The Honorable James Geringer
Governor of Wyoming
123 Capitol Building
Cheyenne, WY 82002

Re: Wyoming State Penitentiary

Dear Governor Geringer:

I am writing to report the findings of our investigation of conditions at the Wyoming State Penitentiary ("WSP"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. Section 1997 et seq. On October 13-16, 1998, we toured the prison with expert consultants in prison security; correctional health care; correctional mental health care; fire safety; and environmental health and safety.

While at WSP, we interviewed administrators, staff, and inmates and reviewed documents, including policies and procedures, incident reports, and medical records. The investigation focused upon allegations of inadequate supervision of inmates, insufficient officer staffing, crowding, inadequate provision of medical and mental health services, fire hazards, and general sanitation and environmental deficiencies. At the end of our on-site investigation, our expert consultants conducted exit interviews in which they conveyed their preliminary findings. We appreciate the assistance provided by Director Uphoff and prison personnel during our visit.

In addition, we received and reviewed the documents provided to us following our on-site tour and appreciated the opportunity to meet in January to discuss remedial measures the State had implemented or planned to implement in light of our October 1998 tour. We would like to commend you on the prison's proactive approach to problem solving following our experts' exit interviews. We believe that a number of the measures proposed by the State represent important steps to improving conditions at WSP.

Based on our investigation, however, and as described more fully below, we conclude that certain conditions at WSP violate the constitutional rights of inmates. We find that persons confined in WSP risk serious injury from deficiencies in the following areas: medical care, mental health care, security and protection from harm, environmental health and safety, and fire safety. Crowding in the facility exacerbates these deficiencies.

I. LEGAL FRAMEWORK

The Eighth Amendment's ban on cruel and unusual punishment governs conditions of confinement for convicted inmates. It "imposes duties on [prison] officials, who must provide humane conditions of confinement." Farmer v. Brennan, 511 U.S. 825, 832 (1994). In addition to providing "adequate food, clothing, shelter, and medical care ... prison officials have a 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 future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993) ("It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition ... on the grounds that nothing yet had happened to them ... a remedy for unsafe conditions need not await a tragic event.") Like other conditions of confinement, medical care provided to inmates is subject to scrutiny under the Eighth Amendment's prohibition against cruel and unusual punishment. Helling v. McKinney, 113 S. Ct. 2475, 2480 (1993). "Medical needs" include not only physical health needs, but mental health needs as well. Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977).

II. WYOMING STATE PENITENTIARY

A. Introduction

The State of Wyoming opened WSP, located in Rawlins, Wyoming in 1981. WSP operates as the State's primary prison facility, confining minimum, medium, close, and maximum custody state-convicted felons. The prison is comprised of three main housing compounds: West, East, and Central. The West Compound contains three housing areas: A-Star with 96 single cells, B-Star with 96 single cells, and C-Star with 48 single cells. The East Compound contains two housing areas: A-Star with 96 single cells and B-Star with 96 single cells. The Central Compound contains two housing areas: Admissions & Orientation ("A&O") with 32 single cells and the Dorm with 58 beds. In addition, the prison has a ten-bed infirmary and a number of holding cells in each compound.

Over the years, WSP increased the prison's bed capacity through the construction of new cells, addition of five modular housing units, and the increased use of double celling. With the additions, single cell and dormitory capacity is approximately 770. On the West compound, approximately 20 percent of the cells have been designated as double cells. On the East compound, approximately 25 percent of the cells have been designated as double cells. Using all designated double celling, including A&O, the infirmary, and the holding cells, the facility can house 930 inmates. The State projects that in July 2000 it will open a new, 404-bed facility adjacent to the existing prison.

B. Medical Care

WSP provides inadequate medical services, including: physician coverage, medication management and distribution, timeliness and continuity of care, chronic illness management, and medical safety.

1. Staffing and Professional Credentials

WSP provides inadequate physician coverage. At the time of our visit, the prison had only one staff physician and routinely had not been providing physician coverage when the physician was off duty, sick or otherwise unavailable. As a result, WSP frequently experienced periods of a week or more without any physician coverage. Similarly, WSP lacked adequate on-call physician availability for emergency and urgent care needs.

Physician and nursing coverage since our visit has apparently deteriorated further. Documents provided by the Department show that the current medical contractor, Wexford, relies on part-time physicians to provide coverage at the facility. The number of reported hours of coverage amounts to less than one full-time equivalent physician. In contrast, WSP has budgeted an adequate number of medical staff positions for all other medical services. The facility, however, has not hired and retained employees to fill all of the budgeted positions.

At the time of our visit, WSP could not provide documentation of appropriate credentials for its health service professionals. For the psychiatrist and for the Director of Nursing, WSP did not have current licensing information available. Without such information, we could not determine whether these employees were minimally qualified to practice in their fields, or whether they had any licensing restrictions or sanctions.

