APPENDIX J

The Honorable Jim Rout
Mayor of Shelby County
160 North Main, Suite 805
Memphis, Tennessee 38103

Re: Investigation of Shelby County Jail Memphis, Tennessee

Dear Mayor Rout:

On August 24, 2000, we notified you of our intent to investigate conditions in the Shelby County Jail ("SCJ"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. Section 1997 et seq. Our investigation focused on allegations of inadequate supervision of inmates and staff that lead to excessive levels of violence in the facility, inadequate mental health and medical care, and deficient sanitation and environmental health. I am writing to report the findings of our investigation, supporting facts, and recommended remedial measures, as required by CRIPA.

On October 4-6, and December 11-13, 2000, we toured the SCJ with expert consultants in prison security, correctional health care, mental health care and environmental health and safety. Our consultants subsequently prepared reports to us of their findings and recommendations. While at the SCJ, we interviewed administrators, staff, and inmates and reviewed documents, including policies and procedures, incident reports and medical records. In addition, we received and reviewed the documents provided to us before, during and following our on-site tours. We also reviewed the December 22, 2000 Opinion Finding Defendants in Contempt of Court, entered by the district court in Little v. Shelby County, No. 96-2520 (W.D. Tenn.) (the "Little Findings"), and the March 14, 2001 Technical Assistance Report from the National Institute of Corrections ("NIC"). At the end of our October visit, our expert consultants in corrections, medical care and environmental health conducted exit interviews in which they conveyed their preliminary findings.

We appreciate the assistance provided to us by the Shelby County Sheriff's office and representatives of the county government. In particular, staff at the Jail and in the office of the Sheriff's legal advisor extended every courtesy to us during our visits, and provided all documents we requested.

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

I. Legal Framework

The constitutional law governing conditions of confinement for inmates has two sources, the Eighth and Fourteenth Amendments. Pre-trial detainees, individuals who have not been convicted of the criminal offenses with which they have been charged, comprise the majority of inmates at the SCJ. Under the Fourteenth Amendment, these inmates "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). Further, the Fourteenth Amendment prohibits punishment of pretrial detainees or the imposition of conditions or practices not reasonably related to the legitimate governmental objectives of safety, order and security. Id. at 535-37.

Under the Eighth Amendment, convicted inmates at the SCJ are entitled to "humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter and

medical care and must 'take reasonable measures to guarantee the safety of the inmates.'" Farmer v. Brennan, 511 U.S. 825, 832-833 (1994) (quoting Hudson v. Palmer, 468 U.S. 517, 526 (1984)). The Eight Amendment also forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1, 9 (1992). Likewise, prison officials have a duty to protect prisoners "from violence at the hands of other prisoners." Farmer, 511 U.S. at 833. The Eighth Amendment protects prisoners not only from present and continuing harm, but from future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993).

The SCJ must ensure that inmates receive adequate medical care, including mental health care. See Farmer v. Brennan, 511 U.S. 825, 832 (1994); Phillips v. Michigan Department of Corrections, 731 F. Supp 792 (W.D. Mich. 1990, aff'd 932 F.2d 969, 1991 WL 76205 (6th Cir. (Mich.)). Deliberate indifference to inmates' (including pretrial detainees) serious medical needs violates the Eighth Amendment because it constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Rich v. City of Mayfield Heights, 955 F.2d 1092, 1096 (6th Cir. 1992).

II. The Shelby County Jail Facilities

The Shelby County Sheriff's Office operates the SCJ, which consists of four physically separate facilities: the main Jail at 201 Poplar Street in downtown Memphis ("Jail"), the Jail East facility for women located in East Memphis, the prison ward at the University of Tennessee Medical Center (know as the Med), and leased dormitory-style space, known as P Dormitory, at the Shelby County Corrections Facility. We were informed that, by agreement with the City of Memphis, the SCJ also detains all inmates charged by the City, which has no separate jail of its own. Thus, the SCJ houses both men and women of minimum, medium, and maximum security custody, plus an average of more than 100 state-convicted inmates, and a varying number of juvenile detainees who have been remanded, under state law, to face criminal charges as adults.

The downtown Jail was opened in 1981, and had 2,789 beds at the time of our tours. Two floors of the Jail contain dormitory housing, a small number of single cells on the second floor are reserved for inmates with special needs, and the remaining Jail housing is in double-bunked cells. An addition to the Jail is currently under construction, and we are told it will contain space for as many as 250 inmates. The lower level of the Jail is used for intake, booking, classification and pretrial services. The Jail also contains a small medical area on the second floor, an indoor gymnasium, a secure roof-top recreation area, a chapel and a small room used as a law library.

The Sheriff's Office opened a facility known as Jail East in 1999, and moved all female inmates to that facility, which has a separate intake and booking area, a small medical area, and a capacity of 384. P Dormitory, space leased from the Department of Corrections, houses 200 low security male inmates.[1] Unless otherwise noted, our findings refer to the main Jail and to Jail East.

III. Findings and Supporting Facts

A. Deficient Security and Supervision and Protection from Harm

1. Inmate-on-Inmate Violence

Inmates at the SCJ face an unconstitutional threat of violence from attacks by other inmates. In November of 1997, the district court in the Little case found that:

Gang involvement is very prevalent in the Shelby County Jail. Gangs known as the Gansta Disciples and Vice Lords are present in the Shelby County Jail. Gang members are responsible for many violent acts, stabbings and rapes in the Shelby County Jail.

Little Findings of Fact and Conclusions of Law at 5 (November 12, 1997). On December 22, 2000, the court held, on plaintiffs' motion for contempt, that "[t]hose same conditions exist unchanged in the Shelby County Jail today."

Little Findings at

1. The court found that:

[T]here is no evidence to demonstrate that the guards are adequately supervising the inmates to ensure that the pods to which they are assigned are safe and compatible housing assignments. Rather, the evidence presented [at 5 days of testimony in November and December of 2000] demonstrates that gang members control the daily life of the inmates in 95% of the pods; that the gang members run organized brawls between gang members and non-gang members [referred to as "Thunderdome"]; that the gang members post rules in the pods that are imposed on other inmates upon threat of physical violence . . . . The Court heard testimony from inmates who had been assaulted in the Jail, both in Thunderdome events and for failing to participate in them, that the guards responsible for supervising the pods to prevent the inmates from assaulting each other were either away from their assigned posts, aware of the assaults but failed to stop them, or asleep.

