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January 4, 1999

The Honorable Brian S. Quirk
Chair
Black Hawk County Board of Supervisors
316 E. 5th Street
Waterloo, Iowa 50703

Re: Black Hawk County Jail

Dear Mr. Quirk:

On May 8, 1998, we notified you, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997et seq., that we were initiating an investigation of conditions of confinement at the Black Hawk County Jail ("Jail") in Waterloo, Iowa. In June 1998, we conducted investigative tours of the facility with expert consultants who specialize in the fields of correctional medicine, correctional psychiatry, and penology. During our visits we interviewed administrators, corrections officers, professional staff, contract medical and mental health providers, and inmates. We also observed conditions and facilities at the Jail, including inmate housing areas. Further, we reviewed numerous documents, including facility policies and procedures, intake screening and classification forms, inmate medical and mental health records, incident reports, records of attempted and completed suicides, and minutes of the meetings of the Black Hawk County Correctional Facility Coordination Task Force. Finally, we interviewed a number of former inmates and family members as well as advocates from the community. Throughout the investigative process the administrators and staff of the Black Hawk County Jail have been cooperative and responsive to our requests. We thank them for their assistance. Consistent with CRIPA's statutory requirements, we are now writing to inform you of our findings.

The Black Hawk County Jail, a 272-bed facility, opened in September 1995. At the time of our visits, the Jail housed approximately 240 pre-trial detainees and sentenced misdemeanants, of whom about 160 were from Black Hawk County, 60 were from other counties, and 20 were from the federal system. According to Jail personnel, however, ordinarily about half of the Jail's inmates are from outside Black Hawk County.

The Jail is divided into six housing units, or "pods", each of which house between 36 and 50 persons. Five of the six pods use direct correctional officer supervision, where a deputy circulates among the prisoners while supervising the pod. The sixth pod is a maximum security area that consists of three sections: a section for inmates who have not yet been classified; a section for inmates classified as requiring maximum security; and a special housing unit

("SHU") for inmates in disciplinary or administrative segregation, including inmates who are determined to pose a suicide risk. This pod is supervised by an officer in a secure control center.

The constitutional law governing conditions of confinement for inmates has two sources. With respect to inmates who have been convicted of criminal offenses, the Eighth Amendment's ban on cruel and unusual punishment governs all aspects of conditions discussed here. The Eighth Amendment "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, including mental health care, and must 'take reasonable measures to guarantee the safety of the inmates.'" Farmer v.Brennan, 511 U.S. 825, 832 (1994) (quoting Hudson v. Palmer, 468 U.S. 517, 526-27 (1984)). Pretrial detainees "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Id. at 545. With respect to pretrial detainees, the Fourteenth Amendment prohibits conditions or practices not reasonably related to the legitimate governmental objectives of safety, order and security. Bell v. Wolfish, 441 U.S. 520 (1979). Pretrial detainees have not been convicted of anything and therefore they may not be punished.

Based on our investigation of the Black Hawk County Jail, we have concluded that conditions at the Jail violate the inmates' federal constitutional rights with respect to medical and mental health care, suicide prevention, inmate supervision and protection from harm, and improper use of the restraint chair. We also have serious concerns about other allegations we have received regarding excessive use of force, particularly in the intake area of the Jail. These allegations, which are bolstered by evidence of inadequate documentation and monitoring of use of force by the Jail, will require further investigation.

I. INADEQUATE MEDICAL CARE

The Black Hawk County Jail fails to provide adequate medical care services to inmates. Our investigation revealed serious deficiencies in each major component of the Jail's system for providing medical care, including staffing, intake, sick call, emergency care, and infection control. As a result of these deficiencies, inmates frequently do not receive adequate evaluation or treatment for their illnesses, and there exists an ongoing potential for serious harm or death to the inmate population.

A. Inadequate Physician Involvement

An inadequate level of physician involvement underlies many of the problems in the Jail's medical delivery system. Emergency Practice Associates, a group of emergency room physicians, provides physician services at the Jail on a contractual basis. Under the group's current contract with the Jail, a physician comes on-site once a week for a maximum of one and a half hours. According to sick call calendars kept by the Jail's nursing staff, it is not uncommon

for the physician to see only one or two inmates a week. This amount of physician coverage is inadequate to meet the medical needs of the inmates housed at the Jail. As a result, the Jail's nursing staff[(1)] does not receive adequate supervision and, at times, nurses practice beyond the scope of their licenses. The physician group is only aware of and involved with the patients the nurses refer to them, a very small percentage of the inmates requesting services.[(2)] Nurses routinely diagnose inmates and decide upon treatment plans, or deny treatment, without physician supervision or review.[(3)] As examples set forth below will demonstrate, this puts inmates at high risk for misdiagnosis or improper treatment.