2. Intake Screening, Sick Call and Medication Continuity

a. Intake Screening

At the time of our site visit, WSP was not performing timely initial health screening for new inmates. Such screenings help ensure continuity of medication and identify communicable diseases. Since our inspection, WSP created a new Pre-Intake Transport Questionnaire and reports that it has assigned a nurse and physician to perform initial inmate examinations. We would like to perform an audit of medical records to assess whether these measures have significantly improved the intake screening process.

b. Sick Call

Inmates consistently complain about the quality and timeliness of WSP's sick call, the method by which inmates generally access medical care at the prison. According to inmates, they must make numerous requests in order to be seen by health care personnel. Once inmates access initial medical assistance, they often complain that the prison fails to follow-up on medication orders or to keep return appointments. Our random review of inmate medical "kites" verified these and related complaints. For example, in seven of ten patients reviewed, WSP medical personnel failed to follow through adequately. In two of these cases, nursing staff received the inmates' sick call medical kites but did not provide any medical attention to the inmates. In another instance, an inmate was seen by a physician who ordered a prescription medication but health care staff failed to provide the inmate with the medication.

Following our visit, WSP adopted a new policy for nurse sick call, which requires daily nurse sick call to be held on each unit of each compound. This policy, if fully implemented with adequate staffing, could ameliorate some of the sick call deficiencies described above.

c. Medication Continuity

WSP medical staff have had considerable difficulty administering prescribed medications. Our review

disclosed numerous instances where WSP failed to provide inmates with prescribed medication. These failures covered a variety of medications, including essential medication for conditions such as diabetes, asthma, and HIV. In most of these instances, WSP failed to document in the medical charts any reason explaining the missed doses. Further inquiry disclosed that WSP's pharmacy routinely ran out of stock of medications. At other times, staffing shortages may have contributed to WSP's failure to administer medication as prescribed.

In addition to lacking documentation for missed doses, medical records also lacked critical information regarding actual doses administered. This haphazard distribution of medication poses significant risk for the health of inmates, particularly in cases where inmates are prescribed antibiotics or medications for blood pressure control, diabetes, and HIV, which require uninterrupted medication administration.

WSP reports that it now delivers medications in a timely manner since its medical provider has contracted with a major supplier of pharmaceuticals in lieu of a smaller pharmacy which proved incapable of meeting the volume demands of the penitentiary. Likewise, in January 1999, WSP adopted a comprehensive policy that allows authorized inmates to "keep on person" a thirty day supply of formulary medications, excluding certain categories of drugs. Another new policy provides for daily pill call on each housing unit. As with other recently adopted measures, it is too early to determine whether these measures will fully address noted deficiencies. Moreover, we have received recent information regarding medical care conditions that describe continuing significant delays and lack of medication continuity.

3. Medication Management

Medication management refers to the manner in which institutions monitor medication usage. Under-utilization, over-utilization and misuse of medications all pose extremely high risk of harm. Our review of more than 100 medical files revealed dangerous patterns of over prescription, polypharmacy, excess prescription of psychotropic medication and excess prescription of pain medication.

Additionally, as described below in the mental health section, at the time of our visit, the primary care physician, without proper expertise, monitoring, or supervision, routinely prescribed psychotropic medications incorrectly.

4. Infirmary Care

We reviewed medical records for all of the current inmates "hospitalized" in the infirmary as well as three of the ten most recently discharged inmates. This review revealed unacceptable levels of care in WSP's infirmary. Inmates in need of medical care often experience excessive delays in the infirmary. For example, an inmate with a fractured jaw waited four days to see an oral surgeon. Other patients did not receive adequate physical examinations or care. For example, WSP failed to monitor nutrition and fluid intake or weight levels of an inmate admitted due to a hunger strike. Meanwhile, for other patients in the infirmary, WSP did not provide admission or discharge notes or document any physical examination, making proper continuity of care extremely difficult, if not impossible to achieve.

5. Referrals to Specialty Services

WSP, in general, appropriately refers individuals for specialty medical care. Review of a random selection of cases disclosed that nine of ten Wexford denials of specialty care recommended by line staff were reasonable. In a few cases, however, WSP's physician failed to respond to Wexford's requests for more information in order to decide whether to grant or deny the referral request. Likewise, in many cases, WSP failed to inform the inmate of the reason for denial of services originally requested by the treating physician. In these cases, WSP provided inadequate care due to the physician's failure to follow through with responses to requested information. In contrast, WSP's in-house specialty care, such as dentistry and optometry, generally provided adequate care in a timely manner.

6. Chronic Care

Patients with chronic diseases, defined here as persons with asthma, diabetes, HIV, and hypertension, typically need repetitive, essentially standardized medical services over extended time spans. Since these medical needs often include routinized tasks, health care providers must plan sufficiently in order to assure that chronic care patients will be seen by appropriate medical personnel and that standardized evaluation and treatment procedures will be followed. Nevertheless, WSP has no chronic disease registry or treatment guidelines for chronic disease management, essential elements of chronic disease management.

