U.S. Department of Justice

Civil Rights Division

Special Litigation Section - PHB
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

June 4, 2003

HAND DELIVERED

Subodh Chandra, Esq.
Law Director
Cleveland City Hall
601 Lakeside Avenue
Room 106
Cleveland, Ohio 44114

Re: Investigation of Cleveland Division of Police
Central Prison Unit and Holding Cell Facilities

Dear Mr. Chandra:

As you know, the Civil Rights Division is conducting an investigation of the Cleveland Division of Police (CDP) pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141, as well as the Safe Streets Act, 42 U.S.C. § 3789d. On July 23, 2002, we notified you that the Division had expanded the scope of this investigation to include conditions of confinement at the Central Prison Unit (CPU) and district police station holding facilities. We greatly appreciate the continuing cooperation of the City and the CDP in our investigation.

The CDP has a total of 150 holding cells currently in use located in six separate facilities. The CPU is a 50-cell, secure facility located within the police headquarters building in the Third District. The five separate holding cell facilities in the First, Second, Fourth, Fifth, and Sixth Districts have approximately 20 cells in each district. We understand that each of these facilities is considered to be a "five day facility" as defined by Ohio Revised Code § 5120:1-7-02(A)(2). Accordingly, these facilities are subject to the standards set forth in the *Minimum Standards for Jails In Ohio*, promulgated by the Ohio Director of the Department of Rehabilitation and Correction. Although we are ultimately guided by constitutional and federal statutory standards, we have considered these standards as well,

along with other relevant materials, in making the observations and formulating the recommendations described below.

In 2001, over 50,000 detainees were held in CDP holding cells. The holding cells are intended for short-term, pre-arraignment detention. Our preliminary review indicates that detainees are typically held for 24-48 hours, but that a number of detainees were held for as long as five days. The Deputy Chief for administrative operations has responsibility for all holding cell operations. The CPU and holding cell facilities are supervised by the CDP Commander for Administrative Services, assisted by a CDP captain, lieutenant and a sworn officer-in-charge (OIC). At the CPU, the OIC's sole responsibility is to supervise the day to day operation of the jail. By contrast, each district's OIC, often a sergeant, is responsible for overseeing the general operation of the district, as well as the holding cell facilities. The district OICs report directly to the district commanders. The CPU and district OICs each supervise a staff of Institutional Guards (IGs), civilian CDP employees who perform the day-to-day functions within the facilities. Although the CPU OIC exercises significant supervision over the IGs under his/her command, in the districts the IGs generally operate the district facilities with limited involvement by the OIC. District holding cell facility operations also are supervised by the Commander for Administrative Services.

Over the course of three trips, September 5-6, October 15-16, and October 22-23, 2002, we toured the CPU and each of the five police district holding facilities three separate times with consultants in medical care, suicide prevention, correctional practices, and environmental health and safety. We have interviewed the command staff charged with administration of these facilities, medical personnel, the food service contractor, numerous institutional guards and detainees, and the officers in charge of each facility. Following each of our visits, we conducted informal exit conferences with CDP command staff and holding cell supervisors in which we related our preliminary concerns about conditions in the holding cells and highlighted particular areas including suicide prevention, fire safety, and security practices. This letter provides a more comprehensive discussion of our concerns and recommendations in the following areas: suicide prevention, medical care, fire safety, security and administration practices, and environmental health and safety. This letter is limited to conditions in the

holding cell facilities and does not include further discussion of the issues raised about other CDP policies and practices in our letter dated July 23, 2002.

Some of the concerns addressed in this letter relate to physical and environmental conditions in the CDP holding cells, while others relate to detention policies and procedures, e.g. detainee intake. The City and the CDP could address many of the concerns regarding medical care, physical conditions and environmental conditions by implementing our recommendations in the CDP holding cells or by housing detainees in an expanded or alternative facility. With respect to other concerns raised in this letter, we suggest that the CDP revise and expand upon its detention polices and procedures in order to implement our recommendations, regardless of whether the CDP decides to house detainees in an alternate location.

This letter discusses the results of our tours and investigation of the CPU and holding cell facilities to date. We continue to review documents that were recently provided to us by the CDP relating to the use of the restraint chair at the CPU. We will notify you of any additional concerns.

