to inadequate interior security visibility, during a night time tour of CCJ, we observed approximately 22 external post and building lights that were not functioning in the area between Division I and Division V. This is unacceptable and a significant security risk.

e. Inadequate Security Policies and Procedures

At CCJ, each separate division has Standard Operating Procedures ("SOPs") that cover all the necessary components for a security program, such as key control, cell locking procedures, incident reporting, and search procedures. During our review, we found that while some CCJ policies and procedures were up to date, many were not. Generally accepted correctional practices require that post orders should be reviewed on a quarterly basis. CCJ policy requires that post orders be reviewed annually. We reviewed the post orders available at various security posts throughout CCJ and found many post orders that had not been reviewed in multiple years. For example, in Division XI, we inspected a manned gun tower. The post order for the tower was dated January 1996 and was last revised on January 15, 2003. In addition to being outdated, the post order did not contain essential information for an armed post, including instruction on when and under what circumstances the weapon should be used. CCJ is also lacking in proper policies regarding inventory of security equipment, including the newly introduced OC spray, which could allow for unaccounted misuse by correctional

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officers. When post orders are not updated regularly and do not address vital information, facility practices will develop in an ad hoc nature and will not account for current needs. Outdated policies, procedures, and post orders are inconsistent with generally accepted correctional standards and contribute to a failure of the overall security system.

Although CCJ policies must adapt to some extent to account for the different security levels and different physical layouts in the various divisions, there is widespread policy variation from division to division on issues ranging from the handling of grievances to incident reporting. This can be confusing for correctional officers, who rotate posts every 90 days and may be transferred from one division to another without adequate training on division-specific SOPs. Policy discrepancies abound division to division, which result in widely different security practices. There is no standardized format in use throughout CCJ for division Roster Staffing Reports and Post Analysis Reports. Even CCJ's top level administration is unclear how security procedures are implemented throughout the facility. For example, a high level security official told us that each and every inmate should be patted down when he or she returns from the recreation yard. However, Division I supervisors reported that inmates are only subjected to pat downs at random upon their return from the yard.

An additional area of policy concern is with regard to special management units, which include the Special Incarceration Units, disciplinary segregation, and protective custody units. Generally accepted correctional practices require that officers who are assigned to these types of units possess a higher level of detention experience, receive focused training in special management operations, and are regularly assigned to these units for stability purposes. Correctional officers in CCJ's special management units rotate on a regular basis and do not receive specialized training for working with high risk inmates. This practice should be changed at the policy level.

f. Disciplinary Process

CCJ operates the inmate discipline component with a policy and procedure that appears to be adequate and provides sufficient due process to inmates. However, we did note some concerns with regard to the disciplinary process. First, hearings are not consistently conducted in a private, confidential manner and secure setting in accordance with generally accepted correctional standards. During our observation of the disciplinary hearings in Division II, 12 inmates were brought into a large room and

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seated together for their individual disciplinary hearings, including inmates whose disciplinary charges involved incidents of violence against each other. The proceedings were conducted within hearing of the other inmates. This process certainly presents safety and security issues because there may still be animosity between inmates who were involved in an altercation. For example, on July 26, 2007, two inmates began fighting during a disciplinary hearing in the Division VI library, and required medical care. Also, the victim may be reluctant to be truthful during the hearing for fear of retaliation by the aggressor. In addition, we noted that the statements made by the inmates during the hearing are written down by the disciplinary board in a very abbreviated fashion that may not adequately represent the inmates' statements.

3. Deficient Classification Procedures

All inmates admitted or discharged from CCJ are processed in the RCDC. The RCDC is located in the basement of Division V, and was originally designed as a storage area. Instead of storage, it holds several hundred inmates as they are strip searched, processed through booking, fingerprinted, photographed, screened for medical and mental health problems, and assigned to a bullpen until they can be transferred to their appropriate divisions. Almost every evening, the RCDC bullpens hold hundreds of inmates, for several hours at a time, who are crowded shoulder-to-shoulder behind chain link fences so tightly that there is insufficient space for them to sit or lie down. There is one female bathroom and only one male bathroom, with two toilets, and no hand washing facilities, for hundreds of male inmates to share.[28] While the RCDC overflows with hundreds of inmates, a surprisingly small number of correctional officers attempt to perform a multitude of duties, including the supervision of inmates. In addition to the natural stress resulting from admission to jail, inmates upon booking, who may have been held for multiple days in various police departments before arriving at CCJ, can be medically and mentally unstable. Newly admitted inmates are very unpredictable. The overcrowded, disorganized, and understaffed RCDC is a major security and safety risk to staff and inmates.

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[28] On January 14, 2008, the Sheriff's Office sent us photographs of recent renovations to the RCDC bathroom, including six new sinks and five new urinals. This is a vast improvement, but the single bathroom and limited toilets is still problematic, given the immense number of inmates in the RCDC each evening.

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The John Howard Association found the RCDC "grossly inadequate in size, design, and virtually every other respect."[29] We concur. The Sheriff's Office and the County concede that the RCDC physical plant is inadequate and we understand that funds have been allocated for construction of a new RCDC and RTU, but the new facility will not be completed until late 2009, at the earliest.[30]

Classification problems do not end with the physical plant of the RCDC. The Sheriff's Office admits that the present classification system is "extremely obsolete."[31] The system was purchased in 1991 and last updated in 1993. It is an antiquated inmate tracking system that is incapable of tracking basic information, such as the number of empty beds in each CCJ division at any time. The RCDC Superintendent is required to make telephone calls on a constant basis to the other divisions in order to ascertain the bed availability. Although the RCDC Superintendent has access to e-mail, the superintendents of the other divisions do not.

The classification system contains provisions for initial custody assessment and for custody re-assessments. However, although CCJ uses a Special Incarceration Unit "level system" to manage high risk inmates and security threat groups, that information is not contained within the classification policies and procedures manual.

Perhaps more troubling than the obsolete nature of the CCJ classification system is the fact that many supervisors do not understand how to properly utilize the system. Midway through our second site visit to CCJ, we learned that information on each inmate's classification status and history is readily available from terminals in every division. However, many CCJ supervisors and even division superintendents had previously reported to us that they could not access such information on the system. The superintendent who revealed the broader tracking capabilities to

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[29] 2007 Court Monitoring Report at 67.

[30] President Todd H. Stroger and the Cook County Board of Commissioners' Status Report, Duran v. Dart, No. 74-C-2949, at 8 (N.D. Ill. June 11, 2007).

[31] Sheriff's 2007 Status Report and Response to John Howard Association Court Monitoring Report, Duran v. Dart, No. 74-C-2949, at 22 (N.D. Ill. June 11, 2007).

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us acknowledged that many CCJ supervisors are not proficient with the CCJ system.

Given the high level of inmate assaults and gang-related violence at CCJ, it is clear that inadequacies of the classification system are contributing to CCJ's security deficiencies.

4. Inmate Grievance Procedure

An inmate grievance system is a fundamental element of a functional jail system, intended to provide a mechanism for allowing inmates to raise conditions of confinement related concerns and issues to the administration. If viewed as credible by inmates, it can also serve as a source of intelligence to staff regarding potential security breaches as well as staff excessive force or other misconduct. The grievance system should be readily accessible to all inmates. Inmates should be able to file their grievances in a secure and confidential manner and without the threat of reprisals. Staff responsible for answering inmate grievances should do it in a responsive and prompt manner. Unfortunately, we noted a number of serious concerns with the inmate grievance process at CCJ.

The primary responsibility for coordinating and responding to inmate grievances lies with the Correctional Rehabilitation Workers ("CRWs"). Each of the approximately 40 CRWs, if evenly distributed throughout CCJ, has a caseload of well in excess of 200 inmates, which is extremely ambitious. Although management staff expect that the CRWs conduct at least two visits to each of their assigned units per week to collect grievances and to perform other duties, this is not occurring on a consistent basis. Moreover, numerous inmates complained that they do not have access to the CRWs (and consequently, the grievance process) if they are locked in their cells when the CRWs conduct rounds, which is a common occurrence.

At the divisional level and by divisional policy and procedure, there are supposed to be locked grievance boxes in the housing units for inmates to place their grievances in. The CRWs are supposed to collect the grievances from the locked boxes each weekday. However, the grievance system functions differently in practice, and varies from division to division and even from tier to tier. Although it is not reflected in the written policies, the prevailing current practice is for the inmate to give the completed grievance to the CRWs when they conduct rounds. Staff reported that inmate grievances are to be inserted in confidential envelopes and sealed by the inmate, which is also

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not written in the divisional policies. In some divisions, an inmate can also give the completed grievance to a security supervisor, who will record it in a log and give it to a CRW. In other divisions, security staff refuse to handle any grievance, to avoid conflicts and the appearance of impropriety. In yet another version, inmate grievance forms are kept and passed out only by the CRWs and completed forms are collected by the block sergeant and brought to the CRWs' office. Although most of the divisions are not using the grievance boxes, many staff members, including the Program Services Administrator, were under the impression that inmates were using the boxes. There is an extremely high level of confusion regarding the grievance policy and practice at all levels of CCJ.

In addition, access to grievance forms by inmates is a universal problem. Although many management staff believe that the grievance forms are available on the tiers, this is simply not the case. The vast majority of the units that we visited during our June and July 2007 site visits did not have inmate grievance forms or confidential envelopes available on the housing units. Grievances forms are not available in Spanish language, despite the fact that many CCJ inmates can only speak, read, and understand the Spanish language.[32]

We also found that inmates believe the grievance process is unreliable and repeatedly complained about its effectiveness, with reason. For example, inmates stated that grievances related to the use of force generally result in one of two inadequate responses. Sometimes an investigator will speak to inmates after they file use of force grievances, but the inmates stated that they never heard back about their grievances. Most inmates complained that they heared nothing at all in response to a use of force grievance or received a summary denial. Inmate Byron S. filed a grievance approximately one month after an officer broke his jaw in January 2006. Thirteen days later he received a one sentence response to his grievance stating that there would be no IAD investigation because Byron had been found to have "assaulted and battered staff . . . as detainee was combative." In fact, although the officer initially reported that he was attacked by inmates, the officer admitted he had fabricated the story weeks before Byron filed the grievance. IAD filed a complaint against the officer for falsification of a report, yet the response to Byron's grievance, over a month later, was factually inaccurate according to CCJ's own records. Moreover, the grievance did not

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[32] See Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq.

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trigger an investigation. CCJ opened the investigation seven months later, after Byron filed a lawsuit.

5. Access to Information

Generally accepted correctional practice requires that newly admitted inmates are given an opportunity to learn about the facility rules and regulations, services that are available, policies and procedures that affect the inmate, and facility schedules. Each inmate should receive a facility handbook, containing all the relevant information, and should have an opportunity to have the information explained to him or her if the inmate cannot read. Most facilities have a formal orientation procedure as a part of the intake processing. At CCJ, officers reported that they offer inmates a copy of the inmate handbook in the RCDC. There is no documentation as to whether a handbook is offered or accepted. Although there was a small stack of inmate handbooks behind a counter in the RCDC strip search area, we did not observe a single inmate of the hundreds present in the RCDC area with a CCJ handbook during either of our site visits.

