MEMORANDUM

Agenda Item No. 8(B)(1)

TO: Honorable Chairwoman Rebeca Sosa
and Members, Board of County Commissioners

DATE: April 16, 2013

FROM: R. A. Cuevas, Jr.
County Attorney

SUBJECT: Resolution authorizing execution of consent agreement and settlement agreement with the U.S. Department of Justice ("DOJ") regarding alleged violations in DOJ findings letter dated August 24, 2011

Resolution No. R-291-13

The accompanying resolution was prepared by the Corrections and Rehabilitation Department and placed on the agenda at the request of Prime Sponsor Commissioner Jose "Pepe" Diaz.

R. A. Cuevas, Jr.
County Attorney

RAC/jls

Memorandum

MIAMI-DADE COUNTY

Date: April 16, 2013

To: Honorable Chairwoman Rebeca Sosa
and Members, Board of County Commissioners

From: Carlos A. Gimenez
Mayor

Subject: RESOLUTION REGARDING PROPOSED SETTLEMENT OF FINDINGS BY U.S. DEPARTMENT OF JUSTICE (DOJ) REGARDING JAIL CONDITIONS, PURSUANT TO INVESTIGATION UNDER AUTHORITY OF THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT (CRIPA), 42 U.S.C. §1997

RECOMMENDATION

It is recommended that the Board of County Commissioners approve the proposed consent agreement between Miami-Dade County and the Public Health Trust and the U.S. Department of Justice, and the settlement agreement between Miami-Dade County, which operates the Miami-Dade Corrections and Rehabilitation Department, and the U.S. Department of Justice.

SCOPE

The impact of these agreements is countywide.

FISCAL IMPACT/FUNDING SOURCE

There is fiscal impact to Miami-Dade County and the Public Health Trust regarding the implementation of provisions required from these agreements. Significant cost implications are summarized in the Background Section of this memorandum. Operating costs borne by Miami-Dade County will be supported by the Countywide General Fund. Capital costs are supported either through the bond proceeds or the Capital Outlay Reserve, depending upon the project. Operating costs borne by the Public Health Trust will be supported by operating revenues, including the maintenance of effort paid by the County.

TRACK RECORD/MONITOR

Mr. John Johnson, Captain, will serve as the monitor and be responsible to comply with the provisions of the settlement agreement for Miami-Dade Corrections and Rehabilitation Department. Mr. Patrick Morse, Director, will serve as the monitor and be responsible to comply with the provisions of the consent agreement for the Public Health Trust's Corrections Health Services.

BACKGROUND

On April 2, 2008, the Department of Justice initiated an investigation of conditions at the County's Jail facilities (Jail), pursuant to Civil Rights for Institutionalized Persons Act, 42 U.S.C. § 1997. The Department of Justice toured the Jail with its team of consultants on June 9 – 13 and June 16 – 20, 2008, and on April 7 – 8, 2009. On August 24, 2011, the Department of Justice issued a Findings Letter, alleging various violations regarding medical care, mental health care and suicide prevention, use of force, fire safety and environmental health, as well as recommending remedial measures. The medical and mental health issues are primarily the responsibility of Corrections Health Services, a division of the Public Health Trust, while the issues concerning jail operations are under the purview of the Miami-Dade Department of Corrections and Rehabilitation. Both agencies have collaborated closely in responding to the Department of Justice.

In response to the Findings Letter, the Miami-Dade Corrections and Rehabilitation Department and Corrections Health Services ("the County") provided the Department of Justice a comprehensive matrix which correlates numerous measures already undertaken by the County with the corresponding remedial responses identified in the Findings Letter, as well as substantial documentation of the numerous measures implemented since the time of the inspections. On October 4, 2011, County representatives met with the Department of Justice in Washington, D.C., to discuss these documented changes. As a result, the Department of Justice agreed to re-inspect the Jail facilities on November 30 – December 2, 2011. After the re-inspection, the Department of Justice concluded that significant improvements had been made in many areas, while other conditions still warranted remedial efforts.

On July 9, 2012, the Department of Justice presented the County with a proposed draft of a consent agreement. Extensive negotiations, including three days of direct discussions with Department of Justice attorneys in Miami on September 17 - 19, 2012, resulted in the two accompanying proposed agreements. Issues related to medical and mental healthcare, including suicide prevention, are addressed by the consent agreement. Issues related to jail operations are addressed by the settlement agreement. These agreements are consistent with, and in furtherance of, the accreditation efforts to which the County is already committed.

The statute (18 U.S.C. §3626(c) authorizes two different forms of settlement agreements. The first, and by far the most common, is a consent agreement that is filed with and enforced by a federal district court. The second is referred to as a "private party settlement agreement," and while not under direct oversight by a court, the Department of Justice retains the ability to initiate an action in the event of noncompliance by the County. The Department of Justice agreed to utilize a settlement agreement for issues relating to jail operations because related improvements had been in place and sustained for a substantial period of time. The settlement agreement is expected to remain in effect between five to seven years as individual provisions shall terminate after the Department of Justice confirms the maintenance of substantial compliance for a period of 18 months. While improvements in medical and mental healthcare also were acknowledged by the Department of Justice, it required a consent agreement to address these issues as these improvements were more recent and not as fully implemented.

There is fiscal impact for both the Miami-Dade Corrections and Rehabilitation Department and the Public Health Trust/Corrections Health Services. The consent agreement requires the construction of the Mental Health Treatment Facility at an estimated cost of $12,000,000 - $16,000,000, which is currently funded in the Building Better Communities General Obligation Bond Program. Operations of the Mental Health Treatment Facility will be phased in commencing by the end of 2014 with an estimated annual cost of $22,000,000 for custodial staff, once fully operational. The consent agreement also requires the implementation of an electronic medical records system estimated at $230,000; additional mental health staffing with an estimated cost of $7,317,000, once fully operational; additional medication and supplies estimated at $293,000; and the annual cost of $125,000 for an outside Monitor for medical-related provisions.

Significant cost implications associated with the settlement agreement include an automated jail management system with an installation cost of $6,000,000 and annual maintenance cost of $500,000; additional video monitoring equipment estimated at $1,200,000; and increased staff training with an

estimated annual cost of $1,300,000 annually. Additional costs include $300,000 for a comprehensive staffing analysis and plan, as well as any required additional security staffing identified by the staffing analysis; and the cost of an outside Monitor for jail operation-related provisions estimated at $250,000 annually until the completion of the settlement agreement.

Miami-Dade County will work diligently to meet the provisions indentified in these agreements. Both Miami-Dade Corrections and Rehabilitation Department and the Public Health Trust's Corrections Health Services will continue to collaborate to ensure the mandates in these agreements are met as well as continue professional accreditation efforts of their facilities and programs.

Genaro "Chip" Iglesias
Deputy Mayor

MEMORANDUM
(Revised)

TO: Honorable Chairwoman Rebeca Sosa
and Members, Board of County Commissioners

DATE: April 16, 2013

FROM: R. A. Cuevas, Jr.
County Attorney

SUBJECT: Agenda Item No. 8(B)(1)

Please note any items checked.

_____ **"3-Day Rule" for committees applicable if raised**

_____ **6 weeks required between first reading and public hearing**

_____ **4 weeks notification to municipal officials required prior to public hearing**

_____ **Decreases revenues or increases expenditures without balancing budget**

_____ **Budget required**

_____ **Statement of fiscal impact required**

_____ **Ordinance creating a new board requires detailed County Mayor's report for public hearing**

✓ **No committee review**

_____ **Applicable legislation requires more than a majority vote (i.e., 2/3's ____, 3/5's ____, unanimous _____) to approve**

_____ **Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required**

Approved _____ Mayor
Veto _____
Override _____

Agenda Item No. 8(B)(1)
4-16-13

RESOLUTION NO. R-291-13

RESOLUTION AUTHORIZING EXECUTION OF CONSENT AGREEMENT AND SETTLEMENT AGREEMENT WITH THE U.S. DEPARTMENT OF JUSTICE ("DOJ") REGARDING ALLEGED VIOLATIONS IN DOJ FINDINGS LETTER DATED AUGUST 24, 2011

WHEREAS, on April 2, 2008, the Department Of Justice (DOJ) initiated an investigation of conditions at the Miami-Dade County's jail facilities, pursuant to the Constitutional Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997; and

WHEREAS, on August 24, 2011, DOJ issued a Findings Letter, in which it alleged various violations regarding medical care, mental health care, suicide prevention, use of force, fire safety and environmental health, as well as recommending remedial measures; and

WHEREAS, inmate medical and mental health care are provided by Corrections Health Services (CHS), a division of the Public Health Trust, and jail operations are the responsibility of the Miami-Dade County Department of the Corrections and Rehabilitation (MDCR); and

WHEREAS, both before and after the commencement of DOJ's CRIPA investigation CHS and MDCR implemented a variety of measures and improvements as part of an ongoing effort to achieve accreditation by professional correctional organizations, including the American Correctional Association ("ACA") and the National Commission on Correctional Health Care ("NCCHC"); and

WHEREAS, DOJ expressly acknowledged the Miami-Dade County's full cooperation throughout the CRIPA investigation and significant improvements made since the commencement of the investigation; and

WHEREAS, in further acknowledgment of improvements made by the County in many areas of jail operations, DOJ has agreed to address these matters in the form of a "private party settlement agreement", 18 U.S.C. §3626(c)(2), which does not require direct court oversight; and

WHEREAS, while acknowledging that improvements in medical and mental healthcare have also occurred, DOJ requires a judicially enforceable consent agreement to address those areas because these improvements are more recent and have not been as fully implemented; and

WHEREAS, the proposed settlement agreements are consistent with MDCR's and CHS's ongoing efforts to achieve professional accreditation of their facilities and programs; and

WHEREAS, County representatives from MDCR, CHS and the County Attorney's Office have engaged in extensive, good faith negotiations with DOJ to reach a full and fair settlement of the violations alleged in DOJ's Findings Letter dated August 24, 2011,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that the Board hereby authorizes the County Mayor and County Attorney to execute the consent agreement and settlement agreement with the U.S. Department of Justice in substantially the form attached hereto and made part hereof for and on behalf of Miami-Dade County.

The foregoing resolution was offered by Commissioner **José "Pepe" Diaz**, who moved its adoption. The motion was seconded by Commissioner **Sally A. Heyman** and upon being put to a vote, the vote was as follows:

Rebeca Sosa, Chairwoman	**aye**		
Lynda Bell, Vice Chair	**aye**		
Bruno A. Barreiro	**aye**	Esteban L. Bovo, Jr.	**absent**
Jose "Pepe" Diaz	**aye**	Audrey M. Edmonson	**aye**
Sally A. Heyman	**aye**	Barbara J. Jordan	**aye**
Jean Monestime	**aye**	Dennis C. Moss	**aye**
Sen. Javier D. Souto	**aye**	Xavier L. Suarez	**aye**
Juan C. Zapata	**aye**		

The Chairperson thereupon declared the resolution duly passed and adopted this 16th day of April, 2013. This resolution shall become effective ten (10) days after the date of its adoption unless vetoed by the Mayor, and if vetoed, shall become effective only upon an override by this Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF
COUNTY COMMISSIONERS

HARVEY RUVIN, CLERK

By: Christopher Agrippa
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency.

BP for RAD

Robert A. Duvall

IN THE UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA, PLAINTIFF, v. MIAMI-DADE COUNTY; MIAMI-DADE COUNTY BOARD OF COUNTY COMMISSIONERS; MIAMI-DADE COUNTY PUBLIC HEALTH TRUST DEFENDANTS.	)	Civil No. _____

CONSENT AGREEMENT

Table of Contents

I. INTRODUCTION

1. The purpose of this Consent Agreement ("Agreement") is to remedy the alleged constitutional violations at the Miami-Dade County Jail identified in the findings letter that the United States issued on August 24, 2011 ("Findings Letter"). The Jail is an integral part of the public safety system in Miami-Dade County, Florida. Through the provisions of this Agreement, the Parties seek to ensure that the conditions in the Jail respect the rights of inmates confined there. By ensuring that the conditions in the Jail are constitutional, Miami-Dade County, the Miami-Dade County Board of Commissioners, and the Miami-Dade County Public Health Trust will also provide for the safety of staff and promote public safety in the community.

2. Plaintiff is the United States.

3. Defendants are: (1) Miami-Dade County ("County"); (2) the Miami-Dade County Board of County Commissioners; and (3) the Miami-Dade County Public Health Trust. Defendants shall ensure that the Miami-Dade County Corrections and Rehabilitation Department ("MDCR"), Corrections Health Services of Jackson Memorial Hospital and all other agencies and individuals under their control take all actions necessary to comply with the provisions of this Agreement.

4. MDCR operates correctional facilities in Miami, Florida (collectively known as "MDCR Jail facilities" or "the Jail") and is responsible for providing care, custody, and control of prisoners. The Jail currently consists of 6 corrections facilities and currently houses approximately 5,200 inmates in a complex of buildings spread out across the county, well below the design capacity of 5,845.

5. On April 2, 2008, the United States Department of Justice ("DOJ") notified Miami-Dade County officials of its intention to investigate conditions at the MDCR facilities, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. The DOJ toured the MDCR Jail facilities with consultants in the fields of corrections, medical and mental health care, suicide prevention, fire safety and environmental health and safety on June 9 – 13 and June 16 – 20, 2008, and on April 7 – 8, 2009.

6. On August 24, 2011, the DOJ issued a Findings Letter, pursuant to 42 U.S.C. § 1997 (a) (1), which concluded that certain conditions in the MDCR Jail violated the constitutional rights of inmates, and recommended remedial measures. Under cover letter dated September 27, 2011, the County provided to DOJ substantial documentation of changes and measures implemented at the MDCR facilities since the time of the DOJ inspections. On October 4, 2011, County representatives met with DOJ in Washington, D.C., to discuss the aforementioned documentation of remedial measures undertaken by the MDCR Jail facilities.

7. At the request of MDCR, the DOJ conducted an additional tour of the MDCR Jail facilities with consultants on November 30 – December 2, 2011. Based upon this inspection, the DOJ concluded that some of the violations identified in its Findings Letter were improved, while other conditions still warranted remedial efforts.

8. Throughout the course of the investigation and inspection of the MDCR Jail facilities, the DOJ received complete cooperation from the County and unfettered access to all facilities, documents and staff. In addition, DOJ acknowledges that the County made significant improvements in many areas of Jail operations and the physical plant since its initial Jail tours in 2008. This Agreement is the result of a cooperative effort that evinces a commitment to constitutional conditions at the MDCR Jail facilities on the part of the United States and Defendants. Through the provisions of this Consent Agreement, the Parties seek to avoid the risks and burdens of litigation while ensuring that the conditions in the Jail are constitutional so as to respect the rights of inmates and provide for the safety of staff.

9. This Consent Agreement only addresses provisions regarding medical care, mental health care, and suicide prevention. A separate Agreement between the United States and the County and its entities addresses protection from harm, fire and life safety, and inmate grievances.

10. No person or entity is intended to be a third-party beneficiary of this Agreement for purposes of any civil, criminal, or administrative action. Accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Agreement. This Agreement is not intended to impair or expand the right of any person or entity to seek relief against the County or its officials, employees, or agents, for their conduct. This Agreement is not intended to alter legal standards governing any such claims.

11. For the purposes of this lawsuit only and in order to settle this matter, Defendants stipulate, and this Court finds, that the conditions at the MDCR Jail facilities necessitate the remedial measures contained in this Agreement, including medical, mental health and suicide provisions. The County, MDCR and the United States entered into a separate Settlement Agreement regarding protection from harm, fire and life safety, and inmate grievances.

12. The Parties stipulate that this Agreement complies in all respects with the Prison Litigation Reform Act, 18 U.S.C. § 3626(a). The Parties further stipulate and the Court finds that the prospective relief in this Agreement is narrowly drawn, extends no further than necessary to correct the violations of federal rights as alleged by United States in its Complaint and Findings Letter (attached as Exhibit "A"), is the least intrusive means necessary to correct these violations, and will not have an adverse impact on public safety or the operation of a criminal justice system. Accordingly, the Parties represent, and this Court finds, that the Agreement complies in all respects with 18 U.S.C. § 3626(a).

II. DEFINITIONS

1. "CHS" refers to Corrections Health Services of Jackson Memorial Hospital, the medical provider for the MDCR Jail facilities on behalf of the Public Health Trust.

2. "Compliance" is discussed throughout this Agreement in the following terms: substantial compliance, partial compliance, and non-compliance. "Substantial Compliance" indicates that Defendants have achieved compliance with most or all components of the relevant provision of the Agreement. "Partial Compliance" indicates that Defendants achieved compliance on some of the components of the relevant provision of the Agreement, but significant work remains. "Non-compliance" indicates that Defendants have not met most or all of the components of the Agreement.

3. "Custodial Segregation" is the solitary confinement of an inmate to a specific secure housing unit or single cell that is separated from the general population continuously for 15 or more hours a day. There are three forms of segregation: Administrative, Disciplinary Detention and Protective Custody.

4. "Effective date" means the date the Agreement is entered as an order of the Court.

5. "Include" or "including" means "include, but not be limited to" or "including, but not limited to."

6. "Inmates" or "Inmate" broadly refers to one or more individuals detained at, or otherwise housed, held, in the custody of, or confined in the Jail.

7. "Interdisciplinary Team" refers to a team consisting of treatment staff from various disciplines, including medical, nursing, and mental health and one or more members from corrections.

8. "Interdisciplinary Treatment Plan" refers to an individualized plan that is based on assessments, identifies the care needs, and develops strategies to meet those needs. The purpose of the plan is to transition the inmate through the continuum of care in a safe and effective way. In order to accomplish this goal, the plan documents treatment goals and objectives; states criteria for terminating specific interventions; and documents the inmate's progress in meeting the goals and objectives. The plan requires that each discipline must collaborate in the assessment and reassessment of the patient, and then integrate interdisciplinary documentation of needs, goals, strategies and interventions. Disciplines represented shall include, at a minimum, medical, mental health, and custodial staff.

9. "Jail " refers to all correctional facilities operated by the Miami-Dade County Corrections and Rehabilitation Department and includes: the Pre-Trial Detention Center ("PTDC"); the Women's Detention Center ("WDC"); the Training and Treatment Center ("Stockade"); the Turner Guilford Knight Correctional Center ("TGK"); the Metro West Detention Center ("MWDC"), and any facility that is built, leased, or otherwise used, to replace or supplement the current the MDCR Jail facilities, including the anticipated correctional

mental health facility ("Mental Health Treatment Center"). Additionally, MDCR operates a boot camp program, with a housing facility adjacent to TGK ("Boot Camp").

10. "Long-term custodial segregation" means a period of custodial segregation intended to last, or that does last, more than 14 consecutive days.

11. "Levels of Care" shall be defined as follows:

    a. Level I. Inmates deemed appropriate for this level of care meet the following criteria:
        (1) Persistent/imminent danger of harm to self or others.
        (2) Performed a self-injurious act, with the clear intention of suicide.
        (3) Inmate placed on suicide precaution.
        (4) Inmate who is unable to maintain a minimal level of personal hygiene.

    b. Level II. Inmates deemed appropriate for this level of care meet the following criteria:
        (1) Inmate who engages in an act of self-mutilation without the intent to commit suicide, and without psychotic symptoms.
        (2) Inmate with some notable impairment in reality testing, or gross level of psychotic process.
        (3) Inmate with significant, rapid decline in baseline level of functioning (isolative from family/friends, new onset poor judgment, decline or oscillations in mood, etc.).

    c. Level III. Inmates deemed appropriate for this level of care meet the following criteria:
        (1) Inmate with Mood Disorders with moderate to severe levels of impairment, and unable to function in the general population.
        (2) Inmate with Anxiety Disorders with moderate to severe levels of impairment, and are unable to function in the general population.
        (3) Inmate with Thought Disorders and are not acutely psychotic, and stable with current medication regimen. These individuals are able to function in a less restrictive environment other than the general population.
        (4) Inmates with documented explosive anger outbursts, and frequent impulsive acts with recent observed improvement in frequency and intensity of these episodes.

    d. Level IV. Inmates deemed appropriate for this level of care meet the following criteria:
        (1) Inmates with stable psychiatric symptoms and on a current regimen of psychotropic medications.

12. "Mental Health Review Committee" refers to a group consisting of CHS Director, CHS Medical Director, CHS Lead Psychiatrist, Lead Social Worker, Assistant Director MDCR, MDCR Medical Liaison, and related clinical disciplines.

13. "Monitor" means the individual selected to oversee implementation of the Agreement.

14. "Privacy of Care" or "Private Assessments" means discussions of patient information and clinical encounters are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of health services.

15. "Psychotropic medication" means any substance used in the treatment of mental health problems or mental illness that exerts an effect on the mind and is capable of modifying mental activity or behavior.

16. "Qualified Health Care Professionals" and "Qualified Medical Staff" refer to Qualified Medical Professionals and Qualified Nursing Staff, as well as other Qualified Health Care Professional staff providing services within the scope of their practice, licensure, training, supervision and qualifications.

17. "Qualified Medical Professional" means a physician, physician assistant, or nurse practitioner, who is currently licensed by the State of Florida to deliver those health care services he or she has undertaken to provide.

18. "Qualified Mental Health Professional" includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

19. "Qualified Mental Health Staff" refers to Qualified Health Care Professionals who have received instruction and supervision in identifying and interacting with individuals in need of Mental Health Services.

20. "Qualified Nursing Staff" means registered nurses and licensed practical nurses currently licensed by Florida to deliver those health care services he or she has undertaken to provide.

21. "Quality Improvement Committee" refers to an appointed group consisting of one or more members of Jail operations, the medical department, mental health department and related clinical disciplines, corrections and a risk manager.

22. "Serious injury" means any injury that requires immediate medical attention or hospitalization.

23. "Serious mental illness" ("SMI") means a mental, behavioral, or emotional disorder of mood, thought, or anxiety that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

24. "Serious suicide attempt" means a suicide attempt that is either potentially life-threatening or that requires hospitalization for medical treatment.

25. "Special Management Units" mean those housing units of the Jail designated for inmates in administrative or disciplinary custodial segregation, in protective custody, on suicide precautions, or with mental illness.

26. "Suicide Precautions" means any level of watch, observation, or measures to prevent self-harm.

27. "Sustain Implementation" means to achieve a prolonged and continuous practice.

28. "Train" means to instruct in the skills addressed to a level that the trainee has demonstrated proficiency. "Trained" means to have achieved such proficiency in the skills and to implement those skills regularly. The majority of training shall be in person, with online training functioning as a supplement rather than a stand–alone option. The County will document and track training of all staff.

29. "Threshold" means requiring a certain level of intervention due to a serious event or a number of serious events.

30. "Trigger" means an event or events, like a suicide or serious suicide attempt, which causes the County to self-assess.

III. SUBSTANTIVE PROVISIONS

Defendants shall take all actions necessary to comply with the substantive provisions of this Agreement detailed below. Compliance with the Agreement will be measured both by whether the technical provisions are implemented and whether the conditions of confinement in the Jail meet the requirements of the United States Constitution.

A. MEDICAL AND MENTAL HEALTH CARE

Defendants shall ensure constitutionally adequate treatment of inmates' medical and mental health needs. Defendants' efforts to achieve this constitutionally adequate treatment will include the following remedial measures regarding: (1) Intake Screening; (2) Health Assessments; (3) Access to Medical and Mental Health Care; (4) Medication Administration and Management; (5) Record Keeping; (6) Discharge Planning; and (7) Mortality and Morbidity Reviews.

