U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

MAY 22 2013

Interim County Administrator George Touart
Board of County Commissioners, Escambia County
223 Palafox Street
Pensacola, FL 32591

Sheriff David Morgan
Escambia County Sheriff's Office
1700 West Leonard Street
Pensacola, FL 32501

Re: Investigation of the Escambia County Jail

Dear County Administrator Touart and Sheriff Morgan:

The Civil Rights Division has concluded its investigation of conditions of confinement at the Escambia County Jail ("the Jail" or "the Facility"). The investigation was conducted pursuant to our authority under the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997.[1] CRIPA authorizes the U.S. Department of Justice ("DOJ") to file a civil action to obtain equitable relief where conditions violate the constitutional rights of prisoners in state detention and correctional facilities.

While Sheriff David Morgan has implemented meaningful reforms that have led to significant improvements at the Escambia County Jail, conditions there still routinely violate the constitutional rights of prisoners. Specifically, we find that obvious and known systemic deficiencies at the Facility continue to subject prisoners to excessive risk of assault by other prisoners and to inadequate mental health care.[2]

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[1] We also commenced a concurrent investigation regarding alleged police misconduct involving the Escambia County Sheriff's Office pursuant to 42 U.S.C. §14141. That investigation has been resolved with the issuance of a technical assistance letter on September 4, 2012.

[2] While we do not at this time find that the quality of the Jail's non-mental health medical care violates prisoners' Eighth Amendment rights, we note that certain problematic practices could lead to unconstitutional conditions in the future if left unattended. These problematic medical practices include the intake health assessment process, the lack of guidelines for follow-up care, the scheduling for off-site treatment and management of communicable diseases, and the lack of adequate data in the quality improvement process.

We also find that the Jail's decades-long unwritten policy of designating some of its housing units as only for black prisoners violates the Fourteenth Amendment's Equal Protection Clause.[3] We expressed our concerns with the practice of race based housing classifications when we last toured the Facility in October 2012. On April 12, 2013, counsel for the Sheriff's Office informed us that the Jail has desegregated all of its pods. We commend the Jail for doing so. However, given that the Jail has only just now dismantled an entrenched decades-long practice that was very much in place when we toured, we will want to ensure that any agreement we reach with the Jail completely and permanently eliminates racially segregated housing units.

The initiation of our investigation coincided with the installation of Sheriff Morgan as the new Sheriff for Escambia County. Recognizing the need for reform, the Sheriff has responded to our recommendations by changing for the better many of the Jail's practices and procedures. We applaud the Sheriff's on-going reform efforts, and have appreciated his collaborative approach toward working with us to ensure conditions at the Jail comport with constitutional imperatives.

Corrective measures undertaken by Escambia County Jail in response to the concerns we have raised include: the purchase and implementation of a formal objective classification system; making improvements to the monitoring in the use of force by correctional personnel; the development of a prisoner grievance process; increased use of surveillance cameras; retrofitting four cells to minimize suicide risk; development and implementation of a new prisoner disciplinary process; increased emphasis on jail cleanliness; revamping the process for juvenile housing; taking steps to address the needs of prisoners with physical disabilities; instituting improvements to female housing; developing a prisoner handbook; improvements in the reading program; increased and improved visitation privileges for prisoners; improvements to the provision of medications; the adoption and implementation of better policies on infection control; improvements to the health services policy and procedure manual; the adoption of more detailed and better sick call, emergency care and continuity of care policies; adoption and implementation of new, more effective health screening procedures; the development of a new medical grievance procedure; the creation of new infirmary bed space; improvements made to medical care documentation; greater credentialing of medical staff; improvements made to clinical quality; and the acquisition of improved medical equipment. The Sheriff's reform efforts are ongoing, and, in a letter dated November 9, 2012, and in subsequent correspondence, counsel for the Sheriff's office provided information regarding additional corrective measures being implemented at the Facility. We commend the Escambia County Sheriff's Office on these advances and view them as progress toward improved conditions at the Facility.

We also thank the Sheriff's staff for their continued cooperation throughout the course of the investigation. Staff have provided us with access to records and personnel, and responded to our requests before, during, and after each on-site visit in a transparent and forthcoming manner. We also appreciate staff's receptiveness to our expert consultants' on-site recommendations.

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[3] Counsel for the Sheriff's Office "concurs that this arrangement will not withstand the 'strict scrutiny' of the practice as required" and indicates that they have developed "a plan to desegregate all pods in the Jail using a phased approach." November 9, 2012 letter to DOJ at 13.

I. SUMMARY OF FINDINGS

We have made the following factual determinations:

- Prisoner-on-prisoner assaults are a common occurrence at the Jail, making the Facility unsafe for prisoners. Assaults occur routinely primarily because of a shortage of correctional staff. The Facility needs more staff to patrol Jail pods, intervene when altercations or fights break out, and search cells for dangerous items that could be used as weapons against fellow prisoners;

- A staffing study released in March 2011 commissioned by County leadership has given Jail leadership good reason to know that staffing shortages pose a significant risk to prisoner safety. Among other findings, the study concluded that: the Jail "is operating with only about three-fourths of its needed staff;" that "the Jail has been understaffed for many years;" that "[d]eputies . . . are routinely borrowed from other jobs which results in leaving their posts unmanned;" that "[t]he frequency of some important operations, such as cell searches, is reduced due to lack of staff to conduct the searches;" that "[p]osts are understaffed or not staffed at all;" and that, "[l]arge insufficiencies in jail staffing . . . raise the likelihood that something serious could happen that would overwhelm the jail's ability to respond;"

- The Jail's leadership fails to appropriately monitor and track prisoner-on-prisoner violence and staff-on-prisoner uses of force;

- The Jail's decades-long practice of housing some prisoners in housing units designated as only for black prisoners ("black-only pods") discriminates against African-Americans on the basis of their race, contributes to prisoner perceptions that the Jail favors white prisoners over black prisoners, and makes the Facility less safe by fanning racial tensions between prisoners;

- The Jail does not afford prisoners timely and adequate access to appropriately skilled mental health care professionals;

- The Jail routinely fails to provide appropriate medications to prisoners with mental illness;

- The Jail provides inadequate housing and observation for prisoners with serious mental illness and/or at risk of self-injury, including suicide; and

- On average, the Jail sends roughly one prisoner per month to the hospital after an incident of self-injury, a rate our expert found indicative of a clearly inadequate mental health program.

