

December 29, 2006

The Honorable Ruth Ann Minner
Governor of Delaware
Tatnall Building
William Penn Street, 2nd Fl.
Dover, DE 19901

RE: Investigation of Delaware Correctional Center, Smyrna, Delaware; Howard R. Young Correctional Institution, Wilmington, Delaware; Sussex Correctional Institution, Georgetown, Delaware; John L. Webb Correctional Facility, Wilmington, Delaware; and Delores J. Baylor Women's Correctional Institution, New Castle, Delaware

Dear Governor Minner:

I am writing to report the findings of the Civil Rights Division's investigation of conditions and practices at the following five Delaware Department of Correction ("DOC") facilities: the Delaware Correctional Center ("DCC"), the Howard R. Young Correctional Institution ("HRYCI"), the Sussex Correctional Institution ("SCI"), the John L. Webb Correctional Facility ("Webb"), and the Delores J. Baylor Women's Correctional Institution ("BWCI").

On March 7, 2006, we notified you of our intent to conduct an investigation of these facilities pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, which gives the Department of Justice authority to seek remedies for any pattern and practice of conduct that violates the constitutional or federal rights of incarcerated persons. We informed you that our investigation would focus on medical and mental health care.

We note that the State has cooperated thoroughly with our investigation and, under the leadership of DOC Commissioner Stanley W. Taylor, Jr., has unequivocally indicated its clear desire to improve medical and mental health care services at the facilities. From the outset of our investigation, the State has been proactive in evaluating the conditions at the facilities.

Indeed, the State retained its own expert consultants, Dr. Ronald Shansky and Dr. Roberta Stellman, to evaluate medical and mental health care services, respectively, at DCC, HRYCI, SCI, Webb, and BWCJ in July and September 2006. Following these evaluations, the State shared the results of its internal evaluations with us.

The State's experts identified systemic deficiencies in medical and mental health care at four of the five facilities: DCC, HRYCI, SCI, and BWCJ (hereinafter, "the facilities"). These findings were presented to the Department of Justice in oral and written presentations by Fried, Frank, Harris, Shriver & Jacobson, outside counsel for the State. To facilitate our investigation, the State agreed to stipulate to the accuracy of these factual findings. Given the State's complete cooperation with our investigation, the unsolicited disclosure of its comprehensive internal audit of medical and mental health care services, and the State's stipulation, we elected to limit our expert tours to a representative subset of the facilities.

Department of Justice staff toured the five facilities on June 22, 2006, July 17-19, 2006 and August 14-16, 2006. We conducted additional tours of HRYCI, Webb and BWCJ, accompanied by expert consultants in the fields of medicine, mental health care, and suicide prevention on October 4-6, 2006, October 23-25, 2006, and November 15-17, 2006. During these tours, we reviewed a wide variety of State and facility documents, including policies, procedures, and medical and mental health records relating to the care and treatment of inmates. We interviewed prison administrators, professionals, staff and inmates at each facility. In keeping with our pledge of transparency and to provide technical assistance where appropriate regarding our investigatory findings, we conveyed our preliminary findings to certain State and facility administrators and staff during verbal exit presentations at the close of each of our on-site visits. As detailed below, our investigative findings mirrored those of the State's experts.

We commend the administrators and staff of the five facilities we toured for their helpful and professional conduct throughout the course of the investigation. In particular, facility personnel cooperated fully and expeditiously with our document requests.

We are confident that our work with the State will continue in the same cooperative manner we have enjoyed throughout our investigation. However, consistent with our statutory obligation under CRIPA, we set forth below the findings of our investigation, the facts supporting them, including those facts

stipulated to by the State, and the minimum remedial steps that are necessary to address the deficiencies we have identified. As described below, we conclude that inmates confined at the facilities suffer harm or are placed at the risk of harm from constitutional deficiencies in certain aspects of the medical and mental health care services, including suicide prevention. Notwithstanding the foregoing, we are pleased to report that we find no constitutional deficiencies at Webb.