1. Intake Screening

a. Qualified Medical Staff shall sustain implementation of the County Pre-Booking policy, revised May 2012, and the County Intake Procedures, adopted May 2012, which require, *inter alia*, staff to conduct intake screenings in a confidential setting as soon as possible upon inmates' admission to the Jail, before being transferred from the intake area, and no later than 24 hours after admission. Qualified Nursing Staff shall sustain implementation of the Jail and CHS's Intake Procedures, implemented May 2012, and the Mental Health Screening and Evaluation form, rev*ised May* 2012, which require, *inter alia*, staff to identify and record observable and non-observable medical and mental health needs, and seek the inmate's cooperation to provide information.

b. CHS shall sustain its policy and procedure implemented in May 2012 in which all inmates received a mental health screening and evaluation meeting all compliance indicators of National Co*mmission o*n Correctional Health Care J-E-05. This screening shall be conducted as part of the intake screening process upon admission. All inmates who screen positively shall be referred to qualified mental health professionals for further evaluation.

c. Inmates identified as in need of constant observation, emergent and urgent mental health care shall be referred immediately to Qualified Mental Health Professionals for evaluation, when clinically indicated. The Jail shall house incoming inmates at risk of suicide in suicide-resistant housing unless and until a Qualified Mental Health Professional clears them in writing for other housing.

d. Inmates identified as "emergency referral" for mental health or medical care shall be under constant observation by staff until they are seen by the Qualified Mental Health or Medical Professional.

e. CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.

f. CHS shall sustain implementation of the intake screening form and mental health screening and evaluation form revised in May 2012, which assesses drug or alcohol use and withdrawal. New admissions determined to be in withdrawal or at risk for withdrawal shall be referred immediately to the practitioner for further evaluation and placement in Detox.

g. CHS shall ensure that all Qualified Nursing Staff performing intake screenings receive comprehensive training concerning the policies, procedures, and practices for the screening and referral processes.

2. Health Assessments

a. Qualified Medical Staff shall sustain implementation of CHS Policy J-E-04 (Initial Health assessment), revised May 2012, which requires, *inter alia*, staff to use standard diagnostic tools to administer preventive care to inmates within 14 days of entering the program.

b. Qualified Mental Health Staff will complete all mental health assessments incorporating, at a minimum, the assessment factors described in Appendix A.

c. Qualified Mental Health Professionals shall perform a mental health assessment following any adverse triggering event while an inmate remains in the MDCR Jail facilities' custody, as set forth in Appendix A.

d. Qualified Mental Health Professionals, as part of the inmate's interdisciplinary treatment team (outlined in the "Risk Management" Section, *infra*), will maintain a risk profile for each inmate based on the Assessment Factors identified in Appendix A and will develop and implement interventions to minimize the risk of harm to each inmate.

e. An inmate assessed with chronic disease shall seen by a practitioner as soon as possible but no later than 24-hours after admission as a part of the Initial Health Assessment, when Clinically indicated. At that time medication and appropriate labs, as determined by the practitioner, shall be ordered. The inmate will then be enrolled in the chronic care program, including scheduling of an initial chronic disease clinic visit.

f. All new admissions will receive an intake screening and mental health screening and evaluation upon arrival. If clinically indicated, the inmate will be referred as soon as possible, but no longer than 24-hours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.

g. All individuals performing health assessments shall receive comprehensive training concerning the policies, procedures, and practices for medical and mental health assessments and referrals.

3. Access to Medical and Mental Health Care

a. Defendants shall ensure inmates have adequate access to health care with a medical and mental health care request system, ("sick call" process), for inmates. The sick call process shall include:

(1) written medical and mental health care slips available in English, Spanish, and Creole;

(2) opportunity for illiterate inmates and inmates who have physical or cognitive disabilities to confidentially access medical and mental health care.

(3) a confidential collection method in which designated members of the Qualified Medical and Qualified Mental Health staff collects the request slips every day; and

(4) an effective system for screening and prioritizing medical and mental health requests within 24 hours of submission and priority review for inmate grievances identified as emergency medical or mental health care.

b. CHS shall continue to ensure all medical and mental health care staff are adequately trained to identify inmates in need of acute or chronic care, and medical and mental health care staff shall provide treatment or referrals for such inmates.

4. Medication Administration and Management

a. CHS shall develop and implement policies and procedures to ensure the accurate administration of medication and maintenance of medication records.

b. Within eight months of the Effective Date, CHS shall develop and implement a medication continuity system so that incoming inmates receive medications for serious medical and mental health needs in a timely manner, as medically appropriate and as follows:

(1) Upon an inmate's entry to the Jail, a Qualified Medical or Mental Health Professional shall decide and document the clinical justification to continue, discontinue, or change an inmate's reported medication for serious medical or mental health needs, and the inmate shall receive the first dose of any prescribed medication within 24 hours of entering the Jail;

(2) A medical doctor or psychiatrist shall evaluate, in person, inmates with serious medical or mental health needs, within 48 hours of entry to the Jail.

c. Psychiatrists shall conduct reviews of the use of psychotropic medications to ensure that each inmate's prescribed regimen is appropriate and effective for his or her condition. These reviews should occur on a regular basis, according to how often the Level of Care requires the psychiatrist to see the inmate. CHS shall document this review in the inmate's unified medical and mental health record.

d. CHS shall ensure nursing staff pre-sets psychotropic medications in unit doses or bubble packs before delivery. If an inmate housed in a designated mental health special management unit refuses to take his or her psychotropic medication for more than 24 hours, the medication administering staff must provide notice to the psychiatrist. A Qualified Mental Health Professional must see the inmate within 24 hours of this notice.

e. CHS shall implement physician orders for medication and laboratory tests within three days of the order, unless the inmate is an "emergency referral," which requires immediately implementing orders.

f. Within 120 days of the Effective Date, CHS shall provide its medical and mental health staff with documented training on proper medication administration practices. This training shall become part of annual training for medical and mental health staff.

5. Record Keeping

a. CHS shall ensure that medical and mental health records are adequate to assist in providing and managing the medical and mental health needs of inmates. CHS shall fully implement an Electronic Medical Records System to ensure records are centralized, complete, accurate, legible, readily accessible by all medical and mental health staff, and systematically organized.

b. CHS shall implement an electronic scheduling system to provide an adequate scheduling system to ensure that mental health professionals see mentally ill inmates as clinically appropriate, in accordance with this Agreement's requirements, regardless of whether the inmate is prescribed psychotropic medications.

c. CHS shall document all clinical encounters in the inmates' health records, including intake health screening, intake health assessments, and reviews of inmates.

d. CHS shall submit medical and mental health information to outside providers when inmates are sent out of the Jail for health care. CHS shall obtain records of care, reports, and diagnostic tests received during outside appointments and timely implement specialist recommendations (or a physician should properly document appropriate clinical reasons for non-implementation).

6. Discharge Planning

a. CHS shall provide discharge/transfer planning for planned discharges of those inmates with serious health needs to ensure continuity of care upon inmates' release. These services shall include:

(1) Arranging referrals for inmates with chronic medical health problems or serious mental illness. All referrals will be made to Jackson Memorial Hospital where each inmate/patient has an open medical record;

(2) Providing a bridge supply of medications of up to 7 days to inmates upon release until inmates can reasonably arrange for continuity of care in the community or until they receive initial dosages at transfer facilities. Upon intake admission, all inmates will be informed in writing and in the inmate handbook they may request bridge medications and community referral upon release.

(3) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.

7. Mortality and Morbidity Reviews

a. Defendants shall sustain implementation of the MDCR Mortality and Morbidity "Procedures in the Event of an Inmate Death," updated February 2012, which requires, *inter alia*, a team of interdisciplinary staff to conduct a comprehensive mortality review and corrective action plan for each inmate's death and a comprehensive morbidity review and corrective action plan for all serious suicide attempts or other incidents in which an inmate was at high risk for death. Defendants shall provide results of all mortality and morbidity reviews to the Monitor and the United States, within 45 days of each death or serious suicide attempt. In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt.

b. Defendants shall address any problems identified during mortality reviews through training, policy revision, and any other developed measures within 90 days of each death or serious suicide attempt.

c. Defendants will review mortality and morbidity reports and corrective action plans bi-annually. Defendants shall implement recommendations regarding the risk management system or other necessary changes in policy based on this review. Defendants will document the review and corrective action and provide it to the Monitor.

B. MEDICAL CARE

CHS shall ensure constitutionally adequate treatment of inmates' medical needs. CHS's efforts to achieve this constitutionally adequate treatment will include remedial measures regarding (1) Acute Care and Detoxification, (2) Chronic Care, and (3) Use of Force Care.

1. Acute Care and Detoxification

a. CHS shall ensure that inmates' acute health needs are identified to provide adequate and timely acute medical care.

b. CHS shall address serious medical needs of inmates immediately upon notification by the inmate or a member of the MDCR Jail facilities' staff or CHS staff, providing acute care for inmates with serious and life-threatening conditions by a Qualified Medical Professional.

c. CHS shall sustain implementation of the Detoxification Unit and the Intoxification Withdrawal policy, adopted on July 2012, which requires, inter alia, County to provide treatment, housing, and medical supervision for inmates suffering from drug and alcohol withdrawal.

2. **Chronic Care**

a. CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy J-G-01 (Chronic Disease Program), which requires, *inter alia*, that Qualified Medical Staff perform assessments of, and monitor, inmates' chronic illnesses, pursuant to written protocols.

b. Per policy, physicians shall routinely see inmates with chronic conditions to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.

3. **Use of Force Care**

a. The Jail shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15-minute in-person visual observation by trained custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.

b. The Jail shall ensure that inmates receive adequate medical care immediately following a use of force.

c. Qualified Medical Staff shall question, outside the hearing of other inmates or correctional officers, each inmate who reports for medical care with an injury, regarding the cause of the injury. If a health care provider suspects staff-on-inmate abuse, in the course of the inmate's medical encounter, that health care provider shall immediately:

(1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence);

(2) report the suspected abuse to the appropriate Jail administrator; and

(3) complete a Health Services Incident Addendum describing the incident.

C. MENTAL HEALTH CARE AND SUICIDE PREVENTION

Defendants shall ensure constitutional mental health treatment and protection of inmates at risk for suicide or self-injurious behavior. Defendants' efforts to achieve this constitutionally adequate mental health treatment and protection from self harm will include the following remedial measures regarding: (1) Referral Process and Access to Care; (2) Mental Health Treatment; (3) Suicide Assessment and Prevention; (4) Review of

Disciplinary Measures; (5) Mental Health Care Housing; (6) Custodial Segregation; (7) Staffing and Training; (8) Suicide Prevention Training; and (9) Risk Management.

1. Referral Process and Access to Care

a. CHS shall develop and implement written policies and procedures governing the levels of referrals to a Qualified Mental Health Professional. Levels of referrals are based on acuteness of need and must include "emergency referrals," "urgent referrals," and "routine referrals," as follows:

(1) "Emergency referrals" shall include inmates identified as at risk of harming themselves or others, and placed on constant observation. These referrals also include inmates determined as severely decompensated, or at risk of severe decompensation. A Qualified Mental Health Professional must see inmates designated "emergency referrals" within two hours, and a psychiatrist within 24 hours (or the next business day), or sooner, if clinically indicated.

(2) "Urgent referrals" shall include inmates that Qualified Mental Health Staff must see within 24 hours, and a psychiatrist within 48 hours (or two business days), or sooner, if clinically indicated.

(3) "Routine referrals" shall include inmates that Qualified Mental Health Staff must see within five days, and a psychiatrist within the following 48 hours, when indicated for medication and/or diagnosis assessment, or sooner, if clinically indicated.

b. CHS will ensure referrals to a Qualified Mental Health Professional can occur at the time of initial screening or 14-day assessment or at any time by inmate self-referral or by staff referral.

2. Mental Health Treatment

a. CHS shall develop and implement a policy for the delivery of mental health services that includes a continuum of services; provides for necessary and appropriate mental health staff; includes treatment plans for inmates with serious mental illness; collects data; and contains mechanisms sufficient to measure whether CHS is providing constitutionally adequate care.

b. CHS shall ensure adequate and timely treatment for inmates, whose assessments reveal mental illness and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.

c. Each inmate on the mental health caseload will receive a written initial treatment plan at the time of evaluation, to be implemented and updated during the psychiatric appointments dictated by the Level of Care. CHS shall keep the treatment plan in the inmate's mental health and medical record.

d. CHS shall provide each inmate on the mental health caseload who is a Level I or Level II mental health inmate and who remains in the Jail for 30 days with a written interdisciplinary treatment plan within 30 days following evaluation. CHS shall keep the treatment plan in the inmate's mental health and medical record.

e. The Jail currently houses Level I inmates in housing unit 9C. Any inmate who is housed in 9C (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care within the next seven days and every 30 days thereafter. In addition, the County shall initiate documented contact and follow-up with the mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. The interdisciplinary team will:

(1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan.

(2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.

f. CHS will classify inmates diagnosed with mental illness according to the level of mental health care required to appropriately treat them. Level of care classifications will include Level I, Level II, Level III, and Level IV. Levels I through IV are described in Definitions (Section II.). Level of care will be classified in two stages: Stage I and Stage II.

g. Stage I is defined as the period of time until the Mental Health Treatment Center is operational. In Stage I, group counseling sessions targeting education and coping skills will be provided, as clinically indicated, by the treating psychiatrist. In addition, individual counseling will be provided, as clinically indicated, by the treating psychiatrist.

(1) Inmates classified as requiring Level IV level of care will receive:

i. managed care in the general population;
ii. psychotropic medication, as clinically appropriate;
iii. individual counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and
iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 90 days.

(2) Inmates classified as requiring Level III level of care will receive:

i. evaluation and stabilizing in the appropriate setting;
ii. psychotropic medication, as clinically appropriate;
iii. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days;
iv. individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist; and
v. access to at least one group counseling session per month or more, as clinically indicated.

(3) Inmates classified as requiring Level II level of care will receive:

i. evaluation and stabilizing in the appropriate setting;
ii. psychotropic medication, as clinically appropriate;
iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks;
iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and
v. access to individual counseling and group counseling as deemed clinically appropriate by the treating psychiatrist.

(4) Inmates classified as requiring Level I level of care will receive:

i. evaluation and stabilizing in the appropriate setting;
ii. immediate constant observation or suicide precautions;
iii. Qualified Mental Health Professional in-person assessment within four hours,
iv. psychiatrist in-person assessment within 24 hours of being placed at a crisis level of care and daily thereafter
v. psychotropic medication, as clinically appropriate; and
vi. individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist.

h. Stage II will include an expansion of mental health care and transition services, a more therapeutic environment, collaboration with other governmental agencies and community organizations, and an enhanced level of care, which will be provided once the Mental Health Treatment Center is opened. The County and CHS will consult regularly with the United States and the Monitor to formulate a more specific plan for implementation of Stage II.

i. CHS will provide clinically appropriate follow-up care for inmates discharged from Level I consisting of daily clinical contact with Qualified Mental Health Staff. CHS will provide Level II level of care to inmates discharged from crisis level of care (Level I) until such time as a psychiatrist or interdisciplinary treatment team makes a clinical determination that a lower level of care is appropriate.

j. CHS shall ensure Level I services and acute care are available in a therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling, as clinically indicated.

k. CHS shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.

3. Suicide Assessment and Prevention

a. Defendants shall develop and implement a policy to ensure that inmates at risk of self harm are identified, protected, and treated in a manner consistent with the Constitution. At a minimum, the policy shall:

(1) Grant property and privileges to acutely mentally ill and suicidal inmates upon clinical determination by signed orders of Qualified Mental Health Staff.

(2) Ensure clinical staff makes decisions regarding clothing, bedding, and other property given to suicidal inmates on a case-by-case basis and supported by signed orders of Qualified Mental Health Staff.

(3) Ensure that each inmate on suicide watch has a bed and a suicide-resistant mattress, and does not have to sleep on the floor.

(4) Ensure Qualified Mental Health Staff provide quality private suicide risk assessments of each suicidal inmate on a daily basis.

(5) Ensure that staff does not retaliate against inmates by sending them to suicide watch cells. Qualified Mental Health Staff shall be involved in a documented decision to place inmates in suicide watch cells.

b. When inmates present symptoms of risk of suicide and self harm, a Qualified Mental Health Professional shall conduct a suicide risk screening and assessment instrument that includes the factors described in Appendix A. The suicide risk screening and assessment instrument will be validated within 180 days of the Effective Date and every 24 months thereafter.

c. County shall revise its Suicide Prevention policy to implement individualized levels of observation of suicidal inmates as clinically indicated, including constant observation or interval visual checks. The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.

d. CHS shall sustain implementation of its Intake Procedures adopted in May 2012, which specifies when the screening and suicide risk assessment instrument will be utilized.

e. CHS shall ensure individualized treatment plans for suicidal inmates that include signs, symptoms, and preventive measures for suicide risk.

f. Cut-down tools will continue to be immediately available to all Jail staff who may be first responders to suicide attempts.

g. The Jail will keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff shall know the location of this emergency response bag and the Jail will train staff how to use its contents.

h. County shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating: (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation.

4. Review of Disciplinary Measures

a. The Jail shall develop and implement written policies for the use of disciplinary measures with regard to inmates with mental illness or suspected mental illness, incorporating the following:

(1) the MDCR Jail facilities' staff shall consult with Qualified Mental Health Staff to determine whether initiating disciplinary procedures is appropriate for inmates exhibiting recognizable signs/symptoms of mental illness or identified with mental illness; and

(2) if a Qualified Mental Health Staff determines the inmate's actions that are the subject of the disciplinary proceedings are symptomatic of mental illness, no disciplinary measure will be taken.

b. A staff assistant must be available to assist mentally ill inmates with the disciplinary review process if an inmate is not able to understand or meaningfully participate in the process without assistance.

5. Mental Health Care Housing

a. The Jail shall maintain a chronic care and/or special needs unit with an appropriate therapeutic environment, for inmates who cannot function in the general population.

b. The Jail shall remove suicide hazards from all areas housing suicidal inmates or place all suicidal inmates on constant observation.

c. The Jail shall allow suicidal inmates to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate. If inmates are unable to leave their cells to participate in these activities, a Qualified Medical or Mental Health Professional shall document the individualized clinical reason and the duration in the inmate's mental health record. The Qualified Medical or Mental Health Professional shall conduct a documented re-evaluation of this decision on a daily basis when the clinical duration is not specified.

d. County shall provide quarterly reports to the Monitor and the United States regarding its status in developing the Mental Health Treatment Center. The Mental Health Treatment Center will commence operations by the end of 2014. Once opened, County shall conduct and report to the United States and the Monitor quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds. The Parties will work together and with any appropriate non-Parties to expand the capacity to provide mental health care to inmates, if needed.

e. Any inmates with SMI who remain on 9C (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care, as per the Mental Health Treatment section of this Agreement (Section III.C.2.e).

6. Custodial Segregation

a. The Jail and CHS shall develop and implement policies and procedures to ensure inmates in custodial segregation are housed in an appropriate environment that facilitates staff supervision, treatment, and personal safety in accordance with the following:

(1) All locked housing decisions for inmates with SMI shall include the documented input of a Qualified Medical and/or Mental Health Staff who has conducted a face-to-face evaluation of the inmate, is familiar with the details of the inmate's available clinical history, and has considered the inmate's mental health needs and history. If at the time of custodial segregation Qualified Medical Staff has concerns about mental health needs, the inmate will be placed with visual checks every 15 minutes until the inmate can be evaluated by Qualified Mental Health Staff.

(2) Prior to placement in custodial segregation for a period greater than eight hours, all inmates shall be screened by a Qualified Mental Health Staff to determine (1) whether the inmate has SMI, and (2) whether there are any acute medical or mental health contraindications to custodial segregation.

(3) If a Qualified Mental Health Professional finds that an inmate has SMI, that inmate shall only be placed in custodial segregation with visual checks every 15 or 30 minutes as determined by the Qualified Medical Health Professional.

(4) Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes:

i. Qualified Mental Health Professionals conducting rounds at least three times a week to assess the mental health status of all inmates in custodial segregation and the effect of custodial segregation on each inmate's mental health to determine whether continued placement in custodial segregation is appropriate. These rounds shall be documented and not function as a substitute for treatment.

ii. Documentation of all out-of-cell time, indicating the type and duration of activity.

(5) Inmates with SMI shall not be placed in custodial segregation for more than 24 hours without the written approval of the Facility Supervisor and Director of Mental Health Services or designee.

(6) Inmates with serious mental illness shall not be placed into long-term custodial segregation, and inmates with serious mental illness currently subject to long-term custodial segregation shall immediately be removed from such confinement and referred for appropriate assessment and treatment.

(7) If an inmate on custodial segregation develops symptoms of SMI where such symptoms had not previously been identified or the inmate decompensates, he or she shall immediately be removed from custodial segregation and referred for appropriate assessment and treatment.

(8) If an inmate with SMI in custodial segregation suffers deterioration in his or her mental health, decompensates, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment and removed if the custodial segregation is causing the deterioration.

(9) The MDCR Jail facilities' staff will conduct documented rounds of all inmates in custodial segregation at staggered intervals at least once every half hour, to assess and document the inmate's status, using descriptive terms such as "reading," "responded appropriately to questions" or "sleeping but easily aroused."

(10) Inmates in custodial segregation shall have daily opportunities to contact and receive treatment for medical and mental health concerns with Qualified Medical and Mental Health Staff in a setting that affords as much privacy as reasonable security precautions will allow.

(11) Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals.

7. Staffing and Training

a. CHS revised its staffing plan in March 2012 to incorporate a multidisciplinary approach to care continuity and collaborative service operations. The effective approach allows for integrated services and staff to be outcomes-focused to enhance operations.

b. Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for review and comment its detailed mental health staffing analysis and plan for all its facilities.

c. CHS shall staff the facility based on the staffing plan and analysis, together with any recommended revisions by the Monitor. If the staffing study and/or monitor comments indicate a need for hiring additional staff, the parties shall agree upon the timetable for the hiring of any additional staff.

d. Every 180 days after completion of the first staffing analysis, CHS shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If they do not, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.

e. The mental health staffing shall include a Board Certified/Board Eligible, licensed chief psychiatrist, whose work includes supervision of other treating psychiatrists at the Jail. In addition, a mental health program director, who is a psychologist, shall supervise the social workers and daily operations of mental health services.

f. The County shall develop and implement written training protocols for mental health staff, including a pre-service and biennial in-service training on all relevant policies and procedures and the requirements of this Agreement.

g. The Jail and CHS shall develop and implement written training protocols in the area of mental health for correctional officers. A Qualified Mental Health Professional shall conduct the training for corrections officers. This training should include pre-service training, annual training for officers who work in forensic (Levels 1-3) or intake units, and biennial in-service training for all other officers on relevant topics, including:

(1) training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern);

(2) identification, timely referral, and proper supervision of inmates with serious mental health needs; and

(3) appropriate responses to behavior symptomatic of mental illness; and suicide prevention.

h. The County and CHS shall develop and implement written policies and procedures to ensure appropriate and regular communication between mental health staff and correctional officers regarding inmates with mental illness.

8. Suicide Prevention Training

a. The County shall ensure that all staff have the adequate knowledge, skill, and ability to address the needs of inmates at risk for suicide. The County and CHS shall continue its Correctional Crisis Intervention Training a competency-based interdisciplinary suicide prevention training program for all medical, mental health, and corrections staff. The County and CHS shall review and revise its current suicide prevention training curriculum to include the following topics, taught by medical, mental health, and corrections custodial staff:

(1) suicide prevention policies and procedures;

(2) the suicide screening instrument and the medical intake tool;

(3) analysis of facility environments and why they may contribute to suicidal behavior;

(4) potential predisposing factors to suicide;

(5) high-risk suicide periods;

(6) warning signs and symptoms of suicidal behavior;

(7) case studies of recent suicides and serious suicide attempts;

(8) mock demonstrations regarding the proper response to a suicide attempt; and

(9) the proper use of emergency equipment.

b. All correctional custodial, medical, and mental health staff shall complete training on all of the suicide prevention training curriculum topics at a minimum of eight hours for the initial training and two hours of in-service training annually for officers who work in intake, forensic (Levels 1-3), and custodial segregation units and biennially for all other officers.

c. CHS and the County shall train correctional custodial staff in observing inmates on suicide watch and step-down unit status, one hour initially and one hour in-service annually for officers who work in intake, forensic (Levels 1-3), and custodial segregation units and biennially for all other officers.

d. CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").

