The Honorable Parris N. Glendening
Governor of Maryland
Annapolis, Maryland 21401

Re: Baltimore City Detention Center

Dear Governor Glendening:

We write to report the findings of our investigation of conditions at the Baltimore City Detention Center ("BCDC"). On October 16, 2000, we notified you of our intent to investigate BCDC pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. In addition, 42 U.S.C. § 14141 provides us jurisdiction to investigate the conditions of confinement for juveniles at the facility.

On December 12-15, 2000, January 3-5, 9-12 and April 25-27, 2001, we conducted on-site inspections of the facility with expert consultants in corrections, medical care, mental health care, sanitation, fire safety, juvenile detention and education. While at BCDC, we interviewed correctional and administrative staff, inmates, medical and mental health care providers, fire safety, food service and sanitation personnel, and school staff. Before, during and after our visit we reviewed an extensive number of documents, including policies and procedures, incident reports, medical and mental health records, inmate grievances, use of force records, investigative reports and school documents. Consistent with the statutory requirements of CRIPA, we write to advise you of the results of this investigation.

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

As described more fully below, we conclude that certain conditions at BCDC violate the constitutional rights of inmates. We find that persons confined suffer harm or the risk of serious harm from deficiencies in the facility's fire safety protections, medical care, mental health care, sanitation, opportunity to exercise and protection of juveniles. In addition, the facility fails to provide education to eligible inmates as required by the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1401, et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and violates some inmates' rights to equal protection in the provision of educational services.

I. BACKGROUND

A. FACILITY DESCRIPTION

With portions of the facility dating to 1803, BCDC is Maryland's oldest pretrial detention facility.[(1)] During fiscal year 2000, there were 43,456 persons admitted to BCDC. During our April 2002 visit to the facility, there were approximately 2500 inmates housed at BCDC, of whom about 2000 were awaiting trial. Of these 2500 inmates, there were approximately 125 juveniles ranging in age from 15 to 17 (including a handful of female juveniles) who were charged as adults, and approximately 500 women. These inmates are housed in 5 separate buildings: the Men's Detention Center, the Wyatt Building, the Annex Building, the Jail Industries Building, and the Women's Detention Center. Inmate housing includes single cells, double cells and dormitories. The facility also has modular educational facilities and space for drug treatment programs.

Male inmates with chronic mental illnesses are housed in the Special Needs Unit (SNU). Other inmates with mental illness, both male and female, are housed in Inpatient Mental Health Units (IMHU).

Those with serious medical illnesses are temporarily housed at the infirmary, which for the women is inside the Women's Detention Center. The men's infirmary is located within the Metropolitan Transition Center (MTC), which is a regional facility located nearby, serving four other Maryland state correctional facilities as well as BCDC. Our investigation examined the medical care provided at the infirmary, but did not examine the overall conditions of confinement at that facility.

Alongside BCDC is the Baltimore City Booking and Intake Center (BCBIC). All inmates pass through BCBIC upon intake, but some remain housed there. This facility is operated as a separate institution from BCDC, with its own administrative staff hierarchy. Our investigation examined those functions at BCBIC that impact the services provided to BCDC detainees, such as intake medical screening and processing. This investigation did not examine the overall conditions of confinement for inmates housed at BCBIC.

B. LEGAL BACKGROUND

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights of inmates in jails, prisons and juvenile detention facilities (and the federal statutory rights of juveniles in juvenile facilities). 42 U.S.C. § 1997. Section 14141 of the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, makes it unlawful for any governmental authority to engage in a pattern or practice of conduct by officials with responsibility for the incarceration of juveniles that deprives them of constitutional or federal statutory rights. Section 14141 grants the Attorney General authority to enter a civil action to eliminate the pattern or practice.

With regard to sentenced inmates, the Eighth Amendment's ban on cruel and unusual punishment "imposes duties on [prison] officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care." Farmer v. Brennan, 511 U.S. 825, 832 (1994). Prison officials have a further duty "to protect prisoners from violence at the hands of other prisoners." Id. at 833. The Eighth Amendment protects prisoners not only from present and continuing harm, but from the possibility of future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993). It also forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1 (1992). Medical needs which must be met include not only physical health needs, but mental health needs as well. Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977); Young v. City of Augusta ex rel Devaney, 59 F.3d 1160 (11th Cir. 1995).

With regard to pre-trial detainees, the Fourteenth Amendment prohibits imposing conditions or practices on detainees not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. 520 (1979).

Juvenile detainees at BCDC, at a minimum, have the same constitutional rights as adult detainees. See also Gary H. v. Hegstrom, 831 F.2d 1430 (9th Cir. 1987); Youngberg v. Romeo, 457 U.S. 307 (1982). In addition, as applicable to this investigation, juvenile detainees also possess federal statutory rights under the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq., Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 ("Section 504"), and the Americans with Disabilities Act, 42 U.S.C. §12101 et seq. ("ADA".)

II. FINDINGS

A. FIRE SAFETY

Inadequate fire safety measures at BCDC compromise residents' safety. These deficiencies include

inoperable fire alarm and smoke detection systems, improper maintenance of the sprinkler system, insufficient protection from smoke exposure, excessive combustible materials, and substandard evacuation routes and procedures.

1. Alarm, detection and sprinkler systems

At the time of our visit, BCDC's fire alarm and smoke detection systems were inoperable, and we have not received word of any changes, despite our invitation to the facility to update us on changes since the time of our tours. Some staff members we interviewed were unaware that these systems were not working; thus they had a false sense of security that a mechanical system would detect smoke or fire, when in fact staff and inmate awareness was the only detection system in place.

In addition, BCDC's sprinkler system, which is required to cover all areas from which fire can spread to resident living areas, suffers from serious deficiencies. Many of the sprinkler heads have been painted over or have clothing or other materials hanging from them. In other cases, they are too close to debris, walls or ceilings. These conditions may not only prevent the sprinkler heads from activating promptly during a fire, but also may interfere with the sprinkler head's fire suppressing spray of water after activation. Moreover, there are several locations within the facility in which there is no sprinkler coverage, or sprinkler heads were missing from the fixtures. Finally, the sprinkler main shutoff valves, at the time of our fire safety tour, were neither secured nor electronically monitored. Without proper security, someone could tamper with or deactivate the sprinkler system undetected.

2. Smoke exposure

The facility does not protect residents from dangerous exposure to smoke. For example, the exhaust system in the Men's Detention Center circulates air in such a manner that every cell within a particular cellblock is subject to smoke contamination from the generation of smoke in any cell. Moreover, stairwells in the Men's Detention Center, the Women's Detention Center, the Annex Building, and the Jail Industries Building are not fully enclosed to prevent them from becoming avenues by which heat, smoke, toxic fumes and other products of combustion can spread throughout those buildings. The stairwells in their present condition are also unreliable means of escape, as they provide no protection from heat, smoke, toxic fumes and other products of combustion. In the Annex building, an office space had been constructed on the landing of a stairwell, eliminating its use as an area of refuge protected from smoke or fire.

In addition, in the Men's and Women's Detention Centers, piping and chases (spaces between walls in which pipes are located) create vertical openings through floors which could allow the spread of smoke, debris and fumes during a fire. The Men's and Women's Detention Centers also have walls intended to be smoke barriers that do not effectively keep out smoke, and therefore fail to serve their intended purpose of providing a refuge in the case of fire.

3. Combustibles

Many of the cells and other locations throughout the facility contain excessive amounts of combustible materials including clothing, books, paper, bedding material, and other personal property. These combustibles will help fuel any fire that is ignited in the facility. Similarly, paper bags are used as waste receptacles, which can contribute to the ignition or spreading of fire.