B. Intake/Screening

The Jail's intake screening procedures are not adequate to identify inmates with serious medical needs. Intake medical screening is administered by a civilian booking officer in the Jail's intake area. Inmates in the booking area stand approximately three feet away from the booking officer on a designated spot on the floor. Sensitive questions pertaining to the inmate's medical and mental health, use of medication and suicidal tendencies are asked and answered from that distance, often in the presence of other inmates and Jail staff. This lack of confidentiality in the intake screening process discourages inmates from giving candid answers to health-related questions.

The possibility that inmates will not disclose their medical conditions at intake is particularly problematic at the Black Hawk County Jail, because the facility does not provide routine post-admission health assessments of all inmates who remain at the Jail for extended time periods. Only inmates who self-report their illnesses or are referred by corrections personnel are seen by the medical staff. The absence of routine evaluations, together with the lack of confidentiality in the screening process, creates a significant risk that inmates with serious illnesses (including contagious diseases such as tuberculosis) will not be identified at intake or within a reasonable period of time thereafter.

Morever, even inmates who are identified at intake as having medical problems are not thoroughly examined by the Jail's medical staff. Ordinarily, the nurses do not perform physical examinations or even take the vital signs of the inmates who are seen; rather, "evaluations" consist of asking the inmates questions and following up with calls to private physicians, if any, or to family members, in an attempt to obtain medication. The physician group does not see or even know about these inmates.

One inmate, for example, came into the Jail with a history of hypertension. Although he was not given a physical examination, the inmate's blood pressure was taken and found to be high. The nurse did not call the Jail's physician or do a complete assessment. Instead, she attempted unsuccessfully to get the inmate's medication from his private doctor and his family. Five days later, the inmate complained of a headache and again was found to have high blood pressure. Still, he was not referred to the physician or fully examined. The nurse continued to seek to

obtain the inmate's medication from his family, and gave him one dose from the Jail's supply until the inmate's sister brought in the medication. The Jail's delay in treating this inmate put the inmate at unnecessary risk of serious complications or even death.

This was not an isolated incident. Our review of inmate medical records revealed many examples of incomplete examinations, lack of physician involvement, and delays in treatment for individuals with potentially life-threatening conditions, including HIV, asthma, and chest pain.

C. Sick Call

Inadequate physician input characterizes the sick call process. For the most part, the Jail's nursing staff conducts sick call independently with no physician supervision or review. Fewer than 10 per cent of the inmates requesting sick call are ever seen by a physician. Moreover, the nurses providing sick call have no treatment protocols to follow. As a result, nurses make decisions that they are not qualified to make, placing inmates at high risk of faulty diagnosis and treatment.

One inmate, for example, came to sick call complaining of an upset stomach. The nurse did not take the inmate's vital signs or conduct a physical exam. Two days later the inmate returned, complaining that he had vomited blood. Again, the nurse failed to examine the inmate. Later that day the inmate claimed to have vomited blood again. Still, the nurse did nothing. Finally, the inmate was taken to the hospital for internal bleeding, a condition that could have been life-threatening.

In other instances, the nurses not only practice medicine without a physician's supervision, but actually override decisions made by a physician. For example, an inmate with a history of asthma requested his inhaler, which had been prescribed by a physician. Without evaluating the inmate or consulting a physician, the nurse stopped the medication because, according to nursing notes, she felt he did not need it. Another inmate, who was HIV-infected, returned from an appointment with a physician with a prescription for another condition. After reviewing the inmate's record, the nurse refused to give the inmate the medication ordered because she had previously advised the inmate to exercise and drink water for the same problem. For nurses unilaterally to override physicians' orders in this manner poses a serious health risk to the inmate population.

D. Emergency/Urgent Care

It was difficult to evaluate the Jail's system for providing emergency or urgent care because inmates' medical encounters outside intake or sick call are not recorded in a manner that permits

tracking or quality control. No logs are kept of after-hours encounters with on-call nurses or emergency room physicians. We were told, however, that nurses are the first to be called in the case of an emergency when there is no medical staff on site. To assure accurate diagnoses and sound responses in medical emergencies, physicians should be the first point of contact for emergency care. The physician can then decide whether it is appropriate for a nurse to handle the situation.