I. BACKGROUND

Delaware is one of six states that house both pre-trial detainees and sentenced prisoners in a single unified system, although detainees and prisoners are not housed together. Medical and mental health care services at the facilities are provided through a contract with a private vendor. DCC is located in Smyrna, Delaware, and houses approximately 2,500 male inmates, including both pre-trial detainees and sentenced prisoners. DCC also contains the Security Housing Unit ("SHU"), which houses inmates with disciplinary problems or who otherwise require the maximum level of security. DCC also contains the State's death row. HRYCI is located in Wilmington, Delaware. The facility houses approximately 1800 males, both pre-trial detainees and sentenced inmates. SCI is located in Georgetown, Delaware, and houses approximately 1200 male inmates, including a 100-bed boot camp. BWCI is located in New Castle, Delaware, and houses approximately 400 female pre-trial detainees and sentenced inmates at all security levels. Webb is located in Wilmington, Delaware, and houses approximately 80 minimum security male inmates.

II. FINDINGS

A. MEDICAL CARE

Under CRIPA, the Department of Justice has authority to investigate violations of the constitutional rights of inmates in prisons, and pre-trial detainees in jails. The rights of sentenced inmates fall under the Eighth Amendment, which prohibits the imposition of cruel and unusual punishment. Under the Eighth Amendment, jails must provide humane conditions of confinement, which include adequate medical care. Farmer v. Brennan, 511 U.S. 825, 832 (1994). Failure to provide adequate care to address the serious medical needs of inmates can constitute deliberate indifference, a violation of the Eighth Amendment prohibition against cruel and unusual punishment. Estelle v. Gamble, 429 U.S. 27 (1976). The responsibility to provide adequate medical care includes mental health care.

Tillery v. Owens, 907 F.2d 418 (3d Cir. 1990). Failure to protect a suicidal prisoner from self-harm can also amount to a constitutional violation. Inmates of Allegheny County v. Pierce, 612 F.2d 754, 763 (3d Cir. 1979); Colburn v. Upper Darby Township, 838 F.2d 663 (3d Cir. 1988). The responsibility to protect inmates from harm includes the possibility of future harm as well as present harm. Helling v. McKinney, 509 U.S. 25, 33 (1993); Tillery, 907 F.2d at 426.

With regard to pre-trial detainees, the Fourteenth Amendment prohibits imposing conditions or practices on detainees not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. 420 (1979). The Third Circuit has opined that the protections afforded to pre-trial detainees are at least as great as those afforded to sentenced prisoners. Hubbard v. Taylor, 399 F.3d 150, 166-167 (3d Cir. 2005) (pre-trial detainees claims of constitutional violations to be analyzed under Fourteenth Amendment).

Our investigation revealed that the medical care provided at the facilities falls below the standard of care constitutionally required in the following areas, all of which were also identified by the State as deficient: intake; medication administration and management; nursing sick call; provider sick call; scheduling, tracking, and follow-up on outside consults; monitoring and treatment of communicable diseases; monitoring and treatment of chronic diseases; medical records documentation; scheduling; infirmary care; continuity of care following hospitalizations; grievances; and patient confidentiality. In addition, we found that care for patients with acute medical urgencies was also constitutionally inadequate.

1. Sick Call

The State's expert found that sick call is not being regularly conducted at the facilities and that sick call "no-shows" (inmates who do not appear for their scheduled medical appointments) are not tracked. Our investigation confirmed that there are inadequate sick call systems in place which directly interferes with inmates' access to care for their serious medical needs. Specifically, the systems are deficient in scheduling appointments, and tracking no-shows. For example, the inadequate scheduling system at HRYCI resulted in only seven of the representative sample of 14 patients scheduled for sick call on one day being seen. In addition, we found that inmates who missed sick call were not tracked and, as a consequence, often not rescheduled. The sick call process for inmates' requiring

mental health care suffers from similar inadequacies in scheduling and follow-up. During our tours of BWCI and HRYCI, we found that the sick call process is not functioning properly and that there were significant delays for inmates who had requested to see the psychiatrist. Overall, these conditions place inmates at serious risk of harm.

2. Acute Care

Our investigation revealed that patients with life-threatening conditions are not receiving timely care. We reviewed the records of ten patients sent to the local emergency room; six of these patients were admitted. One patient, known to be infected with HIV, was admitted from HRYCI with pneumocystis carinii pneumonia ("PCP"), a potentially fatal infection in people with AIDS. We determined that this inmate's care had been mismanaged at HRYCI for one month before the inmate was finally sent to the hospital. In addition, this inmate was never tested for active tuberculosis, a likely diagnosis for patients with HIV and pneumonia. The failure to properly diagnose and treat this inmate could have put other inmates and staff at risk of contracting tuberculosis.

