Harris County's Response to the United States Department of Justice Civil Rights Division June 4, 2009 Civil Rights of Institutionalized Persons Act "Findings" Letter regarding: The Harris County Jail System

Vince Ryan
Harris County Attorney

August 24, 2009

The Office of Vince Ryan
County Attorney

August 24, 2009

Honorable Eric Holder, Attorney General of the United States, Harris County Judge Emmett, Commissioners Lee, Radack, Eversole and Garcia, Sheriff Garcia, District Attorney Lykos and Members of the Criminal Justice Coordinating Council:

Re: Harris County Jail –Response to U.S. Dept. of Justice

This is a summary of the voluminous response that I have submitted to the United States Department of Justice Civil Rights Division's June 4, 2009 Civil Rights of Institutionalized Persons Act "Findings" Letter regarding the Harris County Jail.

In the 12 months since Department of Justice investigators last inspected the Harris County jail system, several factors have led to improvements in crucial policies and practices in the jail, ranging from the Harris County Commissioners Court decision to use stimulus package funds for the computerization of Harris County inmate medical records as a tool for improving care, to the election of a new Harris County Sheriff, Adrian Garcia, new District Attorney, Pat Lykos, and a new County Attorney, Vince Ryan. These officials are dedicated to working together to support and institute improvements and have already instituted several best practices in and for the jail system.

In addition the Harris County Commissioners Court responded to a comprehensive report by the Justice Management Institute [JMI] by setting up a Criminal Justice Coordinating Council to make comprehensive improvements in county's criminal justice system.

This Council had its first meeting last week and selected Harris County Precinct One Commissioner El Franco Lee to serve as its chair.

Moreover Harris County, which by the Justice Department's own statements, has been highly cooperative with the investigation and in many ways runs a jail system that "actually performs quite well," respectfully disagrees with the Department's assertions that any of its practices or conditions have been or are unconstitutional or that there has been an alarming rate of in-custody deaths in the county.

The gap between "**unconstitutional**" and "**optimal**" contains several levels of performance, including meeting minimal standards, meeting generally accepted standards and implementing best practices. At the least, the jail system of the past and present meets minimal standards. It also sometimes soars to best practices. Indeed, Harris County provides constitutionally adequate conditions of confinement to inmates incarcerated in its facilities, constitutionally adequate continuity of medical care to inmates, constitutionally adequate protection from the excessive uses of force to inmates,

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constitutionally adequate sanitation and hygiene, including constitutionally adequate laundry facilities, bedding, clothing and mattresses, and constitutionally adequate plumbing, mechanical systems and fire safety in the Harris County Jail. In 2008, the HCSO booked approximately 134,000 inmates into the Harris County Jail, yet the Civil Rights Division cites only five Use of Force incidents.

In its finding that the county jail system has experienced an alarming rate of inmate deaths the Department cites no rate. In reaching the conclusion that some conditions have been unconstitutional, the department fails to find any evidence of systemic patterns, relying instead on anecdotal information. (The Department has no authority to file suit over episodic acts). Further, the Department fails to show deliberate indifference to problems, as required in a finding of unconstitutionality. The Department also makes representations that are unsupported and/or incorrect. And it fails to adhere to a single standard, instead moving the bar from "generally accepted standards" to "minimum standards" to other levels inconsistent with the aforementioned.

The DOJ need look only as far as its other branches for findings inconsistent with those stated in the letter. The Department's own National Institute of Corrections' technical consultants inspected the Harris County jail facilities in June 2009 and issued such findings. The DOJ's own United States Marshals Service has assessed the Harris County jail facilities and it is Harris County's understanding that the USMS's findings are also inconsistent with allegations in the Department's letter. And the National Commission on Corrective Health Care, not a part of the Department, found that the jail system's medical and mental health policies and procedures not only comply with minimum constitutional standards, but comply with the commission's best practice community standards.

In conclusion although we strongly disagree with the allegations lodged by the Civil Rights Division advocates, we hope to continue working with the Division in an amicable and cooperative fashion. As noted in the June 4, 2009 letter, Harris County continues to proactively adopt improvements which ultimately inure to the benefit of prisoners incarcerated in the Harris County Jail system. We welcome the opportunity to sit down and thoroughly address these serious matters.

Sincerely,

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5. The Justice Management Institute's June 17, 2009 "Harris County Criminal Justice System Improvement Project—Preliminary Report"

6. Harris County Commissioners Court's June 23, 2009 Order

7. Harris County Commissioners Court's July 14, 2009 Order

8. Harris County Commissioners Court's July 28, 2009 Order

9. Harris County Criminal Justice Coordinating Council's August 20, 2009 Agenda (with attachments)

10. United States Department of Justice—National Institute of Corrections July 2, 2009 Jail System Assessment

11. Curriculum Vitae of William James Crout

12. Curriculum Vitae of James E. Coleman

13. USMS' July 27, 2009 Detention Facility Investigative Report

14. Currriculum Vitae of Dr. Dwight Steward

15. Advocacy's Beth Mitchell's July 22, 2009 Letter to Loretta King, Acting Assistant Attorney General, United States Department of Justice, Civil Rights Division, regarding the Civil Rights Division's Investigation of the Harris County Jail

16. Dr. John Peters' August 14, 2009 Report in Response to the U.S. Department of Justice's Investigation of the Harris County Jail & attached Curriculum Vitae

17. Consultants Ronnie Aldridge and Jonathan Roberts' July 24, 2009 Response in regard to the U.S. Department of Justice Investigation of the Harris County Jail

18. Curriculum Vitae of Consultant Ronny Aldridge

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20. Curriculum Vitae of Dr. Michael Seale

The Office of Vince Ryan
County Attorney

August 24, 2009

Loretta King
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Civil Rights Division
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Re: Department of Justice's Investigation of the Harris County jail facilities pursuant to the Civil Rights of Institutionalized Persons Act

Dear Ms. King:

This will respond to your June 4, 2009 letter regarding the Civil Rights Division advocates' investigation of the conditions of confinement in the Harris County jail facilities pursuant to 42 U.S.C. § 1997, *et seq.*, the Civil Rights of Institutionalized Persons Act ("CRIPA" or "the Act"). As more fully explained below, Harris County disagrees with the findings and conclusions set forth in such letter. Newly elected Harris County Sheriff Adrian Garcia,[1] Harris County Judge Ed Emmett and Harris County Commissioners El Franco Lee, Sylvia Garcia, Steve Radack and Jerry Eversole remain firmly committed to the incarceration of prisoners in safe, humane and constitutionally adequate conditions of confinement.[2]

By letter dated March 7, 2008, Acting Assistant Attorney General Grace Chung Becker of the Department of Justice's ("DOJ") Civil Rights Division informed Judge Emmett, Commissioners Lee, Garcia, Radack and Eversole, and then-Sheriff Tommy Thomas that the Special Litigation Section of the Civil Rights Division was initiating an investigation regarding the conditions of confinement in the Harris County Jail system pursuant to the Division's authority under CRIPA. Ms. Chung Becker informed Harris County that the investigation would focus on four general issues: the protection of inmates from harm, environmental conditions and inmate medical and mental health care. Ms. Chung Becker explained that the Division would seek to determine whether there are systemic violations of inmates' federal constitutional rights in the Harris County jail facilities. Ms. Chung Becker encouraged Harris County to fully cooperate with the

[1] Sheriff Adrian Garcia was elected last November and took office on January 1 of 2009. Tommy Thomas served as the Sheriff of Harris County during the Civil Rights Division's July 8 - 12, 2008 and August 5 – 8, 2008 inspections of the Harris County Jail system.

[2] In this response, the Harris County Commissioners Court and Sheriff Garcia will at times be collectively referred to as "Harris County." Harris County notes that it reserves its right to supplement this preliminary response as necessary.

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Division's investigation. In several subsequent communications, the Civil Rights Division pledged complete transparency in the Division's investigation.

The DOJ's Civil Rights Division—Special Litigation Section attorneys and their team of support staff and consultants conducted on-site inspections of the jail facilities from July 8 – 12, 2008, and from August 5 – 8, 2008. The Division advocates also delivered extensive requests for production to Harris County prior to, during and between the Division's July and August 2008 jail inspections. Harris County fully cooperated with the Division's investigation, allowing the DOJ's Civil Rights Division complete access to the Harris County jail facilities and personnel during the Division's inspections and producing 34,458 pages of documents and other things in response to the Division's requests for production.

I. Summary of Harris County's Response

Harris County appreciates the Division's acknowledgment of County and Jail officials' full cooperation during the Division's review of the Harris County Jail system, as well as acknowledgement of the level of professionalism exhibited by staff at all levels and the sophistication of many jail systems.[3] Harris County appreciates the Division's acknowledgment of Harris County officials' and employees' substantial and continuing efforts to manage a large prisoner population.[4] Harris County appreciates the Division's general recognition of the initiatives implemented in the jail facilities in 2008 and 2009.[5] These observations aside, Harris County disagrees with the Civil Rights Division advocates' findings and conclusions, as explained in this response. While prisoners cannot expect, and Harris County does not provide, "the amenities, conveniences and services of a good hotel,"[6] Harris County is committed to providing, does provide and will continue to provide constitutionally adequate conditions of confinement to prisoners incarcerated in the Harris County Jail system.

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[3] *See* Letter from Loretta King, Acting Assistant Attorney Gen., U.S. Dep't of Justice, to Ed Emmett, County Judge, Harris County at 1-2 (June 4, 2009) (on file with author) ("Throughout this process, County and Jail officials cooperated fully with our review. We appreciate the assistance that they provided us and the candor of their response. Indeed, we were impressed by the level of professionalism exhibited by staff at all levels and with the sophistication of many Jail systems. ... [W]e are aware that this facility has a very difficult task handling large numbers of detainees, many of whom have serious medical and mental health problems.").