I. Suicide Prevention

Within the past three years there have been a number of near fatal suicide attempts, by hanging, by CDP detainees. Our review of suicide prevention measures throughout the CDP holding cells revealed that the CDP lacks adequate measures for suicide risk assessment and suicide prevention. We recommend that the CDP immediately address this potentially life-threatening issue. While further specific recommendations are provided below, in general, we recommend that the CDP develop and implement written policies and procedures in the following areas of suicide prevention: intake screening focusing on suicide risk; staff training; communication and intervention; safe housing of suicidal detainees; follow-up; and mortality review.

A. Identification and Screening

Effective identification and screening procedures are critical to any jail's suicide prevention efforts. The CDP's initial identification and screening process is insufficient to identify a detainee's suicide risk for several reasons. When a detainee is initially processed into a holding cell, a Booking

Information Form is completed. This form has only two areas of suicide risk inquiry, and we understand that the arresting officer fills out the form without necessarily consulting the detainee. This process is problematic because the arresting officer may not have or be able to solicit accurate information regarding the detainee's level of suicide risk. In addition, there is an increased likelihood that suicidal indicators will be overlooked to the extent that an officer relies on observations of any suicidal behavior instead of direct questioning of the detainee. The likelihood that suicidal indicators will be overlooked is further increased by the fact that the arresting officers have not received adequate training to identify potentially suicidal behavior and the lack of involvement by medical personnel in screening detainees.

The Booking Information Form is also an inadequate screening tool because it does not sufficiently inquire into a detainee's potential suicide risk. For example, the form fails to inquire about a detainee's current thoughts of self-harm, history of suicidal behavior and current or prior mental health treatment. In addition, the Booking Information Form fails to include a "Disposition" section indicating actions which are to be taken once a detainee is determined as a potential suicide risk. Further, the CDP does not have an automatic mechanism for staff to determine whether the detainee was deemed to be a suicide risk during a prior CDP confinement.

We recommend that the Booking Information Form be revised to include all areas of inquiry into potentially suicidal behavior identified below. The revised booking procedures should include inquiry by the booking officer as to any information known to the arresting officer and/or the detainee which indicates that the detainee is a medical, mental health or suicide risk. Further, inquiries should be directed to the detainee regarding his/her current thoughts of self-harm, recent significant loss (death of a family member/close friend, break-up of a significant relationship, job loss); history of suicidal behavior by the detainee or a family member; expression of hopelessness/ helplessness; and current or prior mental health treatment.

In addition, we recommend that the CDP review and revise its Record Management System (RMS)to provide for easier access to information regarding a detainee's prior suicide risk while in the jail system. When a new detainee is booked, CDP personnel should verify through RMS whether the detainee was a medical,

mental health, or suicide risk during any prior CDP confinement.

B. Staff Training

The CDP lacks written policies to guide staff regarding the appropriate levels of supervision of suicidal detainees. The CDP's training curriculum for both IGs and sworn officers fails to convey current standards of care. In addition, the CDP does not provide any annual suicide prevention training to its facility staff. This overall lack of suicide prevention training and guidance significantly hampers the IGs, who have the most contact with the detainees, in their ability to prevent a suicide. Moreover, OICs and other sworn officers who may come into contact with potentially suicidal arrestees are not provided appropriate training to help identify and assist such individuals. For example, the CDP training does not provide adequate training on the specific indicators of an increased risk of suicide.

We strongly recommend that the CDP develop pre-service and annual in-service training programs for both IGs and sworn officers in the area of suicide prevention. Training for IGs should also include specific instruction regarding the role of jail and medical staff in responding to suicide attempts and providing first aid and CPR. Annual suicide prevention in-service training should be provided for holding cell and medical staff.

We would be pleased to provide further technical assistance in the development of appropriate policies and a training curriculum.

C. Communication and Intervention

The CDP also lacks formal policies governing the communication of information regarding suicidal detainees. We observed a general absence of the communication among staff in the holding cell facilities that is necessary to prevent detainee suicide attempts. Because detainees can pose a suicide risk at any point during their detention, staff must constantly maintain awareness, share information and make appropriate referrals to mental health and medical staff. However, as discussed below, there is insufficient medical staff involvement in the initial screening and intake of detainees. This inadequacy is compounded by the lack of verbal and written communication between and among

staff, especially medical staff. For example, an in-custody death at the CPU occurred shortly before our October 2002 tour, however, medical staff we spoke with were unable to provide us with information regarding the surrounding circumstances. Although apparently not a suicide, this incident demonstrates the medical staff's lack of involvement in or knowledge of significant events in the holding cell facilities. In addition, during our second tour of the CPU, we noticed that a detainee was dressed in a paper gown and was housed in a cell reserved for suicidal detainees. Despite the fact that the detainee was on "suicide watch," the IG we spoke with was unable to provide us with any documentation indicating that the detainee was potentially suicidal. Instead, the CPU "jail log" only indicated that this detainee had hepatitis B.