3. Chronic Care

The State's expert found that there are consistent backlogs with respect to the treatment of chronic care inmates as evidenced by infrequent scheduled appointments. When appointments are scheduled, they are subject to cancellation without explanation or follow-up. The State's expert also found that the chronic care rosters are not adequately maintained.

Our investigation confirmed that there is no functioning chronic disease registry at HRYCI. The absence of a chronic disease registry means that patients with chronic diseases, such as diabetes, hypertension, asthma, HIV, and Hepatitis C are not being followed and treated according to generally accepted medical standards for chronic care. As a result, inmates with chronic disease are at risk for deterioration in function, including blindness, kidney disease, heart disease, liver failure, and death.

We found that care was especially poor for inmates with diabetes, asthma, and HIV. Of nine inmates with diabetes whose charts we reviewed, only four had received tests deemed necessary pursuant to generally accepted professional standards for care of persons with these serious, chronic diseases. In addition, only two inmates had been immunized against pneumococcus, a bacterium

that is the leading cause of bacterial pneumonia. The failure to immunize chronically ill inmates against pneumococcus places them at serious risk of harm, including death from pneumococcal pneumonia, and constitutes a substantial departure from generally accepted standards of care. Another diabetic inmate whose chart we reviewed went without insulin for three days, despite severely elevated blood sugar levels that were known to staff, placing him at risk of death.

Similarly, for inmates with asthma, the chronic care practices also fall below a minimally acceptable standard of care. For example, of nine asthmatic inmates who should have been seen in the chronic care clinic over a three month period, only three were seen. Only two had documented measurement of peak expiratory flow, which is a departure from the generally accepted standard of care for asthmatic patients.

Finally, with respect to HIV-infected inmates, we found that chronic care practices also fall below a minimally acceptable standard of care. Only two of five patients whose records our medical consultant reviewed had documented laboratory measurements of their CD4 cells¹ and their viral load, both of which are necessary to gauge response to medication.

4. Specialty Care

The State's expert found that outside consultations are delayed by days or even weeks in non-emergency situations because of bureaucratic obstacles within the private vendor's system for obtaining authorization. The State's expert also found that shortages of security staff available to transport inmates to outside medical appointments contributes to the inadequacy of care. In addition, the State's expert determined that, even when outside consults are scheduled, post-consult follow-up does not consistently occur.

Similarly, our investigation found that access to specialty care is untimely, and that tracking of outside care is deficient, creating an unacceptable barrier to adequate medical care ordered by physicians. For example, of 10 patients who were referred by facility doctors for outside care, three received no care at all. All three patients had serious medical issues: two had upper gastrointestinal symptoms, including one patient who had

¹ CD4 cells are white blood cells that identify, attack and destroy infections. A normal CD4 cell count measures the strength of a person's immune system.

documented possibly cancerous polyps with a biopsy ordered and performed, but no results in his file. A third patient had no documented follow-up with an orthopedist following serious trauma to his finger.

And, in the most extreme example, specialty care may have been denied altogether: in March, 2002, an SCI inmate died from a malignant brain tumor that had grown so large that it distorted his facial features, and was so noticeable that other inmates referred to him as "the brother with two heads." Fourteen months before he died, SCI medical staff allegedly misdiagnosed the cancerous growth as a cyst or an ingrown hair, and allegedly made no specialty care referral nor provided any specialty care to the inmate before he died.

5. Skin Infections

It is well-documented that, across the country, the incidence of skin infections among inmates is rising. These skin infections can include methicillin-resistant staphylococcus aureus ("MRSA"), a potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death. MRSA transmission can be prevented by environmental controls, scrupulous laundry practices, early identification, effective treatment, wound care, and follow-up.

The State's expert found that, until recently, the medical staff were generally unfamiliar with the diagnosis and treatment of MRSA, and that the medical staff did not culture potential MRSA infections or educate inmates on proper precautions against the spread of MRSA until Fall 2005.