Our review of medical records of patients with chronic illnesses showed a significant pattern of disruption in care for the majority of patients whose records were reviewed. Additionally, WSP failed to provide important routine tests or appropriate treatment for chronic conditions. For example, WSP failed to provide peak flow breathing measurement for asthma patients, appropriate antiretroviral care for inmates with HIV, or routine eye examinations for diabetics. Likewise, WSP often did not document whether it had provided periodic electrocardiograms for hypertensive inmates. In sum, review of chronic disease care disclosed a pattern of spotty or nonexistent follow-up. This pattern represents a serious systemic deficiency in medical care at WSP and is related to the prison's failure to adopt standardized care protocols.

7. Medical Safety

At the time of our visit, WSP provided insufficient medical equipment safety procedures to assure inmate and staff well-being. We found numerous lapses in equipment maintenance and inspection. For example, WSP could provide no documentation to show annual inspection or calibration of X-Ray machines. Additionally, WSP's tuberculosis (TB) isolation room lacked sufficient negative pressure to prevent the transmission of TB from an infected individual to an uninfected one. Likewise, WSP utilized surgical masks in lieu of the proper dust mask respirators in medical areas.

Subsequent to our survey, WSP provided extensive documentation regarding replacement of defective X-Ray equipment and contracts for maintenance, inspection and calibration of all X-ray equipment. Moreover, WSP reports that it has purchased a new medical X-ray unit. Likewise, according to WSP,

since our visit, it has purchased equipment to eliminate the air pressure deficiencies.

WSP's policy for the control of blood borne pathogens was significantly outdated and in need of revision. In addition, WSP uses medical examination rooms without proper sanitation facilities including sinks, hot and cold running water and towels. Sound public health and medical safety practices require that medical examination rooms contain hand washing facilities inside of the rooms or immediately nearby (so that touching of doorknobs does not occur). Inadequacies and lapses in basic medical health and safety practices, such as medical sanitation, pose a significant threat to the well-being of all persons confined or employed within WSP.

On May 28, 1999, the State notified us that it terminated its contract with its current medical provider and that it plans to contract with another provider for medical and mental health services at WSP. We are hopeful that these plans will improve care at WSP. We are pleased to accept the State's offer to allow us and our experts to re-tour WSP following a reasonable period of implementation of services by the new provider.

C. Mental Health Care

WSP provides critically deficient mental health services in several respects: staffing, inmate screening (at intake and in administrative segregation), diagnostic assessments, medication practices, seclusion and restraint procedures (particulary with respect to medical monitoring), and psychiatric records. On a positive note, when WSP utilizes *full* suicide prevention measures, it generally does a good job.

1. Staffing

WSP, in addition to housing inmates, performs male inmate reception and orientation for Wyoming's entire prison system. Since WSP functions as a prisoner intake facility and a long-term incarceration facility, it requires a significantly higher mental health services workload than does an ordinary prison of the same size. WSP suffers from inadequate mental health services personnel staffing to meet these needs.

Wexford, the current contractual provider of medical and mental health services, provides a full-time chief psychologist who functions primarily as an administrator; a three-day per week social worker; a part-time psychologist who works approximately four days per month; and a psychiatrist who works only two days per month. The psychiatrist sees approximately 25 inmates per month, but can not keep up with the number of new mental health referrals. Our consultant noted that, in the three months preceding our site visit, WSP had 95 new referrals to mental health and 12 psychiatric emergencies treated in psychiatric observation or suicide watch in the infirmary. Of the 95 referrals, however, WSP administered only six psychiatric diagnostic evaluations during this time period. Due to inadequate staffing, if seen at all, most inmates in need of crisis psychiatric intervention were seen by an infirmary physician rather than by a trained mental health care provider.

WSP's fragmented mental health recordkeeping system and lack of comprehensive treatment plans make it difficult to ascertain the total number of inmates in need of active mental health treatment at any one

time. Based upon the number of inmates receiving psychotropic mental health medication, (147 at the time of our visit), plus the additional 60 or so inmates receiving mild sedative-hypnotics, the actual caseload of inmates requiring psychiatric mental health treatment approaches 20 percent of the inmate population at this facility. Conservatively, on a routine basis, at least 150 inmates require medical evaluation and intervention for chronic psychiatric conditions. Additionally, inmates who present with acute emergency mental health needs also require mental health care.

Despite dedication and hard work, current mental health staff simply cannot keep pace with the volume of work it must perform which includes: providing adequate mental health treatment; planning appropriate treatment plans; maintaining adequate mental health records; screening inmates upon arrival; evaluating inmates to determine appropriate placements within the institution; and dealing with acute mental health episodes.

In an effort to alleviate some of its staffing pressures, WSP has taken some innovative initial steps to install communications with the Wyoming State Hospital to provide "telepsychiatry" services to the prison. At this juncture, however, we are unable to conclude whether this measure will significantly remedy the current lack of adequate mental health staffing because the system is not yet operational.

2. Mental Health Screening

a. Intake

In addition to providing mental health services to inmates in general population with chronic or acute mental health needs, WSP medical and psychological staff spend considerable time evaluating incoming inmates in the A&O unit. This unit receives incoming inmates from county jails. The screening process, particularly evaluations which utilize psychologist services, requires intensive staff participation. Upon intake, corrections staff perform an initial screening designed to capture any mental health emergencies that may require acute care or suicide watch. Meanwhile, a physician may detect other mental health cases during intake medical examinations.