[4] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 16-17 ("Moreover, the Sheriff's Department has adopted a number of measures to alleviate crowding issues, such as transferring detainees to outside facilities and providing 'portable bunks.' Conditions would likely be much worse if the detainees at outside contract facilities had to be housed in the Houston Jail complex. The Sheriff's Department is clearly trying to manage its population, and we acknowledge its efforts.").

[5] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 ("Since we toured, the County has reported that it has adopted a number of improvements, many of which appear to be designed to address issues raised during our exit interviews. We appreciate the County's pro-active efforts.").

[6] Prisoners "cannot expect the amenities, conveniences, and services of a good hotel." *McBride v. Shackleford*, No. 2:07CV143-P-B, 2008 WL 544941, 1 (N.D. Miss. Feb. 22, 2008) (dismissing, for failure to state a claim upon which relief could be granted, Coahoma County Jail inmate's civil rights case alleging that he was compelled to wash and re-use his disposable cups and eating utensils and that his window was covered with sheet metal) (citing *Wilson v. Lynaugh*, 878 F.2d 846, 849 n. 5 (5th Cir. 1989), *cert. denied*, 493 U.S. 969 (1989)).

Section II, at pages 3 – 7 of this response, outlines the scale of the HCSO's detention operations. Section III, at pages 7 – 14 of this response, summarizes the Attorney General's limited authority to initiate or intervene in federal civil rights suits under CRIPA. Section IV, at pages 14 - 31 of this response, includes Harris County's general objections to the Civil Rights Division advocates' June 4, 2009 letter. Section V, at pages 31 - 56 of this response, reviews inspections performed, and assessments made, by Department of Justice's National Institute of Corrections, the DOJ's United States Marshals Service, the Texas Commission on Jail Standards and other experts. The Civil Rights Division's allegations are inconsistent with the findings made by each of the referenced entities and experts. Section VI, at pages 57 - 87 of this response, responds to the allegations made by the Civil Rights Division regarding medical care in the Harris County Jail system. Section VII, at pages 87 - 117 of this response, responds to the allegations made by the Civil Rights Division regarding mental health care in the jail facilities. Section VIII, at pages 117 - 139 of this response, responds to the use-of-force related allegations made by the Division. Section IX, at pages 140 - 161 of this response, responds to the prisoner population-related allegations made by the Division. Section X, at pages 162 - 179 of this response, responds to the sanitation and life safety-related allegations made by the Division. Section XI, at pages 179 – 195 of this response, responds to the Division's recommended proposed remedial measures.

In addition to directly responding to the Division's June 4, 2009 letter, this response will also bring to the Division's attention various changes, improvements and initiatives which have been implemented by Harris County since the completion of the Division's inspection of the County's jail facilities that were not previously highlighted in Harris County's January and June 2009 updates to the Division. Since receiving the Division's letter, many positive developments have occurred in the Harris County criminal justice system that will enhance the conditions of prisoners' confinement in the County's Jail system and are dedicated to reduce the prisoner population numbers in the Jail. As more fully explained in Section IX(B), at page 149 of this response, the Harris County Commissioners Court immediately created the Criminal Justice Coordinating Council ("CJCC") upon receipt of the Justice Management Institute's preliminary report. The CJCC consists of policymakers and stakeholders in the criminal justice system. The CJCC had its first meeting on August 20, 2009, and immediately began focusing on prisoner population and other criminal justice-related issues.

II. Scale of the Harris County Jail System's Operations

The Harris County Sheriff's Office ("HCSO") is one of the two largest law enforcement agencies in Harris County, Texas.[7] Harris County encompasses approximately 1,729 square miles, including most of the City of Houston, and has almost four million residents. The HCSO currently employs 3,996 full-time personnel and is the third largest Sheriff's Office in the United States.

[7] The HCSO is second in size to only the Houston Police Department.

In addition to performing law enforcement functions, the HCSO operates the third largest county jail system in the nation. The Harris County jail facilities (collectively referred to as the Harris County Jail system) consist of temporary lockups in four patrol district substations, a downtown Inmate Processing Center and three housing locations—the 1200 Baker Street Jail, the 1307 Baker Street Jail, and the 701 North San Jacinto Street Jail.[8] Since January of 2005, the HCSO has received and processed over half a million prisoners in its jail facilities. The HCSO received approximately 128,518 prisoners in 2005; 136,026 prisoners in 2006; 135,050 prisoners in 2007; and 134,000 prisoners in 2008.[9] During each of these years, the HCSO released, or transferred to another detention facility, approximately the same volume of inmates received by the Harris County Jail system.

Inmates are generally held for short periods of time in the Harris County Jail system before release or transfer to other detention facilities. In 2006, Hermes Architects and Pulitzer/Bogard & Associates examined intake and release statistics relating to the inmates incarcerated in the Harris County Jail system between November 2004 and October 2005 to determine the average length of inmates' confinement in the jail facilities. This study determined that 30.4% of the inmates received by the jail facilities were released less than or within 24 hours of their intake. The study also found that 42.6% of the inmates received by the jail facilities were released within two days of their intake. The study concluded that 53.5% of the inmates received by the jail facilities were released within three to five days of their intake. While prisoners charged with felony cases, parole violations, awaiting transfer to TDCJ, etc., can remain incarcerated for much longer periods, the study found that the average length of stay for all inmates during that one-year time period was 26.6 days. The vast, overwhelming majority of the 130,000-plus annual admissions into the Harris County Jail system are released within a relatively short period of time.

In general, the intake process includes a search, property inventory, receiving screening, AFIS,[10] photograph, pre-trial interview, probable cause hearing, booking, immigration status screening, dress-out, and a health assessment by a medical professional, including a chest x-ray for TB screening. Any inmate requiring more extensive medical and/or mental health services is escorted to the 1200 Baker Street Jail Clinic prior to classification and housing. All HCSO housing jails include basic inmate service components, including, for example, a clinic, laundry, commissary, recreation areas, law library, visitation areas, kitchen, and all qualified inmates have access to educational programs, vocational training, and inmate jobs.

The total *design* capacity of the Harris County Jail system, including the housing facilities and the Inmate Processing Center ("IPC"), is approximately 9,800 inmates. The Texas Commission on Jail Standards ("TCJS") has granted the HCSO permission to add up to 1,612 temporary

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[8] A photograph of the 701 North San Jacinto Jail facility, which was taken on August 20, 2009, appears on the cover of this response. The 711 North San Jacinto Jail is attached to, and referred to, as part of the 701 North San Jacinto Jail.

[9] In 2008 alone, the HCSO received an average of 367 prisoners daily (or approximately 134,000 inmates in total) into Harris County Jail.

[10] "AFIS" refers to the HCSO's automatic fingerprint identification system.

(portable) beds in existing housing cellblocks. The Harris County jail system's *rated* capacity is thus 11,412 inmates.[11] To provide a single example of operational scale, the Harris County Jail system's kitchens prepare and serve more than 30,000 meals each day in the Harris County Jail system.

In addition, the HCSO incarcerates approximately 1,100 inmates in private contract jail facilities in Louisiana. Due to the distance from the Harris County courts system, only inmates who have been convicted and sentenced can be housed in Louisiana. On August 13, 2009, the total Harris County Jail inmate population in all local and out-of-state locations was 11,248. Recently, Sheriff Garcia sought the Harris County Commissioners Court's approval to enter into agreements with four Texas county jails to transfer and incarcerate some of the Harris County jail's prisoners in those facilities. This request, which was made for the purpose of decreasing prisoner population numbers, overtime costs and transportation costs, was unanimously approved by the Commissioners Court on August 11, 2009. Harris County entered into interlocal agreements totaling $16,504,935.00 for that purpose with Newton, Bowie, Dickens and Jefferson Counties.[12] It is expected that the Commissioners Court will, on August 25, 2009, approve additional interlocal agreements totaling $3,276,788.00 for that purpose with San Jacinto County and McLennan County.[13]

The HCSO's Health Services Division is accredited by the National Commission on Correctional Health Care ("NCCHC"), and has been so accredited since 1991. The HCSO contracts with the University of Texas' Health Science Center ("UT" or "UTHSC") to provide all physician services in the jail facilities. The HCSO contracts with the Mental Health and Mental Retardation Authority ("MHMRA") to provide all psychiatric services in the jail facilities. The Harris County Hospital District provides specialty services on an out-patient basis to inmates incarcerated in the Harris County Jail system. The Harris County Hospital District provides emergency and in-patient care to HCJ inmates. The HCSO also contracts with the Harris County

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[11] The term "rated capacity" is the sum of design capacity and the additional beds approved by the TCJS through the variance process. The TCJS is empowered to grant prisoner population-related variances in the event that it reasonably appears to the TCJS that the variance requested would not "permit or create unhealthy, unsanitary, or unsafe conditions or otherwise jeopardize the security or supervision of inmates or the programs and services required by law or rule" of the TCJS. *See* 37 Tex. Admin. Code § 299.4 & 299.5.

[12] *See* Exhibits 1 ($6,538,610 interlocal agreement between Newton County, Texas and Harris County, Texas to detain, care and transport up to 872 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options), 2 ($4,106,250 interlocal agreement between Bowie County, Texas and Harris County, Texas to detain, care and transport up to 500 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options), 3 ($3,285,000 interlocal agreement between Dickens County, Texas and Harris County, Texas to detain, care and transport up to 400 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options) & 4 ($2,575,075 interlocal agreement between Jefferson County, Texas and Harris County, Texas to detain, care and transport up to 376 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options).