Our investigation revealed that proper diagnosis of and care for skin infections falls below the minimally acceptable level of care. We also found that medical staff routinely failed to culture skin infections; in addition, we found that wound care and follow-up were inadequate. For example, we reviewed the charts of eight inmates with skin infections at HRYCI; only two of these inmates received adequate care. One had a deep skin infection of the neck, but had no follow-up to see if his infection was spreading. Another inmate had inappropriate treatment for an infection that was accompanied by fever and chills, indicative of a systemic infection that could have led to pneumonia, brain infection, and death. Both of these patients were treated with the antibiotics that are ineffective in treating MRSA. With respect to wound care, we found another inmate at BWCI who was inappropriately treated with a topical cream for an infection on her face, but who did not see the

doctor for six days, by which time she had developed cellulitis, a deep skin infection that ultimately required hospitalization. Our investigative findings and the State's stipulation are also consistent with reports that DCC staff failed to properly diagnose and treat an MRSA infection in an inmate for four months in 2005. This failure to recognize and treat MRSA allegedly caused the inmate to be hospitalized for five weeks, lose the skin on his scrotum, and undergo painful skin grafts, resulting in permanent deformity.

Our investigation confirmed that the existence of the above inadequacies place inmates and staff at risk of acquiring the infection and passing it to others in the community beyond the prison walls. We also found that identification and treatment of skin infections at the facilities is inadequate, including failure to culture and treat wounds. We found that facility staff does not keep adequate logs of skin infections, which prevents staff from being able to analyze data and identify potential sources of transmission. Notably, in many cases physicians were prescribing the antibiotic Keflex, which not only is rarely effective for skin infections, including MRSA, but actually leads to prolonged infection and increased opportunities for the infection to spread. Finally, we found that laundry practices at the Facilities are inadequate to prevent the spread of skin infections, including MRSA.

6. Medication Administration and Management

The State's expert found that prescribed medications are routinely discontinued or delayed and that the current vendor has no systems in place for ensuring that medications do not run out, for notifying inmates when their medications have arrived, or for verifying that the vendor is providing inmates with the correct medications.

Our investigation confirmed these deficiencies which put inmates at risk of harm, particularly those with chronic conditions such as HIV. We observed significant lapses in medication, due either to lack of availability of medications or the failure to administer medications consistently. For example, one inmate had missed 20 consecutive days of his anti-viral medication used to treat the HIV, a potentially life-threatening situation; another inmate with HIV had a one month lag in receiving his HIV medications.

We also found that serial refusals to take medications were not monitored. Numerous inmates missed three or more doses of medications on three consecutive days, without any evidence of

follow-up by the prescribing practitioner, or evidence that the inmate was sought out or counseled.

The State's expert found that numerous systemic problems with medication administration and management exist at the facilities, including: failure to distribute medications at the proper time intervals, leading to over- or under-prescribing medications; failure to provide necessary food at night to diabetic inmates; failure to properly monitor whether inmates are actually swallowing their medications; and pre-pouring medications.

Our investigation found similar deficiencies. Our review of medication administration records at HRYCI revealed that approximately ten percent of the entries were left blank, indicating that inmates had not received their medication, or that the medication administration was undocumented. We also found that the State routinely prescribes Keflex, an antibiotic, for skin infections, despite the fact that Keflex is rarely effective when used to treat skin infections. We also learned that the State plans to administer each dose of medication from stock bottles, instead of filling prescriptions for each patient, a practice which we believe will lead to poor inventory control, diversion, error, and lack of accountability.

B. MENTAL HEALTH CARE

The responsibility to provide adequate medical care includes mental health care. Inmates of Allegheny County Jail v. Pierce, 612 F.2d 754, 763 (3d Cir. 1979); Tillery v. Owens, 907 F.2d 418 (3d Cir. 1990). The State is constitutionally required to provide adequate mental health care to inmates with serious mental or emotional disturbances. The failure to provide necessary psychological or psychiatric treatment to such individuals will result in the "infliction of pain and suffering just as real as would result from the failure to treat serious physical ailments." Inmates of Allegheny County Jail, 612 F.2d at 763. The key to determining whether the State has provided constitutionally adequate mental health care depends on whether inmates have reasonable access to "medical personnel qualified to diagnose and treat such illnesses or disturbances." *Id.*

The State's mental health expert found substantial deficiencies with the mental health care provided at the facilities. The State's expert conducted a number of on-site visits and determined that there is a "continuing need for substantial remedial efforts, training and auditing of mental health services provided by [the State's medical care provider]."

