CRIPA Investigation

JC-NY-003-002

Memorandum

AEP:MHN:SYB:KAK:drb
DJ 168-50-25

Subject

Notice of Findings Regarding the Onondaga County Jail

Date

SEP 30 1994

To

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

From

Arthur E. Peabody, Jr.
Chief
Special Litigation Section

Attached for your approval and signature is a findings letter pertaining to the Onondaga County Jail, Public Safety Building (PSB) Syracuse, New York.

We opened our CRIPA investigation of the PSB on March 29, 1994. Following expert tours and document review, we have found numerous constitutional violations. We cite certain security practices and environmental health and safety conditions which present a threat to the safety and well-being of prisoners. We also cite the Jail for violations of the constitutional rights of prisoners in the delivery of health care services including medical and dental services. Finally, we cite the Jail for fostering a racially hostile environment.

The PSB is an especially deficient and dangerous facility. Immediate action is needed to address the use of force and chemical agents by deputies, which reportedly resulted in a recent death of a PSB inmate.

Attachment

Approved: 

Disapproved: _____

Comments:

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

Mr. Nicholas J. Pirro
Onondaga County Executive
421 Montgomery Street
Syracuse, New York 13202

October 18, 1994

Re: Investigation of Onondaga County Jail, Syracuse, New York

Dear Mr. Pirro:

On March 29, 1994, we notified you of our intent to investigate the Onondaga County Jail, Public Safety Building (PSB) pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. §1997 et seq. Consistent with the requirements of CRIPA, the purpose of this letter is to advise you of the conditions at the Public Safety Building that violate the federally protected rights of prisoners confined there, the supporting facts, and to recommend necessary remedial measures.

Our investigation consisted of three tours of the facility with expert consultants, the examination of numerous documents, including records, policies and procedures of PSB, and extensive interviews with prisoners and staff at the facility. We were accompanied on our tours by 3 consultants: a penologist, a medical expert, and a fire safety/environmental sanitarian, all with expertise in jail facilities. Throughout the course of this investigation, County officials and PSB staff extended to us and our consultants their cooperation, for which we wish to convey to you our thanks.

In making our findings, we recognize that PSB confines both pre-trial detainees and post-conviction inmates. In general, inmates may not be subjected to conditions that are incompatible with evolving standards of decency or deprive them of their basic human needs while incarcerated. See Estelle v. Gamble, 429 U.S. 97 (1976). With respect to the pre-trial detainees, the Fourteenth Amendment prohibits punishment of these persons and restrictive conditions or practices that are not reasonably related to the legitimate governmental objectives of safety, order and security. Bell v. Wolfish, 441 U.S. 520 (1979). For those convicted of a crime, the standard to be applied is the Eighth Amendment's proscription against cruel and unusual

punishment. Wilson v. Seiter, ___ U.S. ____, 111 S.Ct. 2321 (1991); Rhodes v. Chapman, 452 U.S. 337 (1981). When convicted prisoners are not, as here, separated from pretrial detainees, the Fourteenth Amendment standard applies to all inmates.

Based on our investigation, we believe that conditions at the Public Safety Building are grossly deficient and violate the constitutional rights of prisoners.

I. Lack of Protection from Harm.

A. The excessive use of force threatens the safety and well-being of the inmates.

1. Use of Force. An unacceptably high use of excessive force exists at PSB. Almost every inmate interviewed by our consultant voluntarily told of incidents involving an excessive use of force by the correctional officers on prisoners. Reportedly, such acts occur quite frequently. Our consultant found that force is used as a punitive measure for misbehavior. In one instance, a woman 8 months pregnant, who had been released from the hospital hours earlier for a possible miscarriage, was dragged 40 yards by several officers because she "refused" to move to another cell as directed. The inmate told the officers that she could not move because she was in labor. Her inability to move was deemed a "refusal." In another instance, a newly arrested inmate who was afraid to be in the jail, wrapped his arms around cell bars to prevent the officers from moving him. He was reportedly beaten by 5 to 6 officers until he let go of the bars. Such conduct is unacceptable. According to national standards, use of force is never justifiable as punishment.

