SPECIAL LITIGATION SECTION CASES AND MATTERS

>
The Honorable Bruce L. Woodbury
Chair, Board of County Commissioners
Clark County
500 South Grand Central Parkway
Las Vegas, NV 89155-1601

Re: Clark County Detention Center

Dear Mr. Woodbury:

On December 4, 1997, we notified you of our intent to investigate the Clark County Detention Center ("the Detention Center") in Las Vegas, Nevada, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. On January 20-22, 1998, we conducted an on-site inspection of the Detention Center with expert consultants in adult penology and mental health care. On February 10-12, 1998, we conducted a second on-site inspection with expert consultants in correctional medicine and health and environmental safety.

The Detention Center is a multi-story building located in downtown Las Vegas. The first floor consists of booking and holding, the second floor contains medical, mental health, and protective custody units, and the third, fifth, seventh and ninth floors contain general population inmates. For general population inmates, the floor consists of six separate and secure housing areas or modules. Four of the six modules per floor contain 24 rooms and the remaining two modules consist of 50 and 46 rooms. Each module has adjoining day space and outdoor recreation space. On the day of our site visit, January 20, 1998, the inmate population was 1704, with over 200 in the holding/booking area. Of the 1704 inmates, 180 were sentenced inmates and the remaining were pretrial detainees.

In addition to our on-site inspections, our investigation included numerous interviews with Detention Center correctional and administrative staff, inmates, and medical and mental health care providers. We reviewed an extensive number of documents, including policies and procedures, booking records, incident reports, internal investigation reports, and medical records. We wish to thank the Detention Center staff for their professional conduct and cooperation throughout the course of the investigation.

Consistent with the statutory requirements of CRIPA, we write to advise you of the findings of our investigation. We find that conditions at the Detention Center violate the inmates' federal constitutional rights with respect to conditions of confinement in the holding area, inadequate mental health care and suicide prevention, and inadequate environmental health and safety in the areas of fire safety, protection from communicable disease, and sanitation.

I. LEGAL FRAMEWORK

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.

II. CONDITIONS OF CONFINEMENT IN HOLDING AREAS

Conditions of confinement in the first floor booking and reception area violate an inmate's right to safe and humane conditions of confinement. The booking and reception area has seventeen separate holding rooms where inmates are housed for their first several days in the facility. The cells range in size from single and double occupancy to multiple occupancy rooms of over 20 inmates. Most cells are equipped with benches and all rooms have toilet facilities. These cells are distant from the central booking area and direct sight and sound supervision of the majority of the cells is not possible. None of the cells is equipped with audible two-way communication capability. These isolated settings make it difficult to monitor suicidal behavior or inmate-on-inmate violence.

Moreover, the holding cells are extremely crowded and unsanitary. During our site visit, the holding area housed 208 inmates. Many of the rooms were so crowded that there was little visible floor space and inmates lay underneath the benches in the room. Facility records indicate that these booking areas are frequently crowded with as many as 300 inmates. The number of detainees routinely processed through the booking/reception area is simply too numerous for the resources of the facility to properly handle. Detainees sometimes may not even shower because the shower area is used as a staging area for moving detainees in and out of the facility. Due to the overcrowding, routine visual checks required by security personnel are ineffective. There are too many people to see if anything is happening in the holding cells. We reviewed the housing cards posted outside the rooms and noted that inmates have been held in such conditions for up to three days. Many of the inmates confined in the rooms claim not to have received any shower, bedding, or hygiene articles in excess of 24 hours. The stench in the housing cells is overpowering. In one of the holding cells there was human excrement on the walls and the toilet was filthy and unsanitary. The overcrowding causes the temperature in the holding areas to reach excessive levels and the lighting is inadequate.

The conditions in the holding area have caused serious harm and death to the detainees. Fights over space and for other reasons are frequent, occurring more often than in most areas of the jail, as do officer applications of force. Jail staff know that the conditions in the crowded large cells are anxiety producing and especially difficult for inmates who are particularly vulnerable for various reasons. One frequent response is to move inmates who "get in trouble" in the large cells to smaller, less crowded ones. These rooms are not appropriately designed for high risk populations. In particular, they have a partition (separating the toilet from the rest of the cell) that obscures sight surveillance into the cell and creates a protuberance for suicide by hanging. Furthermore, as discussed later, suicide screening upon booking and mental health care in the holding cells is inadequate.