These factual determinations provide us with reasonable cause to believe that Escambia County Jail's practices violate the Fourteenth Amendment's due process protections for pre-trial detainees, as well as the Eighth Amendment's protections for those convicted of a criminal

offense. Those amendments prohibit jail officials from showing deliberate indifference to conditions of confinement posing an excessive risk of harm to prisoners. *Cook v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1115 (11th Cir. 2005) (holding that in the Eleventh Circuit, protections for pre-trial detainees are "the same as [those] allowed by the [E]ighth [A]mendment for convicted persons," and applying the Eighth Amendment's deliberate indifference standard to pretrial detainees). They obligate officials to "take reasonable measures to guarantee the safety of" prisoners, *Farmer v. Brennan*, 511 U.S. 825, 832 (1994), and to satisfy prisoners' basic needs, including their basic mental health care needs. *Estelle v. Gamble*, 429 U.S. 97, 103-05 (holding that Eighth Amendment prohibits deliberate indifference to prisoners' serious mental health care needs). Notwithstanding all of the significant improvements made to Jail operations in recent years, the Jail's practices continue to run afoul of these basic obligations.

We also have reasonable cause to conclude that the Jail's practice of relegating some of its prisoners to black-only pods discriminates against its African-American prisoners on the basis of their race in violation of the U.S. Constitution's Equal Protection Clause. For decades, the Jail's officials have assumed that segregating on the basis of race would lead to a safer facility. This assumption, unproven and untethered to data, is insufficient to justify an explicit racial classification. *See U.S. v. Wyandotte County, Kansas*, 480 F.2d 969, 971-972 (10th Cir. 1973) (holding that a general fear that desegregating the county jail would lead to violence is not enough to justify a policy of segregation under the Equal Protection Clause). Indeed, our investigation indicates that the practice of segregating on the basis of race has compromised security by exacerbating racial tensions within the Facility.

II. INVESTIGATION

Our investigation into the practices of Escambia County Jail, which commenced prior to the installation of the current Sheriff, has been broad in scope. We have investigated practices relating to the level of security at the Jail, the adequacy of medical and mental health services, and sanitation/environmental conditions. Since opening the investigation, we have conducted a series of tours of the Jail, each lasting between three to five days. Our most recent tour was conducted on October 15-17, 2012.

Our tours have been in-depth examinations into the conditions at the Facility. Nationally recognized expert consultants in the fields of corrections and custodial medical and mental health care have accompanied us on each of our tours. During the tours, we inspected the Facility, and we also conducted interviews of administrative and corrections staff, medical and mental health care providers, prisoners, and members of the Escambia County community. In addition to touring the Facility, we also reviewed thousands of pages of documentation, including policies and procedures, incident reports, use of force reports, investigative reports, prisoner grievances, disciplinary reports, unit logs, orientation materials, and medical records.

After each of our tours, we and our consultants met with the Sheriff and his command staff to provide technical assistance and to convey our impressions and concerns. In keeping with this practice, after our most recent tour, we again met with the Sheriff, his attorney, and most of the command staff. We informed them of our view that significant progress had been made toward addressing many of the systemic deficiencies we had observed in past tours, but we also described to them the serious continuing problems we perceive in the areas of security and

mental health services, as well as certain outstanding issues concerning the provision of medical services.

In recent weeks, the Jail's attorney has kept us up to date on recent reforms the Facility has implemented in response to our concerns. Specifically, he has forwarded documentation of changes that address a number of the issues we raised after our last tour. These findings account for those changes, as well as all of the information we have received about conditions at the Jail to date.

III. BACKGROUND

Escambia County is located in the northwest corner of Florida. The estimated population of Escambia County is 295,426 persons. The Escambia County Sheriff is responsible for overseeing county law enforcement services and correctional operations at the county detention facilities. The Detention Division of the Sheriff's Office is responsible for operating the Jail, and employs approximately 260 detention staff.

Escambia County Jail can house up to 1,442 prisoners. The Jail's current population is 1,314, consisting of 1,092 male and 222 female prisoners.[4] Roughly 65 percent of the Jail's prisoners are African-Americans and 35 percent are Caucasian.[5] About 72 percent of the Jail's prisoners are pre-trial detainees.

The Jail consists of the Main Detention Facility ("Main Jail"), with a capacity of 815 prisoners, and a current daily occupancy of 713, and a Central Booking and Detention Facility ("CBD"), with a capacity of 697 prisoners, and a current daily occupancy of 601. The Main Jail provides general population housing for male prisoners, special housing for juveniles, and administrative, mental health, infirmary, disciplinary confinement, and protective custody housing. CBD houses the Jail's female prisoners in general population and prisoners entering the Jail, not yet screened or classified. CBD provides general population housing for female prisoners, as well as housing for prisoners entering the Jail who have not yet been booked, screened or classified. CBD is the central intake and booking facility for all of the County's law enforcement agencies.

In much of the Jail, prisoners are housed in housing units called pods. Typical pods house roughly 15 to 25 prisoners. At the lower security level, prisoners in a pod share one large area, and their beds are located in the common area. At the higher security levels, prisoners sleep in their own cells, but are let out of their cells for much of the day and can share a common area with others in their pod. Certain pods house prisoners in administrative or disciplinary confinement. Prisoners in those pods are restricted to their cells for much of the day.

IV. FINDINGS

While conditions at the Escambia County Jail have improved significantly in recent years, serious problems remain, and we have reasonable cause to believe that the Jail continues to routinely violate the constitutional rights of prisoners. Specifically, in violation of the Eighth

[4] The prison population data detailed in this letter is current as of April 9, 2013.
[5] The Sheriff's letter dated November 9, 2012.

Amendment, the Due Process Clause of the Fourteenth Amendment, and the Equal Protection Clause of the Fourteenth Amendment, jail officials: (A) ignore conditions that lead to prisoner-on-prisoner violence and pose an obvious and serious risk to prisoner safety; (B) discriminate against prisoners on the basis of their race by housing a significant percentage of African-American prisoners in black-only pods; (C) and provide clearly inadequate mental health care. The constitutional deprivations our investigation uncovered are not the result of isolated incidents or the misconduct of just a few of the staff. Rather, numerous incidents over the years involving prisoners who have suffered serious harms speak to obvious systemic failures in the areas of prisoner safety and mental health services.