B. INADEQUATE MEDICAL CARE

Jail officials are responsible for providing adequate medical care to inmates. Moreover, a jail may not deny or intentionally interfere with medical treatment. A delay in providing medical treatment may be so significant that it amounts to a denial of treatment. Our investigation revealed that medical care provided at CCJ falls below the constitutionally required standards of care. We found the following deficiencies: (1) inadequate medical staffing; (2) inadequate intake screening; (3) inadequate health assessments; (4) inadequate acute care; (5) inadequate chronic care; (6) inadequate emergency care; (7) inadequate record keeping; (8) inadequate medication administration; (9) inadequate management of communicable diseases; (10) inadequate access to medical care; (11) inadequate medical facilities; (12) inadequate dental care; and (13) inadequate quality assurance.

1. Inadequate Medical Staffing

CCJ lacks the medical staff necessary to provide adequate medical services. Generally accepted correctional standards of care require that facilities maintain adequate staffing to provide inmates with necessary medical care. Many of the problems identified below are exacerbated by the inadequate medical staffing. In early 2007, there were significant health

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care cutbacks at CCJ, including 23 clinical positions (four physicians and three dentists), nine management positions, and 16 other health care positions. These cutbacks have severely impacted the quality and timeliness of medical care at CCJ. Most notably, the nursing staff shortages, which have left many divisions understaffed during periods of the day, and the dental staff shortages have caused or aggravated inadequate medical services.

2. Inadequate Intake Screening

CCJ fails to adequately identify inmates' urgent and/or ongoing health needs through appropriate intake screening. Adequate intake screening is essential for ensuring that inmates are receiving proper care for acute or chronic needs. Generally accepted correctional medical standards require that incoming inmates be screened by staff trained to identify and triage serious medical needs, including drug and alcohol withdrawal, communicable diseases, acute or chronic needs, mental illness, and potential suicide risks. CCJ's intake screening fails to identify such needs and increases the risk of serious harm.

At CCJ, correctional medical technicians are responsible for conducting intake screenings. If an inmate's intake screening is positive for a possible acute or chronic condition, the inmate should be referred to a physician assistant for an evaluation. Nationwide, more than 30 percent of inmates have acute or chronic conditions that would require a medical or mental health evaluation on the first day at a correctional facility.[33] In contrast, only 15 percent of the 100 intake screening records we reviewed during our June 2007 on-site visit resulted in a referral for evaluation. During our July 2007 on-site visit, we reviewed 120 intake screening records and found that only six of the inmates were referred to the physician assistant. These numbers depart significantly from what would be expected in CCJ's inmate population, which strongly suggests that the CCJ intake screening process is incomplete and inadequate.

Screenings take place in an area of the RCDC that is chaotic, noisy, and crowded. The screening interviews often occur while inmates are handcuffed together, resulting in a total lack of privacy, which compromises the quality of information received. Further, CCJ's screening form is deficient because it

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[33] National Commission on Correctional Health Care, The Health Status of Soon-to-be-Released Inmates: a Report to Congress (May 2002). http://www.ncchc.org/pubs/pubs_stbr.html.

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lacks sufficiently specific questions regarding acute and chronic illnesses, including drug and alcohol withdrawal. We found several instances where acute and chronic medical needs were not recorded on intake. These practices contravene generally accepted correctional medical standards, and place inmates at significant risk of harm.

For example, we identified the following cases of intake screening deficiencies:

a. Nadia H. died in late 2006, one day after being booked into CCJ, likely of withdrawal syndrome.[34] During intake, she reported a history of heroin addiction, yet staff failed to document her drug use and history of addiction. Despite knowledge that Nadia had a history of addiction, staff disregarded her emergent condition and placed her in general population. The next day she was found dead in her cell.

b. Julia G. was booked into CCJ in 2007 with a history of alcoholism and a dangerously high blood pressure. The screening process failed to identify that she was at risk of developing delirium tremens, a potentially life-threatening, but preventable, complication of alcohol withdrawal. Instead of evaluating and treating her medical condition, she was transferred to general population, where she developed delirium tremens and had to be admitted to the hospital. She also had co-morbid hyperthyroidism, which should have been detected during the intake screening. Because of CCJ's inadequate screening, Julia was at a very high risk of death.

c. In June 2007, David M. was booked into CCJ with a history of heart disease, deep vein thrombosis, depression, and recent trauma. Despite his serious medical history, he was neither examined by a physician assistant nor did he receive any medical care. Even after informing CCJ personnel on several occasions that he was currently taking a prescription for Coumadin (a blood-thinner prescribed for those at high risk for a

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[34] We reviewed the medical records of 20 inmates seen by the physician assistants in the intake area on June 18, 2007, and found that none of the inmates were asked about a history of alcohol withdrawal syndrome, a life-threatening condition that is common among inmates.

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blood clot and for some heart conditions), it took staff over three weeks before David finally received his first dose of Coumadin.

d. In June 2007, Lyle P. was booked into CCJ. At intake, Lyle reported his HIV infection and his strong adherence to his medication regimen, but he did not receive his medication prescription. Nearly two weeks passed before he was finally seen by an infectious disease specialist. Because of the two week lapse in medication, the specialist chose to delay treatment, which further enhanced the risks for Lyle to develop potentially-fatal drug resistance.

e. During our July 2007 on-site visit, we encountered an inmate who suffered from a recent facial trauma, including redness, swelling, and abrasions on the left side of his face. He complained of visual disturbances and discomfort over the entire left side of his face during intake, yet he was not examined by medical staff. It was only after we brought his condition to CCJ personnel that he was re-evaluated by medical staff.

3. <u>Inadequate Health Assessments</u>

CCJ does not give its inmates an adequate health assessment within a reasonable period after admission. The generally accepted standard of care is to conduct a health assessment within fourteen days of admission, or sooner when medically indicated. This assessment typically includes a review of intake information, a complete medical history, a physical examination, and screening for tuberculosis ("TB") and sexually transmitted diseases ("STDs"). Appropriate and timely health assessments are particularly critical should screening procedures fail to identify an inmate's serious health needs and improves the facility's ability to provide efficient and adequate care.

The great majority of inmates admitted to CCJ do not receive a health assessment within a reasonable period after admission. Many inmates never receive a physical examination at all. Even inmates who were appropriately referred to the physician assistants upon intake did not consistently receive appropriate referrals for follow-up or assessment.[35] The necessity for a full

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[35] The physician assistants in intake spend approximately five minutes per patient and conduct very cursory examinations

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health assessment is underscored by the grossly inadequate intake screening process. In addition to the risk to individual inmates with untreated conditions, CCJ's failure to conduct health assessments puts all inmates and staff at risk from the spread of disease.

4. Inadequate Acute Care

CCJ fails to provide adequate and timely acute care to inmates with serious or potentially serious acute medical conditions. CCJ's acute care services substantially depart from generally accepted correctional medical care standards. We identified grossly inadequate acute care that led to prolonged suffering and premature deaths of inmates at CCJ. Acute care was so deficient that inmates suffered needlessly because medical staff failed to ensure that inmates met scheduled appointments, failed to monitor acute conditions, and failed to timely treat inmates' conditions. We found numerous instances where CCJ's failure to adequately assess and treat inmates likely contributed to preventable deaths, amputation, hospitalizations, and unnecessary harm.[36]

The following examples highlight CCJ's deficiencies in providing acute care:

a. In early 2006, Gloria D. died after not receiving adequate care for an emergent and life threatening condition. Gloria, who suffered from human immunodeficiency virus ("HIV"), was admitted to CCJ in early 2006. After one month in the facility, staff ordered an x-ray after Gloria complained of persistent cough and shortness of breath. Although her x-ray was abnormal, Gloria did not receive any follow up care. Less than three weeks after her abnormal x-ray, Gloria developed a fever, tachycardia,[37] and low oxygen

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without privacy or an appropriate facility.

[36] Our medical chart review was hampered by CCJ's highly disorganized and incomplete medical records. For example, 72 percent of the records we requested for inmates sent to hospital emergency rooms were unavailable. While the medical records deficiencies hindered our review, we were still able to document serious lapses in medical care.

[37] Tachycardia is a rapid heart rate, over 100 beats a minute, which can be caused by cardiac arrhythmia.

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saturation. Gloria was hospitalized and died of untreated Pneumocystis carinii.[38]

b. In July 2006, Manuel M. was admitted to CCJ with a life-threatening blood pressure reading, an elevated pulse, and a history of alcohol use. Although he was medicated and monitored daily for hypertension, he was not treated for alcohol withdrawal and, on his third day at CCJ, exhibited tremors and an altered thought process, signs of delirium tremens. He should have been hospitalized at this point, but was not. On his sixth day at CCJ, when his blood pressure decreased some from its previously high levels, he was put in general population. He was never treated for delirium tremens and committed suicide while delirious.

c. In August 2006, inmate Aaron B.'s leg was amputated as a result of a bone infection resulting from CCJ's failure to provide adequate acute care. On August 8, 2006, Aaron was admitted to CCJ. He arrived at CCJ with a soft cast on his leg. Medical staff removed the soft cast and replaced it with a hard cast. Aaron complained of constant pain for nearly a week before he was finally seen by a physician on August 14. The physician scheduled an immediate orthopedist appointment for August 16. Unfortunately, Aaron never saw the orthopedist because the orthopedist refused to treat Aaron without his medical chart, which CCJ staff did not provide. After complaining of discomfort and a malodorous discharge dripping from his hard cast, on August 31, he was admitted to Cermak infirmary with osteomyelitis (an acute or chronic inflammatory process of the bone). His leg was later amputated because the severe infection had destroyed substantial soft tissue.

d. In late 2006, Aidan A. died after suffering from sepsis.[39] He was admitted to CCJ after suffering from a gunshot wound in his arm. His wound was surgically repaired and he had metal inserted in his arm to set the bone. The orthopedist scheduled an appointment so

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[38] Pneumocystis carinii is an opportunistic but preventable infection that occurs in immunosuppressed populations, primarily HIV patients with advanced infection.

[39] Sepsis is the presence of bacteria or other infectious organisms or their toxins in the blood or in other tissue.

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that the metal insert could be removed, but CCJ failed to take him to the hospital for his scheduled appointment. After seven weeks at CCJ, Aidan developed a deep tissue infection which elevated his respiratory rate and his pulse rate became dangerously high. By the time he was finally taken to the hospital, it was too late to contain the infection and Aidan died at the hospital of sepsis two months after his admission to CCJ. This was a preventable death.

e. Five days after his 2007 intake to CCJ, Henry H. had a new, on-set seizure and suffered a fractured jaw during the incident. It took six days for him to be seen by an oral surgeon and he was never evaluated for the cause of his seizure, as he should have been.

5. <u>Inadequate Chronic Care</u>

CCJ fails to provide adequate care to inmates with serious medical needs that require monitoring and follow-up medical care. Inmates who suffer from chronic medical illnesses must be regularly monitored by medical professionals to prevent the progression of their illnesses. Monitoring should occur on a regular basis to ensure that symptoms are under control and that medications are appropriate based on generally accepted correctional medical standards. However, we found that CCJ was deficient in ensuring that patients are seen on a regular basis, that medications are timely distributed, and that inmates are monitored and treated to prevent the progression of illnesses.