4. Fire and evacuation preparedness

In parts of the Men's Detention Center, the mechanism that allows the staff to release all of the cell doors without a key is inoperable. Furthermore, throughout the facility, staff were unable to identify the keys that open cells or exit doors without looking at the keys. Conditions may arise during a fire which make visual identification impossible, and therefore the inability to identify keys by touch may prevent resident evacuation in cases of emergency.

In other places in the facility, correctional staff responsible for those areas did not carry keys to unlock doors blocking routes for resident evacuation, and there was considerable delay during our fire safety tour in locating the keys. Such delay could be fatal in a fire emergency. Furthermore, officers asked to open other non-occupied spaces such as storage rooms and cleaning supply closets were unable to do so, despite the possibility that staff might need to open such spaces in an emergency.

There are additional problems with the fire evacuation routes in several of the buildings. For example, in the Men's Detention Center, in several sections, residents do not have sufficient alternative methods of exit. Such alternate exits are required to keep occupants from being trapped if the primary exit is blocked by a fire. In the Jail Industries Building, for example, one exit stair discharges into the garage in which a large amount of combustible material is stored, making it an unsafe route of escape from a fire.

During our fire safety tour, officers in at least some buildings seemed unaware of evacuation procedures. This appears to be the result of the failure to conduct frequent fire drills. Many officers could not remember when the last fire drill had occurred. A mock fire drill conducted at our request confirmed that staff are unprepared to evacuate inmates safely in the event of a fire. During the drill, officers did not respond in sufficient number and took too long to arrive on the scene. Officers asked to demonstrate the use of the self-contained breathing apparatus were unable to use the equipment properly with sufficient speed.

The facility relies on the local fire department to respond to any emergency related to fire. However, jail officials have not conducted any emergency planning with the fire department to improve the likelihood of effective emergency response.

5. Problems with particular buildings

The educational and drug treatment buildings have particular fire safety problems. The men's drug treatment building is located close to the Wyatt Building, does not have sprinklers, and contains a high level of combustible material. Thus, there is danger that a fire started in the drug treatment building would spread to the Wyatt Building. Similarly, the women's drug treatment building is located close to the Women's Detention Center and lacks sprinklers. This creates the danger that a large fire, unsuppressed by any sprinkler system, will spread from the drug treatment building to the Women's Detention Center. Finally, part of the drug treatment building blocks access to water that the fire department would use to pump water into the sprinkler and/or standpipe system to fight any fire.

In the Jail Industries Building, newer acoustical ceiling tiles appear to have been installed below older fiber tiles. The older tiles, which should have been removed when new ceilings were installed, are out of reach of the sprinkler system, and are highly combustible.

The education building, a wood frame modular structure, has no sprinkler system. Some of the classrooms have no emergency escapes or have escapes that are blocked by metal security screens. Moreover, this building only has battery operated smoke detectors. Because the alarms are not part of a building-wide system, only an alarm in the immediate area of smoke or fire would sound. The individual

alarms are not loud enough to warn all occupants of the building in the event of a fire, so an alarm might go undetected if rooms near the fire were not occupied.

6. Fire Extinguishers

On our initial safety tour, we noted that fire extinguishers were not inspected or repaired at appropriate intervals. By the end of our on-site investigation work, the extinguisher inspections and repairs had been brought up to date.

B. Medical Care

The provision of medical services to inmates at BCDC is seriously deficient and puts inmates at risk of serious harm.

1. Intake Screening and Assessment

The screening and assessment process is insufficient to ensure that inmates receive necessary medical care in the first few days of their stay at the facility. Inmates arrive at the facility through the Booking and Intake Center. There, an Emergency Medical Technician (EMT) meets arrestees at the entrance and refuses to admit anyone in obvious need of medical attention. An EMT is not there at all hours, however. If there is no EMT, or if the EMT allows admission, the arrestee is brought to an officer for booking and asked a series of personal data and medical screening questions. The booking screen is intended to determine whether the inmate needs prompt medical attention, but the system fails to provide timely treatment to those who need it, and fails to collect accurate information to guide future care.

The officer booking screen process is crucial to the success of the medical intake system, because it is the only formal opportunity an inmate has to signal to the jail that he or she has medical needs and to have those needs addressed for the first 24 hours or more of confinement at the facility. The policy is that arrestees who answer "yes" to any of the questions about medical needs are seen by a triage nurse immediately on site, rather than waiting for the nursing health screen, which is supposed to occur within 24 hours of bail review. In practice, the officer booking screen does not produce accurate information, and the nursing screen is not occurring quickly enough.

Our observations revealed that some officers do not conduct the screen properly. We observed officers filling in the answers on the computer screen before the inmate had given the answer, skipping asking some questions altogether, and putting in answers contrary to what the inmate had responded. Furthermore, the physical setup for the officer booking screen is such that arrestees are asked to respond to questions about confidential medical information in an open space. Sometimes another arrestee is handcuffed at the same booking window. The lack of confidentiality minimizes the likelihood that inmates will respond truthfully to questions about whether they have serious medical or mental illness. This puts the booked inmate and other inmates at risk because inmates may not be provided with timely medical care, and inmates with communicable diseases may be mixed with the general population. Finally, it was unclear from the medical record review whether each inmate even had a booking screen completed. In 65% of the records, no booking screen was to be found in the file, or it was completed improperly.

One inmate died of hypertension and cardiovascular disease on May 19, 2000, after one and a half days at the facility. His file indicated an officer booking screen (with all "no" answers) and no medical screening or other attention during his time at the facility. Investigation revealed that he had needle

tracks on his arms and cocaine and other drugs in his system. While there is insufficient information in his record to determine if medical intervention could have saved his life, it is possible that appropriate screening would have identified potential withdrawal problems that the booking officer did not.

Another inmate died at the facility on July 18, 2000, after being in custody for only 24 hours. His pretrial services information printout indicates that he had a ten-year daily heroin addiction and high blood pressure, and his officer screening indicated that he was on medication for high blood pressure. Despite this information available to the detention center, this inmate's medical record has no indication of contact with a health professional during his stay at the facility. He died of cardiovascular disease, complicated by vomiting and diarrhea, which may have been the result of detoxification from drugs. These and other records reveal that the booking screen process does not sufficiently identify those who need medical attention or observation, nor sufficiently trigger medical care when needed.

Inmates should be seen for screening by a health care practitioner promptly upon entering a detention facility. While we were told that those who answered "yes" to any of the questions would be seen by a triage nurse within an hour (BCDC's policy says "immediately"), in reality it took up to seven hours for those individuals to be seen. This delay is problematic for inmates who may need to receive the next dose of a medication, who are experiencing detoxification from drugs or alcohol, or who suffer from mental illness. Those inmates whose answers were recorded incorrectly, who did not feel comfortable telling the truth about their medical conditions to a non-medical practitioner in this non-confidential setting, or whose booking officers failed to ask the questions might have to wait until the scheduled nursing screen, often three to seven days later, to see a medical practitioner.

Records indicated in some cases that a nursing screen had been performed, and that the nurse determined that the inmate needed to be seen by another medical or mental health practitioner, but the inmate did not receive the care recommended. In other cases, the nurse should have referred the inmate for immediate care, but did not. For instance, in numerous files, the inmate's substance abuse practices indicated the potential need for detoxification or withdrawal treatment yet there was no referral to an appropriate practitioner for such care.

One 15-year-old inmate showed clear signs of suicidality during his receiving screen, stating that he thought he would harm himself. Instead of referring him immediately for appropriate mental health care, medical staff placed him in protective custody and made no attempt to restart the medication he reported to have been prescribed for his attention deficit/hyperactivity disorder prior to incarceration. He was not seen by a mental health professional until 25 days later, after his attorney called to seek attention for him, at which time the psychiatrist evaluated him and ordered medication. Records do not show the patient ever receiving those medications.