Inadequate suicide screening, inadequate supervision of the holding areas, and failure to provide mental health care in the holding area combine to create an especially dangerous inmate suicide risk. In 1997, there were two completed suicides in the holding area. In each instance, the inmate had been moved to a small holding cell, with few cell mates, and hanged himself from the partition. Another inmate in one of these cells attempted to hang himself from the partition in July of 1997 but the inmate's cell mate was able to summon officers to intervene.

The two completed suicides in the holding area highlight the dangerous features of current operations at the jail. The first suicide took place in February 1997. The day before it happened, the inmate had been the victim of a fight in a large holding cell. He was treated at the nursing station, and the facility doctor ordered him housed in the medical unit for observation. However, there was no available housing in the medical unit, so he was placed in a small holding cell to await a bed. Late in the day, a nurse observed him and wrote that the inmate had told her that "He is just giving up; you're not giving medications correctly; his life is not worth anything; just leave him alone." Despite this obvious expression of suicidal ideation, he was not placed in a more controlled or supervised environment. He was discovered hanging from the partition that night.

The second holding area suicide took place in October 1997. In that case, the inmate had asked an officer to see the sergeant "before something happened and I snap" and because he was "going crazy." He was moved from the crowded large room where he was housed into a smaller cell. No timed observation was done. He hanged himself less than one hour after the move.

Inmates in the holding area are given a medical and mental health screen by a nurse, but they do not receive the opportunity for sick call. Deputies hand out Tylenol and Maalox, but requests for other medical attention very frequently go unanswered. Where staff know that inmates are in a medical crisis, efforts are made to move them to the medical section of the facility. But because of the lack of supervision, some inmates' emergency medical needs go unobserved and unmet. For example, one inmate was discovered dead in the late evening in one of the small holding cells. Staff concluded that he died from a "possible drug related overdose." The Officer's Report did not note his condition prior to placing him in the holding cell. Another detainee was moved from the holding area to the medical floor where an officer removed a nylon rope that had been wrapped around the detainee's ankles. Thirty minutes after reaching the medical floor, the detainee required emergency life-saving medical treatment. He was transported to a local hospital where he was pronounced dead shortly after arrival. The Officer's Report did not explain or note why the detainee had a rope around his ankles or why he had been transported to the medical floor.

In addition, inmates in the holding areas typically do not receive needed psychotropic medications because the detention center will not fill even verified psychiatric prescriptions without an independent evaluation by the facility's psychiatrist, which usually cannot be done

for several days due to inadequate staffing. Many mental health crises are precipitated by the lengthy stays and conditions in the holding area and by the failure to provide timely medication.

In sum, operation of the holding area violates inmates' right to adequate safety and protection from harm, adequate medical care, and, as described more fully below, adequate mental health care.

III. SUICIDE PREVENTION AND MENTAL HEALTH CARE

Suicide screening in the booking and holding area is inadequate. In particular, the jail's suicide screening form lacks sufficient criteria for mental health referrals, as well as emphasis on the history of psychiatric/mental health treatment and medication and possible current suicide ideation. Nursing staff who conduct the screening are insufficiently trained to perform the brief mental health status examination needed to identify mentally ill inmates. Moreover, they fail to conduct this examination in a setting as private as possible given legitimate penological considerations. This lack of privacy greatly undermines any effort to obtain sensitive information from inmates. The result of inadequate screening is that inmates with mental health problems slip through the booking process and remain unidentified and untreated until their mental health problems often escalate to the point where security staff must later call mental health personnel.

For example, one inmate was given a negative mental health screening at intake and four days later was placed on suicide watch by an officer because of his bizarre behavior. After being placed on suicide watch, he had a mental health evaluation that revealed a history of depression and substance abuse along with an extensive history of hospitalization. In another example, our expert observed one female inmate who had been in holding for an hour and was complaining of claustrophobia and extreme anxiety bordering on panic. The other inmates in the holding cell indicated that she was pacing around banging her head on the door. She stated that she felt a nervous breakdown coming on. A review of her initial medical screening later that day showed that the nurse had failed to refer her to the mental health unit even though she had a history of mental hospitalization and was extremely vocal concerning her anxiety.