Little Findings at 38 - 39. The County stipulated that assaults by inmates on other inmates occur in the intake area of the Jail, and that the Gangsta Disciples are responsible for many violent acts towards other inmates in the Jail. Id. at 10-11. These facts concerning gang control and frequent assaults of inmates are consistent with the observations of our consultants.

2. Inmates Are Not Supervised Adequately.

The Jail is chronically short-staffed and plagued by high turnover and absenteeism. Interviews with SCJ officials and correctional officers, review of staffing rosters and the December 22, 2000, Little Findings confirm that the SCJ incurs substantial overtime in order to staff necessary posts. The ongoing personnel shortage compromises institutional security and the safety of inmates and staff. (2) Due to short staffing, the SCJ routinely requires officers to supervise more than one pod (3) of inmates at a time -- notwithstanding that officers have no line of sight supervision of the cells in these pods. Little Findings at 10, Stipulated Facts Nos. 6 - 9. Moreover, the significant crowding results in so many inmates congregating inside the dayrooms that an officer's view of the back of the dayroom is also obstructed. Officers do not make required rounds of the catwalks to observe conditions inside the cells, and even when they make infrequent rounds, their view into the cells is obstructed by poor lighting and various obstructions hung by the inmates. Thus, housing staff cannot, and do not, supervise inmates adequately. (4) The recent testimony in the Little contempt hearings was replete with examples of inmates who suffered harm at the hands of other inmates without interference from -- indeed, often without the knowledge of -- correctional officers. Little Findings at 17, 19-20, 38-39.

Staffing shortages also are blamed for consistently, dangerously low staffing in the intake area, where assaults by inmates upon other inmates frequently occur. The County admits that as many as 150 inmates may be awaiting classification in the intake area, and that only three officers per shift are regularly assigned to intake. Id., Stipulated Facts Nos. 4, 6.

3. SCJ Fails to Classify Inmates Effectively.

SCJ further compromises safety by classifying inmates with a system that has substantial deficiencies. First, a significant flaw with the current classification system is that an inmate's classification is not reviewed on a periodic basis, to take into account possible changes in charges and institutional behavior that might warrant an increase or a reduction in the inmate's classification level. Reviews are particularly important because many inmates remain in the SCJ for many months or years. Second, the system considers only prior convictions in assessing an inmate's criminal history, and does not consider prior assaultive charges for which an inmate currently may be on bond awaiting trial. Third, the SCJ routinely fails to discipline misbehavior while in the facility, and thus, routinely fails to incorporate information about disciplinary findings in its classification and re-classification decisions. Finally, the classification system does not take into account gang affiliation or participation in gang-related activity -- even activity that occurs in the Jail. These deficiencies substantially increase the likelihood of an inmate's classification not reflecting his or her true potential for violence, and increases the risk of serious harm to inmates.

In addition, the Jail's intake area consistently fails to separate and supervise inmates with a potential for violence, leaving inmates prone to attack during the hours -- and sometimes days -- that it takes to complete the booking and classification process. The Jail was designed with separate holding tanks on either side of a hallway of central offices used for booking, identification, preliminary classification, medical screening and pretrial services. The Jail separates inmates and processes them through either the assaultive or the non-assaultive corridor, based only on information available at arrest, primarily, their charges. Both sides of the intake area suffer from deficient staff supervision. In addition, these areas are grossly crowded, with as many as 100-150 inmates at peak times. The holding tanks, with a maximum total capacity of 75 inmates, are inadequate to contain this number of inmates, who often spill into the hallways. The identification unit and medical screening area can be accessed from either the assaultive or the non-assaultive hallways, and basic security is consistently lax, permitting assaultive and non-assaultive inmates to mix in these areas.

4. SCJ Does Not Discipline Inmates Who Violate Jail Rules.

SCJ officials have not taken the necessary steps to control inmate misconduct through the disciplinary process. Disciplinary infractions routinely result in no formal discipline, both because mandated hearings are not held within 72 hours, after which the charges expire, and because staff, knowing that follow-up with a hearing and punishment is unlikely, frequently do not initiate the process by charging or "writing up" the inmate. One of the factors contributing to this problem is the lack of sufficient disciplinary segregation beds. "Waiting lists" are common as inmates determined to have violated institutional regulations must wait for a bed in disciplinary segregation to become available. The NIC report also highlighted this problem, calling the number of disciplinary segregation beds "seriously inadequate." NIC Technical Assistance Report at 20. Furthermore, even when disciplinary action is taken, that information is not incorporated into re-classification decisions. This failure substantially increases the likelihood of inmates' classification not reflecting their true potential for violence, and increases the risk of serious harm to inmates.

5. SCJ Does Not Control Dangerous Contraband, Tools or Keys.

The SCJ fails to conduct sufficient searches of inmate living areas to control inmates' accumulation of dangerous contraband. For example, the shakedown team conducted no shakedowns at Jail East between March and December 2000. During our visit in October, inmates at Jail East complained that other inmates had accumulated stocks of disposable razors from the commissary, a clear security concern. At the main Jail, the shakedown team's log included shanks, razor blades removed from their disposable

handles and other forms of life-threatening contraband, as well as stockpiled medications and other items frequently used for barter and extortion among inmates.

Inadequate tool and key control at SCJ create a significant risk of harm to both institutional security and the health and safety of inmates and staff. SCJ staff members at both the Jail and Jail East were unable to identify emergency keys for unlocking doors,[(5)] and a lieutenant assigned to the key storage area could not identify any use for a number of keys under his control. The NIC team made similar observations in its tour of the SCJ in January 2001. We observed inmates with broad access to dangerous tools which could easily be used as weapons, for example, acetylene torches and heavy metal cutters used by unguarded workmen installing a railing in the lower level. We also observed the door to the DRT staging room left open to an adjoining hallway where unescorted inmates walked, despite the fact that chemical agent sprays, among other items, are stored in unlocked cabinets and file drawers in the room.

6. Excessive Use of Force Is Prevalent.

The level of force used by staff against inmates at the SCJ is excessive, and senior Jail management is aware of the problem. The Chief Jailer conceded that the use of force "may be bordering on high," the Commander of Security acknowledged that staff routinely use chemical agents before using hands-on control techniques (an express violation of SCJ policy), and a former commander of Internal Affairs confirmed the use of force outside the parameters of the staff's training. The use of pepper spray is particularly uncontrolled. The reasons include the lack of guidance in policies, the lack of inventory control for chemical agents, the lack of effective oversight or investigation of all incidents involving this type of force, and the lack of supervision to prevent the staff's use of force exceeding the limitations of policy.

a. Policies on the Use of Force Provide No Operational Guidance.