9. Risk Management

a. The County will develop, implement, and maintain a system to ensure that trends and incidents involving avoidable suicides and self-injurious behavior are identified and corrected in a timely manner. Within 90 days of the Effective Date, the County and CHS shall develop and implement a risk management system that identifies levels of risk for suicide and self-injurious behavior and results in intervention at the individual and system levels to prevent or minimize harm to inmates, as set forth by the triggers and thresholds in Appendix A.

b. The risk management system shall include the following processes to supplement the mental health screening and assessment processes:

(1) incident reporting, data collection, and data aggregation to capture sufficient information to formulate a reliable risk assessment at the individual and system levels;

(2) identification of at-risk inmates in need of clinical or interdisciplinary assessment or treatment;

(3) identification of situations involving at-risk inmates that require review by an interdisciplinary team and/or systemic review by administrative and professional committees; and

(4) implementation of interventions that minimize and prevent harm in response to identified patterns and trends.

c. The County shall develop and implement a Mental Health Review Committee that will review, on at least a monthly basis, data on triggering events at the individual and system levels, as set forth in Appendix A. The Mental Health Review Committee shall:

(1) require, at the individual level, that mental health assessments are performed and mental health interventions are developed and implemented;

(2) provide oversight of the implementation of mental health guidelines and support plans;

(3) analyze individual and aggregate mental health data and identify trends that present risk of harm;

(4) refer individuals to the Quality Improvement Committee for review; and

(5) prepare written annual performance assessments and present its findings to the Interdisciplinary Team regarding the following:

i. quality of nursing services regarding inmate assessments and dispositions, and

ii. access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.

d. The County shall develop and implement a Quality Improvement Committee that shall:

(1) review and determine whether the screening and suicide risk assessment tool is utilized appropriately and that documented follow-up training is provided to any staff who are not performing screening and assessment in accordance with the requirements of this Agreement;

(2) monitor all risk management activities of the facilities;

(3) review and analyze aggregate risk management data;

(4) identify individual and systemic risk management trends;

(5) make recommendations for further investigation of identified trends and for corrective action, including system changes; and

(6) monitor implementation of recommendations and corrective actions.

D. AUDITS AND CONTINUOUS IMPROVEMENT

1. Self Audits

a. The County shall undertake measures on its own initiative to address the protection of inmates' constitutional rights and the risk of constitutional violations. The Agreement is designed to encourage the County to self monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.

b. Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to identify potential patterns or trends resulting in harm to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.

c. The County and CHS shall develop and implement corrective action plans within 30 days of each quarterly review, including changes to policy and changes to and additional training.

2. Bi-annual Reports

a. Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following:

(1) All psychotropic medications administered by the Jail to inmates.

(2) All health care delivered by the Jail to inmates to address serious medical concerns. The report will include:

i. number of inmates transferred to the emergency room for medical treatment and why;

ii. number of inmates admitted to the hospital with the clinical outcome;

iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and

iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.

(3) All suicide-related incidents. The report will include:

i. all suicides;

ii. all serious suicide attempts;

iii. list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear);

iv. all restraint use related to a suicide attempt or precautionary measure; and

v. information on whether inmates were seen within four days after discharge from suicide monitoring.

(4) Inmate counseling services. The report and review shall include:

i. inmates who are on the mental health caseload, classified by levels of care;

ii. inmates who report having participated in general mental health/therapy counseling and group schedules, as well as any waitlists for groups;

iii. inmates receiving one-to-one counseling with a psychologist, as well as any waitlists for such counseling; and

iv. inmates receiving one-to-one counseling with a psychiatrist, as well as any waitlists for such counseling.

(5) Total number of inmate disciplinary reports, the number of reports that involved inmates with mental illness, and whether Qualified Mental Health Professionals participated in the disciplinary action.

(6) Reportable incidents. The report will include:

i. a brief summary of all reportable incidents, by type and date;

ii. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and

iii. number of grievances referred to IA for investigation.

b. The County and CHS shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.

IV. COMPLIANCE AND QUALITY IMPROVEMENT

A. Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as

screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly-adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.

B. The County and CHS shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in medical care, mental health care, and suicide prevention to assess and ensure compliance with the terms of this Agreement on an ongoing basis.

C. On an annual basis, the County and CHS shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and the United States for review any changed policies and procedures.

D. The Monitor may review and suggest revisions on the County and CHS policies and procedures on medical care, mental health care, and suicide prevention, including currently implemented policies and procedures, to ensure such documents are in compliance with this Agreement.

V. REPORTING REQUIREMENTS AND RIGHT OF ACCESS

A. Defendants shall submit bi-annual compliance reports to the United States and the Monitor, the first of which shall be submitted within six months of the Effective Date. Thereafter, the bi-annual compliance reports shall be submitted 15 days after the termination of each six-month period thereafter until the Agreement is terminated. The report shall summarize audits and continuous improvement and quality assurance activities and contain findings and recommendations that would be used to track and trend data compiled at the Jail. The report shall also capture data that is tracked and monitored outlined in "Substantive Provisions" (Section III) of this Agreement.

B. Defendants shall promptly notify the Monitor and the United States upon the death or serious suicide attempt of any inmate. Defendants shall forward to the Monitor and the United States incident reports and medical and/or mental health reports related to deaths, autopsies, and/or death summaries of inmates as well as all final Internal Affairs Division investigations reports that involve inmates.

C. Each compliance report shall describe the actions Defendants have taken during the reporting period to implement this Agreement and shall make specific reference to the Agreement provisions being implemented.

D. Defendants shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the

United States for inspection and copying. In addition, Defendants shall maintain, and provide upon request, all records or other documents to verify that they have taken such actions as described in their compliance reports (e.g., census summaries, policies, procedures, protocols, training materials, investigations, and incident reports).

E. The United States and its attorneys, consultants, and agents shall have unrestricted access to the Jail, inmates, staff and documents as reasonably necessary to address issues affected by this Agreement.

F. Within 30 days of receipt of written questions from the United States concerning Defendants' compliance with the requirements of this Agreement, Defendants shall provide the United States with written answers and any requested documents.

G. MDCR and CHS shall each designate compliance coordinators to oversee compliance with this Agreement and to serve as the points of contact.

VI. MONITORING

A. Monitor Selection: The Parties will jointly select a Monitor to oversee implementation of the Agreement. Should the Parties be unable to agree on the Monitor, each shall recommend no more than two candidates to the Court and the Court will appoint the Monitor from the names submitted by the Parties. Neither Party, nor any employee or agent of either Party, shall have any supervisory authority over the Monitor's activities, reports, findings, or recommendations. The cost for the Monitor's fees and expenses shall be borne by Defendants. The selection of the Monitor shall be conducted solely pursuant to the procedures set forth in this Agreement, and will not be governed by any formal or legal procurement requirements. The Monitor may be terminated only for good cause, unrelated to the Monitor's findings or recommendations, and only with approval of the Court. Should the Parties agree that the Monitor is not fulfilling his or her duties in accordance with this Agreement, the Parties may move the Court for the Monitor's immediate removal and replacement. One Party may unilaterally move the Court for the Monitor's removal for good cause, and the other Parties will have the opportunity to respond to the petition.

B. Monitor Qualifications: The Monitor and his or her staff shall have experience and education or training related to the subject areas covered in this Agreement.

C. Monitoring Team: The Monitor may hire or consult with such additional qualified staff as necessary to fulfill the duties required by the Agreement ("Monitoring Teams"). The Monitor is ultimately responsible for the findings regarding compliance. The Monitoring Teams will be subject to all the same access rights and confidentiality limitations as the Monitor. The Parties reserve the right to object for good cause to members of the Monitoring Teams. The Court will decide any unresolved objections to members.

D. Monitor Access: The Monitor shall have full and complete access to the Jail, staff, inmates, all Jail records, and inmate medical and mental health records. Defendants shall direct all employees to cooperate fully with the Monitor. All non-public information obtained by the Monitor shall be maintained in a confidential manner.

E. Monitor Ex Parte Communications: The Monitor shall be permitted to initiate and receive ex parte communications with all Parties.

F. Limitations on Public Disclosures by the Monitor: Except as required or authorized by the terms of this Agreement or the Parties acting together, the Monitor shall not make any public statements (at a conference or otherwise) or issue findings, except as required under paragraph G, *infra*, with regard to any act or omission of Defendants or their agents, representatives or employees. Any press statement made by the Monitor regarding the monitoring of this Agreement or his or her employment as Monitor must first be approved in writing by all Parties. The Monitor shall not testify in any other litigation or proceeding with regard to any act or omission of Defendants or any of their agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement. Reports issued by the Monitor shall not be admissible against Defendants in any proceeding other than a proceeding related to the enforcement of this Agreement by Defendants or the United States. Unless such conflict is waived by the Parties, the Monitor shall not accept employment or provide consulting services that would present a conflict of interest with the Monitor's responsibilities under this Agreement. Neither the Monitor nor any person or entity hired or otherwise retained by the Monitor to assist in furthering any provision of this Agreement shall be liable for any claim, lawsuit or demand arising out of the Monitor's performance pursuant to this Agreement. This provision does not apply to any proceeding before a court related to performance of contracts or subcontracts for monitoring this Agreement.

G. Monitor's Reports: The Monitor shall file with the Court, and provide the Parties, reports describing the steps taken by Defendants to implement this Agreement and evaluate the extent to which Defendants have complied with each substantive provision of the Agreement. The Monitor's Reports shall indicate a compliance rating for each provision and provide recommendations for achieving compliance with any provisions not in compliance at the time of the Report. The Monitor shall issue an initial report four months after the Effective Date, and then every six months thereafter. The reports shall be provided to the Parties in draft form for comment at least two weeks prior to their issuance. These reports shall be written with due regard for the privacy interests of individual inmates and staff.

H. Compliance Assessments: In the Monitor's report, the Monitor shall evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) Partial Compliance, and (3) Non-compliance. To assess compliance, the Monitor shall review a sufficient number of pertinent documents to accurately assess current conditions; interview all necessary staff; and interview a sufficient number of inmates to accurately assess current conditions. The Monitor shall be responsible for independently verifying representations from Defendants regarding progress toward compliance, examining supporting documentation, where applicable. Each Monitor's report shall describe the steps taken by each member of the monitoring team to analyze conditions and assess compliance, including documents reviewed and individuals interviewed, and the factual basis for each of the Monitor's findings.

I. Monitor's Budget: Defendants shall provide the Monitor with a budget sufficient to allow the Monitor to carry out the responsibilities described in this Agreement. The Monitor shall pay the members of the Monitoring Teams out of this budget.

J. Technical Assistance by the Monitor: The Monitor shall provide Defendants with technical assistance as requested by Defendants. Technical assistance should be reasonable and should not interfere with the Monitor's ability to assess compliance.

VII. CONSTRUCTION, IMPLEMENTATION, AND TERMINATION

A. Defendants shall implement all reforms within their areas of responsibility, as designated within the provisions of this Agreement that are necessary to effectuate this Agreement. The implementation of this Agreement will begin immediately upon the Effective Date.

B. Except where otherwise agreed to under a specific provision of this Agreement, Defendants shall implement all provisions of this Agreement within 180 days of the Effective Date.

C. An individual substantive provision in this Agreement shall terminate after the United States finds that Defendants maintained sustained substantial compliance of that provision for a period of 18 months. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, will not constitute failure to maintain substantial compliance. Temporary compliance during a period of otherwise sustained non-compliance will not constitute substantial compliance.

D. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein shall not be construed as a waiver of its right to enforce other deadlines or provisions of this Agreement.

E. If any unforeseen circumstance occurs that causes a failure to timely carry out any requirements of this Agreement, Defendants shall notify the United States in writing within 20 calendar days after Defendants become aware of the unforeseen circumstance and its impact on the Defendants' ability to perform under the Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. Defendants shall implement all reasonable measures to avoid or minimize any such failure. Notice shall not prevent the United States from seeking court intervention.

F. This Agreement constitutes the entire integrated Agreement of the Parties, as it relates to medical care, mental health care, and suicide prevention (See Section I.5.). With the exception of the United States' Findings Letter, no prior or contemporaneous communications, oral or written, will be relevant or admissible for purposes of determining the meaning of any provisions herein in this litigation or in any other proceeding.

G. The Agreement shall be applicable to, and binding upon, all Parties, their officers, agents, employees, assigns, and their successors in office.

H. Each Party shall bear the cost of its fees and expenses incurred in connection with this cause.

I. If any provision of this Agreement is declared invalid for any reason by a court of competent jurisdiction, said finding shall not affect the remaining provisions of this Agreement.

FOR THE UNITED STATES:

WIFREDO A. FERRER
United States Attorney

By: _____
Veronica Harrell-James
Assistant U.S. Attorney
Southern District of Florida

_____
THOMAS E. PEREZ
Assistant Attorney General
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FOR THE DEFENDANTS MIAMI-DADE COUNTY:

_____

HONORABLE CARLOS A. GIMENEZ
Mayor
Miami-Dade County

_____

CARLOS MIGOYA
President & Chief Executive Officer
Public Health Trust
Miami-Dade County

By:_____

ROBERT A. DUVALL
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So ORDERED this _____ day of _____, 2012

_____
United States District Court Judge

MIAMI-DADE COUNTY CONSENT AGREEMENT
APPENDIX A
Screening and Suicide Risk Assessment Factors, Triggers, and Thresholds

Screening Factors	Assessment Factors	Trigger Events Occurring in the Jail	Thresholds Reached in the Jail
History, Ideation and Observation			
Screening shall inquire as to the following: 1. Past suicidal ideation and/or attempts 2. Current suicidal ideation, threat, or plan 3. Prior mental health treatment or hospitalization 4. Recent significant loss - such as the death of a family member or close friend 5. History of suicidal behavior by family members and close friends 6. Suicide risk during any prior confinement 7. Any observations of the transporting officer, court, transferring agency, or similar individuals regarding the inmate's potential suicidal risk	Any of the following: 1. Suicide risk screening indicates moderate or high risk 2. Any suicide attempt in the past 3. Any suicidal ideations, with intent/plan within the past 30 days 4. Any command hallucinations to harm self within the past 30 days 5. Any combination of the following: a) Suicidal ideations within the past year with or without intent/plan b) Suicidal gestures (current and/or within past year) c) One or more of the following diagnoses: i) Bipolar Disorder, Depressed ii) Major Depression With or Without Psychotic Features iii) Schizophrenia iv) Schizoaffective Disorder v) Any diagnosis within the Pervasive Developmental Disorder Spectrum vi) Any other factor(s) determined by the interdisciplinary team (IDT) as contributing to suicide risk (e.g. recent loss, family history of suicide, etc.) 6. Any history of self-injurious behavior (SIB) resulting in injury requiring medical attention within the past year	1. Any suicide attempt 2. Any aggression to self resulting in major injury	1. Any suicide 2. Any suicide attempt resulting in outside medical treatment 3. Two or more episodes of suicidal ideation/attempts within 14 consecutive days 4. Four or more episodes of suicidal ideations/ attempts within 30 consecutive days

U.S. Department of Justice

Civil Rights Division

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

The Honorable Carlos A. Gimenez
Mayor, Miami-Dade County
Stephen P. Clark Center
111 Northwest First Street, 29th Floor
Miami, FL 33128

AUG 24 2011

Re: Investigation of the Miami-Dade County Jail

Dear Mayor Gimenez:

The Department of Justice's Civil Rights Division has concluded its investigation of conditions at the corrections facilities operated by the Miami-Dade County Corrections and Rehabilitation Department ("MDCR"). This letter provides MDCR with our findings.

On April 2, 2008, we notified officials of Miami-Dade County ("County") of our intent to investigate the MDCR corrections facilities pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C.§ 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of prisoners in adult detention and corrections facilities. CRIPA requires that we advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 U.S.C. § 1997b.

I. SUMMARY OF FINDINGS AND CONCLUSIONS

We conclude that that there is a pattern and practice of constitutional violations in the correctional facilities operated by MDCR, and as a result of the unconstitutional operation of the Jail, prisoners suffer grievous harm, including death. As described more fully below, our specific findings include:

- MDCR is deliberately indifferent to the suicide risks and serious mental health needs of its prisoners. At least eight prisoners have committed suicide since 2007, and thousands of prisoners have suffered from inadequate mental health crisis services.

- MDCR fails to provide adequate acute care, chronic care, outpatient treatment, and

EXHIBIT "A"

discharge services to prisoners with mental illness. Instead, MDCR inappropriately relies on medication management that fails to consistently incorporate diagnoses or treatment plans, even for prisoners with the most serious mental illnesses.

- MDCR is deliberately indifferent to the serious medical needs of prisoners including access to care for acute medical needs, management of chronic health problems, and record keeping and quality assurance. Prisoners wait weeks and even months to receive consultations for care from HIV, cardiology, and neurology specialists.

- MDCR fails to provide adequate intake screening, initial health assessments and acute care for newly incarcerated prisoners. Since 2008, at least five prisoners have died from MDCR's failure to identify and treat prisoners withdrawing from drugs or alcohol.

- MDCR is engaged in a pattern or practice of using excessive force against prisoners. MDCR corrections officers openly engage in abusive and retaliatory conduct, which frequently causes injuries to prisoners.

- MDCR is deliberately indifferent to the serious risk of harm to prisoners posed by fellow prisoners. Corrections officers fail to supervise prisoners, particularly prisoners known to be violent, resulting in ongoing harm and serious risk of harm. There is significant evidence to be concerned that the Jail fails to take reasonable steps to protect prisoners from sexual assault.

- The conditions of confinement within the Jail expose prisoners to an unreasonable risk of harm from inadequate fire and life safety systems and environmental health and sanitation deficiencies, including unreasonable risk of infection from overcrowding and inadequate laundry, housekeeping, and pest control.

II. INVESTIGATION

On June 9-13, 2008, June 16-20, 2008, and April 7-8, 2009, we inspected the facility together with consultants in the fields of corrections, custodial medical and mental health care, suicide prevention, and environmental health and sanitation. We interviewed administrative and corrections staff, medical and mental health care providers, prisoners, and members of the Miami-Dade community. Our investigation also included the review of policies and procedures, incident reports, grievances, medical records, and use of force records and investigations, including documents provided by the County subsequent to our on-site visits. In keeping with our pledge of transparency and providing technical assistance where appropriate, our consultants conveyed their preliminary impressions and concerns to County officials and the MDCR command staff at the conclusion of our tours.

We are grateful to MDCR Director Timothy P. Ryan and his entire staff for the assistance and cooperation extended to us. We found the MDCR officials helpful and professional throughout the course of the investigation. MDCR provided us with access to records and personnel, and responded to our requests, before, during, and after our on-site visits, in a transparent and forthcoming manner. We also appreciate MDCR's receptiveness to our consultants' on-site recommendations.

III. BACKGROUND

The corrections facilities operated by MDCR (collectively "Miami-Dade County Jail" or "the Jail") hold an average of 7,000 prisoners in a complex of buildings spread out across the county, making it the nation's eighth largest jail. The Jail has six corrections facilities: the Pre-Trial Detention Center ("PTDC"); the Women's Detention Center ("WDC"); the Training and Treatment Center ("Stockade"); the Turner Guilford Knight Correctional Center ("TGK"); and the Metro West Detention Center ("MWDC"). Additionally, MDCR operates a boot camp program, with a housing facility adjacent to TGK ("Boot Camp").

The prisoners incarcerated in the Jail are awaiting trial or serving sentences of less than one year. Two of the five facilities, PTDC and TGK, are booking facilities. These two facilities process and house all classifications of prisoners. PTDC, the County's main jail building located across the street from the County Courthouse, has approximately 1,700 beds for male prisoners, and TGK has 1,300 beds for male, female, and juvenile prisoners. WDC has 375 beds and only houses female prisoners. The Stockade, the oldest MDCR facility, has approximately 1,200 beds for adult males. The largest of the five facilities is the MWDC, which is located approximately 16 miles west of PTDC and downtown Miami, and has approximately 3,000 beds for male prisoners of all classifications.

Health care, including mental health care, is provided to prisoners on-site by Correctional Health Services ("CHS"), a division of the Jackson Health System of Miami-Dade County (a community healthcare system consisting of Jackson Memorial Hospital, primary care centers, health clinics, and rehabilitation, nursing, and mental health facilities). Additionally, the Jackson Memorial Hospital, the largest of the medical centers operated by the Jackson Health System, maintains a specialized unit known as "Ward D" to provide emergency hospital care to MDCR prisoners in a secure environment staffed by MDCR corrections officers. Each month, CHS staff members see several thousand prisoner-patients, several hundred of whom require physician-level care, and approximately 75 prisoners who need inpatient care at Ward D. Moreover, of the approximately 7,000 MDCR prisoners, on average 1,000 suffer from mental illness, making the Jail one of the largest psychiatric facilities in Florida.

IV. FINDINGS

A. MDCR PROVIDES CONSTITUTIONALLY INADEQUATE MEDICAL AND MENTAL HEALTH CARE.

Jail prisoners have a constitutional right to be protected from harm, Farmer v. Brennan, 511 U.S. 825, 832 (1994), and serious risk of harm, Helling v. McKinney, 509 U.S. 25, 33-35 (1993). Whether that harm takes the form of illness, injury, or inhumane conditions, jailors cannot display "deliberate indifference" to a prisoner's serious needs. Wilson v. Seiter, 501 U.S. 294, 302-303 (1991) (citing Estelle v. Gamble, 429 U.S. 97, 104-106 (1976)). MDCR is deliberately indifferent to the risk of suicide and the serious medical and mental health needs of prisoners. As illustrated below, the constitutional deprivations uncovered by our investigation are not the result of isolated incidents or the misconduct of a few MDCR staff members. Instead,

MDCR's deliberate indifference to protecting the Jail's prisoners from harm is a systemic failure.

1. MDCR is deliberately indifferent to prisoners' suicide risks and serious mental health needs.

Our investigation revealed that MDCR is deliberately indifferent to the suicide risks and serious mental health needs of prisoners who present symptoms of suicidal behavior or serious mental illness. See Campbell v. Sikes, 169 F.3d 1353, 1362 (11th Cir. 1999) (noting that a failure to provide proper medical care, includes a psychiatrist providing grossly inadequate medical care); Steele v. Shah, 87 F.3d 1266, 1269 (11th Cir. 1996) (same); Harris v. Thigpen, 941 F.2d 1495, 1505 (11th Cir. 1991) (noting that "this court has acknowledged that the deliberate indifference standard also applies to inmates' psychiatric or mental health needs."). Furthermore, jail officials have a constitutional obligation to act when there is a strong likelihood that a prisoner will engage in self-injurious behavior, including suicide. See Snow ex rel. Snow v. City of Citronelle, Ala., 420 F.3d 1262, 1268-69 (11th Cir. 2005) (noting defendants are deliberately indifferent if there is a strong likelihood that an inmate would commit suicide). In jail suicide cases alleging constitutional violations, "the plaintiff must show that the jail official displayed 'deliberate indifference' to the prisoner's taking of his own life." Cook ex. rel. Tessier v. Sheriff of Monroe County, 402 F.3d 1092, 1115 (11th Cir. 2005) (quoting Cagle v. Sutherland, 334 F.3d 980, 986 (11th Cir. 2003)). Deliberate indifference is demonstrated by: "(1) subjective knowledge of a risk of serious harm; (2) disregard of... that risk; (3) by conduct that is more than mere negligence." Cook, 402 F.3d at 1115 (quoting Cagle at 986).