In many cases, inmates who are mentally ill go unrecognized and untreated in general population units, as well, despite obvious signs of mental health problems. The officers in general population units are not adequately trained to recognize and refer mentally ill inmates to the mental health professionals at the Detention Center. A study completed by our expert of suicide attempts from January 1994 through February 1998 revealed that officers missed important and obvious precursor behavior to suicide attempts. Officers recorded inmates "acting strange" and mutilating themselves but did not refer such inmates to the mental health unit and in several instances the inmates subsequently attempted suicide.

Supervision of potentially suicidal inmates is inadequate not only in the holding area but also in the mental health unit (Unit 2) and the administrative segregation unit (Unit 5) where aggressive mentally ill inmates are sometimes housed. In particular, jail records show that numerous inmates already on suicide watch -- and occasionally already in restraints -- have been able to attempt suicide. This is a clear indicator of several problems: inadequate mental health staffing; inadequate observation; absence of timely evaluation and treatment; and unsafe cells being used for suicide watch. As a result, acute or crisis mental health care in the mental health unit is inadequate.

A final problem with the mental health unit and the mental health unit in administrative segregation, is that inmates on lengthy suicide watch are not allowed to participate in exercise, recreation, or other out-of-cell activities even when the inmate is not violent to others. Indeed, violent inmates being isolated for disciplinary reasons receive more out-of-cell time than those who are suicidal or mentally ill, despite the fact that isolation aggravates the very condition for which the inmates are isolated.

Inadequate mental health staff not only contributes to a dangerous lack of supervision, but also to a lack of mental health treatment and programming and to an increased use of unnecessary restraints. Individual counseling is rare and group counseling is non-existent. The lack of treatment and staff results in untreated and uncontrolled mental health problems escalating often into violent self-injurious behavior. The mental health staff admitted that they spend most of their time at the Detention Center working in crisis mode to handle such escalated mental health conditions. Furthermore, with regard to the mentally ill inmates, security staff generally initiate restraints without medical review while mental health staff are involved only in terminating the restraints. Review of restraint use demonstrates that inmates are improperly placed in restraints for an extended period of time where intervention by medical and/or mental health personnel would have made the restraint use unnecessary. Restraint use for mentally ill inmates is improperly driven by the inability to initiate less restrictive emergency measures.

Suicide response is also inadequate due to the absence of readily available "seat belt cutters" or other sharp cutting instruments to cut down hanging victims. In one suicide, in 1996, staff spent several minutes attempting to locate scissors to cut the bed sheet an inmate had used to hang himself. Finally, inmates with mental illness leaving the jail are discharged with a list of medications but without any

supply of those medications.

IV. ENVIRONMENTAL HEALTH AND SAFETY IN CERTAIN AREAS

With regard to fire and life safety, the facility does not adequately train its line officers in fire and emergency procedures. Furthermore, staff do not routinely conduct and document fire drills and inspections of fire safety equipment**.** The lack of adequate fire and life safety exposes the inmates and staff to substantial risk of harm from fire and smoke hazards.

The medical unit contains negative pressure rooms that cause the air to flow into the room from outside the room and thus prevent contaminated air inside the room from flowing to the outside areas. These negative pressure isolation rooms are not being adequately maintained to provide sufficient negative pressure in the rooms to cause the airflow to reverse. Inadequate negative pressure rooms dramatically increase the risk of harm to staff and inmates contracting tuberculosis and other highly communicable diseases designed to be controlled through such isolation rooms.

Finally, because of the high inmate population, inmates sleep on mattresses on the floor in several of the outer day rooms. By facility policy, such inmates have access to the toilets in the inner day room and the outdoor recreational area only when such areas are not occupied by other inmates. In inclement weather, when other inmates occupy the inner day room, they are forced to go outside to use the toilet but are permitted to do so only with an escort, which often is not readily available. Furthermore, when other inmates occupy the inner day area and the outdoor recreation area, the inmates in the outer day rooms have no access to toilets. During our tour, on the ninth floor in units 9C and 9D, the outer day room housed twenty-five inmates who had access to one toilet in the outside recreation area when the other inmates were using the inner day area. Such restricted access to a toilet is unacceptable.