The SCJ's use of force policies and procedures are too vague to provide guidance to staff in identifying the limited appropriate circumstances for uses of force. The Constitution permits the use of force in correctional settings only to the extent that the force used by officials is reasonably necessary to respond to a threat to security or discipline reasonably perceived by officials. Hudson v. McMillian, 503 U.S. at 7 (discussing factors that courts evaluate in determining "whether the use of force could plausibly have been thought necessary in a particular situation"); Williams v. Browman, 981 F.2d 901, 905 (6th Cir. 1992) (same). The SCJ's policies, however, describe permissible uses of force more indiscriminately. For example, the SCJ "Use of Chemical Agents" policy permits the use of chemical agents when an inmate "shows no intention of complying" with a verbal order, no matter what the order or how insignificant its impact on security. Inmates complain of being sprayed by officers in the course of verbal disagreements, and numerous reports indicate that inmates are sprayed with chemical agents on little provocation. However, if an officer states that the inmate refused a verbal order, the officer's behavior is safely within the bounds of SCJ policy. Less forceful alternatives to control inmate behavior, including a show of force through additional or supervising officers, hands-on control tactics, and discipline through the administrative process, are neither encouraged nor required by this policy.

SCJ policy also authorizes the use of force to prevent destruction of county property, no matter how insignificant its value. The exertion of force against inmates, including chemical sprays, to prevent insignificant property damage is excessive, yet is within the bounds of this policy. See Hudson v. McMillan, 503 U.S. at 7 (the need for force, the relationship between that need and the amount of force used, and any efforts made to temper the severity of a forceful response are among the factors properly used to evaluate whether the use of force was wanton and unnecessary); Lock v. Jenkins, 641 F.2d 488,

496 (7th Cir. 1981) (although the significant destruction of prison property might justify the use of tear gas, damage to a food tray does not rise to this level). This policy, in particular, should be amended to authorize force only in the face of destruction of valuable property. Sound use of force policies should provide guidance to staff so that staff's response to the threat posed by an inmate's behavior employs only the force reasonably necessary to control that behavior.

b. Chemical Agents Are Not Inventoried.

There is no inventory control of canisters of pepper spray. In fact, numerous canisters are held in unlocked file cabinets in the DRT staging room, and canisters are issued to each officer at the training academy. Depleted canisters are replaced upon application. A 1996 policy requiring canisters to be weighed upon issue and quarterly was revised in 1998 to eliminate the quarterly weighing. Monitoring the volume of chemicals used by staff is one way to identify heavy use -- and prevent excessive use -- of chemicals.

c. Uses of Chemical Agents Are Not Investigated.

There is no effective investigation of the use of chemical agents, the most routine use of force at the SCJ. Staff are required to fill out a form entitled "Use of Chemical Agent," but even the most blatantly inappropriate reasons for the use of chemicals stated on these reports -- indeed, even reports with no stated reasons -- are not investigated by the Internal Affairs Bureau.[(6)]

For example, staff spray inmates when they are verbally aggressive, as in the following report: "Inmate refused to remove his clothing after being placed on suicidal precaution and became verbally abusive and very hostile." Staff frequently spray inmates displaying behaviors characteristic of mental illness, as in the following examples: "Inmate was beating his head against tank door. He was sprayed to prevent him from hurting himself;" and "[Inmate] refused to talk sensible, he began to praise the devil pulling off all his clothes, walking naked . . . given several orders to go to his cell, but still refused."

None of these instances was investigated, as evidenced by the fact that none appeared in the Internal Affairs Bureau's investigation logbooks. Incidents where inmates were sprayed while lying prone on the floor or while locked in their cells were also not investigated. Indeed, the use of chemicals against an inmate is seldom reported on the separate forms designed for that purpose and is even more rarely investigated. To ensure the appropriate use of chemicals by staff, supervisors should provide oversight, feedback and discipline for misuse.

d. Examples of Excessive Force

A hearing-impaired, mentally ill inmate was pepper sprayed while laying quietly in his cell, then he was forcibly removed from the cell by five members of the Detention Response Team ("DRT") wearing riot gear and gas masks, strapped into a five-point restraint chair, and a solid hood placed over his head. He was then transported to and from a shower in the restraint chair. The stated justification for this extraordinary show of force was that the inmate, who was known to be hearing impaired, had refused a verbal order to take a shower. The use of this level of force in these circumstances, upon an inmate with known disabilities that would affect his ability to comply with staff orders, appears to us to be an example of wilful and wanton infliction of pain without justification.

The policy on use of the restraint chair requires the use of a "disposable spit cap." The policy states that the spit cap is used to "eliminate any potential health hazards." Staff proffered to us that it was used to reduce the possibility of transmitting HIV. We are aware of no medical or scientific literature to suggest

that HIV is transmitted by spitting. Moreover, the disposable mesh bag (i.e. spit cap) that was used in a demonstration on a member of the DOJ team is distinguishable from the opaque bag that was placed over the head of the deaf inmate described above. In the actual incident, as opposed to the demonstration, the inmate's eyes, ears, nose and mouth were completely covered by the "spit cap" that resembled a canvas pillow case. The canvas bag was placed back on the inmate's head after he complied with the DRT's instruction to shower and dress out. The use of the canvas hood is never appropriate. Moreover, because no valid penalogical purpose has been suggested for the disposable spit cap, its use is also inappropriate.

Inmates reported many additional examples of the use of excessive force, particularly involving pepper spray. Several inmates in one pod, independently and without collusion, told us that the DRT had sprayed gas into the dayroom of their pod during what the inmates described as a practice session, while inmates were locked in their cells. This appears to be confirmed by a DRT incident report stating that the team used two cans spray in one pod. The DRT report alleged that a number of inmates in the pod had refused a verbal order to lock down. Inmates report that pod officers routinely use pepper spray in the course of verbal altercations.

In summary, the vague policies on use of force, the admissions of senior management, the review of incident reports and complaints, and the lack of oversight on the use of chemical agents lead us to conclude that the SCJ violates the constitutional rights of inmates by permitting the excessive use of force by staff. We conclude that there is a pattern or practice of excessive use of force against inmates at the SCJ and that management has failed, in particular, to correct the clear misuse of chemical agents by staff.