Specifically, in examining a sampling of medical records of inmates with chronic conditions, we found the following instances of deficient chronic care:

a. In reviewing the records of ten CCJ inmates with diabetes, we looked for seven nationally accepted interventions.[40] Inadequately monitored diabetes can lead to stroke, vision loss, diseases that effect the feet and muscles, kidney damage, coma, and death. In a gross departure from generally accepted correctional standards, none had a documented urinary microalbumin

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[40] These interventions are: measurement of sugar levels upon intake, measurement of urinary microalbumin, dilated examination of the retina, cholesterol measurement, measurement of A1c hemoglobin, chronic care visit with physician, and aspirin therapy.

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within the last 12 months; only two had a measurement of A1c hemoglobin within the past three months; four had a cholesterol measurement within past year; two were on aspirin prophylaxis; and two had a dilated retina exam. Our review of these files revealed that CCJ was not adequately monitoring these inmates through chronic care visits or consistently screening them from the conditions that they are at risk of developing.

b. We reviewed the treatment of 14 inmates suffering from moderate or severe asthma. Chronic follow-up care and regular monitoring of peak expiratory flow (a test that measures how well the airways are working) are critical in the proper care for persons with asthma. We found five of the 14 inmates had not been seen for chronic care within the last three months and only seven of the 14 had any measurement of their peak expiratory flow. We also requested records of 13 inmates seen in the Cermak emergency room for acute asthma between March 5 and May 2, 2007. None of these patients had follow-up to see if they were improving.[41]

c. Similarly, we requested the records of 15 inmates at the facility who are on the blood thinner Coumadin. This medication has very narrow therapeutic range; if an inmate is given too little, the medication will be ineffective, but if the medication is given too much, he or she will experience substantial detrimental effects. Accordingly, frequent measurement of the blood-clotting ability of patients taking Coumadin is critical. Of the records we requested, two were lost, one inmate was not scheduled for follow up for eight weeks, instead of the typical one to two weeks, and another inmate did not have necessary laboratory tests at intake. Inmates who are taking Coumadin but who are not monitored appropriately are placed at risk for a potentially life-threatening blood clot or a hemorrhage.

d. We also reviewed the records of five paraplegic inmates who suffered skin breakdowns, skin ulcers (bed sores), or wound infections. Our expert consultant found patterns of egregious failures of care regarding wound care in each of these cases. In one startling example,

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[41] Only 23 percent of the records requested were available and only one of those charts contained the emergency room record.

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> we reviewed the chart of inmate Wallace G., who suffered a skin breakdown. An x-ray revealed that his initial skin breakdown caused a soft tissue infection which likely caused a bone infection. Despite the abnormal x-ray, we were unable to find any follow-up care, treatment for the condition, or assessment by the physician. These failures are gross deviations from generally accepted correctional medical standards.[42]

6. <u>Inadequate Emergency Care</u>

CCJ fails to provide adequate emergency care. We observed an emergent incident during July 2007 on-site visit, when we encountered a male inmate who was known by CCJ staff to have a history of heart disease. While we were on his housing unit, inmate Mitchell H. experienced severe heart complications and lost consciousness. Although the dispensary nurse responded to the emergency call, it took 15 minutes for the ambulance and EMT to arrive. While the dispensary nurse was struggling to revive Mitchell, the EMTs were chatting and inattentive to Mitchell's needs. After nearly 45 minutes of suffering severe chest pains, Mitchell was finally placed in the ambulance. CCJ's slow response does not comport with generally accepted correctional medical standards and placed this inmate at risk of serious harm.

We found additional instances of deficient emergency care that put inmates' health and lives at risk. As part of our review, we randomly selected five inmates who were seen in the Cermak emergency room for alcohol withdrawal symptoms in the spring of 2007 and concluded that CCJ's treatment and assessment was deficient in four out of five cases. Two of the inmates were sent to the emergency room because of their significant elevations of blood pressure. In both cases, CCJ staff neither treated their high blood pressure nor adequately monitored their condition. Rather, CCJ sent both inmates back to general population without a thorough examination. Two other inmates were seen in the emergency room, but we were unable to find emergency room notes that documented any treatment.[43] The last

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[42] Our expert consultant advised CCJ of this patient's inadequate care during our July 27, 2007 exit conference.

[43] CCJ has a responsibility to obtain discharge summaries or notes from the hospital when inmates are treated at outside facilities in order to adequately assess and treat inmates upon their return to CCJ.

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inmate received no treatment because he suffered from asthma and did not require treatment for alcohol withdrawal.

7. Inadequate Medication Administration

We found numerous systemic problems with medication administration and management. CCJ frequently fails to: (1) verify identification of inmates receiving and ingesting medication; 2) provide critical medications to inmates without delay or lapses; and (3) maintain inmate medication administration records ("MARs") concurrently with distribution.

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

During our on-site visits, we observed the distribution of medication in each of the CCJ divisions. In every instance, we found nurses throughout the facility who failed to verify inmates' identification before administering medication. This deficient practice increases the chances of dispensing medications to the wrong inmate or dispensing medication to an inmate who may have an adverse reaction to medication. Also problematic was the failure of nursing staff to observe inmates swallowing prescribed medication. This failure prevents nursing staff from accurately recording administered medications and creates an unsafe and potentially dangerous environment where medication could be hoarded, sold, or result in overdoses. The nurses' failure to verify identification and observe inmates swallowing medications is inconsistent with generally accepted professional standards of correctional medical care and greatly increases the risks for error and harm.

Our investigation also revealed significant delays, errors, and lapses in medication administration, all of which have contributed to needless suffering and inmate hospitalizations. The following examples illustrated the medication administration deficiencies:

a. As discussed above, David M. was booked into CCJ in June 2007 with a prescription for the blood thinner Coumadin, but there was a 22-day delay before he finally received his first dose of Coumadin.

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b. In May 2007, Roy H. was booked into CCJ. He was admitted after a kidney transplant. He was prescribed medication to prevent his body's rejection of his kidney transplant. After 16 days without his prescribed medication, he had to be hospitalized because his body began to reject his kidney and he developed metabolic acidosis, a potentially life-threatening condition.[44]

c. In 2007, Gregory T. was booked into CCJ after a hospitalization for deep vein thrombosis. Although he had a prescription for Coumadin, CCJ staff failed to order his prescription. For nearly 20 days, he needlessly suffered. He developed a blood clot in his leg and had to be hospitalized because of CCJ's failure to order his prescribed medication.

d. In 2007, Stella R. had a prescription for Coumadin and a prescription for hypertension medication, yet CCJ staff failed to order her prescriptions. Stella went nearly 20 days without her prescriptions. It was only after we brought this medication error to CCJ's attention that Stella had her prescriptions ordered.

e. In 2007, Rebecca N., an HIV-positive inmate, had a prescription for antiretroviral medication, but CCJ staff failed to administer her medication daily as prescribed. There was a five-day lapse in her medication, which is especially dangerous for inmates with HIV.

f. In 2007, Grant P. suffered head trauma during seizure, which was likely caused by his not receiving 11 of his 31 prescribed doses of his anticonvulsant medication.

We also found deficiencies in CCJ's MARs. Contrary to generally accepted correctional standards, numerous MARs were not contemporaneously completed or signed as medication was distributed. CCJ medical staff often left records blank or failed to log critical clinical information upon distribution of medication to inmates. We spoke with a medication technician who told us that because of staffing problems in several divisions it was virtually impossible to distribute medications and document MARs at the same time. This practice is inconsistent with

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[44] Metabolic acidosis is a clinical disturbance characterized by a relative increase in total body acid.

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generally accepted professional standards of correctional medical care and greatly increase the risk of error.

We also reviewed a sampling of MARs during our on-site visits and found that approximately 15 percent of the MARs were blank which made it difficult to determine if inmates were receiving medications as prescribed. In Division IV, we found particularly high level of blank MARs. When we spoke to the nursing staff on the division, we learned that Division IV was severely understaffed. Further, we learned that staffing shortages had resulted in the division and nurses being unable to dispense medications in the afternoon or evening. Inmates were forced wait until the morning before they were able to get their medications. Similarly in Division III, we learned that medications were not delivered because of staffing shortages and inmates were not receiving medications as prescribed. Blank MARs are indicative of inadequate training, supervision, and staffing.

8. <u>Inadequate Infectious Disease Control</u>

CCJ fails to adequately treat, contain, and manage infectious disease. This failure is dangerous and places inmates, staff, and the community at unnecessary risk of serious health problems. CCJ's management of TB, Methicillin-resistant Staphylococcus aureus ("MRSA"),[45] and other infectious diseases deviates from generally accepted correctional medical standards. Inmates with infectious diseases are not appropriately contained, treated, or managed. The overcrowding, poor ventilation, and constant exposure of inmates to each other and CCJ staff are conditions conducive to the spread of disease. CCJ's containment and management of infectious disease substantially departs from generally accepted correctional medical standards.

CCJ fails to ensure adequate containment of TB. Once TB has been identified, treatment must be initiated and monitored. Inmates believed to have infectious TB should be placed in specialized respiratory isolation ("negative pressure") rooms to reduce the risk of transmission through airborne particles. Isolation rooms are essential to the prevention of contagion. These isolation rooms should be tested to ensure proper ventilation. In addition, staff who are potentially exposed to the risk should wear masks and be trained in the use of

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[45] MRSA is a potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death.

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specialized respirators. We found that CCJ does not comply with these generally accepted correctional standards.

The most egregious example of CCJ's failure to provide adequate containment of TB is inmate Wallace G. Wallace was housed in a respiratory isolation room because of his abnormal chest x-ray and a history of TB. The room purportedly had negative pressure to contain any TB organisms. However, we inspected the respiratory isolation room and discovered that the room did not contain negative pressure. A correctional officer was stationed outside the hallway to the negative pressure rooms, in order to ensure that people entering the area wore proper masks, but the doors to the area were propped open. Immediately following our discovery of the possible inadequate containment, we informed CCJ personnel of our finding and the potential health risks. CCJ staff later moved Wallace to another respiratory isolation room that contained negative pressure.

Thereafter, we inquired into whether CCJ was following the Centers for Disease Control and Prevention's recommendations for containment of TB. The recommendations require facilities to check respiratory isolation rooms monthly, and daily when rooms are occupied.[46] We found that neither CCJ, Cermak, nor Facilities Management Department inspect the isolation rooms. This oversight exposes staff and other inmates to a high risk of TB infection.

Similarly, CCJ fails to provide adequate management of skin infections. Consistent with generally accepted correctional practices, jails should adopt a skin infection control plan to guide the prevention of transmission of skin infections, including drug-resistant infections such as MRSA. MRSA transmission can be prevented by early identification, effective treatment, wound care, follow-up, environmental controls, and efficient laundry practices. We found serious deficiencies in these critical areas at CCJ.

CCJ lacks an adequate tracking system to ensure that skin infections are properly treated. We learned that CCJ had a nurse practitioner responsible for wound care and tracking patients with skin infections, but she did not record any of her findings in inmates' medical records. Without an adequate tracking system, inmates with infections are not properly treated and the risk of transmission increases significantly. Similarly, we found that the CCJ laboratory did not report diagnostic cultures

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[46] http://www.cdc.gov/mmwr/PDF/rr/rr5509.pdf

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of skin infections to the nurse practitioner. A culture, which is an examination of a sampling of cells taken from the affected area, may be done to identify the microorganism causing the skin infection and to determine the antibiotic or other treatment that will effectively treat it. Without wound cultures, it is impossible to recommend appropriate antibiotics and increases the risks of harm.