We observed systemic failures to address serious risks of prisoner suicide and to treat prisoners' serious mental health needs. Thousands of prisoners with serious mental illness have suffered in the Jail in recent years without adequate care. Instead, medication management is the only treatment available, and it is plagued with errors. The Jail does not provide adequate mental health crisis services, including access to: beds in a health care setting for short-term treatment and acute care (an inpatient level of care); chronic care and/or a special needs unit for prisoners who cannot function in the general population; outpatient treatment for prisoners in the general population; or services for prisoners in need of further treatment at the time of transfer to another institution or discharge to the community.

a. MDCR is deliberately indifferent to prisoners who pose a significant risk of suicide and self-harm.

Eight Miami-Dade County prisoners, including one in March 2011, committed suicide in the past four years, illustrating the harm resulting from MDCR's failure to take reasonable preventative measures.

- *The Death of A.N.*:[1] On March 26, 2011, at approximately 9:45 p.m., A.N., a 24-year-old male, committed suicide by asphyxiation with a bed sheet tied around his neck. A.N. was booked on August 3, 2010. At various times during his incarceration at MDCR, he was evaluated by mental health providers as suicidal.

[1] To protect the identity of prisoners, we use coded initials throughout this letter.

A.N. was housed in the general psychiatric unit. On February 4, 2011, less than one month prior to his death, A.N. was evaluated as suicidal and placed in the suicide precaution housing unit. He was subsequently returned to the general psychiatric unit, where he reportedly committed suicide on March 26, 2011.

- *The Death of A.G.*: On September 16, 2010, at approximately 6:30 p.m., A.G., a 33-year-old male was found by a correctional officer hanging in his cell. A.G. was booked on September 10, 2010. The next day, the Jail transported him to the emergency room, noting him to be combative and psychotic. A.G. returned later that day, was seen by a mental health provider, and subsequently cleared for general population in medium level custody on September 14, 2010. There, A.G. reportedly committed suicide on September 16, 2010 by affixing a sheet to an upper corner portion of the cell and asphyxiating himself.

- *The Death of A.H.*: On February 11, 2010, A.H., a 40-year-old female was found by a corrections officer hanging by a bed sheet. A.H. was booked into the Women's Detention Center on February 9, 2010. She was reportedly seen by a mental health care provider and cleared for general population. Subsequently, A.H. was sent to administrative segregation under medical observation. There, A.H. reportedly committed suicide on February 11, 2010 by affixing a sheet to a vent and asphyxiating herself.

- *The Death of A.I.*: On May 20, 2009, at approximately 4:45 a.m., A.I., a 34-year-old male, was found by a correctional officer hanging from a ceiling light fixture by a bed sheet. A.I. was subsequently transported to the hospital and pronounced dead. A.I. was housed in administrative segregation for most of his confinement due to the high profile nature of his charges.

- *The Death of A.J.*: On April 18, 2007, A.J., a 50-year-old male, entered PTDC. The booking and intake screening process identified the prisoner in need of kidney dialysis. Accordingly, this prisoner was housed in a health clinic cell at PTDC. At approximately 12:30 a.m. on August 15, 2007, a corrections officer found A.J. hanging from the cell bars by a bed sheet. The prisoner was transported to the hospital, where he survived until life-support equipment was disconnected eight days later.

- *The Death of A.K.*: On July 9, 2007, A.K., a 32-year-old male, entered PTDC. This prisoner was housed in administrative segregation due to the high profile nature of his charges. Less than one month later, on August 5, 2007, a corrections officer found A.K. hanging from the cell bars by a bed sheet. The prisoner was pronounced dead by the Miami-Dade County Fire Rescue Department upon their arrival.

- *The Death of A.L.*: On April 26, 2007, A.L., a 23-year-old male, entered PTDC. The prisoner was transferred to MWDC and housed in administrative segregation due to the high profile nature of his charges. On May 27, 2007, a corrections officer found this prisoner hanging from a ceiling grate by a bed sheet. The

prisoner was pronounced dead by the Miami-Dade County Fire Rescue Department upon their arrival.

- *The Death of A.M.*: On August 5, 2006, A.M., a 41-year-old male, entered PTDC. The prisoner was housed in a multiple-occupancy classification cell at PTDC. The following day, August 6, 2006, other prisoners discovered this prisoner hanging from the cell bars by a shoelace. The other prisoners yelled for assistance. A corrections officer arrived but did not have appropriate tools to cut down the prisoner, so he gave a prisoner his personal keys to try to cut him down. Although MDCR policy requires responding corrections officers to initiate cardiopulmonary resuscitation ("CPR"), the prisoner was not administered CPR until nursing staff arrived six minutes later. MDCR's investigation of this suicide revealed that A.M. had expressed suicidal ideation several months earlier and had a history of at least one suicide attempt, neither of which was elicited by MDCR's screening process.

1) Suicide Risk and Mental Health Screening

Incoming prisoners' serious psychiatric needs, including suicidal ideation, go unidentified and unaddressed due to MDCR's deficient intake screening process. Deliberate indifference to a prisoner's serious medical needs violates the Eighth Amendment. See Mann v. Taser Int'l, Inc., 588 F.3d 1291, 1307 (11th Cir. 2009) ("...Serious medical need is determined by whether a delay in treating the need worsens the condition."); Farrow v. West, 320 F.3d 1235, 1243 (11th Cir. 2003) (noting a serious medical need is one that is diagnosed by a physician as requiring treatment or obvious to a lay person, as needing medical care); see also Madrid v. Gomez, 889 F.Supp. 1146, 1256-1257 (N.D. Cal. 1995) ("While a functioning sick call system can be effective for physical illnesses, there must be a 'systemic program for screening and evaluating inmates in order to identify those who require mental health treatment.'").

We found the Jail's suicide risk and mental health intake screening to be deficient in several key respects. Significantly, the intake form does not require the intake officer to ask the prisoner if he or she is currently suicidal or has a history of suicidal behavior. Nor does it require the intake officer to solicit input from the transporting officer upon a prisoner's admission to the Jail. The form also does not indicate how many questions must be answered affirmatively in order for the corrections officer to make a referral. In addition to the defects in the form, the screenings are conducted in a large open room in full view and hearing range of other staff and prisoners. The likelihood of obtaining accurate mental health information is seriously compromised by the lack of privacy. Once the intake form is complete, it is placed in the prisoner's booking jacket, rather than being forwarded to staff conducting the second round of screening.

The Jail's second round of intake screening, conducted by either a social worker or a nurse, also omits important inquiries, including whether the prisoner is currently suicidal, had a recent significant loss and/or suicide by family members or close friends. CHS nursing staff who screen and refer prisoners for mental health services also informed us that they do not review the intake screening form completed by the intake corrections officer, thus negating the entire

purpose of the screening by the intake corrections officer.[2]

The efficacy of the second round of screening is also compromised by CHS's failure to retrieve charts or other documentation of prior mental health treatment or suicide attempts from previous incarcerations. Further, social workers at the Jail do not have access to the Jackson Health System computerized records from treatment at Jackson Memorial Hospital, which would provide valuable information about previous mental health treatment and suicide attempts. Communication among medical, mental health, corrections, and transport staff is important because certain signs exhibited by suicidal prisoners can foretell a possible suicide. Staff may be able to prevent a suicide by communicating and acting upon these signs.

There also is a failure to consistently provide screening information to medical and mental health staff via placement of screening forms in the chart, and there is no formal communication between intake screening and classification staff. Without formal communication between screening and classification staff, prisoners with mental illness or at risk of suicide can be placed in housing units that are counter-therapeutic and potentially dangerous, based on the vulnerability of these prisoners. See Estelle, 429 U.S. at 104-05 (prison officials have an obligation to take action or to inform competent authorities once the officials have knowledge of a prisoner's need for medical or psychiatric care).

We observed that certain PTDC housing units appear inherently inappropriate and potentially dangerous for mentally ill or suicidal prisoners because of the types of prisoners housed on the floor (e.g., violent maximum security prisoners), the chaotic atmosphere, the design of the cells (e.g., traditional steel cell bars surrounding the cell), and poor officer visibility into the cells.

2) Suicide Risk and Mental Health Assessment, Treatment, and Observation

MDCR fails to properly observe and assess suicidal prisoners. The mental health staff fails to take adequate precautions to ensure that prisoners who have been identified as at risk of suicide are protected. They fail to write orders that specify how closely corrections staff should observe the prisoner and fail to reassess the prisoner daily.

The Jail's observation of suicidal prisoners is deficient in both policy and practice. MDCR's policy fails to clearly describe the types of behavior that should result in a prisoner being placed on observation for suicide. The policy also does not clearly delineate between the types of observation that may be implemented. Instead, MDCR policy has a single observation status: "[l]ine staff will maintain direct continuous observation of suicidal prisoners and document checks at intervals not to exceed every 15 minutes." Although it requires

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2 Prior to our April 2009 site visit, this screening was done by a licensed practical nurse ("LPN"), who was not trained in identification of mental illness or suicide risk, a common theme that we highlighted during our June 2008 site visit. By the time of our April 2009 site visit, MDCR had started assigning a social worker to complete this screening during ordinary business hours. While this assignment is an improvement, untrained LPNs still conduct the screening after ordinary business hours.

documentation at 15-minute intervals, it appears to require constant observation. In practice, suicidal prisoners are not constantly observed. This is particularly dangerous for the female suicidal prisoners at WDC who are housed in cells that have protrusions that can be used for hanging.

The Jail's clinical assessment of suicidal prisoners also is inadequate. A psychiatrist and social worker share an office, conducting simultaneous interviews with the office door open while other staff enter and exit. Progress notes we reviewed did not document suicide risk assessments or justification for any particular level of observation.[3] In fact, the only indication in a prisoner's chart that the prisoner was on suicide watch was a notation that the prisoner shall "remain on 9-C-1." Such a notation does not constitute a suicide risk assessment. Instead, mental health staff must document the prisoner's current behavior and justify the particular level of observation that is ordered. Furthermore, the Jail does not require development of treatment plans for suicidal prisoners.

The deficiencies of this assessment process are exacerbated by the deficiencies in mental health rounds. Daily psychiatric rounds of the most seriously mentally ill prisoners, housed on the ninth floor of PTDC, are conducted cell-side, in full view and hearing of the other prisoners. These rounds are conducted quickly, often without psychiatric review of prisoners' charts. Although CHS improved its psychiatric rounds by making prisoner charts available to psychiatrists during rounds, our observation revealed that the psychiatrists rarely consult them.

Complicating these deficient assessment, treatment, and observation practices, we observed that prisoner medical charts did not consistently contain a mental health diagnosis for prisoners receiving psychotropic medications. Basic clinical processes require development of a diagnosis in order to treat the mental illness.

For example: A.B. had an initial psychosocial assessment on December 31, 2007. Although A.B.'s chart did not reflect a mental health diagnosis, A.B. continued to receive psychotropic medications for at least six months. Similarly, A.C.'s chart stated that he was receiving psychotropic medications. A.C.'s chart also noted that he was "known" to the mental health team, yet there was no diagnosis. CHS staff informed us that the failure to diagnose has been an ongoing problem.

Although MDCR's Suicide Prevention policy requires that medical staff determine the permitted activities and possessions for prisoners on suicide watch, CHS clinicians informed us that, contrary to policy, the practice is for corrections staff to make these decisions. This practice is inappropriate. For example, MDCR's practice is to require each prisoner placed on the 9-C wing to wear only a safety smock without any underwear, regardless of the specific reason for

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[3] We note that TGK does have a standard operating procedure providing that mental health staff conduct assessments of prisoners placed in segregation in a safety cell after 24 hours, 5 days, 30 days, 6 months, and every 6 months thereafter. While we commend MDCR for implementing this procedure and attempting to address the potential for decompensation of a prisoner's mental health status in segregation, it appears from documentation that, in practice, mental health staff merely "see" the prisoners on these intervals without conducting assessments.

the prisoner's assignment to the unit. MDCR and CHS need to have a clinical justification for limiting the property and clothing issued to prisoners. If a prisoner is issued only a safety smock and no underwear, it should be because this is clinically indicated, not because that is the usual practice. Corrections officers should not be making these decisions.

3) Medication Administration

MDCR's procedures for administering psychotropic medications are dangerous. We observed nurses administer psychotropic medications on PTDC's 9-C wing during our April 2009 site visit. The procedure is for one nurse and one corrections officer to walk from cell to cell in the unit with a cart containing drawers of alphabetically arranged paper medication records and medication bottles. Upon arrival at each cell, the corrections officer calls out the prisoner's name. Each cell houses multiple prisoners; however, no process was employed to verify the identity of the prisoner to whom the psychotropic medications were given.

The medication administration procedure lacked appropriate controls. After the corrections officer attempted to identify the prisoner, the nurse flipped through the paper records to try to determine if the prisoner was prescribed medications. She would then pour the medications in a cup for the prisoner. We observed the nurse repeatedly pouring medications back and forth between the medication bottle and the cup, with only an eye account of the actual number of pills to be included. The nurse also had to cut the pills in half on multiple occasions with an ineffective pill cutter that caused fragments of the medications to fall onto the cart, resulting in inaccurate medication dosing.

We observed several prisoners tell the nurse that she was giving them the wrong medication, or dosage, or at the wrong time frame. Six prisoners received no medications, even though these prisoners apparently required an intensive level of mental health services, as they continued to be housed on PTDC's 9-C wing after psychiatric rounds had taken place. For each of these prisoners, the nurse flagged the medication administration record ("MAR") with the reported intent to later return and review the medical record for verification. We concluded that the Jail's medication administration is chaotic, inefficient, and fraught with risk of errors that can cause serious harm to prisoners.

4) Suicide Prevention Training

The Jail fails to provide adequate suicide prevention training to all corrections, medical, and mental health staff. Successful suicide prevention is a collaborative process among all staff; however, training is particularly critical for corrections officers because they are often the only staff who are available 24 hours per day and who have regular contact with prisoners. Pre-service and annual training requirements should be clearly set forth in the relevant policy and should include sufficient topics to ensure that staff are able to recognize the verbal and behavioral signs that indicate a suicide risk, know what to do when a risk is suspected, and understand how to respond when there is a suicide attempt (generally achieved through mock drills).

The eight-hour training program initiated in April 2007 is not mandatory for MDCR staff. Our review of suicide prevention training records as of May 22, 2008, revealed that only

approximately 10% of MDCR's over 2,000 corrections officers had received it. None of CHS's nursing staff had been trained in suicide prevention, even though intake nurses are charged with identifying suicide risk. CHS mental health staff also did not receive any suicide prevention training until May 2008, when a facility psychiatrist provided social workers with a one-hour workshop consisting of seven Power Point slides. Notably, MDCR's suicide prevention policy does not address suicide prevention training requirements.

Even if the Jail's policy appropriately required that all corrections, medical and mental health staff receive adequate initial and annual suicide prevention training, current training staff resources at the Jail are woefully inadequate to complete even just the initial training on a timely basis. As was the case in April 2007 with the inception of MDCR's training, a single training officer is responsible for training all MDCR staff. According to this staff person, it will take approximately six years to complete initial suicide prevention training for all corrections officers, mental health care staff, and nursing staff at the current pace of training and training staff levels. The Jail is unable to adequately train staff with a single training officer. Moreover, training performed by a sole corrections officer omits important instructional input from mental health and medical staff.

MDCR's corrections officers also lack sufficient training in emergency intervention. According to MDCR policy, all corrections officers are required to be certified in first aid, CPR, and the use of an automated external defibrillator ("AED"). Although training records were not available during our June 2008 site visit, MDCR officials informed us that only approximately 75% of corrections officers have actually received the emergency intervention training that is required by policy. The impact of MDCR's failure to follow its own policy of training all corrections officers in emergency intervention is evident in MDCR's inadequate emergency responses to suicides.

b. MDCR's segregated housing units for prisoners with serious mental illness and suicidal behaviors are inhumane and unconstitutional.

1) The physical conditions are dangerous.

Prison officials have a duty under the Eighth Amendment to ensure "reasonable safety," a standard that incorporates due regard for prison officials' "unenviable task of keeping dangerous men in safe custody under humane conditions." Farmer, 511 U.S. at 845 (quoting Helling, 509 U.S. at 33). A prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement if he knows that prisoners face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it. Farmer, 511 U.S. at 847 n.9. In addition, elements of the conditions of confinement may establish an Eighth Amendment violation "in combination" even if each would not do so alone if "they have a mutually enforcing effect that produces the deprivation of a single, identifiable human need such as food, warmth, or exercise—for example, a low cell temperature at night combined with a failure to issue blankets." Wilson v. Seiter, 501 U.S. at 304.

The Jail houses male prisoners with serious mental illness and suicidal behaviors on PTDC's segregated ninth floor, 9-C wing. Prisoners on the 9-C wing are locked in their cells nearly 24 hours a day and do not receive recreation, telephone calls, or visitation, unless they are

in one of the five step-down cells on the wing.[4] Rather than being therapeutic, the 9-C wing is chaotic, crowded, foul-smelling, depressing, and unacceptable for housing prisoners who are mentally ill or suicidal.[5] It has 19 single-bunk cells for prisoners who are acutely mentally ill or suicidal, and the cells are frequently double or even triple bunked. In fact, we calculated the rate of overcrowding during one day of our visit, June 10, 2008, to be 62%—greatly exacerbating the already abysmal conditions on the wing. When these single-person cells house more than one prisoner, as they often do, the second or third prisoner must sleep on the bare floor because there is no additional mattress or bedding. The floors are often very cold, as the poor circulation of the wing's air-conditioning traps the cold air in the cells causing the temperature in the cells to drop as much as 20 degrees below room temperature. During our June 2008 site visit, we also observed that, for some of the 9-C wing prisoners who do have a bed, the bedding in some of the cells (e.g., cells 16 and 19) was so old and worn that it could no longer be adequately sanitized and should have been replaced.

Female prisoners who are identified as suicidal are housed in five cells on the 3-C wing of the WDC. The five cells used for suicidal prisoners at WDC are dangerous because they have many protrusions, including ventilation grates, exposed pipes in the toilet areas, and holes in restraint beds, all of which are potential anchor points for self-asphyxiation. Moreover, there are several blind spots in these cells, preventing officers from being able to minimize the risk of a suicide by closely observing the prisoner. In sum, the WDC suicide watch cells provide ample opportunity for the exact outcome that they should be designed to prevent.

Because MDCR staff and prisoners are aware of the horrid conditions on the 9-C wing, staff will threaten, punish, and retaliate against prisoners by transferring them (or threatening to transfer them) to the 9-C wing. For example, we reviewed an incident report from March 14, 2008, in which a prisoner was kicking his cell door, asking to see a doctor. After the Jail sent a nurse to see the prisoner, the prisoner continued to kick his door, demanding to see a doctor. The nurse ordered that the prisoner be placed on suicide precautions and, when the prisoner refused to be handcuffed for transport to the ninth floor, officers sprayed him with oleoresin capsicum agent ("OC spray") and escorted him to the 9-C wing. We could not find any documentation in this prisoner's file that indicated this prisoner presented a risk of suicide or had acute mental illness. We spoke with many prisoners who consistently reported being threatened with transfer to the 9-C wing.

The conditions of the PTDC ninth floor mental health unit are not new to MDCR and County officials. Over the past several years, print and television news media, as well as a non-

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4 At the time of our April 2009 tour, no recreation officer was yet available to provide recreation to the prisoners on the 9-C wing, though a recreation officer was reportedly going to be hired.

5 The foul odor of the cells, and to a slightly lesser extent, the rest of the wing, is caused in part by the practice of not providing showers for the more acutely mentally ill or suicidal prisoners. We observed a garden hose attached to the wall on the 9-C wing which, although not in use during our visit, reportedly has been used to periodically spray prisoners in lieu of showers.

fiction book, have reported on the deplorable conditions of the ninth floor. Also chronicling the ongoing inhumane conditions on the ninth floor, a Miami-Dade County grand jury toured the 9-C wing in 2004 and again in 2008, concluding that "[n]ot much has changed . . . . The setting was not appropriate for treatment then. It is not appropriate now."[6] In February 2009, local state legislators toured the 9-C wing and called it "inhumane . . . . a God-awful place."[7]

2) MDCR fails to provide adequate mental health services or other programming appropriate to the needs of prisoners confined to mental health units.

Despite the fact that MDCR categorizes the 9-C wing as its housing unit for prisoners who are acutely mentally ill or suicidal, no mental health programming is available to the prisoners confined there. Grossly incompetent or inadequate care can constitute deliberate indifference to the prisoner's needs. Waldrop v. Evans, 871 F.2d 1030, 1033 (11th Cir. 1989) (quoting Rogers v. Evans, 792 F.2d 1052, 1058 (11th Cir. 1986)). Any individual contact with clinical staff is done cell-side, where clinicians attempt to assess the prisoners' suicidality and mental status by talking to them through the food-tray slot in full view and hearing a range of the other prisoners in the cell and on the wing.

MDCR also does not consistently document a clear rationale explaining why prisoners are housed on the 9-C wing, rather than a less restrictive setting. For example, we reviewed documentation in W.W.'s medical chart indicating that, between April 23 and May 26, 2008, W.W. said he was "alright, ready to be transferred," was "alert, calm, and cooperative," and was "awake, alert, [and had] good eye contact." Yet W.W. remained on the 9-C wing for the entire month despite clinical notations indicating that the 9-C wing was not appropriate for W.W. Other prisoner charts we reviewed contained no rationale for transferring a prisoner from other mental health units to the 9-C wing. For example, X.X. was housed on the 9-C wing during the week of our April 2009 site visit. Yet there was no documentation in his chart supporting the Jail's decision to move X.X. from the 9-B wing—a unit for prisoners with less acute mental illness—to the 9-C wing.

c. MDCR's discipline process fails to account for behaviors that are the product of a mental illness.

Another critical shortcoming of MDCR's mental health services is MDCR's failure to ensure disciplinary penalties are not imposed on prisoners with mental illness for conduct that is symptomatic of their mental illness. See Thomas v. Bryant, 614 F.3d 1288, 1307-17 (11th Cir. 2010) (holding that repeated chemical sprayings of a mentally ill prisoner constituted cruel and unusual punishment when facility did not evaluate whether the prisoner's conduct was symptomatic of mental illness). Although corrections staff indicated that disciplinary measures

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[6] Final Report of the Miami-Dade County Grand Jury, Fall Term 2007, at 27 (Fla. Cir. Ct. August 11, 2008).

[7] Carol Marbin Miller, Mentally Ill in Jail in a New Crisis, Miami Herald, February 20, 2009, at B1.

are "rarely used" for mentally ill prisoners, our review of records of disciplinary proceedings against mentally ill prisoners revealed that they were routinely subject to discipline for their symptomatic behavior. There is no formal system at the Jail for CHS mental health staff to advise or consult with corrections staff that conduct disciplinary hearings and assign punishment for disciplinary violations. Corrections staff who perform these functions agreed that mental health staff should be formally involved in disciplinary decisions regarding mentally ill prisoners.

2. MDCR is deliberately indifferent to the serious medical needs of prisoners.

A corrections official's "deliberate indifference" to a prisoner's serious medical needs is a violation of the Eighth and Fourteenth Amendments. Estelle, 429 U.S. at 104; Farrow v. West, 320 F.3d 1235, 1243-46 (11th Cir. 2003); Steele, 87 F.3d at 1269. Jail officials act with deliberate indifference when a prisoner needs serious medical care and the officials knowingly fail or refuse to provide that care. Farrow, 320 F.3d at 1246. The Constitution is violated if a prison official "knows of and disregards an excessive risk to inmate health or safety." Farmer, 511 U.S. at 837. Providing only cursory care in such a situation amounts to deliberate indifference. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999). Conditions violate the Constitution if they pose an unreasonable risk of serious damage to a prisoner's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling, 509 U.S. at 33-36; Chandler v. Crosby 379 F.3d 1278, 1289 (11th Cir. 2004).