B. Mental Health and Medical Care Is Constitutionally Deficient.

Shelby County contracts with Correctional Medical Services ("CMS") to provide mental health and medical care at the Jail and Jail East; critical care is provided by the University of Tennessee's Regional Medical Center. Medical and mental health services at the Jail and Jail East are critically deficient in several respects:

- initial evaluations are frequently deficient;
- access to both medical and mental health care through sick call is deficient because there are too few qualified professionals on staff to evaluate sick call requests and perform examinations in a timely manner;
- mental health diagnostic assessments are inadequate;
- prescription medication is not managed and administered reliably;
- chronic illnesses, including severe mental illnesses, are not managed effectively; and
- there is no screening for emergent mental health concerns in the general housing areas.

1. Deficient Access to Care

a. Intake Evaluations

There is a critical shortage of qualified health professionals to serve an inmate population the size of the

SCJ. In the year 2000, the Jail booked more than 64,000 inmates, averaging more than 5,300 bookings per month. The staff is hard-pressed to provide complete intake evaluations for such large numbers of inmates, and we noted numerous lapses in medical intake evaluations, particularly in screening for transmissible infectious diseases, taking and recording vital signs, and assuring timely continuation of prescription medications.

The following examples illustrate lapses in providing minimally competent medical intake evaluations. Problems with screening for infectious diseases were evident from the files of two inmates with recorded histories of tuberculosis, neither of whom was screened for current signs of the disease, even though our review occurred almost two months after their admissions. We discovered many cases where previously-prescribed medication was not continued upon intake, including an inmate who required seizure medication that was not ordered by a physician until four days after intake. Another inmate, a renal dialysis patient with hypertension and diabetes, received no treatment for either condition for three days, and no blood pressure or blood sugar monitoring. An inmate admitted on medications for HIV received no physician evaluation and no medication evaluation during five months of incarceration. These are all potentially life-threatening delays.

There is inadequate evaluation and treatment of substance abuse and the symptoms of withdrawal. Inmates are not asked directly about drug and alcohol use. A recently-implemented protocol to screen inmates for drug or alcohol withdrawal relies heavily upon reviewing vital signs for indications of withdrawal, yet vital signs are routinely not taken and recorded during intake evaluations. One inmate who admitted to drug and alcohol abuse at intake received no physical evaluation or physician appointment during two months of incarceration.

Failure to continue medication promptly and to monitor vital signs at intake also contributes to deficiencies in mental health care. One inmate was admitted and discharged within two days without receiving previously-prescribed medication for bipolar disorder, although the medications were identified on his intake forms. He was re-arrested a day later but his psychiatric medication again was delayed for two days. This inmate committed suicide five days after his first admission (on the third day of his second admission), having not received prescribed mood-stabilizing medication for four of his last five days. It took two weeks for another inmate to receive the psychotropic medication he had been taking at the time of his arrest.

Lack of privacy in the intake area may inhibit candid responses to the intake screening questions, increasing the chances of missing an inmate with a significant mental health or suicide concern.

Although national statistics suggest a higher prevalence of mental health concerns among female than male inmates, there is a disturbing shortage of qualified mental health professionals at Jail East. The mental health staffing for inmates at Jail East consists of a technician working two hours per day, five days per week, and a psychiatrist working three hours per week. There is no substitute staffing during staff vacations or other absences. This is insufficient to accomplish timely screening for mental health concerns, or to provide essential treatment for those with identified needs, including those on psychiatric medication. For example, the psychiatrist canceled his one-morning per week visit to Jail East during our December tour. In his absence, no new or altered prescriptions could be ordered, and inmates who required psychiatric services faced a longer wait for those services. During our October tour, a nurse at Jail East told us that an inmate who appeared to be depressed and in need of mental health treatment had not been seen by mental health staff in the four days since her admission, despite this nurse's phone calls to the main Jail's mental health staff requesting an evaluation.

b. Sick Call

Access to non-emergency care is deficient, both because it is not timely, and because it is not provided by appropriately-qualified professionals. For non-emergency care, both medical and mental health visits are initiated by submission of a sick call slip, which inmates complained were often unavailable. One inmate told us that he used his library time to make copies of the slips because they were so hard to come by. SCJ policy states that sick call will be scheduled at least once per week for all inmates. The Jail's policy does not meet accepted national standards for large jails, which require requests for medical care to be reviewed by a qualified medical professional within 24 hours, and the patient to be seen by a qualified professional within the following 24 hours (72 hours if a weekend). The Jail's actual practice, described below, deviates even further from accepted national standards. In practice, it appears that sick call requests are triaged by a nurse,[7] and inmates are scheduled for the next weekly sick call on their floor - which could be as much as a full week later. One inmate, known to have AIDS, submitted a sick call request complaining of sores and a burning sensation, but was not called for an evaluation until ten days later. If a case is deemed by correctional staff to be sufficiently urgent, an inmate instead might be escorted to the second floor medical area for an evaluation prior to the next weekly sick call on his floor. The NIC report found that the Jail's ad hoc sick call practice placed correctional staff in the untenable position of being gatekeepers for medical services. NIC Technical Assistance Report at 15.

In addition to its limited availability, sick call is constitutionally deficient because sick call examinations are conducted by staff not qualified to do so.[8] This has compromised the health of inmates and subjected them to unnecessary pain. For example, an inmate who had recently undergone surgery to repair a hernia in his groin area requested sick call in June and again in July, complaining of pain in his groin, particularly when urinating. He was examined by a registered nurse ("RN") and then a licensed practical nurse ("LPN"), but did not see a doctor and did not receive antibiotics, despite indications of an infection. In August, two months after his first complaint to the Jail, the inmate's genitourinary infection was diagnosed during a surgery followup visit at a hospital clinic. Another inmate twice requested attention for a suspected broken finger and was twice seen by an LPN, but did not see a physician for a week. These delays unnecessarily prolonged the inmates' pain and/or illness, and could have resulted in significant medical complications.

c. Mental Health Diagnosis and Treatment

All mental health staff interviewed acknowledged significant difficulty in responding to the mental health needs of inmates.[9] The staff at the main Jail, but not Jail East, performs timely, cursory evaluations of all inmates with identified mental health concerns, primarily those identified at intake. Outreach is necessary to identify other inmates with mental health concerns before those concerns escalate to crises that require intensive intervention and threaten the health and safety of inmates and staff alike. However, no designated mental health staff persons review sick call requests to identify inmates with emerging mental health concerns. Moreover, despite CMS policy requiring mental health workers to make rounds to housing units, and national standards with the same recommendation, the only housing areas in which mental health workers conduct rounds to identify emergent needs are the pre-classification cells on the Jail's lower level. Outreach by mental health staff is particularly important because correctional staff at the SCJ demonstrate little training in or understanding of the needs of inmates with mental illness or suicidal tendencies.