Many of the medical records we reviewed did not include record of a nursing screen. If the nursing screen did not occur, this means that inmates whose booking officers completed the booking screen improperly could go for two weeks or longer without medical evaluation, until the history and physical examinations are performed. While the jail's policy requires the history and physical to be done within 14 days of admission, which is the standard of care in the industry, the records we reviewed showed some delays as long as 28 days before this exam was completed.

In addition to delay, the history and physical procedures are also flawed in ways that can be dangerous for inmates. For example, we observed one nurse asking an inmate's history questions too fast for an inmate to respond with needed detail and accuracy. Our chart review indicated that many records had histories with insufficient information recorded in the file.

Interviews with medical staff revealed that in the Women's Detention Center, medical staffing is insufficient to perform complete histories and physicals with the care and time necessary for them to be completed properly. Only one staff member is responsible for all histories and physicals for women entering the facility. One former staff member who had been in that role reported that her job was overwhelming, that she was pressured to complete more exams than she believed she could conduct competently, and that she eventually quit as a result of these conditions.

We were also concerned about the lack of sensitivity to mental health needs. For example, an inmate indicated that he had thought about suicide in the past and might be feeling suicidal currently. The nurse told the inmate, "If you say that, they will strip you naked, put you into a room and send you to mental health." He then said he was not suicidal. Such an approach could allow a suicidal inmate to be placed in the general population without proper mental health attention and precautions to protect him from self-harm.

Our review also revealed that inmates experiencing or with the potential to experience detoxification often do not receive the treatment or supervision necessary for safe withdrawal from drugs or alcohol. We observed one inmate who had arrived at the facility at 5 a.m. and reported experiencing opiate withdrawal. At noon she was just seeing a triage nurse for the first time, and had not been provided any medical attention or treatment for withdrawal. A large number of inmates reported to us that they experienced withdrawal from drugs or alcohol at the facility without any supportive measures, despite reporting symptoms to health care staff and requesting treatment. Our conversations with health staff confirmed that while they have stock medications available for treating drug withdrawal, they rarely use them.

File review revealed many cases in which inmates who were likely candidates for withdrawal did not receive sufficient supervision. For example, an inmate who was eight months pregnant reported a history of daily heroin use. While she received a history and physical one day after arrival at the facility, it took three more days for her to see an OB/GYN. Heroin withdrawal in a pregnant woman can have quite harmful results for a fetus, and it appeared that insufficient attention was paid to this risk.

When health care staff does place male inmates under medical supervision for alcohol withdrawal, the treatment appears adequate. However, the female inmates appear to receive inadequate observation. Only one nurse is available in the Women's Detention Center medical unit to monitor both the infirmary and the mental health unit, which are separated by security doors. Given the potential lethality of alcohol withdrawal, this level of supervision is inadequate.

Finally, inmates who come in to the facility on medications experience serious delays in restarting those medications, including medications needed to control asthma, seizures, mental illness, HIV and blood clotting. In the meantime, they may experience withdrawal symptoms and/or re-experience the symptoms of their illnesses. The failure to provide medications in a timely manner is a serious deficiency in care at this facility.

2. Acute and Emergent Care

BCDC fails to provide adequate medical care for inmates with acute and emergent care needs. Our review indicated that nurses sometimes practice outside the scope of their training and licensure, by failing to refer patients with serious symptoms for appropriate evaluation by a medical practitioner. Some inmates' files revealed that they had requested attention through sick call on several occasions for the same problem without having been referred to a physician assistant, nurse practitioner or physician.

For example, an inmate came to the infirmary after being kicked in the face. He was not referred to a medical practitioner for evaluation. Another inmate had systemic lupus. She went to sick call on several occasions complaining of cough, chest pain and other symptoms which would be consistent with a possible recurrence of her condition, but the nurse never sent her to a higher level practitioner. Another inmate came to sick call complaining of chest pain and headache on at least four occasions without a referral to a higher level provider. Still another inmate with a history of cocaine addiction complained of chest pain and had an elevated blood pressure, a profile putting her at high risk for cardiac disease. She was treated with Tylenol and sent away, when she should have been referred to a higher level practitioner immediately. The medical staff places inmates at risk of serious harm by failing to evaluate serious symptoms at an appropriate level.

Men's Detention Center sick call is conducted in a large room with a desk and numerous chairs. Because it is only one room, without a separate waiting area or sight and sound separation, there is no opportunity to maintain appropriate confidentiality. This both limits the information that an inmate may feel comfortable sharing with the nurse and limits the scope of the examination the nurse can conduct, compromising the quality of care.

Sick call completion is also a large problem. While triage logs reflected that those inmates seen in sick call were generally seen within 48 to 72 hours of their complaint, we also understood from both inmates and staff that many inmates with complaints were never seen in sick call, or that they waited excessively long periods of time. Health care staff reported that some inmates on their scheduled sick call list were never brought to sick call, and that when they tried to contact correctional staff they were told that due to insufficient staff or other reasons the inmate would not be brought to sick call. Inmates reported having to put in more than one request to be seen, or to wait periods up to one month to be seen by medical staff. Correctional staff reported that inmates sometimes had to wait up to 10 days to be seen. Thus, it appears that not all inmates with medical complaints are actually getting to sick call for treatment, and others must wait too long to be seen.

In some instances, practitioners ordered additional care for inmates, but the care was delayed or the inmate never received such care. For example, a 16-year-old with a stab wound was ordered by a doctor during his history and physical to return for removal of stitches four days later. Three days after he should have been seen, the inmate had to file a sick call slip to request that the stitches be removed, and then waited another three days to be seen. The history and physical had noted signs of potential infection, and when he finally saw a nurse, the nurse referred him to be seen by a nurse practitioner or physician for evaluation of pus pockets in the wound. The record has no indication that he was ever seen by the higher level practitioner. These delays and omissions in the course of his treatment put this youth at unnecessary risk of infection. Other examples of failure to complete ordered treatment include orders to monitor elevated blood pressure, laboratory work, dental care and follow-up physician visits.

Because inmates in segregation are isolated, special care must be taken to ensure that their health and mental health are not deteriorating. Inmates at BCDC have insufficient opportunity to communicate confidentially with health care professionals about their needs.

Correctional staff in the Women's Detention Center reported that when they had an immediate need to refer an inmate for care, they were frequently told by medical staff that the health unit was too busy and they could not send someone to the unit, regardless of the inmate's discomfort. In one striking example of lack of responsiveness by the health unit, an inmate had painful lesions on her face, which our expert recognized as Herpes zoster. Many inmates had called her to our attention, because they were concerned for her health as her condition seemed to be worsening. The correctional officer on duty reported that she had to try several times for that inmate to be seen for medical care, and regularly had to "fight" with the nurses to have inmates seen right away when she was concerned that it might be

necessary.

Upon review of the inmate's medical records we discovered that the inmate had been mis-diagnosed in our medical consultant's opinion, and that her condition was deteriorating. Our medical consultant recommended to appropriate medical personnel that she be re-evaluated quickly, as the condition appeared to be spreading closer to her eyes, which had the potential to cause blindness. Even our requests for attention for this woman were not heeded; when we checked back 24 hours later this inmate had not received care. At that point BCDC's lawyer arranged for her immediate attention and she was subsequently hospitalized.

In addition, correctional staff confirmed that access to emergency care can vary depending on which correctional officer an inmate asks or which unit the inmate is on. Staff explained that some staff will not call the medical unit to seek attention for an inmate complaining of emergent symptoms, even though they are trained to do so. This problem may in part be due to the lack of responsiveness the officers receive from the medical department, and in part due to the lean security staffing which allows little time for officers to advocate for inmates or transport them for care.