WSP's reception unit refers approximately 10 percent of arriving inmates for mental health services, some of whom arrive at WSP carrying their psychotropic medications with them. Our review of charts disclosed that WSP regularly failed to provide mental health referrals to inmates with clearly documented mental health histories, including histories of hospitalization. As a result, a number of these inmates ultimately deteriorated into psychiatric crisis situations. Other reception inmates requested mental health services but were not seen by mental health staff. Thus, each month, WSP refers a substantially lower number of inmates to mental health services than the number of those actually needing such services.

Classification personnel, who primarily administer psychological tests designed to determine inmate program needs, interview and evaluate mental health referrals from A&O. Although the intake process does capture inmates with immediate mental health needs, chart reviews revealed that WSP failed to refer for mental health services other inmates with clearly indicated mental health histories (for example,

psychotic but in remission) until they were in crisis. Meanwhile, others arriving at the institution who requested mental health assistance did not receive services until they, too, were involved in a mental health crisis. For example, upon admission to the prison, an inmate with a history of state hospitalization requested mental health assistance. Mental health personnel, however, did not see this individual for over a month, waiting until he attempted to commit suicide by slashing his wrists. We found a number of instances where WSP failed to refer inmates with prior mental health hospitalizations for mental health services and did not document the hospitalization information in intake records. These failures place inmates at substantial risk of avoidable harm.

WSP administrators have recently issued an additional guideline to assure that all Pre-Intake Transport Questionnaires that identify seriously ill new inmates will be forwarded to the facility psychologist. This procedure, if followed and if supplemented with adequate staff to provide mental health services, could ameliorate some of the screening and services issues discussed above.

b. Administrative Segregation

The administrative segregation unit houses inmates with behavioral problems and those who must be placed in a punitive setting for rules infractions or for the safety of others. Despite the increased likelihood that the types of inmates assigned to the unit may require mental health services, WSP performs virtually no mental health screening related to the administrative segregation unit. As a result, inmates who had been receiving mental health services outside of administrative segregation experienced discontinuity in care once assigned to the unit. For example, we discovered numerous instances of inappropriate cessation of long-standing mental health medications. Likewise, inmates widely complained of and our chart reviews confirmed a general lack of responsiveness to mental health services requests from administrative segregation unit inmates.

Additionally, WSP's failure to consider mental health issues during disciplinary matters has caused inappropriate or questionable referrals to administrative segregation. For example, in several cases we reviewed, inmates in general population predictably became problematic after WSP inappropriately and suddenly withheld long-standing dosages of benzodiazapines. The discontinuation of medication resulted in irritability, which led in turn to charges of threats and abusive language, and resulted in punitive detention placements in administrative segregation. In another instance, a schizophrenic inmate, unable to urinate due to urinary retention problems caused by psychotropic medications, and who was afraid to urinate in front of other people, was placed in administrative segregation for refusing a urinalysis. In these and many other cases, had mental health staff participated in the administrative segregation referral process, they could have identified the mental health medication issues at the root of the problems and recommended appropriate remedial action. Instead, WSP ignored the mental health issues at the core of these cases and placed the inmates in an environment lacking appropriate mental health services.

3. Medication Practices

WSP staff, on a recurrent basis, improperly prescribe and monitor psychotropic medications used for the treatment of mental illness. A physician without expertise in mental health treatment regularly prescribes a number of powerful psychotropic medications. At times, the physician prescribed such medication

without ever seeing the patient. In some instances the lack of mental health expertise by the prescribing physician resulted in incorrect or dangerous choices of medications, inappropriate polypharmacy, improper and abrupt discontinuances of addicting psychotropics and occasional inappropriate use of emergency medications. We could find no evidence of appropriate and timely medication reviews by experienced psychiatric staff or any policy delineating appropriate roles for non-psychiatric physicians. Medical records frequently contain no justification whatsoever for psychotropic medication treatments, no evidence of regular monitoring for dangerous side effects, and no record of psychiatric evaluation even after a crisis event has occurred.

Additionally, WSP distributes psychotropic medications in a substandard manner. The prison routinely fails to provide prescribed psychotropic medication or provides improper dosages, particularly in the administrative segregation unit. Of further concern, WSP does not monitor inmates adequately to ensure that they do not hoard medications. For example, in one case, an inmate attempted suicide by ingesting hoarded medications obtained from other inmates.

4. Seclusion and Restraint

When WSP places inmates under full suicide watch in the infirmary or in C-Block, it does a commendable job. However, when it places inmates on less than full suicide watch in the infirmary area or in the administrative segregation unit, it places inmates at risk for harm. In fact, on the administrative segregation unit, some secluded inmates suffered serious injuries while not under constant observation.

With respect to restraints, WSP generally uses them for appropriately short time periods and, utilizes proper restraint practices, with one exception--the prison should monitor more closely the hydration of restrained inmates.