We recommend that the CDP develop and implement written policies for communicating the medical and mental health needs of detainees, including potential suicide risk, to relevant personnel. These policies should establish a procedure for communicating information from one shift to another, as well as from one district holding facility to another following transportation. In addition, we recommend that medical staff, who currently have very limited holding cell facility duties, meet on a regular basis to assess suicidal detainees.

The CDP's practices regarding intervention measures following the discovery of a suicide attempt are adequate in general, although these practices were not formalized in a written policy and we noted inconsistent implementation of these practices. For instance, all IG and police personnel were reported to be certified in first aid and CPR (although one sergeant admitted that he had not received any CPR training since 1993). In addition, each facility had a first aid kit (although several kits were not fully stocked) and appropriate cutting tools in the event of a suicide attempt by hanging. Finally, each facility had an Automated External Defibrillator (AED) and the IGs were trained in its use. The placement of AEDs exceeds both state and national standards and is commendable.

We recommend that the CDP develop and implement written policies and procedures for intervention following a suicide attempt. These policies should include specific instruction regarding the role of all jail and medical staff in responding to suicide attempts and providing first aid and CPR. In addition, with respect to the proposed annual in-service suicide prevention

training, the CDP should also review its intervention procedures and schedule "mock drills."

D. Housing and Level of Supervision

All of the CDP's holding cells pose significant problems for housing suicidal detainees. All of the facilities have cells containing dangerous protrusions that can serve as anchoring devices in hanging attempts. For instance, all facilities have cells with horizontal and vertical bars, with large-gauge mesh wiring on the upper bars that obstructs visibility, and air vents located on the walls, also with large-gauge mesh wiring. Other dangers evident in all facilities were large-gauge cages over smoke alarms and large-gauge mesh wiring over ceiling vents. At the First, Fourth and Fifth Districts, we observed holes in the mattress platforms through which a sheet or other item could be anchored. Exposed electrical conduits were observed at the CPU, the First, Fourth and Fifth Districts. The Fourth and Fifth Districts also have blind spots that prevent staff from monitoring potentially suicidal detainees.

We recommend that the CDP ensure that specific cells are designated to house suicidal detainees and that these cells be made as suicide resistant as possible, i.e., remove obvious protrusions, such as those described above. As our consultants emphasized during our exit interviews, we also recommend that due to the numerous protrusions, distance from staff, and obstructed visibility in the present isolation holding cells, suicidal detainees should not be housed in these cells, until the designated cells are made as suicide resistant as possible. We recommend that these cells not be used until they can be modified. As an interim measure, suicidal detainees should be housed in cells where they may be continuously observed by staff.

In addition to the physical deficiencies of the cells, we also found that the supervision provided to suicidal detainees is inadequate. It appears that the CDP's practice is to isolate suicidal detainees in a cell that is in reasonably close proximity to staff. However, the cells utilized in some districts were too far away from the IG's station to allow for close supervision or obstructed from view because of the physical design of the facility. For example, in the Fifth District, the cells used for isolating detainees were located in a separate area behind a cement wall; an area reportedly designated for renovations.

E. Follow-Up and Mortality Review

The CDP does not currently have a formalized "follow-up review process" for suicide attempts or "mortality review process" for all detainee deaths, and the current process appears to be inadequate. The purpose of follow-up or mortality reviews is to investigate the underlying events and to learn how to prevent future incidents. This does not appear to be the focus of the CDP's follow-up or mortality reviews, however. For instance, regarding an attempted hanging in the First District, the CDP review failed to raise any issues concerning basic suicide prevention practices. In fact, the two reviewing sergeants concluded only that no actual policies were violated in that case. The review did not address that fact that the detainee had made multiple suicide attempts in the same holding facility, indicating that the second and third attempts could have been prevented.

We recommend that the CDP institute a formalized follow-up and mortality review process following a detainee death or suicide attempt. Furthermore, we recommend that the review be conducted by a multi-disciplinary committee comprised of jail personnel and medical and mental health professionals.