Staff also reported that there is some delay in getting inmates emergency care from the more remote locations of the jail such as the Jail Industries building. For example, an inmate was stabbed in the Jail Industries building and was first transported through many security gates and doors to the Medical Unit before being brought to a hospital, even though an ambulance could have pulled directly up to the street entrance to the Jail Industries building. Such delay in an emergency such as a stabbing could be fatal. One inmate died at BCDC on December 2, 2000, unable to breathe due to his asthma. Once the correctional officer became aware of the emergency, it took 15 minutes to contact the medical unit. There was no answer when the officer first called.

Our review of inmate deaths revealed several instances in which correctional officers failed to perform CPR, and waited for health care or emergency personnel to arrive instead. In an interview with a nurse by an investigator of a death that occurred at Central Booking on October 29, 2000, the nurse complained that she noted a pattern of correctional officers failing to initiate or assist in CPR.

Especially troubling was a death at BCBIC on November 22, 2000, in which an inmate collapsed and his roommate tried for several minutes to get the attention of corrections personnel before someone responded. Even after that, correctional personnel were on the scene for several minutes before medical staff arrived and began CPR. Brain death occurs within four to five minutes after blood flow to the brain ceases. If CPR is not initiated during this time, then it is likely that the individual will not be revived, or if revived will have serious brain injury. Correctional officers, who are likely the first responders to an inmate emergency, need to be prepared to perform this crucial life-saving skill, and should be trained and supplied accordingly.

3. Chronic Care

In order to properly treat inmates with chronic illnesses, a correctional facility health clinic must see inmates on a regular schedule appropriate to the disease, so that their illnesses may be monitored, the symptoms controlled and documented, and medications delivered and adjusted in a timely manner. BCDC has established lists for chronic care treatment of patients with a variety of chronic illnesses. However, a review of charts illustrates that treatment is not provided on a regularly occurring schedule, medications are frequently not ordered or delivered, recordkeeping is poor, and records do not show timely lab work or physician response to lab reports in some cases.

Treatment of patients with asthma at the facility is especially problematic. Our medical consultant deems that two deaths at the facility attributed to asthma (one in August 1999 and one in December 2000) were preventable if the inmates' conditions had been properly treated. In both cases, the inmates experienced wheezing and required medical intervention in the days prior to their deaths, but relief of their bronchospasms was never achieved. Health care providers failed to bring the inmates back into the clinic for prompt re-evaluation after intervention, to see if treatment had been successful, even though peak flow measures indicated that the patient was in serious jeopardy. The inmate who died December 2, 2000 was last seen in the medical unit on November 17, 2000, at which time he had a severely limited peak air flow and was experiencing severe enough problems to require IV fluids and other treatments. The treating physician ordered that he be re-evaluated in one week, which was insufficient monitoring of his condition as it presented itself. Furthermore, there is no record that the re-evaluation occurred. He died from uncontrolled asthma, struggling to use an inhaler to relieve his bronchospasms. By that point, the inhaler failed to work because he had overused it, due to lack of appropriate treatment and follow-up.

Both medical records and reports from inmates indicated that some inmates had trouble accessing their prescribed inhalers. In several medical records it appeared that inhalers had been prescribed but not provided to the inmates. Records indicate that some inmates' asthma was not stabilized and when they began having problems breathing, the response was not as swift or aggressive as it should have been. Some inmates also reported that they were not allowed to keep their inhalers themselves and that corrections staff sometimes did not allow access when they requested their inhalers. In a building such as BCDC, which is old and poorly ventilated, health care staff should be especially vigilant in its monitoring and treatment of asthma.

The treatment of HIV-positive individuals is also of concern. We noted records in which patients' medication was halted while the facility awaited medical records or awaited approval of nonformulary medications. Because of the risk that patients may develop resistance to HIV drugs, lengthy interruption of medications is especially problematic. One HIV positive individual experienced seizures for the first time, but a nurse never referred her to a higher level practitioner.

It appears that the medical grievance system is failing to provide the safety net that it should for inmates in need of care. The grievance system should respond in a timely manner to remedy failures in the system of care. While BCDC has a responsive grievance system for other matters, the system for medical grievances breaks down due to the need for communication between jail administration and the medical contractor. Despite a facility policy that requires medical grievances to be forwarded to the contractor for response within two days of receipt, and written response from medical within five days thereafter, it took 25 days on average for inmates to receive responses, if they received them at all.

One inmate had asthma and complained that she was not able to get her inhaler and was having attacks. It took almost one month for a response to her grievance, and the response was that the grievance coordinator could not assist until she filled out the section of the form indicating what action she wanted taken. Another inmate was seven and a half months pregnant and wished to be housed in the maternity dorm. She also complained that she had not yet received any medical attention at the facility. Although the grievance was marked received three days after it was written, there was no response for another month. A third inmate complained of chest pains and chills. It was over one month before the grievance reached the grievance coordinator and almost seven weeks before he was seen by a physician.

C. MENTAL HEALTH

BCDC fails to deliver adequate mental health care to its residents who need such services. Specifically, BCDC does not provide adequate access to medication, access to care, and suicide

prevention. Certain conditions in the men's inpatient mental health unit (IMHU) present particular problems.

1. Access to medication

A significant number of newly admitted residents to BCDC do not receive needed psychotropic medications in a timely fashion. During our investigation, we learned of residents who did not receive their medications until a week or even two weeks after their arrival at the facility. Treatment records reveal cases of residents decompensating and requiring admission to BCDC's IMHU because of this delay in receiving medication. One staff member estimated that 25% of the inmates admitted to the men's IMHU had problems due to discontinuation of medications at the time inmates were incarcerated. Sudden withdrawal of some psychotropic medications may have physiological effects in addition to contributing to mental decompensation.

For example, one inmate was incarcerated on December 5, 2000. During a mental health status examination he reported that prior to his incarceration he had been taking Risperdal and Thorazine, which are antipsychotic medicines. At the time of the examination he reported experiencing auditory hallucinations. Two days later he cut himself on his left forearm and was sent to the IMHU. It took five more days before a psychiatrist visited him or prescribed any psychotropic medications.

Another inmate arrived at the facility October 10, 2000, and only began receiving his psychotropic medications on October 20. He attempted suicide on October 26 and required admission to the IMHU. It is likely that his need for an IMHU admission was related to the delay in starting his psychotropic medications after incarceration.

BCDC also fails to ensure that residents in the general population have their psychotropic medications renewed in a timely fashion once prescriptions run out. Again, this failure leads to residents decompensating and having to be admitted to BCDC's inpatient facility. Significant staff shortages contribute to the problems achieving timely delivery of medications to both new and continuing inmates.

Finally, stimulant medications are not available to juvenile residents with diagnosed attention deficit hyperactivity disorder. Failure to provide these medications can cause youth to re-experience symptoms. They may act out in inappropriate ways because they cannot control their behavior, thus leading to increased punishment. In addition, failure to provide medications which youth have been taking for several months may cause physiological effects. Elavil, a anti-depressant which has side effects such as drowsiness, constipation, dry mouth, sedation and slowed mental status is used to treat juveniles at this facility, when other medications with fewer side effects are available and would be more appropriate.

2. Access to care

When residents need mental health services, such services are not provided in a timely fashion. This has led to residents decompensating and requiring admissions, and sometimes multiple admissions to the inpatient mental health units. Inmates do not receive timely follow-up once they have been seen by a mental health provider either. These deficiencies are tied, at least in part, to significant staff shortages.

For example, an inmate submitted a sick call request on December 13, 2000, requesting emergency mental health services. He was not seen until December 30, at which time he was experiencing auditory hallucinations and having trouble sleeping.

Another inmate was admitted to the IMHU on November 7, 2000, after attempting to swallow a razor

blade. He was not seen by a psychiatrist until November 13, and received no medications until November 20, 2000.