[13] It is expected that the Harris County Commissioners Court will, on August 25, 2009, approve a $574,875 interlocal agreement between San Jacinto County and Harris County, Texas to detain, care and transport up to 70 adult inmates from August 25, 2009 to February 28, 2010 with annual renewal options. It is expected that Commissioners Court will approve, on that same day, a $2,701,913 interlocal agreement between McLennan County and Harris County to detain, care and transport up to 329 adult inmates from August 25, 2009 to February 28, 2010 with annual renewal options.

Psychiatric Center ("HCPC") to reserve and utilize twenty-four inmate mental health treatment beds at the University of Texas Health Science Center at Houston's Harris County Psychiatric Center ("HCPC"). In addition to a wide variety of support services directly provided by the HCSO (radiography, dietary, counseling, dental, etc.), the HCSO contracts for the services of an on-site radiologist, an on-site optometrist, on-site dialysis and on and off-site laboratory services.

During the 2008-2009 fiscal year, the Harris County Commissioners Court provided the HCSO with an operating budget of $406,700,000.00. Of that total budget, $234,100,000.00 was allotted to jail system operations. Jail funding included $50,500,000.00 in direct expenditures to provide inmate medical and mental health services, and another $15,500,000.00 for the associated uniformed personnel assigned to HCSO Medical Security (jail clinics and infirmary), Hospital Security (for inmates transported to local hospitals) and the Jail's Mental Health Unit. The HCSO expended approximately $39,400,000.00 in employee overtime to meet all appropriate staffing levels within the Jail. In response to the Jail system's prisoner population numbers, Harris County also expended $15,400,000.00 to house inmates in private contract jails in Louisiana.

Other Harris County Departments also incur costs in support of the HCSO's detention operations. Theses costs are compiled by the Public Consulting Group and are documented in their Full Cost Allocation plan. For fiscal year 2008-2009, the overhead costs allocated to support the HCSO detentions operations were $27,865,823.00. These costs include, among other costs, the costs incurred for building use charges, human resources and risk management, retiree healthcare, management services, building services, utilities and building maintenance.

The HCSO is committed to providing training to its personnel. The HCSO requires that all of its officers, whether they are sworn personnel or detention officers, meet the applicable requirements of the Texas Commission on Law Enforcement Officer Standards and Education ("TCLEOSE") for licensing and continuing education.[14] Each newly-hired detention officer completes a three week new-employee orientation class prior to being assigned to one of the jail facilities. During the first year, each newly hired detention officer attends the six week Jail School conducted by Harris County Sheriff's Academy staff teaching TCLEOSE's curriculum. At the end of the Jail School, each new detention officer must take and pass an examination given by the State of Texas to obtain his or her jailer's license.

While the number of formal training hours accrued by HCSO law enforcement and detention officers cannot be broken down between those two functions, the number of training hours accrued by conscientious HCSO officers is truly impressive. In 2006, HCSO officers accrued 279,204 formal hours of training. In 2007, HCSO officers accrued 353,271 formal hours of training. In 2008, HCSO officers accrued a total of 374,259 formal hours of training. These

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[14] *See* 37 Tex. Admin. Code §§ 217.1 ("Minimum Standards for Initial Licensure"), 217.19 ("Reactivation of a License"), 217.9 ("Continuing Education Credit for Licensees"), 217.11 ("Legislatively Required Continuing Education for Licensees"). *See generally*, 37 Tex. Admin. Code §§ 217.1 – 217.21 ("Licensing Requirements"), 219.1 – 219.7 ("Prelicensing and Reactivation Courses, tests and Endorsements"), 221.1 – 221.33 ("Proficiency Certificates and Other Post-Basic Licenses"), 223.1 – 223.21 ("Enforcement").

figures do not include the on-the-job training which takes place within each bureau, such as the specialized on-the-job training conducted in the HCSO Inmate Processing Center.

The Harris County Commissioner's Court has strongly supported the HCSO by allocating the required resources to address prisoner population and other jail-related issues. In May, 2009, for example, Harris County Commissioner's Court approved $5,300,000.00 dollars to upgrade the 701 North San Jacinto Jail's security systems, and funded an additional forty new detention officer positions. On November 4, 2008, the Harris County Commissioner's Court commissioned the Justice Management Institute ("JMI") to conduct a study of the criminal justice system in Harris County in an effort to improve criminal justice system operations. Two months ago, JMI issued its preliminary report and associated recommendations for reductions in the Harris County Jail's prisoner population, involving improvement initiatives for the criminal justice system.[15] On June 23, 2009, the Harris County Commissioners Court accepted JMI's preliminary report and, on July 14, 2009, began moving forward on JMI's recommendations as more fully discussed below.[16] The Court formed the Harris County Criminal Justice Coordinating Council, which had its first meeting on August 20, 2009.[17]

The HCSO faces broad challenges in its management of the Harris County Jail. As the recent report issued by the Justice Management Institute indicated, ninety percent of the inmates who are diagnosed as mentally ill have cycled through the Harris County Jail multiple times. The majority of the Harris County Jail inmates have abused drugs. The HCSO has been proactive in addressing concerns which have been raised, including seeking assistance from the Department of Justice's National Institute of Corrections, and utilizing the recommendations of the Justice Management Institute. Harris County, and in particular, the HCSO, is known for many significant accomplishments, and is committed to making the Harris County Jail a model for the rest of the nation.

III. CRIPA's Framework

Congress enacted CRIPA to grant the Attorney General statutory authority to initiate and intervene in civil actions brought to redress systematic deprivations of constitutional rights of institutionalized persons.[18] In a November 15, 1979 report, the Senate cited these, among other,

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[15] *See infra* at Section IX(B) & Exhibit 5 (JMI's June 17, 2009 "Harris County Criminal Justice System Improvement Project—Preliminary Report).

[16] *See infra* at Section IX(B) & Exhibits 6, 7 & 8 (Commissioners Court's June 23, 2009, July 14, 2009 and July 28, 2009 Orders).

[17] *Exhibit 9* (Harris County Criminal Justice Coordinating Council's August 20, 2009 Agenda with attachments).

[18] *See* S. REP. NO. 96-416, at 1, *reprinted in* 1980 U.S.C.C.A.N. 787, 787 ("The committee on the judiciary, to which was referred the bill (S. 10) to grant the United States Attorney General statutory authority to initiate and to intervene in civil actions brought to redress systematic deprivations of constitutional ... rights of persons residing in state institutions ..."); H.R. REP. 96-897, at 9, *reprinted in* 1980 U.S.C.C.A.N. 832, 833 ("Although Congress has, in other contexts, given the attorney general explicit authority to redress systematic deprivations of constitutional rights, it has never expressly authorized him to enforce fundamental federal rights of institutionalized individuals.").

examples of institutional abuses warranting the Department of Justice's involvement in civil rights litigation against state and local institutions confining individuals:[19]

> ... In a suit challenging the adequacy of care at New York's Willowbrook State School for the mentally retarded, the trial record revealed equally appalling conditions. ... Unsanitary conditions led to 100 percent of the residents contracting hepatitis within 6 months of their admission.[20] ... Justice Department-assisted litigation challenging conditions of confinement in prisons and jails revealed that conditions in correctional facilities across the nation were, if possible, worse than those in mental institutions. In a suit attacking conditions in the prisons of Oklahoma's State Penitentiary System,[21] the court found that facilities designed to accommodate 2,400 inmates housed 4,600. Inmates were compelled to sleep in garages and stairwells. Groups of four men were regularly confined in 6-by-6-foot cells with no ventilation, no hot water, and sewage leaks. Over a 3-year period, one facility reported 40 stabbings, 44 serious beatings, and 19 violent deaths.[22] Kitchen and food storage areas were found to be infested with mice, rats, and vermin, and firefighting capabilities were deemed "nonexistent." The court ultimately concluded that conditions in the prisons constituted "an immediate and intolerable threat to the safety and security of inmates, prison personnel, and the state."[23] A similar conclusion was reached by a trial court evaluating evidence in a suit brought with the assistance of the Justice Department against Mississippi State Penitentiary at Parchman.[24] Dead rats surrounded the barracks, broken windows were stuffed with rags to keep out the cold and rain, exposed wiring posed a constant threat of fire, and open sewage contributed to the spread of contagious disease. In one camp, 80 men shared three wash basins, which consisted of oil drums cut in half.[25] Milk of magnesia was forceably administered to inmates as a disciplinary measure; cattle prods were used to keep inmates standing or moving. In a 6-by-6-foot cell with no light, toilet, sink, bed, or mattress, inmates were confined naked for up to three days,

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As the Supreme Court has noted, CRIPA is legislation pertaining to a specific class of § 1983 actions. *Felder v. Casey*, 487 U.S. 131, 148-49 (1988).

19 *See* Senate Report 416, at 10-12 & nn.10-27

20 *See* Senate Report 416, at 11 & nn.13-14

21 *See* Senate Report 416, at 11 & n.21

22 *See* Senate Report 416, at 11 & n.22

23 *See* Senate Report 416, at 12 & n. 23

24 *See* Senate Report 416, at 12 & n. 24

25 *See* Senate Report 416, at 12 & n. 25

without hygienic materials, heat, or adequate food. The court characterized the prison as "unfit for human habitation under any modern concept of decency."[26]

Those conditions, or conditions bearing any similarity to those conditions, do not exist now in the Harris County Jail, did not exist during the Civil Rights Division advocates' July and August, 2008 inspections, and did not exist during the time period ostensibly covered by the Division's investigation. The Division has come forward with no evidence reasonably supporting the conclusion that there are now, or have been, widespread, systematic violations of inmates' constitutional rights in the Harris County Jail system. Indeed, the Division has come forward with no evidence supporting a district court's finding of County liability for any violation of any inmate's constitutional rights. Contrary to the Division advocates' allegations, Harris County provides constitutionally adequate conditions of confinement to prisoners incarcerated in the Harris County Jail system.