The State identified the following deficiencies: poor responses to sick call requests, particularly in cases involving potentially suicidal inmates; inadequate group and individualized therapy; staffing inadequacies, lack of privacy for inmate mental health counseling, insufficient discharge planning, inadequate administration and management of psychotropic medications, failure to properly develop treatment plans that are regularly updated, failure to develop site-specific policies and procedures for mental health care, failure to properly document medical/mental health records, and failure to obtain consent forms. Our investigation confirmed the serious systemic deficiencies in psychiatric staffing, treatment and counseling, medication administration and management, and intake and screening identified by the State's mental health expert. We conclude that these deficiencies violate inmates' constitutional right to adequate care for serious mental illness.

1. Psychiatric Staffing Deficiencies

The State's expert found that low psychiatric staffing at the facilities have caused a backlog of inmates requiring psychiatric care. Although the facilities do have psychiatrists who are available to provide care on-site, their hours at the various facilities are limited.

Our investigation confirmed that psychiatric staffing is inadequate to provide for inmates' serious mental health needs. For example, during our tour of HRYCI, the State informed us that there are two part-time psychiatrists who provide care at HRYCI, but our investigation revealed that their combined time on-site totals less than twenty hours, and there is no on-site psychiatric coverage provided for two days out of the week. Psychiatric coverage at BWCI is even more limited. Our investigation revealed that a psychiatrist is on site only four hours per week, and the "on-call psychiatrist" generally provides guidance only via telephone. Further, we understand that included in the four hours is time that the psychiatrist spends at the Violation of Probation Center attached to BWCI for two hours every other week. Such limited psychiatric staffing is not constitutionally adequate care because inmates do not have reasonable access to psychiatrists. See Inmates of Allegheny County Jail v. Pierce, 487 F. Supp. 638, 643 (W.D. Pa. 1980).

As a result of inadequate psychiatric staffing, we found numerous instances in which the mental health clinical staff are providing care that they are not licensed to provide (e.g., diagnosis of mental health disorders, treatment development without proper psychiatric consultation, decisions regarding

suicide watch step-downs, etc.). We found that psychiatrists are routinely unavailable for treatment team and staff meetings, and often are not involved in crucial decision-making, and are not adequately involved in monitoring and supervision of staff. In addition, we found that the psychiatrist who provides most of the care at HRYCI was not familiar with the procedures utilized for making decisions about which medications to prescribe for patients with psychotic disorders. Generally accepted standards of care dictate that a psychiatrist be responsible for providing mental health treatment to seriously mentally ill patients should lead treatment teams, direct medication procedures, and be meaningfully involved in treatment decisions.

2. Treatment Planning and Counseling Deficiencies

The State's expert found that treatment plans for inmates need to be developed more regularly so that psychologists do not unnecessarily change diagnoses and so that patients are put on the appropriate problem list. Treatment plan development is an integral part of mental health care. One aspect of treatment planning consists of psychiatric and clinical staff providing consistent notations in medical records to ensure that important information regarding an inmate's care is documented. The State's expert, Dr. Stellman, concluded that there is a continued need for remedial efforts and training in the area of medical records documentation at DOC facilities. Dr. Stellman also found that many medical records do not contain consent forms, and contain improperly completed mental health forms.

Likewise, we found that the poor documentation impacts treatment because it is virtually impossible for a qualified mental health professional to review patient medical records and determine how basic clinical decisions are being made (e.g., why an inmate was admitted to the infirmary; why medications are prescribed; why and how psychiatric close observation levels are changed; what are the bases for diagnostic conclusions). During our tour of BWCJ, we reviewed the medical record of an inmate who had recently attempted suicide and found the psychiatric notes were deficient and difficult to interpret. Both the on-site and "on-call" psychiatrists made adjustments to this inmate's medication without any explanation. Also, despite the fact that this inmate had been on suicide watch on three occasions within a four-month period and was obviously in distress, there were sparse psychiatric notes in her file.