Lack of adequate training, according to our penologist, is the primary cause for the unacceptably high incidence of use of force. The jail has a Certified Emergency Response Team (CERT), comprised of a select group of staff who are reportedly specially trained to handle use of force at PSB. According to the jail's training officers, none of the members of the CERT team are up-to-date on their CERT training.

2. Use of Chemical Agents. PSB officers use the chemical agent commonly known as pepper spray. While the use of chemical agents under controlled situations and in accordance with established policies and procedures is acceptable for correctional staff in eminently dangerous situations, it should never be used as punishment. An unacceptably high and improper use of pepper spray exists at PSB. Nearly every inmate interviewed told our consultant of excessive and improper use, or threat of use, of pepper spray. Indeed, our consultant found that in many cases, excessive amounts of pepper spray are used unnecessarily, particularly when inmates are not resistant and after the inmate has been restrained and presents no danger.

Pepper spray is also used on prisoners who attempt suicide. In a particularly egregious instance, a prisoner attempted to kill himself by repeatedly throwing himself head first from the sink to the cement floor of his cell. Several officers restrained and maced the prisoner, reportedly using three canisters of pepper spray. The prisoner died shortly thereafter of positional asphyxia and chest compression. In another instance, a prisoner attempted to hang himself from the bars of his bed. Officers entered the cell, untied the prisoner, cuffed him to his bunk, and sprayed him with pepper spray. Such use of chemical agents is totally unacceptable.

3. Use of Physical Restraints. PSB uses emergency restraint belts (ERB) as "hoods", by placing the device around the prisoner's head over the nose and mouth. ERBs are wide bands of heavy vinyl which are intended to secure limbs during cell extractions. According to our consultant, no other facility within his knowledge uses an ERB as a "mask" or a "hood." Reportedly, PSB uses the ERB in conjunction with pepper spray. In one instance, an inmate told our consultant that he flooded his cell in an effort to be moved to protective custody. Reportedly, he was restrained, handcuffed by 5 officers, and then sprayed with pepper spray. An emergency restraint belt was used as a "hood" and was placed on his face to disorient him. The restraint had the effect of restricting his breathing. He was then reportedly beaten by several officers. Such conduct is unacceptable.

4. Floor Checks. PSB officers reportedly make "floor checks" every 15 to 20 minutes. The deputies are to walk the perimeters of the cells and move a security card through a stationary computer device to indicate that the check was completed. Disciplinary records indicate that these checks are not properly conducted. In numerous instances, officers give the appearance that the floor check was completed when in fact it was not, resulting in large periods of times when proper supervision for prisoners is not provided. PSB has failed to take any disciplinary action against any of the officers involved in these deceptive practices.

B. Grievance System. Our consultant concluded that although PSB's grievance policy and procedure may be acceptable in writing, the grievance system is not properly implemented. Numerous inmates reported to our penologist that they never received an answer to their written grievances. A non-functioning grievance process serves as an additional source of frustration for inmates and exacerbates unnecessary tensions, fear, and violence at the jail.

C. Staffing. Security staffing at PSB is inadequate. Indeed, PSB operates below its designated staffing complement. Jail deputies are required to work large amounts of overtime,

many times without prior notice. In addition, PSB fails to provide the necessary amount of management supervision for officers. Finally, actual staff coverage is often reduced 25 to 33 per cent by officers who are on restricted duties which prevent them from having prisoner contact. Inadequate security personnel directly contributes to the increased levels of tension and violence at PSB.

In sum, PSB fails to protect inmates from harm or implement systems and practices designed to avoid harmful incidents.

II. Measures Recommended to Ensure Adequate Security.

A. Security Practices.

1. Use of Force. All staff must be retrained in the use of force. All members of the CERT team must be properly trained to handle special needs inmates. Those members who have not received recent training in the proper use of force should be restricted from participating in CERT activities until their training is in order. Supervisory personnel must take an active role in monitoring use of force and be held accountable for their staff's actions as well as their own. All use of force incidents must be documented, reviewed and analyzed by qualified staff for compliance with policies and procedures to ensure that staff use the least amount of force necessary to bring the situation under control.

