U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

March 25, 1996

Mr. Ed King
Chairman
Maricopa County Board of Supervisors
301 West Jefferson
Phoenix, Arizona 85003

Re: Maricopa County Jails

Dear Mr. King:

On August 8, 1995, we notified your predecessor, Mr. Rawles, of our intent to investigate conditions at the Maricopa County Jails ("Jails") to determine whether those conditions violated inmates' constitutional rights. The investigation was conducted pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. §§ 1997 et seq., and it focused on allegations of excessive force and denial of adequate medical care. Having concluded our initial investigation, we are writing to advise you of our findings, supporting facts, and recommended remedial measures, as required by CRIPA.

We have concluded that unconstitutional conditions exist at the Jails with respect to (1) the use of excessive force against inmates and (2) deliberate indifference to inmates' serious medical needs. These conclusions and our recommendations for remedial measures are based in significant part, but not exclusively, on the opinions of the two expert consultants whom we retained to advise us in this matter. We already have provided your counsel with the vitae and reports of these experts.

Before we explain our findings and recommendations in more detail, we wish to thank your counsel, Sheriff Arpaio, and the Jails' staff for their unfailing cooperation and assistance. The professionalism and good faith which have pervaded the response to our investigation makes us optimistic that we will be able to resolve the issues raised in this letter in an amicable and efficient manner.

I. LEGAL FRAMEWORK

The constitutional rules regarding both the use of force against inmates and the provision of medical care to inmates are

relatively clear. With respect to inmates who have been convicted of criminal offenses, it is well settled that "the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment." Helling v. McKinney, 113 S.Ct. 2475, 2480 (1993). Under the Due Process Clause of the Fourteenth Amendment, pretrial detainees "retain at least those constitutional rights ... enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). Further, with respect to pretrial detainees, the Fourteenth Amendment prohibits punishment of these persons and restrictive conditions or practices that are not reasonably related to the legitimate governmental objectives of safety, order and security. Bell v. Wolfish, 441 U.S. 520 (1979).

A. Use Of Excessive Force.

Acts of excessive force against convicted prisoners violate the Eighth Amendment. "The Eighth Amendment places restraints on prison officials, who may not, for example, use excessive physical force against prisoners." Farmer v. Brennan, 114 S.Ct. 1970, 1976 (1994). "Being violently assaulted in prison is simply not 'part of the penalty that criminal offenders pay for their offenses against society.'" Id. at 1977, quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981) (referring to inmate-on-inmate assaults).

In excessive use of force cases, plaintiffs must show that officials used such force "maliciously and sadistically for the very purpose of causing harm...." Hudson v. McMillian, 503 U.S. 1, 6 (1992) (internal citations and quotations omitted). Malicious use of force inflicted to cause harm violates the Constitution even in the absence of serious injury. Id. at 7-11.

B. Medical Care.

"[P]rison officials must ensure that inmates receive adequate ... medical care ...." Farmer v. Brennan, 114 S.Ct. 1970, 1976 (1994). "'Deliberate indifference to serious medical needs of prisoners violates the [Eighth] Amendment because it constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency." Helling v. McKinney, 113 S.Ct. 2475, 2480 (1993), quoting Estelle v. Gamble, 429 U.S. 97, 104 (1976). "Deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are 'serious.'" Hudson v. McMillian, 503 U.S. 1, 9 (1992), quoting Estelle, supra, at 104.

The Eighth Amendment protects prisoners not only from present and continuing harm, but from future harm as well. Helling v. McKinney, 113 S.Ct. 2475, 2481 (1993) ("It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition ... on the ground that nothing

yet had happened to them ... a remedy for unsafe conditions need not await a tragic event."). Thus, deliberate indifference to prisoners' serious medical needs violates the Constitution even if that indifference has not yet resulted in injury.