Laundry is also an important component to prevent the transmission of infection. Inmates should have access to clean underwear and regular changes of uniform. CCJ launders inmates' clothing once per week, thereby increasing the risk of infection transmission. Inmates informed us that the only way to maintain clean underwear is to wash it themselves in sinks and toilets in the cell area. We observed uniforms, underwear, and linen hanging to dry throughout the cell area and on railings and dayroom window ledges on every division. These deficient practices greatly increase the risk of intramural transmission of skin infections.

9. <u>Inadequate Record Keeping</u>

CCJ fails to maintain complete, accurate, readily accessible, and systematically organized medical records. CCJ lacks an adequate medical records system to ensure that inmates' records are correct and accessible so that physicians can provide appropriate care.

CCJ's medical records system is strained and overflowing with unfiled and inaccurate medical records. For example, there is a three month backlog of unfiled medical records in the central medical records room; a two month backlog of unfiled emergency room records; and a three to 14 month filing back log of medical records in various CCJ divisions. The backlog of unfiled records seriously interferes with the continuity and coordination of care at CCJ. This inefficient filing system greatly increases the risk of error in treatment, assessment, and care. Further, the current system does not facilitate a system for coordinated treatment by multiple providers because inmates' records are not accurate, organized or timely filed.

We found records throughout the facility with critical medical information missing. For example, as discussed above, although inmate Aaron B. was scheduled to see the orthopedist for his serious knee injury, the physician refused to treat Aaron because CCJ could not find his medical chart. Aaron's leg was subsequently amputated because of a serious infection that

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developed due to inadequate care resulting from a chart that was missing in the medical record.

The inadequate record system is further impeded by clinicians who created “shadow charts.” Physicians kept lists, logs, or filed copies of progress notes and diagnostic reports in their desks so that they could properly monitor their patients’ progress. While the concept of creating shadow charts might seem to enhance continuity of care, they actually create another barrier for maintaining accurate, complete, and accessible medical records. In most instances, physicians maintained notes, lists, and logs that were not updated in central records, which further created a gap in maintaining complete records.

Our investigation also revealed that medical records were not readily accessible. For example, we found that clinicians did not have access to inmates’ records maintained in the divisions after 3:00 p.m. because the medical records rooms were locked at that time due to staffing problems. This lack of medical continuity and coordination of care seriously interferes with the clinician’s ability to manage medical emergencies outside of the Cermak units.

10. <u>Inadequate Access to Medical Care</u>

The CCJ sick call process fails to provide adequate access to medical care. CCJ inmates access medical care by completing sick call requests. Although CCJ correctional staff are responsible for collecting sick call requests, inmates reportedly make multiple requests before receiving medical care. Our review of medical records confirmed that many inmates made several requests for care before receiving treatment. For example, on July 25, 2007, inmate Jackson E. requested medical treatment for staples that had been left in his scalp and sutures that had been left in his arm. Although he made several requests to have the staples and sutures removed, he did not receive treatment, even after our consultant alerted CCJ staff to his condition. He reportedly was placed in lock down for ten days for making repeated requests for medical care. It is inappropriate to punish inmates for requesting medical care. Similarly, inmate Donald C. made repeated unanswered requests for medical care for eye hemorrhages and lacerations he sustained in an altercation with custody staff.

Also of concern, inmates reported that they were limited in their ability to access medical care by the practice of extended half-tier lockdowns, discussed above. When inmates are confined to their cells for extended periods, they have limited access to

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custody staff and can be denied access to medical and mental health care. For example, inmate Chester H. reported that he had a seizure during the 26-hour lock down period and he was unable to receive medical care and was unable to attract the attention of CCJ personnel. He needlessly suffered while he waited for medical care. Because the nurses do not go onto the units to deliver medications to inmates who are locked in their cells, inmates who are on lockdown status during medication administration do not receive their prescribed medications. The extended lockdowns interfere with implementation of prescribed treatment plans and continuity of care for inmates.

11. Inadequate Medical Facilities

Medical facilities at CCJ lack adequate space, privacy, lighting, and sanitation to provide inmates with medical care consistent with generally accepted correctional standards. Approximately 300 inmates receive face-to-face medical care daily.

Inadequate space is especially significant because it limits CCJ's ability to provide medical services such as intake screenings, sick calls, and health assessments as well as care for inmates with specialty, chronic, and acute needs. The RCDC intake area is inadequately equipped to manage the daily volume of inmates during the essential intake screening process. The area is constantly congested and overcrowded.

Generally accepted professional standards of correctional medical care require that for a proper clinical evaluation inmates be examined in a clean and private setting with sufficient lighting and access to necessary diagnostic tools. We found mouse droppings in dispensaries and medication rooms throughout the facility. Moreover, some of these rooms lacked accessible hand-washing sinks or disinfectant, and contained unsecured syringes and other sharp implements, which can be potentially dangerous. Further, the floors and work surfaces of all of the medical units and intake screening area were filthy.

12. Inadequate Dental Care

CCJ fails to provide adequate dental care to its inmates. Dental care is an important component of overall inmate health care. Poor oral health has been linked to numerous systemic diseases. Contrary to generally accepted correctional standards, dental care at CCJ is not timely and does not include immediate access for painful or urgent conditions. During our June 2007 on-site visit, we found that there was only one dentist

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responsible for over 9,500 inmates.[47] We further learned that the dentist was unable to perform any restorative care. The dentist's services were limited to extractions and it usually takes about two weeks before the dentist was able to perform any necessary follow-up care. More alarming, we learned that over 25 percent of the extractions performed at CCJ resulted in chronic infections such as osteitis (inflammation/disease of the bone) or dry sockets.

We also found that the dentist typically was unable to treat inmates with serious or urgent dental needs. We found many instances where inmates complained of tooth abscesses, but the dentist was unavailable to treat their serious dental needs. For example, inmate Derek B. was admitted to CCJ on June 17, 2007, with a tooth abscess. Although Derek requested dental care, the CCJ dentist did not provide treatment for his tooth abscess. Without proper treatment, Derek is at risk of serious deep tissue infection, pneumonia, sepsis, septic shock, and possibly death.

As a result of the dentist's inability to treat serious dental needs, the Cermak emergency room and sick call are inundated with dental emergencies. Despite having Cermak physicians treat these serious dental emergencies, inmates continue to suffer needlessly because they do not receive appropriate follow-up care.

13. <u>Inadequate Quality Assurance and Performance Measurement</u>

CCJ fails to engage in consistent, effective quality assurance reviews in order to monitor and assess the quality of medical care offered at the facility. An adequate quality assurance and performance measurement instrument is necessary to examine the effectiveness of health care delivered at CCJ, to discuss medical care results, and to implement corrective action so that the quality of care is improved. During our on-site visits, we found that CCJ had discontinued many of its performance measurements in February 2007 because CCJ lost accreditation by the National Commission on Correctional Health Care. As a result, CCJ discontinued its review of chronic disease care, acute and chronic care, completion of treatment for STDs, and access to care. Performance measurements are a critical component to ensure that polices and procedures are in place and to ensure adequate care. Without performance measures, the quality of medical care will suffer.

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[47] Three dentists, one dental hygienist, and seven full-time equivalent dental assistants were cut in February 2007.

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We also found that CCJ failed to conduct self-critical mortality reviews. Our expert reviewed mortality reviews and autopsies of 13 inmates who died while in custody at CCJ and found that none of the mortality reviews were self-critical. The absence of self-critical review creates a barrier for proper review that will ensure that proper policies and procedures are in place to correct failures and ensure adequate care, prospectively.

Finally, staff involved in the inmate grievance process are frustrated that once a medical or mental health related grievance is referred to Cermak, a response is not forthcoming. The inmate grievance system should alert medical staff to possible weaknesses in the provision of medical care. We reviewed numerous grievance files that alleged the need for medical services, some of an emergent nature, that showed a referral to Cermak, but contained no actual response to the grievance. For example, inmate Steve S. filed a grievance on March 19, 2007 alleging that he was taken off his psychotropic medication without seeing a doctor, that he had been experiencing nightmares that prevented him from sleeping at night, that he was hearing voices, and that he was contemplating taking his own life and desperately needed help. The CRW acknowledged receipt of the grievance on March 23, 2007, but did not mark the grievance as an emergency and referred the grievance to Cermak with a statement that Steve S. merely alleged he was not getting proper medical attention. On April 2, 2007, Steve S. received a response stating, “Referred to Mental Health Services.” The grievance file does not contain any information indicating whether Steve S. ever received mental health treatment.

C. INADEQUATE MENTAL HEALTH CARE

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

Mental health services at CCJ are provided through a combination of County Cermak employees and a contract with the Isaac Ray Center (“IRC”) for psychiatric services. Cermak mental health services are directed by a Chief Psychologist who supervises a staff of approximately 50 individuals, including two medical social workers, three activity therapists, one mental health specialist supervisor, and approximately 40 Mental Health

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Specialists ("MHSs"). County mental health services have recently experienced specific cuts in staffing. The result is an inadequate number of trained staff to provide adequate programming and coverage in the mental health areas.

1. Failure to Timely and Appropriately Evaluate Inmates

CCJ fails to properly identify inmates with mental illness through adequate screening. Adequate screening of incoming detainees for mental health care needs is instrumental to a facility's ability to identify inmates in need of mental health services, to provide appropriate mental health care, and to reduce potential harm to those whose conditions would otherwise go unrecognized. Mental health screening should comport with generally accepted correctional standards of care to aid in classification, identification of emergent mental health care needs, provision of continuous care, and management of medication.

Follow-up of known or new mental health problems is a key focus of intake screening. Mental health screening information should be incorporated into an inmate's medical record. This ensures the prompt continuation of necessary medication for all inmates with chronic or newly identified mental health conditions. Persons with potentially serious and/or chronic mental health illness (i.e., active psychosis, suicidal ideation) should be referred from screening for prompt mental health evaluations and examinations by a psychiatrist.

As indicated, CCJ's medical screening and follow-up care procedures deny necessary care to inmates. The policy governing the CCJ mental health screening process is completely inadequate. Insufficiently trained MHSs perform mental health initial intake screening at CCJ. This screening is not accomplished under appropriate medical supervision. The system allows technicians, who are not adequately or appropriately trained in detecting mental illness, to query inmates and detainees regarding their mental health history.

For mental health screening, CCJ staff utilize a form entitled "Department of Mental Health Services Brief Primary Psychological Screening Tool" which is not then incorporated into the medical record. This is a one page form that is used to collect brief demographic information and answers to 11 general questions. No mental status exam is completed at that time. At the end of this brief interview, which lasts for less than five minutes, the MHS makes a decision whether to refer the inmate to general population, refer the inmate for admission to psychiatric

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services, or to conduct a secondary interview. The screeners do not ask questions beyond those on the form, and do not appear to understand when additional questions were indicated or what those questions might be, especially relating in the area of assessment of suicide risk. Thus, mental health symptomatology that is associated with past hospitalizations, current treatment, or suicidal ideation, is unlikely to be uncovered.

Consequently, our expert consultant found that less than five percent of inmates screened are identified as having psychiatric problems. The County's Director of Psychiatric Services acknowledged that the screening process was flawed and one would expect the percentage of inmates identified with psychiatric problems to be as much as ten percent. No psychiatrists are assigned to supervise or support the RCDC intake area where the initial mental health screening is conducted. In addition, we found that even for those inmates who screen positively for serious mental illness, the subsequent referral process to mental health treatment providers is flawed.