PSB must review its policy and training procedures to ensure compliance with professional standards.

2. Chemical Agents. Chemical agents may not be used on any inmate once the inmate has been secured (i.e. restrained via handcuffs), or has complied with staff instructions. Chemical agents, restraining chairs, and emergency restraint belts may never be used as punishment. Such devices are to be used only as the last measure in the chain of actions against an inmate who is presenting an imminent danger to self or others. Chemical agents may not be used on suicidal prisoners.

3. Use of Physical Restraints. Physical restraints, including emergency restraint belts, may not be used in a manner inconsistent with generally accepted correctional and medical standards. Physical restraints may never be used as a punitive measure.

4. Floor Checks. Floor officers must make rounds of housing areas on a periodic, random basis at least once each hour to ensure the safety of inmates. Rounds shall include the visual observation of all inmates. All rounds shall be documented in an appropriate log. Officers shall be appropriately disciplined for failure to make appointed rounds.

B. Grievance System.

PSB must retrain all staff in the area of grievances. Supervisors must be proactive in assuring the current grievance policies are followed. Moreover, PSB must instruct each inmate at intake on the use of the grievance procedure to ensure that each inmate understands the procedure. Additionally, PSB must ensure that inmate grievances are investigated and responded to within a reasonable time frame.

C. Staffing. To ensure safety and security, supervision of inmates must be significantly enhanced by increasing the number of qualified deputies and other security personnel.

III. Medical Care is Grossly Inadequate and Fails to Meet the Serious Needs of Inmates.

A. Medical Intake Screening. Major deficiencies exist in PSB's medical intake screening. All prisoners are required to have a complete medical history and physical examination within 14 days of intake. Numerous records indicate, however, that medical screening does not occur within 14 days after intake. One prisoner did not receive a complete physical examination until 44 days after he entered, another prisoner did not receive a physical until 34 days after entry, and still another had not received an exam although he entered PSB 21 days prior to our review. Additionally, our consultant discovered that the physician does not routinely review the physical examinations performed by the nurse practitioners. Our consultant found at least two instances where the nurse practitioner noted "normal adult male" on individuals who were identified as having chronic illnesses on intake.

B. Screening and Treatment of Tuberculosis. Deficiencies exist in tuberculosis screening as well. Reportedly, PSB requires that TB skin tests be completed within 7 days of admission. Our consultant concluded that PSB's practice is not in compliance with its policy. One prisoner was arrested 33 days prior to our tour and had not received a tuberculosis skin test. Another prisoner received his physical exam after 27 days, but had not received a tuberculosis skin test. And still another prisoner had not received his tuberculosis skin test after two months of being in the PSB. Further, following receipt of a positive test, an average of 4 weeks lapses until receipt of a chest x-ray. There is an average of 12 days between the receipt of the chest x-ray and the start of TB prophylaxis treatment. Our consultant concluded that given the crowded nature of the environment, particularly on the second floor, the potential for spread of tuberculosis is substantial.

C. Treatment of Chronic Illnesses. In general, prisoners known to have chronic illnesses were seen on a regular basis and

were being appropriately followed up. PSB fails, however, to maintain a list of prisoners who have such chronic illnesses. Moreover, PSB fails to use peak flow meters in evaluating asthmatic prisoners. PSB's failure to use peak flow meters results in insufficient objective data on which to determine treatment.

D. Access to Medical Services. The sick call system at PSB requires prisoners to complete slips requesting medical care to access medical services. The biggest problem with the sick call system is that prisoners are not seen in a timely fashion. Only 50% of prisoners are seen within 48 hours of submitting a slip. Indeed, sick call triages are performed according to an unspecified priority system and with complete disregard to protocols.

Prisoners' only access to over-the-counter medication is via the sick call system. Accordingly, simple symptoms as headaches and indigestion must be endured for two or more days before over-the-counter medication is available.