II. FINDINGS AND SUPPORTING FACTS

A. Use Of Excessive Force.

1. Sources of information.

Our findings are based upon several sources: (a) the expert report of Eugene Miller, previously provided to your counsel, (b) interviews with prisoners conducted by personnel from the Department of Justice and the Office of the U.S. Attorney for the District of Arizona, (c) certain videotapes taken at the Jails, (d) documents we requested from the Jails, including grievances, use of force reports, and investigative reports, and (e) written communications sent directly to us by prisoners and former prisoners.

We do not believe it necessary or appropriate to discuss in detail all of the evidence that we have collected. Such a discussion obviously would add substantially to the length of this letter, and it would be somewhat repetitive of Eugene Miller's report. Moreover, while some of the items of evidence that we obtained might be subject to reasonable dispute, we do not anticipate that the Sheriff's Office will disagree with most of our recommendations. If there are disagreements with respect to particular recommendations, we are prepared to discuss the information on which those recommendations are based more fully with Sheriff's representatives. For present purposes, at least, we believe it is sufficient to note that our findings are based in part on videotapes and the Sheriff's own documents, and in part on the number and pattern of the complaints we received from inmates.1/

2. Findings regarding use of excessive force.

We find that the use of excessive force by detention officers has been especially and unacceptably prevalent at three facilities: Intake, Madison Street, and In-Tents. We find the following types of excessive force at those facilities.

a. We find that some Jail staff apply force to prisoners without any initial justification. Examples include using force against prisoners in Intake to hasten movement of prisoners when those prisoners were neither combative nor

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1/ Like Mr. Miller, we recognize that inmate complaints cannot simply be accepted at face value.

resistant; use of a stun gun against a prisoner simply to see its effect; and use of force to send a message (for example, to stop acting up verbally), rather than for control, self-defense, or any other legitimate reason.

b. We find that some Jail staff apply more force than necessary to accomplish a goal which requires some legitimate use of force, such as restraining a combative prisoner. Examples include punching and kicking inmates in the head, shoving or throwing prisoners against walls to gain control, rather than using standard restraint techniques.

c. We find that some Jail staff continue to apply force to prisoners after those prisoners are completely restrained by placement in cuffs or restraint chairs. Examples include use of a stun gun to a prisoner's testicles while in a restraint chair; using stun guns on prisoners in restraint chairs; punching or kicking prisoners in cuffs.

d. We find that some Jail staff engage in the practice of hog-tying prisoners as a form of restraint. We define hog-tying as the cuffing of hands behind the back, the cuffing of feet bent back towards the buttocks, and the attachment together of the wrist and feet restraints. Hog-tying can be life-threatening, particularly when the person so restrained is placed on their stomach. Given alternative restraints available, hog-tying is never justified. See Madrid v. Gomez, 889 F. Supp. 1146, 1168-71 (N.D. Cal. 1995) (practice of hog-tying with arms in front of body may cause serious pain and injury, defendants' experts did not defend practice, and no legitimate penal purpose was advanced for its use); Jones v. Thompson, 818 F. Supp. 1263, 1268 (S.D. Ind. 1993) (hog-tying for extended periods without medical review and with denial of bathroom and personal hygiene needs is not related to legitimate penological interest); Huffman v. Fiola, 850 F. Supp. 833 (N.D. Cal. 1994) (allegation of hog-tying states claim for excessive force). We understand that the Jail's training officers, for whom we have high regard, condemn hog-tying and teach alternative restraint methods to staff trainees. These methods should be used instead of hog-tying.