MDCR fails to identify and treat prisoners in the Jail who present obvious symptoms of serious illness and injury. When MDCR does identify prisoners in need of medical treatment, the treatment provided is often insufficient, placing the prisoners' health and safety at risk. Prisoners are needlessly suffering and, in some cases dying, due to deliberate indifference. Below we highlight five major areas of deficiencies: correctional medical care intake screening and initial health assessments; access to care for acute medical needs; management of chronic health problems; record keeping; and quality assurance.

a. MDCR fails to identify timely the acute and chronic care needs of prisoners booked into the Jail.

MDCR's failure to identify the acute and chronic care needs of prisoners entering the jail is clearest with respect to those prisoners who are withdrawing from drugs and alcohol. As a result, prisoners do not receive necessary care, which in turn, can lead to tragic results, as the following examples demonstrate:

- *The Death of E.E.*: On July 19, 2008, E.E. was processed into the Jail and received an intake screening at approximately 1:00 a.m. on July 20. Twelve hours later, E.E. was pronounced dead. The intake screening, completed by a licensed practical nurse ("LPN"), indicated no medical problems or history of drug or alcohol use, and E.E.'s behavior was noted as appropriate. At 5:30 a.m., however, E.E. suffered a seizure. Although an ambulance was called, neither MDCR nor CHS staff authorized E.E.'s transfer to the hospital. A nurse conducted a medical assessment following the seizure and noted E.E.'s blood

pressure to be 203/139.[8] Despite this high reading, there is no mention of the elevated blood pressure in the comments to the assessment in the prisoner's medical chart. Additionally, there was no mention of the prisoner being disoriented. This is noteworthy because a social worker also evaluated E.E. and documented that E.E. appeared lethargic and disoriented. At 9:30 a.m., MDCR staff transported E.E. to the PTDC ninth floor mental health unit for a mental health evaluation and treatment. CHS staff did not, however, order treatment for E.E.'s seizure, monitor his blood pressure or other vital signs, or conduct further clinical evaluation. Approximately three hours later, staff reported finding E.E. unresponsive and transferred him to the hospital, where he was pronounced dead.[9]

- *The Death of B.B.*: B.B. died on May 22, 2008, the same day he entered the Jail. B.B. had a history of drug withdrawal. Staff reported finding B.B. unresponsive in his cell, and started CPR. Staff did not, however, use an automated external defibrillator ("AED").[10] In facilities as large as MDCR, an AED should be available for an emergency situation when a prisoner is without both a pulse and respirations. More important, despite B.B.'s known history of drug withdrawal, MDCR did not provide an appropriate level of observation and monitoring of B.B.'s condition.

- *The Death of A.A.*: A.A. was admitted to the Jail on April 9, 2008, and died the following day. A.A. had a history of serious medical problems, including congestive heart failure, hypertension, and heart attack. At the time of his intake, A.A. was withdrawing from alcohol, and CHS staff placed him on a detoxification program. However, a detoxification form was not completed, and a physician did not sign the health assessment (indicating that a physician did not review the nurse's assessment findings). At 8:00 a.m. on April 9, A.A.'s blood pressure was 199/102, and by 10:00 a.m. it was 218/121. Given A.A.'s medical history and severely elevated blood pressure, A.A. should have been immediately treated by a physician.

- *The Death of C.C.*: On March 6, 2008, MDCR officials processed C.C. into the Jail with a slightly elevated pulse of 111. C.C. died the next day. A physician did not sign C.C.'s health assessment on March 6 (indicating that a physician did not review the nurse's assessment findings), and although a nurse referred C.C. to a physician due to the abnormal pulse, there is no documentation of nursing staff conducting follow-up vital sign monitoring. On the next day, March 7, staff

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8 A normal blood pressure reading is 130/80.

9 This letter discusses prisoner deaths but the cause of death is not explained. MDCR does not maintain autopsy reports, and prisoner deaths are not formally reviewed. Therefore, the causes of death in the examples provided have not been formally determined.

10 An AED is an electronic device designed to deliver an electric shock to a victim of sudden cardiac arrest in order to restore heart rhythms to their normal pace.

found C.C. unresponsive, but did not use an AED as should be expected under the circumstances.

- *The Death of D.D.*: MDCR officials processed D.D. into the Jail on November 6, 2007. D.D. died on November 8, 2007. During the intake screening and initial assessment, CHS staff identified an infection in D.D.'s chest wall, as well as symptoms of drug withdrawal. CHS staff ordered monitoring of vital signs and a follow-up appointment with the physician on November 8. There is, however, no documentation of vital signs monitoring, and the follow-up appointment did not occur. Instead, on November 8, CHS staff reported finding D.D. unresponsive and transferred him to the hospital, where he died.

These prisoner deaths demonstrate that initial screening and health assessments are woefully inadequate. Obvious medical signs and symptoms, such as E.E.'s seizure and disorientation, are often missed by MDCR and CHS staff. Known issues like D.D.'s chest wall infection, or the elevated blood pressures of E.E. and A.A., or the history of drug and alcohol use by B.B., D.D., and A.A., are not sufficiently addressed.

Screenings and health assessments must be timely and thorough, and completed by competent professionals with the necessary training to identify signs that pose risks to prisoners' health. Just as important, correctional facilities must have quality assurance systems in place to ensure accountability for errors that lead to grievous harm. See Helling, 509 U.S. at 35; see also Chandler, 379 F.3d at 1289. MDCR is deliberately indifferent when it routinely provides only cursory care (or no care at all), when the need for more serious medical treatment is obvious at the time of the incident, and then made plain by the resulting harm. Farmer, 511 U.S. at 837.

b. MDCR fails to act on known medical problems discovered through its "sick-call" process.

MDCR prisoners can request medical treatment through sick-call. Despite its knowledge of sick-call complaints, the Jail fails to take timely and necessary action. This failure to act is unconstitutional deliberate indifference to prisoners' serious medical needs. Estelle, 429 U.S. at 104.

CHS nursing staff triage sick-call complaints during routine medication administration. These brief cell-side interactions do not allow for adequate assessment or medication administration. Prisoners are denied privacy, as the assessment is done with other prisoners standing in line for medication, well within hearing distance.

Nurses do not employ protocols or assessment forms during the sick-call triage. We observed nurses routinely failing to take and record vital signs. Vital signs should be a part of every medical clinical encounter and must be recorded in the medical record. In addition to these concerns, we found evidence that prisoners had to make several sick-call requests before a nurse would initially evaluate them, and then prisoners would endure extensive delays before seeing a physician after a nurse's referral.

Through CHS's sick-call process, CHS is made aware of prisoners' serious medical needs. Yet, CHS repeatedly fails to provide the necessary level of care. This situation amounts

to deliberate indifference resulting in grievous harm, as the following examples demonstrate:

- *The Death of F.F.*: F.F., a 48-year-old male with hypertension, died on January 5, 2008, two months after being admitted to the Jail. On January 2, 2008, F.F. complained to a CHS nurse of chest and gas pain. A complaint of gas pain must be evaluated carefully and fully in a prisoner with hypertension due to the risk for heart disease, as gas can mimic heart disease symptoms. The following day, a physician ordered tests to rule out heart disease. F.F. was supposed to see the physician again the next day, but did not, for reasons unknown. Instead, he was seen by a nurse who administered an antacid. No nursing protocols were used during the exam. The content of both nurse exams exceeded the scope of the nurses' qualifications. On January 5, 2008, F.F. was brought to the medical clinic unresponsive.

- *The Death of G.G.*: G.G. died on October 23, 2007. The day before his death, a CHS nurse evaluated G.G. for complaints of shortness of breath. The nurse's exam was inadequate and incomplete. During the exam, no vital signs were taken, no lung exam was completed, and G.G. was only given medication for a cold. The following day, G.G. made the same complaint and was taken to the hospital, where he died.

F.F.'s chest pain and G.G.'s shortness of breath were serious medical symptoms brought to the attention of MDCR and CHS staff. Disregarding the excessive risks to the prisoners' health and safety, MDCR failed to provide an appropriate level of care.

c. MDCR fails to provide adequate care to prisoners with serious chronic medical needs.

The Jail is deliberately indifferent to prisoners' serious medical needs when it fails to identify or adequately treat a prisoner's serious chronic illness. Lancaster v. Monroe County, Ala., 116 F.3d 1419, 1425 (11th Cir. 1997) (noting that an official acts with deliberate indifference when he knows that an inmate is in serious need of medical care, but he fails or refuses to obtain medical treatment for the inmate). See also Hill v. Dekalb Regional Youth Detention Ctr., 40 F.3d 1176, 1186 (11th Cir. 1994) ("Knowledge of the need for medical care and intentional refusal to provide that care constitute deliberate indifference.").

The systemic nature of MDCR's deliberate indifference is evidenced by the Jail's failure to operate a functional chronic care program. Prisoners who suffer from chronic medical illnesses must be regularly monitored by qualified medical professionals to prevent the progression of their illnesses. Monitoring should occur on a regular basis to ensure that symptoms are under control and that medications are appropriate. Morbidity and mortality rates of prisoners with chronic illnesses can be reduced with regular monitoring.

The Jail does not track prisoners with chronic illness nor monitor their conditions. Chronic care programs in correctional settings are critical to avoid placing prisoners with serious medical needs at excessive risk. The requirements of chronic care are addressed in guidelines

developed by the National Commission on Correctional Health Care ("NCCHC").[11] While the Jail claimed to be following the NCCHC guidelines, our review of prisoner charts revealed that no chronic care program exists. For example, we found prisoners with HIV without any medication. We also found prisoners with diabetes and hypertension who were without expected tests in order to assess the status of their kidneys, cholesterol level, or heart functions. And, prisoners with histories of seizures were not monitored closely to determine the level of their seizure medication, which is necessary, as incorrect dosages above necessary levels can cause serious side-effects, such as brain and heart damage.

In addition, a critical component of a chronic care program is appropriate and timely referrals to medical specialists. MDCR acknowledged delays in consultations for specialty services such as cardiology, neurology, and HIV-related services. The Ancata court stated that "deliberate indifference to serious medical needs is shown when prison officials have prevented a prisoner from receiving recommended treatment or when a prisoner is denied access to medical personnel capable of evaluating the need for treatment." Ancata, 769 F.2d at 704 (citing Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980)).

Our review of medical charts and interviews with CHS staff revealed that HIV-positive prisoners may wait up to six weeks for a specialist referral, and that other chronic conditions can take even longer. For example:

- *HIV Consult*: S.S. had an HIV-related referral ordered four weeks prior to our tour, but no response or report had been given about an appointment date.

- *Neurology Consult*: O.O. had a neurology consult ordered five months prior to our tour, but no response or report was present in the medical record.

- *Cardiology Consults*: P.P. had a cardiology consult ordered nearly five months prior to our tour, but no response or report was present in the medical record. R.R. had problems with chest pains and had a cardiology consult ordered six weeks prior to our tour, but no response or report was present in the medical record.

- *Gynecology Consult*: Q.Q. had a history of cervical cancer, and had a gynecology consult ordered seven weeks prior to our tour, but no response or report was present in the medical record.

There is no tracking system for outstanding consultation referrals. It is necessary to track this information, as prisoners with chronic conditions require a higher level of medical care than is often available on-site, making them more vulnerable to harm. This deficiency constitutes deliberate indifference. Ancata, 769 F.2d at 704.

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[11] It should be noted that in 2008, NCCHC elevated the requirement of a chronic care program from "important" to "essential," emphasizing the necessity of a functional chronic care program.

d. **MDCR's poor record keeping practices contribute to the pattern or practice of deliberate indifference to provide adequate medical services.**

MDCR fails to keep complete, accurate, readily accessible, and systematically organized medical records. A complete and adequate medical records system is critical to ensure that medical staff members are able to provide care. Inaccurate or incomplete record keeping places prisoners at excessive risk of serious harm.

The documentation of medical information for MDCR prisoners is done in part through a paper-based system, and in part through an electronic system maintained by the Jackson Health System. The CHS physicians have access to the electronic system to check laboratory data and consultation reports, but the CHS physicians cannot enter data into the system. Instead, CHS maintains a paper chart at the Jail. The current system requires physicians to use both the paper charts and the electronic system to access complete medical information about a prisoner. Moreover, other CHS health care staff, including nurses, do not have access to the electronic system at all; thus, laboratory data in the electronic system is not readily available to CHS non-physician medical staff.

Medical charts often contain an incomplete medical history; fail to document specialist appointments; do not include the medical staff member's name and title attached to notes; and are illegible. Moreover, the Jail's medical records fail to consistently record vital signs during clinical encounters. As noted above, vital signs should be part of every clinical encounter and must be recorded in the medical record.

In addition and contrary to MDCR policy, many charts do not contain the nursing intake screening or the booking officer screening. Thus, medical and mental health staff members do not have information from a prisoner's previous incarceration and often do not have information from the intake screening for the prisoner's current incarceration. Even when the current nursing intake screening is on file, MDCR relies on self-reporting by the prisoner without the benefit of review of prior treatment at the Jail.

B. MDCR IS ENGAGED IN A PATTERN OR PRACTICE OF USING EXCESSIVE FORCE AGAINST PRISONERS.

The Eighth Amendment protection from cruel and unusual punishment forbids the use of excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1, 5-7 (1992); Skrtich v. Thornton, 280 F.3d 1295, 1300-01 (11th Cir. 2002). As the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to a prisoner of a jail incarcerated prior to trial as it would to a convicted prisoner, City of Revere, 463 U.S. at 244, jail officials will violate the Constitution if they use excessive force on jail prisoners. MDCR correctional officers routinely use excessive force against Jail prisoners in violation of the Constitution.

The use of force by a corrections officer violates the Constitution when it is not applied "in a good-faith effort to maintain or restore discipline," but instead is administered "maliciously and sadistically to cause harm." Hudson, 503 U.S. at 6-7; Campbell v.Sikes, 169 F.3d at 1374; Harris v. Chapman, 97 F.3d 499, 505 (11th Cir. 1996). Courts may examine a variety of factors in determining whether the force used was excessive, most commonly including: (1) the need for the application of force; (2) the relationship between the need for force and the amount of force applied; (3) the threat, if any, reasonably perceived by responsible corrections officers; (4) any efforts made to temper the severity of a forceful response; and (5) the extent of the prisoner's injury. Hudson, 503 U.S. at 7-8; Campbell, 169 F.3d at 1375; Harris, 97 F.3d at 505.

Our investigation included an intensive examination of MDCR use of force policies, training, and incident reports. We also conducted many staff and prisoner interviews on this issue. In some cases, our findings of excessive or inappropriate uses of force are in accord with the conclusions from MDCR's own Internal Affairs Unit investigations.

MDCR corrections officers openly engage in abusive and retaliatory conduct, which frequently results in injuries to prisoners. In particular, there is a disturbing and distinct trend of MDCR corrections officers reacting to low level aggression from prisoners (e.g., abusive language or passive resistance to an order) by slapping or punching the prisoner in the head and verbally provoking the prisoner to physically respond. MDCR corrections officers often do not attempt any de-escalation techniques to combat low level aggression before engaging the prisoner in such an inappropriate manner.

Further, MDCR corrections officers frequently employ OC spray under circumstances that do not require such a level of force. Disturbingly, during our interviews with MDCR corrections officers, most officers could not articulate when the use of OC spray was appropriate. Only a few officers were able to competently discuss MDCR policy and explain the use of OC spray as a last resort before using physical force to restrain a resistive, violent, or combative prisoner. When asked, most officers were unfamiliar with the policy or guessed at responses, offering incomplete answers such as "when the prisoner doesn't listen to you." Well-trained corrections officers should be able to articulate clearly and without hesitation the level of prisoner resistance necessitating the deployment of OC spray—or any other use of force—as an appropriate response to restore and maintain order.

The following examples, some derived from MDCR's own internal documents and investigations, illustrate the pattern or practice of using excessive force:

- *Prolonged Fist Fight*: On August 27, 2007, nine MDCR corrections officers, including a Field Training Officer, allowed prisoner A.N. and an officer to engage in a prolonged fist fight at the MWDC. None of the officers involved filed a use of force report. MDCR investigators discovered a video of the fight while investigating a separate incident. The video shows A.N. instigating a fight with an officer, and the officer responding by spraying A.N. with OC spray. A second officer kept other prisoners at arm's length while the prisoner and the officer then engaged in a fist fight. Over a matter of minutes, up to nine other officers responded but failed to intervene in the fight.

- *Physical Assault*: On August 23, 2007, prisoner A.O. rendered a sworn statement to MDCR investigators alleging that a MDCR corporal in MWDC physically assaulted him by slapping him in the face several times, punching him in the right side of his face and his right eye, pushing him to the ground and kicking his face and body. A.O. reported that other corrections officers were present during the assault. A.O. explained that as the assault took place, he attempted to run toward the view of the security cameras, but was dragged back out of view by the officers. A second attempt to run toward the camera view was successful. The corporal caught A.O. at the elevators, however, and choked him and punched him in the side of the face. After reviewing the videotape, which also showed the officer pushing A.O.'s face to the floor while A.O. was restrained in handcuffs, MDCR's Internal Affairs Unit sustained the allegations in part, giving credit only to the acts caught on video, despite A.O.'s injuries corroborating the prisoner's full account. Internal Affairs further noted that several corrections officers, including a supervisor, either failed to report the incident accurately, or did not report the incident at all.

- *Instigating Fights*: In a May 2007 incident at PTDC, prisoner A.P. claimed that a corrections officer ordered him out of his cell and placed him in a visiting booth because the prisoner made derogatory comments about MDCR staff. While in the visiting booth, A.P. claims that an officer asked him if he wanted to fight one of the other officers. A.P. claims he told the officer he did not want to fight. Although the prisoner received a laceration above his eye, no use of force incident report was filed.

- *Striking Restrained Prisoners*: We requested to view videotapes from randomly selected shifts at the different facilities. One of the videotapes from PTDC's ninth floor mental health unit showed a prisoner being dragged to a chair by several MDCR corrections officers and then handcuffed to a table. After being restrained in handcuffs, the video shows an officer punching the side of the prisoner's face. Moments later, another officer arrived to photograph the prisoner's face. It does not appear, however, that any use of force report was filed in regard to this incident.

Interviews with juvenile prisoners housed in the TGK facility revealed a particularly violent atmosphere, often involving the corrections officers directly or indirectly. For example:

- *Violence Against Juveniles*: A videotape of the juvenile unit in May 2008 shows two officers casually engaged in conversation with a prisoner, when one of the officers—unprovoked by any physical movement by the prisoner—grabbed the prisoner and threw him onto a table, and then to the floor. The prisoner struggled to protect himself, while the other officer looked on without taking any action. The prisoner was then escorted to the front of the unit and left locked between two security doors in the hallway leading into the unit.

Contributing to this pattern or practice, use of force reporting in the Jail is frequently inaccurate or incomplete, and in incidents involving multiple officers, not all officers are

submitting individual reports. For example, according to MDCR records, there were 272 use of force incidents in a six-month period from October 2007 through March 2008. Most of the incidents involved physical force or the use of OC spray.[12] MDCR's Internal Affairs Unit, however, independently reported over 1,000 use of force incidents just involving OC spray in 2007. This level of discrepancy in use of force reporting generally, and incidents involving OC spray specifically, indicates a serious issue of under-reporting use of force incidents by MDCR officers.

C. MDCR IS DELIBERATELY INDIFFERENT TO SERIOUS RISKS TO PRISONER SAFETY POSED BY PRISONER VIOLENCE.

Prisoners have a constitutional right to be protected from harm. Farmer, 511 U.S. at 832. Corrections officials have a specific duty "to protect prisoners from violence at the hands of other prisoners." Id. at 833 (internal quotation marks and citations omitted). MDCR is violating that constitutional right through its deliberate indifference to the prisoner violence within the Jail. According to MDCR's own reporting of prisoner-on-prisoner assaults, the Jail is experiencing well over a hundred incidents every month.[13] In fact, in a six-month period just prior to our tour, the Jail reported over 300 incidents of prisoner-on-prisoner assaults just in the MWDC facility. In that same six-month period, the Jail reported nearly 250 such incidents in the PTDC facility, and approximately 125 such instances in the Stockade facility.

Not every injury suffered by a prisoner at the hands of another prisoner will violate the Eighth and Fourteenth Amendments to the Constitution. The prisoner invoking the right must demonstrate that, (1) he or she was "incarcerated under conditions posing a substantial risk of serious harm," and (2) corrections officials were "deliberately indifferent" to the risk. Id. at 834. Accordingly, Jail officials must take reasonable steps to protect prisoners from physical violence and to provide humane conditions of confinement. Providing humane conditions requires that a corrections system satisfy prisoners' basic needs, such as their need for safety. A corrections official's failure to supervise prisoners, particularly prisoners known to be violent, may result in unconstitutional conditions of confinement where assaults between prisoners occur due to the lack of supervision. Cottone v. Jenne, 326 F.3d 1352, 1359-60 (11th Cir. 2003) (noting that a lack of monitoring and supervision of known violent inmates, which led to inmate-on-inmate violence, constituted impermissible unconstitutional conduct).

There is a dangerous lack of meaningful supervision in the housing units, particularly the dormitory settings housing maximum security prisoners in PTDC and the Stockade. The

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[12] We found that many use of force incidents in the Jail involved the use of OC spray. At the time of our tour, MDCR did not have a uniform system in place throughout the facilities to measure (by weight) OC spray canisters following deployment by a corrections officer (or on an otherwise regular basis) to ensure that the reported use was consistent with the contents of the container.

[13] Nationwide, prisoner-on-prisoner assaults are under-reported, as prisoners often fear retaliation from other prisoners as a consequence of reporting such assaults. This trend of under-reporting suggests that the problem within MDCR facilities is even greater than the statistics noted in this letter would indicate.

problems with providing adequate supervision to the units in PTDC and the Stockade stem largely from the antiquated design of these facilities. For example, there are no officers stationed inside the majority of the dormitory housing units in PTDC and the Stockade. Therefore, in order for MDCR corrections officers to view the maximum security prisoners housed in most PTDC units, the officers must either enter the unit or walk along a narrow catwalk that runs behind the unit. The catwalk in PTDC is not designed for patrol and does not provide access into the unit should the officer observe an incident that calls for immediate response. MDCR corrections officers patrol the units regularly, but prisoners are aware of the patrol schedule and know when they are, and are not, being directly supervised. A similar situation exists in the Stockade. Most units in the Stockade, including those housing maximum security prisoners, are dormitory settings without a corrections officer present in the unit. Instead, officers patrol outside the several units. Due to the structure of the units in the Stockade, however, officers patrolling outside the units cannot effectively observe the prisoners without actually entering the units to conduct direct observation. As a result, during the time the officer is inside a particular unit conducting direct observation, the remaining units are unsupervised.

Supervision problems also persist in the two units housing male juveniles in TGK. The male juvenile prisoners (those prisoners under the age of 18 years, but being criminally charged as adults under Florida state law) are housed on the second floor of TGK. The juvenile housing units are not equipped to adequately separate the juveniles according to their classification status, resulting in juveniles of mixed security levels being housed in the same unit. The units are often overcrowded, exacerbating security concerns by increasing the number of mixed classification prisoners housed in close proximity, and decreasing the ratio of officers to prisoners. While corrections officers are posted inside the unit, there are blind spots throughout the unit that pose a danger to officers and prisoners when only a single officer is stationed within the unit.

Juvenile prisoners selected as "trustees" are often involved in the incidents of violence. Trustees assist in the jail operations by cleaning the unit and delivering food trays and hygiene supplies. The Trustee program is dangerous and contributes to unconstitutional conditions. First, Trustees reportedly withhold food and hygiene supplies from other prisoners creating a high risk of conflict. Second, we observed trustees being allowed free movement through the unit, including secure areas, when not working, even in nighttime hours. Surveillance videotapes revealed juvenile prisoners often walking behind the control panel that electronically locks and unlocks the individual cell doors. Reportedly, the prisoners on videotape were "trustees" and would do this to retrieve cleaning or hygiene supplies, such as toilet paper. Regardless of the reason, it is extremely dangerous to allow prisoners to have this type of access to the unit's control panel. Third, trustees are reportedly selected based on their ability to physically control the other juvenile prisoners. Juvenile prisoners reported that trustees are often asked by the corrections officers to physically discipline other prisoners.

