U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Avenue, NW - RFK
Washington, DC 20530

August 30, 2007

Mayor Robert Dedman
228 E. Main Street
Lebanon, TN 37087

Re: Investigation of the Wilson County Jail

Dear Mayor Dedman:

On April 11, 2006, we notified you of our intent to investigate conditions at Wilson County Jail ("Wilson" or the "Jail"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Consistent with our statutory requirements, we write to report the findings of our investigation and to recommend remedial measures to ensure that Wilson meets federal constitutional requirements. See 42 U.S.C. § 1997b.

Between June 27 and 29, 2006, we conducted an on-site inspection of Wilson with consultants in the fields of medical care and correctional management. While on-site, we interviewed the Sheriff, jail staff, medical care providers, and inmates. We received and reviewed a large number of documents, including jail policies and procedures, daily rosters and log books, incident reports, medical files, inmate intake records, individual inmate records, and other records.[1] Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided an extensive debriefing at the conclusion of our inspection, in which our consultants expressed their initial impressions and concerns. We appreciate the full cooperation we received from Wilson County ("the County") and Jail officials throughout our investigation. We also wish to

[1] We also reviewed a packet that Sheriff Ashe provided to us at the beginning of our tour, which contained various correspondence and other information regarding his efforts to seek funding, among other things, to address a number of deficiencies at the Jail.

extend our appreciation to the Sheriff and his staff for their professional conduct and timely response to our requests.

Having completed the fact-finding stage of our investigation of Wilson, we conclude that certain conditions at the Jail violate the constitutional rights of inmates confined there. As detailed below, we find that Wilson fails to: (1) provide for inmates' serious medical and mental health needs; (2) protect inmates from harm and provide adequate supervision; and (3) prevent exposure to unsanitary and unsafe environmental conditions.

I. BACKGROUND

A. Facility Description

Wilson is located in Lebanon, Tennessee. The Wilson County Sheriff is responsible for the operation of the Jail. The Jail is designed to house 106 inmates and has been in use as a jail for over two decades. The physical plant includes court rooms and other court administrative offices, as well as the Sheriff's office.

In the Jail, inmates are housed in seven pods (which each contain a central day room) that are two stories high. The pods are divided into minimum, medium, and maximum security, and a minimum security pod for inmate trustees. In addition to the seven pods, the Jail has a central control room, secure outside recreation yards, kitchen, medical office, visitation room, a booking area, and administrative offices for corrections and court staff and some sheriff's deputies. The sally port for new admissions was closed during our tour due to construction. The County is currently building a 300-bed facility adjacent to the existing Jail that is scheduled for completion in the Fall of 2007.

On June 28, 2006, the second day of our tour, Wilson had an inmate population of 192; there were 159 males and 33 females.

B. General Legal Framework

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of inmates. 42 U.S.C. § 1997. The Eighth Amendment places an affirmative duty on prison officials to provide humane conditions of confinement and to ensure that inmates receive adequate food, clothing, shelter, medical care, and are kept safe from harm at the hands of other prisoners. Farmer v. Brennan, 511 U.S. 825,

832-833 (1994). As discussed below, the conditions at Wilson do not comport with these legal standards.

II. FINDINGS

A. Medical Care

The Eighth Amendment requires that inmates be provided with adequate medical care. Id. at 832. Moreover, "[t]he Eighth Amendment forbids prison officials from 'unnecessarily and wantonly inflicting pain' on an inmate by acting with 'deliberate indifference' toward the inmate's serious medical needs." Blackmore v. Kalamazoo County, et al., 390 F.3d 890, 895 (6th Cir. 2004) (quoting Estelle v. Gamble, 429 U.S. 97, 104 (1976)); Horn v. Madison County Fiscal Court, 22 F.3d 653, 660 (6th Cir. 1994). The Due Process Clause of the Fourteenth Amendment provides the same protections to pretrial detainees. Bell v. Wolfish, 441 U.S. 520, 545 (1979). Prison guards manifest deliberate indifference by intentionally refusing to provide or delaying access to medical care for a serious medical condition. Estelle, 429 U.S. at 104.

To establish that a County has denied adequate medical care to an inmate requires a demonstration of both the objective and subjective components of deliberate indifference. Farmer, 511 U.S. at 834. The objective component requires the existence of a "sufficiently serious" medical need and a showing that the inmate is being incarcerated under conditions posing a substantial risk of serious harm. Id. A serious medical condition can be established when the prison fails to treat a condition adequately or where the affliction is seemingly minor or non-obvious and medical proof is presented that the delay caused serious medical injury. Blackmore, 390 F.3d at 899 (citing Napier v. Madison County, 238 F.3d 739, 742 (6th Cir. 2001)). Additionally, the objective component can be established when the medical need is one that has been diagnosed by a physician as mandating treatment or it is so obvious that a layperson would easily recognize the necessity for a doctor's attention. Blackmore, 390 F.3d at 897, 899. In other words, the violation does not necessarily have to be based upon the detrimental effect of the delay and may be premised upon the delay alone in providing medical care, thereby creating a substantial risk of harm. Id.

The subjective component requires a showing that prison officials have "a sufficiently culpable state of mind in denying medical care." Id. The subjective component "should be determined in light of the prison authorities' current attitudes and conduct." Helling v. McKinney, 509 U.S. 25, 36 (1993).

Although deliberate indifference "entails something more than mere negligence," it can be "satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result." Farmer, 511 U.S. at 835.

Wilson County Jail fails to provide inmates with medical care that complies with these constitutional requirements. We found the following deficiencies: 1) deficient intake screening and lack of routine health assessments; 2) inadequate access to medical care; 3) lack of sufficient chronic and emergent care for inmates with serious diseases; 4) inadequate infection control; 5) inadequate medical administration and oversight; and 6) improper administration and control of medications.

1. Inadequate intake screening and routine health assessments

An adequate intake medical screening, assessment, and referral process is necessary to ensure that inmates receive necessary medical care during their incarceration. The Jail's intake process is constitutionally inadequate because it does not attempt to identify inmates' urgent and/or ongoing health needs. Compounding this deficiency, the Jail does not provide routine health assessments to determine the current health status or chronic health care needs of inmates.

The accepted standard of care in jails requires that all arrestees receive an initial health screening at the time of booking. Incoming inmates should have an intake assessment performed by qualified medical staff who have been trained to take medical histories, and identify symptoms of drug and alcohol withdrawal, communicable diseases, acute or chronic illness (including mental illness), and potential suicide risk.

Standardized intake screening forms or procedures are critical because they supply medical personnel and jail staff with critical information regarding the inmate's medical and mental health history. And yet, in stark contrast to generally accepted correctional practice, Wilson has none. Generally accepted practice also calls for the initial assessment to include, at a minimum, detailed medical history information such as medications, alcohol or drug withdrawal, and mental illness, including suicidal ideation or behavior. The intake screening form should also prompt questions that when answered in the affirmative require immediate medical review.

Another critical component of the correctional intake process is to ensure that the Jail staff can identify inmates who are potentially suicidal for appropriate follow-up measures. Wilson lacks a suicide prevention policy that directs correctional staff to appropriately employ a preventative strategy involving senior security staff and medical personnel.

Although we were told by the Jail's medical assistant that there is a policy for handling drug withdrawal, we were not provided with one. Additionally, when our consultant spoke with an intake officer who was processing an intoxicated inmate during our tour, he told our consultant that they typically let intoxicated inmates "sleep it off." This practice is unacceptable and fails to recognize the significant dangers associated with drug and alcohol withdrawal. According to our medical consultant, the risks involved with an inmate withdrawing from alcohol or drugs are considerable as there is a 30% mortality rate associated with untreated alcohol withdrawal. After a protocol is developed, all personnel who have contact with intoxicated inmates should be trained in, and aware of, the protocol.