2. <u>Inadequate Assessment and Treatment</u>

CCJ fails to appropriately assess and treat inmates with mental illness, including those inmates on the acute care units and in the RTU. Our investigation revealed two principal problems. The first is the lack of attention to past mental health treatment records including previous psychiatric hospitalizations. Virtually no collateral mental health care information is requested or utilized in the assessment process. The second problem is that medical information already collected is not available for review or utilization in the continued assessment and treatment process. Our review of records indicates that this leads to multiple, often conflicting diagnoses, potential over prescription of antipsychotic and antidepressant medications, and medication dose adjustments without clear rationale. These failures have resulted in mental health deterioration and unnecessary suffering.

We noted that there are significant problems with the mental health treatment records. CCJ fails to maintain complete, accurate, and systematically organized mental health treatment records. CCJ's medical and mental health records system is completely inadequate and mismanaged. We observed numerous incomplete, unfiled, and inaccurate records. This flawed record system greatly increases the risk of error in assessment, treatment, and care. The County Director of Psychiatric Services described the medical record operation within CCJ as "grossly inadequate."

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The following examples are illustrative of the assessment and treatment failures at CCJ:

a. Seth P. was seen for a psychiatric consult during our July 2007 on-site visit. Seth had been admitted to CCJ three to four weeks prior to the consult and, after initial screening, had been placed in the general population. No records were available or requested[48] at the time of the consult. The psychiatrist evaluated Seth and assessed him as exhibiting grandiose thinking and hyperactivity, prescribed medications, and ordered Seth to be admitted to CCJ's acute psychiatric unit for further evaluation. Immediately following the psychiatric consult, Seth was sent to an outside emergency room for evaluation for a possible fracture of his right hand. Upon his return to CCJ, the intake MHS,[49] who was not aware of the recent psychiatric assessment due to the inadequate record keeping, determined independently that Seth was to be admitted to the general population. The result was that Seth received no further psychiatric evaluation and did not receive the prescribed antipsychotic medication ordered by the psychiatrist.[50]

b. Melanie O. had a miscarriage at CCJ on May 25, 2007, was depressed, and had not received any psychiatric follow-up even though she was taking psychotropic medications. During our June 2007 on-site visit, we observed Melanie sitting in a hallway, having what proved to be an acute allergic reaction. No medical records for Melanie were available at that time.

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[48] The Director of Psychiatric Services indicated that to request such records would be fruitless. When we insisted that the records be requested, none were available nor could they be located. Eventually Seth P.'s medical records were located, two days later, and the record was found to be incomplete.

[49] Each time an inmate is transferred or leaves the facility for a consult, he is returned to the intake area for a housing classification. In this case, the housing classification was conducted by the intake MHS.

[50] The psychiatrist was not aware of the mixup and the situation was rectified only after we brought the matter to his attention. The Director of Psychiatric Services indicated that this was typical of what happened at CCJ on a daily basis.

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Eventually, Melanie's medical record was obtained and the record reflected that she had been sent to the emergency room two days earlier because of symptoms of allergic drug reaction. Medication was prescribed, but Melanie had not received the medication because there was no record of the prescription order from the hospital. No medical evaluation had been completed to determine the cause of her allergic reaction and no psychiatric assessment of her mental state occurred.

c. Kyle N., who had been assigned to CCJ's acute psychiatric unit, had a medical record which contained misfiled medical record information belonging to another inmate.

d. Anthony G. was housed on a Division IX segregation unit, with limited out-of-cell time, and had not had any access to psychiatric care in over six months. He reported setting fires to get access to medical and mental health care. The officers' log verified Anthony's fire setting.

e. Drew E. was also housed in Division IX and admitted that he also set fires to get access after repeatedly receiving no response to his grievances over lack of access to medical and mental health care.

As demonstrated, CCJ fails to provide essential, generally accepted components of an adequate treatment programs in a correctional mental health system. The crisis level of care lacks the capacity for necessary short-term treatment. There is not adequate physical space for evaluating and treating inmates in the emergency or RCDC areas. At present, psychiatrists do not go to the general population to see inmates or conduct clinics. In addition, psychiatrists do not make rounds in any segregation areas. Rather, all inmates are brought to the emergency room area to be seen. The result is that inmates who for security reasons or lack of escort correctional staff cannot be brought to the emergency room area, are not seen.

In addition, CCJ does not have access to an acute care program that would provide appropriate access for inpatient hospitalization. For example, mental health staff have no involvement in substance abuse assessment or treatment and make no referrals for substance abuse assessment or treatment. Also, a chronic care program for inmates with serious mental illnesses does not exist. While CCJ does provide segregated housing units for inmates with serious mental illnesses, these housing units

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lack an adequate treatment program, which is an essential component of an adequate chronic care program.

3. Inadequate Psychotropic Medication Administration

CCJ fails to timely and appropriately evaluate inmates for the administration of psychotropic medications and to monitor their continued administration. Many CCJ inmates require psychotropic medications to avoid the unnecessary suffering of acute and chronic episodes of mental illness. Generally accepted correctional mental health care standards require that a physician see an inmate usually before, but clearly shortly after, a prescription for psychotropic medication is written in order to evaluate whether the medication should be maintained and to evaluate the continued administration for proper dosage and effectiveness. Inmates who remain untreated, or who are treated without being seen by a physician, may suffer from a worsening of their symptoms, including suicidal and homicidal thoughts, or from the potentially lethal side effects of medication. CCJ consistently fails to follow this practice.

We found significant problems with regard to medication management, which include the following: (1) delays ranging from days to weeks for inmates having their psychotropic medications started after their admission to CCJ; (2) breaks in receiving their medications after their prescriptions were initiated at CCJ related to housing changes and nurse unavailability for medication administration; (3) inmates not receiving their prescribed medications due to being locked down for extended periods of time and unable to receive medications when called; (4) numerous medication errors appeared to be common; (5) psychotropic medications being prescribed or reordered without any clear medical rationale or justification; and (6) lack of monitoring for side effects, or potential toxicity, particularly with regard to the psychotropic drugs Lithium, Depakote, and Clozaril.

As confirmed by our investigation and acknowledged by the Director of Psychiatry, inmates routinely do not receive medications as prescribed or have lapses in medication administration. Medication errors were common due to nurses being overwhelmed and failing to observe inmates taking their medications or to assure that the medication was delivered as prescribed.

Medication administration problems are compounded by the fact that psychiatrists do not utilize any formal practice guidelines or protocols with regard to the psychiatric care being

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provided at CCJ. No routine lab work, weights, measurements, or screenings are conducted regardless of the medication being prescribed. Generally accepted professional standards require regular blood draws and lab work whenever certain psychotropic drugs are prescribed to ensure that the patient is receiving therapeutic levels of the medication. Metabolic syndrome which is characterized by the presence of risk factors including obesity, abnormal lipid profiles (high LDL cholesterol, low LDL cholesterol, and high triglycerides) is not tracked. Screening for the side effects of antipsychotic medication is not routinely done. The result is that CCJ is providing medication management that significantly departs from generally accepted professional standards. Illustrative examples from 2007 include:

a. Salazar F. did not receive his antipsychotic medication after his transfer to Division IX from CCJ's acute psychiatric unit.

b. Although Raul G. was housed in the Division V medical unit, he did not receive his prescribed antipsychotic medications for three weeks after intake.

c. Julius T. was prescribed antipsychotic, antianxiety, and antidepressant medications. The rationale for prescribing these medications could not be determined. In fact, the psychiatric portion of his medical record concerning substance abuse, depression, anxiety, and withdrawal could not be located.

d. Jones C. was prescribed three varying doses of an antipsychotic medication without clarification as to which dosage was appropriate (40mg, 60 mg, or 80 mg) or clarifying changes in dosage, if that was the case. It appeared that CCJ clinicians were engaging in polypharmacy, the inappropriate practice of prescribing multiple medications within the same class, without justification, for the same illness. He was also being prescribed two additional antipsychotic medications with no justification in the record for the multiple medication orders. It is likely that the lack of available records contributed to the disorganization of the care of this inmate.

e. Arnold R. was being prescribed an antipsychotic medication and an antidepressant without any documentation in his medical record as to the rationale for the prescription or any follow-up on his psychiatric medications.

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f. Diego F. was receiving two antipsychotic medications and an antidepressant medication. His record contained no rationale for the medications and identified him as having no psychiatric problems.

4. <u>Inadequate Suicide Prevention</u>

Suicide prevention practices at CCJ are grossly inadequate. Constitutional requirements mandate the development of suicide prevention standards. These standards require (1) an appropriate policy and procedure; (2) education and training for all staff members; (3) appropriate screening to assess suicide risk; (4) appropriate housing for those identified as at risk; (5) appropriate supervision, observation, and monitoring of those inmates so identified; (6) appropriate referrals to mental health providers and facilities; (7) appropriate communication between correctional health care and correctional personnel; (8) appropriate intervention addressing procedures of how to handle a suicide in progress; and (9) appropriate notification, reporting, and review if a suicide does occur.

CCJ's current practice of suicide prevention does not comport with generally accepted professional standards of correctional mental health care. CCJ's written policy on suicide prevention fails to ensure appropriate management of suicidal inmates and lacks major components of an adequate suicide prevention program. For example, CCJ's policy states that "if a patient is determined to be an imminent risk of harm to self, they will be placed in restraints following protocol." This practice of manually restraining suicidal individuals is contrary to generally accepted professional standards and, as affirmed in conversations with CCJ staff, being utilized solely due to lack of staff for continuous observation of the suicidal inmate. The result of this inappropriate policy is the unnecessary and excessive use of restraints.

An illustrative example is inmate Dallas W. who was placed in four-point leather restraints (all limbs) after expressing thoughts of committing suicide, despite the fact that he exhibited no aggressive or suicidal behavior. The review of restraint logs from July 2006 to June 2007 showed that in over 50 percent of the episodes, inmates were shackled with full leather restraints because of suicidal ideation and the fact that continuous observation was unavailable. This is grossly inappropriate.

In addition, the appropriate observation of suicidal inmate patients is hindered by physical limitations of the rooms in

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which they are being placed. Observation rooms have blind spots and windows that are set too high for routine viewing. Moreover, many of the rooms contain numerous environmental risk factors including exposed plumbing and electrical hazards.

Contrary to generally accepted correctional practices, CCJ correctional officers and other staff have no access to cut-down tools for quick response in the event of a suicide attempt by hanging. In each of the three CCJ suicides completed in 2008, there was a delay between discovery of the inmate hanging and removal of the noose. For example, on January 1, 2008, the first correctional officer to discover inmate Grant N. hanging from his bunk attempted to lift Grant to remove the sheet from his neck, but was unable to do so. Approximately six additional minutes elapsed before paramedics were able to cut Grant down, using a key to sever the noose.