3. Findings regarding systemic factors facilitating the use of excessive force.

We have concluded that the use of excessive force at the Jails is facilitated by several interrelated systemic factors: inadequate staffing levels, youthfulness and inexperience of jail staff, the overavailability of non-lethal weapons, overcrowding in Intake, insufficient inservice training, inadequate use of force reports, inadequate use of force investigations, and inadequate tracking of potentially problematic staff. These issues are discussed below.

a. We understand that over the past several years, the number of authorized Jail staff positions has not kept pace with the steadily increasing inmate population. Moreover, we understand that approximately 15 percent of the authorized detention officer positions are vacant (in part because the low wage scale for detention officers does not permit the Jail to attract qualified persons to these positions). The result is that the Jails are seriously understaffed, despite the use of substantial amounts of overtime. Both understaffing and excessive reliance on overtime may increase the use of excessive force for several reasons. With fewer staff available to respond, situations requiring staff intervention become more dangerous and threatening, increasing the likelihood that staff who feel outmanned will seek to send a deterrent message to inmates by using force without real provocation or by using more force than necessary. Moreover, staff working overtime are tired and therefore more likely to make mistakes, such as overreacting to a provocation or sending forceful messages as prophylactic measures. We are particularly concerned with staff levels at the In-Tents facility, where it appears that at certain times only two staff members are available to monitor about 800 prisoners. This staffing level is dangerous for both prisoners and staff.

b. Many detention officers are young or inexperienced, or both. Youth and inexperience increase the likelihood of overreaction to inmate provocation because of lack of judgment.

c. Eugene Miller, the expert we retained to advise us about use of excessive force at the Jails, has condemned strongly the fact that all Jail guards carry stun guns, and opines that the easy availability of these weapons has contributed to the use of excessive force.

d. Substantial overcrowding increases the possibility of use of force for the same reasons as understaffing. In addition, overcrowding increases inmate tension and aggression; this increases inmate-on-inmate violence, which may result in staff use of force. The more staff are required to use force, the more opportunities are created for misuse of that force. We are particularly concerned with overcrowding in Intake, where at times inmates are forced to stand because there is not enough room to sit down. That level of overcrowding is dangerous not only from a penological perspective, but from a medical perspective as well.

e. While we are pleased with the quality of the Jails' training officers and pre-service training, we believe that in-service training is inadequate. Professional standards require 40 hours of in-service training yearly, while the Jails provide only eight hours. This lack of necessary training is yet another repercussion of understaffing.

f. Jail policy requires that a use-of-force report be completed after each use of force in the Jails. The purpose of that requirement should be to document fully all information relevant to the precipitating incident and response. We found completed use of force reports to be incomplete and uninformative. Compounding this problem, supervisors responsible for reviewing these obviously deficient reports often do not note or address the problem. Absence of command level monitoring and understanding of the use of force perpetuates problems.

g. Investigations of alleged use-of-force incidents are deficient in several respects. Many of the investigative reports we reviewed were perfunctory and incomplete, and it appears that inmate witnesses (including the alleged victim) often are not interviewed. Moreover, most investigations are handled within the Jail facility in which the alleged incident occurred. Allegations of the use of excessive force are investigated by the Internal Affairs Unit only if authorized by the Sheriff or the Chief Deputy. This system is inadequate to uncover and deter the use of excessive force.

h. Given the perception of some inmates that investigations of allegations of the use of excessive force are biased and inadequate, not all inmates who allege abuse submit grievances. However, the Jails have created a useful database of grievances inmates have filed that could be used to track those use-of-force allegations and identify detention officers who are the subjects of complaints and who, therefore, might be scrutinized more closely or counseled. However, because that capability is not used systematically by all Jail commanders, the Jails are foregoing an opportunity to take a more proactive approach toward use of excessive force.

i. The information that we have obtained is not sufficient to permit us to draw firm conclusions regarding the general adequacy of disciplinary sanctions imposed on Jail staff who use excessive force. However, we would note that appropriate discipline was imposed with regard to the incidents involving inmates Campos and Kolpack, but not with regard to the incident involving inmate Johnson.

B. Denial Of Adequate Medical Care.

1. Sources of information.

We have reviewed and considered inmate grievances and written communications sent directly to us by current and former inmates. However, our findings are based primarily on the report of Dr. Michael Puisis, the Medical Director of the Cook County Jail, which previously was provided to your counsel. We adopt all of Dr. Puisis' findings, the most important of which are outlined below.