When enacting CRIPA, Congress limited the circumstances under which it authorized the Department of Justice to initiate or intervene in civil rights litigation challenging the conditions of confinement in state and local jail facilities. The Attorney General has no authority to initiate or intervene in civil rights litigation raising episodic acts or omissions claims. Instead, the Attorney General has limited "pattern and practice" authority. CRIPA provides, in pertinent part, that the Attorney General may go beyond "informal methods of conference, conciliation and persuasion" and initiate a suit for or in the name of the United States for "such equitable relief as may be appropriate to insure the minimum corrective measures necessary to insure the full enjoyment" of inmates' constitutional rights, if the Attorney General:

1. has reasonable cause to believe that any State or political subdivision of a State, official, employee, or agent thereof, or other person acting on behalf of a State or political subdivision of a State is subjecting persons confined to an institution[27] to "egregious or flagrant conditions";

2. which deprive such persons of rights protected by the United States Constitution;[28]

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26 *See* Senate Report 416, at 12 & n. 26

27 As used in CRIPA, the term "institution" includes, among other institutions, facilities or institutions which are "owned, operated, or managed by, or provide[ ] services on behalf of any State or political subdivision of a State" and which are "a jail, prison, or other correctional facility" or "a pretrial detention facility." 42 U.S.C. § 1997(1)(A), (B)(ii) & (B)(iii).

28 42 U.S.C. § 1997a(a) ("... [S]uch equitable relief shall be available under this subchapter to persons residing in or confined to an institution as defined in section 1997(1)(B)(ii) of this title only insofar as such persons are subjected to conditions which deprive them of rights, privileges, or immunities secured or protected by the Constitution of the United States."); 42 U.S.C. § 1997(1)(B)(ii) (jails, prisons or other correctional facility). *See* Senate Report 416, at 30 ("The legislation further limits actions to enforce the rights of persons residing in 'any jail, prison, or other correctional facility, or any pretrial detention facility,' as defined in section 8(a)(2)(b). Relief will be available to such persons through actions brought under this bill's authority only if the persons are subjected to conditions which deprive them of 'rights, privileges, or immunities secured or protected by the Constitution of the United States'; relief in such actions will not be available on the basis of the broader term 'Constitution or laws of the United States' which applies to persons residing in the other institutions. The purpose of this amendment is to

3. causing such persons to suffer grievous harm; and that

4. such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment of such rights, privileges or immunities.[29]

CRIPA creates no new substantive rights,[30] and grants the Attorney General no authority to directly represent any institutionalized person.[31] After satisfying CRIPA's preconditions to suit, the Department of Justice must also prove a pattern of underlying constitutional violations, and an official policy or custom of the State or political subdivision's final policymaker that was the moving force in causing the constitutional deprivations.[32]

The courts distinguish between individual violations by local employees and those that can be fairly attributed to the governmental unit itself.[33] The Supreme Court has repeatedly emphasized

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preclude suits under this bill on behalf of persons in jails, prisons, correctional facilities or pretrial detention facilities arising solely from federal statutory violations rather than constitutional violations.").

[29] 42 U.S.C. § 1997a(a). *See* 42 U.S.C. § 1997b (regarding certification requirements). Alternatively, the DOJ may under limited circumstances intervene in an existing federal civil rights lawsuit. 42 U.S.C. § 1997c(a)(1). *See* 42 U.S.C. §§ 1997c(a)(2) & 1997c(b) (re preconditions & certification requirements).

[30] *See* Senate Report 416, at 3 (CRIPA "creates no new substantive rights. It simply gives the Attorney General legal standing to enforce constitutional ... rights of institutionalized persons. By codifying the authority of the Attorney General to initiate and to intervene in suits to redress serious and pervasive patterns of institutionalized abuse, [CRIPA] ensures that institutionalized citizens will be afforded the full measure of protections guaranteed them by the constitution of the United States."); House Report 897, at 9 (H.R. 10 "creates no new substantive rights. It simply gives the Attorney General legal standing to enforce existing constitutional and federal statutory rights of institutionalized persons. By codifying the authority of the Attorney General to initiate and to intervene in suits to redress serious and pervasive patterns of institutional abuse, H.R. 10 insures that institutionalized citizens will be afforded the full measure of protections guaranteed them by the Constitution of the United States.").

[31] *See* Senate Report 416, at 31 ("Finally, it should be emphasized that under Section 1, the Attorney General's authority extends to initiating suit 'for or in the name of the United States,' in order to represent the national interest in securing constitutionally adequate care for institutionalized citizens. As a representative of the United States, the Attorney General does not directly represent any institutionalized plaintiffs, and the authority granted him is in no way intended to preclude, delay or prejudice private litigants from enforcing any cause of action they may have under existing or future law."); House Report 897, at 13 ("It should be emphasized that under Section 3, the Attorney General's authority extends to initiating suit 'for or in the name of the United States,' in order to represent the national interest in securing constitutionally adequate care for institutionalized citizens. As a representative of the United States, the Attorney General does not directly represent any institutionalized plaintiffs, and the authority granted him is in no way intended to preclude, delay or prejudice private litigants from enforcing any cause of action they may have under existing or future law. This point is made explicit in section 12 of the Act. The Attorney General must also certify that he believes that intervention by the United States will materially further the vindication of constitutional or federal rights, and that the issue is of general public importance.").

[32] *E.g.*, *Collins v. City of Harker Heights*, 503 U.S. 115, 120 (1992); *Monell v. Dep't of Soc. Services*, 436 U.S. 658, 694 (1978); *Piotrowski v. City of Houston*, 237 F.3d 567, 578 (5th Cir. 2001); *United States v. Commonwealth of Pa.*, 902 F. Supp. 565, 579, 580, 649 (1995), *aff'd sub nom.*, *United States v. Ridge*, 96 F.3d 1436 (3d Cir. 1996).

[33] *E.g.*, *Piotrowski*, 237 F.3d at 578-79.

the need for an official policy as a predicate to recovery against a governmental unit. A governmental unit may not be sued for federal constitutional violations for an injury inflicted solely by its employees or agents.[34] "Instead, it is when execution of a governmental unit's policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts the injury that the government as an entity is responsible."[35] Governmental units thus may not be held liable for acts of lower level employees, but may be held liable for constitutional violations committed pursuant to an official policy or custom.[36] The United States must not only prove that a governmental unit's official policy or custom was the "moving force" in causing a pattern of constitutional violations; it must also prove that the governmental unit was "deliberately indifferent" to the known consequences of the policy.[37] The Fifth Circuit has explained that a civil rights plaintiff bears an "extremely heavy burden" in establishing both the governmental unit's deliberate indifference and a causal link between the alleged custom and the alleged constitutional violation.[38]

The Attorney General's limited "pattern or practice" authority does not include a grant of authority to initiate or intervene in civil rights litigation raising episodic acts or omissions claims. The Attorney General likewise has no authority to lend the United States' name to a suit merely for the benefit of some private individual.[39] The legislative history of the Act expressly memorializes Congress' intent to limit the Attorney General's authority to file suit to cases where unconstitutional practices are widespread, pervasive, and systematic, and adversely affect significant numbers of incarcerated individuals, causing them to suffer grievous harm:

> The Attorney General's authority to litigate is limited to situations in which he has reasonable cause to suspect a "pattern or practice" of institutional abuse in violation of the constitution or Federal laws. This "pattern or practice" authority has been interpreted by the courts in other contexts, and the committee intends the language here to be construed in conformity with established precedent. *Thus, the Attorney General does not have authority under this bill to redress isolated instances of abuse or repeated violations against an individual. Rather, the Attorney General's authority is limited to cases where unconstitutional or illegal practices are widespread, pervasive, and systematic, and adversely affect significant numbers of institutionalized individuals. It is clearly the intent of the committee that minor or isolated acts or injuries are not intended to be the subject*

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34 *E.g., Board of Comm'rs of Bryan County v. Brown,* 520 U.S. 397, 403 (1997); *Monell,* 436 U.S. *at* 695.

35 *E.g., Monell,* 436 U.S. *at* 695.

36 *E.g., Piotrowski,* 237 F.3d at 578. In addition, governmental units (and their officials and employees) may not be held constitutionally liable for negligent acts. *Daniels v. Williams,* 474 U.S. 327 (1986), *Davidson v. Cannon,* 474 U.S. 344, 347-48 (1986).

37 *E.g., Piotrowski,* 237 F.3d at 580.

38 *E.g., Piotrowski,* 237 F.3d at 580; *Snyder v. Trepagnier,* 142 F.3d 791, 798 (5th Cir.1998).

39 *United States v. San Jacinto Tin Co.,* 125 U.S. 273, 286 (1888); *Calhoun County v. Roberts,* 137 F.2d 130, 131 (5th Cir. 1943).