E. Absence of Infection Control

The Jail has an inadequate program for infection control. It does not conduct regular testing for either tuberculosis or sexually transmitted diseases, even though it is well established that detainees are at high risk for these diseases. A representative from the Black Hawk County Department of Health confirmed that the risk of exposure to both tuberculosis and sexually transmitted diseases exists in Black Hawk County. The absence of adequate infection control at the Jail seriously threatens not only the health of inmates, but of the Jail staff and the community at large, as well.

F. Inadequate Documentation/Lack of Quality Assurance/Mishandling of Inmate Grievances

The medical record keeping practices at the Jail are deficient. Inmate medical charts are poorly organized and fail to provide the documentation needed to make sound medical judgments and ensure continuity of care. Further, there is no record review or quality assurance program at the Jail to ensure that health care is being delivered in a safe, effective and constitutionally sound manner.

The Jail has established an inmate grievance procedure through which inmates can have complaints concerning medical care, as well as other types of complaints, reviewed. Our analysis of incident reports revealed, however, that in some instances, correctional officers deny inmates access to grievance forms on the ground that the inmate does not have a valid grievance (e.g., "no civil rights were broken"). The withholding of grievance forms defeats the purpose of a grievance system, which is the independent review of inmate complaints. A properly-managed grievance system enhances quality assurance by bringing legitimate complaints and problems to the attention of management, and may lessen tensions in the Jail.

II. INADEQUATE MENTAL HEALTH CARE

The Black Hawk County Jail fails to provide inmates access to adequate mental health care. Many of the systemic deficiencies affecting the delivery of general medical care affect the provision of mental health care as well. In addition, there are significant issues unique to the

Jail's mental health care system.

A. Inadequate Mental Health Staffing

The Black Hawk County Jail contracts with an outside provider to supply mental health services to inmates. Between July 1997 and July 1998, this outside provider was a private mental health group, which consisted of a physician with a background in substance abuse treatment and two licensed mental health counselors.

The County's arrangement with this private provider did not result in an adequate level of mental health staffing at the Jail. The group did not include a psychiatrist and, therefore, could not provide a full range of mental health services. As a result, between July 1997 and July 1998, the Jail's nursing staff relied primarily on inmates' outside psychiatrists or physicians (who had no formal relationship with the Jail) to write orders for psychiatric medications. Ordinarily, this was accomplished over the telephone with no face-to-face encounters between the inmates and the psychiatrists. Further, the psychiatrists who wrote the orders were seldom, if ever, involved in follow-up or monitoring of the inmates' conditions. As discussed below, this led to serious inadequacies in medication management, with the nursing staff operating virtually unsupervised. The Jail's "system" of using outside psychiatrists also failed to meet the needs of inmates who were not diagnosed as mentally ill or on medication prior to their incarceration and, therefore, did not have an outside provider. There was no established procedure for evaluating these inmates (although on rare occasions, usually in response to a court order, they would be transported to the local community mental health center for assessment), and often they would go untreated.

In addition, the Jail failed to utilize the services the private provider could provide. The counselors had no regular hours at the Jail, did not provide ongoing counseling or therapy to inmates, and were called only sporadically to perform evaluations. Although the group had expected to receive two to five calls a week when it contracted with the County, this did not occur. During the first six months of the contract, Jail personnel sought the private provider's services only about five times. All together, the Jail called the group fewer than 20 times during a one year period.[(4)]

Black Hawk County has recently taken action to correct these deficiencies, including contracting with a different mental health provider and significantly changing the terms of the contract. Under the new contract, approved by the Black Hawk County Board of Supervisors in August 1998, the community mental health center will supply mental health services[(5)]

at the Jail, for a minimum of four hours and an average of no less than 12 hours per week. The contract requires that a board-certified psychiatrist serve as mental health authority. If this contract is implemented properly, it will be a significant step toward correcting many of the

mental health-related issues identified herein.

B. Intake/Screening

The Black Hawk County Jail does not adequately screen inmates for mental illness at intake. As discussed previously, the lack of privacy provided during intake questioning deters inmates from giving candid answers to medical questions; this is particularly true when it comes to sensitive questions regarding an inmate's mental health and suicidal tendencies. In fact, we reviewed a number of screening forms that indicated negative responses to mental health-related questions despite the conclusion of our expert that the inmate showed symptoms of an obvious mental illness. The problems with intake screening are compounded by the fact that only inmates who self-report or who are identified by correctional staff as being mentally ill are evaluated by medical staff. There are no routine mental health assessments of new inmates.