5. Treatment Planning and Documentation

WSP lacks adequate mental health treatment planning and documentation for persons needing significant or ongoing mental health services. For example, WSP provides virtually no diagnostic assessments utilizing past treatment records and diagnoses, multi-disciplinary treatment planning, or aftercare planning. WSP's erratic mental health care documentation exacerbates these problems. The prison often fails to document services rendered, mental health records do not contain physicians' orders, and the records have large gaps during periods of critical care.

The Department of Corrections, in March 1999, entered into a Memorandum of Understanding with the Wyoming Department of Health, Division of Behavioral Health, to enhance mental health services at the prison, including: intake and screening issues; mental health treatment plans; crisis intervention; infirmary care; administration of psychotropics; and mental health care documentation. In addition, the prison has created a new position, Associate Warden for Mental Health Services, to coordinate mental health services at WSP. Both of these measures are significant and promising developments. However, given that they are in their formative stages, we are unable to assess the extent of the impact they will have on the mental health issues discussed above.

D. Security and Protection from Harm

At the time of our site inspection, a review of daily shift rosters revealed regular and substantial disparities between the number of security officers required for each shift and the actual number of security officers present during the shifts. According to a 1994 National Institute of Corrections staffing study of WSP, the prison has been plagued by high turnover rates, forcing existing staff to incur substantial overtime on a regular basis. WSP officials, correctional officers, and overtime rosters confirm that staff continue to incur substantial overtime in order to staff necessary posts. Excessive overtime accrual compromises security because exhausted officers are less likely to remain alert or be able to respond adequately to normal or exigent security needs.

The ongoing personnel shortage compromises institutional security and the safety of inmates and staff. Due to short staffing, the prison must routinely call security personnel away from fixed posts in order to provide coverage elsewhere in the facility. When this occurs, the fixed posts remain vacant -- sometimes for substantial periods of time. Likewise, at least two units that house some medium custody inmates have no assigned coverage. As a result, in these units and others, including the Protective Custody unit, inmates comingle for substantial periods of time without direct supervision. Lack of adequate supervision by staff greatly increases the likelihood of inmate-on-inmate violence. To help alleviate this problem, since our visit, WSP developed a post order which requires regular

security officer rounds in particular units. However, given chronic staffing shortages, it is unclear how WSP will implement this new policy without compromising security elsewhere in the facility.

WSP further compromises safety by failing to house some inmates appropriately. Our on-site survey of inmate classification and housing configuration revealed several instances of dangerously inappropriate housing assignments. Due to the increasing population pressures at WSP, space for inmates with special needs is at a premium. For example, WSP failed to provide any special needs restrictions on an inmate despite clear documentation that he was "severely limited intellectually" and "could very easily be misused by other inmates." After WSP placed the inmate in general population housing, he was involved in a serious assault. Despite this history, at the time of our inspection, WSP was double celling this inmate in general population.

In addition, WSP currently houses protective custody inmates in the same housing facility as maximum custody, disciplinary segregation, and death row inmates. In other words, WSP houses the most vulnerable members of the inmate population in the same housing facility as the most high risk inmates, thereby dramatically increasing the risk of harm to protective custody inmates. Protective custody inmates interviewed on-site report receiving numerous and severe threats of violence from maximum custody inmates.

Moreover, within the PC unit, WSP does not adequately classify or supervise inmates. For example, WSP assigned two inmates to the same cell despite the existence for both inmates of well-documented and extensive histories of serious mental health problems and histories of sexual predation. Within a matter of days, a rape was alleged to have occurred involving these inmates. Regardless of the nature of the sexual activity between these inmates, they should not have been housed together or permitted to comingle for substantial periods of time without direct supervision. Due to their documented institutional histories, both of these inmates should have received single cell designations and been housed in a closely supervised special needs environment. In addition, WSP failed to incorporate critical

housing and management information into these inmates' files in a timely fashion. This type of failure substantially increases the likelihood of serious harm to inmates.

Despite the existence of a high security housing policy for inmates found guilty of certain infractions, in addition to the example described above, our review of inmate files revealed numerous instances where WSP failed to reclassify inmates involved in serious disciplinary violations, including assaultive behavior. On a positive note, according to WSP, following our on-site inspection, WSP implemented a policy and practice of reclassifying all inmates at the time of disciplinary hearings. We are particularly encouraged that, WSP, assisted by the National Council on Crime and Delinquency (NCCD), has recently undertaken a comprehensive reevaluation of its classification model. The NCCD consultant intends to present her findings and recommendations to WSP in mid- to late summer, 1999.

WSP further endangers the safety of inmates and staff by maintaining a population significantly in excess of the facility's current design and staffing level. Prior to and during our on-site inspection, we were provided with several documents, each providing different estimates of the facility's safe operational capacity. It is unclear precisely what the facility considers to be the safe operational capacity because we were provided with at least three different estimates of this figure. WSP "Monthly Population Summary" forms calculate excess population using a capacity figure of 710. A 1995 facility study conducted by the Criminal Justice Institute concluded that the "safe and reasonable capacity" for WSP was 786. WSP produced an additional document listing an operational capacity of 821.