2. Findings regarding medical care.

a. Insufficient access to medical care.

i. We understand that in some jail locations inmate workers transport tank orders (requests for medical care), and that detention officers may attempt to resolve medical issues reflected on tank orders prior to (or instead of) forwarding the orders to medical personnel. Both of these practices are dangerous. Inmates should not have control over tank orders for other inmates, and detention officers lack the necessary medical training to make medical decisions.

ii. Many inmates say it takes days or weeks to be seen by medical staff after submitting a tank order. These complaints were corroborated by Dr. Puisis' chart reviews, which showed instances of significant delays in medical treatment after initial inmate complaints.

iii. Compounding the problem of delayed access to care is the fact that inmates who are eventually seen by medical personnel are frequently assessed by persons without sufficient medical training to make sound medical judgments. The Jails currently have only three physicians, and both Towers and Durango, with about 1,000 inmates each, have only two or three days a week of physician coverage. The scarcity of physicians leaves nurses as the major medical decision makers, and many inmates who should be seen by doctors are not. Dr. Puisis' chart reviews showed that nurses are asked to make medical decisions which should be made by physicians, and that some of the decisions they are forced by necessity to make are wrong, resulting in serious injury.

iv. There are problems with the Jails' system of referrals to outside medical sub-specialists in that scheduled appointments are frequently missed; and there are no written policies and procedures for determining when outside specialists should be used.

v. Lengthy delays exist in providing necessary dental services to prisoners, who may wait longer than a month to be seen for serious dental and oral disease. Dr. Puisis' chart reviews corroborate these gross delays in treatment, and reveal the damage that such delays can produce. On one or more occasions numerous inmates broke or chipped teeth on rocks mixed in with their food. The Jails, despite acknowledging that rocks were in fact contained in food, refused to fix inmates' broken teeth.

b. Inadequate medical screening in Intake.

Identifying serious medical and psychiatric problems is a vital component of the process of admitting a new prisoner into the Jails. That process, however, is seriously deficient.

i. Medical intake screening is conducted by regular detention officers, not medical personnel. These officers are trained neither in medical nor mental health screening. Thus, they have no understanding of the questions they ask, the answers they receive, and are incapable of conducting adequately the required visual inspection of new inmates. The officers we observed conducting medical intake interviews did so perfunctorily (in less than 20 seconds) and in a public setting where others could overhear. Public questioning may deter truthful answers about such things as communicable diseases. Questions on the screening forms omitted from the intake screenings we observed included questions about tuberculosis and suicidal tendencies. When questions on the health screening form are not asked, the form nevertheless reflects a "no" answer, which is misleading.

ii. The intake nurse currently must conduct her business in public. Intake has insufficient space for legitimate nursing requirements.

iii. Intake nurses appear to be inadequately trained in dealing with new admissions with psychiatric problems. Such prisoners may wait up to 12 hours before being seen by mental health professionals, and they may be restrained continuously during that time. In general, corrections, not medical, personnel care for mentally ill inmates in Intake.

iv. Current professional standards require that prisoners be given comprehensive physical exams within 14 days of admission to a penal institution. We understand that the Jails meet this timetable less than half the time, and that these assessments can take as long as six weeks. Dr. Puisis' chart reviews show the harm caused by delays in initial diagnoses and treatment.

c. Inadequate protection from infectious disease.

i. The Jails fail adequately to protect staff and prisoners against infectious diseases, including, but not limited to, tuberculosis. The Jails appear not to have an infection control manual; staff training on infectious diseases is poor or non-existent; statistical data on infectious diseases is poor or non-existent; the infection control nurse was poorly informed about crucial aspects of her job; the infection control coordinator has no experience in infection control; and the infection control committee appears not to meet.

ii. Perhaps even more troubling, the Jails fail to screen incoming prisoners adequately for tuberculosis. TB skin tests are administered too infrequently; and when they are done at all, are done too late after incarceration to perform any useful prophylactic function. Medical staff were unable to provide the most basic information about tuberculosis screening, skin tests, and active TB cases. The results of these deficiencies are dangerous. In one case a prisoner with active TB did not have a chest x-ray until a month after incarceration, and he was not isolated until two days later. Another inmate with active TB was incarcerated twice in the general jail population, endangering both prisoners and staff.

d. Inadequate psychiatric care.