Diagnostic evaluations of those inmates identified as needing mental health treatment are deficient, with only three of seventeen charts reviewed containing any diagnostic assessment at all. A diagnosis is critical to assessing the adequacy of the inmate's medication and any treatment. The SCJ employs no psychologists to assist the psychiatrists with diagnoses.

Because there is almost no outreach to identify inmates in need of mental health services who have not

self-identified, large numbers of inmates at the SCJ receive little or no mental health care. There is no education or programming on important mental health topics, such as drug and alcohol dependance or medication compliance. Finally, as described in the context of medication administration, infra, the SCJ fails to administer prescription medication reliably. Because the dominant mental health intervention at the SCJ is medication, missed doses (both not administered and not taken) are unacceptably high and likely to have serious consequences for behavioral disorders within the Jail.

d. Care of Chronic Medical Conditions is Deficient.

Although the SCJ has a rudimentary computerized tracking system for chronic care patients, we found many significant lapses in the care of these patients. For example, one inmate who was receiving HIV medications prior to incarceration received no medication or evaluation during five months of incarceration at the SCJ. Another inmate had numerous serious medical conditions identified at intake, including diabetes, [(10)] high blood pressure, and mental illness. He received no physician evaluation for diabetes until five months after intake, and no physician evaluation during a two month period when he was experiencing dizziness and other symptoms of hypoglycemia. He was found dead in his cell one year after his initial intake, with the probable cause of death noted to be heart disease and diabetes. It is likely that poor control of these chronic and life-threatening conditions contributed to this death. The lack of sufficient qualified staff is a likely cause of the SCJ's failure to ensure that chronic care patients receive necessary care for their life-threatening conditions.

e. There is no Infirmary Care for Inmates Requiring Close Observation By Medical or Mental Health Staff.

There is no infirmary for observation and treatment of inmates with serious medical or mental health conditions requiring ongoing medical treatment, but not hospitalization. This is a significant deficiency. In addition to the examples of chronically ill inmates noted above, a 24-year-old inmate died at the Jail in December of pneumonia, a treatable illness. Although the inmate had visited the emergency room the day before his death, he was released and returned to general housing, where his condition deteriorated rapidly. In the day before his death, he was not observed by medical staff except for two brief encounters with a nurse (there is no indication if the nurse was an LPN or RN). Another inmate exhibited uncontrolled hypertension for nine months, during which time he suffered two strokes and possible heart injury. He was transferred to the hospital four times, and each time he was returned to general population housing. He should have been housed in an infirmary with the ability to monitor his blood pressure and medications to bring the hypertension under control, to lessen the chance of suffering the additional stroke and heart damage. A third inmate, who died of heart failure in October 2000, went back and forth between general population housing and the hospital. On his last release from the hospital, he was placed in a cell with no running water because the hospital suggested that he would exacerbate his heart condition by drinking too much water. A far more appropriate placement would have been an infirmary, where fluid intake and output could have been monitored. In each of these instances, the inmates' care was compromised, and their pain or illness exacerbated, by the unavailability of close medical monitoring in an infirmary.

2. Medication Administration is Deficient.

Both medical and mental health care is compromised by significant lapses in administration of medications. Missed doses included medications essential for conditions such as serious mental illness, diabetes, asthma, and HIV. Of 17 charts reviewed, at least 10% of the prescribed doses of psychotropics on the second floor medical housing unit and 20% of the doses on the general housing units were never delivered. On occasion, no medications were distributed to an entire pod and quite possibly the entire

floor. In many instances, contrary to the stated policy and procedure, there is no documentation in the medical charts explaining the missed doses.

Staff also fails to ensure that inmates take their prescribed medication. Our review of shake-down logs confirm that numerous pills are confiscated from hordes in inmates' cells. During our December tour, we observed inmates place medication in their mouth and then turn their backs to the staff to walk back to their cells, enabling them to spit out and save the medication unobserved by staff.

3. Suicide Precautions Are Inadequate.

The cells in the area of the Jail reserved for suicidal inmates are unsanitary, foul-smelling, contain bunks and plumbing fixtures from which an inmate could hang himself, and cannot all be seen and heard from the control room where staff are stationed. Inmates in these cells are required to strip completely, and are not given paper gowns or blankets, despite complaints that the cells are chilly. The condition of these cells is well-known among inmates, who told us that they are loathe to say anything to staff that could result in being placed in these cells.

In addition to the inmates' expressed reluctance to self-identify suicidal thoughts, our psychiatrist noted that correctional staff throughout the SCJ appeared untrained in identifying inmates with mental illness or those with suicidal or self-injurious tendencies. Mental health professionals do not visit general housing units, despite a policy requiring them to do so. The emergent mental health problems missed due to inadequate screening and outreach include suicidal tendencies.

4. Medical Safety and Related Security Concerns

Mental health staff do not communicate with security staff. This failure has significant consequences, particularly in crisis intervention and the use of restraints. We reviewed a video tape of a use of force incident involving the deaf inmate discussed under security concerns, supra. Mental health personnel had identified the inmate as having schizoaffective disorder. Either this information was unavailable to security staff, or, staff acted upon misinformation about mental illness in their approach to this inmate. Appropriate training by mental health professionals and consultation with the mental health providers at the Jail at the time of this incident could have prevented the excessive use of force in this case.

In addition, in our review of records provided to us by the SCJ we discovered many incidents where staff used force, including pepper spray, against inmates displaying self-injurious behavior characteristic of mental illness, without consulting with mental health staff about appropriate interventions.

At the time of our visits, there were numerous lapses in maintenance and inspection of essential medical equipment. For example, there was no documentation of weekly sterility checks for the autoclave, no inspection of the temperature of the medicine refrigerator in nearly a month, and no inspection of emergency medical kits (which lacked essential equipment, as we observed when a nurse at Jail East opened one to attend to an inmate in crisis during our October tour).

Finally, SCJ's policy for the control of blood borne pathogens was not communicated to line staff through training or policy. Lapses in basic medical sanitation and safety practices pose a significant threat to the well-being of all persons confined or employed at SCJ.