Meanwhile, the population count on the first day of our site inspection was 904. Despite the prison's recent transfer of approximately 100 inmates to an out of state facility and efforts to identify additional housing options, WSP regularly operates between approximately 110% to 128% of safe capacity levels. Assuming adequate staffing and supervision, the State's plan to open a new, 404-bed facility could greatly improve these conditions.

Crowding is of particular concern when it exists in combination with deficient security officer staffing levels. Together, crowding, staffing deficiencies, and classification problems drastically decrease the facility's ability to supervise inmates, secure the facility, and provide adequate services.

E. Fire Safety

WSP places inmates and staff occupying the prison at significant risk of serious injury or loss of life in the event of a fire. Despite the fact that the State opened WSP within the past twenty years, it lacks many of the most basic and critical fire safety elements. Our inspection revealed serious deficiencies in fire detection and suppression; occupant protection; ignition and fuel control; and fire safety training and planning.

Smoke inhalation stands as the single leading cause of death in fires, yet virtually none of the inmate living units or gathering areas contain adequate smoke detection devices. WSP's reliance on heat detectors poses an unacceptable risk because smoke and toxic fumes often spread rapidly without the presence of high temperatures. The fact that the majority of the facility does not have an automatic fire suppression system (e.g., sprinklers) exacerbates this problem. Meanwhile, some of the few existing sprinkler heads were painted over or being used as clotheslines and were thus rendered nonfunctional. In

addition, in the Central Housing Compound, the stairs from the second floor discharge onto the first floor instead of discharging directly to the outside. Thus, in the event of a fire on the first floor, inmates on the second floor would have no choice but to exit directly onto the floor of the fire.

Likewise, the excessive presence of improperly controlled combustibles and highly flammable materials throughout the institution and inmate living areas dramatically increases the risk of harm to inmates. Since inmates are locked in their cells, the amount of combustible material should be limited. Yet, in many of the sleeping rooms at WSP, inmates used paper bags as trash receptacles and highly combustible cardboard and wooden containers as storage lockers. Meanwhile, our inspection revealed evidence of cigarette smoking by inmates in cells and by inmates and staff throughout the facility without regard to the presence of highly flammable chemicals and other hazardous materials. For example, the paint shop contained multiple open fifty-five gallon barrels of flammable liquids and evidence of cigarette smoking in the shop. Additionally, WSP had not supplied fire resistant mattresses to some inmates. Elsewhere in the facility, improperly stored and labeled flammable liquids and other chemicals presented serious fire hazards. Throughout the facility, use of electrical extension cords, makeshift electrical repairs, and poor power cord conditions increase the likelihood of fire and electrical shock. According to WSP, since our inspection, it has corrected some of these electrical hazards and intends to conduct regular preventive maintenance inspections.

In several kitchens, WSP had locked in the manager's office the remote pull-pin to activate the stove hood extinguishing system in the event of a fire. In light of the frequency of cooking fires, this practice creates an extremely dangerous environment.

Since WSP does not have any manual fire alarm systems, the only way to alert the facility of a fire is by the use of radios or the actuation of a localized detector or sprinkler head. Many of the staff do not carry radios, and as described above, the existing detectors and sprinkler systems are grossly inadequate. As a result, depending on the location of a fire or smoke buildup, serious injury or loss of life may occur before the fire department ever learns of the fire. WSP has connected its exit signage and emergency lighting to an emergency generator. According to WSP staff, however, the generator does not start unless the main electrical feed into the facility loses power. Thus, if the infirmary or another single building loses power, the generator will only begin if manually started. With respect to critical emergency equipment such as exit signage and emergency lighting, this manual start-up system may cause life-threatening delays.

In correctional facilities, the safety of inmates, in the event of an emergency, absolutely depends upon the rapid unlocking of doors. Nevertheless, during our inspection, WSP staff members were unable to identify emergency keys for unlocking doors. For example, not a single staff member was able to identify appropriate keys without first visually examining them. This deficiency poses extreme dangers because, in the event of a power outage or smoke buildup, visual examination of keys is generally impossible. Several staff members also had difficulty identifying the keys even after visually examining them.

Most of the correctional officers were unable to explain their roles in the event of an emergency. Instead, they appeared to rely excessively upon the shift commander to tell them what to do. Likewise, with the exception of staff members who are also members of the local fire department, WSP staff have not received formal training in the use of fire protection or manual fire extinguishing equipment. Critical

employees, such as those stationed in areas containing fire hoses from a standpipe system, had no training in their use and admitted to having no idea how the equipment worked. While WSP does have an emergency response plan for security-related emergencies, it does not have an emergency response plan for fires or other related emergencies. At the time of our visit, WSP was not conducting regular fire drills. Our consultant conducted a timed drill in the machine shop in order to identify the length of time it would take staff to unlock the shop's rear exit door in the event of a fire or other emergency. A security officer radioed the main control center to request that the door be unlocked. The drill, however, was canceled after ten minutes because no one came to unlock the door.