It is well known that mentally ill persons account for a significant percentage of those incarcerated in the United States. Thus, any penal system must be equipped and able to deal with the unique and serious issues raised by detaining persons with serious mental illnesses. Although the Jails at one time were at the forefront of positive programs to address these special needs, that once proud status has deteriorated badly. Several recent audits by the court monitor in Arnold v. Sarn were highly critical of psychiatric care, and the response of Correctional Health Services to those audits contained significant admissions of inadequate care.

i. We understand that there have been almost no psychiatric staff increases since 1985, when the prisoner population was roughly one third its present count. Current psychiatric services and physical plant are deficient, which may result in serious harm.

ii. Apparently, psychiatric patients lack access to standard medical care, which must be provided by the psychiatric staff.

iii. There are too few staff at Madison's acute psychiatric unit. Patients in full four point restraints are not checked as often as necessary (while every 15 minutes is the generally accepted standard, patients at Madison can go for hours in restraints without attention).

iv. Detention officers appear to order restraints for psychiatric patients, and they also order inmates who are not mentally ill to be confined in the psychiatric units. Both practices are unacceptable.

v. The acute care facility at Madison is inappropriate, which contributes to deficient care. The facility is designed to house typical inmates, not ones exhibiting serious, active mental illness, and, therefore, is neither

designed to prevent suicides nor to accommodate observation and care for those in restraints. In addition, there is no room at Madison for group or individual therapy, or for ordering a patient temporarily isolated, a more humane alternative to four point restraints.

e. Deficient medical care at In-Tents.

We understand that prisoners on work furlough living at In-Tents are required to obtain medical care outside the Jails, except in emergencies. We noted numerous problems with this arrangement, including undue delays in obtaining medication and denial of access to medical care for prisoners who need more than, or who cannot obtain, visits to outside doctors. We also have serious concerns about the sanitation of the In-Tents facility.

f. Other issues.

i. The Jails are unable to provide adequate on-site emergency care, and patients with critical medical needs often are treated by medical staff other than a physician.

ii. We heard repeated complaints that medications are not timely delivered. The Jails' pharmacy system, in which all medication orders for 6,000 inmates are recorded and kept track of by hand, is antiquated. Inmates are not allowed to keep their own medications, which also contributes to the failure to timely provide all needed medications. This is particularly problematic for inmates who change facilities.

g. Dr. Puisis' chart reviews.

i. Dr. Puisis reviewed 26 patient charts, including the charts of 12 prisoners who died in custody. We cannot emphasize enough the importance of understanding Dr. Puisis' precise and detailed evaluation of the medical care provided these 26 prisoners. In almost every chart Dr. Puisis found significant and sometimes life-threatening problems with medical care. We have profound regret that several prisoners may well have died unnecessarily due to deficient or nonexistent medical or psychiatric care. The problems Dr. Puisis identified can be summarized in the following categories: undue delays in diagnosis and treatment, inadequate diagnosis and treatment, inadequate medical follow-up after diagnosis and treatment, inadequate recordkeeping, and poor communication between medical professionals.

ii. In addition to the problems noted in subsections (a)-(f) above, Dr. Puisis' chart reviews found the following additional concerns: (a) patient charts do not contain problem lists, a standard device used to make reading charts easier and

more efficient; (b) mortality reviews, essential tools for evaluating the quality of medical care, were grossly deficient, failing to identify even the most blatant errors in medical care.