Wilson does not give its inmates a full initial health assessment within a reasonable period after their arrival at the Jail.[2] The accepted standard of care is to conduct a health assessment within fourteen days of admission to a correctional facility. Such an assessment typically includes a review of intake information discussed above, the collection of a complete medical and mental health history, a physical examination, and screening for Tuberculosis ("TB") and sexually transmitted diseases. Without this assessment, inmates cannot be appropriately evaluated, and thereby treated for chronic disorders, communicable disease, and mental illness. The following inmates were admitted to the Jail 60 days prior to our

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[2] To ensure inmates' serious medical needs are identified and addressed, facilities must identify inmates with chronic, acute, or contagious conditions or other serious health care needs. National standards require that inmates who stay for more than a few days at a facility be given a detailed health assessment to detail their current histories and conditions beyond the limited information collected during intake screening. These assessments ensure that inmates' ongoing health care needs are met and appropriate care provided.

tour and each had incomplete health assessments: P.R.[3] (admitted 03/11/06), K.B. (admitted 03/22/06), F.T. (admitted 04/29/06), and L.T. (admitted 04/29/06). Inmate G.A. (admitted 02/14/06) is HIV positive and had no health assessment completed at all. Inmates D.G. (admitted 04/02/06) and Q.Y. (admitted 04/12/06) also did not have health assessments in their records.

A comprehensive health assessment is particularly critical for the number of inmates who are housed at the Jail for extended periods of time. In the State of Tennessee, inmates can serve up to six years at a local jail before transfer to a State facility. Not only are comprehensive health assessments inconsistently performed, if at all, when they are performed at the Jail, they are conducted by a staff member who is not trained or skilled to perform these types of evaluations. For example, the Jail's medical assistant performed a health assessment on inmate W.D. While she noted in the chart that she heard abnormal lung sounds, there was no review by a qualified medical professional, no recommendation for follow-up, and no clinical plan of action for W.D. This amounts to a failure to provide medical care.

A critical component of the health assessment is Tuberculosis ("TB") testing. All inmates should be tested for exposure to TB within fourteen days of admission to the facility, to preserve the safety of staff and other inmates from the spread of communicable diseases. Inmates at Wilson are not currently tested for TB. The Centers for Disease Control ("CDC") also recommends that correctional facilities designate a staff member to manage TB control.[4] Wilson lacks such a designee.

Also problematic is the Jail's practice of taking inmates who arrive at the Jail with medications off the medications, regardless of the medication and its purpose (including chronic illness or antipsychotic medications), until the inmate provides documentation regarding their necessity or the Jail is able to verify their necessity. Although it is an acceptable practice to confiscate drugs upon an inmate's arrival, a qualified medical professional should promptly review the various medications and

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[3] To protect inmates' privacy, throughout the document we identify inmates by initials other than their own. We will separately transmit to the County a list that cross references the initials with inmate names.

[4] CDC, Mortality and Morbidity Weekly Report, June 7, 1996/Vol. 45/no RR-8, Prevention and Control of TB in Correctional Facilities.

make a determination about critical medications that are required for chronic illnesses, that do not have potential for abuse.

2. The Jail provides inadequate access to medical care

In general, the sick-call process is a fundamental component of the health care system in a correctional setting because inmates typically access medical care by completing sick call forms. The forms are retrieved daily and triaged by a member of the medical staff, and inmates receive medical care according to the urgency of their medical needs.

Contrary to generally accepted professional correctional standards, Wilson does not have an effective system for inmates to gain timely, basic access to medical care. Based on our review of documents and discussions with inmates and medical staff, the manner in which the Jail handles medical requests (equivalent to sick call forms) and forwards them to the medical unit is putting inmates at risk. As an initial matter, the sick-call request system breaches confidentiality because inmate requests are handed to correctional officers, who are then supposed to forward them to the medical staff. There is, however, no record, that this is being done nor whether the medical staff ever receives these requests. Indeed, inmates expressed concern that their forms were not received and Jail staff are unable to refute this concern. In addition, requiring medical requests to go through Jail staff may create a barrier to care since it allows staff (who lack medical training) to arbitrarily decide which requests merit medical attention, and which do not. For example, in a June 2006 incident, a diabetic inmate reportedly was placed on lock down for 72 hours for mouthing off to an officer who refused to check her blood sugar levels. This is wholly inappropriate. Medical decisions should not be made by a non-medical provider.

As noted above, access to medical care at Wilson is constitutionally deficient because care is often administered by staff not qualified to do so (i.e., medical assistant making medical decisions regarding x-rays). In instances where inmate medical requests are successfully received by appropriate medical staff, the Jail fails to establish a time-frame for the review or triage of the requests, or for scheduling inmates for medical appointments. It is standard medical practice for sick call or medical requests to be reviewed and triaged by a qualified medical professional within 24 hours. Moreover, generally accepted correctional professional standards provide that inmates with more serious or emergent medical issues receive immediate or

prioritized attention, and that inmates with routine medical issues be seen within three business days of their request. According to our review, a number of inmates at the Jail who submitted medical requests were never seen by any medical staff. For example, we reviewed the medical requests from inmates C.F., N.B., and Y.S., dated the week prior to our visit, and there was no evidence of them being seen or triaged.[5]

Also of concern, some inmates indicated that if medical staff responded to their request at all, they often may receive medication without being seen by any medical personnel. Indeed, inmates report that they have learned the "necessary symptoms" to include in their request forms in order to receive a prescription. Ordering prescription medication for a patient based only upon a written complaint and without a face-to-face evaluation is not only contrary to generally accepted professional standards, it may also be deadly if an inmate who, for example, is allergic to a certain drug and is prescribed medication without an assessment of his or her allergy history. We identified a similar concern with respect to the Jail's provision of psychotropic medications to inmates with mental illness. Although we identified instances where the Jail's physician wrote prescriptions for pyschotropic drugs, he did not have regular contacts with patients with mental illness and there is no coordinated or ongoing monitoring of these inmates' mental health status, diagnoses, or treatment by a qualified mental health professional. With respect to inmates with mental illness, this practice is particularly dangerous in the psychiatric context because lack of proper monitoring and assessment of psychotropic prescriptions may lead to decompensation or lack of proper treatment. Finally, as described more fully in Section II.B, the Jail's failure to maintain proper control over prescription medications exacerbates the problems described above.

Additionally, the Jail does not provide its female inmates with pap smears and mammograms, when clinically indicated. Generally accepted professional correctional standards of care for women's health provide that women should receive pap smears annually, three years after the onset of vaginal intercourse or

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[5] Similarly, request forms we reviewed from March and May 2006 for the following inmates: F.L., P.T., A.D., and Z.W. 03/22/06 had incomplete or no documentation recorded regarding a response to their requests. This lack of a documented response is an indication that no higher level of review or triage of the requests, such as by the nurse or physician, was conducted.

no later than 21 years-of-age, and mammograms annually for women over forty or otherwise clinically indicated (i.e., family history). Wilson also has no protocols for women regarding cervical and breast cancer assessments or for women who enter the jail pregnant. Pregnancy tests should be included in the initial intake assessment for all women. Initial pap smears and mammograms should be performed on women as clinically indicated in accordance with the national standards outlined above and who will have or do have longer stays at the Jail, such as after 90 days, and as clinically indicated, thereafter. The Jail should also implement a tracking system to monitor such diagnostic procedures for women.

Wilson requires inmates to pay for all medical services. Although the "fee-for-service" system is not unconstitutional *per se*, the practice of charging inmates fees to access medical care at every level of the medical evaluation process may have the effect of deterring access to necessary medical care. Contrary to other correctional facilities' practices, inmates are charged comparatively high co-pay fees for every component of the medical evaluation process. For example, there is a $5.00 charge to see the nurse, a $10.00 charge to see the physician/dentist, a $25.00 charge for laboratory work and x-rays, a $5.00 charge for each medication, and $25.00 charge for hospitalization per day and for an emergency room visit. Generally, there should be one charge to access the sick-call system, especially when additional care or follow-up (i.e., laboratory work, x-ray, medication, and/or referral to a specialist or physician) is deemed necessary at the initial encounter. It appears from our records review that inmates are even charged when they are not actually seen by medical personnel. For example, when medication is dispensed in response to a sick-call request.

3. Deficient chronic and emergent care

The Jail fails to address the ongoing medical needs of inmates with chronic illnesses such as diabetes, heart disease, asthma, hypertension, seizure disorder, hepatitis, and HIV disease. Inmates who suffer from chronic medical illnesses must be regularly monitored by medical professionals to ensure that their symptoms are under control and their medications are appropriate based on generally accepted professional standards. Many chronic illnesses can have significant complications, such as heart attack, stroke, and/or kidney failure, if they are not routinely evaluated and treated.