We interviewed many of the juvenile prisoners, most of whom said they did not feel safe in the unit. Most of the juvenile prisoners we interviewed spoke about the practice of "taxing," an unauthorized and undocumented method of discipline in which corrections officers will lock down a juvenile prisoner in his cell for rule violations and force another prisoner (or prisoners) to inflict physical punishment on the locked-down prisoner. The juveniles reported that a "tax" also can result in extended lockdowns, sometimes lasting up to three days.

In addition, there is evidence that the Jail fails to take reasonable measures to protect prisoners from sexual assault. The August 2010 national survey on sexual victimization in jails and prisons conducted by the Department of Justice's Bureau of Justice Statistics found a high prevalence of sexual victimization at the Miami-Dade County PTDC.[14] In this report, the Miami-Dade County PTDC ranks among one of the worst jails in the country with a high rate of prisoner-on-prisoner rape and sexual abuses in the facility. The national rate for jails is 1.5% and the PTDC had an alarming rate of 5.5%.[15] The Office of Justice Programs of the Department of Justice notified MDCR that it is required to appear for a Prison Rape Elimination Act hearing in Washington, DC on September 15-16, 2011.[16] We intend to monitor the results of the hearing and any related matters of sexual victimization at MDCR.

D. DANGEROUS AND UNSANITARY CONDITIONS EXPOSE PRISONERS UNWILLINGLY TO AN UNREASONABLE RISK OF HARM.

The Eighth Amendment guarantees that prisoners will not be "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). As the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to a prisoner of a jail incarcerated prior to trial, as it would to a convicted prisoner, City of Revere, 463 U.S. at 244, MDCR jail officials may not deprive prisoners of the minimal civilized measures of life's necessities. Accordingly, MDCR officials must provide, among other necessities, "reasonably adequate ventilation, sanitation, bedding, hygienic materials, and utilities (i.e., hot and cold water, light, heat, plumbing)." Chandler v. Baird, 926 F.2d 1057, 1065 (11th Cir. 1991) (citations omitted). Conditions violate the Constitution when they pose an unreasonable risk of serious damage to a prisoner's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling, 509 U.S. at 33-35; Crosby, 379 F.3d at 1289.

The Miami-Dade County Jail is failing to ensure that sanitation and environmental health conditions are consistent with constitutional standards. Simply stated, conditions within the Jail are unsuitable for detention housing, posing unreasonable risks of serious harm to prisoners' health and safety. In particular, our investigation revealed deficiencies in the following areas: (1) fire and life safety; (2) housekeeping; (3) hygiene and infection control; and (4) chemical control.

1. The inadequate fire and life safety systems of the Jail pose an unreasonable risk of harm to prisoners.

MDCR fails to ensure adequate fire and life safety systems throughout the Jail, particularly in PTDC. We observed numerous deficiencies during our tour that endanger the life and safety of prisoners and staff. In the event of a fire, there are several areas of the Jail where

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[14] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-2009, http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2202 (August 2010).

[15] Id.

[16] Prison Rape Elimination Act of 2003, P.L. 108-79.

the sprinkler system would not activate or function properly because sprinkler heads were painted over or otherwise damaged. The lack of an operational sprinkler system greatly increases the risk of injury and death in a fire. For example: In PTDC East Wing Cell 2, all six sprinkler heads were non-functional because they had been recently painted over. In PTDC East Wing Cell 1, none of the sprinklers were operable because of paint coverings, parts missing, or cloth ropes tied to them. On PTDC's third, fifth, and seventh floors, sprinkler heads were covered with paint, or found to be inoperable for other reasons.

More fires occur in the laundry area of jails than in any other part of corrections facilities, and in PTDC, we observed a clothes dryer with no lint filter, resulting in a heavy lint accumulation behind the machine. In TGK, we observed a clothes dryer with a detached vent hose, blowing lint out behind and under the machine. Dryer lint is highly flammable and can cause a fire to spread rapidly.

In the event of a serious fire that requires an evacuation of prisoners from the facility, it is critical that the evacuation is conducted quickly, before toxic fumes begin to develop at the fire site. Therefore, in a jail setting, staff should be able to quickly access emergency keys that will unlock all doors along an evacuation route, including the final exit door to the outside of the building. Keys must be marked so as to be identifiable by sight and touch. However, within the Jail:

- *Inadequate Emergency Evacuation Key*: In WDC, we observed a corrections officer having difficulty locating the correct key to open the locked box containing the emergency evacuation key. When the officer did produce the key, it was not marked for identification by sight and touch.

- *Inadequate Emergency Evacuation Routes*: In PTDC, the evacuation route leads prisoners to the small enclosed recreation yard, but there is no access to the outside of the recreation yard away from the facility. Instead, an officer must unlock the recreation yard from the outside during an evacuation. This procedure creates an unacceptable risk of injury and death to prisoners and staff. In addition, several of the exit signs in PTDC were not properly marked and labeled.

When MDCR corrections officers working in control booths were asked about fire safety equipment such as the self-contained breathing apparatus ("SCBA"), on at least two occasions, the officers could not demonstrate how to properly determine air pressure in the SCBA, even though such tasks are required at the beginning and end of each shift by policy, and are supposed to be documented in log books. Our observations reveal that training is inadequate; log book documentation is of questionable veracity; and the officers are endangering prisoners (and themselves) by their lack of knowledge.

2. **The sanitation within the Jail is not reasonably adequate to provide minimal civilized standards of life's necessities.**

The level of cleanliness at the Jail is poor. While some facilities, such as WDC, are generally clean, other facilities are deplorable. During our site visit, the medical clinic area in MWDC was dangerously dirty. Bags of biohazardous materials and trash were stored in

hallways unsecured and unattended. The isolation cells in the clinic were filthy. One cell contained a bloody sheet that had not been removed from the bed. The floor behind the bed in the unit had a heavy accumulation of dirt, paper, and other debris. The other cell in the clinic contained a toilet that obviously had been continually used for some time despite a flushing malfunction.

PTDC, a nearly 50-year-old facility with structural deficiencies, such as cracked concrete and rusting metal, is difficult, if not impossible, to adequately clean. This is a serious issue because such surfaces collect dirt, dust, and debris which lead to bacterial growth, particularly in shower areas. Similarly, the age and condition of the Stockade make it difficult, if not impossible, to adequately clean. The construction of the Stockade includes concrete surfaces that cannot be adequately cleaned by normal cleaning methods, and the window openings are sealed with metal grating too small for normal cleaning equipment. As a result, dirt and grime build up on these sills and are carried into the unit on air currents. The Stockade units are said to be cleaned twice a year with a pressure washer, but the condition of the units we observed suggests that the power washing is ineffective or too infrequent.

In addition, the Stockade is infested with ants and rodents. Poor housekeeping contributes to the presence of these pests, which increases the risk of harm to the prisoners' health. We observed signs of insects and rodents throughout the facilities, including a heavy infestation of drain flies in shower and floor drains, particularly in TGK. Floor drains and shower drains throughout the facility had heavy accumulations of debris and organic matter, which serve as a food source and breeding site for drain flies. Outbreaks of adult flies have been associated with bronchial asthma in susceptible individuals. Their presence is a sign of inadequate housekeeping and sanitation.

TGK housekeeping also falls below constitutional standards. The TGK medical clinic was in need of immediate cleaning. We observed an ice machine in TGK with mold growth in the ice bin and an unapproved ice scoop made from a plastic jug lying on the ice. Molds and bacteria can thrive in the cold temperatures of an ice machine; therefore such machines should be emptied and cleaned regularly to prevent illness to those prisoners and staff consuming the ice.

In addition, improper storage, labeling, and use of cleaning chemicals in a corrections facility can lead to injuries to prisoners (as well as staff). During our tour, we observed unsafe and insecure storage of cleaning chemicals and spray bottles. Additionally, bulk containers were mislabeled or not labeled at all.

3. Hygiene and infection control are inadequate in the Jail, subjecting prisoners to an unreasonable risk of harm.

Communicable diseases may spread in areas where there is close skin-to-skin contact and where personal hygiene is compromised. Overcrowding in corrections facilities will compromise personal hygiene efforts due to the limited numbers of facility showers and sinks, and overburdened services such as laundry, maintenance, and food preparation. We observed overcrowding and the associated problems of personal hygiene.

- *MWDC Overcrowding*: MWDC, the newest of the five MDCR facilities, has a working capacity for 2,234 prisoners. MWDC was averaging approximately 2,700 prisoners at the time of our tour on June 9-13, 2008. The exact population on the day we toured MWDC was 2,691 prisoners. On that day, one entire unit was closed for shower repairs, further exacerbating the crowding issue.

- *PTDC Overcrowding*: In PTDC's 9-C wing, the mental health unit was over-populated by 62% during our tour on June 9-13, 2008.

In addition to overcrowding, improper attention to personal hygiene and biohazards are a major cause of the spread of diseases and infections in health care settings. We observed several medical exam rooms with no hand washing sinks or hand sanitizer dispensers on the wall. In addition:

- *Nonfunctional Negative Pressure Rooms*: The TGK medical unit contains six negative pressure rooms used for prisoners with serious respiratory diseases, such as tuberculosis. The negative air pressure in such rooms prevents aerosolized pathogens from escaping the patient's room into the hallway and other areas. Only one room was occupied, and when we tested the air pressure, it contained positive air pressure.

- *Unsecure Sharps*: In various medical clinics throughout the Jail, we observed containers for needles and other sharp objects ("sharps containers") not securely mounted or protected. In many cases, the containers are kept on the floor under desks or tables where they could be easily knocked over.

Further, proper maintenance of mattresses plays an important role in preventing the spread of diseases and infections in a corrections setting. Mattresses that are damaged or worn beyond their ability to be properly disinfected should be discarded. We observed dozens of mattresses in use or waiting to be issued to prisoners that should have been discarded.

Similar to the inadequate mattress maintenance, MDCR laundry procedures fail to protect prisoners from the risk of contagious diseases and infections. The laundry operation of the Jail consists of several laundry areas at each facility. There are no uniform policies, however, and the procedures, machines, chemicals, and schedules differ in each MDCR facility. Some MDCR facilities are employing domestic grade washers and dryers that not suitable for institutional use.

We observed that blankets were not washed for months at a time, and that most prisoner uniforms were washed once a week at best, but many prisoners went longer without clean clothing. This practice is unhygienic and can contribute to the spread of disease. Moreover, as a result of these laundering practices, prisoners at the Jail resort to washing their clothes in sinks and showers and hang the clothes on lines to dry. Such clothes lines create security and fire risks within correctional settings.

V. REMEDIAL MEASURES

As stated above, MDCR is deliberately indifferent to the constitutional deficiencies of its facilities and is engaging in the use of excessive force against Jail prisoners. We believe that the deficiencies discussed in this letter are directly tied to current operational standards which grossly fall below what is required by generally accepted correctional standards. The following remedial measures should be immediately implemented by MDCR to correct the constitutional deprivations outlined above. The remedial measures below are consistent with generally accepted correctional standards. We believe that adopting the following measures will remedy the constitutional deficiencies found in medical care, mental health care, prisoner violence, sanitation and environmental health, and the use of excessive force.

A. MENTAL HEALTH CARE AND SUICIDE PREVENTION

1. Suicide Prevention

Generally accepted professional standards of correctional mental health care mandate the development of a suicide prevention policy, including evaluation by a psychiatrist and development of a management plan. These standards require eight critical components of a suicide prevention policy: staff training, identification/screening, communication, housing, levels of observation/assessment, intervention, reporting, and follow-up/morbidity-mortality review.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Require corrections intake screening to include a specific inquiry from transporting officer regarding whether the incoming prisoner's behavior indicates that he/she is at risk of suicide.

- Cease denial of property and privileges to acutely mentally ill and suicidal prisoners unless clinically indicated.

- Ensure that adequate pre-service and annual in-service suicide prevention training is mandatory for all corrections officers, medical, and mental health staff. Ensure an adequate number of corrections, medical, and mental health staff to conduct multidisciplinary pre-service and annual in-service suicide prevention training and a system of prioritization for attendance in training classes.

- Provide a curriculum for pre-service and annual in-service suicide prevention training that includes an array of topics and mock drills, sufficient for staff to be adequately trained to identify and manage suicide risk.

- Ensure that decisions regarding clothing, bedding, and other property given to suicidal prisoners are made by clinical staff on a case-by-case basis.

- Ensure that each suicidal prisoner has a bed and does not have to sleep on the

floor.

- Provide quality private suicide risk assessments of suicidal prisoners on a daily basis.

- Ensure that staff does not retaliate against prisoners by sending them to suicide watch cells. Ensure that prisoners placed in suicide watch cells are appropriately placed there based on sound suicide risk assessments.

- Clarify MDCR's policy regarding levels of observation of suicidal prisoners (e.g., constant observation, 15-minute intervals checks, etc.) and ensure that corrections officers implement documented appropriate levels of observation.

- Implement treatment plans for suicidal prisoners that identify signs, symptoms, and preventive measures for suicide risk.

- Require adequate emergency intervention training for all staff that regularly interact with prisoners. Enforce a policy requiring corrections officers to initiate CPR if they are the first responders to suicide attempts.

- Ensure that cutdown tools are readily available to staff who may be first responders to suicide attempts.

- Conduct adequate multidisciplinary morbidity-mortality reviews of all suicides and serious suicide attempts (i.e., suicide attempts requiring hospitalization). A preliminary review should occur within 30 days of the incident, and a comprehensive review should occur within 30 days of the completion of a coroner's report.

2. **Mental Health Care Treatment**

Mental health treatment should comport with constitutional requirements and generally accepted standards of care to aid in classification, identification of emergent mental health care needs, provision of continuous care, and management of medication. An adequate correctional mental health system will commonly include the following: crisis intervention program, acute care program, chronic care program/special needs unit, outpatient treatment services, consultation services, discharge/transfer planning, therapy services, and dedicated rounds by mental health professionals.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Revise intake procedures and forms to adequately screen incoming prisoners for mental health issues and ensure timely access to mental health professionals when the prisoner is presenting symptoms requiring such care.

- Incorporate mental health screening results into prisoners' files and implement a

formal communication process between intake and classification staff.

- Ensure that all staff conducting intake screening are trained adequately, including regarding identification and assessment of suicide risk, and are given appropriate tasks and guidance.

- Ensure that intake screening is conducted in a setting that provides the privacy consistent with correctional security and which includes specific inquiry regarding whether an incoming prisoner is currently suicidal or has a history of suicidal behavior.

- Ensure that medical and mental health staff conducting screening incorporate the corrections screening information into their screening process.

- Ensure that all reasonable efforts are made to obtain a prisoner's prior mental health records and that this information, along with all MDCR screenings, is incorporated into prisoners' charts.

- Develop and implement policies and procedures to ensure prisoners with serious mental health needs receive timely treatment as clinically appropriate, in a clinically appropriate setting.

- Ensure crisis services and acute care in an appropriate therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling.

- Ensure that mental health staff conduct documented in-person assessments of prisoners prior to placement in a special management unit (segregation) and on regular intervals thereafter as is clinically appropriate.

- Ensure an inpatient level of care that is available to all prisoners who need it, including regular, consistent therapy and counseling.

- Provide adequate on-site psychiatry coverage and psychiatry support staff in order to timely address prisoners' serious mental health needs.

- Ensure that psychiatrists provide documented diagnoses of prisoners.

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

- Ensure that adequate psychotherapeutic medication administration is provided.

- Ensure that mental health care staff are able to access prisoner medical records that are up-to-date, accurate, and that contain all clinically appropriate information.

- Implement policies and procedures requiring that mental health staff review mentally ill prisoners' disciplinary charges to ensure that MDCR does not impose a significant disciplinary penalty on mentally ill prisoners for conduct that is symptomatic of the prisoner's mental illness.

- Ensure that MDCR's quality assurance program is adequately maintained to identify and correct deficiencies with the mental health care system.

- Provide outpatient treatment, including regular, consistent therapy and counseling, to general population prisoners who are on the mental health caseload.

- Provide discharge/transfer planning, including services for prisoners in need of further treatment at the time of transfer to another institution or discharge to the community. These services should include the following:

  a) arranging an appointment with mental health agencies for all prisoners with serious mental illness;

  b) providing referrals for prisoners with a variety of mental health problems;

  c) notifying reception centers at state prisons when mentally ill prisoners are going to arrive; and

  d) arranging with local pharmacies to have prisoners' prescriptions renewed.

3. Mental Health Care Housing Units

Generally accepted professional standards of correctional mental health care require that correctional facilities provide correctional mental health systems that allow prisoners to leave their cells for recreation, telephone calls, and visitation, unless prisoners are restricted by a physician's written orders.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Provide for appropriate housing for mental health care, including a chronic care and/or special needs unit for prisoners who cannot function in the general population.

- Provide an appropriate housing unit for suicidal prisoners, and allow those prisoners to leave their cells for recreation, showers, and mental health treatment as clinically appropriate.

- Remove suicide hazards from all areas housing suicidal prisoners or place all

suicidal prisoners on constant observation.

B. MEDICAL CARE

MDCR should not deny, significantly delay, or intentionally interfere with medical treatment to prisoners. To the contrary, MDCR should provide adequate medical care to prisoners in need of serious medical attention.

1. Acute Care

Generally accepted correctional medical standards require that incoming prisoners be screened by staff trained to identify and triage serious medical needs, including drug or alcohol withdrawal, communicable diseases, serious acute or chronic illnesses, mental illness, and potential suicide risks. In particular, screening for symptoms of drug or alcohol withdrawal must begin at the initial intake or booking process.

In addition to the initial intake screening, the initial health assessment of a prisoner is an important aspect of corrections health care. Adequate and timely health assessments are necessary for the appropriate treatment of those prisoners who present either acute or chronic needs during intake screening. Generally accepted correctional medical standards require that an initial health assessment be conducted within fourteen (14) days of admission, or sooner when medically necessary. Initial health assessments also provide a secondary screening process for the identification of serious medical needs, should the intake screening procedure fail to do so.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that adequate intake screening and health assessments are provided.
- Ensure that intake screening is conducted as soon as possible, no later than 24 hours after prisoners enter the Jail.
- Ensure that prisoners are not transferred from the intake area until an intake screening is completed.
- Ensure that trained medical care providers review on a daily basis the medical screening information of those prisoners whose screening indicates a need for medical care, to provide prisoners timely access to a physician as is clinically appropriate when presenting symptoms requiring medical care, with the physician assessment occurring no later than 14 days after intake.
- Ensure that prisoners' acute and chronic health needs are identified in order to provide adequate medical care.
- Ensure that appropriate drug or alcohol withdrawal screening is conducted for all prisoners immediately upon entering the Jail, and prisoners presenting symptoms of drug or alcohol withdrawal are immediately evaluated by trained medical care

professionals.

- Ensure that appropriate detoxification monitoring is conducted in an appropriate infirmary setting on prisoners identified as withdrawing from drugs or alcohol.

2. Access to Care

Generally accepted correctional medical standards require that facilities like those operated by MDCR maintain a system to track prisoner requests for medical care, to evaluate whether prisoners are medically assessed in response to their requests, and to identify those prisoners still in need of medical care after the request is made. Moreover, corrections facilities must provide appropriate policies and procedures to guide nursing staff on how to conduct sick-call assessments, and when to refer requests to higher levels of care.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that the medical request process for prisoners provides prisoners with adequate access to medical care. This process should include logging, tracking, and timely responses by medical staff as clinically appropriate.

- Ensure that trained medical professionals review medical requests on a daily basis.

- Ensure that medical/sick call requests are appropriately triaged based upon the seriousness of the medical issue.

- Provide timely medical appointments and follow-up medical treatment.

- Ensure that prisoners receive treatment that adequately addresses their serious medical needs.

- Ensure that prisoners receive acute care in a timely and appropriate manner.

3. Chronic Care

Generally accepted standards of correctional medical care require that medical staff identify detainees with chronic conditions such as diabetes, tuberculosis, and heart disease and provide timely treatment for such conditions. Jails should have an assessment process to adequately identify detainees with serious chronic medical conditions. Prisoners who suffer from chronic medical illnesses must be regularly monitored by medical professionals to prevent the progression of their illnesses.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Develop a chronic care program. This program should include the following:

a) a process that will identify prisoners who should be enrolled in a chronic care program;

b) a roster of prisoners enrolled in the program;

c) a schedule of medical visits for each prisoner enrolled in the program;

d) a system for determining which diagnostic tests will be required for each chronic condition; and

e) record-keeping which includes documentation of laboratory tests and medical orders.

- Ensure that prisoners receive thorough assessments for, and monitoring of, their chronic illnesses.

- Ensure that standard diagnostic tools are employed to administer the appropriate preventative care in a timely manner.

- Adopt and implement appropriate clinical guidelines for chronic diseases such as HIV, hypertension, diabetes, and policies and procedures on, inter alia, timeliness of access to medical care, continuity of medication, infection control, medicine dispensing, intoxication/detoxification, record-keeping, disease prevention, and special needs.

- Ensure that the medical staff is adequately trained to identify prisoners in need of immediate or chronic care, and provide timely treatment or referrals for such prisoners.

- Ensure that prisoners with chronic conditions are routinely seen by a physician as clinically appropriate, to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.

4. **Medical Record Keeping**

A critical component in providing adequate medical care is a complete, accurate, readily accessible, and systematically organized medical records system. In a correctional setting, inaccurate or incomplete record keeping places prisoners at risk of serious harm.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that medical records are adequate to assist in providing medical care and managing the medical care needs of prisoners. Medical records must be complete, accurate, legible, readily accessible, and systematically organized.

- Ensure that all clinical encounters and reviews of prisoners are documented in the prisoners' records.

- Ensure that specialty consultations are timely and that any resulting reports are forwarded to medical staff. Specialist recommendations should be implemented in a timely manner or, where deemed inappropriate, a physician should properly document why such recommendations were not followed.

5. Quality Assurance

Correctional facilities benefit from having an adequate quality assurance process. Quality assurance is a basic component of clinical practice that is consistent with generally accepted correctional medical standards.

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Develop and implement an adequate mortality review system.

- Ensure that the Jail's quality assurance system is adequate to identify and correct serious deficiencies with the medical system.

C. USE OF EXCESSIVE FORCE

Force used should not be disproportionate to the threat posed by the prisoner. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

Our investigation identified a pattern and practice of excessive force employed by MDCR corrections officers against prisoners. In a correctional facility, an effective way to remedy a pattern or practice of use of excessive force is to address the deficiencies in the areas of policies and procedures, training, and accountability. Improvement in these areas will have the most impact on MDCR in reducing uses of excessive force.

1. Policies and Procedures

Adequate policies and procedures regarding the appropriate use of force are essential to ensuring that prisoners are not unnecessarily injured by corrections officers and corrections officers are not unnecessarily injured engaging with prisoners. The policies should be comprehensive, clear, up-to-date, and reflect current generally accepted correctional standards. We found that while MDCR's use of force policy is generally adequate as written, most officers were unfamiliar with the policy. Well-trained corrections officers should be able to articulate clearly and without hesitation the level of prisoner resistance necessary for any use of force, as an appropriate response to restore and maintain order.

To this end, MDCR should implement the following policy measures to correct the constitutional deprivations:

- Expressly prohibit the use of force as a response to verbal insults or prisoner threats.

- Expressly prohibit the use of force as a response to prisoners' failure to follow instructions where there is no immediate threat to the safety of the institution, prisoners, or staff, unless corrections officers have attempted a hierarchy of documented nonphysical alternatives.

- Expressly prohibit the use of force as punishment.

- Expressly prohibit the use of punching and slapping to the head, absent exigent circumstances.

- Develop and implement policies and procedures for the effective and accurate maintenance, inventory and assignment of OC spray and other security equipment.