As a result of the administrative division between corrections and health care at CCJ, communication between mental health staff and correctional staff is informal and often strained. Significant communication problems between custody and mental health staff result in a fragmented, uncoordinated system. This problem is exacerbated because suicide prevention is not under the direction and supervision of mental health staff. Inmates placed on suicide watch are being observed by correctional officers who have a myriad of other responsibilities in addition to the observation task and have limited or no familiarity with the on-going assessment of suicidal individuals. The current suicide prevention program fails to contain different levels of supervision of the inmate based on the presenting risk factors for suicide. Staff are not appropriately trained in suicide prevention. Annual training for correctional officers regarding suicide prevention is not required. Correctional officers assigned to the mental health units do not receive any additional specialized training on working with individuals with mental illness. Finally, contrary to generally accepted practice, there is no adequate clinical administrative review by mental health staff following a suicide or a suicide attempt to identify what could have been done to prevent the act. Our

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review of the records of two recent inmate suicides[51] illustrates the significant problems:

a. On July 27, 2006, inmate Manuel M. hanged himself to death in a maximum security wing of CCJ. A correctional officer reportedly found Manuel hanging from a bed sheet at 3:20 a.m. He had been in CCJ approximately one week on a charge of failing to register as a sex offender. His records reveal that at intake he provided a history of suicide attempts in the past, but denied current suicidal ideation. No secondary mental health evaluation was conducted. Manuel received no additional mental health assessment prior to his death in the facility.

b. On July 25, 2006, inmate Andrew K. committed suicide by hanging himself in his cell, two days after arriving at CCJ. Andrew was discovered by another inmate. His record reveals that at the time of intake, Andrew denied suicidal ideation and no secondary mental health evaluation was conducted. Andrew's documented past history included three prior psychiatric hospitalizations, including a suicide attempt by overdose. Nevertheless, Andrew received no additional mental health assessment prior to his death. No recommendations or findings were made in the mortality review, except for the comment "May consider a two person accommodation to watch over each other."

5. <u>Inadequate Staffing, Training, and Supervision</u>

CCJ's fragmented system of providing mental health care has contributed to many of the problems above. In addition, many of the shortcomings in mental health care are exacerbated by the lack of adequate staffing, support, training, and supervision.[52]

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[51] In addition to the suicides discussed above, on March 14, 2008, an inmate was found hanging in his Division I cell. He was hospitalized in critical condition and died when he was taken off life support on March 18, 2008. On April 14, 2008, another CCJ inmate hanged himself with a bed sheet in a Division I cell, and was pronounced dead at the hospital.

[52] Concerns were raised by the Chief Executive Officer of the IRC regarding the decreased budget for mental health services and the resulting mental health staff cuts, particularly the decrease in the number of MHSs and the replacement of existing

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CCJ maintains an insufficient number of appropriately trained mental health and custody staff to provide adequate mental health services.[53] Moreover, delays in access to mental health care are exacerbated by an insufficient number of staff trained to identify, respond, and provide the necessary mental health treatment. Generally accepted correctional standards of care require that facilities maintain adequate staffing to provide inmates with necessary mental health care.

Shortages in key staff areas (MHS, correctional staff, nursing, medical records, and social workers) interfere with adequate access to mental services.[54] As indicated, there is an inadequate number of MHSs to provide screening and supportive mental health care. This problem is compounded by the fact that recently hired MHSs lack the necessary training and experience. As indicated, correctional staff are inadequately trained to work with mental health inmates. In addition, officers are being rotated too frequently to develop familiarity with the

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MHSs with less qualified individuals. The severe budget cutbacks, as reflected in decreased staffing, resulted in a "breakdown in translation and execution of mental health care."

[53] We observed very limited programming on the units. An interview with the Chief Psychologist verified that within the last six months due to budget cuts and the resulting staff reduction, programming on the units had been severely reduced.

[54] These staffing shortages were noted by the Court Monitor for Mental Health responsible for monitoring compliance with the CCJ consent decree in Harrington v. DeVito, No. 74-C-3290 (N.D. Ill. Oct. 19, 1978). In his 1998 and 2002 reports, the Court Monitor for Mental Health found that a shortage of adequately trained nurses, activity therapists, mental health specialists, psychiatrists and psychologists resulted in inmates "facing significant access barriers to care and adequate therapeutic programming resources." He further found that the lack of adequate numbers of medical record technicians resulted in incomplete records, included filing not being completed in a timely fashion or misfiling, and lack of availability of records during clinical assessments. Our independent evaluation identified that inadequate staffing currently results in unconstitutional mental health care deficiencies. These same staffing deficiencies were identified by the Harrington lawsuit and referenced in the 1998 and 2002 Court Monitor for Mental Health's reports.

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population.[55] There are an insufficient number of nurses to provide mental health services for the designated mental health units and to run a medication administration program that comports with generally accepted professional standards.[56] In addition, there are insufficient numbers of social workers to provide for discharge planning, continuity of care, and reintegration into the community. Finally, there are an inadequate number of trained health record technicians to operate an effective health record system.

D. INADEQUATE FIRE SAFETY

The level of fire safety at CCJ is poor. Inadequate fire safety at any correctional institute presents a grave risk of harm from smoke, fire, and the serious security concerns that arise during an emergency. These serious risks are present throughout CCJ. There are no smoke detectors in most inmate housing areas, which means staff have no way to receive warning of fire or smoke other than from the inmates who may have set the fire. Keys are not marked for rapid identification in an emergency. Staff was often not prepared to quickly unlock the doors for rapid evacuation, not knowledgeable of how the fire alarm system works, and poorly prepared for an emergency. Weekly Divisional Reports, from February 26, 2007 through June 17, 2007, show an average of 1.8 fires per week at CCJ. During our site visits, we saw evidence in numerous cells that inmates are setting fires beneath their beds in order to utilize the metal bunk as a hot plate to heat food. Multiple inmates reported that they resort to lighting fires in their cells in order to get correctional officers' attention. Considerable improvement in built-in protection and staff preparedness is necessary to meet generally accepted standards for fire safety in a correctional setting.[57]

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[55] The Court Monitor for Mental Health also noted the lack of compliance with the Harrington Consent Decree with regard to security staffing. He found that the failure to utilize appropriately trained correctional officers on a regular basis in mental health areas was noted to have significantly impacted the treatment offered to inmates with serious mental illness.

[56] This was acknowledged by the Acting Director of Nursing who indicated it is difficult to maintain adequate psychiatric nurse coverage on the psychiatric units.

[57] In addition to generally accepted correctional standards, the Illinois Office of the State Fire Marshal requires

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One CCJ correctional officer is assigned to make monthly fire safety "inspections" for the entire facility. These are cursory inspections to confirm that items on a standard checklist are done. The designated officer has not had training in fire safety and apparently just fills out the inspection check list with little in-depth evaluation of safety issues. Reportedly, there is a fire safety officer for each division, but these officers' only responsibility regarding fire safety is the monthly inspection of fire extinguishers. Fire safety inspections should be done by persons trained in fire safety. They should have knowledge in basic housekeeping, emergency preparedness, basic applicable codes, fire extinguishers, and sprinklers.

Key control is a major problem. On several occasions during our on-site visits, when officers were asked to unlock doors, there was confusion as to which key unlocked a specific door or if the correct key was on the ring the officer carried. In many cases, several keys were tried without success, and then a key on the same ring was found that would unlock the door. The keys were not identified by touch and the visual markings were difficult to read in low light situations. In a correctional setting, generally accepted correctional standards require that all emergency keys be identified by sight and touch.[58] On October 5, 2007, the Sheriff's Office reported that CCJ had made improvements in key control, but we have not yet verified this information.

Divisional emergency procedures and fire plans are different between divisions with no standard format or standard procedures. For example, the Division IV instructions require that emergency keys to be color-coded red, but other divisions do not. Some instructions include floor plans, while others do not. While it is understandable that both the physical plants and levels of security differ by division and require some variation, the general format and information should be similar. This will help employees to more easily familiarize themselves with the procedures as they move positions.

Fire drills are not being done on a regular basis on each shift. Many officers reported that they had not participated in any recent fire drills and had not had training on fire safety

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that all jails must comply with the National Fire Protection Association's Life Safety Code ("LSC") (200).

[58] See also LSC § 23.7.5.

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since the academy. According to generally accepted correctional standards, monthly fire drills are required in institutional occupancies.[59] Monthly drills should rotate so that they are conducted quarterly on each shift. Drills should be conducted at differing times and under differing conditions, such as using different egress routes to confirm that officers have the necessary keys and know how to use them. Records of each drill should be maintained for at least one year.

CCJ does not have sufficient smoke detection and sprinkler systems. Smoke detection should be installed in all housing units in accordance with generally accepted correctional standards.[60] Basement storage areas should have sprinkler protection or be enclosed in fire resistive construction.[61] Stairs should be enclosed so that smoke will not travel throughout the buildings. Most of the CCJ Divisions do not comply with these generally accepted correctional standards. For example, Division I, which was built in 1929, has no sprinklers and no smoke detection. A manual fire alarm system is installed. The cells are open-barred in the front and back and the doors to the stairs are open bars from the basement to the fourth floor, which could allow smoke to spread quickly throughout the building in the event of a fire. Only Division XI, Dorm 4 of Division II, and Cermak are fully protected with automatic sprinklers. Some of the buildings have partial sprinkler protection in selected areas of the basements, while others do not. Several fire/smoke barrier doors were not working properly. Many of the stairwell and fire doors throughout CCJ were wedged open, which would allow smoke and heat to travel quickly throughout the building. In addition, in many divisions no one is consistently checking emergency doors and locks to ensure that they are operational. We found that the locking mechanisms on multiple emergency exits in housing units had been sabotaged by inmates inserting debris into the lock, unbeknownst to staff, which prevented the doors from opening from inside the housing unit. This is a major safety hazard.

In many divisions, we found extra mattresses stored inappropriately in rooms without adequate fire protection. For

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[59] The Municipal Code of Chicago, Fire Prevention Code ("FPC"), also requires monthly fire drills. FPC, Article XVI, § 1 (15-4-920) (Jan. 1999).

[60] See also LSC § 23.3.4.4.

[61] See also FPC § 9 (15-16-030)(b); LSC § 23.3.2.

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example, in Dormitory Two of Division II, we found several mattresses stored in the multi-purpose room on the first floor, which is not designed or protected as a storage room. A fire in these mattresses could quickly spread smoke throughout the building and unnecessarily expose inmates to danger. Mattresses should only be stored in designated areas that are protected against fire risks. The potential risk from CCJ's flammable mattresses is clear. On January 4, 2007, two officers were injured after an inmate in Division IX set his mattress on fire. One officer suffered smoke inhalation and was admitted to the hospital. Another officer was cut on his arm during an evacuation of the housing unit.

Finally, as discussed above, the RCDC becomes very crowded in the late afternoons and evenings. There are two doors out of this area. Assuming each door has a clear width of 34 inches, generally accepted correctional practices indicate that each door is a sufficient exit for a crowd of 135 to 170 persons.[62] That means the RCDC can safely provide emergency exits for 270-340 people. The number of RCDC occupants, including newly admitted inmates, inmates returning from court, correctional officers, and medical and mental health care staff, often swells well beyond 400 persons, clearly exceeding the available egress capacity.

E. INADEQUATE SANITATION AND ENVIRONMENTAL CONDITIONS

CCJ has severe environmental health and safety problems at every level of operation.[63] Most CCJ staff appeared well meaning with regard to environmental conditions, even when, in some instances, the staff person had never received adequate training to sufficiently understand the task at hand. However, inadequate staffing, inadequate training, insufficient oversight, and a lack of uniformity of policies and procedures across divisional lines are detrimental to staff who want to perform at a professional level.

1. Facility Maintenance

In a facility the size and age of CCJ, it is normal and expected that maintenance and repair work would be an on-going

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[62] See, e.g., LSC § 7.3; FPC § 10 (13-160-210).