A. Escambia County Jail has ignored obvious and serious security risks to prisoner safety.

Escambia County Jail has ignored obvious and serious risks to prisoner safety by grossly understaffing its security complement and by failing to take reasonable steps to adequately monitor prisoner violence. Both the Eighth Amendment, which protects those convicted of criminal offenses, and the Fourteenth Amendment's Due Process Clause, which protects pre-trial detainees, prohibit jail officials from acting with deliberate indifference to serious risks to prisoner safety, such as the risk of violence at the hands of other prisoners. *Farmer*, 511 U.S. at 828 (prohibiting prison officials from showing deliberate indifference to excessive risk of harm under the Eighth Amendment's prohibition against "cruel and unusual punishments"); *Cook*, 402 F.3d at 1115. The Jail's own records reveal an unacceptably high level of prisoner-on-prisoner violence. Much of the violence stems from staffing shortages, which means the Jail lacks a sufficient number of officers to patrol housing units, conduct important security functions, and appropriately staff critical areas of the prison. Indeed, a 2011 staffing study confirmed that the Jail faces gross shortages in its security complement, finding that staffing was more than 30% below what would be required to safely operate the Jail. The Jail has also failed to track and monitor prisoner violence properly. The Jail has been largely indifferent to these realities and has failed to take meaningful steps to address the risks to prisoner safety. Deliberate indifference can be inferred where the risk of serious harm is obvious. *Farmer*, 511 U.S. at 842 (noting that a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious).

1. Prisoner-on-prisoner violence is all too common at the Jail.

The Jail's own records reveal that prisoner-on-prisoner violence is commonplace at the Facility, and that the violence often results in serious harm to prisoners. Below we provide summaries of some of the data reviewed:[6]

Prisoner-on-Prisoner Violence from April 1, 2012 to March 31, 2013

Total	Quarter 1 (April – June 2012)	Quarter 2 (July – Sept. 2012)	Quarter 3 (Oct. – Dec. 2012)	Quarter 4 (Jan. – March 2013)
176	49	45	42	40

[6] The data here understates the extent of the problem at the Jail as not all incidents of prisoner-on-prisoner violence and serious resulting injuries are tracked by the Facility. The data presented reflects the information the Facility has provided us and May 3, 2013, discussions with the Sheriff's attorney concerning serious eye and head injuries.

Serious Eye and Head Injuries from April 1, 2012 to March 31, 2013 (including detached retina, orbital fractures, trauma and contusions)

Total	Quarter 1 (April – June 2012)	Quarter 2 (July – Sept. 2012)	Quarter 3 (Oct – Dec. 2012)	Quarter 4 (Jan. – March 2013)
20	5	5	5	5

The data shows that the level of violence far exceeds what would be expected of a facility of the size of Escambia County Jail. Our security expert characterized the level of violence at the Jail as "appalling." She was troubled by the seriousness of many of the injuries, and stated that given the level of violence, the Jail was "lucky that no inmates have been murdered by other inmates."

The data is consistent with what we heard from both prisoners and staff when we toured the Facility in October 2012. Prisoner after prisoner told us that fights were a common occurrence at the Jail. In certain areas of the Main Jail, in particular, we heard credible accounts of several outbreaks of violence between prisoners occurring within just a couple of weeks before our tour. Correctional staff also conceded that prisoner-on-prisoner violence was a serious problem at the Jail.

2. Obvious and severe shortages in security staff have led to unsafe conditions where outbreaks of violence between prisoners are all too common.

Escambia County Jail lacks a sufficient number of detention officers to patrol the Jail, conduct important security operations, such as cell searches, and staff important areas of the prison (such as the Infirmary and the Main Jail Control Room). Without an adequate complement of security personnel, Escambia County Jail cannot possibly keep its prisoners safe. *See Cottone v. Jenne*, 326 F.3d 1352, 1359-60 (11th Cir. 2003) (finding unconstitutional conditions of confinement where assaults between prisoners occurred due to lack of supervision).

According to both line staff and prisoners, the Jail has a grossly inadequate number of correctional officers serving as "Walkers." Walkers are officers who patrol the areas immediately adjacent to where the prisoners are housed. Frequently, a solitary correctional officer has to observe multiple pods from a windowed control center without the backing of a Walker in the vicinity. As compared to a Walker, an officer stationed at a control center has less of an ability to hear activities within the housing pods or to respond to escalating prisoner tensions. By policy, an officer stationed inside of a control center cannot leave the center to respond to a fight until at least two Walkers arrive on the scene. Consequently, the absence of Walkers nearby means that far too much time can elapse between when a fight between prisoners first breaks out and when officers are in a position to intervene.

In recent years, the Jail has attempted to address its security problem by installing cameras in the pods that can be monitored from its windowed control centers. Unfortunately, cameras alone cannot solve the problem. When we toured, both staff and prisoners told us that prisoners know where the cameras' blind spots are and fight in those areas. At best, cameras can record fights; they cannot stop them.

The following examples involving incidents occurring in a typical three month period (from May to July of 2012) speak to the security problems arising from a severe shortage of Walkers, and the inability of cameras to make up for the shortage:

- On May 1, 2012, two prisoners attacked a fellow prisoner. A detention officer stationed at a control center observed the attack on a screen, but was powerless to intervene from his control post. He called for a Walker, but there were no Walkers on hand, so the beating continued. By the time Walkers arrived on the scene, the beating had already ended. The victim sustained injuries to the head too serious to be cared for at the Jail's infirmary, and he was taken to the emergency room of the local hospital.

- On May 3, 2012, two prisoners assaulted a fellow prisoner while he was eating his breakfast. The victim was beaten unconscious and suffered severe swelling and lacerations to his eye. The victim's injuries were too serious to be cared for at the Facility's infirmary, and he was transferred to the emergency room of the local hospital. The beating occurred at one of the Jail's blind spots and was not captured on video. Detention officers were not on hand when the prisoners attacked the victim, and arrived on the scene only after the beating had occurred.