3. Systemic factors responsible for inadequate medical care.

a. We believe that the inadequate medical care at the Jails is due primarily to a severe lack of resources. The Jails have an insufficient number of medical and mental health personnel, which causes or exacerbates the types of problems discussed above. The Jails simply cannot provide adequate medical care when the prisoner population is rising and the medical and mental health budgets are being cut. Many medical service providers at the Jails acknowledged without hesitation that they lacked the necessary resources to perform as they should. To fail to increase necessary resources in the face of those admissions is by any definition deliberate indifference to prisoners' medical needs.

b. We also believe that medical and mental health services at the Jails suffer from a lack of quality control. Many medical departments at state or local institutions attempt to police themselves by means of a quality control process that monitors performance and provides feedback to employees. There are few ways to discover and eliminate problems absent a systematic and deliberate attempt to evaluate the quality of care. The Jails do not have adequate quality control mechanisms, and those they do have (like mortality reviews) are of almost no value.

III. RECOMMENDED REMEDIAL MEASURES

We offer the following recommendations to address the problems discussed above. We do not regard these recommendations as a set of non-negotiable demands; and they leave some details to be worked out. We anticipate discussing our recommendations with the appropriate County officials in the same cooperative spirit that has characterized this matter to date.

A. Use Of Excessive Force.

1. The County should significantly increase the number of authorized staff positions for the Jails as one step to mitigate the current understaffing problem. With respect to specific numbers, we will require further input from Jail administrators.

2. The County should take necessary and appropriate measures to fill all authorized Jail staff positions, to improve staff retention rates, and to increase the age and experience levels of detention officers. Such measures clearly will include

increasing compensation for detention officers (and perhaps other staff as well).

3. Staffing at the In-Tents facility should be increased substantially and immediately. In addition, the practice of assigning inmates with serious felony convictions to In-Tents should be reviewed.

4. The Jails should discontinue the practice of arming all officers with stun guns. These weapons should be able to be accessed only by floor or area supervisors, who can dispense them or authorize their use as needed.

5. All necessary steps should be taken to reduce inmate overcrowding, especially in Intake which should be greatly expanded in physical size and staffing.

6. The Jails should increase in-service staff training to 40 hours per year. That training should focus on, e.g., use of force, including proper restraint techniques, disturbance control and how to handle difficult inmates.

7. The Jails should (a) create a meaningful use of force reporting form and (b) require all corrections officers involved with a use of force incident, even if they only witnessed it, to complete the forms in a complete and thorough manner. Those forms should then be reviewed by supervisors, who should require those forms to be re-done if incomplete, and who should refer any discrepancies in the forms to outside investigators.

8. All allegations of significant use of force -- including those necessitating medical attention -- should be referred to outside investigators for a complete review. Those investigators must interview not only staff, but all inmate witnesses and alleged victims. Jail command staff should have authority to order such investigations.

9. Any person found to have engaged in use of excessive force must be disciplined appropriately, including termination.

10. The Jails should take a proactive stance towards stopping use of excessive force. Command staff (a) should actively and regularly monitor inmate grievances and use of force reports to identify any officers who may be problematic and (b) take appropriate action with respect to such officers (for example, counseling or increased supervision).

B. Medical Care.

We adopt the recommendations contained in the report by Dr. Puisis, the most important of which are summarized below.

1. Staffing. Medical staffing should be increased as follows:

a. Add sufficient RNs and LPNs to perform all intake health assessments. This would increase current staffing by 3.2 fte RNs and 3.2 fte LPNs.

b. Add one RN responsible solely for infection control.

c. Add eight full-time physicians -- one per facility, plus three for intake screening, infirmary and psychiatric patients, and one as medical director.

d. Add one physician's assistant for intake screening.

e. Acute psychiatric units should have continual RN presence in a 1:5 ratio, and mental health technicians or LPNs in a 1:10 ratio. On chronic psychiatric units, the ratios should be 1:15 for RNs and 1:30 for LPNs or technicians.

f. Six full-time psychologists should be added to the psychiatric units and three full-time psychologists should be added to perform intake medical assessments.

g. Each psychiatric unit should be run by an MA-level psychiatric nurse.

h. At least two new dentists should be hired. If that number proves to be insufficient, additional dentists should be hired.

i. Each pharmacist should have two technicians.