C. The SCJ Does Not Provide Adequate Food, Clothing and Shelter.

Our inspection revealed deficient food service, basic sanitation and safety practices at the SCJ. Unsafe

food handling and inadequate sanitization of kitchen utensils and cooking equipment present an unacceptably high risk of food contamination and food-borne disease. Similar risks of disease result from SCJ's inadequate level of overall sanitation and pest control. Our consultant concluded that these practices stem from a failure to train and supervise staff in rudimentary concepts of sanitation, food handling, and pest control. In addition, more maintenance and food service workers and supervisors are needed to prepare and serve food properly and to maintain food service equipment in a facility this large.

1. Unsafe Food Handling and Food Service

The freezers and food storage areas at the main Jail are filthy. There is evidence of roach infestation, gnats and rodents in the kitchen, dishwashing and food storage areas. During our tour in October, we observed servers without hair coverings, gloves or serving utensils. Personal articles of clothing were stored on a shelf in the kitchen next to clean pots and pans. In the laundry area, food service trays are stored on a shelf next to mop heads. There is a practice of serving food to inmates working in the laundry area, and washing serving trays and utensils in the mop sink in this area. There is no attempt to sanitize these items. Each of these practices violates basic tenets of sanitation and safe food handling, and should be stopped immediately.

Pots and pans and serving pieces are neither fully cleaned nor sanitized because the dishwashing equipment does not reach sanitizing temperatures. Of four units tested by our consultant, none functioned to sanitize cooking and eating utensils. The dishwashing area had a putrid smell, and food residue was visible on pots and pans after they had been "cleaned." Inmates complained of being given a single utensil, often of disposable plastic, and having to reuse this utensil and clean it in their cells, although sanitizing agents are not available in the cells for this purpose.

Foods on the serving line and in holding ovens and refrigerators and freezers on the day of our visit deviated significantly from temperatures recommended for safe food handling. The NIC report also found food served at improper temperatures. Food held at improper temperatures invites contamination that can sicken inmates through food poisoning.

2. Pest Control and Sanitation is Inadequate.

Roaches, rodents and spiders are present in inmate housing and the medical area at both the main Jail and Jail East. Both inmates and staff showed evidence of bites from brown recluse spiders.

3. Lighting, Ventilation, Sanitation and Laundry Service in Housing Units Is Inadequate.

Proper sanitation is hampered by the lack of hot water in some inmate cells and shower areas. Our consultant noted numerous examples of broken plumbing fixtures and inmate cells without access to hot water or to water at all. Both staff and inmates told us that such conditions are longstanding. The lack of a preventative maintenance plan or a system for scheduling and prioritizing work orders for repairs contributes to a backlog of essential repairs.

The current policy regarding access to laundry must be reviewed and updated. The laundry service is neither frequent enough nor reliable. We heard many reports from inmates of clothing and bedding not being returned from the laundry, or coming back stained and ripped. As a result, many inmates wash clothing and bedding in sinks and toilets. This contributes to poor sanitation and threatens security, because items left hanging to dry impede staff's ability to observe and supervise inmates.

Finally, our consultant identified numerous areas where there was virtually no ventilation and where the

lighting was not adequate to maintain hygiene, allow individuals to move around safely and prevent eyestrain.

4. Improper Storage and Handling of Hazardous Materials

We observed numerous examples of unacceptable storage of hazardous materials during our tours. Unless properly labeled, stored, and disposed, these materials can cause a variety of serious health problems. Bio-hazardous waste containers in the medical area used gray liners without bio-hazard markings, making inadvertent exposure or improper disposal likely. Caustic chemicals in the laundry and storage areas were labeled only with a marker, which can be rubbed off and contains no information about the contents, effects of exposure or appropriate first aid, or other important labeling information. In storage areas, some of these containers were "sealed" by placing latex gloves over their openings, which is inadequate. There must be an accessible eye wash fountain and training in the use of personal protective equipment for inmates who work with these caustic chemicals, yet neither appeared to be provided.

5. Fire Safety and Prevention Is Deficient.

In correctional facilities, the safety of inmates in the event of an emergency depends upon the rapid unlocking of doors. In October, two officers stationed near an exit door at Jail East had no idea how that door could be opened in the event of an emergency. During our December tour, deputy jailers on the second floor administrative segregation/deadlock unit (P and Q pods) were unable to comply with our request to manually unlock the sally port doors because the manual override was broken. [11] This is indicative of a lack of a regular preventive maintenance program and is also a serious safety lapse in the event of a fire emergency. In the event of a power outage or smoke buildup, visual examination of keys is generally impossible, and keys should be notched for easy identification under such conditions. Yet, as noted above and in the security section, staff at both locations were unable to identify keys even after several minutes of visual examination.

Improperly controlled combustibles and highly flammable materials throughout the institution and inmate living areas dramatically increase the risk of harm to inmates. Because inmates are locked in their cells, the amount of combustible material should be limited. Yet, in many of the cells, inmates used paper bags as trash receptacles. We saw numerous examples of ripped fire-retardant mattress covers and, as mentioned earlier, improperly stored and labeled flammable liquids and other chemicals, all of which presented serious fire hazards. Sprinkler heads in the food storage units in the kitchen were rendered ineffective because cartons were stacked too close to the ceiling and sprinkler heads.

We observed serious deficiencies in fire or emergency safety training and planning. Available documentation suggests that fire drills happen infrequently, and do not occur on all shifts. Correctional officers we spoke to were unable to explain their roles in the event of an emergency. Our consultant also noted numerous examples of electrical problems that could be fire hazards throughout the Jail and Jail East.

D. Insufficient Access to the Courts

As presently constituted, the law library offers little effective assistance to most inmates. Legal materials, including the single copy of the Tennessee Code Annotated, are not up to date. A not-yet-certified paralegal is available for limited hours during weekday daytime shifts. Inmates reported that the one-hour time slots they may request to visit the legal room are often shortened because pod officers may not release them or arrange an escort for them in a timely way. One inmate complained that his

legal mail had been opened, and that staff delayed mailing court papers. Our review of inmates' access to legal services at the SCJ was limited, and we did not identify any inmate whose ability to pursue a claim was impaired because of the deficiencies in services. Nonetheless, we are concerned that such an injury is likely to occur.