II. Medical Care

The CDP has no systematic method of providing medical care to detainees. There are no policies or procedures specifically directed to guide medical treatment for detainees. The only existing policies that touch on medical care are general police orders that provide guidance for accepting detainees into the jail and relate to transporting detainees to the hospital or emergency room. The CDP has very limited medical staffing, who only treat detainees housed at the CPU, consisting of: a registered nurse from Employee Health Care, which is located in the police headquarters building, who conducts limited review of screening and medications on week days; and a physician, who conducts rounds five days per week for approximately one-half hour per day. Because there is no medical supervision of health care in the district facilities, the IGs of the different districts, under the supervision of the OICs, have developed their own ad hoc practices for dispensing medication and identifying persons with medical conditions. These practices put detainees at risk.

Our consultant's review of four in-custody deaths which occurred between 1999 and 2002 exemplify the problems with the ad hoc system. In these cases, the detainees described being on medication for a chronic disease, but there was no medical follow-up and they did not receive their medication in the holding cells. For example, on April 6, 2000, a detainee was ill at the time of her arrest and transported directly to a local hospital and admitted for asthma. Two days later, she was released from the hospital and taken to the First District, but her asthma became worse and she was readmitted to the hospital on April 9. She was returned to the First District the same day with a prescription for prednisone and an inhaler. The following day she was brought to the CPU for a court appearance where she complained of shortness of breath and died. Despite two trips to the hospital, there was no evidence that the detainee received her medications as ordered or that there was any medical follow-up following her return to CDP custody.

While further specific recommendations are provided below, in general we recommend that the CDP develop and implement a program to provide medical care to detainees. Further, we recommend that the CDP utilize qualified medical personnel to help develop appropriate policies and procedures.

A. Detainee Intake/Screening

Effective intake and screening procedures are crucial to the early identification of medical and mental health issues among detainees and, thereby, the prevention of injury, illness and death among detainees. There is insufficient involvement of medical professionals in the CDP intake/screening process. Instead, IGs who have not received sufficient medical training are tasked with conducting an initial medical screening of detainees by asking a series of questions on the booking form.

In the district holding facilities, there are no trained medical staff.[1] We were informed that any detainee with an apparent medical condition or who reports that he/she requires medication is taken to the hospital for treatment. This practice was not reflected in our review, particularly with regard to medication. For example, during our first tour, a detainee with

[1] The First District had an EMS team located in the police station, but they were not involved in detainee screening.

epilepsy had a seizure while we were on site at the Second District. Although he had indicated earlier, during intake screening, that he took prescription medication for epilepsy and did not have that medication with him, he was not sent to the hospital until after he suffered a seizure.

While there is more involvement of medical professionals at the CPU than in the district facilities, the practices at CPU are also insufficient. A registered nurse from Employee Health Care may review selected intake forms at the CPU; however, there is no systemic process, governed by policy, to review each of these intake forms relating to medical conditions. Effectively, the only medical screening that occurs on a routine basis throughout all holding cell facilities is that done by the IGs.

CDP's procedures to screen for contagious diseases also are inadequate. There is no routine tuberculosis or other contagious disease screening at the CPU or in the districts. Isolation of detainees is based on the judgment of IGs who rely on detainees' self-identification through responses to the medical questionnaire, which does not include routine symptom screening for tuberculosis.

The CDP's isolation procedures for contagious diseases have been developed without medical oversight, resulting in inadequate precautions in some cases and needless precautions in others. Both in the CPU and the districts, detainees who report that they had or have tuberculosis are put in single cells which have open bars, do not have negative pressure ventilation and are in close proximity to the other holding cells. These cells do not sufficiently isolate such individuals from other detainees and are therefore inappropriate for housing persons with active tuberculosis. The Employee Health nurse does visit the CPU and contact the Cuyahoga County Health Department to determine the current medication for a detainee with tuberculosis; however, the nurse is on-site only Monday through Friday, so detainees with tuberculosis who enter on a Friday night may not be seen for three days. Detainees who report a history of HIV or hepatitis are deemed to be contagious and are also housed in single cells. These practices are not generally necessary for individuals with HIV or hepatitis.

We recommend that either 1) intake, contagious disease and isolation screening be conducted by a medical professional, or 2) IGs receive additional training on conducting intake, contagious

disease and isolation screening and that such screening is reviewed by a medical professional. All detainees with symptoms of, or who report having, a chronic illness should be examined on the day of intake by a nurse and appropriate follow-up by the physician should occur. Contagious disease screening and isolation practices should be modified to be consistent with generally accepted medical practices.