> *of litigation under this bill. The bill authorizes action only where persons residing in an institution are subjected to "egregious or flagrant conditions (conditions which are willful or wanton or conditions of gross neglect) ... causing them to suffer grievous harm."* These descriptive terms are intended to parallel the limitations that have been applied to actions brought under 42 U.S.C. 1983 and similar rights enforcement statutes.[40]

Like the Senate, the House of Representatives memorialized Congress' intent to limit the Attorney General's authority to initiate CRIPA suits only where the Attorney General has reasonable cause to conclude that (1) a local governmental entity "is subjecting" inmates "to egregious or flagrant conditions" which deprive them of their constitutional rights, and (2) such deprivations are part of a "pattern or practice" of denial of constitutional rights, rather than isolated or accidental incidents:

> This section grants authority to the Attorney General to initiate actions in federal courts for such equitable relief as may be appropriate *when he has reasonable cause to believe that a state or political subdivision of a state or person acting on behalf of a state or political subdivision is subjecting persons residing in or confined to any institution to egregious or flagrant conditions which deprive them of rights protected by the constitution ...* of the United States. *In order for the attorney general to initiate a suit under this section he must have reasonable cause to believe that the deprivation of rights is part of a 'pattern or practice' of denial rather than an isolated or accidental incident.*

When imposing these limitations upon the Attorney General's authority, the House cautioned that a "high degree of care must be taken when one level of government sues another in our federal system." The House underscored Congress' intent to limit the Department of Justice's involvement to instances when "egregious or flagrant" conditions violate inmates' constitutional rights, and admonished that its "egregious or flagrant" language established a higher standard for DOJ involvement than that required of plaintiffs other than the United States:

> The adoption by the conference committee of the language "egregious or flagrant" establishes a standard for the Department of Justice's involvement that reflects Congressional sensitivity to the fact that a high degree of care must be taken when one level of sovereign government sues another in our federal system. *This is a higher standard than that required of plaintiffs other than the United States. This is not intended to expand or restrict the existing rights of plaintiffs other than the United States. This standard applies to the United States only in actions brought under this Act.* Congress recognizes that this Act does not require that private litigants meet the 'egregious or flagrant standard' in any action which they may have the power to bring.[41]

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[40] Senate Report 416, at 29.

[41] House Report 897, at 11. "Mindful of the importance of harmonious federal-state relations, the Congress has also required that the Attorney General of the United States sign both the complaint itself and the certificate." House Report 897, at 13. Senate Report 416, at 31 ("The requirement that the Attorney General personally sign the

The House also noted that while "pattern or practice" was not legislatively defined, that term had come to have a clear meaning through litigation, and requires the United States to prove that the act at issue resulted from more than an isolated or accidental or peculiar event.[42]

In a CRIPA suit, the Attorney General cannot recover monetary damages. The Attorney General may initiate actions under CRIPA for such equitable relief as may be appropriate.[43] Although a court is not prohibited from imposing any equitable remedy deemed to be appropriate, CRIPA's legislative history indicates Congress' clear preference for the injunctive remedy to other equitable remedies.[44] Congress limited the Attorney General's authority to seek only "minimally corrective measures."[45] Congress further limited the Attorney General's authority to enforce the rights of prisoners incarcerated in jails, prisons and other correctional facilities under CRIPA. Equitable relief may only be available insofar as such incarcerated individuals are subjected to conditions which deprive them of constitutional rights,[46] as opposed to federal statutory rights.[47]

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complaint is intended to ensure that any decision to initiate suit shall be made by the Attorney General himself but is not intended to preclude an acting Attorney General from signing the complaint. This provision is also modeled after existing legislation and is included in recognition of the important issues inherent in litigation by the federal government against state and local officials."). *See* 42 U.S.C. § 1997a(c) ("The Attorney General shall personally sign any complaint filed pursuant to this section."); 42 U.S.C. § 1997b(b) ("The Attorney General shall personally sign any certification made pursuant to this section.").

[42] House Report 897, at 11 ("Several of the existing civil rights laws permit the attorney general to initiate 'pattern or practice' suits. These laws do not provide an explicit definition of 'pattern or practice' in the statutory text, however, through litigation the term has come to have a clear meaning. To fulfill the requirement the illegal acts must result from more than an isolated or accidental or peculiar event[,] the government must show that the unlawful act by the defendant was not an isolated or accidental departure from an otherwise lawful practice. It has been held, however, that there is no requirement that a conspiracy be alleged, or found for a 'pattern or practice' of rights violations to take place.").

[43] 42 U.S.C. § 1997a(a) (limiting AG's requests for recovery to "such equitable relief as may be appropriate to insure the minimum corrective measures necessary to insure the full enjoyment of such [Constitutional] rights, privileges, or immunities"); Senate Report 416, at 31 (1980) ("However, the committee does not believe that such relief sought by the Attorney General should include money damages."); House Report 897, at 12 ("Section 3 also authorizes the Attorney General to seek 'such equitable relief as may be appropriate to insure the minimum corrective measures necessary to insure the full enjoyment' of the rights secured or protected by the Constitution or laws of the United States. Of course, the specific relief appropriate in any particular care will depend on the facts presented to the court. ...").

[44] Senate Report 416, at 31 (1980) ("While it is not the intention of the Committee that the court be precluded from applying any equitable remedy deemed appropriate by a court, it is nevertheless the hope of the Committee that the courts will choose to use the injunctive remedy, if appropriate, to other equitable remedies imposing affirmative burdens upon the defendants.").

[45] House Report 897, at 12 ("The Attorney General may only seek relief appropriate to insure the minimum corrective measures ...").

[46] 42 U.S.C. § 1997a(a) (1996).

[47] *Id. See* House Report 897, at 12 ("The legislation further limits actions to enforce the rights of persons residing in 'any jail, prison, or other correctional facility,' as defined in section 2(1)(b)(ii). Relief will be available to such persons through actions brought under this bill's authority only if the persons are subjected to conditions which deprive them of 'rights, privileges, or immunities secured or protected by the Constitution of the United

In a CRIPA suit, a court may award the prevailing party, other than the United States, a reasonable attorney's fee against the United States as part of the costs.[48]

As shown below, the Civil Rights Division has failed to meet each or any of CRIPA's threshold requirements for suit.

IV. Harris County's Objections

A. When reporting the results of its investigation of the conditions of prisoners' confinement in the Harris County Jail system, the Civil Rights Division failed to apply the constitutional standards applicable to medical care, mental health care, protection from harm, and sanitation and life safety issues.

Section 1997i of CRIPA expressly provides that "[p]rovisions of this subchapter shall not authorize promulgation of regulations defining standards of care."[49] Harris County objects to the Civil Rights Division advocates' findings and recommended remedial measures because the Division has informally done exactly what the Act prohibits. The Division incorrectly redefined the minimum constitutional standards applicable to the conditions of inmates' confinement in the Harris County Jail system; applied these ambiguous standards; summarily declared constitutional violations; and recommended "minimum remedial measures" based upon these ambiguous standards.

In the "Legal Framework" section of their June 4, 2009 letter, the Civil Rights Division briefly noted that the "deliberate indifference to serious medical needs" standard is the applicable constitutional standard.[50] The Division then failed to apply this or any other applicable

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States': relief in such actions will not be available on the basis of the broader term 'Constitution or laws of the United States' which applies to persons residing in the other institutions. The purpose of this amendment is to preclude suits under this bill on behalf of persons in jails, prisons, or other correctional facilities arising solely from federal statutory violations rather than constitutional violations. Of course any other authority the Attorney General may have to address any other violations of law, criminal or civil, in prisons is not affected by this act."); Senate Report 416, at 30.

[48] 42 U.S.C. § 1997a(b) (1996) ("In any action commenced under this section, the court may allow the prevailing party, other than the United States, a reasonable attorney's fee against the United States as part of the costs."). *See* Senate Report 416, at 31 (1979) ("An amendment was accepted to S. 10 during subcommittee consideration which would allow the prevailing party other than the United States a reasonable attorney's fee at the discretion of the court."); House Report 897, at 12-13 ("In both the initiation and intervention sections, the Act makes clear the liability of the United States to opposing parties for attorneys' fees whenever it loses. The award is discretionary with the court, and it is intended that the present standards used by courts under the civil rights laws will apply. However, it is not intended that recovery be allowed from the United States, as a plaintiff, by another plaintiff or plaintiff-intervenor. The award is to be made to an opposing party who prevails.").

[49] 42 U.S.C. § 1997i (1980). *See* House Report 897, at 18 (same).

[50] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3 para. 2 ("Detainees have a constitutional right to adequate medical and mental health care, including psychological and psychiatric services. ... *Detainees' constitutional rights are violated when prison officials exhibit deliberate indifference to their serious medical needs.*") (emphasis added; citations omitted).

minimum constitutional standard to the issues their investigation focused upon, including inmate medical care, inmate mental health care, protection of inmates from harm and sanitation/life safety issues.[51]

The Civil Rights Division failed to direct Harris County to any specific, written standards supporting their findings and recommended remedial measures. The Division vaguely advanced "generally accepted standards of correctional medical care" as the applicable constitutional standard throughout the "Medical Care" section of the Division's June 4, 2009 letter.[52] The Division similarly referenced non-specific "generally accepted correctional mental health standards," "generally accepted correctional medication standards," "generally accepted correctional standards," "generally accepted professional mental health standards," and "minimum standards of care" as the applicable constitutional standards in the "Mental Health Care" section of the letter.[53] The Division held out similarly vague "minimum correctional standards" as the applicable constitutional standard in the "Excessive Use of Force" section of the letter.[54] The Division cited amorphous "minimum sanitary standards" as the applicable constitutional standard in the "Sanitation and Hygiene" section of the letter.[55] The Division cited no standards whatsoever in the "Fire Safety" section of the letter.[56]

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[51] *See infra* at Sections VI(A) (discussing applicable minimum constitutional standards relating to inmates' medical and mental health claims); VIII(A) (discussing applicable minimum constitutional standards relating to inmates' use-of-force claims). IX(A) (discussing applicable minimum constitutional standards relating to crowding claims). & X(A) (discussing applicable minimum constitutional standards relating to inmates' sanitation, hygiene and life safety claims).

[52] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 2 (generally accepted standards of correctional medical care); *Id.* at 4 para. 3 – 4 para. 1 (generally accepted correctional medical standards); *Id.* at 7 para. 5 – 8 para. 1 (generally accepted correctional medical standards); *Id.* at 8 para. 2 (generally accepted correctional medical standards).