Generally accepted standards of care dictate that discharge treatment planning be provided for inmates who have serious mental illness to ensure continuity of care. The State's expert

found that its inmate treatment plans fail to address how the patient's care will continue once he or she is released from the DOC facility.²

The State's expert also found deficiencies in the individual and group counseling services provided at DOC correctional facilities. There appears to be a limited ability to provide individual counseling sessions to inmates because of a lack of privacy. The State's expert found that when inmates are housed in the infirmary, psychiatrists and mental health staff do their interviews through the cell door and that, because cells typically have at least one other occupant when these interviews are being conducted, the encounters are not confidential. This is a wholly inadequate practice evidencing a denial of reasonable access to psychiatric diagnosis and care. See Inmates of Allegheny County Jail, 612 F.2d at 763.

Group counseling services at the facilities fall below accepted standards, as well. The State's expert found that there was a need for remedial measures and training with respect to the provision of group and individualized therapy.

Similarly, we found the counseling services to be constitutionally inadequate. Because the facilities are substantially understaffed with respect to psychiatrists, physicians generally do not participate in the treatment team or staff meetings. For example, during our tour of BWCI we found that the master's level clinicians who run the group psychotherapy program (e.g., depression group, anger management group, and addiction group) in the Harbor House Unit do not receive any oversight from a psychiatrist. Generally accepted professional standards dictate that the psychiatrist be the treatment team leader and be meaningfully involved in key treatment decisions. However, clinicians are making important treatment decisions that should be left to the professional judgment of a psychiatrist, or at least made with the consultation of a psychiatrist. Our review of the medical records at BWCI and HRYCI revealed that clinicians are recording

² NCCHC standards J-E-13 and P-E-13 require jurisdictions to develop discharge planning for inmates with serious mental illness (e.g., medication for a short period of time following release and referrals to community health providers). Also see, Foster v. Fulton County, 223 F. Supp 2d 1301, 1310 (N.D. Ga. 2002) (holding that a jurisdiction was required to develop meaningful discharge planning for physically and mentally ill prisoners).

psychiatric diagnoses and making observation status decisions about patients in the infirmary, including which inmates should be removed from suicide watch, and at what pace. Psychiatrists should be performing these tasks because psychiatric diagnoses drive treatment decisions.

The State's practice of allowing clinicians to make important decisions regarding the care and treatment of inmates with serious mental illness puts patients at risk. There were three suicides at HRYCI in 2006. A clinician's decision, in May 2006, to downgrade an inmate's observation status may have aided the inmate's ability to commit suicide a few days after he entered the facility. The State took custody of this inmate after his release from a local hospital for treatment related to a suicide attempt. Apparently he was initially placed on one-to-one observation status, but he was later downgraded to a less-restrictive suicide watch despite warnings from a mental health advocate about his vulnerable mental state and need for a mental health evaluation.

3. Psychotropic Medication Administration and Management

The State's expert found that there is a continuing need for substantial remedial efforts, training, and auditing with respect to the management of psychotropic medications.

Our investigation revealed that the medication administration and management of psychotropics at DOC facilities is constitutionally inadequate. We observed during our tours at BWC and HRYCI that there are systemic problems with initiating drug therapy for newly admitted inmates. It appears that this problem may be partially the result of a deficient intake and screening process. Because the intake process is deficient there is rarely an attempt to obtain psychiatric records from community providers which would identify any psychotropic medications that were previously prescribed. If outside records were routinely obtained the delay that we observed with regard to initiating drug therapy for newly admitted inmates might be eradicated or at least greatly diminished.

We also found that the psychotropic medications that newly admitted inmates are often prescribed by community providers were substituted with other medications which may not be as therapeutically effective. We encountered inmates at HRYCI who appeared to have diminished symptom control and decreased functional ability as a result of the substitution of psychotropic medications. Another deficiency that we found with psychotropic medication administration is a lack of consistent

and timely distribution of medications. Because the medication inventory does not appear to be properly controlled, medication shortages have resulted in interrupted drug therapy.

Finally, we found that monitoring of medication is deficient at the facilities. The use of certain psychotropic medications may cause metabolic effects, such as weight gain, hyperlipidemia, and type II diabetes mellitus. As such, generally accepted standards of care require prescribing physicians to monitor weight, body mass index, and abdominal girth on a regular basis. Our review of medical records at BWCI and HRYCI indicate that the State is not following this practice. Another side effect of certain psychotropic drugs is tardive dyskinesia (involuntary movement disorder). Psychiatrists generally monitor this side effect by performing the Abnormal Involuntary Movement Scale ("AIMS") on a regular bases. The State's expert found that AIMS tests are not being done once every six months as required.