E. Medical Services. A review of records and other information regarding medical care provided to several inmates, including a diabetic inmate who died after not receiving insulin, indicate either a lack of knowledge about acute medical problems, such as diabetes, abdominal discomfort and head trauma, or indifference to such medical problems. Indeed, our consultant concluded that one nurse in particular posed a genuine danger to the prisoners and should not be allowed to work alone.

The quality assurance program at PSB is seriously deficient. While PSB's quality assurance committee has identified important issues to study, it fails to establish a threshold of minimum care to indicate the effectiveness of the services provided. Further, the quality assurance program fails to develop corrective action plans. Our consultant concluded that the quality assurance program is particularly deficient in ensuring the timely initiation of TB therapy. Indeed, the program fails to contain an infection control program.

F. Medical Emergency Response Program. PSB fails to conduct regular medical emergency drills. The mock fire drills currently conducted by PSB are routine and in no way test the skills of the medical providers. A major deficiency in PSB's emergency response program is its failure to record elements necessary to ensure the effectiveness of the program, e.g., the time the medical unit is called, the time the medical unit reaches the prisoner, the time the ambulance is requested, and the times the ambulance arrives and departs.

G. Medical Records. Inadequacies in the medical records system at PSB seriously jeopardize the health of prisoners.

Documents were improperly filed and our consultant experienced difficulty in locating items in medical records. Our consultant discovered that numerous medical records failed to contain required "problem list" forms and when the records did contain the form, the medical staff never utilized it. A professionally based record keeping system is necessary to ensure medical staff have timely access to information necessary to exercise informed medical judgments with respect to care and treatment.

H. Outside Consultations. While PSB generally provides necessary outside consultations, prisoners often do not receive timely specialty consultations due to lack of adequate means to transport prisoners to medical facilities outside the jail. Some consultations are cancelled. Additionally, PSB fails to properly document consults for pregnant prisoners. Such a lack of data in jail medical records may result in a disruption in the continuity of care provided.

I. Staffing. PSB attempts to provide 24 hour on-site medical services. The inability of PSB to provide adequate medical care has been jeopardized by numerous medical staff vacancies -- vacancies which have existed for a significant period of time. Accordingly, PSB attempts to compensate for inadequate staffing by utilizing excessive amounts of overtime. Over-reliance on overtime is inconsistent with an adequate medical care delivery system.

J. Dental. PSB does not provide routine dental intake screening. PSB's on-site dentist merely screens prisoners for off-site referrals, as all prisoners with dental problems are reportedly referred to a private dentist or dental services at a neighboring university. Only 6 prisoners per month receive dental services. Our consultant concluded that for a population with as much dental pathology as PSB, the amount of dental services provided is quite inadequate.

IV. Measures Recommended to Ensure Medical Care Satisfies Constitutional Standards.

A. Intake and Screening.

1. Ensure licensed and trained personnel perform intake screening within a timely manner of a prisoner's entry into PSB. Results of the screening must be provided to the physician within the next working day and recorded in the prisoner's chart within four days. The intake screening must include a medical history and health care assessment. Inmates housed in the jail for more than seven days must be tested for tuberculosis and other communicable diseases, as appropriate.

2. Complete physical exams must be performed by qualified medical staff within 14 days of a prisoner's entry into PSB.

B. Proper Screening and Treatment of Tuberculosis.

1. All TB skin test positive prisoners should be x-rayed within 5 days of a positive result and TB treatment should be initiated within 48 hours.

2. Implement Centers for Disease Control guidelines for TB and infection control.

C. Proper Treatment of Chronic Illnesses.

1. Develop and maintain lists of current prisoners with chronic illnesses such as high blood pressure, diabetes, seizure disorder, asthma, HIV disease, and tuberculosis prophylaxis, as a means of ensuring timely treatment.

2. Implement the use of peak flow meters in evaluating asthmatic prisoners.

D. Access to Basic Medical Care.

1. Implement policies and procedures to ensure timely access by prisoners to needed medical services.

2. Ensure sick call triaging is completed appropriately in accordance with generally accepted medical standards and protocols. The sick call process must be reviewed on a regular basis with feedback provided to the nurses regarding the quality of their work.