B. Medication Administration

Medication administration practices at the CPU and district holding facilities are inadequate and put detainees at substantial risk. At all facilities, we observed lax practices regarding the storage, dispensing and provision of prescription medications. At the CPU, if detainees have medication with them at intake, IGs place those medications in a cardboard box in a locked cabinet and write instructions in the logbooks for the IGs to dispense the medication. There is insufficient medical supervision over this process. During the week, the nurse visits the CPU daily and checks the medication box to see what it contains. The nurse may inspect the medication containers to verify the contents, but there is no other supervision by a health professional over medication distribution. During the weekends, IGs inspect medication containers and make judgments as to whether the containers are appropriately labeled with the detainee's name and whether the detainee will be permitted to take the medication. If the container is not marked, the detainee must wait until Monday for the nurse to review the container, which results in detainees being without medication for two or three days. For detainees on insulin the nurse will draw the insulin in a syringe and place the syringe in a refrigerator with instructions in the logbook for IGs to deliver the medication. This is not a medically acceptable practice.

There is no standardized control or storage of medication in the districts. For example, in the Fifth District medications are kept in open drawers and in the Fourth and Sixth Districts detainees are permitted to keep some medications, like asthma inhalers, in their cells. In several districts expired medication was stored in cabinets with medication currently used by detainees. Moreover, narcotics and other scheduled drugs were not handled differently than other medications and not stored in double locked cabinets, as required by standard pharmacy protocols. In several districts, expired narcotic medications remained in medication drawers or cabinets and were not

destroyed. No process for inventory or disposal of drugs is maintained. At the Fifth District, medications which must be refrigerated are kept in refrigerators that also hold food.

Practices for dispensing medication in the district facilities are also inadequate and vary from district to district. For example, in some districts, detainees who are admitted with asthma inhalers are permitted to keep these on their persons, in other districts, detainees are prohibited from keeping inhalers. These decisions are not made by medical personnel, but apparently by IGs. If detainees have medication with them at intake, the IGs will also examine the label and determine whether the detainee will be permitted to take the medication. If the detainee is permitted to take the medication, the IG will store the medication and note the administration of the medication in the general log book. There is no medical personnel supervision of this practice for dispensing medication, resulting in inconsistent administration of medication. For example, at the Second District where the detainee suffered a seizure during our tour, another detainee was taking medication for epilepsy and had only received one dose of his medication at 5:00 p.m. although he was prescribed to take it three times per day.

In both the CPU and the districts, the treatment of detainees who state that they are on medication but do not have it on their person varies with the IG on duty. In some cases, IGs will attempt to verify with a pharmacy or physician what medication is currently prescribed. In other cases, the detainee is sent to a local emergency room to see a physician. The general, unwritten policy appears to be that detainees who come in without medications should be taken to the local emergency room, but this is not consistently followed, as noted above. One factor leading to such departures from generally accepted practices is that, at all the holding facilities, medical information regarding detainees is communicated by word of mouth between shifts.

We recommend that medication, prescription, storage and distribution systems be improved and made uniform. Further, written policies and procedures should be developed to be compliant with current correctional medical standards and pharmacy regulations.

C. Clinical Treatment

Although the CPU and district holding facilities are intended for short term detention, chronically ill detainees need to receive appropriate medical care to prevent relapse or exacerbation of their conditions. At the CPU, based on the history obtained at intake, the IG will refer to the nurse any detainee who is ill or who may have a chronic disease that the IG believes requires medical attention. These referrals are judgments made by untrained IGs and can result in untimely medical referrals. The physician makes rounds in the CPU four days a week for approximately one half-hour each day. There is no sick call process other than requesting the attention of the physician at the time he makes his rounds. Moreover, most physician encounters are done cell-side and evaluations are generally without examination. Medical encounters with the physician are documented by single line entries in a book that includes only the name, age, race and complaint of the detainee and the medication that is being taken or was prescribed. Detainees we spoke with apparently did not know how to access medical services. No separate medical records on detainees are kept and records that are maintained are not confidential. The CDP provides even less medical treatment to detainees at the districts, where there is no medical staff. Any treatment is obtained by conveying detainees to the hospital and, as noted above, the CDP does not transport detainees in need of medical evaluation or treatment to the hospital consistently.

The problems with screening, medication administration and treatment are exacerbated by the lack of adequate medical staffing at the CPU and district holding facilities. There is no single position specifically assigned to manage health care for detainees in the holding cell facilities. As a result, practices relating to medical treatment for detainees have apparently been developed and instituted by CDP sworn and civilian staff. At the CPU, a registered nurse from the Employee Health Services, provides a brief period of time from Monday through Friday to assess detainees brought to her attention by CPU staff. In addition, an Employee Health Services physician spends approximately one half-hour, 5 days per week at the CPU. Neither the nurse nor the physician evaluate or treat detainees in the districts. IGs, who reportedly receive no medical training, apparently perform medical evaluations, distribute medication and perform medical triage at all facilities.