A third inmate we interviewed reported experiencing panic attacks following his start on a medication prescribed for him in BCDC that was different from the one he had received before his incarceration. Despite initiating several sick call requests, he had not yet seen a psychiatrist for this problem.

These deficiencies in care continue through the resident's discharge from the facility. Residents do not receive needed psychotropic medications at the time of their discharge from BCDC, nor do staff attempt to connect mentally ill inmates to the community resources they will need upon release.

3. Suicide prevention

There were at least five completed suicides during the six months prior to our on-site investigation of BCDC. For example, on December 18, 2000, a 41-year-old inmate committed suicide. The mentally ill inmate, who appeared to be intoxicated when admitted, was never referred to a mental health professional for evaluation. Moreover, although staff put the inmate on a suicide watch, a nurse discontinued the watch, even though there is no evidence that the nurse performed any assessment. A doctor at BCDC found that the case demonstrated deficiencies in the intake screening and evaluation process. He noted that there was no policy or practice that required a mental health provider to even look at an inmate who during admission admits to a history of mental health problems, but then refuses further evaluation. To date, we have not received any revised policy that would require an inmate who refuses a mental health referral to have a face-to-face mental health evaluation, which would be appropriate practice.

On August 15, 2000, a 29-year-old inmate attempted to hang herself with her paper gown. A physician ordered that she continue in a single cell with suicide precautions and without a paper gown. Despite this order, the next day she committed suicide by tying a paper gown around her neck. Investigators found no explanation as to why she did not receive a suicide smock, and was instead given a paper gown in violation of physician's orders. These and other completed suicides illustrate lapses in the suicide prevention system and also reflect the systemic mental health service delivery problems such as inadequate access to care outlined in this findings letter.

4. IMHU

There are also deficiencies in the care provided at BCDC's inpatient mental health units. As in other parts of the facility, psychiatrists often do not see inmates in a timely fashion, and do not prepare treatment plans. Staff providing care in a setting such as an IMHU should coordinate care to ensure proper follow-through of treatment goals and to solve treatment problems, but this does not occur at BCDC.

Provision of mental health care to women is especially limited. During the time that a psychologist position for women remained unfilled, mental health treatment of female inmates declined due to lack of staff. During the same time, there was an increase in the number of female inmates experiencing severe enough mental health problems that they needed to be admitted to the women's IMHU.

In addition, inmates in the men's IMHU do not have reasonable access to bathrooms. In some parts of that unit, inmates are expected to urinate into bottles instead of having access to toilets. This practice does not meet standards of reasonable care.

The men's IMHU contains two crisis management cells, in which inmates sometimes stay for one to three days. Staff often fail to provide timely mental health assessments or interventions other than medication management, which may result in stays in isolation longer than necessary. Until shortly before our visit to the facility, there was no policy nor procedure governing the use of restraints in the mental health setting. The new policy, not yet implemented, fails to guide staff in the appropriate use of restraints.

D. SANITATION

1. Food service and pests

The food service operation at BCDC does not meet sanitation requirements and puts residents at risk of developing food borne illness.

Food service staff are storing food improperly. For example, trays of food were observed on top of garbage containers prior to service. We also observed food trays being placed on the floor. Major pieces of food storage and service equipment were broken, including refrigerators, ice machines and baking equipment. In addition, we found numerous examples where foods were kept at unsafe temperatures, which could allow for growth of food borne bacteria.

The floors and walls in the kitchen in the Men's Detention Center are not properly sealed, which exposes food to insects and rodents. In fact, insects are a major problem in the facility. Dead roaches and droppings were prevalent in the commissary area of the Jail Industries Building. We found evidence of roaches and rodents throughout the kitchen in the Men's Detention Center, including live roaches in the dishwashing equipment. We also found roach droppings, spiders, and gnats in residence areas throughout the facility. Many parts of the facility are not treated for rodents, especially the utility chases. The improper storage of food service equipment and materials contributes to this rodent problem.

Finally, food utensils, trays, preparation equipment and pots are not always sanitized as required. Some dishwashers do not reach sufficient temperatures to achieve sanitization. Moreover, chemical test strips were not available in many locations, making it difficult for facility staff to test whether sanitization requirements are being met. The hand washing sink in the Women's Detention Center was broken, making it unlikely that food workers were washing their hands when necessary.

2. Plumbing, ventilation, light, electricity

The facility also has serious problems with plumbing, ventilation and lighting. With regard to plumbing, vacuum breakers are missing in various places throughout the facility. Vacuum breakers are crucial to proper sanitation because they prevent introduction of contaminated water into the potable water supply. Moreover, we observed broken toilets throughout the facility, water in showers that was either too hot or too cold for safety and hygiene purposes, and broken lavatory sinks and drains. There were also insufficient shower and lavatory facilities in some places. Showers throughout were dirty and mildewed.

The facility lacks proper ventilation to prevent disease transmission and control odors. For example, a block of rooms in the Women's Detention Center where medically fragile inmates reside was too cold because of windows that allow wind in, and an inadequately balanced heating system. Other parts of the facility were far too hot. Some areas lacked any ventilation at all, or were recirculating stale air. The facility's school trailer was not circulating air properly. When inmates lack adequate personal space in an environment in which ventilation is poor, disease transmission is more likely. Numerous locations in

the facility house inmates too closely together for their health and safety, given the other sanitation problems in existence in this facility.

Lighting at the facility must be a least 20 foot candles to provide for reading, sanitation and personal hygiene. Some showers had no functioning light source, and some dorms had lighting as low as two to seven foot candles. In addition, we found instances of exposed wires, frayed power cords and other electrical shock hazards.

3. Medical examination areas

The medical examination areas present special sanitation concerns. These areas are dirty, equipment is in bad repair, hot water for hand washing is not consistently maintained and some lighting is below acceptable standards. Some examination table covers are torn and cannot be properly cleaned or sanitized. Moreover, medicine refrigerators do not have thermometers to check that proper temperatures are maintained. We observed medication being improperly disposed of in trash cans (which inmates empty and may therefore access the medications) and drugs and food being stored in the same refrigerator as medications, which can lead to contamination.

We also found expired medical equipment. For example, in the Men's Detention Center first floor medical screening area, there were expired Occult Blood Specimen kits. The use of this equipment could lead to errors in diagnosis.

4. Mattresses

Our inspection revealed torn and cracked mattresses throughout the facility. Such mattresses cannot be cleaned or sanitized properly. Furthermore, they present an increased fire risk, as torn and cracked mattresses lose their fire-resistive qualities.

5. Laundry

We observed many inmates washing their clothes in the toilets in their cells. While facility staff claim that inmates have access to utility sinks or can send their wash to the laundry, inmates reported that they do not have time to wash their clothes in the sink and also shower and take care of other needs during their very limited out-of-cell time. They reported that they did not always get their clothes back if they sent them to the laundry.

E. EXERCISE AND OUT-OF-CELL TIME

Residents receive insufficient opportunities for exercise and out-of-cell time. A majority of residents housed in the Men's Detention Center, notwithstanding that they are classified as general population residents, are confined in small cells in excess of twenty-two hours per day. During the winter months, the outdoor recreation yard is closed. As a result, the limited out-of-cell time for Men's Detention Center residents is confined to small indoor day-spaces that do not have room for large muscle exercise, with use of the gymnasium perhaps once per week. The limited out of cell time and opportunity for outdoor exercise provided to inmates can exacerbate the conditions of residents with mental illnesses, and can put inmates, especially the juveniles, at risk of developing anxiety and symptoms of depression.