- On June 3, 2012, a fight between two prisoners resulted in one of the prisoners sustaining a serious injury to his left eye, which included a detached retina. Because of the seriousness of the eye injury, the prisoner was transferred to the local hospital's emergency room. He subsequently had a number of follow-up admissions to the hospital to receive additional treatment for his eye injury. The fight had been captured on video camera, but officers only arrived on the scene after the fight had already ended.

- On June 18, 2012, a detention officer was doing a routine check when he noticed a prisoner wandering around his pod's common area with a torn shirt, a bloody forehead, and welts on his face. The victim was transferred to Sacred Heart's emergency room. Upon investigation, Jail authorities discovered that another prisoner had assaulted the victim, that the assault had taken place at a "blind spot" known to the prisoners, and that, consequently, the assault had not been captured on video.

Staffing shortages also cripple the Jail's ability to conduct a sufficient number of cell searches. To protect both prisoners and staff from serious harm, the Jail should routinely search prisoners, prisoner living areas, and prisoner property for contraband and potentially dangerous items. Indeed, under generally accepted correctional standards, selective searches should routinely occur in each housing unit every shift. However, because of staffing shortages, the Jail is failing to do so. When we reviewed a sampling of the Facility's cell search data, we found that for an entire year, only 33 cell searches were conducted in the Main Jail, and only 8 occurred at CBD. We brought these gross deficiencies to the attention of the Jail's leadership and were told that staffing levels prevented the Jail from significantly improving upon this record. In fact, jail officials acknowledge that staffing shortages prevent them from doing anything more than searching cells on a haphazard basis.

Additionally, staffing shortages prevent the Jail from having a sufficient complement of staff assigned to important areas of the Facility at all times. For instance, the Jail's infirmary has an observation module that is supposed to have a detention deputy permanently stationed to it. However, due to staffing shortages, the infirmary's observation module is often left unattended entirely in clear violation of jail standards.

During our most recent tour, we learned that the shortage of security staff may even be causing staff to use more force than would otherwise be necessary in an effort to maintain order at the Facility. One of the officers we interviewed admitted that on certain days, when staffing levels are particularly low, officers resort to using extra force when interfacing with prisoners for fear that they have "no room for error," and "to avoid seeming vulnerable when no one has their back." These admissions are consistent with what we heard from prisoners at the Main Jail, who complained both that correctional officers are nowhere to be seen when violence breaks out in the pods, and that, on occasion, correctional officers escort prisoners to areas out of camera range and assault them.

In sum, because of understaffing, officers are not on hand to break up fights between prisoners; staff does not have enough of a presence to anticipate or defuse tensions in the housing units; cells are inadequately checked for dangerous items and contraband; and officers may be using more force against prisoners to maintain order. Until the Jail addresses staffing shortages, the Jail will remain unsafe.

3. A March 2011 staffing study provided Jail and County officials with good reason to know that staffing shortages pose a serious risk to prisoner safety.

Jail and County officials know that, at current prisoner levels, they will have to significantly increase the number of security personnel employed at the Facility to keep prisoners safe. Not only have we consistently told the Jail's command staff that their security staffing is inadequate for the number of prisoners housed at the Facility, but the County's own examination into the Jail's staffing levels has underscored the magnitude of the problem. In 2009, the County retained the National Center on State Courts and Justice Concepts, Inc. ("Justice Concepts") to conduct a staffing analysis of the Jail, and in March 2011, Justice Concepts released a report summarizing the findings of its analysis. In the report, Justice Concepts stated that the Facility was significantly understaffed for security personnel and recommended that the Jail hire 83 additional detention staff and 12 civilian personnel.[7] Since the time of the study, staffing at the Jail has gotten worse, not better. As the chart below indicates, the Jail currently employs 115 fewer detention staff than recommended by Justice Concepts.

[7] Escambia County Jail Study Part 1: Operational Analysis and Part 2 Staffing Analysis; Justice Systems Incorporated; March 2011 ("JCI Staffing Study").

Table 1 – Security Staffing Comparison (2012)

Positions	Working as of October 2012	Justice Concepts' Recommendation	Difference	% Difference
Sergeants	25	37	12	32
Officers	238	336	103	31
Total - Sergeants & Officers	263	373	115	31

In its report, Justice Concepts' consultants described the many ways in which the Facility's inadequate staffing has compromised security operations. Among other issues, they explained that: (1) "Deputies from other units are routinely borrowed from other jobs which results in leaving their posts unmanned;" (2) "Some critical areas, such as Central/Main Control, often operate without the needed supervision of a sergeant;" (3) "The frequency of some important operations, such as cell searches, is reduced due to lack of staff to conduct the searches;" (4) "Posts are understaffed or not staffed at all. For example the posts of Ground Floor Escort Officer, which require eight deputies are not filled;" and (5) "Large insufficiencies in jail staffing, as were found in this instance, raise the likelihood that something serious could happen that would overwhelm the jail's ability to respond." By continuing to ignore the very serious staffing inadequacies identified in the staffing study, the Jail is showing deliberate indifference to a real and present danger to prisoner safety.

4. The failure to track and monitor prisoner violence properly and the use of black-only pods contributes to the risk of prisoner violence.

At Escambia County Jail, security problems stemming from staffing shortages combine with other systemic problems – specifically, the failure of the Jail to monitor prisoner violence properly and the use of black-only housing pods – to produce "the deprivation of a single, identifiable human need," namely the need to be safe from violence. *Wilson v. Seiter*, 501 U.S. 294, 304 (1991) ("Some conditions of confinement may establish an Eighth Amendment violation in combination . . . when they have a mutually enforcing effect that produces the deprivation of a single, identifiable human need," such as protection from violence).

While improvements have been made to the way in which leadership gathers and reviews information about safety risks at the Jail, much more needs to be done. Leadership still needs to do a better job of gathering quantitative information about violence at the Facility. For instance, when we asked the Jail to provide us with a break-down of violence by pod – an important data point that should be routinely reviewed by leadership – we were told that the information was not readily available, and that technical assistance would be needed to generate a special report to satisfy our request. Second, Jail officials responsible for security at the Facility routinely fail to obtain information about Jail conditions directly from prisoners. We appreciate that some in the line staff may interpret efforts by leadership to obtain information directly from prisoners through conducting rounds in the pods as a vote of no confidence in them, but leadership needs to monitor conditions at the Jail by getting unfiltered information from prisoners. Third, the Jail

currently has nothing in the way of policies and documentation requirements in place to ensure leadership both gathers and uses quantitative and qualitative information to track and monitor violence and uses of force at the Jail. Unless it improves the way it gathers and reviews quantitative and qualitative information, leadership will be unable to effectively assess and minimize risks to prisoner safety.