Even when there are reasons to suspect mental illness, inmates are not always properly evaluated. In one case, an inmate's mother notified the Jail's nursing staff shortly after intake that her son had a history of paranoid schizophrenia, and requested that he be evaluated for mental illness. The nurse, however, reviewed the inmate's intake sheet which (based on the inmate's own responses) did not indicate any psychiatric problems or medications, and decided simply to "observe for problems." The inmate was never interviewed or evaluated by mental health personnel, or even by the nursing staff, and at the time of our visit, he was receiving no treatment for mental illness. When we interviewed this inmate at the Jail, he was very guarded and denied having any psychiatric history. However, our psychiatric consultant concluded that the inmate was exhibiting symptoms that were "certainly consistent with the presence of a serious mental disorder." The nursing staff's response to information concerning this inmate was inadequate and demonstrated a lack of understanding of relevant psychiatric issues.

C. Sick Call/Treatment

Between July 1997 and July 1998, the Jail's nursing staff routinely evaluated and dismissed inmates' sick call requests for mental health treatment with little or no input from qualified mental health professionals, including the Jail's contracted mental health provider. There was virtually no mental health counseling or crisis intervention program available at the Jail. As a result, inmates with serious mental illnesses did not receive adequate assessment of or treatment for their conditions.

A tragic example of this deficiency occurred when an inmate, who claimed to have received mental health treatment on the outside, requested to see mental health personnel. According to nursing notes, a nurse told the inmate that "we do not routinely have (mental health personnel) come out," and advised him "to read, exercise and talk with others." Nursing notes indicate that the nurse called outside providers to determine whether the inmate was on medication (he was not), but no further follow-up or evaluation was ordered. Two days later, this inmate hanged

himself from a horizontal window bar in his cell.

D. Medication Management

A lack of psychiatric involvement also contributed to deficiencies in medication management. Inmate medical charts show that inmates were not adequately assessed for changes relevant to their medications, even when they reported changes in their clinical conditions. For example, one inmate, who had been prescribed Haldol for his psychotic illness complained he was having a heart attack due to his medication. According to nursing notes, the nurse "explained to inmate that he was not having a heart attack and he should not be complaining about things that are not true." Although individuals taking Haldol can experience side effects, including heart symptoms, the nurse dismissed the inmate's complaints without a thorough medical examination and without any psychiatric input. The inmate thereafter refused to take his medication, causing his psychiatric condition to deteriorate. At the time of our visit, this inmate was in the SHU because of out of control behavior and claimed to have been subject to restraints several times during the prior week. His chart did not contain an adequate treatment plan, and he was not receiving treatment for his serious mental illness.

There also has been inadequate psychiatric input into decisions involving the use of controlled substances, such as Valium. Although it is not an unreasonable practice to significantly limit and discourage the use of controlled substances within a correctional facility, the decision to discontinue medications should be made by a physician based on clinical findings and not solely premised on correctional policy or practice. At the Jail, however, the nursing staff often discontinues controlled substances based on the Jail's "unwritten rule" that such medication is simply not allowed, without regard to a clinical assessment of the specific inmate in question. For example, one inmate who was diagnosed with schizophrenia and depression, had been taking Haldol and Diazepam (a controlled substance) for his mental illness. While he was incarcerated at the Jail the inmate allegedly was not given his Diazepam, which had been prescribed by the Jail's own mental health provider. After the inmate was released from Jail he began experiencing symptoms of a schizophrenic cycle, which may have been caused by the interruption in his medication. Terminating inmates' medication without medical consultation is a dangerous practice that can result in serious side-effects or even death.

E. Barriers to Access

There are substantial barriers to access to the mental health resources available at the Black Hawk County Jail. First, inmates are not specifically informed of the availability of mental health services either in the orientation video shown to all new inmates or in the inmate handbook. Without clear notice that the Jail provides mental health services, some inmates will not seek care for their serious mental illnesses.

Access to mental health care is also impeded by the Jail's fee-for-service policy. Although charging inmates who have funds available minimal fees for health services is not per se unconstitutional, such fees must not significantly inhibit access to care. Because of the nature of mental illness and the characteristic reluctance of some individuals with mental illness to seek treatment, charging fees for mental health care will discourage persons with mental illness from seeking care and taking the medications necessary to stabilize their conditions.

Although the Jail's written policy regarding fee-for- service appears to apply to all medical care, the Jail's head nurse informed us that there is an "unwritten policy" that inmates will not be charged for mental health services. Notwithstanding this "unwritten policy", there is a perception among inmates that they must pay for mental health care. For example, during one of our visits to the Jail, an inmate told us that he was suffering from depression but that he had not sought treatment because he could not afford the $5 fee. Another inmate reported that she was not charged a fee when she visited the nurse to request medication for anxiety (which the nurse refused); however, she was warned that she would be charged if she came back again for the same problem.