The Jail does not have a chronic illness program that identifies, tracks, and treats diseases that can be controlled

when periodic and routine medical encounters take place. Because the Jail lacks protocols or policies, medical care is often reactionary, and serious medical conditions or complications are not brought to the medical staff's attention until a medical event occurs which is often preventable. For example, F.L. is a diabetic inmate who had been housed at the Jail for nearly three years at the time of our visit. Although diabetics have increased risks for vision loss and developing kidney and/or heart diseases, inmate F.L. had not had eye examinations, vaccinations, or kidney or cholesterol evaluations. In addition, despite generally accepted professional standards that diabetes in correctional settings be given hemoglobin A1c checks two to four times a year to ensure proper control of their disease, several diabetic inmates stated that they have been taken off their medications and that their disease is out of control. For example, F.L., referenced above, has complained that his medications are not controlling his diabetes. Review of his file indicates that he has had only two blood tests in the three years he has been incarceration at Wilson. Both tests indicated that his hemoglobin A1c was 11.7 and 12.6, respectively. A normal hemoglobin A1c result is 7.0 or less. Notwithstanding clear indications from over six months ago that F.L.'s diabetes is poorly controlled, there was no change or follow-up to his treatment. P.R. also had a hemoglobin A1c reading of 10.8 in April 2006, yet the Jail had done nothing to improve the control of her diabetes at the time of our visit.

The only "program" the Jail follows is to check diabetic inmates' glucose levels twice a day and provide a sliding scale of insulin based on the inmates' glucose levels. This procedure is reactive and is typically used only to supplement diabetic care and is not the accepted primary standard of care for diabetic treatment. Appropriate care for diabetic inmates requires annual eye examinations, routine urine tests (critical to the detection of kidney disease), and monitoring of routine blood work (so that changes in a diabetic's worsening status might be addressed by medication or other steps to prevent further deterioration).[6]

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[6] In the medical community, there are clearly established clinical guidelines for monitoring chronic illnesses. Likewise, generally accepted professional standards of care require, for example, that diabetics be given hemoglobin A1c checks two to four times a year, an eye examination annually, blood pressure checks quarterly, and lipid profiles annually. Failure to provide these interventions can result in complications such as loss of vision and stroke. See Harrison, Principles of Internal

Additionally, the Jail has a population of HIV positive inmates. These patients have compromised immune systems and should be routinely monitored at least every three months. A failure to provide HIV positive patients with appropriate blood tests (e.g., CD4 and HIV viral load checks) every three months could result in opportunistic infection – a major cause of illness and death in HIV positive patients. Inmate G.A. is HIV positive and she had to make repeated requests for a viral load check when she was admitted. Although our review of her records indicate that her viral load was within normal limits once she was tested, she was not informed of the results and, at the time of our tour, she was overdue for another assessment. The results of necessary laboratory and diagnostic tests should be available for the clinical encounters. The Sixth Circuit has held that prison officials who have been alerted to a prisoner's serious medical needs are under an obligation to offer medical care to such a prisoner. Johnson II v. Karnes, 398 F.3d 868, 874 (6th Cir. 2005).

Further, despite initial reports to the contrary, the Jail fails to provide a medically appropriate diet for inmates with conditions that require such diets. In addition to a lack of documentation, our discussions with kitchen staff confirmed that medical diets are not provided.

The Jail also fails to provide reasonable medical treatment to inmates with serious or potentially serious acute medical conditions. Although the Jail has a physician under contract, and he reports that he is "available" for on-call consultation and emergencies, it appears that he is rarely called or consulted for emergency situations. The Jail made this decision with little to no input from the physician. Wilson's failure to provide adequate care to inmates with acute conditions is exacerbated by the Jail's limited amount of standard emergency equipment. Although the Jail has an Automatic External Defibrillator ("AED"), the nurse indicated that she does not know how to use the AED. In addition, there are no standard protocols for medical and security staff responding to medical emergencies. This failing is illustrated by the January 2006 death of inmate S.R., who was jailed at Wilson after swallowing a large bag of cocaine. After he started to have a seizure, the nurse responded without any medical equipment and made a medical assessment that his medical crisis symptoms were feigned. She reached this conclusion despite pleas from correctional staff who had to

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Medicine, 15th Edition, McGraw-Hill.

ultimately call 911 for help. It is possible that the resultant delay in S.R. receiving medical treatment resulted in his death.

In providing her account about this incident, the nurse unapologetically reported that she lacks knowledge of the symptoms of drug induced distress because she doesn't have any friends or family members with those types of problems.[7]

4. Inadequate Infection Control

The Jail fails to take reasonable steps to prevent the spread of potentially contagious diseases. As outlined above in the intake assessments section, inmates are not tested or evaluated for TB. TB is a potentially lethal respiratory disease commonly found in correctional facilities, and whose transmission to other inmates and jail staff can be prevented or controlled.[8] On intake, inmates with signs and symptoms of TB disease can be identified and isolated until TB is ruled out.[9] Wilson does not administer TB tests to inmates. As a result, inmates and staff risk exposure to TB.

The Jail has no formal written plan to prevent exposure of inmates and staff to an inmate who has any contagious disease. The crowded conditions at the Jail and the constant exposure of inmates to each other and Jail staff present a serious risk of the spread of infectious respiratory diseases. For example, during our tour, E.F. returned from the hospital after an emergency room visit and was placed into one of the "isolation" cells.[10] The nurse indicated that she placed the inmate there

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[7] While S.R.'s death cannot be directly linked to the nurse's actions that day, procedures for handling medical crises should be standardized and all security and medical staff should be trained in those protocols so that critical response is not left to Jail staff's personal experience or guess work.

[8] A TB control plan provides guidelines for the identification, treatment, and prevention of TB transmission to inmates, staff, and the general public.

[9] Active and inactive TB can be identified by a skin test. If the skin test is positive, a chest x-ray is performed to rule out active TB. Meanwhile, the inmate can be isolated to prevent potential spread of the disease.

[10] Although the Jail has a cell designated for isolating inmates for medical reasons, this cell is not designed to have a

because she was "not sure what type of pneumonia" the inmate had. The inmate had not been assessed by the nurse and information regarding her status was limited. After we requested that the nurse call the physician to ascertain additional information, the doctor released the inmate to general population over the telephone. Not only was a potentially contagious inmate returned to the Jail with little information, but there was no routine procedure in place or performed for evaluating an inmate who had returned from an emergency room visit.

Similarly, the Jail fails to adequately manage transmission of infections. At the time of our tour, the Jail had an outbreak of a contagious skin infection, known as Methicillin-Resistant Staphylococcus Aureus ("MRSA"), and the Jail failed to be aggressive in treating it.[11] During our tour, we were told that inmates on Pod E were recently moved there prior to our arrival because it was suspected that infection existed among those inmates. Although isolation may be necessary in cases where an inmate has open wounds which cannot be managed by appropriate medical dressing, a number of inmates on Pod E did not appear to require isolation. Important to the control of MRSA infection and contamination is prompt and thorough responses to medical requests that indicate a MRSA infection.[12] Prompt and aggressive treatment of MRSA with antibiotics is necessary to resolve the infection and contain contamination to others. In addition, the hasty placement of inmates in Pod E represents the lack of

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reverse airflow or negative pressure, thus making it ineffectual for isolating persons with suspected TB or other airborne pathogens.

[11] MRSA is a bacteria resistant to certain common antibiotics, such as methicillin, oxacillin, penicillin, and amoxicillin. Centers for Disease Control and Prevention, at http://www.cdc.gov/ncidod/hip/Aresist/ca_mrsa_public.htm. MRSA manifests itself as a boil or skin sore and is spread through contact with an infected person or a surface the person has touched. Id. In some cases, MRSA can have serious medical consequences, such as causing surgical wound infections, bloodstream infections, and pneumonia. Id.

[12] Generally accepted medical care standards dictate that a jail adopt a skin infection control plan to guide the prevention of transmission of skin infections, including drug resistant infections such as MRSA. An effective control plan would outline a course of care to prevent the spread of infection.

coordination between sick-call, medication administration, and medical follow-up by the physician. For example, Inmate DI was placed in Pod E, but his infection had been resolved and he was no longer on any medication; while another inmate on Pod E, W.D., had an open wound and was no longer receiving any antibiotics.