[63] Although the John Howard Association found "reasonably successful" sanitation efforts in 2007 (Court Monitoring Report at 64), conditions at CCJ were far below compliance with constitutional requirements during our on-site visits.

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challenge. In a correctional setting where inmates and staff are dependent on maintenance staff for their water, heat, lighting, and ventilation, it is also expected that these issues would be addressed in a timely manner in order to reduce risks of illness and injury to inmates and staff alike. That is not the case at CCJ. Work orders generated by correctional staff are transmitted to the Cook County Facilities Management Department. During our site visits, we observed hundreds of maintenance and repair needs, many of which had not been addressed for months. Upon review of work orders generated between February and July 2007, we found 2715 were uncompleted, including many that were more than four months old. With the exception of Division XI, staff uniformly complained about the lack of timely responses to work order requests. The failure to timely process work orders exacerbates the overcrowding issues at CCJ. In Division V alone, more than 100 cells (approximately ten percent of the division's capacity) were closed because of maintenance issues during our July 2007 visit.

Part of the backlog regarding work orders is a result of the division between CCJ's correctional staff and the County Facilities Management Department. Correctional staff are not permitted to undertake any facility repair work. Even a burned out lightbulb in an inmate's cell requires a Facilities Management work order and an electrician to change the bulb. This results in inmates having no lighting in their cells for multiple days in a row, which is especially dangerous when the inmates are locked inside their cells for extended periods.

Electrical hazards were prominent throughout the housing areas and neither correctional officers nor maintenance staff seemed to be concerned about them. During our July 2007 on-site visit, 34 uncompleted work orders for exposed wiring in Division XI dated as far back as February 23, 2007. We frequently observed broken switch plate and receptacle covers with exposed live wires throughout the housing units, including shower and toilet areas where floors were wet, creating a severe shock hazard. In Division VIII, a receptacle in a recreation room was pulled completely away from the wall, with no cover plate. The outlet tested live, which is a major safety hazard to inmates and staff.

Plumbing deficiencies were also abundant. It was common to find that multiple sinks, toilets, and showers were inoperable in a single tier. It was rare to find hot water availability in a cell, and we observed many inmates locked in cells for as long as 26 hours with no access to drinking water. We saw multiple in-

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cell plumbing leaks that resulted in constant cell flooding. Many of these conditions had existed for more than a month.

Serious ventilation issues were observed in some areas. In Division VI, Unit 2-C, 21 out of 22 cells had no ventilation because metal plates had been installed behind the grate on the supply ducts, prohibiting the movement of air into the cells.[64] Although the unit was designed to house 44 inmates, it was overpopulated at the time of our visit and housed more than 60 inmates, with many inmates housed three to a cell and locked in for 26-hour periods every other day. These cells are not big enough to meet generally accepted correctional standards for three inmates.[65] Air quality measurements indicated excessive temperature and relative humidity within the tier. The combination of high temperature and humidity, overcrowding, and lack of air movement creates an unhealthy environment that increases the risk of disease transmission. This particular tier also had exposed wiring in the dayroom; all three of the sinks in the toilet area were out of order; two of the three showers were inoperable; a water leak under the tile on both sides of the bathroom door created a falling hazard; and six burned out lights in the dayroom resulted in unacceptably low light levels.

Finally, as discussed above, conditions in the RCDC intake area are grossly inadequate for the purpose it serves and the number of inmates who are processed through the area each day. Consistent with generally accepted correctional standards, the limited toilets available should serve a dormitory of a maximum of 36 inmates, not the several hundred inmates processed through the RCDC each day. Given the lack of timely responses to plumbing problems at CCJ, it is easy to imagine the filthy

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[64] This condition violated Illinois County Jail Standards 701.120(a)(4).

[65] None of the cells at CCJ are sized to accommodate more than two inmates per cell. In fact, the American Correctional Association waived their sizing standards for portions of the facility to allow accreditation because many of the cells do not meet current standards for housing two inmates. A third inmate in these cells has to place his mattress on the floor of the cell, further reducing the unencumbered space in the cell and making it difficult for the inmates to move around in the cell. The third inmate on the floor is forced to sleep with his face at floor level where he inhales dust particles and airborne allergens that settle to the floor, increasing the risk to the inmate of contracting respiratory infections.

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environmental conditions that exist in the RCDC when the toilets become clogged.

Maintenance and sanitation are categorically inadequate throughout the facility, exposing inmates and staff to unhealthy and unsafe environments as a result.

2. Pest Control

The three major pest problems observed during our site visits involved mice, cockroaches and drain flies. Although mice and cockroaches are nocturnal by nature and are not generally seen in daylight hours, we did observe a few of these during our visits and found evidence of their presence. Staff and inmates alike commented on the presence of mice in the facility and many inmates had towels or other types of barriers across the bottom of their celldoors to keep the mice out of their cells at night. Drain flies are small flies that are found in shower and toilet areas where they lay their eggs in gelatinous organic matter that builds up under the rim of toilets and in floor drains. These flies were noted in several of the divisions including the Cermak medical area where fly traps were being used to capture adult flies. Outbreaks of adult flies have been associated with bronchial asthma in susceptible individuals. Their presence is also a sign of inadequate housekeeping and sanitation.

Except for the food service and Cermak hospital areas, pest control is managed by CCJ staff. CCJ has only one person assigned to conduct pest control for the entire 96-acre facility. While this person is a licensed and certified pest control operator ("PCO"), one person cannot perform adequate pest control for a facility of this size and nature. Staff indicated that the PCO works on an on-call basis to resolve acute problems. Pest control at CCJ is totally a reactive effort. The size of the facility does not allow the PCO to do much follow up or preventive work. We found numerous mousetraps that had heavy layers of dust on them, indicating that little follow up work was done to check the traps and to replace bait as needed.

3. Sanitation Oversight

We were informed that CCJ has a single registered sanitarian on staff. However, upon interviewing the facility's sanitarian, we learned that she was not registered by any state or national professional organization and had no formal education as a sanitarian. She has been in her current position for six years, but has never had an opportunity for any in-service training outside of the department. She also had not had any

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opportunities for training on the few pieces of sanitation equipment provided to her. This lack of training severely limits her ability for professional growth to learn about current environmental health practice as well as emerging environmental issues in correctional facilities such as MRSA. The CCJ sanitarian is not being supported through training and education.

CCJ's sanitarian functions as an inspector who also provides some training to staff on chemical usage. Her inspections duties cover areas such as housekeeping, lighting, plumbing, chemicals, pest control, fire extinguishers, hot water temperatures, and the like. Housekeeping inspections are done by visiting one tier per division per month. Given the facility's size, it could be six months to a year before she is able to make a return visit to a particular tier. She checks hot water temperatures by asking the inmates because she has no tools to measure the temperature. She checks fire drill logs and the inspection tags on the fire extinguishers to make sure documentation is completed, but she has no involvement in the actual fire drills themselves. She checks lighting by looking for burned out fixtures because she has had no training on how to use a light meter. She inspects the kitchen but has no equipment to test or measure anything with to insure that safe food conditions exist in the kitchen. Her last ServSafe© and Illinois Department of Public Health Food Service Certification training occurred in 2001 and expired in 2006. Despite all of the inspection work she does, she has no authority to effect changes in housekeeping practices, food service operations, housing conditions, pest problems, or fire safety issues. In effect, she is an inspector of documentation more than a verifier of actual conditions at CCJ.

Organizational oversight appears to be weak throughout the divisions. We constantly observed conditions that should not have existed if staff were being held accountable for conditions in the housing areas. Staff must be aware of and take action when policies are violated by inmates and unsafe conditions are seen. Staff frequently seemed to turn their back on issues such as obvious safety hazards caused by inmates tampering with electrical outlets, hanging clothes lines from damaged light fixtures in cells or in shower areas, the accumulation of large amounts of commissary items and/or food items in their cells, etc. Apparently no one is held accountable for the poor levels of housekeeping that we observed throughout the jail.

Oversight must also extend to the inmates themselves. They must be held accountable for their actions when they do not adequately clean their cells and dayrooms, when they damage CCJ property, and when they openly violate CCJ policies. Failure to

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enforce inmate accountability greatly increases the maintenance load on staff and creates a higher risk for staff and inmate injuries.

4. Housekeeping

The level of cleanliness at CCJ is very poor. In the housing and medical areas we observed accumulations of dirt, trash, mold, and mildew that had been allowed to exist for long periods of time. Cells frequently had heavy layers of dirt and dust under the bunks and around the toilet areas. Shower areas frequently had dirt, mold, and mildew on walls and ceilings. Toilet areas were extremely unsanitary.

Mattresses are not cleaned and sanitized between uses. Hundreds of mattresses were seen in use that were worn to the point that they were incapable of being cleaned and many covers were missing entirely. Torn and damaged mattresses allow the transfer of harmful pathogens, such as MRSA, from person to person and also serve as convenient hiding places for shanks and other contraband.

5. Food Service

The food service program at CCJ is contracted to the Aramark Corporation, which operates two kitchens, one located in the basement of Division XI and a larger, central kitchen. The kitchens operate under a Health Analysis Critical Control Point process that is approved by the Chicago Department of Health. The food service supervisors currently have ServSafe© and Illinois Department of Public Health Food Service Manager Certifications. They receive outside inspections once or twice a year from the Cook County Department of Public Health and are inspected on a weekly and monthly basis by jail personnel.

The Division XI kitchen prepares approximately 4500 meals per day and operates three shifts per day seven days per week. While sanitation was problematic during our June 2007 visit, the Division XI Superintendent took immediate action and conditions were vastly improved during our July 2007 visit. However, as both of the dishwashing machines in this kitchen had been out of order since March 2007, so all pots, pans, and preparatory utensils are washed by hand without adequate sanitization procedures.

The central kitchen prepares approximately 30,000 meals per day and works 200 inmates per day in four crews. Although the County selects the inmates who work in the food service area,

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Aramark is responsible for their training and supervision. Inmate workers reported that they receive no training prior to working in the kitchen. Aramark staff confirmed that no formal training takes place. The correctional officers who work in the kitchen are responsible only for security.

In March 2007, CCJ found that inmate workers were not utilizing gloves or hairnets, numerous sinks had clogged drains, and excessive garbage was piled on the floor. During our on-site visits, the dishwashing machines had a very heavy scale buildup from hard water deposits that tend to clog spray nozzles and limit the effectiveness and proper washing of food contact surfaces. The floor in the dishwashing area is in poor repair, causing standing water, and is not easily cleanable as required by food codes. The Cook County Department of Public Health cited CCJ on March 13, 2007 for this violation.

The delivery of food to the housing areas is accomplished with non-insulated carts that are loaded from the plating line and held until they are picked up by the staff who are responsible for the delivery. The kitchen supervisor estimated that some carts are held two to three hours between plating and delivery. Because these carts are not insulated or heated, food is allowed to cool to a point at which bacterial growth can occur. Additionally, food was observed being plated at unacceptable temperatures. Food codes require that hot food be held and served at 140 degrees, but we observed food being plated for delivery at 26 to 44 degrees below the required temperatures. The low plating temperatures and significant delays in food delivery greatly increase the risk of food borne disease.

IV. REMEDIAL MEASURES

In order to rectify the identified deficiencies and protect the constitutional rights of inmates confined at CCJ, this facility should implement, at a minimum, the following remedial measures:

A. Protection from Harm

1. Use of Force

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

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

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

(3) Prohibit the use of force as punishment.

b. Establish effective oversight of the use of force.