Even assuming that the Jail's current practice is not to charge inmates for mental health care, this exception to the Jail's fee-for-service has not been clearly communicated to inmates. Moreover, it appears that the decision whether to charge an inmate who visits the nurse with a mental health related complaint, may depend on the nursing staff's assessment of whether the inmate's complaint is legitimate (i.e., whether mental health care is actually needed). As long as this type of uncertainty and subjectivity exists regarding the Jail's fee-for- service policy, inmates' access to mental health care will be impeded by their perception that fees may be charged for mental health services.

F. Improper Restraint and Seclusion of Mentally Ill Inmates

Because it lacks an adequate system for delivering mental health care, the Jail relies on punitive methods, including segregation and restraint, to control the behavior of inmates who are mentally ill. During one of our visits to the Jail, the only inmate in the women's SHU and one of four inmates in the men's SHU were identified by our psychiatric consultant as having a serious mental illness. The severe conditions in the SHU, particularly the almost total isolation imposed, presents a serious risk of harm to persons with mental illnesses. For this reason, it is unacceptable to house such persons in the SHU except in emergency situations for a limited period of time. Acutely mentally ill persons who cannot function in the Jail's general population must be transferred to a treatment facility as expeditiously as possible.

The female inmate we observed in the SHU, for example, was actively psychotic and unable to explain why she was in segregation. This inmate had been placed in the SHU related to symptoms of her mental illness including assaultive behaviors, taking her clothes off and standing on a sink, and defecating inappropriately while being escorted by deputies. There was

inadequate documentation in this inmate's chart concerning her mental health history and treatment plan. The chart showed that a psychiatrist had given telephone orders to administer psychotropic medication. However, the inmate had not undergone a face to face evaluation and was not receiving an adequate level of mental health care.

We also identified several inmates who had recently been restrained in the Jail's restraint chair due to symptoms of their mental illnesses. Medical or mental health personnel did not appear to be involved in the decisions to use restraint in these cases, and did not consistently participate in the monitoring of the individuals restrained. Further, it appears that the use of the restraint chair was not documented in all cases. These practices create a serious risk of harm to mentally ill inmates, and violate the Jail's own policy regarding the use of restraints for medical or psychiatric purposes. See Policy Number 4.3.2, §VII (requiring that the use of medical restraints be approved by the Jail Nurse and the Shift Supervisor, and that all orders for restraints be documented in the inmate's medical record).

G. Inadequate Identification and Treatment of Suicidal Inmates

The systemic deficiencies in the Jail's provision of mental health care, including inadequate screening, lack of counseling and crisis intervention, and lack of on-site mental health personnel, have also led to inadequate suicide prevention. There is a lack of mental health input into both the identification and treatment of suicidal inmates.

For example, one inmate who attempted suicide by hanging was restrained in the restraint chair for an hour and placed on a 30- minute watch for about 12 hours. The only nursing note regarding this suicide attempt indicated that the inmate was "just worked up about wife and everything was closing in." The nursing staff apparently concluded that there was no need for a mental health evaluation or suicide risk assessment by mental health personnel. No mental health counseling or crisis intervention services were sought or provided. Other incident reports involving attempted suicides similarly revealed an absence of mental health follow-up.

Two suicides have occurred at the Jail (one at the old facility in 1993). Both appear to be linked to lack of access to mental health services. As discussed above, the most recent suicide victim had been refused mental health treatment two days prior to his suicide. The earlier suicide victim had also attempted to obtain treatment. Found in the inmate's garbage can after his suicide, were two torn pieces of paper with the following message: "Hello Mom. Get hold of the doctor. I still haven't gotten my medication yet. About (half) crazy."

III. FAILURE OF CORRECTIONS AUTHORITIES TO SUPERVISE AND PROTECT INMATES FROM HARM

Inmates are entitled to incarceration in an environment that offers reasonable protection from harm. Jail authorities are affirmatively obliged to provide appropriate inmate observation and remove, whenever identified, physical conditions that may give inmates an opportunity to attempt suicide. The Jail does not provide adequate supervision of inmates. Furthermore, certain physical features in the Jail provide unacceptable opportunities for inmates to attempt suicide.

The Jail's SHU houses the most troubled and troublesome inmates in the facility, including suicidal, mentally ill and violent, special control inmates. The SHU, which consists of eight single cells within a larger maximum security pod, is monitored with closed circuit television cameras, by an officer who is assigned to that unit. During our inspection of the Jail, however, we found that no one monitored the cameras when the officers assigned to the SHU left their post unattended for meals and breaks for extended periods of time. These staff absences, are unacceptable for monitoring a population with severe behavior deficits and pose a substantial threat to the safety of inmates housed within the SHU.