5. Access to Medical Care is Inhibited by Limited Policies and Procedures and Inadequate Oversight of Medical Care Services

The Jail lacks adequate policies and procedures and a sufficient oversight system to ensure that health staff provide appropriate services. As a result, staff often are unaware of evolving inmate medical problems, or simply fail to implement appropriate remedies. Policies and procedures are needed to ensure consistency and to communicate appropriate standards of care at a correctional facility. With a few exceptions (noted below), the Jail does not have adequate written policies to govern the provision of medical services. Most, if not all, of the delivery of medical care at the Jail is ad-hoc and piecemeal. For example, the Jail has a total of two pages of substantive medical care and services policies to guide the limited number of medical personnel regarding medical care delivery at the Jail.[13] Lack of training and/or policies regarding serious medical conditions may also be considered in the deliberate indifference determination. Blackmore, 390 F.3d at 899 (reversing district court's grant of summary judgment to prison officials because the serious medical condition was obvious and issues of fact remained regarding the lack of policies, practices, and adequate training).

Nurses are often the first health professional an inmate encounters for access to care for both routine sick-call and emergency complaints. At Wilson, the Jail's nurse provides the primary medical services at the facility. Accordingly, nursing protocols are critical for a jail, such as Wilson, that uses nurses as the initial triage point for access to health care. The Jail, however, does not have nursing protocols to direct nurses in the treatment of illnesses and in making medical

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[13] The Jail does not have, and needs, policies, protocols, and procedures in the following fundamental health areas: intake screening, infection control, sick-call, chronic illness, comprehensive health assessments, medication administration, mental health, suicide prevention, detoxification, women's health, quality improvement, and emergent response.

assessments.[14] The Jail should develop and implement appropriate nursing protocols (typically by the physician), and thereafter the physician and/or the health authority should conduct periodic reviews of the nurse's records, assessments, and physician referrals in order to ensure adherence to the protocols. Additionally, the Jail should hire another nurse to actually conduct medical encounters with inmates. At present, the one nurse has little clinical contact with inmates and functions more as a clinical administrator.

The Jail does not have an individual who serves as the health authority and has responsibility overseeing the health care program (and ensuring adherence to policies) at the Jail.[15] The primary site physician reported that he does not consider himself the health authority at the Jail, and nor could he serve in that capacity with his current schedule of only two hours per week at the Jail. Given the deficiencies in care and other problems identified in this letter, additional physician supervision at the Jail is necessary. At a minimum, the Jail should increase the physician assistant or physician time spent at the Jail to 20 hours per week, in order to accommodate the current population and to provide adequate supervision of other medical staff.

As a result of the Jail's lack of policies and procedures and supervisory oversight, various medical staff and personnel are performing duties and responsibilities outside the scope of their licensure and training. For example, the Jail's medical assistant – who is well-meaning – often dispenses medical care

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[14] Nursing protocols provide important and detailed guidance to nurses regarding treatment guidelines and standards for management of a specific disorder or clinical situation.

[15] The Jail's current medical staff consists of a part-time physician, Dr. Scott Giles; one full-time nurse, Ms. Cathy Dillard, LPN; a full-time medical assistant, Ms. Lisa Smith; and three physician assistants who rotate through the facility. Dr. Giles averages about two hours a week at the Jail and one of the physician assistants spends another two hours per week at the Jail, for a total of half a day per week of Advance Level Provider time at the Jail. Advance Level Providers are generally licensed nurse practitioners (RNs with an advanced degree) or physician assistants, or other professionals who are licensed and qualified to examine, diagnose and treat patients and order prescription medication - tasks an RN or Licensed Practical Nurses may not perform.

outside her area of expertise. She performs physical examinations, independently evaluates inmates' various medical complaints, and orders tests and x-rays without any clinical supervision or review. The night before our investigatory tour, a female inmate D.G. was beat up by other inmates. Reportedly, her head was slammed repeatedly into the concrete floor. Following the beating, she complained to the medical assistant of headaches and nausea. The medical assistant ordered a skull x-ray. Notably, the type of x-ray ordered was not appropriate to rule out the serious risk of injuries as presented by the inmate's symptoms. We found no record that follow-up was conducted or that the nurse or physician was even informed about this medical decision. In fact, there was no documentation in the medical record at all that the medical assistant evaluated the inmate and ordered the x-ray. Both the inmate and the medical assistant informed us verbally that she had ordered the x-ray. The medical assistant's duties and responsibilities at the Jail are contrary to generally accepted professional standards because a medical assistant serves, at most, to support the nurse or physician, but not as the sole individual who conducts medical examinations and makes medical decisions. Allowing the medical assistant to function in this capacity places the inmates at unnecessary risk of mis-diagnosis and potential for harm and even death.

6. Improper administration and control of medications

In addition to the lack of any clear policies or protocols regarding medication administration, we observed serious lapses in the Jail's current procedure for medication administration and control.

Contrary to generally accepted standards, numerous medication administration records were not completed or signed as medication was distributed. Moreover, records we reviewed routinely did not indicate the duration for which the medication was to be dispensed. For example, W.D. was being treated for a MRSA infection but his medication record did not indicate whether he was to continue to receive antibiotics or whether he completed the necessary treatment. We also observed problems with distribution of medication in a medication call we observed within a housing unit; it was disorganized, i.e., with several inmates crowding around the medication cart. Also problematic was the failure of staff dispensing the medication to document, and perhaps control, the medication that it distributed to inmates. For example, an officer was provided Tylenol to distribute to inmates. Reportedly, he distributed the Tylenol but half of the supply was later found missing. When our

consultant raised this issue with the nurse, she indicated that she has been unsuccessful in her attempts to get officers who are dispensing medications to complete the appropriate documentation.

Additionally, fundamental principles of medical administration are not followed at the Jail. Inmates' medical records were disorganized, had papers not in chronological order, and had little, if any, documentation regarding the clinical encounter or plan of care. Critical and basic health care information, such as vital signs were also missing. All doctor/inmate medical encounters should have documentation that includes the standard SOAP format that is routinely used in the medical community.[16]

The Jail also distributes a number of controlled substances. However, it fails to limit access or maintain the substances under locked conditions. During our tour, a narcotic, Percocet, was missing from the medication cart. After several hours, and after our repeated inquiries emphasizing the seriousness of the missing narcotics, we were told by staff that the Percocet was given to an inmate who was prescribed the Percocet and had been recently released from the Jail. However, there was no documentation to confirm this and staff readily admitted they couldn't be certain this indeed occurred. If Wilson employed proper procedures for controlled substances, including requiring the documented accounting for controlled substances at the end of each shift and proper release records, this error could have been avoided and/or promptly identified.

As discussed above in the section regarding inmate intake and assessments, the Jail's current practice of confiscating and/or discontinuing medications upon inmates' arrival to the Jail is also haphazard and dangerous. For example, inmate O.J. has a history of seizures and reportedly has made repeated requests for his seizure medications. We reviewed his medical request form, dated May 24, 2006, which stated that his medication must be verified before starting him on the medication. At the time of our tour, it had yet to be verified, and his medication had not been started. It is critical that inmates with certain disease processes receive continuous medication, such as Type 1 Diabetes and seizures. An

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[16] SOAP is a standard diagnostic assessment tool used by doctors. It stands for: Subjective (e.g., complaints from the patient), Objective (e.g., visible signs of injury), Assessment (e.g., diagnosis), and Plan (e.g., antibiotics).

interruption in medication for certain chronic illnesses may cause an inmate's chronic condition to worsen. Diabetics for whom treatment or medications are delayed may, for example, suffer diabetic comas and possibly even death.

B. Mental Health Care

Jail officials violate the Eighth Amendment when they exhibit deliberate indifference to inmates' serious mental health needs. Perez v. Oakland County, 466 F.3d 413 (6th Cir. 2006) (citing Estelle, 429 U.S. at 103-104 (1976)). Deliberate indifference may include intentionally denying or delaying access to care, or intentionally interfering with treatment or medication that has been prescribed.