The use of black-only pods also contributes to the level of violence. The Facility's decades-long, unwritten policy of housing many of its black prisoners in black-only pods creates the impression in the minds of both black and white prisoners alike that the Jail is biased against black prisoners. When we spoke to black prisoners, many expressed tremendous anger that the Jail segregates some of its black prisoners into black-only pods. All of the prisoners we spoke to housed in the black-only pods and many of the white and black prisoners we spoke to housed in other pods alleged that correctional officers mistreat those in the black-only pods. Those allegations include the following: (1) correctional officers order more pod-wide lock downs of the black-only pods than the other pods; (2) prisoners in the black-only pods routinely receive cold food because correctional officers consistently serve food to the prisoners in the black-only pods last; (3) correctional officers provide those in the black-only pods with fewer cleaning materials and implements to keep their cells and common area clean; and (4) the Jail sometimes overrides its own classification system by housing prisoners in pods too dangerous for their security levels when making housing placements into black-only pods.

Even if all these allegations of discrimination are untrue – and we do not have enough information at this time to opine on the matter – the Jail's practice of segregating on the basis of race has clearly contributed toward the perception held by many prisoners that some in the Jail are intent on discriminating against African-Americans. This perception leads to racial tensions at the Facility and, along with staffing shortages and a failure to adequately monitor violence, creates a combustible situation that poses a serious and significant threat to the safety of both prisoners and staff.

B. The Jail's use of black-only pods impermissibly discriminates against African-Americans.

As discussed above, as of our last tour, the Jail segregated a significant number of its African-American prisoners into black-only pods. In addition to making the prison less safe, the practice also impermissibly discriminated against African-Americans. *Lee v. Washington*, 390 U.S. 333 (1968) (holding that Alabama's practice of segregating prisoners by race violates the Equal Protection Clause). Under the Equal Protection Clause of the Fourteenth Amendment a racial classification is subject to "strict scrutiny" and deemed impermissible unless narrowly tailored to further a compelling governmental interest. *Johnson v. California*, 543 U.S. 499, 505 (2005); *see also Fischer v. Ellegood*, 238 Fed. Appx. 428, 434 (11th Cir. 2007) (applying the "strict scrutiny" standard articulated in *Johnson*). No such narrow tailoring existed here.

Jail officials acknowledge that the Facility has had an "informal' policy of housing some prisoners in black-only pods, and that this practice continued until as recently as February 2013. Sheriff's Letter, November 9, 2012, at 12. They have explained that black-only pods have been used in the Jail for decades to prevent violence and to "foster prisoner safety." *Id. at 13.* However, as discussed above in some detail, our investigation suggests that segregating on the

basis of race has had exactly the opposite effect and has undermined prison security. Moreover, this type of general, unsubstantiated concern that integrating a public facility may lead to violence can never be used to justify unconstitutional segregation by race, especially in a situation such as this one where alternative measures for enhancing safety at the Facility, such as improving security staffing levels have not yet been fully explored. *U.S. v. Wyandotte County, Kansas*, 480 F.2d 969, 971-972 (10th Cir. 1973) ("[T]he argument that desegregation of public facilities might provoke violence has never been accepted to justify unconstitutional segregation.").

Counsel for the Sheriff's office readily acknowledges that the use of an informal segregation policy "will not withstand the 'strict scrutiny' of the practice," and on April 12, 2013, he informed us that the Jail has dismantled its black-only pods in February. Sheriff's Letter, November 9, 2012, at 12; Attorney Gerald Champagne's email, April 12, 2013. We commend the Jail for doing so. Given that the Jail has only just recently desegregated its housing units, and that segregated housing has been an entrenched decades-long practice that was very much in place when we toured toward the end of 2012, we will want any agreement we reach with the Jail to ensure against the re-emergence of racially segregated housing.

C. Escambia County Jail has ignored obvious and serious risks to prisoners' mental health.

Escambia County Jail officials have elected to ignore obvious and serious systemic deficiencies impacting the provision of mental health services at the Jail and posing an excessive risk of harm to prisoners. *See Steele v. Shah*, 87 F.3d 1266, 1269-70 (11th Cir. 1996) (holding that obvious deficiencies, including substantial deviations from accepted standards, may evidence deliberate indifference to serious psychiatric needs); *see also Harris v. Thigpen*, 941 F.2d 1495, 1505 (11th Cir. 1991) ("[T]he deliberate indifference standard also applies to prisoners' psychiatric or mental health needs"). Providing only cursory care is insufficient when the need for more serious treatment is obvious. *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999); *Ancata v. Prison Health Services, Inc.*, 769 F.2d 700, 704 (11th Cir. 1985) ("Knowledge of the need for medical care and intentional refusal to provide that care has consistently been held to surpass negligence and constitute deliberate indifference").

Systemic deficiencies in the area of mental health include: (1) a failure to adequately staff the mental health care program, leading to problems with the screening for and evaluation of mental illness in the Jail population, difficulties in accessing mental health professionals, and an absence of meaningful mental health therapy and programming; (2) a failure to provide appropriate medications to prisoners with mental illness; (3) inadequate housing and observation policies and practices; and (4) an absence of effective oversight mechanisms. These systemic deficiencies result in serious harm to prisoners. According to the Jail's own records, on average, the Jail sends roughly one prisoner per month to the hospital after an incident of self-injury. Our psychiatric expert characterized this hospitalization rate as indicative of a clearly inadequate mental health care program.

1. A dearth of mental health professionals and the resultant inadequate mental health care at the Facility has led to excessive risks to prisoners' safety.