In 1998, BCDC implemented a violence reduction program which has effectively reduced assaults on staff and other residents, and acts of malicious destruction. However, this has been achieved in large part by increasing the time during which residents are confined to their cells. If residents are allowed out of

their cells to remedy exercise deprivation, security deficiencies that currently exist caused by lack of sufficient correctional staff could be exacerbated and could well lead to increase violence and acts of destruction. In other words, to achieve needed remedies, additional staff will be necessary to avoid security problems. For example, at times only a single officer provides security for each of several units in the Men's Detention Center. When fully double celled these cellblocks each have populations of 120 residents. In double-celling situations, having only one staff member is dangerous because an officer can be overtaken when opening a cell door. Furthermore, no one is available to handle emergencies such as transporting an ill inmate to receive emergency care, when only one officer is on a unit.

The current mixing of security classifications could also threaten resident safety once residents are given more freedom of movement. Residents are assigned to a bed primarily based on space availability, not security classification. Consequently, most housing units contain mixed security levels. Even inmates who commit institutional infractions and are reclassified often are not moved to more secure housing. Current housing arrangements may need to be altered with increased movement of inmates, in order to protect staff and inmate safety.

F. JUVENILE DETENTION

1. Sight and Sound Separation From Adults - Protection from Harm

Boys under age 18 detained at BCDC are housed in four locations, two of which do not provide sight and sound separation between youth and adult inmates. The majority of boys reside in cells in the L Unit, the general population juvenile boys' housing unit. Boys in protective custody reside in the R Unit. In these units, youth are sight and sound separated from adults, as no adult males reside in those units. This is not the case, however, in either the male maximum segregation or medical units, where juveniles and adults are housed side-by-side. None of the girls at BCDC are sight and sound separated from adult women except for girls in the area reserved for protective custody, administrative segregation, and medical quarantine.

Finally, youth are transported to court with adult inmates. Boys are kept in holding cells with groups of men prior to transportation. Only boys on protective custody status are transported separately. Approximately 250 to 300 inmates are transported daily from the holding cell area for male transportation. Inmates await transportation in large holding cells where 25 or more inmates may wait together at one time. While there are many correctional officers present in this area processing people for their trips to court, the holding cells are not closely supervised, nor are there clear sight lines to all inmates in a holding cell. The risk for youth to be victimized in this environment is high.

Failing to sight and sound separate youth from adults in their living areas places them at serious risk of harm, by subjecting them to the undue influence and harassing behavior of adult inmates. For example, girls must pass the women's dormitories on the way to their own, and reported feeling disturbed when adults would frequently yell sexually harassing and frightening comments at them, both in passing and during the night. Such exposure can be psychologically harmful to minors. In addition, in the transportation holding areas and during transportation, where youth and adults are not physically separated, youth are at a risk of physical victimization as well.

2. Excessive Isolation

Some youth are kept isolated in segregation cells for lengthy periods of time that may be psychologically damaging to young people. Juveniles housed at BCDC may be placed in disciplinary segregation for institutional infractions or "supermax" status due to the seriousness of their charges,

sometimes resulting in stays of several months in segregation. These youths are confined 22 to 23 hours per day in single cells, and receive showers approximately twice per week.

Youth generally experience time and confinement more severely than adults. Youth may experience symptoms such as paranoia, anxiety and depression after very short periods of isolation, and thus the lengthy stays in segregation at BCDC are inappropriate.

Youth first admitted to the facility remain on medical quarantine until they are cleared for release into the population. During this time they are single celled on a separate tier of the juvenile unit. While intended to last only two to three days, staff reported that youth sometimes remain under medical quarantine for up to three weeks. During this time, youth are allowed out of their single cells only for an occasional shower or dayroom recreation time, medical appointment or to see the social worker. They are not enrolled in school until after clearing medical quarantine. This extent of isolation is excessive and potentially harmful to youth.

G. EDUCATION

The Baltimore City Public School System operates a school within the walls of BCDC for the minors incarcerated there. The school operates during hours comparable to those of other public schools during the school year, and a partial day during the summer. It has six classrooms at the main school (a collection of trailers on the grounds of the jail), plus one self-contained classroom inside the protective custody unit. Students are assigned to classes based on the last grade in which they were enrolled, with the girls grouped all together with the boys who are working toward their General Educational Development degrees (GED's).

We commend the jail, the State Department of Education and the Baltimore City Public School System for having an organized school program which most minors at the facility attend. However, the education program at BCDC violates the rights of disabled students to a free and appropriate education as defined in the IDEA and Section 504 of the Rehabilitation Act. The school fails to identify and evaluate adequately those suspected of needing special education services. Furthermore, the school does not develop, update or follow Individualized Education Programs for students identified as disabled, and fails to provide most related and transitional services as required by the IDEA.

In addition, BCDC violates girls' rights to equal protection under the law; girls are not provided with educational opportunities and programs comparable to those of their male counterparts, and there is no penological justification for this difference. Youth housed in maximum custody are not receiving adequate education comparable to their general population counterparts (they receive packets of written worksheets with no feedback or instruction) and there is no penological interest served by this deprivation; therefore their equal protection rights are violated as well as their rights to a free and appropriate education if disabled. Finally, youth ages 18 to 21 receive no opportunity for education at this facility.[(2)]

1. Special Education

a. Screening and Identification

The IDEA requires that all children with disabilities who are in need of special education and related services be identified, located and evaluated. Youth who enter the BCDC school are not screened sufficiently for identification of special education needs. The school system fails to transfer records in a timely manner, so the BCDC school generally gathers only a narrow amount of information available by

computer. The school relies on SETS, the computer system from the Baltimore City Public Schools, to determine whether a student was identified as disabled in the Baltimore City Public School System (BCPSS). No further attempt at screening incoming students for disabilities occurs.

This is an insufficient process for screening. Proper screening should include systematic observation of students, interviews and assessment of entering students to determine prior history of special education and/or referral for evaluation for special education eligibility. Staff should also have the opportunity to refer students for special education evaluation when they observe that a student may need services, but the school has no such means for referral.

The test administered to incoming students, the Test of Adult Basic Education (TABE) can only determine the grade level at which someone is functioning, not assess individual skill deficiency or skill acquisition. Thus it is an insufficient screening or assessment tool for meeting the requirements of the IDEA.

b. Evaluation

The IDEA requires that schools conduct a full and complete assessment of students suspected of having disabilities and that the assessment be done by an appropriate evaluation team that includes specialists in the areas of the student's suspected disabilities. While there is a part-time certified school psychologist on staff at BCDC, he does not review previous special education evaluation results, conduct initial evaluations or conduct re-evaluations of students who have or are suspected of having disabilities. The BCDC school staff maintains that because it is a temporary education site and students are not enrolled long enough to complete a three to four month evaluation process, they are not required to identify or evaluate any student.

Students at BCDC, however, are detained from as little as a few hours to as long as a year awaiting trial. The average length of stay for students is 69 days. Thus, many students are enrolled long enough to be evaluated and provided special education services. Even those who leave before the evaluations are complete are entitled to begin the evaluation process, which could then be completed at their home schools.

c. Free Appropriate Public Education and Individualized Education Programs

Individualized Education Programs (IEPs) must be developed for each child determined to be entitled to special education services. The IDEA requires that there be a written document that: states the student's present level of performance; specifies short term instructional objectives that are measurable and within the student's capabilities; sets objective criteria and a timetable for measuring achievement; defines a transition plan and services necessary to help the student move from school to post-school activities; outlines the special education and related services to be provided; describes the extent to which the student will be able to participate in the general education program; and sets forth projected dates for the initiation and duration of services. IEP's must be developed within 30 days of a determination that a student needs special education and related services, and reviewed at least annually. An IEP must be in place each school year.