3. Implement policies and procedures to ensure that over-the-counter medications are reasonably accessible to prisoners.

E. Medical Services.

1. Retrain all medical providers in assessing and responding to acute medical symptoms. This training must be complemented with emergency drills.

2. Provide proper medical supervision to all medical providers.

3. Develop and implement a comprehensive quality assurance program with quarterly meetings by appropriate professionals covering all aspects of services provided. Establish thresholds and other indicators to determine the effectiveness of the program. The findings of the program must be reviewed monthly. Corrective action plans must be developed and implemented, where appropriate. The program must include the development and implementation of a well designed infection control program, with appropriate monitoring and educational activities and compliance with universal precautions.

F. Medical Emergency Response Program.

Conduct quarterly medical emergency drills and annual mass casualty drills and critique such drills in a written report. The timing of emergency responses to requests for assistance must be included in the drill report.

G. Medical Records.

Medical records should be maintained and reviewed in a manner consistent with generally accepted medical standards. Supervision of medical records by an accredited records technician with proper clerical support must be provided.

H. Consultations.

Necessary steps must be taken to ensure that prisoners are scheduled for and receive recommended outside consultations in a timely manner. Ensure recommendations made by outside medical consultants are reviewed, implemented, and properly recorded by an appropriate physician in a timely manner together with all necessary follow-up care.

I. Staffing. The medical services provided to inmates must be significantly enhanced by increasing the number of qualified medical care providers to ensure adequate medical care for inmates.

J. Adequate Dental Services. Routine dental screening must be provided by qualified professionals in a professional manner utilizing appropriate facilities. PSB must provide sufficient dental support so that all prisoners requiring dental services receive them in a timely manner.

V. Serious Deficiencies in Fire Safety Result in a Life-Threatening Environment.

A. Fire Protection Systems. PSB fails to provide necessary fire protection. PSB does not have an adequate program for maintenance and testing of the fire alarm system and the alarm system is not properly connected to the steam station to provide twenty-four hour monitoring. Further, PSB fails to properly maintain its fire extinguishers. Indeed, numerous extinguishers had not been serviced in over one year. PSB was unable to produce records to document that the smoke detectors had ever been checked. Finally, while PSB policy requires that internal fire inspections of the jail occur weekly and monthly, documentation indicates PSB has not conducted a fire safety inspection in over one year.

While PSB has a sprinkler system on the floors which house prisoners, there is no sprinkler system on the fifth floor which

also houses prisoners due to overcrowding. Further, PSB fails to maintain the fire door which separates the steam station from the tower building where inmates are housed in a proper manner, resulting in the possibility that in the event of a fire, fire and smoke might migrate and involve other areas unnecessarily.

Significantly, our consultant concluded that high level jail officials fail to grasp the seriousness of fire safety deficiencies at the jail. PSB uses fire safety policies and procedures from 1989, which are old and outdated. Further, PSB had not provided fire prevention or fire safety training for its correctional officers for many years until it was reinstated when we initiated our investigation (April 1994). Finally, PSB has failed to even allow those responsible for training other jail personnel to get proper training and certification in "fire safety matters."

B. Combustible Materials. The penthouse mechanical equipment room contains wood, cardboard, and other combustibles which pose a hazard. Additionally, our consultant concluded that serious asbestos problems also exist in the penthouse mechanical room. Further, PSB consistently uses combustible (non-fire rated) plastic trash containers, despite continuous violation citations regarding this practice by the Fire Marshal.

C. Evacuation Plan. PSB reportedly conducts a number of fire drills. PSB fails, however, to stagger such drills throughout the housing areas and during different work shifts. As such, these drills fail to ensure that all areas of the facility can be evacuated in a timely manner.

Overcrowding at PSB is particularly significant because of fire safety. PSB houses numerous prisoners in dayroom areas and on the fifth floor in the gymnasium. As a result, the exit pathway is partially blocked on numerous occasions. This circumstance presents a serious fire safety risk. Further, PSB consistently stores various carts in exit pathways. Indeed, the Fire Marshal has repeatedly cited PSB for this potentially dangerous practice.