E. Insufficient Access to Exercise

The Sixth Circuit has not defined a constitutionally required amount of exercise, however, it has recognized that one hour per day, five days per week every thirty days is unconstitutional, even as a punitive sanction. Rodgers v. Jabe, 43 F. 3d 1082, 1088 (6th Cir. 1995). Inmates at SCJ receive far less opportunity for exercise, averaging less than two trips to recreation per inmate per month in the year 2000 (the Jail's records do not specify whether the recreation period was indoors or outdoors). In the winter months of 2000, it appears from the Jail Monthly Summary Reports that inmates each received slightly more than one trip to recreation per month.[(12)]

Lack of exercise opportunities, which may create a constitutional violation standing alone, may also exacerbate other constitutional violations. In Gilland v. Owens, 718 F. Supp. 665, 689 (W.D. Tenn. 1989), involving the SCJ, the district court found that a monthly average of 1.35 trips to recreation per inmate was a "near-total deprivation" of opportunities for exercise that violated the constitutional rights of inmates. 718 F. Supp. at 688. The court also held that lack of exercise opportunities was a factor contributing to unconstitutional violence at the SCJ. Id.[(13)] In many respects, conditions at the SCJ today seem little improved from those found unconstitutional in 1989.

IV. Recommended Remedial Measures

To rectify the identified deficiencies and to ensure that the Shelby County Jail complies with federal constitutional requirements, the following minimum remedial measures must be implemented.

A. Security, Supervision and Protection From Harm

1. To reduce inmate-on-inmate violence, the County must increase direct sight and sound supervision of inmates in their housing units. If the current configuration of the Jail, in which staff have limited direct sight and sound supervision of inmates, is maintained, then the County must significantly reduce double celling, or hire significantly more staff to supervise housing units. The County must increase the frequency of shakedowns and provide timely and sufficient escort of inmates to other areas of the Jail and for essential programming and services.

2. The County must improve the quality of staff through hiring and enhanced training. Well-trained and knowledgeable supervisory personnel must be available to supervise line staff.

3. The County must take steps to implement basic security procedures, including but not limited to key control, tool control, and the control of dangerous contraband (such as razor blades fused to toothbrush handles). Staff should be aware of these procedures, including the use of emergency keys. The County also must ensure that security inspections occur on a regular basis and must provide ongoing maintenance to security devices such as door locks and manual unlocking mechanisms.

4. The County must revise its inmate classification system to take into account gang-related information. The County must review inmates periodically for possible reclassification. Any new or revised classification system must be validated in advance of its final implementation.

5. The County must implement an effective and timely system of inmate discipline and provide an adequate number of single-occupancy cells for the immediate segregation of all inmates sentenced to the disciplinary segregation unit. Closely related, the County must implement procedures for assigning otherwise unmanageable inmates to administrative segregation and must provide an adequate number of single-occupancy cells for these inmates.

6. The County must take more effective steps to separate assaultive from non-assaultive prisoners during the intake process.

7. The County must revise its policies on the use of force, including the use of chemical agents and the use of mechanical restraints, to provide clearer guidance to staff and to ensure that physical force is limited to clearly identified situations, such as threatened escape, harm to persons, or damage to valuable property. Security staff should receive special training on all the new policies.

8. The County must ensure appropriate use of the restraint chair, by restricting its use to tightly prescribed circumstances, and requiring pre-authorization and supervision by mental health staff for any use of the restraint chair involving mentally ill inmates. The chair must not be used for punishment and no hoods or disposable spit caps should be used under any circumstances.

9. Staff must report all uses of force (including chemical agents and mechanical devices). Trained investigators should investigate all such reports. These investigators must also thoroughly investigate all allegations of failure to report a use of force. The County must implement an effective system for the prompt discipline of staff who violate policies in this area.

10. The members of the Detention Response Team must be dedicated to that purpose and must not fill other posts. In addition to responding to emergencies, including necessary cell extractions, the DRT must provide additional back-up security for officers in housing units and enhance pod officers' capability to conduct housing unit shakedowns and security inspections.

11. The County must adopt an aggressive program to identify and control inmates who are members of organized gangs. While such membership itself is not unlawful, staff at the jail must eliminate all forms of control currently exercised by gangs and their leaders and must be vigilant in detecting and punishing gang-related misconduct of all forms. Illicit gang-related behavior should be an important factor in increasing an inmate's classification status.

B. Mental Health and Medical Care

1. The County must comply with SCJ's stated policies for providing timely medical and mental health intake screening of all inmates. In particular, increase timeliness of mental health evaluations at Jail East.

2. The County must ensure SCJ's continuation of prescription medication promptly upon admission.

3. The County must ensure SCJ's compliance with stated policies for screening of infectious diseases, particularly tuberculosis.

4. The County must provide access to sick call to all inmates five days per week. Increase professional staff so that all sick call examinations are conducted by appropriately licensed professionals.

5. The County must ensure compliance with SCJ's policy that mental health professionals make regular

rounds to all housing units.

6. The County must provide accurate diagnoses, or differential diagnoses, for all inmates identified as requiring mental health services at SCJ.

7. The County must improve monitoring and treatment of chronically ill inmates, including those with serious mental illness, through regularly scheduled visits to Jail medical (or mental health) professionals.

8. The County must establish an on-site infirmary at the SCJ to provide more intensive medical and mental health monitoring for inmates who are unstable or otherwise medically inappropriate for general population housing.

9. The County must comply with stated policy for medication administration, including documentation of missed doses. Ensure that oral medications dispensed to inmates are ingested.

10. The County must provide disposable paper gowns to inmates in suicide precaution cells.

11. The County must remove suicide hazards from suicide precaution cells.

12. The County must provide proper sanitation and lighting for cells in suicide precaution areas.

13. The County must provide direct line of sight supervision to all inmates on suicide precautions. Increase the number of suicide precaution beds to include sufficient beds for constant observation, and for "close" observation (meaning frequent, but not constant observation).

14. The County must train all SCJ staff in policies for the control of blood borne pathogens. Provide adequate personal protective equipment to all staff.

C. Environmental Health and Safety

1. The County must ensure that officers who supervise the inmates serving food on the units are trained in food service operations, or, properly trained civilian staff should perform these tasks. Proper equipment for serving must be provided and used. All food service staff, including civilians, need food service training.

2. The County must assign more staff and supervisors to oversee food service and maintenance to ensure proper sanitation and safe food handling practices.

3. The County must repair or replace malfunctioning equipment, including refrigeration units, cooking units and dishwashing and tray washing units, and provide properly-sized units designed to serve a food service operation the size of SCJ.

4. The County must ensure that a dietician or nutritionist support the special medical diet operation. A dietician must also evaluate standard menus on at least an annual basis. Operations must be able to support the menu provided by the dietician.

5. The County must improve sanitation in the food service operations, housing units and medical intake and housing units. Adequate cleaning supplies and equipment should be provided on a more routine basis to help improve cell sanitation, in particular.

6. The County must improve pest control. Supervisors must receive training to ensure that this program is implemented effectively.