Wilson fails to meet this constitutional minimum standard because it does not provide adequate mental health care for its inmates. There is no qualified mental health professional who routinely treats inmates at the Jail. The sole mental health provider is a counselor at a local mental health hospital, Cumberland Mental Health Facility ("CMHF"), who comes to the Jail once a week to meet with inmates that are identified for him by the Jail's nurse. The counselor does not routinely see inmates who are on suicide watch or who have just returned from the hospital after a suicide attempt. Although the counselor undoubtedly provides an important service to the Jail, he is not a qualified mental health professional as he possesses only a Master's level degree in divinity.[17]

Wilson does not conduct mental health evaluations of the larger inmate population. Such outreach is necessary to identify 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.

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[17] Notwithstanding the weekly visits by the mental health counselor to the Jail and Wilson's arrangement with two local agencies (CMHF and Middle Tennessee Mental Health Institute ("MTMHI")) to receive Jail inmates in mental health crises, the Jail does not provide adequate mental health care for the inmate population at the Jail. At a minimum, the Jail should have the services of a full-time master's level psychologist on staff at the Jail, and psychiatric services, either on site at the Jail or at a local mental health center, at least eight hours per week. The Jail also should have a designated psychiatrist to assist with overseeing the mental health care and clinical activity at the Jail.

However, no designated mental health staff review sick call requests to identify inmates with emerging mental health concerns. Outreach by mental health staff is particularly important because correctional staff at the Jail demonstrate little training in, or understanding of, the needs of inmates with mental illness or suicidal tendencies.

For those inmates who are identified as suicidal or who are suffering from acute mental illness, the Jail fails to provide reasonable care. The Jail relies entirely on MTMHI for inpatient care. Inmates are transferred to MTMHI when they attempt suicide or have acute episodes of psychotic behavior. According to the mental health counselor and our review of records, it is typical for suicidal inmates who are referred to MTMHI to have to wait over twelve hours before they are transferred to MTMHI. The Jail's current policy requires inmates to be medically cleared by the contract physician and for blood work/toxicology screens to be completed before they can leave the Jail, which oftentimes delays emergency medical attention. It is unacceptable to require acutely suicidal inmates to remain at the Jail for prolonged periods of time without any mental health intervention. See Gray v. City of Detroit, 399 F.3d 612, 616 (6th Cir. 2005).

Our review indicates (as illustrated by the following examples) that the Jail is failing to adequately monitor, supervise, and intervene with suicidal inmates.

- On January 31, 2006, an inmate informed officers that a fellow inmate was trying to hang himself. When officers went into his cell, they observed him hanging from an air vent using a piece of stripped clothing. The inmate was placed in a paper gown. It is not clear from our record review what, if any, other precautions were taken with this inmate, or whether the medical staff or the mobile crisis unit was called.

- On March 2, 2006, officers were attempting to put a paper gown on an inmate who was refusing to undress. During the encounter, the inmate reportedly banged his head against the wall. The written report on the incident also indicates the inmate was violently resisting. One officer sprayed the inmate with pepper spray. It is generally inappropriate to spray a suicidal inmate without conferring with medical or mental health staff. Further, there is no indication that the inmate was ever decontaminated or that medical staff or the mobile crisis unit was called.

- On June 8, 2006, inmates alerted staff to an inmate found sitting in his cell with blood dripping from his right wrist and a pencil in his left hand. Although the mobile crisis unit from MTMHI was called after he was cleaned up by a nurse and put in a paper gown, this incident is illustrative of inconsistent practice (regarding monitoring and allowable cell items) followed by Jail staff.

- On June 19, 2006, an inmate reportedly alerted a corrections officer that another inmate was cutting himself. The officer found the inmate cutting his stomach and both forearms. When the inmate refused to give the officer the pencil he had been using to cut himself, the officer sprayed him in the face with pepper spray and then handcuffed him. The inmate was then placed in a paper gown and allegedly monitored through the night by correctional staff. There's no indication that the inmate was monitored or seen by medical staff or that either MTMHI or CMHF was called.

Even when Wilson manages to avert suicides, the following incidents amplify that the staff is following inconsistent practice and policy in handling suicidal inmates:

- On February 13, 2006, a corrections officer encountered an inmate he noted as being "upset" according to an incident report we reviewed. The corrections officer asked the inmate if he was suicidal, and the inmate reportedly told the officer that he was not. The officer alleges that he checked on the inmate twice during medication runs and the inmate told him he was fine. The officer reports learning the next day that the inmate tried to hang himself. The significance of this incident report is that despite the inmate's entreaties that he was not suicidal, the officer was apparently concerned enough to continue to check on him. However, the officer, beyond completion of the incident report, apparently failed to inform staff on duty or in the control center, and failed to alert anyone on the medical staff of his concerns. This apparent lack of communication is symptomatic of a lack of training and inadequate policies and procedures regarding suicidal inmates.

- On February 14, 2006, an inmate reported to an officer handing out inmate medications that he was having suicidal thoughts and wanted to harm himself. The officer appropriately placed the inmate on suicide watch, and ultimately he was deemed eligible for inpatient admission to the mobile crisis unit. While the officer's vigilance averted potential disaster on this occasion, it is

> significant to note that the inmate had previously indicated that he had thoughts of hurting himself and had reported being suicidal upon admission. He also indicated when he was first admitted that he had cut his wrists prior to being arrested. If the Jail had adequate protocols in place, he would have been identified and monitored as potentially suicidal.

Many inmates with mental illnesses require medication to maintain their stability. Missing doses of certain psychotropic drugs, coupled with the stress of incarceration, could lead to unnecessary decompensation and increased risk of suicide gestures or attempts. As noted above, Wilson routinely takes psychotropic medications from inmates upon intake until and unless proper verification is conducted. Wilson lacks a protocol for ensuring that inmates' medications are resumed in a timely fashion. We learned of a number of disturbing accounts from inmates who reported that they resorted to attempting suicide in order to get medical attention/treatment for their mental illness. For example, inmates L.T., K.L., E.O., and A.D. all attempted suicide, reportedly as a last resort to get medical attention. L.T. attempted suicide on April 6, 2006. After he was returned from MTMHI, he attempted suicide again on May 24, 2006.

A related concern is Wilson's lack of a system to ensure the continuity of psychotropic medications for its inmates who are mentally ill, without adequate medical justification. For example, inmate, T.Z. who was bipolar and who was taking lithium to control his mental illness, had his lithium stopped at some point during his incarceration. When we asked the nurse about this inmate, she stated that he "refused" to take his medication. However, there was no documentation of the refusal or that the inmate was advised of the risks and benefits of his decision. After further inquiry, it was determined that T.Z. had not refused the medication, but that CMHF sent a limited amount of the drug to the Jail and although he was scheduled for a return visit to CMHF, the Jail never transported T.Z. to his appointment.

As the foregoing illustrates, the Jail fails to appropriately identify inmates with serious mental health needs at the intake process or to adequately provide mental health needs during their confinement. These deficiencies contribute to unsafe conditions and unnecessary suffering. It is not uncommon for inmates with mental illness to get into altercations with security staff or other inmates and to be subjected to uses of force by security staff. For example, as discussed above, during our tour, one inmate, who by all accounts was actively psychotic,

instigated a fight with the three other inmates because she had not received her medications and wanted to get off the cell block. Staff and inmates alike reported that prior to the fight - in which she repeatedly slammed the head of another inmate into the cement floor - the mentally ill inmate had been demanding her medication, was very aggressive and did not seem to be able to function well in the pod.

Finally, the existing physical structure of the medical clinic has no private areas to ensure appropriate correctional confidentiality and privacy during medical assessment.[18] Nor does the Jail have "safe cells" for suicidal inmates and inmates undergoing alcohol or drug withdrawal. Currently, when a suicidal inmate is placed on suicide watch, the Jail utilizes a room in the intake area where incoming inmates are held until they are processed. This is insufficient because this room does not allow for constant observation and it is not free of suicide hazards. In fact, during our tour, we were told that one female inmate was placed in the general intake holding cell for suicide watch and while she was on suicide watch, she attempted to commit suicide by hanging herself with her undergarment. Although the Jail is soon scheduled to move into a new facility, the Jail should address the current deficiencies in the present physical structure, as well as ensure that future construction will meet the demands of the medical operation.