The BCDC school does not conduct IEP meetings in the manner prescribed by the IDEA nor provide services in keeping with students' IEP's. Charts we reviewed for youth already identified as special education students revealed IEPs as old as 1997. BCDC alters the most recent IEP to match the services currently available at the site, records it on an IEP Minutes Form, then uses this (to a limited extent) to

guide the student's instruction. Without regard to student needs (which BCDC has not evaluated), all students are reclassified as "full-inclusion" and assigned to general education classes, with the expectation that each teacher will provide the necessary modifications of instruction and assignments that each child with a disability needs. BCDC does not provide services such as resource room instruction (prescribed in some students' existing IEP's) to any student. The IDEA does not permit such modification of prescribed services without a determination by the IEP team that such a change in education and services appropriately meets the student's needs.

Furthermore, to the extent that teachers were trying, within the "full-inclusion" model assigned to every student at BCDC, to address the goals and objectives of old IEP's, our review revealed that students are not consistently provided with instruction in keeping with their goals and objectives. The work evidenced in student work files and observed in class was not routinely crafted to fulfill the goals and objectives in students' IEPs. While teachers could name who their students with identified disabilities were, they were not monitoring progress toward goals and objectives nor recording these on students' IEPs. Some staff reported to us that they did not feel prepared or trained to provide modifications to students with disabilities in their classrooms. Classroom observations also revealed that students were not receiving instruction in a manner that kept them on-task and academically engaged. In addition to violating the IDEA, a number of the above findings also indicate failure to comply with the Rehabilitation Act's requirements of a free and appropriate public education.

Finally, BCDC fails to comply with other requirements set forth in the IDEA, such as providing surrogate parents to represent the child in educational decision making where no parent may be located, and providing transition services for teenagers to help them move from school to post-school activities.

2. Education for General Population Girls

Because of the small number of girls detained at BCDC and a desire to keep them safe in their classrooms, staff group the girls together in the classroom with the boys who are working toward their GED's. This means that girls of all ages and grade levels are grouped with boys ages 16 and older who are close to completion of high school equivalency. While the staff's stated goal is to provide individualized instruction to each of the girls at her appropriate grade level, what we observed and what the girls reported was that they were frequently expected to complete the same assignment as the rest of the class, and that only some of their teachers provided a consistent curriculum sculpted to girls' individual levels. Thus, girls do not receive an education of similar quality to that of boys similarly situated.

3. Education for youth in segregation

Boys detained in the maximum security area (M section) of the jail received insufficient educational instruction and services at the time of our visit. An educational staff member brought packets of materials once or twice per week for the boys to complete, but neither he nor anyone else provided feedback or instruction regarding these materials. Boys in the M section reported that they had no idea whether they were receiving any class credit for doing this work, and had no idea whether they had completed it correctly. Since that time, the jail has instituted a policy that provides for education services to juveniles in segregation, including teachers providing assistance with packages of work assignments as needed. We have not been able to verify whether such assistance is being provided adequately.

Girls in administrative segregation, punitive segregation, and protective custody receive even less instruction and services than the boys of similar status. Girls rarely receive education materials while in segregation. The principal of the school reported to us that the staff member responsible for the boys

was gathering materials and providing one on one instruction for the girls as well, but that staff member reported that he never goes to the Women's Detention Center. The girls we interviewed reported that they had not received educational materials while in segregation.

4. Medical Quarantine

BCDC does not allow students to enroll in school until after they have been cleared from medical quarantine upon arrival at the jail. School staff reported that this process takes an average of two weeks, leaving youth without education during this period. This constitutes an unacceptable gap in educational services for students both with and without disabilities. While it is appropriate to ensure that newly-incarcerated youth will not pose a health risk to themselves or others by attending school with the rest of the population, the medical department and the school must coordinate to find a way to avoid lengthy delays in school enrollment and instruction.

III. REMEDIAL MEASURES

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

A. FIRE SAFETY

1) Repair the central fire alarm and smoke detection systems, and ensure that all inmate-occupied areas are protected by sufficiently loud, functioning fire and smoke detection systems.

2) Replace, not just repair, any sprinkler heads that have been painted over or otherwise damaged. Develop and implement policies, procedures and practices to prevent the future painting or damaging of sprinklers.

3) Develop and implement policies, procedures and practices to ensure that sprinkler heads are kept clear of debris and other materials.

4) In those buildings currently having sprinkler systems, install sprinkler heads to cover all areas of the building.

5) Add sprinkler capability to the educational and drug treatment buildings.

6) Move the drug treatment trailer buildings farther away from buildings in which residents are housed.

7) Develop a system to maintain security of the sprinkler shutoff valve.

8) Properly enclose stairwells, piping, chases and smoke barriers.

9) Develop and implement policy, procedures and practices to store all combustible personal property in metal containers.

10) Institute the use of non-combustible waste receptacles.

11) Use door keys that can be identified without the benefit of sight, ensure that all keys to doors on

exit routes are readily available, and train staff in their use.

12) Ensure that there are sufficient exit route options to allow occupants to exit safely in the event of smoke or fire, and maintain those exit routes so that they are free of obstacles, safe and available for use.

13) Conduct regular fire drills and increase staff training in the use of breathing equipment.

14) Train staff in security measures necessary to compensate for any temporary shutoff of the fire and smoke detection systems.

15) Work with the local fire department to develop plans for evacuation and fighting fires at the facility.

16) Ensure that all aspects of fire safety, including training for all staff including preparing and maintaining emergency evacuation procedures and the use of fire protection and suppression equipment are coordinated.

17) Fix inoperable remote locking mechanisms.

18) Install an automatic smoke evacuation system in the plumbing chase areas of the Men's Detention Center.

19) Ensure that fire fighters' access to the sprinkler/standpipe system remains unobstructed.

20) Remove unnecessary combustible material from inside or near inmate-occupied buildings.

B. MEDICAL CARE

1. Intake Screening and Assessment

21) Train booking officers to conduct medical and mental health booking screens properly.

22) Provide for a more confidential environment in which to conduct medical and mental health booking screenings.

23) Develop and implement procedures to ensure that the screen completed by a booking officer becomes part of the inmate's medical record immediately.

24) Train booking officers to look for signs of mental and physical illness in the inmates they interview.

25) Revise and implement procedures to ensure that inmates reporting or exhibiting possible signs of significant medical or mental health problems at booking are seen promptly by a triage nurse and receive appropriate follow-up care.

26) Revise and implement procedures to ensure that all inmates receive medical screening in a timely fashion.

27) Revise and implement procedures to ensure that all histories and physical exams are conducted within 14 days of arrival at the facility.

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

29) Train health care and correctional personnel regarding the signs and symptoms of mental illness.

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

31) Train health care and correctional personnel regarding the signs and symptoms of drug and alcohol withdrawal, and appropriate responses.

32) Develop and implement procedures for validating and continuing, if appropriate, current prescriptions for medications of incoming inmates within 12 hours of arrival at the facility.

33) Staff all medical units with sufficient medical staff to screen and evaluate incoming inmates, and provide adequate treatment and monitoring of inmates with serious medical needs.

34) Provide more complete information regarding treatment availability and options to those incoming inmates experiencing alcohol or drug withdrawal.

35) Develop and implement procedures to ensure that inmates exhibiting signs or known to be at risk of drug withdrawal are questioned by a medical professional regularly during the first three days at the facility regarding their current symptoms and provided information and supportive measures as indicated.

36) Develop and implement policy, procedures and practice for proper recordkeeping of detoxification treatment.

2. Acute and Emergent Care

37) Ensure that nurses provide medical care within the scope of their training and licensure.

38) Develop and implement policy, procedures and practices to ensure that medical staff refer inmates in need of care to the appropriate practitioner in a timely manner.

39) Develop and implement policy, procedures and practices to ensure that inmates receive care from the appropriate level and specialty of practitioner in a timely manner.