[53] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 9 para. 4 – 10 para. 1 (generally accepted correctional mental health standards); *Id.* at 11 para. 4 (generally accepted correctional medication standards); *Id.* at 12 para. 4 (generally accepted correctional standards); *Id.* at 12 para. 5 (generally accepted professional mental health standards); *Id.* at 14 para. 4 (minimum standards of care).

[54] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 14 para. 4 (minimum correctional standards). The Division generally referenced "minimum legal standards" in the "Overcrowding" section of the letter, but expressly alleged no violations of this general standard. *Id.* at 16 – 18.

[55] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 19 para. 2 (minimum sanitary standards).

[56] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 2.

What standards did the Civil Rights Division apply?[57] What specific standards are they referring to with each general reference to "generally accepted" standards, "minimum correctional standards" and the like?[58] Not minimum constitutional standards. Instead, the Division applied the ambiguous, undefined "generally accepted" and "minimum" standards referenced above. It appears that the Division is referring to community-based standards, which are often referred to as "generally accepted" or "best practice" standards, and are far more stringent than the minimum constitutional standards applied by the federal courts to allegations of constitutional deprivations.

After improperly equating non-specific, "generally accepted" and "minimum" correctional and sanitary standards with minimum constitutional standards, the Division incorrectly alleged that Harris County violated their newly-created constitutional standards.[59]

Next, the Division inappropriately recommended that the HCSO implement, "at a minimum," each of their proposed remedial measures "in accordance with generally accepted professional standards of correctional practice."[60] In the same "Recommended Remedial Measures" section of their letter, the Division proposed medical and mental health-related remedial measures based upon "generally accepted correctional medical standards" and "generally accepted correctional mental health standards";[61] use-of-force investigation-related remedial measures based upon

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[57] On a similar note, what methodology did the Civil Rights Division advocates employ? The Division's letter does not specify who the Division or their consultants spoke with, which if any of the more than 34,000 document pages produced to them were reviewed, or what standards they followed. The DOJ's National Institute of Corrections' technical consultants, on the other hand, recently reviewed the conditions of confinement in the Harris County jail facilities and provided the HCSO with their methodology and a description of the documents they reviewed, a list of individuals with whom they spoke and the specific standards they followed. *See* Exhibit 10 at 5 - 10.

[58] And what does the Civil Rights Division mean when it repeatedly states that Harris County must "ensure" certain conditions of confinement? Harris County objects to the Division's repeated use of this ambiguous, misleading term. *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 1 para. 1; 2 para. 4; 3, paras. 1 3; 8 para. 3; 9 para. 1; 14 para. 4; 18 para. 1; 19, paras. 2 & 4; 20, paras. 2 & 5; 21, paras. 1 – 5; 22 para. 5; 6 para. 1; 23 paras. 2, 4, 5. While the Supreme Court has used the term "ensure" in *Farmer v. Brennan* and other cases, the Civil Rights Division appears to have repeatedly taken this term out of context in what looks like an attempt to require Harris County to guarantee conditions of confinement satisfying non-specific "generally accepted" standards. In *Farmer v. Brennan* and other cases using this term, the Supreme Court goes on to identify, explain and apply the deliberate indifference or other applicable minimum constitutional standard. *E.g. Farmer v. Brennan*, 511 U.S. 825, 832 (1994). The Civil Rights Division, on the other hand, has made no attempt to counterbalance or otherwise temper their use of this term with citations to and application of appropriate constitutional standards.

[59] *See generally* Letter from Loretta King to Ed Emmett, *supra* note 3, at 2 para. 2 ("[W]e also conclude that certain conditions at the Jail violate the constitutional rights of detainees. ... As detailed below, we find that the Jail fails to provide detainees with adequate: (1) medical care; (2) mental health care; (3) protection from serious physical harm; and (4) protection from life safety hazards."). *See generally Id.* at 1- 24.

[60] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 3 ("In order to address the constitutional deficiencies identified above and protect the constitutional rights of detainees, the Jail should implement, at a minimum, the following measures in accordance with *generally accepted professional standards of correctional practice* ...").

[61] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 4 (generally accepted correctional medical standards); *Id.* at 20 para. 5 – 21 para. 1 (generally accepted correctional medical standards and generally

"generally accepted correctional standards";[62] and hygiene-related remedial measures based upon "generally accepted health standards."[63]

The Civil Rights Division advocates' application of "generally accepted" and "minimum" correctional and sanitary standards, rather than minimum constitutional standards, is particularly troubling for at least three reasons. First, CRIPA provides the Division with limited authority to initiate or intervene in lawsuits challenging "egregious and flagrant" conditions of confinement violating the constitutional rights of, and causing grievous harm to, significant numbers of inmates pursuant to a pattern or practice of depriving inmates of their constitutional rights. While references to, and discussion of, "generally accepted" and "minimum" correctional and sanitary standards are certainly appropriate (and if specific, could be instructive), the Division's construction and application of "generally accepted" standards as minimum constitutional standards is disingenuous, legally insupportable, and strays well outside the limited authority granted to the Attorney General under CRIPA. The Division's findings are constructed like a house of cards. If you strip away the Division's improper application of "generally accepted" and "minimum" correctional and sanitary standards, rather than minimum constitutional standards, there is nothing left of the house under CRIPA.

Second, the Civil Rights Division advocates' application of "generally accepted" and "minimum" correctional and sanitary standards, rather than minimum constitutional standards, is inconsistent with the representations expressly made by the Division when informing Harris County of the Division's investigation and the scope of the investigation. On March 7, 2008, the Division sent County Judge Ed Emmett and then-Sheriff Tommy Thomas a letter explaining that the Division was commencing an investigation of the Harris County Jail pursuant to the authority granted to the Division under CRIPA.[64] In this letter, the Division represented that "[i]n conducting the investigation, we are obliged to determine whether there are systemic violations of the Constitution of the United States at HCJ."[65] The Division further represented that "[p]rovided that the County cooperates fully with our investigation, if we conclude that there are no systemic violations of constitutional or other federal rights,[66] we will notify you that we are

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accepted correctional medical standards); *Id.* at 21 para. 7 – 22 para. 1 (generally accepted standards of correctional health care); *Id.* at 22 para. 3 (generally accepted correctional mental health standards).

[62] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 9 – 23 para. 1 (generally accepted correctional standards).

[63] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 4 (generally accepted health standards).

[64] *See* Letter from Grace Chung Becker, Acting Assistant Attorney Gen., U.S. Dep't of Justice, to Ed Emmett, County Judge, Harris County at 1, paras. 1-2 (Mar. 7, 2008) (on file with author).

[65] *See* Letter from Grace Chung Becker, Acting Assistant Attorney Gen., U.S. Dep't of Justice, to Ed Emmett, County Judge, Harris County at 1 para. 2 (Mar. 7, 2008) (on file with author). The Division further explained that the investigation would focus on protection of inmates from harm, environmental conditions and inmate medical and mental health care. *Id.*

[66] It also must be noted that CRIPA expressly prohibits the Division from initiating or intervening in a suit involving a local governmental unit's jail facility based upon violations of "other federal rights." 42 U.S.C. § 1997a(a).

closing the investigation."[67] Notwithstanding these representations, the Division inconsistently failed to apply minimum constitutional standards when issuing their findings and recommended remedial measures.

Third, the Civil Rights Division advocates' application of "generally accepted" and "minimum" correctional and sanitary standards, rather than minimum constitutional standards, is inconsistent with the Division's oft-repeated pledge of a fair, impartial and even-handed investigation.

B. Although the HCSO's medical and mental health care policies are accredited by the National Commission on Correctional Health Care ("NCCHC"), the Civil Rights Division failed to acknowledge the HCSO's continuing compliance with the NCCHC's "best practice" community standards.

As discussed above, the Civil Rights Division advocates failed, in their June 4, 2009 letter, to apply the constitutional ("deliberate indifference to serious medical needs") standard applicable to medical and mental health care claims advanced under either the Eighth or Fourteenth Amendments of the United States Constitution. Setting this threshold issue aside, the Division alleges that the HCSO is constitutionally required to, but fails to, comply with non-specific generally accepted medical and mental health standards.

In other CRIPA investigations and litigation, the Division has expressly defined generally accepted medical and mental health standards as NCCHC standards.[68] The Division knows that the HCSO's medical and mental health policies and procedures not only comply with minimum constitutional standards, but also comply with the NCCHC's more stringent "best practice" community standards of care. During the course of the Division's investigation, Harris County produced documents confirming the HCSO's NCCHC accreditation in response to the Division's requests. The Division, however, failed to acknowledge the HCSO's continuing compliance with the NCCHC's "best practice" community standards. If not the minimum constitutional standards and not the NCCHC standards, what standards did the Division apply when reviewing medical and mental health care in the Harris County Jail system?

C. Harris County objects to what appears to be an improper attempt to assume superintendence of the "administration" of the Harris County Jail system, an area in which the Attorney General has no authority and the federal courts will not venture.

Given the Civil Rights Division's failure to apply minimum constitutional standards to the medical, mental health care, protection from harm, and sanitation and life safety issues, the

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[67] *See* Letter from Grace Chung Becker, Acting Assistant Attorney Gen., U.S. Dep't of Justice, to Ed Emmett, County Judge, Harris County at 1 para. 3 (Mar. 7, 2008) (on file with author).

[68] *See infra* at Section VI(C) for a more detailed discussion of this objection, including quotations from the Civil Rights Division's CRIPA agreements with other State and local governments requiring those jurisdictions' compliance with NCCHC's best practice standards in their detention facilities.