C. Protection from Harm

The Eighth Amendment provides that inmates be protected from the unnecessary and wanton infliction of pain by correctional officers, Whitley v. Albers, 475 U.S. 312, 319 (1986). Correctional officers may use force reasonably in a good faith effort to maintain or restore discipline, but force is not to be used maliciously and sadistically to cause harm. Hudson v. McMillan, 503 U.S. 1, 6 (1992); see Webb v. Bunch, No. 93-5258, 1994 WL 36854, at *4 (6th Cir. Feb. 8, 1994). The Eighth Amendment likewise imposes a duty on prison officials "to protect prisoners from violence at the hands of other prisoners." Farmer v. Brennan, 511 U.S. 825, 833 (1994). Prison officials must also take reasonable measures to ensure inmates' safety. Id. at 832; Curry v. Scott, 249 F.3d 493, 506 (6th Cir. 2001).

[18] This may inhibit inmates from being candid in revealing their personal and confidential health concerns.

1. Use of Force

We believe that there is a pattern or practice of the use of excessive force by Wilson correctional officers. In early 2006, the Criminal Section of the Civil Rights Division and the United States Attorney's Office for the Middle District of Tennessee concluded their federal investigation and prosecutions of two of the Jail's former correctional officers.[19] In January 2003, officers at the jail fatally beat inmate Walter S. Kuntz. In addition to his fatal wounds, the officers caused severe head injuries and three broken ribs. The ringleader of the beating was a supervisor at the Jail; in 2006 he received a sentence of life in federal prison without the possibility of parole. According to published news accounts, a federal investigation revealed that 11 beatings occurred at the Jail between July 2001 and January 2003. Sometimes, the beatings resulted in inmates losing consciousness.

In addition, several former inmates have filed civil lawsuits, and one of those suits is still pending. News reports indicate that the County has paid at least $840,000 in settlements, including $400,000 to the Kuntz family and $95,000 to another inmate who alleged that correctional officers beat him after his arrest in April 2002.

Former inmates and correctional officers have testified that Wilson officers routinely cover up incidents of abuse by filing false use of force incident reports. They also report that some Wilson supervisors had tacit knowledge of the assaults and either knew or should have known abuse and staff misconduct had taken place. Although we cannot corroborate the testimony of these former inmates and correctional officers, in interviews that we conducted at the Jail, particularly of the male inmates, we found that they were extremely reluctant to talk to us about staff abuse (even the well known and well documented incidents mentioned above) or any other protection from harm issues for fear of retaliation.

Despite the successful criminal convictions of officers at the facility, Wilson's lack of system reform and oversight to prevent the re-occurrence of excessive use of force give us

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[19] Seven other correctional officers were convicted of civil rights violations ranging from assault to conspiracy. Another officer, who was acquitted of charges, was still employed at the Jail at the time of our visit.

little confidence that inmates are presently safe from ongoing abuse by officers. In fact, as our review of facility records at the time of our tour indicate, use of force remains a problem at the facility. For example, we reviewed a January 2006 use of force report in which a sergeant writes that an inmate complained that a corrections officer pushed and shoved him in the throat, causing his neck to pop and leaving him in extreme pain. We reviewed an April 2006 incident in which an officer acknowledged grabbing an inmate and forcibly placing him in his cell after the inmate addressed the officer in a loud manner, following the conclusion of the inmate's altercation with another inmate.

2. Inadequate Management Review of Use of Force

Inadequate management review and investigation of use of force contributed to the high number of excessive force incidents that occurred at Wilson between 2001 and 2003. The purpose of a management review and investigation of each use of force is to ensure that no criminal conduct has occurred, that facility procedures have been followed, that no remedial training is necessary, and that no review or change in policies is required. There is no indication that the Jail administrator conducts his own review of uses of force. Our review indicated that Wilson's policies and practices have not been reformed as a result of the problematic examples of excessive force mentioned herein. As a result, obvious uses of force are not identified. For example, the sergeant (mentioned above) who wrote in a January 22, 2006 use of force report about an inmate who complained that a corrections officer pushed and shoved him in the throat causing his neck to pop and leaving him in extreme pain, failed to adequately investigate the allegations. Although the sergeant wrote in his report that officers involved in the incident were preparing incident reports, no such reports were attached to the sergeant's report in the information that we received. In addition, while the sergeant's report indicates that the inmate received a spinal x-ray, we did not see any results from the x-rays or evidence that any sort of investigation into the incident took place.

3. Supervision

a. Supervision in the Living Units

Wilson fails to adequately supervise its inmates. The physical layout of Wilson combined with the current placement of correctional staff in the control center and throughout the Jail prevent direct supervision of the housing pods, thereby increasing the risk of harm to inmates and staff. Additionally,

the Jail's supervisory failures promote staff abuse, inmate-on-inmate violence, the introduction of contraband, and the increased risk of inmate suicide, each of which place both inmates and staff at risk of serious harm.

The inmate living pods are clustered around a control center located one story above the floor of the pods. Although all of the pods can been viewed from the control center (except the female pod as discussed below), staff can only observe inmates who are out in the common area or dayroom, and cannot see inside inmate cells. Inmates inside a pod freely enter and exit their own and other's cells at will.[20] Wilson mans the control center with a single staff person, whose sole shift responsibility is the operation of the control center. If someone wishes to access the control center or if the assigned staff person wishes to go to the bathroom, s/he must walk down a narrow spiral staircase to the lower floor to exit – leaving the control center unmanned. We were told that a relief person is called to relieve the staff person. Nevertheless, the functionality of this process leaves periods of time in which no one is watching the pods. We observed that no one was monitoring the inmates on at least one occasion during our visit. It is evident from inmate reports that the pods are not consistently monitored from the control center. Inmates reported fights, especially in E Pod, which are not timely observed by control center staff. Inmates also reported, and staff confirmed, that inmates must holler or throw shoes at the control center window in order to get the attention of correctional staff.

The following incidents illustrate that the poor physical layout of the Jail, as well as the Jail's inadequate supervision, facilitate inmate-on-inmate violence at Wilson. As detailed above in our medical and supervision discussions, on the evening prior to our visit three female inmates were involved in an altercation. The female inmate that was beaten was allegedly actively psychotic and probably should not have been residing at Wilson. Staff have reported several inmate altercations due to racial animosity. In June 2006, a white inmate was attacked by several black inmates without any correctional officer intervention. In May 2006, a white inmate was assaulted by several black inmates in the booking area. The officer explained to the injured inmate that he could file formal charges against the black inmates. The officer provided no other intermediate

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[20] Wilson also utilizes several video monitors to monitor other parts of the Jail, such as the sally port and hallways leading into the pods.

options. The inmate decided not to file formal charges against the inmates out of fear of retaliation, and nothing further was done as a result of the incident.

Finally, in a January 2006 incident, an inmate was overheard telling a correctional officer that he wanted to be removed from his current pod because of all of the "Ns" (apparently referring to a racial epithet) in the pod. After the correctional officer left the pod, the inmate was jumped by approximately 12 black inmates until a white inmate intervened. Apparently, no staff observed the fight or was made aware of it until the following day when the inmate's mother called the Jail stating that her son needed medical care. The inmate had suffered a broken jaw. Wilson's failure to properly supervise and classify its inmates has resulted in inmate-on-inmate violence. Such incidents create risks of harm to inmates and staff who are responsible for intervening in inmate altercations.

Wilson employs two unsafe security practices which put the safety of inmates and staff in the pods at risk. First, we noted that staff did not spend time in the pods other than to distribute meals and medication. As noted above, Wilson's failure to provide more consistent supervision results in inmate fights in which there is often untimely intervention. There should be two staff assigned to the control room who switch duties from watching the monitors to observing inmate and staff activities in the pods. Second, we observed that the female pod is obscured by blinds. This practice appears to be Wilson's attempt to maintain sight separation between the male and female inmates. We were told various reasons for this practice, e.g., to keep male correctional officers from looking at the females, and to obscure the view of the male inmates in the other pods from looking into the reflection of the glass in the control center into the female pod. While Wilson's use of the blinds to preserve some privacy in the female pod may be well-intentioned, it effectively poses a security risk to the inmates and staff because it prevents the control room staff from being able to visually observe activity in the female pod.

b. Supervision in the Food Service Area

Inmates/trustees are not properly supervised in the kitchen at Wilson. For example, we observed an unsupervised inmate in the kitchen office where the kitchen knives are kept unlocked and un-inventoried on top of the desk. Because they are unsecured, an inmate could easily walk back into the housing units with these utensils that can be used as weapons. We were informed that the office is supposed to be off-limits to inmates.