40) Train correctional staff regarding their responsibilities to deliver inmates to sick call and other medical encounters.

41) Train correctional staff regarding their role in securing access to acute and emergent care for inmates, and provide adequate staff to accomplish these tasks.

42) Ensure that all correctional officers are certified annually in CPR. Equip all officers with pocket masks and rubber gloves, and make clear the expectation that correctional officers initiate CPR and continue until medical help arrives.

43) Equip units with sufficient numbers of automatic electronic defibrillators, and train staff in their

use.

44) Ensure that juveniles and adult inmates in segregation have adequate opportunities to contact and discuss health concerns with health care staff in a setting that affords as much privacy as security will allow.

45) Staff health units adequately so that inmates requesting acute and emergent care may be treated timely and appropriately.

46) If the facility uses temporary health care providers, ensure that they are trained adequately regarding the special circumstances of correctional health care and the policies and procedures of BCDC in particular.

47) Provide sight and sound privacy for all health care staff-inmate encounters whenever possible.

48) Provide additional training to nursing staff regarding assessment of diseases, appropriate referrals and professionalism.

3. Chronic Care

49) Establish a chronic care system which includes gathering information and establishing medication upon intake into the facility, establishing a system of care of inmates with chronic diseases at established intervals, standardizing the information gathered at treatment visits, and devoting sufficient attention to inmates whose uncontrolled conditions must be stabilized.

50) Develop and implement policy, procedure and practices to ensure that inmates with chronic medications, including inhalers, have access to those medications when appropriate.

51) Ensure that medical grievances are processed and addressed in a timely manner.

52) Develop and implement an accurate, thorough, legible method of medical recordkeeping.

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

54) Address systemic problems revealed through the grievance system.

55) Develop and implement a quality improvement system that monitors and improves deficiencies identified in this findings letter.

C. MENTAL HEALTH

56) Increase staffing levels of mental health professionals to meet the serious mental health needs of the jail's population.

57) Develop and implement policies, procedures and practices to ensure that staff respond to sick call mental health requests in a timely manner.

58) Develop and implement policies, procedures and practices to ensure that staff provide adequate

ongoing care to inmates determined to need such care.

59) Develop and implement appropriate suicide prevention policies, procedures and practices.

60) Residents who are suicide risks should be given suicide smocks rather than paper gowns.

61) Institute an adequate management information system and improve recordkeeping.

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

63) Develop and implement a system to ensure that inmates receive all necessary mental health medications in a timely manner.

64) Provide for inmates in the men's IMHU to have adequate access to toileting facilities.

65) Develop and implement policies, procedures and practices that limit uses of restraint and isolation to circumstances necessary to protect the inmate, other individuals and property of significant value.

D. SANITATION

66) Develop and implement policies, procedures and practices to maintain food temperatures that avoid the growth of harmful bacteria.

67) Develop and implement policies, procedures and practices to properly maintain food preparation and storage equipment.

68) Develop and implement policies, procedures and practices to properly wash and sanitize food preparation and service equipment.

69) Improve the training and supervision of food workers.

70) Ensure that only proper substitutions are made to dietician-approved meal plans.

71) Develop and implement policies, procedures and practices to provide for safe food handling and storage, including proper handwashing.

72) Repair kitchen sinks to prevent sewer gas backup and allow for clean, fresh water availability.

73) Develop and implement policies, procedures and practices to eliminate insects, rodents and their droppings from the facility.

74) Develop and implement policies, procedures and practices to ensure the proper functioning of vacuum breakers.

75) Develop and implement policies, procedures and practices to ensure that water for showers is maintained at an appropriate temperature and that showers are maintained in a sanitary condition and sufficiently available to residents.

76) Provide proper lighting in all parts of the facility.

77) Ensure proper ventilation and maintain proper ambient temperatures.

78) Develop and implement policies, procedures and practices to ensure that toilets, sinks and drains are maintained in sufficient quantity, clean and in proper working order.

79) Repair electrical shock hazards; develop and implement a system for maintenance and repair of electrical outlets and devices.

80) Develop and implement policies, procedures and practices to adequately maintain sanitation in medical areas.

81) Develop and implement policies, procedures and practices to properly store and dispose of medical supplies; dispose of expired medical supplies.

82) Provide adequate opportunity for inmates to wash their clothes by a sanitary method.

E. INMATE EXERCISE AND OUT-OF-CELL TIME

83) Develop and implement a housing and staffing scheme that would permit increased out-of-cell and exercise time for qualified residents in a safe environment. Retain sufficient qualified security officers to staff this plan and provide for safety of inmates and staff.

84) BCDC's Classification Division and the Traffic Office should develop and implement criteria for initial classification and reclassification of residents who should not be housed in a mixed custody environment.

85) Implement procedures to re-examine classification following discipline of an inmate.

F. JUVENILES

86) Ensure that girls and boys under age 18 do not have harmful contact with adult inmates.

87) Reduce use of isolation of minors to only those circumstances necessary for safety of inmates and others.

88) Ensure that isolated minors receive ample out of cell opportunities.

89) Eliminate unnecessary delay in clearing youth from medical quarantine and enrolling them in school.

90) Ensure that youth on medical quarantine receive at least daily visits by a mental health professional.

91) Develop and implement policies, procedures and practices for disciplining youth that are appropriate to their ages.

92) Increase staffing on the juvenile unit to allow for sufficient out of cell time.

93) Train staff regarding youth development, behavior and correctional supervision.

G. EDUCATION

94) Provide free, appropriate public education, including appropriate related and transitional services, for all qualified students with disabilities under the age of 22.

95) Develop and implement effective screening and assessment of students' special education needs. This includes locating, identifying and evaluating all qualified students with disabilities.

96) Revise assessment materials and procedures to allow for development of functional IEP's.

97) Develop and implement curriculum-based evaluation and measurement procedures to monitor student improvement.

98) Create a continuum of educational placement options that meet the needs of the BCDC student body.

99) Train general education teachers who will have special education students in their classrooms to modify and adapt curriculum for students with special needs.

100) Develop and implement systems for special education teachers to monitor student progress in general education classrooms and provide support to general education teachers.

101) Maintain adequate documentation of progress toward IEP goals and objectives.

102) Provide appropriate educational opportunities for youth housed in segregation and medical quarantine.

103) Comply with timelines and requirements for developing, implementing, reviewing and revising IEP's.

104) Develop a functional, integrated and focused educational curriculum.

105) Train all staff in the recognition and provision of appropriate services for special needs students.

106) Provide appropriate space and resources to deliver effective and meaningful instruction to all students.

107) Ensure that girls are provided equal access to individualized regular and special education services.

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

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

Sincerely,

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: The Honorable J. Joseph Curran, Jr.
Attorney General
State of Maryland

Glenn Marrow, Esq.
Assistant Attorney General
State of Maryland

Mr. LaMont W. Flanagan
Commissioner
Division of Pretrial Detention and Services

Mr. Ralph Logan
Warden
Baltimore City Detention Center

The Honorable Thomas M. DiBiagio
United States Attorney for Maryland

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1. The State took over operation of the facility in 1991. House Bill No. 1059, 1991 Laws of Maryland, ch. 59.

2. With regard to the 18 to 21-year-old population, we recognize that the Maryland State Department of Education issued a memorandum date September 10, 2001, to all school jurisdictions reminding them of their responsibility to provide free, appropriate public education to inmates with disabilities under age 22 in locally operated detention centers and correctional facilities. This memorandum was a partial fulfillment of a Commitment to Resolve a complaint to the Office of Civil Rights of the United States Department of Education. We understand that despite the acknowledgement of the responsibility, as yet no education program for 18 to 21 year olds exists at BCDC.