D. Emergency System. PSB reportedly tests the emergency generator weekly. Our consultant concluded, however, that PSB fails to test the generator for an adequate amount of time. Additionally, PSB reportedly conducts routine inspections of the generator, but was unable to produce supporting documentation.

VI. Measures Recommended to Ensure a Safe Environment.

A. Fire Protection Systems.

1. Maintain and test the fire alarm system to ensure 24 hour monitoring for fire and smoke. Maintain and test at all

smoke detectors and fire extinguishers to assure proper operation and maintain a log of such checks at proper intervals. Conduct regular fire safety inspections and maintain a log of such inspections.

2. Provide automatic sprinklers on all floors housing prisoners. Take all necessary steps to ensure appropriate smoke and fire compartmentation, including the installation of fire rated, self-closing or automatic doors as necessary.

3. Develop and implement policies and procedures regarding proper management of fire safety functions. Review and update fire safety policies and procedures; review and update fire safety training protocols; ensure continued fire prevention/fire safety training for all correctional officers.

B. Combustible Materials.

Remove combustible materials from the penthouse mechanical equipment room. Develop and implement an asbestos abatement program. Use fire rated plastic trash containers.

C. Evacuation Plan.

1. Conduct fire drills throughout the building on a regular basis. Drills should be conducted quarterly on each shift.

2. Ensure compliance with fire codes, particularly regarding exit pathways for emergency egress.

D. Emergency System.

Properly test and routinely inspect the emergency generator and maintain a log of such checks.

E. Overcrowding.

Reduce and eliminate crowded conditions.

VII. The Physical Plant is Unsanitary and Represents a Direct Threat to the Health and Well-Being of Prisoners.

A. Cell Sanitation, Safety, and Hygiene Measures. Numerous cells at PSB are dirty and PSB does not have adequate policies and procedures to ensure clean cells. PSB fails to provide adequate number of operative toilets in the reception area and an adequate number of showers throughout the facility. Lavatories and showers lack adequate hot and cold water.

The lighting in the housing areas is inadequate for reading and sanitation. Indeed, in numerous housing units the lighting

was so poor that it did not register on our environmental sanitarian's light meter.

PSB fails to provide prisoners with adequate personal hygiene supplies and adequate clean clothing and underwear. Numerous indigent prisoners told us that they were unable to obtain clean underwear. Our consultant discovered that the amount of underwear the jail had in stock was grossly deficient. PSB also fails to provide prisoners with adequate sleeping accommodations. The mattresses provided to prisoners are in poor repair, creating sanitation and fire safety problems. Most of the blankets used at PSB are so worn that only the weave remains.

B. General Sanitation. Numerous electrical hazards exist at PSB. The air quality and air circulation at PSB is inadequate. Additionally, the potable water system is in jeopardy of being contaminated by the absence of back-siphonage/back flow devices.

Numerous officers failed to know the clean-up procedure for blood and body fluid spills. Several officers reported that they would defer to the medical unit in the event of such a spill. Significantly, the nurse in the medical unit could not, upon our consultant's request, locate the chlorine sanitizer, a necessary solution for the proper clean-up of bodily fluids.

PSB improperly handles medical wastes. Indeed, PSB stores medical wastes in an area just outside the kitchen where both food and personnel enter and exit.

PSB fails to properly screen areas thereby providing entry pathways for insects and rodents. Indeed, numerous flies were present during our investigation.

PSB fails to properly store medicines and biological laboratory materials. PSB allows employees to store food in the same refrigerator which maintains medicines and lab materials, subjecting each to cross contamination.

C. Food Sanitation Practices. The food preparation and sanitation practices at PSB are woefully inadequate. PSB fails to properly sanitize pots, pans, utensils and equipment. Moreover, food storage and service practices are very poor. Indeed, PSB necessarily disposed of nearly one ton of food due to contamination by vermin. Finally, PSB food facilities fail to maintain food at the temperature necessary to prevent bacterial growth and foodborne illnesses. For example, the food stored in the freezer registered a temperature of 32 degrees fahrenheit. The temperature must be at or below zero degrees fahrenheit to prevent spoilage.