When it comes to providing mental health care services, the Jail's staffing levels are grossly inadequate. The consequence has been that the Jail routinely fails to effectively diagnose and/or treat those with mental illness. This serious deficiency must be addressed if the Jail is to comply with the mandates of the Eighth Amendment. *Hoptowit v.* Ray, 682 F.2d 1237, 1253 (9th Cir. 1982) (stating that the Eighth Amendment requires Jail's to employ staff "competent to examine prisoners and diagnose illnesses" and capable of either "treat[ing] medical problems or [referring] prisoners to others who can").

Inadequate staffing has had the eminently predictable effect of compromising the Jail's ability to screen and evaluate prisoners for mental illness. Escambia County Jail employs only a single part-time psychiatrist for the entire Facility, and relies heavily on unsupervised trainees to screen and evaluate prisoners for mental illness. Using trainees in this way leads to missed and inadequate diagnoses, inadequate assessments of prisoners at risk of self-harm and suicide, and improper housing assignments.

Staffing shortages also prevent the Jail from responding adequately to requests for treatment. The Facility receives approximately 25 sick call requests daily related to mental health care. Trainees, not mental health professionals, respond to these requests in the first instance and have to make initial judgments about whether and how soon a prisoner will receive access to a mental health professional. Records indicate that many of those requesting mental health care never get past the trainee to see an actual mental health care professional. This failure to make appropriate referrals, and the resulting lack of appropriate care, exposes prisoners to a serious risk of harm.

Finally, staffing shortages have hamstrung the Facility's ability to provide both unstructured and structured therapeutic activities to prisoners with mental illness. Although unstructured and structured therapy should be an integral part of the treatment plan for most prisoners with mental illness, at Escambia County Jail those identified as having mental illness receive only medication. Indeed, the Jail is so short-staffed when it comes to mental health professionals that if a prisoner with mental illness refuses his medications, the Facility's practice is to remove the prisoner from its mental health roster. In effect, the Jail's position is that if you are not taking medication, there is nothing the Facility can do for you. This approach substantially deviates from generally accepted practices, and denies mental health treatment to those who clearly need it. This has resulted in the prisoner de-compensating and engaging in a deteriorating cycle of further episodes of inappropriate behavior, self-harm, and suicide attempts.

What follows is a typical example of the way in which inadequate mental health care at the facility poses a serious and excessive risk of harm to prisoners:

- A prisoner was admitted in 2012 with a history of suicide attempts while incarcerated, most recently in 2011. An initial screening conducted by an intern indicated that the prisoner had a history of schizophrenia with auditory and visual hallucinations and possible retardation and a history of four or five suicide attempts by hanging. After conducting a review of this record, the intern cleared the prisoner for placement in the

general population with a referral to psychiatry. The prisoner was seen by the psychiatrist five days later. The psychiatrist noted that the prisoner was hallucinating and diagnosed him as suffering from paranoid schizophrenia with "poor insight and judgment." Notwithstanding this diagnosis, the prisoner remained housed in the general population without a mental health treatment plan or any follow-up by a mental health professional. Nine days after his admission to the Jail, the prisoner attempted to kill himself by hanging, and was only prevented from doing so because two prisoners intervened. Subsequent to this incident, the prisoner was returned to general population without a treatment plan.

This example highlights the treatment deficiencies discussed above. The initial mental health evaluation was done by an intern under no apparent supervision and was, at best, limited in scope, missed important clinical findings, and failed to include a suicide assessment despite the history of recent suicide attempts. Next, the evaluation by the psychiatrist (who at the time was laboring under an excessive case load) was cursory and incomplete, with the psychiatrist also failing to conduct a suicide assessment. For these reasons, the prisoner almost died in a suicide attempt, and even now he remains improperly housed in general population with no treatment plan whatsoever.

2. The Jail creates excessive risk to prisoner safety by routinely failing to provide appropriate medications to prisoners with mental illness.

Escambia County Jail deviates from accepted correctional practices by routinely using older, less effective, first-generation psychotropic medications. According to our psychiatric expert, using first-generation medications in this way saves the Facility money, but routinely leads to detrimental side effects.[8]

The following example illustrates the adverse effects of suddenly changing an incoming prisoner's medications to an older medication simply to save money:

- A prisoner came to the Jail with a history of bipolar, schizophrenia, and anxiety. He was previously on psychotropic medications including Geodon (used to treat acute manic or mixed episodes associated with bipolar disorder) and Haldol (used to treat schizophrenia) which had proven effective. However, when incarcerated, the psychiatrist immediately changed his medication to fit the jail psychotropic medication formulary from Geodon to Risperidal. The prisoner's medical record evidenced that he began experiencing new side effects such as agitation (which is consistent with Risperidal side effects). He later exhibited multiple episodes of self-harm including cutting and getting into altercations with staff and other prisoners.

Our psychiatric expert found that the Jail's abrupt change to this prisoner's medication likely led to his side effects and the resulting aberrant behavior. Additionally, this case illustrates how the Jail fails to provide adequate treatment for prisoners who are mentally ill.

[8] Although psychiatrists are able to order non-formulary medication, this is not done on a frequent basis. In fact, our expert discovered that from January 2012 through October 2012, there were only 12 prescriptions for second generation antipsychotics other than Risperidal.

Records indicate that when the prisoner's condition and behavior deteriorated, no one-on-one or group therapy was provided. In fact, the Jail appears to have done nothing for him other than to provide him with Risperidal, a drug that our expert believes was likely contributing toward the prisoner's agitated state of mind.

In addition, our review of mental health records indicates a heavy reliance on medications in lieu of appropriate treatment modalities. Record after record showed the over-reliance on the use of an inter-muscular ("IM") drug combination of Haldol, Benadryl, and Ativan in a forced medication. The use of such drug combinations should only be used on an emergency basis and the regular practice of forced IM medications is inconsistent with generally accepted correctional health standards.

3. Housing and observation policies and practices provide inadequate protections for prisoners with serious mental illness and prisoners engaged in self-injurious behavior, including suicide.

Jail housing and observation policies and practices create excessive risk for prisoners with serious mental illness and prisoners engaged in self-injurious behavior (or just "vulnerable prisoners"). Jail officials have a constitutional obligation to act when there is a strong likelihood that a prisoner will engage in self-injurious behavior, including suicide. *See Snow v. City of Citronelle, AL*, 420 F.3d 1262, 1268-69 (11th Cir. 2005). Accordingly, a jail official must not display "'deliberate indifference' to the prisoner's taking of his own life." *Cook*, 402 F.3d at 1115 (quoting *Cagle v. Sutherland*, 334 F.3d 980, 986 (11th Cir. 2003)).