In addition to inadequate supervision, several design features in the SHU provide opportunities for inmates so inclined to engage in self-injurious behavior. Air vents in the cells are large enough to permit an inmate to tie cloth through the vent aperture. The type of caulking used between the horizontal window bars and the windows can be removed by inmates, again providing a means to facilitate hanging. Indeed, this is a known, serious danger as one inmate at the Jail committed suicide in this manner. This problem exists throughout the facility, but is of particular concern in a unit which purports to provide a protective environment.

Showers in the SHU do not permit officer observation. The shower entrance has a curtain with a metal bar, lightly attached to the top of the doorway. Even with the curtain removed, the officer is unable to observe the shower from the officer post, or even the shower room door, as the shower head is located deeply within the recess of the shower stall. This significant design deficiency provides special population inmates an unobserved opportunity to engage in self-destructive behavior.

Other security problems related to suicide prevention at the Jail include the availability of cleaning items in inmates' cells that could be fashioned into weapons, and the failure of the facility to provide officers with an emergency tool in the SHU that would enable officers to promptly cut down a hanging victim. All the concerns regarding suicide prevention for male inmates also apply to the smaller female special population unit, with the exception of the shower curtain fastening problem.

In the general population units, we found similar security problems relating to suicide prevention. As previously noted, window caulking and vents were deficient, providing opportunity for hanging attempts. Cells which were handicap accessible had improperly designed grab bars upon which cloth or roping could easily be secured. The intake or booking area had a bathroom in one holding unit with a solid wooden door that when closed provides a space which

is unobservable by sight and sound. Although this design was apparently intended to provide a "normalizing" environment for non-combative, recently arrested inmates, it allows persons with suicidal tendencies an opportunity to hurt themselves without observation. This "blind spot" is a particular risk at intake, when an inmate's behavioral history may not be known to staff.

Correctional officer assignment in the general population areas of the Jail is also deficient. During breaks, correctional officers routinely lock inmates in their cells and leave duty stations unattended because officer relief is unavailable. The Jail's failure to have an officer on duty at all times in all inmate housing areas is an extremely dangerous and unacceptable practice that compromises institutional security.

IV. EXCESSIVE USE OF FORCE

The Jail utilizes a device called a "restraint chair" (chair) in both the Jail's intake area and the pods, purportedly to control inmates who are acting so violently that they pose a significant threat to themselves or others. We find, however, that the Jail at times uses the chair for punitive purposes when inmate control is not an issue. For example, the chair has been used to punish inmates who are verbally disrespectful to officers and inmates who inappropriately call out to other inmates from their cells. Use of the chair in this manner constitutes excessive force. The Jail does not document when the chair is used, how long the chair is used, or whether the inmate is checked routinely by correctional and medical personnel. In addition, when inmates are too noisy, the chair is sometimes moved outside the intake area to a small holding cell near the courtroom. Inmates cannot be adequately observed in this remote location. Although there is a video camera in the cell that is monitored in the main control center, the civilian staff monitoring the screen has other responsibilities that prevent them from focusing sufficient attention on the individual in

the restraint chair.

During the course of our investigation, we heard other serious and seemingly credible allegations of excessive use of force and physical abuse of inmates. Due to the limitations of our previous visits, these allegations will require additional investigation. The alleged abuses include misuse of a stun-gun, choking, beating and kicking of inmates, and use of force on inmates after they are already secured in the restraint chair. Many, but not all, of the allegations involve the intake area of the Jail during the evening shift. Our concerns about a possible pattern of excessive force at the Jail were heightened by our consultant's finding of procedural deficiencies with respect to the Jail's reporting and monitoring of use of force, including inadequate control of security equipment. For example, Jail authorities do not follow the generally accepted correctional practice of keeping separate reports of incidents involving the use of force. Moreover, there is no documented review within the Sheriff's office of use of force incidents. In addition, security equipment, which should be under the control of the shift supervisor, is too readily available to line officers who are not required to document its use. For example, there is no logbook reporting

associated with the use of the Jail's stun gun, an extremely potent and potentially dangerous weapon. Access to the stun gun is readily available to any officer in the intake area without the approval (or knowledge) of the shift supervisor. This lack of accountability concerning the use of force increases the risk that force will at times be misused.