2. Training

Use of force training is an essential tool for a corrections facility to ensure that officers are employing force in a manner consistent with generally accepted correctional standards, and not engaging in excessive force. Generally accepted correctional standards require that corrections officers receive annual refresher use of force training courses.

To this end, MDCR should implement the following training measures to correct the constitutional deprivations:

- Develop an effective and comprehensive training program in the appropriate use of force.

- Ensure that annual refresher training is provided to all MDCR officers.

- Ensure that staff receive adequate competency-based training in MDCR use of force policies and procedures.

- Ensure that staff receive adequate competency-based training in use of force and defensive tactics.

- Ensure that MDCR Internal Affairs management and staff receive adequate competency-based training in conducting investigations of allegations of excessive force.

3. Accountability

Generally accepted corrections standards require a process of reporting, administrative review, and investigation of each use of force. This process facilitates the determination of several critical questions, including: (1) whether criminal activity has occurred; (2) whether facility procedures have been followed; (3) whether remedial training is necessary; (4) whether review or change in policies is required; and (5) whether the incident is part of a larger trend. We found that MDCR is underreporting incidents and producing use of force reports that are frequently inaccurate or incomplete.

To this end, MDCR should implement the following accountability measures to correct the constitutional deprivations:

- Ensure that staff adequately and promptly (within 24 hours) report all uses of force.
- Ensure that management review of incident reports, use of force reports, and prisoner grievances alleging excessive or inappropriate uses of force includes a timely review of medical records of prisoner injuries as reported by medical professionals.
- Ensure that incident reports, use of force reports and prisoner grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, that it is referred for investigation.
- Develop and implement an adequate system of tracking and reviewing use of force incidents by MDCR officers. The system should be capable of identifying patterns and trends that can be addressed through training, administrative, or disciplinary measures.

D. PRISONER VIOLENCE

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

To this end, MDCR should implement the following measures to correct the constitutional deprivations:

- Ensure that corrections officer staffing and supervision levels are appropriate to adequately supervise prisoners.
- Ensure frequent, irregularly timed, and documented security rounds by corrections officers inside each housing unit.
- Ensure that staff adequately and promptly report incidents involving prisoner violence.

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

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

- Develop and implement appropriate training for corrections staff addressing security administration and providing for proficiency training.

- Develop a plan to reduce and prevent overcrowding, most immediately the triple-bunking of prisoners in cells designed for two prisoners.

- Develop and implement policies and procedures for an appropriate, objective classification system that separates prisoners in housing units by classification levels in order to protect prisoners from unreasonable risk of harm.

E. FIRE SAFETY AND ENVIRONMENTAL HEALTH

Generally accepted correctional standards require adequate sanitation and environmental health conditions, such as proper fire safety systems, sanitation, and hygienic materials and utilities. In order to cure its pattern or practice of inadequate sanitation and environmental conditions, the Jail should ensure that the facilities' conditions do not pose serious risks to prisoners' health and safety. To that end, MDCR should implement the following measures to correct the constitutional deprivations:

1. Fire Safety

- Ensure that all facilities have adequate fire and life safety equipment that is properly maintained and inspected.

- Implement competency-based testing for staff regarding fire/emergency procedures. Train and drill staff in use of fire safety equipment.

- Ensure that emergency keys are appropriately marked and consistently stored in a quickly accessible location.

- Ensure that fire alarms and sprinkler systems are installed and adequately maintained in all housing areas.

- Develop and implement policies and procedures for the control of chemicals in the facility, and supervision of prisoners who have access to these chemicals.

2. **Sanitation**

- Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.

- Ensure prompt and proper maintenance of shower, toilet, and sink units.

- Ensure that medical areas are adequately cleaned and maintained, including negative pressure rooms. Ensure that hand washing stations in medical areas are fully equipped, operational, and accessible.

- Ensure proper ventilation and airflow in all cells and housing units.

- Develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials.

- Secure all sharp medical tools.

- Destroy any mattress that cannot be sanitized sufficiently to kill any possible bacteria. Inspect and replace as often as needed all frayed and cracked mattresses.

- Ensure adequate pest control, including sufficient staffing for routine and follow-up pest control services.

3. Hygiene

- Ensure that laundry procedures protect prisoners from exposure to contagious disease, bodily fluids, and pathogens. Develop and implement a policy for handling, washing, and drying of laundry. Train staff and educate prisoners regarding laundry sanitation policies.

* * * * * * *

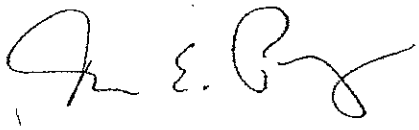
Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. As a matter of courtesy, we will not post this letter to the website until five calendar days from the date of this letter. We will also provide a copy of this letter to any individual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

We hope to continue working with the County officials in an amicable and cooperative fashion to resolve our outstanding concerns regarding the Miami-Dade County Jail. Since we toured, MDCR has reported that the Jail has adopted a number of improvements, many of which appear to be designed to address issues raised at the conclusion of our site visits. We appreciate the Jail's proactive efforts. Nonetheless, the deficiencies we identified are serious and systemic, and we anticipate that a court-enforceable agreement will be necessary to remedy them.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct the deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve all matters by working cooperatively with you and are confident that we will be able to do so in this case. The attorneys assigned to this investigation will be contacting the County's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please contact Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,



Thomas E. Perez
Assistant Attorney General

cc: R.A. Cuevas, Jr.
County Attorney
Miami-Dade County

Robert Duvall
Assistant County Attorney
Miami-Dade County

The Honorable Joe A. Martinez
Chair, Board of County Commissioners
Miami-Dade County

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Miami-Dade County

The Honorable Wifredo A. Ferrer
United States Attorney
Southern District of Florida

MIAMI-DADE COUNTY JAIL
SETTLEMENT AGREEMENT

TABLE OF CONTENTS

I. INTRODUCTION AND BACKGROUND

1. This Settlement Agreement ("Agreement") is among and between the United States Department of Justice ("DOJ"); Miami-Dade County; and the Board of County Commissioners of Miami-Dade County, the governing body of Miami-Dade County, a political subdivision of the State of Florida, which operates the County Jail by and through the Miami-Dade County Corrections and Rehabilitation Department ("MDCR") (collectively referred to as "County") to remedy the alleged constitutional violations at the Miami-Dade County Jail identified in the findings letter that the United States issued on August 24, 2011 ("Findings Letter").

2. The MDCR operates correctional facilities in Miami, Florida (collectively known as "MDCR Jail facilities" or "the Jail") and is responsible for providing care, custody, and control of inmates. The Jail currently consists of 6 corrections facilities and currently houses approximately 5,200 inmates in a complex of buildings spread out across the county, below the design capacity of 5,845. The MDCR Jail facilities are an integral part of the public safety system in Miami-Dade County, Florida.

3. On April 2, 2008, the DOJ notified Miami-Dade County officials of its intention to investigate conditions at the MDCR Jail facilities, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. The DOJ toured the MDCR Jail facilities with consultants in the fields of corrections, medical and mental health care, suicide prevention, fire safety and environmental health and safety on June 9 – 13 and June 16 – 20, 2008, and on April 7 – 8, 2009.

4. On August 24, 2011, the DOJ issued a Findings Letter, pursuant to 42 U.S.C. § 1997 (a) (1), which concluded that certain conditions in the MDCR Jail facilities violated the constitutional rights of inmates, and recommended remedial measures. Under a cover letter dated September 27, 2011, the County provided to DOJ substantial documentation of changes and measures implemented at the MDCR Jail facilities since the time of the DOJ inspections. On October 4, 2011, County representatives met with DOJ in Washington, D.C., to discuss the aforementioned documentation of remedial measures undertaken by MDCR.

5. At the request of MDCR, the DOJ conducted an additional tour of the MDCR Jail facilities with consultants on November 30 – December 2, 2011. Based upon this inspection, the DOJ concluded that some of the violations identified in its Findings Letter were improved, while other conditions still warranted remedial efforts to be fully implemented.

6. Throughout the course of the investigation and inspection of the MDCR Jail facilities, the DOJ received complete cooperation from the County and unfettered access to all facilities, documents and staff. In addition, DOJ acknowledges that the County made significant improvements in many areas of Jail operations and the physical plant since its initial Jail

tours in 2008. This Agreement is the result of a cooperative effort that evinces a commitment to constitutional conditions at the MDCR Jail facilities on the part of the United States and the County. Through the provisions of this Agreement, the Parties seek to avoid the risks and burdens of litigation while ensuring that the conditions in the Jail are constitutional so as to respect the rights of inmates and provide for the safety of staff.

7. This Agreement only addresses provisions regarding protection from harm, fire and life safety, and inmate grievances. A separate Consent Agreement between the United States, the County and its entities, and the Public Heath Trust address medical care, mental health care, and suicide prevention.

8. This Agreement neither constitutes an admission by the County of the truth of the findings contained in the Findings Letter, nor constitutes an admission of liability by the County. Any of the deficiencies, risks, or breach intimated by the language of this Agreement, expressed or implied, are disclaimed by the County. The County enters into this Agreement because it is firmly committed to providing constitutionally and legally compliant conditions in the Jail by effectuating its duties under the Constitution and other applicable law. The County demonstrated this commitment not only by entering into this Agreement but also by pursuing accreditation and auditing by professional correctional organizations, with several of its facilities having achieved accreditation by American Correctional Association and Florida Corrections Accreditation Commission, as well as system-wide compliance with the Florida Model Jail Standards.

9. No person or entity is intended to be a third-party beneficiary of this Agreement for purposes of any civil, criminal, or administrative action. Accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Agreement. This Agreement is not intended to impair or expand the right of any person or entity to seek relief against the County or its officials, employees, or agents, for their conduct. This Agreement is not intended to alter legal standards governing any such claims.

II. DEFINITIONS

1. "Compliance" is discussed throughout this Agreement in the following terms: substantial compliance, partial compliance, and non-compliance. "Substantial Compliance" indicates that MDCR has achieved compliance with most or all components of the relevant provision of the Agreement. "Partial Compliance" indicates that MDCR achieved compliance on some of the components of the relevant provision of the Agreement, but significant work remains. "Non-compliance" indicates that MDCR has not met most or all of the components of the Agreement.

2. "Effective Date" means the date this Agreement is signed by the parties.

3. "Include" or "including" means "include, but not be limited to" or "including, but not limited to."

4. "Inmates" or "Inmate" broadly refers to one or more individuals detained at, or otherwise housed, held, in the custody of, or confined in the Jail.

5. "Jail " refers to all correctional facilities operated by the Miami-Dade County Corrections and Rehabilitation Department and includes: the Pre-Trial Detention Center ("PTDC"); the Women's Detention Center ("WDC"); the Training and Treatment Center ("Stockade"); the Turner Guilford Knight Correctional Center ("TGK"); the Metro West Detention Center ("MWDC"), and any facility that is built, leased, or otherwise used, to replace or supplement the current MDCR Jail facilities, including the anticipated correctional mental health facility ("Mental Health Treatment Facility"). Additionally, MDCR operates a boot camp program, with a housing facility adjacent to TGK ("Boot Camp").

6. "MDCR" refers to Miami-Dade Corrections and Rehabilitation Department. (See the definition for "Jail").

7. "Monitor" means the individual(s) selected to oversee implementation of the Agreement.

8. "Qualified Health Care Professionals" and "Qualified Medical Staff" refer to Qualified Medical Professionals and Qualified Nursing Staff, as well as other Qualified Health Care Professional staff providing services within the scope of their practice, licensure, training, supervision and qualifications.

9. "Special Management Units" mean those housing units of the Jail designated for inmates in administrative or disciplinary segregation, in protective custody, on suicide precautions, or with mental illness.

10. "Sustain Implementation" means to achieve a prolonged and continuous practice.

11. "Train" means to instruct in the skills addressed to a level that the trainee has demonstrated proficiency. "Trained" means to have achieved such proficiency in the skills and to implement those skills regularly. The majority of training shall be in person, with online training functioning as a supplement rather than a stand–alone option. The County will document and track training of all staff.

12. "Use of force" means the application of physical or mechanical measures to compel compliance by a subject. "Use of force" shall include all force except un-resisted handcuffing or un-resisted shackling of inmates for movement purposes.

III. SUBSTANTIVE PROVISIONS

The County shall take all actions necessary to comply with the substantive provisions of this Agreement detailed below. Compliance with the Agreement will be measured both by whether the technical provisions are implemented and whether the conditions of confinement in the Jail meet the requirements of the United States Constitution.

A. PROTECTION FROM HARM

Consistent with constitutional standards, the MDCR Jail facilities shall provide inmates with a reasonably safe and secure environment to ensure that they are protected from harm. MDCR shall ensure that inmates are not subjected to unnecessary or excessive force by the MDCR Jail facilities' staff and are protected from violence by other inmates. The MDCR Jail facilities' efforts to achieve this constitutionally required protection from harm will include the following remedial measures regarding: (1) Safety and Supervision; (2) Security Staffing; (3) Sexual Misconduct; (4) Incidents and Referrals (5) Use of Force by Staff; and (6) Early Warning System.

1. Safety and Supervision

a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including:

(1) Maintain implemented security and control-related policies, procedures, and practices that will ensure a reasonably safe and secure environment for all inmates and staff, in accordance with constitutional standards.

(2) Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs.

(3) Develop and implement a policy requiring correctional officers to conduct documented rounds, at irregular intervals, inside each housing unit, to ensure periodic supervision and safety. In the alternative, MDCR may provide direct supervision of inmates by posting a correctional officer inside the day room area of a housing unit to conduct surveillance.

(4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.

(5) MDCR shall document an objective risk analysis of maximum security inmates before placing them in housing units that do not have direct supervision or video monitoring, which shows that these inmates have no greater risk of violence toward inmates than medium security inmates. MDCR shall continue to increase the use of overhead video surveillance and recording cameras to provide adequate coverage and video monitoring throughout all Jail facilities to include:

i. PTDC – 24 safety cells, by July 1, 2013
ii. PTDC – 10B disciplinary wing, by December 31, 2013; kitchen, by Jan. 31, 2014;
iii. Women's Detention Center – kitchen, by Sept. 30, 2014;
iv. Training and Treatment Center - all inmate housing units areas and kitchen, by Apr. 30, 2014;
v. Turner Guilford Knight Correctional Center – kitchen; future intake center; by May 31, 2014; and
vi. Metro West Detention Center – throughout all areas; by Aug. 31, 2014.

(6) In addition to continuing to implement documented half-hour welfare checks pursuant to the "Inmate Administrative and Disciplinary Confinement" policy (DSOP 12.002), for the PTDC safety cells, MDCR shall implement an automated welfare check system by July 1, 2013. MDCR shall ensure that correctional supervisors periodically review system downloads and take appropriate action with officers who fail to complete required checks.

(7) Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.

(8) MDCR shall maintain a policy ensuring that security staff conduct sufficient searches of cells to ensure that inmates do not have access to dangerous contraband, including at least the following:

i. random daily visual inspections of four to six cells per housing area or cellblock;
ii. random daily inspections of common areas of the housing units;
iii. regular daily searches of intake cells; and
iv. periodic large scale searches of entire housing units.

(9) MDCR shall require correctional officers who are transferred from one facility to a facility in another division to attend training on

facility-specific safety and security standard operating procedures within 30 days of assignment.

(10) Correctional officers assigned to special management units, including disciplinary segregation and protective custody, shall receive eight hours of specialized training for working on that unit on at least an annual basis.

(11) MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively.

2. Security Staffing

Correctional staffing and supervision must be sufficient to adequately supervise incidents of inmate violence, including sexual violence, fulfill the terms of this Agreement, and allow for the safe operation of the Jail, consistent with constitutional standards. MDCR shall achieve adequate correctional officer staffing in the following manner:

a. Within 150 days of the Effective Date, MDCR shall conduct a comprehensive staffing analysis and plan to determine the correctional staffing and supervision levels necessary to ensure reasonable safety. Upon completion of the staffing plan and analysis, MDCR will provide its findings to the Monitor for review. The Monitor will have 30 days to raise any objections and recommend revisions to the staffing plan.

b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.

c. MDCR shall staff the facility based on full consideration of the staffing plan and analysis, together with any recommended revisions by the Monitor. The parties shall agree upon the timetable for the hiring of any additional staff.

d. Every 180 days after completion of the first staffing analysis, MDCR shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If the level of staffing is inadequate, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.

3. Sexual Misconduct

MDCR will develop and implement policies, protocols, trainings, and audits consistent with the requirements of the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601, *et seq.*, and its implementing regulations, including those related to the prevention, detection, reporting, investigation, data collection of sexual abuse, including inmate-on-inmate and staff-on-inmate sexual abuse, sexual harassment, and sexual touching.

4. Incidents and Referrals

a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to take action in a timely manner to prevent additional harm to inmates or take other corrective action. At a minimum, MDCR shall document all reportable incidents by the end of each shift, but no later than 24 hours after the incident. These incidents should include inmate fights, rule violations, inmate injuries, suicide attempts, cell extractions, medical emergencies, contraband, destruction of property, escapes and escape attempts, and fires.

b. Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.

c. MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information:

(1) unique tracking number;

(2) inmate(s) name;

(3) housing classification;

(4) date and time;

(5) type of incident;

(6) any injuries to staff or inmate;

(7) any medical care;

(8) primary and secondary staff involved;

(9) reviewing supervisor;

(10) any external reviews and results;

(11) corrective action taken; and

(12) administrative sign-off.

d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria.

e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.

f. MDCR shall continue to train all corrections officers to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises.

5. Use of Force by Staff

a. Policies and Procedures

(1) MDCR shall sustain implementation of the "Response to Resistance" policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR's bi-annual reports.

(2) MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports.

(3) The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility's Executive Officer's review.

b. Use of Restraints

(1) MDCR shall revise the "Recognizing and Supervising Mentally Ill Inmates" policy regarding restraints (DSOP 12-005) to include the following minimum requirements:

i. other than restraints for transport only, mechanical or injectible restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.

ii. four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions.

iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior.

iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate.

v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.

vi. any standing order for an inmate's restraint is prohibited.

(2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.

c. Use of Force Reports

(1) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.

(2) MDCR shall ensure that use of force reports:

i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;

ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;

iii. contain an accurate account of the events leading to the use of force incident;

iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;

v. are accompanied with any inmate disciplinary report that prompted the use of force incident;

vi. state the nature and extent of injuries sustained both by the inmate and staff member;

vii. contain the date and time any medical attention was actually provided;
viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.

(3) MDCR shall require initial administrative review by the facility supervisor of use of force reports within three business days of submission..The Shift Commander/Shift Supervisor or designee shall ensure that prior to completion of his/her shift, the incident report package is completed and submitted to the Facility Supervisor/Bureau Commander or designee.

(4) The Facility Supervisor/Bureau Commander or his/her designee shall submit the MDCR Incident Report (with required attachments) and a copy of the Response to Resistance Summary (memorandum) to his/her Division Chief within 14 calendar days. If the MDCR Incident Report and the Response to Resistance Summary (memorandum) are not submitted within 14 calendar days, the respective Facility Supervisor/Bureau Commander or designee shall provide a memorandum to his/her Division Chief explaining the reason(s) for the delay.

(5) The Division Chief shall review use of force reports, to include a review of medical documentation of inmate injuries, indicating possible excessive or inappropriate uses of force, within seven business days of submission, excluding weekends. The Division Chief shall forward all original correspondences within seven business days of submission, excluding weekends to Security and Internal Affairs Bureau.

(6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. This criteria should include documented or known injuries that are extensive or serious; injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); injuries that require treatment at outside hospitals; staff misconduct; complaints by the inmate or someone reporting on his/her behalf, and occasions when use of force reports are inconsistent, conflicting, or suspicious.

(7) Security supervisors shall continue to ensure that photographs are taken of all involved inmates promptly following a use of force incident, to show the presence of, or lack of, injuries. The photographs will become evidence and be made part of the use of force package and used for investigatory purposes.

(8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.

(9) Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, the Jail shall initiate personnel actions and systemic remedies, including an IA investigation and report. MDCR shall discipline any correctional officer with any sustained findings of the following:

i. engaged in use of unnecessary or excessive force;
ii. failed to report or report accurately the use of force; or
iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or
iv. interfered with an internal investigation regarding use of force.

(10) The Jail will ensure that inmates receive any required medical care following a use of force.

(11) Every quarter, MDCR shall review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment; a random sampling of at least 10% of uses of force where an injury to the inmate was medically treated at the Jail; and a random sampling of at least 5% of uses of force that did not require medical treatment.

(12) Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy.

(13) MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.

(14) MDCR shall continue its efforts to reduce excessive or otherwise unauthorized uses of force by each type in each of the Jail's facilities annually. If such reduction does not occur in any given year, MDCR shall demonstrate that its systems for preventing, detecting, and addressing unauthorized uses of force are operating effectively.

d. Use of Force Training

(1) Through use of force pre-service and in-service training programs for correctional officers and supervisors, MDCR shall ensure that all correctional officers have the knowledge, skills, and abilities to comply with use of force policies and procedures.

(2) At a minimum, MDCR shall provide correctional officers with pre-service and biennial in-service training in use of force, defensive tactics, and use of force policies and procedures.

(3) In addition, MDCR shall provide documented training to correctional officers and supervisors on any changes in use of force policies and procedures, as updates occur.

(4) MDCR will randomly test at least 5% of the correctional officer staff annually to determine their knowledge of the use of force policies and procedures. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices or frequency. MDCR will document the review and conclusions and provide it to the Monitor.

e. Investigations

(1) MDCR shall sustain implementation of comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.

(2) MDCR shall revise its "Complaints, Investigations & Dispositions" policy (DSOP 4-015) to ensure that all internal investigations include timely, thorough, and documented interviews of all relevant staff and inmates who were involved in, or witnessed, the incident in question.

i. MDCR shall ensure that internal investigation reports include all supporting evidence, including witness and participant statements, policies and procedures relevant to the incident, physical evidence, video or audio recordings, and relevant logs.

ii. MDCR shall ensure that its investigations policy requires that investigators attempt to resolve inconsistencies between witness statements, i.e. inconsistencies between staff and inmate witnesses.

iii. MDCR shall ensure that all investigatory staff receives pre-service and in-service training on appropriate investigations policies and procedures, the investigations tracking process, investigatory interviewing techniques, and confidentiality requirements.

iv. MDCR shall provide all investigators assigned to conduct investigations of use of force incidents with specialized training in investigating use of force incidents and allegations, including training on the use of force policy.

6. Early Warning System

a. Implementation

(1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative

staff shall have access to this information and monitor the occurrences.

(2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit.

(3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level.

(4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below.

(5) The EWS will analyze the data according to the following criteria:

i. number of incidents for each data category by individual officer and by all officers in a housing unit;
ii. average level of activity for each data category by individual officer and by all officers in a housing unit;
iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and
iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).

b. MDCR will provide to DOJ and the Monitor, within 180 days of the implementation date of its EWS, and on a bi-annual basis, a list of all staff members identified through the EWS, and any corrective action taken.

c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.

B. FIRE AND LIFE SAFETY

MDCR shall ensure that the Jail's emergency preparedness and fire and life safety equipment are consistent with constitutional standards and Florida Fire Code standards. To protect inmates from fires and related hazards, MDCR, at a minimum, shall address the following areas:

1. Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.

2. MDCR shall ensure that fire alarms and sprinkler systems are properly installed, maintained, and inspected. MDCR shall document these inspections.

3. Within 120 days of the Effective Date, emergency keys shall be appropriately marked and identifiable by sight and touch and consistently stored in a quickly accessible location; MDCR shall ensure that staff are adequately trained in the location and use of these emergency keys.

4. Comprehensive fire drills shall be conducted every three months on each shift. MDCR shall document these drills, including start and stop times and the number and location of inmates who were moved as part of the drills.