First, the Jail routinely subjects prisoners with serious mental illness to a harmful form of solitary confinement.[9] The Jail's use of solitary confinement on those with serious mental illness is typically accompanied by inadequate mental health treatment and the denial of access to a myriad of activities provided to other prisoners (*e.g.*, showers, visits, telephone calls, recreation). The way in which the Jail warehouses prisoners with serious mental illness in isolation cells serves only to exacerbate their conditions. *See Brown v. Plata,* 131 S.Ct. 1910, 1928 (2011) (finding Eighth Amendment violation where prison officials warehoused prisoners in solitary confinement instead of providing necessary mental health treatment).

Second, the Jail needs to do more to ensure that vulnerable prisoners are housed in close proximity to staff and can be effectively monitored. The Facility's safety cells not only subject vulnerable prisoners to solitary confinement, they also hinder adequate observation. The Jail houses suicidal prisoners in "rubberized" safety cells located in the Facility's infirmary. The rubber walling of the four small infirmary safety cells cover windows of the cells that would otherwise allow for natural light. In addition, the rubber walling covers the window of the cells' doors, which eliminates direct visual contact into or out of the cell, creating isolation from staff, other prisoners, and the Facility's surroundings. As there is no direct line of sight into the safety cells, observation must be conducted by closed circuit video monitoring. The only direct contact

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[9] Solitary confinement at Escambia County Jail consists of confining a prisoner to his/her cell for an average of 23 hours a day. Among other limitations, prisoners in solitary confinement at Escambia County Jail have almost no opportunities to speak to others, eat their meals in their cells, have no access to television or radio, have limited access to reading materials, have restricted ability to shower, have very limited or no ability to exercise outside their cells, and are denied access to various Jail services and programs.

made to prisoners housed in the safety cells occurs during meal time, when a narrow window in the cell door is slid open to pass a food tray.

Instead of relying solely on suicide monitoring, the Jail needs to engage in the proactive treatment of those at risk of committing suicide. As it stands now, prisoners are placed in suicide cells, isolated, removed from routine privileges (such as showering), and monitored until an assessment is made that they can return to the general population. Since they receive no treatment when they return to general population, these prisoners often end up cycling back into the suicide cells. To stop this cycle, adequate programs or access to outside services should be made available.

Third, the "observation cells" in the Facility's booking area are not suicide resistant. These cells are intended for potentially suicidal, self-injurious arrestees/prisoners or arrestees/prisoners otherwise in need of monitoring. Nonetheless, the cells contain a floor-to-ceiling post and easily accessible ceiling vents, with grating wide enough to pose a tie-off hazard for potential suicides by hanging. Moreover, the observation of the prisoners in these cells by corrections staff is limited at best.

Examples of inadequate observation and housing practices include the following:

- A prisoner recently attempted suicide twice in one week. On December 9, 2012, the prisoner, housed with the rest of the Jail's general population, tried to hang himself with his own bed linen. There was no indication that his housing was based on an appropriate mental health assessment. Correctional officers relying on cameras to monitor the prisoner's activities missed the initial steps the prisoner took toward committing suicide because of "blind spots" in camera sight lines, and only were alerted to the suicide attempt when they heard yelling from the prisoner's cellmates. After the first suicide attempt, staff sent the prisoner to the local emergency room for observation and evaluation. Upon his return to the Jail a few days later, a licensed practical nurse, rather than the psychiatrist, made the decision to only temporarily house the prisoner in a safety cell before having him transferred to a non-safety cell in the infirmary. Less than a week later, on December 14, 2012, he was found unresponsive in his bed. The prisoner had attempted suicide a second time and left behind a suicide note in an envelope. On the outside of the envelope, the words, "I give up" were written. He had apparently swallowed 18 packets of non-aspirin, 15 packets of Ibuprofen, and 14 packets of Chlorphen. He was immediately transferred to the emergency room again for evaluation.

- On July 23, 2012, a prisoner housed with the rest of the Jail's general population attempted suicide by tying his jumpsuit to the upper portion of a cell door and proceeding to wrap the jumpsuit around his neck. According to our expert, the absence of a housing decision based on an appropriate mental health assessment in this prisoner's records suggests that he was inappropriately housed and supervised at the time of his suicide attempt.

- On February 23, 2012, a prisoner housed in the Jail's general population attempted suicide by wrapping a blanket around her neck. Again, according to our expert, the

absence of a housing decision based on an appropriate mental health assessment in this prisoner's records suggests that she was inappropriately housed and supervised at the time of her suicide attempt.

Our psychiatric expert found these incidents to be indicative of a failure to appropriately monitor prisoners at risk of attempting to commit suicide. Moreover, these examples demonstrate that prisoners are not being appropriately assessed and treated for their illnesses. While correctional officers may have succeeded in intervening to prevent these prisoners from completing their suicide attempts, the Jail failed to provide adequate assessment and treatment to prevent the self-harm incidents from re-occurring. The incidents also show missteps in assessing whether mentally ill prisoners should be placed in general population and further missteps in administering proper treatment and supervision.

4. The Jail has inadequate accountability and quality assurance mechanisms in place to protect against unnecessary risk.

Jails must have quality assurance systems in place to protect against errors that may lead to grievous harm. *Helling v. McKinney*, 509 U.S. 25, 35 (1993); *Chandler v. Crosby*, 379 F.3d 1278, 1289 (11th Circuit 2004). An adequate quality assurance and performance measurement instrument is necessary to examine the effectiveness of health care delivered in a correctional facility, to evaluate medical care results, and to implement corrective action so that prisoners are kept safe from excessive risks to health and safety. A further goal of quality assurance systems is the overall improvement of health and safety protections. Yet, in light of the foregoing deficiencies, it is especially troubling that the Escambia County Jail also fails to engage in appropriate quality-assurance reviews.

Instead of obtaining and using quantitative information to measure staff performance, command staff relies almost entirely on anecdotal information. The Jail fails to collect information on the use of restraints on prisoners, on how much time prisoners with mental illness spend in solitary confinement, and many other vital data points.