7. The County must provide adequate lighting in cells and showers.

8. The County must repair water leaks in cells and showers and clogged drains.

9. The County must conduct regular cell inspections to enforce Jail rules, including those prohibiting the blocking of air vents and storing large amounts of food, which contributes to the pest control problem. As noted previously, regular inspections will also help control the accumulation of life-threatening contraband (such as razors).

10. The County must implement appropriate housekeeping policies and procedures.

11. The County must ensure that fire and emergency drills are performed quarterly, in all areas including the administrative areas, on all shifts, so that all staff may participate in the drills. Inmate movement should be included in drills, except in those situations where security may be compromised. Adequate emergency operations plans must be developed for all potential natural and man-made disasters that may affect this facility. In-service training in fire safety, including fire drills, must be conducted and documented.

12. The County must develop and implement a written preventive maintenance program and priority-based work order system.

13. The County must provide adequate laundry service.

14. The County must ensure that quality control checks of medical equipment and supplies occur regularly, and, for some equipment, on a daily, per shift basis.

15. The County must improve the storage, labeling, and use of hazardous chemicals so that proper chemical name labels are put on all containers of chemicals and containers are stored with tight fitting caps or tops. An eye wash fountain must be provided where inmates handle hazardous chemicals, for example, in the laundry and storerooms.

16. The County must fix promptly the electrical system problems noted at Jail East, as delineated in an August 29, 2000 letter from EOC to Mr. Ward, Shelby County Maintenance Manager, especially those with a potential to affect life safety systems and those with a possibility of causing a fire.

17. The County must implement a facility-wide procedure, such as color coding and notching, to quickly identify appropriate emergency keys by touch and sight, and must train staff in use of emergency keys and manual override system for the jail's cell and sally-port doors.

18. The County must provide every inmate with a fire resistant mattress and replace paper wastebaskets with fire safe containers.

D. Access to the Courts

1. The County must ensure access to legal assistance by providing inmates with the tools they need to attack their sentences, directly or collaterally, and to challenge the conditions of their confinement.

E. Access to Recreation

1. The County must ensure that inmates have an opportunity to exercise a minimum of one hour per day, five days a week, including outdoor exercise as often as weather permits.

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

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

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

Sincerely,

William R. Yeomans
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable Marron Hopkins
Director
Shelby County Jail

Mr. A.C. Gilless
Sheriff
Shelby County Jail

Donnie E. Wilson, Esquire
Shelby County Attorney

Don D. Strother
Legal Advisor
Shelby County Sheriff's Office

Lawrence J. Laurenzi, Esquire
United States Attorney
Western District of Tennessee

1. The Sheriff's Office also is responsible for a secure ward at the University of Tennessee's Regional Medical Center, known as the MED.

2. SCJ inappropriately attempts to counter staffing shortages by assigning members of the Detention Response Team ("DRT"), the emergency response unit, to posts as pod officers in the housing units. We were advised that DRT members must often wait to be relieved from their post before they can respond to an emergency. Such a practice creates an unacceptably high security risk and compromises the safety of inmates and staff by delaying the DRT's response to emergency situations.

3. Each pod typically contains 46 inmates in 23 double-bunked cells.

4. The NIC report concurs in the conclusion that inmate supervision is poor, finding that any benefit of the court-ordered staffing was lost by placing the staff where they cannot and do not see the inmates, supervise the inmates on a moment-to-moment basis or talk with inmates frequently and informally. NIC Technical Assistance Report at 9.

5. Conversely, inmates are reportedly able to jam cell doors and open them manually without staff's knowledge.

6. Use of Chemical Agent reports frequently are not filled out by staff. For example, in August 2000, the SCJ's Monthly Summary Report notes 38 uses of chemicals, however, the SCJ produced only nine Use of Chemical Agent reports for this period.

7. It is a nationally accepted practice that if triage is utilized, it must be performed by a person with no less than a registered nurse's ("RN") training. At the SCJ, complaints are routinely triaged by licensed practical nurses ("LPN"), who have substantially less training than RNs. For example, an LPN evaluated an inmate's sick call slip complaining of an injured and swollen hand, and an LPN examined the injury six days later. The inmate was not seen by a doctor and sent to a hospital emergency room for his broken finger until seven days after his initial complaint.

8. The SCJ employs no licensed nurse practitioners (RNs with an advanced degree) or physician assistants, professionals who are licensed and qualified to examine, diagnose and treat patients and order prescription medication - tasks an RN or LPN may not perform. The only exception to this accepted practice is that RNs may evaluate and treat minor complaints pursuant to a doctor's standing orders. Thus, the only professionals licensed and qualified to examine more than 2,700 inmates at the SCJ are the Jail's medical doctors, whose hours of employment total less than two full-time-equivalent positions.

9. The SCJ provides only 23 hours per week of psychiatrist staffing, augmented by additional mental health workers equal to 5.2 full time positions. The SCJ employs "counselors" on each floor, however, they have no mental health training and their role appears to be limited to accessing hygiene items, phones, and mail.

10. It appears that no nutritionist or medical staff person provides guidance to food service in the preparation of medically-required diets for diabetics or inmates with high blood-pressure. In response to our request to review a week's menus at the SCJ, we received only regular diets. There was also no documentation of an annual menu evaluation by a qualified nutritionist or dietician. Thus it is unclear whether medically prescribed meals served at the SCJ meet basic nutritional or medical standards.

11. Similarly, deputy jailers on that same floor were unable to open cell doors with a manual override. This indicates a serious lapse in training and is a significant safety concern in the event of a fire or other emergency.

12. For example, in February 2000, when the average daily population was 2,972 inmates, the Jail reported only 3,991 trips to recreation, an average of 1.3 trips per inmate.

13. The court in Gilland cited many factors causing excessive violence in the SCJ that remain unchanged today: "insufficient security staff, the pod man/phone man system [superceded today by gang control, instead of pod man control of the phones], lack of exercise opportunity, frustration over scare resources and space, improper functioning of the disciplinary system, and an inadequate classification

system." 718 F. Supp. at 688. The district court's supervision of the SCJ pursuant to its orders in Gilland terminated in 1993.

UNITED STATES DISTRICT COURT - WESTERN DISTRICT OF TENNESSEE

Notice of Distribution

This notice confirms a copy of the document docketed as number 15 in case 2:05-CR-29999 was distributed by fax, mail, or direct printing on June 16, 2005 to the parties listed.

Monty Mothra
123456789
,

Honorable J. Breen
US DISTRICT COURT