Division's findings and "minimum remedial measures" go well beyond the limited authority granted to the Attorney General by CRIPA and appear to improperly intrude in the administration of the Harris County Jail system.

Federal courts enforce constitutional standards without superintending jail administration.[69] To that end, federal courts have given jail and prison administrators wide discretion regarding the operation of their facilities by establishing a "minimum intrusion policy" into jail and prison administrative decisions.[70] As the Fifth Circuit stated in its 1981 *Jones v. Diamond* opinion:

> Judges are neither correctional officers nor penologists. Even if we had the expertise to analyze the practical and theoretical implications of the conditions of incarceration, we would have no warrant to impose our views, for a legislature state or federal is not required by the Constitution to operate penal institutions in accordance with criminological doctrine or to employ only experts in their management. We are mindful that "courts are ill equipped to deal with the increasingly urgent problems of prison administration ...," ..., and that it is not "wise ... to second-guess the expert (or any other) administrators on matters on which they are better informed," .... Moreover, we are aware that we should not, "in the name of the Constitution, become ... enmeshed in the minutiae of prison operations." ... In determining whether conditions of confinement are unconstitutional under the Eighth Amendment or the Fourteenth Amendment, we do not assay separately each of the institutional practices but look to the totality of conditions. Our task is limited to enforcing constitutional standards rather than assuming superintendence of jail administration. ...[71]

The Civil Rights Division's authority is limited under CRIPA to a review of the HCSO's compliance with minimum federal constitutional standards. The Division's authority does not extend to allow it to find so-called constitutional violations based upon non-specific "generally accepted" community standards, rather than minimum constitutional standards, and to then call for "minimum remedial relief." Under these circumstances, Harris County is compelled to object to what appears to be an improper attempt to assume superintendence of the "administration" of the Harris County Jail system, an area in which the Attorney General has no authority and the federal courts will not venture.

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[69] *Sampson v. King*, 693 F.2d 566, 568 (5th Cir. 1982) (citing *Jones v. Diamond*, 636 F.2d 1364, 1368 (5th Cir. 1981) (en banc)).

[70] *E.g.*, *Procunier v. Martinez*, 416 U.S. 396 (1974); *McCord v. Maggio*, 910 F.2d 1248, 1250 (5th Cir. 1990); *Jones*, 636 F.2d at 1368, *overruled on other grounds by International Woodworkers of Am. v. Champion Int'l Corp.*, 790 F.2d 1174 (5th Cir. 1986), *aff'd sub nom.*, *Crawford Fitting Co. v. J.T. Gibbons, Inc.*, 482 U.S. 437 (1987)).

[71] *Jones*, 636 F.2d at 1368 (quoting *Procunier*, 416 U.S. at 405; *Bell v. Wolfish*, 441 U.S. 520, 531 (quoting lower court opinion); *Miller v. Carson*, 563 F.2d 741 (5th Cir. 1977); *Williams v. Edwards*, 547 F.2d 1206 (5th Cir. 1977)).

D. The Civil Rights Division's findings and proposed remedial measures fail to take into account the typically short-term period of prisoners' confinement in the Harris County Jail system.

Harris County objects to the Civil Rights Division's findings and proposed minimum remedial measures because they fail to take into account the typically temporary nature of custodial confinement in the Harris County Jail system. The Division's findings and recommendations are based upon an incorrect presumption that the Harris County Jail system is essentially a prison system that typically incarcerates inmates for long periods of time.

The functions served by county jails in a state penal system should be taken into account in determining conditions of confinement-related issues.[72] Texas county jails "are generally short-term holding facilities confining individuals serving misdemeanor sentences, or awaiting trial or transfer to prisons."[73] Confinement in jail is by its nature temporary.[74]

As previously noted, the HCSO received approximately 136,026 prisoners in 2006; 135,050 prisoners in 2007; and 134,000 prisoners in 2008.[75] During each of these years, the jail facilities experienced a high turnover of prisoners, releasing or transferring to another detention facility, approximately the same number of inmates received by the jail facilities that same year. The 2006 Hermes Architects and Pulitzer/Bogard & Associates study, referenced earlier, determined that 30.4% of the inmates received by the jail facilities were released less than or within 24 hours of their intake. The study also found that 42.6% of the inmates received by the jail facilities were released within two days of their intake. The study concluded that 53.5% of the inmates received by the jail facilities were released within three to five days of their intake. While prisoners charged with felony cases, parole violations, awaiting transfer to TDCJ, etc., can remain incarcerated for much longer periods, the study found that the average length of stay for all inmates during that one-year time period was 26.6 days. The vast, overwhelming majority of the 130,000-plus annual admissions into the Harris County Jail system are released within a relatively short period of time.

The Civil Rights Division made no attempt to critically analyze the nature of the Harris County prisoner population or duration of confinement before generally declaring that conditions of confinement violate prisoners' constitutional rights. Rather than recognizing the typically short duration of confinement of most of the inmates held in the Harris County Jail System, the

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[72] *Cruz v. Hauck*, 515 F.2d 322, 332-33 (5th Cir. 1975), *cert. denied sub nom., Andrade v. Hauck*, 424 U.S. 917 (1976) (*citing McGinnis v. Royster*, 410 U.S. 263 (1973)).

[73] *Cruz*, 515 F.2d at 333.

[74] *E.g., Bell*, 441 U.S. at 523, 526 n.5 (re temporary nature of confinement at the Metropolitan Correctional Center, a federally operated short-term custodial facility in New York City designed primarily to house pretrial detainees); *Gerstein v. Pugh*, 420 U.S. 103, 110 n.11 (1975) ("Pretrial detention is by nature temporary ..."); *Cruz v. Hauck*, 627 F.2d 710, 716-17 (5th Cir. 1980) ("Confinement in jail is by its nature temporary.").

[75] In 2008 alone, the HCSO received an average of 367 prisoners daily (or approximately 134,000 inmates in total) into Harris County Jail.

Division seeks to incorrectly impose standards and mandate the implementation of relief not constitutionally required in a short-term detention facility.[76]

E. The Civil Rights Division failed to satisfy the pre-suit notification requirements imposed by Section 1997b(a)(1)(A) of CRIPA.

The Civil Rights Division's June 4, 2009 letter failed to satisfy Section 1997b(a)(1)(A)'s pre-suit notification provision, which expressly requires notification to Harris County of "the alleged conditions which deprive rights, privileges, or immunities secured or protected by the Constitution or laws of the United States *and* the alleged pattern or practice of resistance to the full enjoyment of such rights, privileges, or immunities."[77] As more fully discussed below, the Division failed to specifically identify conditions which actually deprive inmates of their constitutional rights. The Division also failed to specifically identify any alleged pattern or practice of resistance to Harris County jail inmates' full enjoyment of their constitutional rights. In fact, review of the HCSO's Systems Plans and policies and procedures produced to the Division demonstrate that the HCSO has extensive, detailed plans, policies and procedures in place that not only protect the security of jail facilities and those within the facilities, but also protect inmates' federal constitutional rights.

F. The Civil Rights Division failed to satisfy the pre-suit notification requirements imposed by Section 1997b(a)(1)(B) of CRIPA.

The Civil Rights Division June 4, 2009 letter similarly failed to satisfy Section 1997b(a)(1)(B)'s pre-suit notification provision, which expressly requires notification to Harris County of "the supporting facts giving rise to the alleged conditions and the alleged pattern or practice, including the dates or time period during which the alleged conditions and pattern or practice of resistance occurred; and when feasible, the identity of all persons reasonably suspected of being involved in causing the alleged conditions and pattern or practice at the time of the certification, and the date on which the alleged conditions and pattern or practice were first brought to the attention of the Attorney General."[78]

1. No notification of supporting facts showing constitutional violations and an alleged pattern or practice of constitutional violations

The Civil Rights Division failed to notify Harris County of specific supporting facts that show constitutional violations and an alleged pattern or practice of constitutional violations. Instead, the Division incorrectly relied upon a few isolated incidents that would be construed by the

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[76] *See e.g.*, *Alberti v. Klevenhagen*, 46 F.3d 1347, 1363 n. 12 (5th Cir. 1995) (quoting district court's memorandum opinion issued during time period when the State of Texas was refusing to accept convicted felons for transfer: "[T]he extensive educational and vocational programs recommended by the monitor are not constitutionally required in a traditional County detention facility where inmates are typically released in a relatively short time.").

[77] *See* 42 U.S.C. § 1997b(a)(1)(A).

[78] *See* 42 U.S.C. § 1997b(a)(1)(B).

courts to raise episodic acts or omissions claims alleging, at worst, negligence.[79] As previously stated, CRIPA does not confer standing upon the Attorney General to pursue, or even advance, isolated claims or episodic acts or omissions claims. The Division also incorrectly relied upon conclusory, unsupported allegations, speculation, unsubstantiated inmate complaints and other hearsay. The Division even relied upon their "personal beliefs" when reporting the results of their investigation.

The Civil Rights Division, for example, lodged allegations of "deficiencies," "systemic deficiencies" and "problems" in the Harris County Jail system that are conclusory, speculative, inaccurate and without foundation. Bare allegations, without more, fails to satisfy CRIPA's pre-suit notification requirements and are simply insufficient to support claim that there existed a policy or custom which was the moving force behind any alleged constitutional violation.