We recommend that a physician be responsible for directing clinical medical care at the facilities. Clinic space should be

improved and minimal medical supplies should be available where detainees are examined. Medical documentation should be improved so that it is confidential and accurately reflects the care provided. Further, we recommend that the CDP designate an appropriate number of holding cell facilities to house those detainees with medical issues, to avoid the need to replicate a medical program in every facility.

III. Fire Safety

Our tours revealed an absence of certain fire safety precautions that cause significant concern. While we noted that all of the facilities had operable smoke detectors, there was no apparent system for regularly checking emergency doors, grills and locking mechanisms for operation. During our second tour, we observed two doors at the CPU to have inoperable locks and an emergency door at the Second District that was extremely difficult to open. Staff attempting to open and lock some of the metal gates at the CPU reported that there was no system for regularly inspecting doors and gates for operability. Further, there was no indication that a safety program was in place for conducting emergency fire drills or evacuations. Although all the facilities reported having evacuation plans, when queried, staff members from all facilities, including some who had worked for the CDP for up to eight years, stated that they had never participated in a fire drill. The CPU and most of the districts lacked sufficient handcuffs or flex cuffs in the event a mass evacuation was necessary.

We recommend that the CPU develop appropriate fire safety policies and procedures, including plans to regularly inspect the operability of all exits, locked doorways, smoke detectors and fire extinguishers. The CDP should also regularly conduct fire drills. Further, we recommend that the CDP acquire a sufficient supply of handcuffs or flexcuffs in the event of a mass evacuation.

IV. Detainee Safety and Security

The CPU and district facilities are often overcrowded and understaffed. These conditions, coupled with deficiencies in the practices used to house and supervise detainees in facilities which lack adequate communication equipment, present substantial risks of harm to detainees. We set forth below how, in our consultant's opinion, these particular deficiencies contributed

to the death of one detainee.

A. Security Screening and Classification

1. Detainee Population and Housing

We observed a number of deficiencies in CDP policies and practices regarding safety and security screening and detainee monitoring. The CPU and district holding cells lack an objective method to screen detainees for potential security risks. Although the security screening necessary in a holding facility is not as extensive as the classifications systems required at a long term facility such as a prison, a system of screening and housing detainees based on objective, behavior-based criteria is an important component of providing a reasonably safe environment. However, the CDP lacks such a system and fails to determine systematically whether detainees are suspected crime partners, combative or assaultive, or may be likely victims of inmate-on-inmate violence while in the holding cells. Booking staff reported that cell assignments are made on the basis of available cell space and unguided judgments by line staff as to the appropriate placement of detainees. These practices pose safety and security risks to both detainees and staff. We recommend that the CDP develop an objective detainee security screening system and would be happy to provide technical assistance in this regard.

The concerns presented by the lack of an objective security screening system are exacerbated by mild overcrowding in the holding cell facilities. The CPU is designed to house 60 detainees in single cells which are approximately 48 square feet in size with one bunk. On the date of our second tour, there were 65 detainees at the CPU, which we were told was a typical daily census. However, a review of recent population counts revealed that the population at the CPU can climb as high as 103. We observed that the majority of detainees in the CPU and in the district holding cells were double celled due to the population and, in some cases, because cells were out of service due to inoperable toilets and sinks. We were also told that triple celling occurs at times, depending on the population and number of cells in service.

While capacity is apparently regularly exceeded at the CPU and often at the districts, there is no procedure to increase staffing levels during these periods. At the CPU, staffing

consists of six to eight IGs, supervised by an OIC. Staffing at the districts consists of an OIC, who is generally not involved in direct supervision of detainees, and one or two IGs. When the district facilities become overcrowded, the discretionary administrative response is to close these facilities for new bookings. This occurs most frequently when there is only one IG on duty who, along with the OIC, bears the responsibility for all holding cell operations including detainee supervision. We recommend that the CDP review staffing and detainee population patterns to ensure that appropriate supervision is provided to detainees at all times.

2. Security Features

We also observed a number of security features typical of jail operations to be absent. Facility staff do not have hand-held radios or body alarms, there are few operable intercoms and surveillance cameras, and there does not appear to be a regular system for conducting cell searches for contraband. These deficiencies can negatively impact staff and detainee safety and communication. For example, our review of the in-custody death of a detainee at the Second District on July 14, 2001, indicates that another detainee heard the deceased's cellmate screaming for an IG and heard the deceased wheezing the night before he died. A witness reported that it took 15 to 20 minutes for an officer to respond. The deceased was later moved to an observation cell, where he was found dead at 10:30 a.m.