4. Intake and Screening

We found the intake and screening process with respect to the identification of seriously mentally ill inmates to be constitutionally inadequate. The intake and screening process for medical and mental health is combined and performed by nursing staff members who do not appear to have received adequate mental health training or have a sufficient background in mental health. Accordingly, they are unable to appropriately identify symptoms of mental illness.

During our tour of HRYCI, we found that the staff's lack of experience with mental health issues is exacerbated by the high volume of newly admitted inmates that are processed per shift. These deficiencies have resulted in the failure to identify inmates with serious mental illness which causes delays in treatment. Another impact of failing to identify inmates with mental illness is that disciplinary sanctions may be inappropriately imposed on mentally ill inmates, because of behavior that could be more appropriately addressed by mental health care and treatment instead of discipline. For example, during our tour of BWCI, we observed inmates in isolation who had not been properly identified as having mental illness, or who had not received adequate treatment for their diagnosed mental illness. For such inmates, care should be taken to ensure that they are not unfairly disciplined for "acting out" when mental health intervention is a more appropriate response.

We also found that intake and screening for juveniles was constitutionally inadequate at HRYCI. During our tour, we

reviewed a number of juvenile medical records to determine whether this special needs population was receiving comprehensive mental health evaluations subsequent to their initial intake survey. However, it appeared that such evaluations were not being routinely performed.

C. Suicide Prevention

Our investigation revealed that the State's practices regarding suicide prevention substantially depart from generally accepted professional standards and expose inmates to significant risk of harm. Our investigation uncovered a system in which inmates at risk for suicide are not adequately identified, housed and supervised.

The State fails to adequately assess and identify inmates at risk for suicide. While the form used to conduct intake assessments is good, the personnel conducting the assessment lack appropriate training and experience with issues related to mental health and suicide prevention. Assessments are often performed by contract or agency LPN's who have not been trained adequately in suicide prevention techniques. Additionally, while the State's medical provider conducts training of its employees on suicide prevention, it has not implemented its training curricula as policy or standard operating procedure. Similarly, correctional staff receive insufficient training in the area of suicide prevention. Training at the academy is only two or three hours, and annual refresher training methods are not adequate.

The intake process also fails to ensure that appropriate action is taken when an inmate reports a history of suicidal thoughts or actions. In these instances, the inmate signs a release, but outside confirmations of their medical and mental health records/histories are not consistently obtained and verified. Furthermore, post-intake follow-up of new inmates, which should be conducted within 14 days, is not done. Instead, follow-up is rolled into the initial intake process, increasing the possibility that at-risk inmates will not be identified.

The State fails to ensure that inmates identified as being at risk for suicide are housed in cells which are sufficient to ensure their safety. Protrusions from walls and ceilings, window frames and grates, and even the design of bunk beds in some cells provide potential anchors strong enough to support an inmate's weight in an attempt at hanging. For example, in August 2006, an HRYCI inmate who hanged himself at HRYCI was housed in an infirmary cell following his admission because he was recovering from a gunshot wound sustained during his arrest. It is not

clear what fixture the inmate used to hang himself, but it is apparent that the cells in the infirmary, like those in the other areas of the facility, are not sufficient to ensure the safety of inmates with suicidal ideations. Hanging was the means used in the May 2006 and February 2005 suicides at HRYCI. Additionally, unsafe light fixtures in some cells, if broken, provide a potential source of sharp-edged pieces of plastic or glass that could be used for self-harm.

The State fails to ensure that appropriate levels of observation are maintained. Documentation of 15- and 30-minute checks does not indicate that these checks are being done. Staff at one facility reported conflicting requirements for checks at lesser levels of observation, highlighting confusion about which interval was the actual policy. Rounds by mental health staff for inmates in isolation and on special units are not regularly done. Additionally, staff at some facilities incorrectly suggested that the various undocumented incidental contacts with at-risk inmates throughout the day, such as dispensing medication or picking up sick call slips, sufficed as a periodic check for inmates' safety.