Regardless, knives and other metal utensils should be kept under lock and key and managed by one kitchen staff person on each shift. Additionally, inventory should be taken at the beginning and end of each day, and inmates who serve as trustees should be searched upon their entry and exit to the building to ensure that the introduction of contraband into the facility is limited or avoided.

4. Classification of Inmates

The classification system at Wilson contributes to its safety and security deficiencies. Generally accepted classification systems separate problematic inmates from those who cause fewer problems or who are vulnerable to violence or abuse. Wilson's failure to do so makes supervision more difficult and increases the risk of harm to both staff and inmates. We learned that Wilson initially places inmates in housing assignments based on two criteria: by sex and available bed space. After a period of residency, some inmates earn "trustee" status and are permitted to transfer to the less restrictive environment of the trustee pod. This option, however, is not available to the female inmates. We also found that inmates in protective custody were placed with inmates who were supposed to be isolated for medical reasons. In fact, in one of the pods, not only were protective custody inmates housed with inmates with active staph infection, but they were also housed with inmates who were on temporary disciplinary segregation.

Wilson officials blame the lack of a classification system on overcrowding, but crowded conditions that place the Jail in legal jeopardy do not trump sound corrections management procedures. A jail's classification system used must meet sound professional and penological principles. Specifically, a good classification system should ensure that inmates are timely classified and housed appropriately for security and safety. Additionally, an effective system includes consideration of an inmate's security level, suicide risk, and past behavior. It should also have the capability to effectively track inmates throughout their incarceration, provide quality control information, identify inmates by gang affiliation or special inmate needs (e.g., mental health or medical, protective segregation, and administrative segregation needs), and assign inmates to housing units within facilities which are appropriate and safe given their classification status.

Finally, there should be classification policies and procedures which classify inmates in accordance with the level of custody (i.e., level of inmate supervision and custodial management issues) and the level of security (i.e., dangerousness and nature of offense) required to ensure safety.

5. Control of Contraband

The safety of staff and inmates is also dependent upon a jail's ability to restrict contraband, i.e., items banned or prohibited by the jail, such as cell phones or cigarettes, because they might pose a security risk. Wilson fails to adequately limit contraband items from entering the Jail. We found that inmates are not properly searched, incoming mail is not properly inspected, and professional visitors (e.g., lawyers and social workers, and correctional staff are not searched). Both staff and inmates confirmed that inmate access to cigarettes (both store bought and hand made) is problematic because the trade and barter of such items increases the number of fights and shake downs by fellow inmates looking to obtain contraband.

Staff and inmates also admitted that inmates have access to lighters and matches to smoke the cigarettes. We found that inmates also use exposed electric wires in the pods to create a spark to light their cigarettes. Exposed electrical wires are a clear security risk and must be secured and repaired immediately. Additionally, inmates reported having over-the-counter and prescription medications hidden in their cells. We were told, and reviewed incident reports that indicated, illegal medications served as inmate currency to purchase items such as cigarettes and to obtain extra food from other inmates.

The Jail also allows inmates to have coffee pots, hot burners, compact disc (CD) players, etc. in their cells/living pods. Although these items are not contraband, these items could easily become fire safety and general security problems. In fact, during our tour, we observed a number of inmates creating "hootch"[21] with their coffee pots and hot burners. In addition to the potential fire hazards from coffee pots and hot burners, if they are used for the production of alcohol, they should be confiscated and prohibited.

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[21] "Hootch" is a colloquial term for alcohol that is created by fermenting bread or fruits for long periods of time. The hot pots are used in this fermenting process.

6. Lack of Quality Control of Chemical and Mechanical Restraints

Wilson suffers from a lack of quality control mechanisms for the distribution and usage of its chemical agents and hard restraints, such as waist chains and handcuffs. First, although Wilson has a policy regarding the use of chemical agents, they lack a policy regarding the storage and distribution of chemical agents. According to Wilson's policy, the chemical agent "Freeze" ("Oleoresin Capsicum" or "OC" spray) is its less-than-lethal method to manage "out-of-control" inmates. The Jail stores canisters of Freeze in an office attached to the Jail's training room, which also serves as an area where officers eat their meals. Both correctional officers and sheriff's deputies have access to the office where the spray is located and stored. A lieutenant told us that corrections officers and sheriff's deputies are allowed to get a new can of spray whenever they need to. We observed the spray canisters in a small cardboard box sitting on top of a cabinet. The canisters were unsecured, and no inventory was kept regarding current stock or the expiration dates of the canisters, nor does Wilson monitor which officers obtain spray, or measure the length of time before an officer requires another canister. It appears possible that an officer or anyone who wanders into that office can take several canisters and they would not be missed. In the absence of such controls, Wilson cannot ensure its staff is properly using spray in its interventions with inmates. Furthermore, we saw no evidence that staff received annual training regarding the usage of OC spray, nor any training on appropriate decontamination procedures when it is used.

Second, Wilson's handcuffs and leg and waist chains are stored unlocked in the booking area of the Jail. Our consultant found it troubling that no inventory list is kept for this equipment and that handcuffs are distributed to the correctional officers and the sheriff's deputies without being tracked. This is problematic because no one is required to sign for the equipment and no one is held accountable for how long or for what purpose the equipment is being used.

All chemical agents, handcuffs, chains, and any other security devices should be kept under lock and key and inventoried. Both correctional and law enforcement officers should be required to sign for all of the security and restraint equipment when it is checked out and returned so an accurate record of the equipment is maintained and reviewed by a supervisor.

7. Grievances

There is no operational grievance process at Wilson because inmates are either confused about how it works, unaware the process exists, or, more commonly, do not trust the process. Grievances are initiated by the inmate completing a "Wilson County Jail Inmate Request" form. As the title of the document would suggest, inmates do not treat this document as an opportunity to grieve issues, concerns, or complaints, but use it to make requests, such as switching from one pod to another. Several inmates who allegedly attempted to write grievances claimed that they were told by staff to stop writing grievances. Some inmates reported that they have seen correctional officers throw the forms away. An adequate grievance process is an integral part of every jail program and should be designed to ensure that there is an administrative means for the expression and resolution of inmate concerns and can serve as a source of information to ensure safety and security. An adequate process includes a written form that is completed by the inmate, an opportunity for staff to investigate and resolve the inmate complaint, and an appeal process within a specific time frame.

8. Due Process

Inmates are routinely locked down for disciplinary reasons without due process. Every inmate confined to their cells for disciplinary reasons should be provided with a written statement of the charges and investigation of the charges as soon as possible, but no later than 24 hours after the offense occurs. A disciplinary hearing, conducted by staff trained specifically for this purpose, should be conducted and the inmate should receive a copy of their findings. In cases where the hearing determines the inmate's innocence, all records pertaining to the incident should be stricken from the inmate's file.

However, at Wilson, we found that inmates can be locked in their cells for up to 72 hours with one hour of out of cell time per day without a process for administrative review. We learned that a supervisor arbitrarily determines the length of the lock down. One inmate who had been at the Jail for a period of time reported that lock down typically will be for either 24, 48, or 72 hours; however, we did not find any lock down that was less than 72 hours. As previously mentioned, four black inmates were accused by a white inmate of assaulting him. The four black inmates were placed on lock down for 72 hours in June 2006. No disciplinary hearing was provided to examine the circumstances

surrounding the incident. As previously mentioned, we reviewed a June 2006 incident in which a diabetic inmate reportedly was placed on lock down for 72 hours for "mouthing off" to an officer who refused to check her blood sugar levels. Finally, we reviewed an incident that occurred in April 2006 where an officer broke up a verbal confrontation between two inmates. According to the incident report, the inmate "got very loud." When another officer tried to quiet him down, the inmate refused and the officer allegedly grabbed the inmate and placed him in his cell. The inmate allegedly resisted and the officer stated that he was forced to use a take down technique and spray the inmate with OC spray. The inmate was placed on lock down for 72 hours without a hearing.

Inmates had only recently been given rule books prior to our visit and reported that staff arbitrarily choose which rules to enforce and create rules to suit their needs. We were provided a copy of the rule book, which is only available in English. We encountered at least one non-English speaking inmate during our visit. In addition, there is no mechanism in place to assist inmates who either cannot read, or who have very poor comprehension skills.