V. MINIMAL REMEDIAL MEASURES

In order to remedy the deficiencies we have identified and

to protect the constitutional rights of its inmates, the Black Hawk County Jail should implement, at a minimum, the following measures:

Medical Care

1. Intake: Establish a method of collecting medical information on intake that will ensure confidentiality. Develop a standard nursing intake form, and ensure, at a minimum, that nurses take and record complete vital signs on all inmates identified as having a medical problem. Provide a complete health assessment by a physician of all inmates within 14 days of admission. Ensure that inmates' medications are provided by the Jail on intake without unreasonable interruption. Ensure that inmates housed in the intake area of the Jail have access to urgent and emergency health care.

2. Staffing: Increase the physician presence at the Jail to a minimum of 20 hours per week. Ensure that the physician supervises all medical activities.

3. Sick Call: Develop treatment protocols for sick call. Ensure that nurses take vital signs on all encounters, and that they conduct physical examinations, and not simply interviews, in response to inmate complaints. Establish physician review of nursing sick call, which includes at least random review of medical charts. Ensure physician review of medical charts in all cases where an inmate's request to see a physician is denied.

4. Emergency Care: Ensure physician participation in the evaluation of inmate medical conditions that may require urgent or emergency care.

5. Infection Control: Develop an effective infection control program which would include, at a minimum: testing of all inmates admitted to the Jail for TB, and testing as appropriate (after consultation with the County Department of Health) for sexually transmitted diseases; record-keeping of all testing and development of a tracking log for TB and sexually transmitted diseases; physician involvement in testing and treatment for TB and sexually transmitted diseases; and development of a training program for universal precautions for all staff.

6. Development of Policies and Procedures: Develop formal policies that clearly set forth the Jail's medical operations, including mental health services. Clearly delineate in writing the Jail's fee-for-service policy, and the circumstances under which fees will not be charged, and provide inmates with notification of this policy. Establish treatment protocols, including protocols for nursing sick call.

7. Documentation/Quality Assurance/Inmate Grievances: Ensure that patient medical charts are maintained and organized in a professional manner. Establish and keep logs of all medical activities, including emergency responses and referrals to outside specialists. Develop a quality assurance program that includes review of medical charts, logs and other records, by a physician to ensure appropriateness of decision-making and documentation. Ensure that inmates have access to the Jail's grievance procedure for complaints concerning medical care, as well as for other types of complaints.

Mental Health Care

1. Staffing: Develop a quality assurance plan to ensure that the level of staffing provided under the County's recent contract for mental health services is sufficient to identify and treat in an individualized manner those inmates suffering from serious mental disorders.

2. Intake: Establish a system of collecting mental health- related information that will ensure confidentiality. The Jail's screening process should not rely on an inmate self-reporting his or her mental illness in a group setting.

3. Evaluation: Provide an adequate and timely mental health evaluation, by a qualified and appropriately trained mental health professional, of inmates who screen positive for possible mental illness at intake (including where relatives or other close associates provide information relating to the inmate's possible mental illness), and of inmates who exhibit symptoms of mental illness (including suicidal ideation or behavior) at any time during their incarceration.

4. Sick Call: Ensure that all inmates requesting mental health care are seen and evaluated by a qualified and appropriately trained mental health professional. Ensure review of mental health-

related sick calls by the Jail's psychiatrist.

5. Treatment: Ensure that an individual, written, mental health treatment plan is prepared in a timely manner by a qualified and appropriately trained mental health professional for every seriously mentally ill inmate. Changes to and compliance with the treatment plan should be thoroughly and accurately documented in the inmate's medical/mental health record.

6. Medication Management: Avoid unreasonable interruptions in inmates' medications upon admission to the Jail. Ensure that the Jail's psychiatrist is involved in the monitoring and follow-up of inmates on medications for psychiatric conditions, including cases where there is inmate noncompliance with medications. Ensure that decisions whether to prescribe or terminate medications, including controlled substances, are based on clinical assessments by the Jail's psychiatrist, and that medically-approved detoxification procedures are utilized.

7. Counseling/Crisis Intervention: Provide adequate counseling and crisis intervention services for all mentally ill inmates who need such care, including, but not limited, to inmates who are observed to be potentially suicidal.

8. Emergency and Acute Care: Ensure that the Jail's psychiatrist is on-call and consulted in the event of mental health emergencies. Consistent with security requirements, inmates with acute psychiatric conditions should be promptly transferred from the Jail to a treatment facility.

9. Barriers to Access: Ensure that inmates are informed in the Jail's orientation video and in the Inmate Handbook of the availability of mental health services and of the Jail's exception to the fee-for-service policy for mental health encounters.