III. MINIMUM REMEDIAL MEASURES

In order to address the constitutional deficiencies identified above and to protect the constitutional rights of inmates, we recommend the following measures:

1. The State should ensure that appropriate access to medical care, including development and implementation of a functional sick call system that appropriately schedules medical appointments, and properly tracks and reschedules "no shows."
2. The State should ensure that chronic disease registries are implemented and maintained at DOC facilities.
3. The State should provide appropriate continuing care for patients with chronic diseases and ensure that backlogs are eliminated and do not redevelop.
4. The State should ensure that outside consultations are not unnecessarily delayed and that appropriate post-consult follow-up care is provided. The State should ensure that security staffing levels do not negatively impact the provision of outside consultations.

5. The State should implement appropriate measures to identify, track, and treat skin infections, including culturing and treating wounds and prescribing effective antibiotics.
6. The State should ensure the distribution of medication to patients at proper time intervals. The State should implement a system to ensure that proper medications are being received and that sufficient stocks of medications are maintained to avoid interruptions or delays in their delivery.
7. The State should track serial refusals of medication by patients and ensure that prescribing physicians are notified of such occurrences and that appropriate follow-up with patients takes place.
8. The State should ensure that there is adequate psychiatric coverage provided at DOC facilities.
9. The State should ensure that psychiatrists are actively involved in inmate care, including: functioning as the treatment team leader; making psychiatric diagnoses; providing necessary monitoring and supervision of staff; and promoting quality mental health care.
10. The State should provide appropriate medication distribution and management systems to ensure that psychotropic medications are available, distributed in a timely manner, and adequately monitored.
11. The State should ensure that psychiatrists prescribe therapeutically effective medications. If a decision is made to adjust or substitute the medications that an inmate was on prior to their detention or incarceration at a DOC facility, the psychiatrist should provide a clear justification for making the adjustment or substitution in the inmate's medical record.
12. The State should ensure that appropriately trained staff perform a mental health screening at intake.
13. The State should provide appropriate counseling space for qualified mental health professionals to provide mental health treatment to inmates with serious mental illness.
14. The State should ensure that the mental health staff is appropriately documenting the care provided to inmates with serious mental illness.

15. The State should provide appropriate treatment plans for inmates with serious mental illness. The treatment plans will be reviewed on a routine bases to ensure quality of care.
16. The State should develop site specific mental health policies for HRYCI and DCC.
17. The State should develop a comprehensive policy regarding suicide prevention for DOC facilities.
18. The State should ensure that all medical, mental health and correctional staff are appropriately trained regarding issues of suicide prevention, and that the content of their training is reflective of that State's suicide prevention policy.
19. The State should ensure that intake staff are sufficiently experienced and qualified to identify inmates that pose a risk for suicide, and that follow mental health staff conduct appropriate follow-up evaluations of new inmates within 14 days of intake.
20. The State should ensure that inmates identified as at risk for suicide are housed in safe cells, free from fixtures and design features that could facilitate a suicide attempt.
21. The State should ensure that 15- and 30-minute checks of inmates under observation for risk of suicide are timely performed and appropriately documented.

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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 and we will provide a copy of this letter to any individual or entity upon request.

As stated above, we appreciate the cooperation we have received throughout this investigation from State officials and staff at the facilities. We appreciate the State's proactive measures to respond to its own internal audit and our feedback to date to improve the quality of services at the facilities. We hope to be able to continue working with the State in an amicable and cooperative fashion to resolve the deficiencies we found at the facilities. Provided that our cooperative relationship continues, we will forward our expert consultants' reports under separate cover. Although their reports are their work - and do not necessarily represent the official conclusions of the Department of Justice - their observations, analyses and recommendations provide further elaboration of the relevant concerns, and offer practical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at prompt remediation.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, within 49 days after your receipt of this letter, the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, to correct deficiencies of the kind identified in this letter. See 42 U.S.C. § 1997b(a)(1). We would very much prefer, however, to resolve this matter by working cooperatively with you. Accordingly, we will soon contact State officials and counsel 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: Carl C. Danberg
Attorney General

Stanley W. Taylor, Jr.
Department of Correction Commissioner

Thomas L. Carroll, Warden
Delaware Correctional Center

Raphael Williams, Warden
Howard R. Young Correctional Institution

Rick Kearney, Warden
Sussex Correctional Institution

Robert Young, Acting Warden
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