We recommend that the CDP repair or replace inoperable surveillance equipment and ensure that there are operable surveillance cameras in strategic locations. We recommend that staff be provided with hand held radios and/or body alarms. In addition, we recommend that a two-way communication system be installed for detainees to contact staff who are outside of normal hearing distance.

Certain other security measures at the CPU appeared lax. For example, at the CPU, cellblock grills, processing cell grills, and control grills were observed to be open simultaneously and were unattended. This practice contravenes standard correctional norms. In one case, we observed one detainee's cell door was left unlocked along with the doors in and out of that detainee's cellblock. At the CPU, we also observed an emergency key, which security staff reported would open the cell areas and the emergency exits, that was stored in a

non-secure location - hanging on the wall by the reception desk, available to anyone. In addition, we observed that the CPU and holding cell facilities lacked security equipment such as metal detectors and search wands. Further, we observed some sworn staff enter the confinement area with their weapons. Although we were told that the weapon was not loaded and the magazine had been secured, this practice is contrary to standard correctional practices and can increase the likelihood of a disturbance should a detainee attempt to gain control of the weapon.

We recommend that the CDP review its policies and training of security staff to develop, implement and train staff with regard to appropriate physical security precautions. In addition, we recommend that the CDP acquire search wands, metal detectors and ample restraining devices for the CPU and holding cell facilities. Further, we recommend that the CDP implement a policy requiring that all firearms be properly secured and kept out of the confinement areas.[2]

3. Policies, Procedures and Post Orders

The basic operational foundation for a well-managed jail is the maintenance of current policies, procedures and post orders. While we understand the CDP is in the process of revising these materials, our tours revealed that the CPU and the holding cell facilities policies, procedures and post orders are outdated or not available. The most recent policy and procedure manual that was available during our tour was dated 1987.

The post orders that the CDP provided to us appear to address, in limited fashion, all security posts. These orders do not contain, however, the duties listed in chronological order, which would make the orders easier to follow. Moreover, the post orders are not signed or dated. There also appears to be no mechanism for ensuring that security staff read and understand the orders.

We recommend that the CDP develop a system whereby policies, procedures and post orders are regularly reviewed and updated by the OIC. All facility policies, procedures and post orders

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[2] At the CPU, we observed firearm lockboxes installed in the corridor leading to the reception area that apparently were not utilized.

should be readily available to staff and consistent among the different facilities. Further, we recommend that, as with CDP General Police Orders, policies, procedures and post orders be dated and signed by the appropriate CDP official. We recommend that security staff regularly review and certify that they have read and understood the policies, procedures and post orders.

B. Information for Detainees and Grievance Procedures

The holding cell facilities lack a system for providing detainees with general information regarding: medical or mental health services, showers, family visits, access to telephones and attorneys, fire evacuations, food service, and any grievance procedure. Moreover, none of the facilities we toured had a written grievance procedure. We recommend that the CDP develop and implement a written procedure for disseminating information regarding obtaining services and a written detainee grievance procedure whereby a detainee can express his or her grievance to the OIC, with an appropriate mechanism to appeal up the chain of command, without fear of reprisal.

C. Use of Force/Restraints

We understand that there is no separate use of force policy applicable to holding cells other than the CDP's general policy on the Use of Force, GPO 2.1.01. While this policy addresses use of force scenarios for police officers, it does not provide appropriate guidance for the use of force in the holding cell facilities staffed by non-sworn IGs. Although we understand that authorization for the use of force by IGs is obtained from the OIC, the policy does not contain a requirement for staff to promptly file use of force reports and submit witness statements. It does not contain provisions for ensuring medical treatment of staff and detainees after a use of force incident in one of the facilities.

The only facility equipped with an emergency restraint chair is the CPU. We understand that use of this chair must be authorized by the OIC, or sworn personnel higher in the chain of command, and that the CDP's practice for use of this chair is to place a detainee in the chair located in an office with its windowless door shut. Security staff apparently do not maintain monitoring or observation logs of detainees while they are restrained and there is no record of checks by medical staff of the restrained detainee. The CPU has no specific policies or

procedures governing the safe use of the restraint chair, although we were told that detainees are not restrained for longer than two hours.

We recommend that the CDP amend the existing use of force policy or promulgate a specific use of force policy applicable to staff in the holding cell facilities. Further, we recommend that the CDP develop policies for the safe and appropriate use of its restraint chair.