2. Quality control. A quality control and improvement program must be implemented which should monitor, provide feedback, and ultimately improve all aspects of medical care, including, but not limited to, delays in diagnosis and treatment, inadequate diagnosis and treatment, recordkeeping, medical personnel communication, use of restraints for psychiatric patients, tuberculosis screening, and treatment plans for psychiatric patients. Mortality reviews, which are a form of quality control and improvement, must be thorough, complete, accurate, and meaningful.

3. Intake. The Jails' intake facilities must be expanded to permit full medical screening of all new prisoners in

privacy. Screenings must be done by registered nurses within the first eight hours of admission. Those with current or chronic problems must be seen by a physician within 24 hours of admission. Screening should include mental health screening by a qualified person.

4. Infection control. The following steps should be taken with regard to infection control:

a. Screening for TB and syphilis should conform to CDC standards. At a minimum, TB skin tests must be administered to all new inmates upon entry. The use of chest radiography should be considered.

b. Sufficient isolation rooms for actively contagious disease carriers should be established.

c. An infection control program should be established, under an active infection control committee, to provide policies and procedures, staff training, exposure control plans, and vaccination and TB testing for inmates and staff, all conforming to CDC and OSHA standards.

5. Tank orders and personal assessments. All inmate requests for medical attention should be forwarded to qualified medical personnel by Jails' staff (not by inmates); and the Jails must make reasonable provision for inmates who cannot effectively communicate in writing and/or in English to request medical care. Necessary personal assessments must take place with reasonable promptness.

6. Off-site and emergency treatment. Specific criteria for providing off-site sub-specialty treatment should be developed and consistently applied, and appointments for such treatment should be timely made and kept. Inmates with emergency medical needs must be given appropriate care, not simply placed in the infirmary.

7. Psychiatric units. Psychiatric units must conform to psychiatric standards, not penal standards. Necessary remedial steps include the following:

a. Potentially suicidal inmates must be in sight and sound contact by staff.

b. Forensic assessments should not be performed by the same psychiatrists who provide clinical treatment.

c. Psychiatric units must not be used for inmates who are not mentally ill; a separate unit for non-mentally ill inmates with behavior problems should be established.

d. Only medical personnel, and not detention staff, should order restraints for mentally ill inmates.

e. Inmates in psychiatric units should have the same access to non-psychiatric medical care as other inmates; and this care should not be provided by psychiatric staff.

f. All psychiatric patients should have treatment plans.

g. Mentally ill inmates should receive the same standard of care as civilians, as delineated in the consent decree in Arnold v. Sarn.

8. In-Tents. In-Tents inmates should receive the same medical care as other inmates. The In-Tents facility should be regularly inspected by public health officials for environmental health risks.

9. Management Tools. An information system, e.g., a computer database system, should be implemented with the following capabilities: index of all prisoners describing medical problems and medications; automated pharmacy system with patient profiles, medicine administration records, and pharmacy labels; schedules for clinical appointments; public health data on infectious diseases; and laboratory test results.

10. Records. Patient records must meet current accepted professional standards for legibility, maintenance of current problem lists, and other core elements.

11. Jail-related medical problems. When the Jail causes injuries to inmates, such as serving food with rocks causing damage to teeth, it should provide the necessary medical or dental care.

12. Dental care. Inmates with serious dental problems must receive prompt treatment.

Neither the preceding outline of recommendations nor the recommendations contained in Dr. Puisis' report are stated in the kind of detail that eventually will be necessary. That is so because we believe that the details should be worked out during the discussions that will follow this letter.

IV. RESOLUTION OF ISSUES

Pursuant to CRIPA, the Attorney General may institute a lawsuit 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, of course, prefer to resolve the issues raised above in the same cooperative spirit