D. Life Safety and Sanitation

1. Fire Safety

We observed during a fire drill that Wilson's fire prevention procedures are substandard and threaten the safety and security of its inmates and staff. The control center houses a series of monitors, a fire annunciator board[22] and other pieces of security equipment. Once the alarm went off during the drill, the annunciator board malfunctioned. The fire horn did not sound in all of the pods and many of the fire alarm lights malfunctioned. Fire alarms and all fire-related apparatus need to be regularly inspected and certified to be in working condition. More disturbing, staff did not know how to shut off the warning horn or the annunciator. The maintenance man was called in from home to shut the systems off. Although all of the pods were monitored by staff during the drill, some staff appeared confused about their responsibilities. Inmates ignored

[22] An annunciator board is an electronic display which monitors the status of the fire alarm system. In the case of Wilson, it is located in the control center.

the alarm (which they did not know was a drill) completely by continuing to watch television or remaining asleep on their cots in the open areas of the pod, while staff simply walked past the inmates making no effort to alert them to emergency protocols. One inmate told us, "We don't really know what to do if there was a fire." Staff could not answer basic questions concerning scenarios such as how to respond if a fire causes a cell door to swell and an inmate is trapped inside. In addition, staff could not readily identify keys that open critical exit points in the Jail. All staff and inmates must be knowledgeable of fire evacuation plans and must participate in drills.

Although no flammable, toxic or caustic materials were found inside of the Jail, they were openly stored under a stairwell immediately next to the front entrance of it. Gas powered tools were also stored there. This area is easily accessible to visitors and anyone walking around the open perimeter of the Jail. All flammable equipment should be inventoried and kept under lock and key outside of the building in a well ventilated storage shed or compartment.

Furthermore, as noted above, Wilson allows inmates to have coffee pots, hot burners, and compact disc players in the pods and in their cells. There is no policy governing the control and use of these items. Allowing inmates to possess and use such items without policies and the strict adherence to them is a security risk for the Jail, as well as a potential fire hazard.

2. Sanitation

Prison officials must ensure that inmates are protected from harm and receive adequate food, clothing, and shelter, Farmer v. Brennan, 511 U.S. 825, 832 (1994). Officials must also ensure that prisoners are not "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981).

When we observed a male inmate sorting the laundry, we noticed an inventory of underwear for the male inmates, but nothing similar for female inmates. When we asked the inmate where the inventory for the underclothing for female inmates was located he responded that there was none. An officer quickly responded that female inmates were "allowed" to wear their own underwear but the male inmates must wear only facility clothing.

The Jail must acquire sufficient stock of female personal clothing items for female inmates to wear when their own underwear is not available, such as when personal items are being laundered.

Everywhere we walked in the pods, we observed mattresses that with frayed and/or cracked vinyl coverings as well as open tears. Inmates reported using these worn mattresses to hide contraband, which makes them a security risk in addition to a sanitation concern. Worn, unsanitary mattresses easily promote the spread of infection. All worn mattresses should be replaced as often as necessary.

III. RECOMMENDED REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and protect the constitutional rights of inmates, Wilson should implement, at a minimum, the following measures:

A. Medical Care

1. Designate a health authority who is a licensed and trained medical professional and qualified to perform the following duties and responsibilities: supervising all medical care rendered to inmates; monitoring care of serious and/or chronic conditions; ensuring that all inmates receive a health assessment within fourteen days of intake; conducting clinical encounters with inmates as appropriate; reviewing and approving all prescription medication dispensed at the Jail; approving revised medical intake screening forms and processes, including confiscated medications upon arrival; and annually reviewing all policies and procedures concerning medical or mental health screening and/or the provision of care.

2. Increase the services of a physician and/or physician assistant to an appropriate number of hours per week to ensure adequate clinical contacts and oversight of the medical care and services at the Jail. Increase the nursing staff to ensure that appropriate medical encounters with the inmates are taking place, are documented, and properly referred for secondary level review as appropriate.

3. Develop and implement policies, procedures, protocols for all medical care and services at the Jail, including, but not limited to, nursing job description, medical assistant job description, documentation and record-keeping, medical triage and physician review, intake screening, infection control, sick-call, chronic illness, comprehensive health assessments, medication administration, mental health, suicide prevention, detoxification, women's health, quality improvement, and emergent response.

4. Develop and implement a program to train all security staff and medical personnel regarding all policies, procedures, protocols, and use of emergency equipment.

5. Develop and implement an appropriate medical intake screening instrument that identifies observable and non-observable medical needs, including infectious diseases, and ensure timely access to the physician when presenting symptoms requiring such care.

6. Develop and implement a chronic care program that ensures timely identifying, tracking and monitoring of chronic illnesses.

7. Revise the sick-call system to ensure confidentiality, prompt delivery and review by medical staff, and appropriate triage. Remove the disincentives to an inmate's seeking and receiving necessary medical care for chronic, pre-existing and/or life-threatening conditions.

8. Develop and implement a formal written plan to prevent exposure of inmates and staff to contagious diseases, including, but not limited to TB and MRSA.

9. Develop and implement a system for monitoring and reviewing the administration and control of medications, including documentation and distribution.

B. Mental Health Care

1. Retain the services of a licensed mental health provider or community mental health clinic whose responsibilities will include supervising and providing mental health care for inmates at the Jail.

2. Develop and implement an appropriate intake screening instrument that identifies inmates' mental health needs and risks of suicide behavior and ensures timely access to the mental health professional when presenting symptoms require such care.

3. Ensure that all staff are regularly trained regarding suicide and suicide prevention and that the shift supervisors take an active role in ensuring that inmates on suicide watch are adequately monitored.

C. Protection from Harm

1. Ensure that inmates and trustees are supervised in the pods and the food service area with appropriate and adequate staffing levels.

2. Develop and implement policies and procedures requiring all tools, utensils, equipment, flammable materials, etc. are inventoried and locked down at all times.

3. Develop and implement policies and procedures requiring all staff involved in a use of force to write a timely report regarding the incident.

4. Develop and implement policies and procedures for supervisory and/or management review and investigation for all uses of force to determine whether force was appropriately used, whether a referral should be made to a local law enforcement agency or county attorney for possible criminal action, whether remedial training is necessary, or whether facility policies should be revisited.

5. Develop a process to track all incidents of use of force that at a minimum includes the following information: the inmate(s) name, housing assignment, date and type of incident, primary and secondary staff

directly involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate) and administrative sign-off.

6. Ensure that all staff are regularly trained regarding the facility's use of force policy.

7. Develop and implement policies and procedures for an objective classification system that separates inmates in housing units by classification levels.

8. Establish a procedure to ensure that inmates do not possess or have access to contraband.

9. Secure and repair all exposed electrical wires in the Jail.

10. Develop and implement policies and procedures for the effective and accurate maintenance, inventory, and assignment of chemical and mechanical restraints.

11. Develop and implement policies and procedures to ensure inmates have access to an adequate grievance process.

12. Ensure that inmates placed in lock down status are provided with appropriate due process that has been developed and implemented in policies and procedures.

D. Life Safety and Sanitation

1. Develop and implement adequate policies and procedures regarding fire prevention including emergency planning and drills.

2. Regularly inspect all fire and life safety equipment to ensure they are in working order.

3. Inventory and store all flammable, toxic, and caustic materials in a well ventilated, but locked compartment.

4. Ensure that there is an inventory of underclothing available for female inmates so that they can at a minimum have a change of clothing when their personal items are being laundered.

5. Inspect and replace as often as needed all frayed and cracked mattresses.

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Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to work with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding Wilson. Assuming there is a spirit of cooperation from the County and Wilson, we also would be willing to send our expert consultants' evaluations of the facility under separate cover. Although the experts consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical, technical assistance in addressing them.

We are obligated by statute to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may institute a lawsuit pursuant to CRIPA 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. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you, and we are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney to discuss this matter in further detail. If you have any questions

regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

/s/ Wan J. Kim
Wan J. Kim
Assistant Attorney General

cc: Mike Jennings, Esq., Wilson County Attorney
Terry Ashe, Wilson County Sheriff
Paul M. O'Brien, United States Attorney,
Middle District of Tennessee