VIII. Remedial Measures for Environmental Issues.

A. Cell Sanitation, Safety, and Hygiene Measures.

1. Develop and implement a housekeeping plan for cell sanitation, e.g., provide proper waste disposal, sanitary supplies, and cleaning equipment. Inspect cells and areas used by prisoners weekly by qualified staff; yearly by local and state health inspectors; maintain a log of such inspections.

2. Ensure proper maintenance of toilets, lavatories, and showers. Provide adequate hot and cold water in lavatories and showers. Provide a sufficient number of toilets and showers to meet the needs of prisoners.

3. Provide lighting adequate for reading and sanitation in the housing areas. The lighting level should be at least 20 foot-candles.

4. Ensure proper temperatures throughout the housing units.

5. Provide each prisoner with adequate clothing, underwear, as necessary, and bedding, including sheets, a pillow, and pillowcase, and sufficient blankets.

B. General Sanitation.

1. Correct all electrical hazards. Implement proper measures to ensure proper air quality and adequate air circulation and ventilation throughout the jail. Install devices to prevent the risk of contamination to the potable water system.

2. Implement an operational safety and health program, with appropriate employee training.

3. Implement an effective pest control system throughout the jail.

4. Ensure proper storage of medicines and biological laboratory materials.

C. Food Sanitation Practices.

1. Develop and implement proper policies and procedures to ensure appropriate sanitation practices throughout the food service areas; ensure proper food and utensil storage practices; store all food in proper containers.

2. Develop and implement proper policies and procedures to ensure that hot food is maintained at 140 degrees fahrenheit at all times and that frozen foods are properly refrigerated. All perishable foods are to be stored in freezers at or below zero

degrees fahrenheit or in refrigeration units at or below 45 degrees fahrenheit.

IX. Inmates' Opportunities for Out-of-Cell/Exercise Time Is Inadequate.

While PSB provides outdoor recreation, prisoners who are taking any type of medication are denied recreation. This practice automatically excludes even those prisoners who are merely taking over-the-counter drugs, such as aspirin or tylenol. Further, numerous inmates, specifically mentally ill and older prisoners, never "qualify" for outside recreation. Significantly, the older prisoners are housed in an area with no windows or fresh air ventilation. It is, therefore, possible for prisoners to be confined for several months without ever seeing daylight. Adequate opportunity for regular exercise is essential for maintaining both physical and mental health. Indeed, our consultant concluded that the very prisoners who would benefit the most from outside fresh air are the ones who are excluded.

The outdoor recreation facilities consist of only 1 operative basketball hoop and underinflated basketballs. PSB fails to provide any other type of equipment.

There is no unit-based recreation program at the jail. Such activities are important as they result in less inmate tension, fewer disciplinary problems, promote positive inmate peer interaction and provide inmates with constructive outlets to channel their energies and overcome anxieties that are normal in any confinement situation.

X. Measures Recommended for Inmates' Recreation.

PSB must evaluate current practices to assure inmates on medication are not routinely excluded from participating in outside recreation. Outside recreation by these inmates should be determined on a case-by-case basis.

Existing outside recreation space must be equipped with sufficient sporting/recreation equipment to afford prisoners the opportunity to participate in large muscular activity.

PSB must assure that both indoor and outdoor recreation programs exist for prisoners.

XI. Minors.

PSB houses minors who have been certified to stand trial as adults. Reportedly the minors are housed separately from the adult population. Our penologist consistently found, however, that minors were housed with the adult general population with no regard to sight and sound separation. Indeed, several minors

reported that they are often moved to the reception floor which is an overcrowded, adult housing area, as punishment for misbehavior.

The minors at PSB are further harmed by PSB's failure to provide any educational materials or regular teaching assistance. Our consultant found that minors at PSB do not receive the minimum hours of required educational services. Indeed, numerous minors are not even registered to participate in the education program.