Generally, quality assurance efforts conducted by the Jail's leadership needs to be more exacting. For instance, the minutes from the September 2012 Quality Assurance meeting reported that the Medical Director reviewed medical charts and concluded that "all looked good," when our expert psychiatric consultant, who reviewed a sampling of the records reviewed by the Medical Director, found a need for improvement in every single one of the 10 records reviewed.

V. REMEDIAL MEASURES

The unconstitutional conditions discussed in this letter are directly tied to deficiencies in the Jail's current operational practices. The Jail needs to address these deficiencies by implementing the remedial measures detailed below:

A. Protection from Harm

Jail officials must take reasonable steps to protect prisoners from physical violence and to provide humane conditions of confinement. Providing humane conditions requires that a corrections system satisfy prisoners' basic needs, such as their need for safety. To this end, the Jail should implement the following measures:

1. Protection from prisoner violence

a) Ensure that corrections officer staffing and supervision levels are appropriate to adequately supervise prisoners. To remedy the problem the Facility must either budget for and employ the additional detention staff recommended by Justice Concepts' or significantly reduce the number of prisoners housed in the Facility.

b) Ensure frequent, irregularly timed, and documented security rounds by corrections officers inside each housing unit.

c) Develop a process to track all serious incidents that captures all relevant information, including location, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results, remedy taken, and administrative sign-off.

d) Increase video surveillance in critical housing areas and adjust staffing patterns to provide additional direct supervision of housing units.

2. Monitoring and tracking prisoner violence

a) Develop a process to track all serious incidents that captures all relevant information, including location, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results, remedy taken, and administrative sign-off.

b) Increase video surveillance in critical housing areas and adjust staffing patterns to provide additional direct supervision of housing units.

c) Conduct an appropriate number of cell searches, and appropriately select cells to search, to decrease the flow of contraband into the Facility.

d) Appropriately document the cell searches and document the contraband found during cell searches.

B. Mental Health

Mental health treatment must comport with constitutional requirements and should include generally accepted standards of care to aid in classification, identification of emergent mental health care needs, provision of continuous care, and management of medication. An adequate correctional mental health system includes: mental health screening and assessment;

crisis intervention program; acute care program; chronic care program; capacity for special needs housing; capacity for outpatient treatment services; capacity for consultation services; discharge/transfer planning; and dedicated rounds by mental health professionals. To this end, the Jail should implement the following measures:

1. Access to appropriately skilled mental health professionals and adequate mental health treatment

Consistent with generally accepted standards of correctional mental health care, timely and adequate access to mental health care is necessary to regulate the symptoms of mental illness and to minimize psychiatric decompensation in prisoners.

a) Ensure the presence of an adequate number of competent mental health professionals, including psychiatrists, psychologists, mental health social workers, and counselors, to meet adequately the needs of prisoners with serious mental needs.

b) Ensure that mental health care staff receive adequate training, physician oversight, and supervision.

c) Ensure the presence of an adequate number of correctional staff so that mental health services are not impaired by the lack of correctional staff to provide security and supervision of mentally ill prisoners.

d) Implement an adequate scheduling system to ensure that mental health professionals see mentally ill prisoners as clinically appropriate, regardless of whether the prisoner is prescribed psychotropic medications.

e) Conduct timely and adequate mental health screenings and assessments;

f) Provide crisis services and acute care in an appropriate therapeutic environment that is available to all prisoners who need it, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent treatment;

g) Ensure regular and consistent inpatient and outpatient care is available to all prisoners.

h) Provide a system to track prisoners with chronic mental illness to ensure that prisoners receive necessary diagnosis, monitoring and treatment.

i) Ensure that psychotropic medications are used only in accordance with accepted professional judgment and standards, in particular, that medication is not used in lieu of lesser-intrusive therapies, for the convenience of staff or as punishment, or as a substitute for adequate staff.

j) Ensure that prisoners diagnosed with serious mental illness and refusing to take medication are not discharged from the mental health caseload, but instead are monitored and counseled on the benefits of medication.

2. <u>Protections against prisoner suicide</u>

The Jail must correct all dangers associated with suicide observation identified herein.

a) Consistent with generally accepted corrections mental health care standards, provide an appropriate housing unit for suicidal prisoners with adequate visibility into and out of the cells, and allow those prisoners to leave their cells for recreation, showers, and mental health treatment as clinically appropriate.

b) Ensure that staff provide constant direct supervision of actively suicidal prisoners and close supervision of prisoners with lower levels of suicide risk (*e.g.*, 15-minute checks). Ensure that staff document the supervision of suicidal prisoners, and only use closed circuit video monitoring as a supplemental supervision technique to direct supervision.

c) Ensure that suicidal prisoners are housed in close proximity to staff. To every extent possible, the isolation of such prisoners should be avoided. Except where the prisoner is actively engaging in self-destructive behavior, the Jail shall ensure that suicidal prisoners are not denied routine privileges such as showers, visits, telephone calls, and recreation.

VI. CONCLUSION

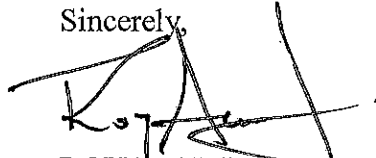
We hope to continue working with Escambia County Jail officials in an amicable and cooperative fashion. In the past, officials have implemented improvements responsive to our concerns. We appreciate these proactive efforts and, in particular, recognize the Sheriff's leadership on these matters. Nonetheless, the systemic problems we have discussed in this findings letter constitute serious risks to prisoner safety that must be remedied in the context of an agreement between the United States and the Escambia County Sheriff's Office.

CRIPA requires us to advise you that in the absence of an agreement, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct the deficiencies of the kind identified in this letter, 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve all matters by continuing to work cooperatively with you and are confident that we will be able to do so in this case. The attorneys assigned to this investigation will be contacting the ECSO General Counsel to discuss this matter in further detail. If you have any questions regarding this letter, please contact Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-6255, Special Litigation Counsel Avner Shapiro (202) 360-7181, or the lead attorney on this matter, David Deutsch, at (202) 514-6270.

Finally, please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. We will also provide a copy of this letter to any individual or entity upon request.

Sincerely,



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