5. MDCR shall sustain its policies and procedures for the control of chemicals in the Jail, and supervision of inmates who have access to these chemicals.

6. MDCR shall provide competency-based training to correctional staff on proper use of fire and emergency equipment, at least biennially.

C. INMATE GRIEVANCES

MDCR shall provide inmates with an updated and recent inmate handbook and ensure that inmates have a mechanism to express their grievances and resolve disputes. MDCR shall, at a minimum:

1. Ensure that each grievance receives follow-up within 20 days, including responding to the grievant in writing, and tracking implementation of resolutions.

2. Ensure the grievance process allows grievances to be filed and accessed confidentially, without the intervention of a correctional officer.

3. Ensure that grievance forms are available on all units and are available in English, Spanish, and Creole. MDCR shall ensure that illiterate inmates, inmates who speak other languages, and inmates who have physical or cognitive disabilities have an adequate opportunity to access the grievance system.

4. Ensure priority review for inmate grievances identified as emergency medical or mental health care or alleging excessive use of force.

5. Ensure management review of inmate grievances alleging excessive or inappropriate uses of force includes a review of any medical documentation of inmate injuries.

6. A member of MDCR Jail facilities' management staff shall review the grievance tracking system quarterly to identify trends and systemic areas of concerns. These reviews and any recommendations will be documented and provided to the Monitor and the United States.

D. AUDITS AND CONTINUOUS IMPROVEMENT

1. Self Audits

MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.

a. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information:

(1) documented or known injuries requiring more than basic first aid;

(2) injuries involving fractures or head trauma;

(3) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.);

(4) injuries that require treatment at outside hospitals;

(5) self-injurious behavior, including suicide and suicide attempts;

(6) inmate assaults; and

(7) allegations of employee negligence or misconduct.

b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.

2. Bi-annual Reports

a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:

(1) Total number of inmate disciplinary reports

(2) Safety and supervision efforts. The report will include:

i. a listing of maximum security inmates who continue to be housed in dormitory settings;

ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and

iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.

(3) Staffing levels. The report will include:

i. a listing of each post and position needed at the Jail;

ii. the number of hours needed for each post and position at the Jail;

iii. a listing of correctional staff hired to oversee the Jail;

iv. a listing of correctional staff working overtime; and

v. a listing of supervisors working overtime.

(4) Reportable incidents. The report will include:

i. a brief summary of all reportable incidents, by type and date;

ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;

iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;

iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;

v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;

vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and

vii. number of grievances referred to IA for investigation.

b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.

IV. COMPLIANCE AND QUALITY IMPROVEMENT

A. Within 180 days of the Effective Date, the County shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County shall send any newly-adopted and revised policies and procedures to the Monitor and DOJ for review and approval as they are promulgated. MDCR shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County shall document employee review and training in policies and procedures.

B. The County shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in protection from harm

and fire and life safety to assess and ensure compliance with the terms of this Agreement on an ongoing basis.

C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and DOJ for review any changed policies and procedures.

D. The Monitor may review and suggest revisions on MDCR policies and procedures on protection from harm and fire and life safety, including currently implemented policies and procedures, to ensure such documents are in compliance with this Agreement.

V. REPORTING REQUIREMENTS AND RIGHT OF ACCESS

A. The County shall submit compliance reports to the DOJ and the Monitor every six months, the first of which shall be submitted within 180 days of the Effective Date. Thereafter, these compliance reports shall be submitted 15 days after the termination of each 180 day period thereafter until the Agreement is terminated. The report shall summarize audits and continuous improvement and quality assurance activities and contain findings and recommendations that would be used to track and trend data compiled at the Jail. The report shall also capture data that is tracked and monitored outlined in "Substantive Provisions" (Section III.) of this Agreement.

B. Each compliance report shall describe the actions the County has taken during the reporting period to implement this Agreement and shall make specific reference to the Agreement provisions being implemented.

C. The County shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to DOJ for inspection and copying. In addition, the County shall maintain, and provide upon request, all records or other documents to verify that they have taken such actions as described in their compliance reports (e.g., census summaries, policies, procedures, protocols, training materials, investigations, and incident reports).

D. The County shall promptly notify the Monitor and DOJ upon the death or serious suicide attempt of any inmate. The County shall forward to the Monitor and DOJ incident reports and medical and/or mental health reports related to deaths, autopsies, and/or death summaries of inmates as well as all final Internal Affairs Division investigations reports that involve inmates.

E. DOJ and its attorneys, consultants, and agents shall have unrestricted access to the Jail, inmates, staff and documents as reasonably necessary to address issues affected by this Agreement.

F. Within 45 days of receipt of written questions from DOJ concerning the County's compliance with the requirements of this Agreement, the County shall provide DOJ with written answers and any requested documents.

G. The County shall appoint a full-time compliance coordinator to oversee compliance with this Agreement and to serve as a point of contact.

VI. MONITORING

A. Monitor Selection: The Parties agree to use the same Monitor selected/appointed under the Consent Agreement, referenced in Section I.7., to oversee implementation of this Agreement. Neither Party, nor any employee or agent of either Party, shall have any supervisory authority over the Monitor's activities, reports, findings, or recommendations. The cost for the Monitor's fees and expenses shall be borne by the County. The selection of the Monitor shall be conducted solely pursuant to the procedures set forth in this Agreement, and will not be governed by any formal or legal procurement requirements. The Monitor may be terminated only for good cause, unrelated to the Monitor's findings or recommendations.

B. Monitor Qualifications: The Monitor and his or her staff shall have experience and education or training related to the subject areas covered in this Agreement.

C. Monitoring Team: The Monitor may hire or consult with such additional qualified staff as necessary to fulfill the duties required by the Agreement ("Monitoring Teams"). The Monitor is ultimately responsible for the findings regarding compliance. The Monitoring Teams will be subject to all the same access rights and confidentiality limitations as the Monitor. The Parties reserve the right to object for good cause to members of the Monitoring Teams.

D. Monitor Access: The Monitor shall have full and complete access to the Jail, staff and inmates, and all Jail records. The County shall direct all employees to cooperate fully with the Monitor. All non-public information obtained by the Monitor shall be maintained in a confidential manner.

E. Monitor Ex Parte Communications: In monitoring the implementation of this Agreement, the Monitor shall maintain regular contact with MDCR and DOJ. The Monitor shall be permitted to initiate and receive ex parte communications with all Parties.

F. Limitations on Public Disclosures by the Monitor: Except as required or authorized by the terms of this Agreement or the Parties acting together, the Monitor shall not make any

public statements (at a conference or otherwise) or issue findings, except as required under paragraph G, *infra*, with regard to any act or omission of MDCR or its agents, representatives or employees. Any press statement made by the Monitor regarding the monitoring of this Agreement or his or her employment as Monitor must first be approved in writing by all Parties. The Monitor shall not testify in any other litigation or proceeding with regard to any act or omission of the County or any of their agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement. Reports issued by the Monitor shall not be admissible against the County in any proceeding other than a proceeding related to the enforcement of this Agreement by the County or DOJ. Unless such conflict is waived by the Parties, the Monitor shall not accept employment or provide consulting services that would present a conflict of interest with the Monitor's responsibilities under this Agreement. Neither the Monitor nor any person or entity hired or otherwise retained by the Monitor to assist in furthering any provision of this Agreement shall be liable for any claim, lawsuit or demand arising out of the Monitor's performance pursuant to this Agreement.

G. Monitor's Reports: The Monitor shall provide the Parties reports describing the steps taken by the County to implement this Agreement and evaluate the extent to which Defendants have complied with each substantive provision of the Agreement. The Monitor's Reports shall indicate a compliance rating for each provision and provide recommendations for achieving compliance with any provisions not in compliance at the time of the Report. The Monitor shall issue an initial report 120 days after the Effective Date, and then every 180 days thereafter. The reports shall be provided to the Parties in draft form for comment at least 15 business days prior to their issuance. These reports shall be written with due regard for the privacy interests of individual inmates and staff.

H. Compliance Assessments: In the Monitor's report, the Monitor shall evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) Partial Compliance, and (3) Non-compliance. To assess compliance, the Monitor shall review a sufficient number of pertinent documents to accurately assess current conditions; interview all necessary staff; and interview a sufficient number of inmates to accurately assess current conditions. The Monitor shall be responsible for independently verifying representations from the County regarding progress toward compliance, including the examination of supporting documentation. Each Monitor's report shall describe the steps taken by each member of the Monitoring Team to analyze conditions and assess compliance, including documents reviewed and individuals interviewed, and the factual basis for each of the Monitor's findings.

I. Monitor's Budget: The County shall provide the Monitor with a budget sufficient to allow the Monitor to carry out the responsibilities described in this Agreement. The Monitor shall pay the members of the Monitoring Team out of this budget.

J. Technical Assistance by the Monitor: The Monitor shall provide the County with technical assistance as requested by the County. Technical assistance should be reasonable and should not interfere with the Monitor's ability to assess compliance.

VII. CONSTRUCTION, IMPLEMENTATION, AND TERMINATION

A. The County shall implement all reforms within their areas of responsibility, as designated within the provisions of this Agreement that are necessary to effectuate this Agreement. The implementation of this Agreement will begin immediately upon the Effective Date.

B. Except where otherwise agreed to under a specific provision of this Agreement, the County shall implement all provisions of this Agreement within 180 days of the Effective Date.

C. An individual substantive provision in this Agreement shall terminate after DOJ finds that the County maintained sustained substantial compliance of that provision for a period of 18 months. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, will not constitute failure to maintain substantial compliance. Temporary compliance during a period of otherwise sustained non-compliance will not constitute substantial compliance.

D. If, after reasonable notice to the County and a reasonable opportunity to cure any deficiencies identified in writing, the DOJ determines that the County has not substantially complied with this Agreement the DOJ may pursue litigation against the County. Notwithstanding the foregoing, the United States reserves the right to file an action under CRIPA alleging a pattern or practice of unconstitutional conditions at the Jail at any time if it believes that the County is not making a good faith effort to substantially comply with this Agreement or if there is an emergent situation involving an imminent, serious threat to the life, health, or safety of inmates or staff. In the event that the allegations in such an action under CRIPA are litigated, this Agreement shall not be introduced or used as evidence.

E. Where there is a disagreement about whether compliance with any provision has been met, the burden shall be on the County to demonstrate compliance. Individual requirements of this Agreement shall terminate prior to the full termination of this Agreement if the parties agree that the County has maintained compliance with the individual requirement for a period of 18 months. Absent indication that the County has fallen out of compliance, the Monitor will no longer monitor or assess that requirement, and the County will be deemed to have met the terms of this Agreement as to that requirement.

F. If any unforeseen circumstance occurs that causes a failure to timely carry out any requirements of this Agreement, the County shall notify DOJ in writing within 20 calendar days after the County becomes aware of the unforeseen circumstance and its impact on the County's ability to perform under the Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. The County shall implement all reasonable measures to avoid or minimize any such failure.

G. This Agreement constitutes the entire integrated Agreement of the Parties, as it relates to provisions regarding protection from harm, inmate grievances, and fire and life safety (see Section I.7.). With the exception of DOJ's Findings Letter, no prior or contemporaneous communications, oral or written, will be relevant or admissible for purposes of determining the meaning of any provisions herein in any proceeding.

H. The Agreement shall be applicable to, and binding upon, all Parties, their officers, agents, employees, assigns, and their successors in office.

I. Each Party shall bear the cost of its fees and expenses incurred in connection with this cause.

J. This Agreement may be posted on the web site of the U.S. Department of Justice, Civil Rights Division, Special Litigation Section and the United States Attorney's Office for the Southern District of Florida.

FOR THE UNITED STATES:

WIFREDO A. FERRER
United States Attorney

By: _____
Veronica Harrell-James
Assistant U.S. Attorney
Southern District of Florida

_____
THOMAS E. PEREZ
Assistant Attorney General
Civil Rights Division

_____
ROY L. AUSTIN, JR.
Deputy Assistant Attorney General
Civil Rights Division

_____
JONATHAN M. SMITH
Chief
Special Litigation Section

_____
LAURA L. COON
Special Counsel
Special Litigation Section

_____
REGINA M. JANSEN
Trial Attorney
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Civil Rights Division
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FOR MIAMI-DADE COUNTY:

_____
HONORABLE CARLOS A. GIMENEZ
Mayor
Miami-Dade County

By:_____
ROBERT A. DUVALL
Assistant County Attorney
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Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

Carlos A. Migoya
President & Chief Executive Officer

TO: Joe Arriola, Chairman
and Members, Financial Recovery Board Fiscal Committee

FROM: Carlos A. Migoya
President & Chief Executive Officer

DATE: January 15, 2013

RE: Resolution authorizing execution of consent agreement and authorizing and directing actions as are necessary to implement said agreement with the U.S. Department of Justice (DOJ) regarding alleged violations in DOJ's Findings Letter dated August 24, 2011

REQUEST

Executive Staff seeks authority from the Financial Recovery Board (FRB) to enter into a consent agreement, in substantially the form attached hereto, with the United States Department of Justice (DOJ) in full settlement of the alleged violations expressed in the DOJ's Findings Letter dated August 24, 2011. Staff also seeks approval to implement all actions necessary to timely fulfill the terms of the consent agreement, once executed.

BACKGROUND

By way of background, on April 2, 2008, the DOJ initiated an investigation of conditions at the County's Jail facilities, pursuant to CRIPA, 42 U.S.C. § 1997. The Public Health Trust provides medical and mental health care to the County's jail inmates through Corrections Health Services (CHS), a division of the Public Health Trust. The DOJ toured the Jail with its team of consultants on June 9 – 13 and June 16 – 20, 2008, and on April 7 – 8, 2009. On August 24, 2011, DOJ issued a Findings Letter, in which it alleged various violations with respect to medical care, mental health care and suicide prevention, use of force, fire safety and environmental health, as well as recommending remedial measures. The medical and mental health issues are primarily the responsibility of CHS, while the issues concerning jail operations are addressed to the Miami-Dade County Department of Corrections and Rehabilitation (MDCR). Both CHS and MDCR have worked closely together in responding to DOJ.

In response to the Findings Letter, MDCR and CHS (collectively, the County) provided DOJ substantial documentation of the numerous measures implemented since the time of the DOJ

inspections. On October 4, 2011, County representatives met with DOJ in Washington, D.C., to discuss these documented changes. As a result, DOJ agreed to re-inspect the Jail facilities on November 30 – December 2, 2011. After the re-inspection, DOJ concluded that significant improvements had been made in many areas, while other conditions still warranted remedial efforts.

The statute authorizes two forms of settlement agreements. 18 U.S.C. §3626(c). The first, and by far the most common, is a consent agreement that is filed with and enforced by a federal district court. On July 9, 2012, DOJ presented the County with a draft proposal for a consent agreement. Extensive negotiations, including three days of direct discussions with DOJ attorneys in Miami on September 17-19, resulted in two proposed agreements. Relevant to the FRB's approval, issues related to medical and mental healthcare, including suicide prevention, are addressed by a proposed consent agreement. While improvements in medical and mental healthcare were acknowledged by DOJ, it required a consent agreement to address these issues because improvements here were relatively recent and not fully implemented.

Significantly, MDCR and CHS are both well along in their efforts to achieve professional accreditation of their facilities and programs (approximate direct Trust cost of NCCHC accreditation being $20,000, one time). Therefore, the proposed consent agreement is consistent with and in furtherance of the accreditation efforts to which the County is already committed.

The proposed agreement has cost implications for both the County and the Trust. Some features of the consent agreement with significant estimated cost implications, are as follows: (1) construction of Mental Health Treatment Facility ($12,000,000 - $16,000,000) with commencement of phased operations by end of 2014 ($22,000,000 annual operating expense with estimated mental health staffing cost to be provided by the Trust of approximately $7,664,368 annually). These additional staffing costs will flow to the Trust as an increase in Maintenance of Effort payments beginning in fiscal year 2014-2015; (2) implementation of an electronic medical records system (direct Trust cost, approximately $230,000 one-time); (3) additional mental health staffing (direct Trust cost of approximately $953,100 annually); and (4) cost of outside Monitor (approximately $100,000 annual Trust cost).

Under the circumstances, Staff believes executing the consent agreement and implementing its terms, are in the best interests of the Trust and CHS, and requests authority to do so.

RECOMMENDATION

The Executive Staff recommends that the Financial Recovery Board approves the proposed consent agreement and authorizes and directs Carlos A. Migoya, President of the Public Health Trust, or his designee, to execute and implement said agreement on behalf of the Public Health Trust pending approval of the Miami-Dade Board of County Commission.

Agenda Item 2 (b)
Special PHT Financial Recovery Board
January 15, 2013

RESOLUTION NO. PHT 01/13 – 002

RESOLUTION AUTHORIZING EXECUTION OF CONSENT AGREEMENT AND AUTHORIZING AND DIRECTING ACTIONS AS ARE NECESSARY TO IMPLEMENT SAID CONSENT AGREEMENT WITH THE U.S. DEPARTMENT OF JUSTICE ("DOJ") REGARDING ALLEGED VIOLATIONS IN DOJ FINDINGS LETTER DATED AUGUST 24, 2011

(Carlos A. Migoya, President and Chief Executive Officer, Jackson Health System)

WHEREAS, jail operations in Miami-Dade County are the responsibility of the Miami-Dade County Department of Corrections and Rehabilitation (MDCR); and

WHEREAS, the Public Health Trust provides jail inmate medical and mental health care to MDCR through its Corrections Health Services (CHS), a division of the Public Health Trust; and

WHEREAS, on April 2, 2008, the United States Department of Justice (DOJ) initiated an investigation of conditions at the County's Jail facilities, pursuant to the Constitutional Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997; and

WHEREAS, on August 24, 2011, DOJ issued a Findings Letter, in which it alleged various violations regarding medical care, mental health care, suicide prevention, use of force, fire safety and environmental health, as well as recommending remedial measures; and

WHEREAS, both before and after the commencement of DOJ's CRIPA investigation, CHS and MDCR implemented a variety of measures and improvements as part of an ongoing effort to achieve accreditation by professional correctional organizations, including the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC); and

WHEREAS, DOJ expressly acknowledged the County's full cooperation throughout the CRIPA investigation and significant improvements made since the commencement of the investigation; and

WHEREAS, while acknowledging that improvements in medical and mental healthcare have also occurred, DOJ requires a judicially enforceable consent agreement to address those areas because these improvements are relatively recent and have not been fully implemented; and

WHEREAS, the proposed consent agreement is consistent with CHS' ongoing efforts to achieve professional accreditation of its programs; and

WHEREAS, County representatives from MDCR, CHS and the County Attorney's Office have engaged in extensive, good faith negotiations with DOJ to reach a full and fair settlement of the violations alleged in DOJ's Findings Letter dated August 24, 2011; and

WHEREAS, the Director of CHS, Vice President of Quality, President/CEO, and the Joint Conference and Efficiencies Committee recommend approval of a consent agreement substantially in conformance with the background memorandum attached hereto and in settlement of the violations alleged in DOJ's Findings Letter dated August 24, 2011.

NOW, THEREFORE, BE IT RESOLVED BY THE FINANCIAL RECOVERY BOARD OF THE PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY, FLORIDA, that this Board hereby authorizes the President and CEO to execute the consent agreement with the U.S. Department of Justice in substantially the form attached hereto and made part hereof for and on behalf of the Public Health Trust of Miami-Dade County, and further authorizes and directs the President and CEO, or his designee, to take actions as are necessary to implement said consent agreement pending approval of the Miami-Dade Board of County Commissioners.

The foregoing resolution was offered by Mr. Sharpton and the motion was seconded by del Cueto as follows:

Joe Arriola	Absent
Michael Bileca	Absent
Joaquin del Cueto	Aye
Mojdeh L. Khaghan	Aye
Marcos Jose Lapciuc	Aye
Stephen S. Nuell	Aye
Darryl K. Sharpton	Aye

The Chairperson thereupon declared the resolution duly passed and adopted this 15th day of January 2013.

PUBLIC HEALTH TRUST OF MIAMI-DADE COUNTY, FLORIDA

BY: _____
Joaquin del Cueto, Secretary

Approved by the Miami-Dade County Attorney's Office as to form and legal sufficiency _____

Commissioners are requested to provide the Office of the Chairwoman with a list of items they wish to insert on the Pull List, as well as requests for co-sponsorship of legislation, by 3:30 pm on the day before the commission meeting. Your assistance with this request is greatly appreciated.

Many have voiced concerns about the need for committee and commission meetings to start at the scheduled time. As a first step towards this goal and in an effort to expedite meetings, I have decided that committee meetings will commence a half hour earlier than in the past. This will allow the Chair of the committee to commence special presentations at an earlier time. I instituted this policy in the Economic Development and Social Services Committee last year to great success. In other words, the flow of the committee meetings should be as follows: special presentations at 9:00 am and 1:30 pm with the balance of the agenda taking place at 9:30 am and 2:00 pm.

Immediately upon the conclusion of the special presentations and upon achieving quorum, the Chair, or in the absence of the Chair, the Vice Chair shall commence the meeting, provided the Chair is afforded the courtesy of fifteen minutes to arrive after special presentations are concluded. In the absence of both the Chair and the Vice Chair, I urge the remaining members, upon achieving quorum, to select a member amongst themselves to officiate the meeting until the Chair or Vice Chair arrive, pursuant to Rule 4.01(g).

Standing Committee Presentation/Employee Recognition Schedule

Committee	Day	Time	
Cultural Affairs and Recreation	Monday	9:00 am	KD
Health and Social Services	Monday	1:30 pm	TL
Finance	Tuesday	9:00 am	TL
Infrastructure and Capital Improvements	Tuesday	1:30 pm	KD
Public Safety and Animal Services	Wednesday	9:00 am	KD
Transportation and Aviation	Wednesday	1:30 pm	TL
Land Use and Development	Thursday	9:00 am	TL
Economic Development and PortMiami	Thursday	1:30 pm	RD

Committee Structure and Assignment

In keeping with the Rules of Procedure set forth by the Board of County Commissioners and the Miami-Dade County Charter, it is my distinct honor to present the committee structure and its respective assignments. When creating these committees, it was my intention to provide a forum where County business can be conducted in a manner that is, first and foremost, respectful of the residents of Miami-Dade County while maintaining our high standard of professional and ethical conduct.

Due to the volume of items generated by the County, I have determined that eight standing committees would be more appropriate to handle the current workload. The committees are as follows:

- Cultural Affairs and Recreation Committee (CRC) KD
- Economic Development & PortMiami Committee (EDPC) KD
- Finance Committee (FC)
- Health and Social Services Committee (HSSC)
- Infrastructure & Capital Improvements Committee (ICIC) KD
- Land Use & Development Committee (LUDC)
- Public Safety and Animal Services Committee (PSASC) KD
- Transportation and Aviation Committee (TAC)

Agendas, Pull List and Start Time

Agendas for committee and commission meetings will be prepared in accordance with our Rules of Procedure. A proposed agenda item will not be assigned or placed on a commission or committee agenda unless it is approved as to form and legal sufficiency by the County Attorney's Office.

As provided in Rule 4.01(f), items that have been forwarded to the full Board during a given committee week will not be placed on the next commission agenda. They will, however, be placed on the next available commission agenda.

Items requested to be waived from committee review shall first be assigned to committee by the Chairwoman of the Board of County Commissioners. Following committee assignment, the item will be submitted to the Chair of the assigned committee for request of waiver of committee review. If such waiver is granted by the committee Chair, the waiver shall then be submitted to the Chairwoman of the Board of County Commissioners for concurrence and placement on an appropriate Board of County Commissioners' agenda.

Furthermore, in keeping with my goal to achieve an orderly and efficient agenda process, if the Chair of a committee is unable to review and approve the preliminary committee agenda in compliance with the established deadlines, the Chairwoman of the Board of County Commissioners will review and approve the agenda in his or her stead. Removing items from a committee agenda is subject to approval by the Chairwoman of the Board of County Commissioners.