XII. Remedial Measures Regarding the Minors Housed at PSB.

1. PSB must classify minors to assure that they are afforded both sight and sound separation from the adult population of the jail. Any area designated as a reception unit should not be used to house minors because of behavioral or discipline problems.

2. PSB must provide educational materials and an adequate educational program for minors.

XIII. Inadequate Access to the Courts.

PSB fails to afford inmates adequate access to the courts. No legal assistance is made available to the inmates. As well, legal books and other materials are inadequate. The library contains one complete set of the New York Statutes and the Federal Procedures -- Lawyer's Edition. However, it does not contain any additional copies of volumes most essential to the inmate population, forcing inmates to wait several weeks to access the material necessary for upcoming court matters.

PSB fails to provide inmates with access to paper, typewriters, xeroxing and other supplies and services related to the preparation of legal documents.

Moreover, PSB fails to provide prisoners with adequate access to their attorneys. Attorney consultation rooms are used for a variety of other purposes, including classroom instruction and probation hearings. Attorneys are, therefore, required to wait for several hours for the availability of a consultation booth before they are able to see their clients. Furthermore, inmates reportedly experience unreasonable delay in attempting to access their attorneys via telephone due to the shortage of telephones in housing units.

XIV. Remedial Measures Regarding Adequate Access to the Courts.

PSB must either provide adequate free legal assistance to assist inmates with criminal, civil, and administrative legal matters, or, in the alternative, provide inmates with adequate

access to legal materials. The numbers and types of legal materials available, the organization of such materials, and other materials, including typewriters and paper, must be enhanced significantly.

PSB must take every step possible to ensure and facilitate inmate access to counsel. PSB must assist inmates in making confidential contact with their attorneys. Attorney contact includes, but is not limited to, telephone communications and visits.

XV. Racially Insensitive Acts.

PSB fosters a racially hostile environment. During our investigation a letter from the Human Rights Commission of Syracuse and Onondaga County came to our attention in which the Commission objects "in the strongest possible terms" to the discovery of a rope unmistakenly fashioned into a hangman's noose and the response of a high level jail official that it was "just a joke." The Human Rights Commission admonishes the County that "the presence of hangman's nooses have characteristically signalled the intention to intimidate African-Americans with a symbol of lynchings."

Several weeks earlier, our consultant also discovered material unmistakenly fashioned into a hangman's noose, which was also lightly dismissed by a high level PSB official as "an officer with idle time." Further, a County official's comment to one of our attorneys regarding the population of PSB, which we believe to be racially insensitive, was dismissed as a "joke" by a high level County official. Most recently, a PSB training officer reportedly instructed his class that the only recreation equipment needed by the inmates would be "a chain, a tire and some Samsonite luggage" equating PSB inmates to gorillas by referring to a popular Samsonite television commercial. Such conduct is unacceptable.

XVI. Remedial Measures to Eliminate Racially Insensitive Acts.

PSB must develop and implement policies and procedures regarding the intolerance of racially hostile acts. PSB must thoroughly document and investigate racially hostile acts. PSB must take necessary steps to communicate that racially hostile acts will not be tolerated.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after appropriate local officials are notified of them. 42 U.S.C. Section 1997b(a) (1). We expect to hear from you as soon as possible, but no later than 49 days after receipt of this letter, with any response you may have to our findings and a description of the specific steps you have taken, or intend to take, to

implement each of the minimum remedies set forth above. If you do not respond within the stated time period, we will consider initiating an action against your jurisdiction to remedy the unlawful conditions.

We look forward to working with you and other County officials to resolve this matter in a reasonable and expeditious manner. If you or any member of your staff have any questions, please feel free to contact Shanetta Y. Brown, Trial Attorney, Special Litigation Section, at (202) 514-0195.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Mr. John C. Dillon
Onondaga County Sheriff

Jon Gerber, Esquire
Onondaga County Attorney

Mr. Charles Pirro
Onondaga County Chief Deputy

Thomas J. Maroney, Esquire
United States Attorney
Northern District State
of New York