WSP has recently provided documentation of having conducted several fire and other emergency drills since our inspection. Additionally, it reports plans to continue regular drills and audits of such drills. Significantly, WSP also reports that it has conducted a number of training courses related to fire safety, including: communications, notification procedures,

familiarity with emergency manuals, key identification, and utilization of staff during emergencies. Likewise, WSP reports that it is developing an annual basic fire extinguisher fire suppression course for WSP staff.

F. Environmental Health and Safety

Our inspection revealed improper temperature and contamination control of some foods and inadequate sanitization of kitchen utensils and cooking equipment. Both of these conditions present an unacceptably high risk of food-borne illness and disease outbreak for the entire population. Similar risks result from WSP's inadequate level of pest control. For example, during our tour, we observed several bags of flour that had been torn open by rodents as rodent prints were evident in the spilled flour.

Inadequate tool and key control at WSP create a significant risk of harm to both institutional security and the health and safety of inmates and staff. During our visit, inmates had broad access to dangerous tools which could easily be used as weapons. WSP particularly lacked appropriate tool control in the maximum-side license plate area, maintenance electrical shop, inmate hobby/craft area, and medium-side vocational area.

In the majority of inmate cells sampled by our consultant, lighting was inadequate and registered well below the twenty foot-candles recommended by most experts. As recognized by federal courts, adequate lighting is necessary to maintain hygiene, allow individuals to safely move around, and to prevent eyestrain.

The absence of vacuum breakers at a number of critical locations in WSP's plumbing system jeopardizes the entire potable water supply system. Without the breakers, the facility risks contaminating its water supply due to back-siphonage. Approximately half of the lavatories and showers tested by our expert produced dangerously high water temperatures. Such temperatures can cause serious skin burns and scalding.

In many cases, WSP was unable to provide us with documentation establishing safe environmental health and safety practices. For example, WSP could not produce any evidence of proper disposal of

hazardous waste from the infirmary, automotive, welding, painting and tag shops. Unless properly labeled, stored, and disposed, these materials can cause a variety of serious health problems.

Several areas at WSP pose extreme respiratory health risks. Despite three boiler-related inmate deaths in 1995, during our site visit, WSP could not produce any evidence of having performed regular or recent "safeguard tests" of the boiler operations. Due to the high hazard nature of the boiler room operation and WSP's lethal history in this area, performance and documentation of regular safety tests is critical. Inmate workers in the coal ash operation were not wearing adequate respiratory protection equipment. We observed an inmate worker covered with coal ash from head to toe, including around his nose and mouth. Excessive coal dust exposure can cause respiratory illness and death. Additionally, as detailed in our expert's report, several of the shop areas and modular units are insufficiently ventilated.

In addition to the fire safety, tool control, ventilation deficiencies, and toxic hazards described above, a number of items in the shop areas pose an unacceptably high risk of injury to inmates. For example, all five of the grinding wheels in the auto shop lack protective shields. In the welding shop, the torches do not have flash arresters, the motorized grinding wheel and metallic brush do not have an adequate tool rest, and existing eye protection is in extremely poor condition.

III. REMEDIAL MEASURES

To rectify the identified deficiencies and to ensure that the Wyoming State Penitentiary complies with federal constitutional requirements, the following minimum remedial measures must be implemented:

A. Medical Care

1. Provide sufficient medical care staffing to provide physician coverage five days per week, 52 weeks per year, plus appropriate 24-hour daily on-call arrangements; provide timely sick call response; adequately manage medication; adequately manage chronic illnesses; and ensure proper documentation of treatment in medical records. Maintain updated documentation of professional credential licensing of medical care staff. Credentials should be verified upon initial hire and within a reasonable time afterward at regular intervals.

2. Provide appropriate transfer summaries of new inmates and screen inmates on reception for health problems, communicable disease and medication needs.

3. Establish procedures for evaluating and improving responsiveness to inmate sick call requests. Evaluate follow-up on needed outside specialty care.

4. Institute a medication management program to ensure continuity for ordered medication. Implement a performance measurement to monitor progress with continuity standards.

5. Implement a review process for medication prescribing patterns and monitor medication usage to assure appropriateness.

6. Implement a medically appropriate program to review quality of care for infirmary patients. This would include review of documentation of clinical evaluations, orders and discharges.

7. Implement mortality reviews of all inmate deaths.

8. Create a chronic disease registry that identifies all inmates incarcerated with chronic medical needs. Review and update as needed chronic care guidelines for the management of chronic disease, including asthma, HIV, diabetes and hypertension. Monitor performance of chronic care against these guidelines.

9. Maintain procedures to ensure the timely inspection and maintenance of X-ray equipment and TB isolation room(s). Ensure that TB isolation areas are appropriately negatively pressurized and vented directly to the outside.

10. Provide appropriate sinks, running water and a sanitary environment for any rooms used for medical examination or treatment. Utilize appropriate respirators to protect against disease transmission, including TB, and utilize appropriate masks in boiler room areas.