III. Environmental Health and Safety

A. Cleaning and Maintenance

In general, all holding cells except those in the Sixth District were dirty and poorly maintained. During our inspections, we identified problems with CDP policies and practices regarding routine cleaning, trash removal, and physical plant maintenance and repair. Accumulations of dirt, trash, and debris, especially in the amounts we observed, can have a serious and wide-ranging impact. Trash, particularly food and paper, attracts insects and rodents, which can spread disease. It also increases the potential for injury to inmates and staff, causes odor problems, and provides a convenient place for detainees to conceal contraband, thereby compromising security.

Neither the cells nor the corridors at CPU appear to be cleaned on any regular basis. With limited exceptions, on three separate inspections, the cells were filthy, with excessive amounts of dirt, dust and grime. Food debris and other trash was frequently observed in and around the cells. Trash, including bread, breakfast cereal, spilled soup, toilet paper, and various types of food containers, was littering the cells and corridors. The CPU has an apparent fly infestation. Fly traps were evident with fruit flies and house flies. Air vents were blocked with paper waste and dirt. During our second tour of the CPU, we observed that the plumbing chases were full of paper debris and dead roaches. Although the chases were significantly cleaner at the time of our third tour, the CDP does not have a system for ensuring that these areas are cleaned routinely.

In the districts, cleaning practices varied widely. While the Sixth District appeared to conduct routine cleaning, the other districts had cells which were filthy and did not appear to be cleaned on a regular basis. The Second District observation

cell had apparent blood stains on the wall during our first tour in September which were still evident during our second tour. Similarly, at the Fifth District, what appeared to be dried feces on toilet paper was observed splattered on a wall outside a cell used for observation of potentially suicidal detainees.

We also observed biohazardous waste disposal practices that are dangerous to both staff and detainees. During our tour of the CPU, a detainee had vomited blood and we observed a small cardboard box being used as a container to capture and dispose of this biohazardous waste. Staff seemed unaware of the appropriate method for disposing of this box and it was left in the front reception area for some time before it was removed. In the First District, we were informed that blood spills are not cleaned up until the following day when the maintenance crews arrive. At the Fourth District, no biohazard bags or containers were available for disposing of biohazardous waste and there was no protective equipment, such as eyewear, gowns or aprons for cleaning up such waste. At the Second District, dried blood residue was observed on a wall in one of the observation cells, and staff were using regular trash bags for discarding biohazardous waste.

We recommend that the CDP develop a routine cleaning and maintenance system for the CPU and district holding facilities. We recommend that sweeping, mopping, toilet and sink cleaning be done on a daily basis. Cells should be cleaned and disinfected after each detainee's release. Pipe shafts, closets and other such areas should be cleaned on a routine basis.

B. Unsanitary Living Conditions

In addition to the inadequacies in cleaning and maintaining the cells, our tours also revealed living conditions to be unsanitary. Although we were told that detainees are afforded the opportunity to shower, our interviews with staff and numerous detainees were to the contrary. Most of the facilities either had no towels or towels were scarce. The shower facilities in the female wing of the CPU had a fly paper strip covered with flies, no working light and had mold on the shower floor. Similarly, the male shower had no light and mold all over the floor. In numerous facilities we observed detainees in dire need of showering. A number of detainees we spoke with had been detained for 3 to 5 days without the opportunity for showers.

Further, there is no system for cleaning or sanitizing mattresses. We observed mattresses in use that could no longer be effectively sanitized because the mattress casing was cracked.[3] As a result, we understand that mattresses are regularly reused by different detainees and that a single blanket can be used by up to three different detainees in a given week. These practices, coupled with the lack of showers, contribute to the unsanitary conditions and foul odors in most of the holding cell facilities, particularly at the CPU.

We recommend that the CDP establish a system whereby newly admitted detainees are provided an opportunity to shower upon reception and on a regular basis. Showering opportunities should be recorded. There should also be delousing supplies available to those who need them, and a system should be developed to ensure that mattresses are sanitized between use and that clean blankets are provided to detainees upon admission.

* * *

In conclusion, we appreciate the cooperation we have received from City and CDP officials and look forward to continued discussion about the issues raised by this letter.

Sincerely,

/s/ Shanetta Y. Brown Cutlar

Shanetta Y. Brown Cutlar
Acting Chief
Special Litigation Section

cc: Gregory A. White
United States Attorney
Northern District of Ohio

[3] We also note that the fire retardancy of mattresses can be significantly compromised if the casing is cracked.