10. Use of Restraint and Isolation: Develop a comprehensive policy on the use of restraint and isolation on inmates with serious mental illnesses. Ensure that mental health personnel are involved in decisions to restrain or isolate mentally ill inmates, and in the monitoring of such inmates while restrained or isolated. Develop policies and procedures to ensure that inmates with acute psychiatric conditions, who cannot function long term in the general Jail population, are transferred or committed to appropriate treatment facilities as expeditiously as possible.

Inmate Supervision and Protection from Harm

1. Staffing/Supervision: Increase the correctional officer staffing complement as necessary to ensure that officers are available at all times to staff designated security posts. Correctional officers must not leave posts in areas housing inmates suspected of being suicidal or leave posts in any Special Housing Unit location unless relieved by another officer. Relief shall mean that the officer is in place at the designated post on the unit. A correctional officer must observe inmate showers directly in the Special Housing Unit, with a second officer providing back-up assistance.

2. Physical Features Creating Unacceptable Opportunities for Suicide: Modify, on a priority basis, all Special Housing Unit areas and the inmate intake area of the Jail to eliminate physical hazards, thereby lessening the risk of suicidal behavior. These modifications include: covering air grille areas in the cells with small diameter mesh or some other material to prevent inmates from attempting to hang from this fixture; replacing window caulking in a manner that will prevent its removal; shielding handicap grab bars to prevent inmates from tying material around the bar; removing curtains and rods from shower stalls; removing the solid wooden door to the washroom in the "honor" intake and booking area (a privacy panel may be installed); and removing cleaning items daily from Special Housing Unit cells to prevent the fashioning of weapons. Additionally, all inmate housing units should have properly secured readily available cutting tools (designed to interrupt suicide attempts).

Use of Restraint

Review and revise, as appropriate, the Jail's policy and procedures regarding use of mechanical restraint, including the restraint chair. Establish a policy to ensure that restraint devices are not used for punitive purposes and that appropriate disciplinary action is taken against staff who violate this stricture. Absent exigent circumstances, a supervisor should be present when inmates are first placed in the restraint chair. Inmates in restraint must be checked by personnel with appropriate training every 15 minutes, and by medical and mental health staff at appropriate intervals. Proper measures should be taken to ensure that inmates in restraint have their limbs exercised to avoid circulation problems, and adequate attention must be given to food, hydration and bodily functions. Logs should be kept of placement in and release from restraint, and of all checks made. This log should be reviewed daily by the Jail Administrator. Inmates should not be restrained in the courtroom holding cell or in any other area that cannot be monitored by frequent, direct, personal observation.

Conclusion

We will forward our expert consultants' reports under separate cover. Although their reports are their work -- and not necessarily the official conclusions of the Department of Justice -- their observations, analyses, and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing outstanding challenges at the Black Hawk County Jail. We hope that you will give this information careful consideration and that it will assist in promoting a dialogue aimed at quickly addressing the problems we noted.

Pursuant to CRIPA, 42 U.S.C. § 1997b(a)(1), the Attorney General may initiate a lawsuit to correct deficiencies at the Jail 49 days after you have been informed of the findings of our investigation. We hope to be able to resolve this matter amicably and cooperatively. We know that Black Hawk County has already taken significant steps to correct some of the deficiencies identified herein, and we look forward to discussing these actions and other actions you intend to take in the near future.

Sincerely,

Bill Lann Lee, Acting Assistant Attorney General, Civil Rights Division

cc: Tom Ferguson, Esquire, Black Hawk County Attorney
Mr. Michael Kubik, Black Hawk County Sheriff

1. The Jail has two full-time and one part-time registered nurses who hold sick call five days a week from 9:00 AM to 7:00 PM.

2. The nursing staff sees approximately 20-25 inmates a day (over 100 inmates weekly), but refers fewer than 10 inmates (and frequently as few as one or two) to the physician per week.

3. The nursing staff relies heavily on private, outside physicians to provide information or advice about inmates (who were their patients prior to incarceration), and to write orders for medication. However, these outside physicians have no formal relationship with or accountability to the Jail and no supervisory authority over the nurses. They do not examine inmates or monitor the progress of inmates for whom they write orders.

4. This represented a sharp decline in the level of mental health services provided at the Jail. Prior to July 1997, a community mental health center funded in part by Black Hawk County, provided approximately 10 hours of inmate services per week, at the Jail's request, out of the

center's own budget. When the community mental health center stopped providing "free" mental health services for inmates, the Jail drastically reduced its use of mental health personnel.

5. The services to be provided under the contract include: assessing requests for mental health services by inmates and Jail personnel; initiating interventions for acute psychiatric conditions; educating Jail personnel; maintaining records; and facilitating referrals to other community based-services.