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

(2) Ensure that management review of incident reports, use of force reports, and inmate grievances alleging excessive or inappropriate uses of force includes a timely review of medical records of inmate injuries as reported by medical professionals.

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

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

(5) Develop and implement policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.

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

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applicable), remedy taken (if appropriate), and administrative sign-off.

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

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

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

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

2. Safety and Supervision

a. Ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise inmates. Discontinue the practice of cross-watching.

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

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

d. Develop and implement policies and procedures requiring all tools, utensils, equipment, flammable materials, etc. are inventoried and locked down at all times.

e. Ensure that staff adequately and promptly report incidents.

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

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

h. Ensure that inmates placed in lock down status are provided with appropriate due process that has been developed and implemented in policies and procedures.

i. Increase use of overhead recording security cameras throughout the common areas of the facility.

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

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

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

m. Revise policies, SOPs, and post orders for all armed posts to include instruction on use of deadly force and when and under what circumstances the weapon should be used.

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

o. Provide formal training on division-specific post orders each time a correctional officer is transferred from one division to another.

p. Implement specialized training for officers assigned to special management units, which include the Special Incarceration Units, disciplinary segregation, and protective custody units. Officers assigned to these units should possess a higher level of experience and be

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regularly assigned to these units for stability purposes.

3. Disciplinary Process

   a. Ensure that inmates are afforded due process for any disciplinary actions against them, including promptly receiving a disciplinary ticket and a fair hearing.

   b. Ensure that disciplinary hearings are conducted in a private setting.

4. Classification

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

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

   c. Update the classification system to include information on each inmate’s history with the Special Incarceration Unit “level system” at CCJ.

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

5. Inmate Grievance Procedure

   a. Develop and implement policies and procedures to ensure inmates have access to an adequate grievance process that ensures that grievances are processed and legitimate grievances addressed and remedied in a timely manner, responses are documented and communicated to inmates, inmates need not confront staff prior to filing grievances about them, and inmates may file grievances confidentially.

   b. Ensure that grievance forms are available on all units and are available in Spanish.

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c. Ensure that inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, referred for investigation.

6. Access to Information

a. Ensure that newly admitted inmates receive information they need to comply with facility rules and regulations, be protected from harm, report misconduct, access medical and mental health care, and seek redress of grievances.

b. Ensure that inmates who are not literate are afforded the opportunity to have information on facility rules and services explained to them orally.

c. Ensure that information on facility rules and services is available in Spanish.

B. Medical Care

1. Intake Screening

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

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

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

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

e. Ensure that tuberculosis (“TB”) screening is conducted in a timely manner.

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2. Acute care

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

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

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

3. Chronic care

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

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

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

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

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

4. Treatment and Management of Communicable Disease

a. Provide adequate treatment and management of communicable diseases, including TB and Methicillin-resistant Staphylococcus aureus ("MRSA").

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

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

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

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

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

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

5. Access to Health Care

a. Ensure inmates have adequate access to health care.

b. Ensure that the medical request process for inmates is adequate and provides inmates with adequate access to medical care. This process

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should include logging, tracking, and timely responses by medical staff.

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

6. Follow-Up Care

a. Provide adequate care and maintain appropriate records for inmates following hospitalization. Ensure that inmates who receive specialty or hospital care are evaluated upon their return to the facility and that, at a minimum, discharge instructions are noted and appropriately provided.

7. Record Keeping

a. Ensure that medical records are adequate to assist in providing and managing the medical care needs of inmates at CCJ.

b. Ensure that medical records are complete, accurate, readily accessible, and systematically organized. All clinical encounters and reviews of inmates should be documented in the inmates' records.

8. Medication Administration

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

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

c. Ensure that medicine distribution is hygienic and appropriate for the needs of inmates.

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9. Medical Facilities

   a. Ensure that sufficient space is available to provide inmates with adequate medical care services including: intake screening, sick call, physical assessment, and acute, chronic, emergency, and speciality medical care (such as geriatric and pregnant inmates).

   b. Ensure that medical areas are adequately clean and maintained, including installation of adequate lighting in medical exam rooms. Ensure that hand washing stations in medical areas are fully equipped, operational, and accessible.

10. Specialty Care

   a. Ensure that specialty consultations are timely and that any resulting reports are forwarded to CCJ staff. Specialist recommendations should be implemented in a timely manner or, where deemed inappropriate, a CCJ physician should properly document why such recommendations were implemented. Provide adequate long-term care planning for inmates with chronic illnesses.

   b. Ensure that inmates are provided adequate access to specialty care in accordance with generally accepted professional standards of care.

   c. Ensure that pregnant inmates are provided adequate care in accordance with generally accepted professional standards of care.

11. Staffing, Training, and Supervision

   a. Provide adequate staffing, training, and supervision of medical and correctional staff necessary to ensure adequate medical care is provided.

   b. Ensure that medical staffing is adequate for inmates’ serious medical needs and that physicians adequately monitor their patients.

   c. Provide adequate physician oversight and supervision of medical staff.

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d. Ensure that there is an adequate number of correctional officers to escort inmates to medical units.

12. Dental Care

a. Ensure that inmates receive adequate dental care in accordance with generally accepted professional standards of care. Such care should be provided in a timely manner.

13. Quality Assurance Review

a. Ensure that CCJ's quality assurance system is adequate to identify and correct serious deficiencies with the medical system.

b. Ensure that CCJ's quality assurance system is capable of assisting in managing and treating inmate medical needs. At a minimum, such a system should be reliable and capable of tracking medical related incidents.

B. Mental Health Care:

1. Timely and Appropriately Evaluate Inmates

a. Ensure CCJ properly identifies inmates with mental illness through adequate screening.

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

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

d. Ensure that adequate crisis services are available to address the psychiatric emergencies of inmates.

e. Provide staffing adequate for inmates' serious mental health needs. Provide adequate on-site psychiatry coverage. Ensure that psychiatrists see inmates in a timely manner. Ensure that psychotropic medication prescriptions are reviewed by a psychiatrist on a regular, timely basis.

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f. Provide adequate screening to properly identify inmates with mental illness. Ensure that CCJ's intake evaluation process includes a mental health screening that is incorporated into an inmate's medical record.

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

2. Assessment and Treatment

a. Ensure that treatment plans adequately address inmates’ serious mental health needs and that the plans contain interventions specifically tailored to the inmates’ diagnoses and problems. Provide therapy services where necessary for inmates with serious mental health needs. Provide adequate opportunities for inmates and staff to have confidential communications related to mental health treatment, while maintaining appropriate security precautions.

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

c. Provide adequate on-site psychiatry coverage for inmates’ serious mental health needs. Ensure that psychiatrists see inmates in a timely manner and that psychotropic medication orders are reviewed by a psychiatrist on a regular, timely basis.

d. Ensure that medications are provided to inmates in a timely manner and that they are properly monitored.

e. Provide staffing adequate for inmates with serious mental health needs. Ensure that services, such as distribution of medications, are performed by nurses or other properly trained staff.

f. Provide policies and procedures that appropriately assess inmates with mental illness.

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g. Provide adequate medical documentation and general procedures as part of the mental health assessments that accounts for inmates' psychiatric histories.

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

3. Psychotherapeutic Medication Administration

a. Ensure timely responses to orders for medication and laboratory tests, and prompt documentation thereof in inmates' charts.

b. Ensure that adequate psychotherapeutic medication administration is provided in accordance with generally accepted professional mental health care standards.

c. Ensure that changes to inmates' psychotropic medications are clinically justified. Screen inmates on psychotropic medications for movement disorders and provide treatment where appropriate.

d. Ensure that inmates receive adequate screening and evaluation for the administration of psychotropic medications in a timely manner.

4. Other Mental Health Issues

a. Ensure that administrative segregation and observation status are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.

b. Ensure that CCJ mental health records are centralized, complete, and accurate.

c. Ensure that CCJ quality assurance system is adequate to identify and correct serious deficiencies with the mental health system.

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d. Ensure that a psychiatrist or physician conducts an in-person evaluation of an inmate prior to a seclusion or restraint order, or as soon thereafter as possible. Seclusion or restraint orders should include sufficient criteria for release.

e. Ensure that all staff who directly interact with inmates (including Correctional Officers) receive competency-based training on basic mental health information (e.g., diagnosis, specific problematic behaviors, psychiatric medication, additional areas of concern); recognition of signs and symptoms evidencing a response to trauma; and the appropriate use of force for inmates who suffer from mental illness.

D. Suicide Prevention Measures

1. Provide adequate treatment for inmates with self-injurious behavior.

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

3. Ensure that all staff are educated and adequately trained on suicide recognition and intervention, including pre-service and annual in-service suicide prevention training.

4. Provide a curriculum for pre-service and annual in-service competency-based suicide prevention training that includes an array of topics so that staff are adequately trained to identify and manage suicide.

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

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

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

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

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

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

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

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

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

14. Provide different levels of supervision of an inmate based on the presenting risk factors for suicide.

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

16. Ensure that cut-down tools are readily available to staff in all housing units. Train staff in use of cut-down tools.

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

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E. Fire and Life Safety

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

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

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

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

5. Ensure that fire alarms are installed and maintained in all housing areas.

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

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

F. Sanitation and Environmental Conditions

1. Sanitation and Maintenance of Facilities

   a. Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.

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

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

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

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

f. Ensure that all inmates have access to needed hygiene supplies.

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

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

i. Secure all sharp medical tools.

j. Destroy any mattress that cannot be sanitized sufficiently to kill any possible bacteria. Inspect and replace as often as needed all frayed and cracked mattresses.

k. Develop a plan to reduce and prevent triple-bunking of inmates in cells designed for two inmates.

l. When triple-bunking of inmates is unavoidable, provide a stackable bunk, moveable platform, or cot for each triple-bunked cell, so that inmates are not required to sleep with the mattress directly on the cell floor.

3. Environmental Control

a. Ensure adequate control and observation of CCJ cells, particularly with regard to razors, fire loading materials, commissary items, and cleaning supplies.

b. Repair electrical shock hazards; develop and implement a system for maintenance and repair of electrical outlets, devices, and exposed electrical wires.

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4. Sanitary Laundry Procedures

   a. Ensure that laundry delivery procedures protect inmates from exposure to contagious disease, bodily fluids, and pathogens by preventing clean laundry from coming into contact with dirty laundry or contaminated surfaces.

   b. To limit the spread of MRSA and other infectious disease, require inmates to provide all clothing and linens for CCJ laundering and prevent inmates from washing and drying laundry outside the formal procedures.

   c. To limit the spread of MRSA and other infectious disease, ensure that clothing and linens returned from off-site laundry facility are clean, sanitized, and completely dry.

   d. Provide all inmates with properly cleaned and adequate bedding and clothing.

5. Food Service

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

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

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

* * * * * * *

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

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns

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regarding CCJ. Assuming there is a continuing spirit of cooperation from the County, we also would be willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195, or Joan Laser, of the United States Attorney's Office, at (312) 353-1857.

Sincerely,

/s/ Grace Chung Becker

Grace Chung Becker
Acting Assistant Attorney General

Patrick J. Fitzgerald
United States Attorney
Northern District of Illinois

cc: Salvador Godinez
Executive Director
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