11. Update blood-borne pathogen control plan to comport with current OSHA requirements and CDC recommendations.

B. Mental Health Care

1. Provide sufficient mental health staffing to screen inmates upon arrival; provide adequate mental health treatment; plan appropriate treatment plans; maintain adequate mental health records; evaluate inmates to determine appropriate placements within the institution; and handle acute mental health episodes.

2. Develop and implement policy and procedure to provide for appropriate monitoring of hydration needs during seclusion and restraint.

3. Develop and implement policy and procedure to manage use of psychotropic medication, including medication reviews and delineation of appropriate roles for non-psychiatric physicians. Newly arrived inmates with verified psychotropic medication should have medication continued and receive prompt psychiatric evaluation.

4. Develop and implement policy and procedure to provide for intake mental health screens, comprehensive diagnostic assessments, and multi-disciplinary treatment plans for inmates with mental health needs.

5. Develop and implement policy and procedure to improve medication distribution practice and medication compliance assurance.

6. Provide enhanced mental health professional presence in the administrative segregation unit, including mental health

screening, psychological evaluations and mental health input into the disciplinary process.

7. Improve staff development for prison healthcare staff, particularly in-service training in management of psychiatric emergencies.

C. Security Officer Staffing and Classification

1. Provide sufficient trained staff to monitor inmates,

respond to emergencies, observe suicidal inmates, supervise out-of-cell activities, satisfy basic medical and other needs, without vacating fixed posts and without excessive reliance upon staff overtime.

2. Improve and implement the inmate classification program

to ensure that: (1) the classification system includes inmate housing assignment considerations beyond merely which facility an inmate should be placed in, i.e., the system should also match special inmate needs with specific housing within individual facilities; and (2) the system provides for adequate tracking of inmates throughout their incarceration, including timely documentation in inmate files of incidents, housing needs, and other classification matters.

3. Identify and utilize additional appropriate

alternative placements for WSP inmates in order to alleviate crowding pending the opening and proper staffing of the new facility.

D. Fire Safety

1. Install a facility-wide sprinkler system at WSP or install smoke detectors and provide smoke tight conditions in all corridors, day rooms, common spaces, and hazardous storage areas in all buildings in which inmates live, work, or enter.

2. Equip each security officer with a radio or install manual fire alarm pull stations at designated locations that only staff may operate.

3. Train all correctional staff in the use of all fire suppression equipment available in the facility.

4. Maintain Self Contained Breathing Apparatus (SCBA)equipment on site and train sufficient staff so that at least two (2) staff persons on each shift are trained and certified in SCBA use.

5. Implement a facility-wide procedure, such as color coding and notching, to quickly identify appropriate emergency keys by touch and sight.

6. Install emergency wall mounted battery-packs for emergency lighting and exit signage in all buildings in which inmates live, work, or enter.

7. Provide every inmate with a fire resistant mattress and replace paper wastebaskets and cardboard and wood storage containers with fire safe containers.

8. Properly label and store flammable chemicals and combustible items in smoke tight rooms or enclosures.

9. Safely make the remote pull-pin readily accessible to kitchen workers for activating the stove hood extinguishing system.

10. Enclose and separate at least one of the stairwells in the Central Housing Compound from the remainder of the first floor.

11. Implement a facility-wide policy on smoking to prohibit smoking in areas where flammable or combustible liquids are stored or used.

E. Environmental Health and Safety

1. Develop and implement measures to prevent the growth of dangerous bacteria in food.

2. Improve pest and rodent control.

3. Implement a preventive maintenance plan, which includes regular comprehensive inspections of boiler room and coal ash operations.

4. Develop and implement a plan, including adequate documentation practices, for the proper disposal of hazardous materials from the infirmary, automotive, welding, painting, and tag shops.

5. Develop and implement a facility-wide respiratory protection program which includes the use of appropriate protective gear, including respirators and SCBAs, and training; and adequate ventilation throughout the facility, including the shop areas.

6. In all inmate showers, provide water at safe temperature levels.

7. Install back-siphonage prevention devices in all locations at risk of water system contamination.

8. Eliminate all electrical deficiencies.

9. Develop and implement adequate facility-wide tool and key control plans.

10. Eliminate safety hazards in all of the shops and develop and implement a safety program for shop operations.

11. Provide a minimum of 20 foot-candles of lighting in all inmate cells. All lighting fixtures should be enclosed in fixtures appropriate for use in a secure setting and free from electrical hazards and unsecured wiring.

* * *

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.

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.

We look forward to meeting with State officials to develop solutions to the noted deficiencies.

Sincerely,

/s/

Bill Lann Lee
Acting Assistant
Attorney General
Civil Rights Division

cc: The Honorable Gay Woodhouse
Attorney General

Ms. Judith Uphoff
Director
Wyoming Department of Corrections

Mr. Everett Vance
Warden
Wyoming State Penitentiary

David D. Freudenthal, Esquire
United States Attorney
District of Wyoming

Return to Jail and Prison Investigations