V. MEDICAL CARE

In addition to medical care in the holding areas that we found inadequate, at the time of our tours, inmates in general population were also receiving untimely and inadequate medical care due to inadequate access to sick call and insufficient physician time allotted to sick call clinics. Furthermore, physician documentation of sick call visits was inadequate and the medical staff needed to develop and implement a better tracking system for pregnant inmates to ensure appropriate and timely care.

Shortly after we concluded our site visit, the Detention Center notified us that it had significantly revised the sick call procedures and that registered nurses would conduct sick call and triage more appropriately, thus better managing physician time. We believe such a system should be able to meet generally accepted correctional medical practices with regard to inmates in general population. Consequently, except for the medical care in the holding areas already discussed, at this time, we do not make a finding of inadequate medical care at the Detention Center subject to our verification that the new system has been implemented and is functioning adequately.

VI. MINIMUM REMEDIAL MEASURES

To rectify the above-cited deficiencies and to ensure that the Clark County Detention Center complies with federal constitutional requirements, the following minimum remedial measures should be implemented:

1. The Detention Center should make conditions of confinement in the holding and booking area safe and sanitary by reducing the inmate population confined to the holding cells of the booking area. The Detention Center should adequately supervise the holding cells to prevent inmate-on-inmate violence. The Detention Center should provide the inmates in the holding cells adequate bedding, hygiene articles, and access to showers. The holding cells should be adequately lit and cleaned.

2. The Detention Center should provide adequate medical and mental health care in the holding area. Such care should include adequate screening during the booking process, adequate access to sick call while housed in the holding area, timely and adequate observation of inmates with mental health and medical problems, including entering the holding cells, especially the smaller holding cells when an inmate is on suicide observation. The suicide hazards should be eliminated from the isolation cells.

3. Detention Center staff should conduct adequate health screenings in an area that affords sufficient privacy consistent with security requirements. Medical staff should administer an inmate's known medications within a reasonable period of time upon arrival to the

facility.

4. The Detention Center should provide the inmates with adequate mental health care services and suicide prevention.

5. Medical staff should be properly trained to conduct medical and mental health screening at intake. Inmates identified with mental illness should be promptly referred to mental health staff. Line officers in the general population units should be adequately trained to recognize basic symptoms of mental illness and refer such cases to the mental health staff.

6. Medical/mental health staff should evaluate persons with mental illness being restrained prior to the restraint and should monitor such persons regularly. Staff should not use restraints before attempting less restrictive alternatives.

7. The Detention Center should hire or contract for sufficient mental health staff to supervise and monitor adequately mental health patients housed in the mental health unit and administrative segregation.

8. Mental health staff should provide adequate mental health treatment and programs, including adequate individual and group therapy.

9. Inmates housed in the mental health unit and in administrative segregation for mental health purposes should receive adequate out-of-cell time and recreation.

10. The Detention Center should implement adequate suicide response procedures, including providing staff with readily available suicide prevention tools such as those needed to cut down attempted suicide victims.

11. The Detention Center should adequately train its line officers in fire and emergency procedures. Furthermore, fire drills and inspections of fire safety equipment should be routinely conducted and documented**.**

12. The Detention Center should provide inmates housed in the outer day rooms in the general population housing areas with adequate access to the toilets.

IX. RESOLUTION OF ISSUES

Pursuant to the Civil Rights of Institutionalized Persons Act, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after notifying appropriate local officials of such deficiencies. 42 U.S.C. § 1997b(a)(1). We will, however, seek to resolve this matter in the same cooperative spirit that has characterized the investigation to date. To this end, we will send you the reports from our experts, Dr. Joe Goldenson, Dr. Dennis Koson, and Steve J. Martin 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 Detention Center.

We look forward to your response to these findings and recommendations and to detailed discussions leading to a final resolution of these issues.

Sincerely,

/s/
Bill Lann Lee
Acting Assistant
Attorney General
Civil Rights Division

Enclosures

cc: Mary Miller, Esq.
Clark County Counsel

Stewart L. Bell, Esq.
Clark County District Attorney

Mr. Jerry Keller
Sheriff
Clark County

Bill Young, Esq.
Deputy Chief
Detention Services Division
Clark County

Kathryn E. Landreth, Esq.
United States Attorney
District of Nevada

Return to Jail and Prison Investigations >

Updated August 6, 2015