The Division engaged in speculation to support their allegations.[80] The Division similarly and erroneously relied upon their personal beliefs to justify their allegations, stating, for example, that "[w]e believe that the incidents noted during our [use-of-force] review may only reflect part of what is really occurring within the facility."[81]

Although it is well settled that unsubstantiated complaints and reports do not amount to a committed act,[82] the Division incorrectly cited unsubstantiated prisoner complaints in support of their allegations. The Division, for example, supported their "delay in care" claim by representing that they received a number of complaints about delays in care at the Jail's 1200 Baker Street facility."[83] In another section of their letter, the Division supported their conclusory allegation that "violence breaks out frequently" in the jail with the amorphous representation that in one unspecified ten month period, "the Jail reported over 3000 fights and 17 reported sexual assaults."[84] The Division's conclusion (that "violence" breaks out

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[79] *See e.g., Scott v. Moore*, 114 F.3d 51 (5th Cir. 1997) (en banc); *Hare v. City of Corinth*, 74 F.3d 633 (5th Cir.1996) (en banc).

[80] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 2 ("For instance, staff may miss some detainees who are degenerating mentally or physically, but who are unable or unwilling to utilize the normal sick call process."); at 6 para. 3 ("This process has apparently little or no physician oversight ..."); at 11 para. 2 ("Given the nature of HH's mental health condition, the Jail's delays in providing mental health treatment and evaluation likely contributed to HH's continuing mental decline and behavioral disturbances."): at 11 para. 4 ("Staff then repeatedly treated JJ with both anti-psychotic and mood-stabilizing medications without adequate laboratory studies or proper monitoring, placing the detainee at risk of sudden death."); at 13 para. 13 ("OO ended up in two altercations, including one in which he struck a deputy."); at 13 para. 4 ("This suggests that the purpose of the medications prescribed was more likely to sedate the inmate, rather than to treat his seizures.").

[81] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2 .

[82] "It is well established that a complaint does not amount to a committed act." *Snow v. City of El Paso, Tex.*, 501 F. Supp.2d 826, 833 (W.D. Tex. 2006) (citing *Estate of Davis ex rel. McCully v. City of N. Richland Hills*, 406 F.3d 375, 384 n.45 (5th Cir. 2005)).

[83] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 2 .

[84] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3. at 17 para. 2 .

"frequently" in the jail) is not supported by their vague reference to "3,000 fights." A reported "fight" can be as minor as a push or shove resulting in no injuries to the involved prisoners. It is not fair to label minor skirmishes which do not even result in injury as "violence" that breaks out "frequently" in the jail. In addition, the Division misinterpreted the report from which they borrowed these numbers. The report included the number of inmates charged with violating the jail rule against fighting, not the actual number of fights. Since at least two inmates would have been involved in each fight, there were, at most, 1,500 altercations generally labeled as fights over a ten-month time period. Since approximately 110,000 prisoners are received in the Harris County Jail system during a typical ten-month period,[85] the number of prisoners involved in altercations is statistically quite miniscule (less than 3%). The huge scale of the Harris County Jail operation must be considered when examining any jail-related numbers. The Division's conclusion (that violence breaks out frequently in the jail) is similarly not supported by the Division's vague reference to 17 reported sexual assaults over that same ten-month time period, since a report does not constitute a committed act, and further inquiry by the Division would have revealed that there were not 17 substantiated sexual assaults over the ten-month period referenced by the Division.[86]

The Division made sensational, gratuitous and baseless allegations. For example, the Division provided what can only be described as an unsupported sound bite, stating: "Indeed, the number of inmates deaths related to inadequate medical care, described below, is alarming."[87] The Division referenced five inmate deaths in its June 4, 2009 letter. Those five deaths occurred between 2006 and 2008. During that time period, 405,076 prisoners were incarcerated in the Harris County Jail system. As discussed in Section V(E), Dr. Dwight Steward, an expert in statistics and economic analysis, found that the three inmate deaths who were alleged by the Division to have died as a result of inadequate medical care represent 0.0000111 (0.00111%) of the 269,050 inmates that Harris County Jail processed over the 2007-2008 time period. Dr. Steward found that the two inmates who the Division alleged to have died as a result of inadequate mental health care constitute 0.0000049 (0.00049%) of the 405,076 inmates that the Harris County Jail system processed over the 2006-2008 time period. The Division failed to show constitutionally inadequate medical care in each or any of the five referenced cases, or a pattern of constitutionally inadequate care. The Division likewise showed no custom, policy or practice of a final policymaker that was the moving force causing any alleged constitutional violation.

The Civil Rights Division also made unsupported and inappropriate leaps in an attempt to show causation.[88] The mere fact that one incident precedes another is not proof of a causal connection and is insufficient to show a constitutional violation.[89]

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[85] Approximately 110,000 prisoners were received in the Harris County jail facilities during a typical ten-month period between 2006 and 2008.

[86] It is also troubling that the Civil Rights Division did not note that every claim of sexual assault is fully investigated.

[87] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3, at 2 para. 2 .

[88] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3. at 11 para. 2 ("Given the nature of HH's mental health condition, the Jail's delays in providing mental health treatment and evaluation likely contributed to

2. No notification of supporting facts showing a pattern or practice of resistance to significant number of inmates' constitutional rights

The Civil Rights Division advocates have alleged what the courts would construe as episodic acts or omissions claims. As previously stated, the Division has no authority to initiate or intervene in civil rights litigation raising isolated claims or episodic acts or omissions claims. The Division acknowledged that "CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of jail detainees and detainees *subject to a pattern or practice of unconstitutional conduct or conditions.*"[90]

Thereafter, the Civil Rights Division made one vague allegation regarding a pattern, stating that their consultant found a pattern of the use of an improper force technique.[91] The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to uses of force. The Division advocates list what they allege to be five (5) incidents (involving an unidentified inmate and Inmates RR – UU) of improper force techniques from January – June, 2008 at pages 15 - 16 of their June 4, 2009 letter. Even assuming that improper force techniques were used in these five incidents, which Harris County expressly denies, five incidents out of approximately 67,000 prisoners incarcerated in the Harris County Jail system during the first six months of 2008 constitute no actionable pattern.[92]

HH's continuing mental decline and behavioral disturbances."); at 13 para. 13 ("OO ended up in two altercations, including one in which he struck a deputy.").

[89] This is the logical fallacy of post hoc ergo propter hoc (after this, therefore on account of this). *E.g. Seven-Up Co. v. Coca-Cola Co.*, 86 F.3d 1379, 1388-89 & n. 15 (5th Cir. 1996) ("We have previously rejected inferences of causation based solely on the chronology of events, where the record contains undisputed testimony to the contrary or other equally credible theories of causation.") (citing *Fenner v. General Motors Corp.*, 657 F.2d 647, 651 (5th Cir. 1981) ("An inference may be unreasonable if it is at war with uncontradicted or unimpeached facts."), *cert. denied*, 455 U.S. 942 (1982); *Dreijer v. Girod Motor Co.*, 294 F.2d 549, 555-56 (5th Cir. 1961) (rejecting an inference of causation based on "post hoc ergo propter hoc reasoning" where the evidence supported several other probable causes for the accident); *Tampa Times Co. v. NLRB*, 193 F.2d 582, 583 (5th Cir. 1952) ("Post hoc ergo protper hoc is not sound logic.") (noting the presence of uncontradicted testimony in the record that individuals responsible for plaintiff's termination from employment were unaware of his union activities, and finding that the "inference that he was discharged on account of such activities may not be drawn merely from the fact that the activities preceded the discharge").

[90] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 2 para. 4 .

[91] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2 .

[92] *E.g., Burge v. St. Tammany Parish*, 336 F.3d 363, 370 (5th Cir. 2003) ("[P]roof of a custom or practice requires more than a showing of isolated acts ..."); *Pineda v. City of Houston*, 291 F.3d 325, 329 & nn. 9-11 (5th Cir. 2002) ("Eleven incidents each ultimately offering equivocal evidence of compliance with the Fourth Amendment cannot support a pattern of illegality in one of the Nation's largest cities and police forces. The extrapolation fails both because the inference of illegality is truly uncompelling—giving presumptive weight as it does to the absence of a warrant—and because the sample of alleged unconstitutional events is just too small. Opinion evidence resting heavily on this data added little if anything. Left without legs, the opinions were little more than suspicion, albeit by informed persons. The weakness in the approach is apparent in its practical effects. It

Turning to the Civil Rights Division's other cited incidents, the Division summarized what they allege to be three (3) cases (involving Inmates AA – CC) of allegedly inadequate periodic assessments from 2007 and 2008 at page 5 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to periodic assessments. Even assuming that the inmates' assessments were inadequate in those cases, which Harris County expressly denies, three cases out of the 269,050 prisoners incarcerated in the Harris County Jail system from 2007 - 2008 constitute no actionable pattern.[93]

The Civil Rights Division advocates cataloged what they allege to be three (3) cases (involving Inmates DD – FF) of allegedly inadequate continuity of medical care from 2007 and 2008 at pages 7 – 8 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to inmates' continuity of care. Even assuming that continuity of medical care was inadequate in those three cases, which Harris County explicitly denies, three cases out of 269,050 prisoners incarcerated in the Harris County Jail system from 2007 - 2008 constitute no actionable pattern.[94]

The Civil Rights Division advocates cited what they allege to be six (6) cases (involving Inmates GG – LL) of inadequate access to mental health treatment from 2007 – 2008 at pages 10 – 12 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to access to mental health treatment. Even assuming the mental health treatment to have been inadequate in those six cases, which Harris County specifically denies, six cases out of the 269,050 prisoners incarcerated in the Harris County Jail system from 2007 - 2008 constitute no actionable pattern.[95]

The Civil Rights Division advocates detailed what they allege to be five (5) cases (involving Inmates MM – QQ) of "improper chemical restraints and unsafe medication practices" from 2006 – 2008 at pages 12 – 14 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to the use of "improper chemical restraints and unsafe medication practices." Even assuming improper chemical restraints and unsafe medication practices in those five cases, which Harris County expressly denies, five cases out of

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requires the City to defend "cases within cases" from historical records to justify searches conduced without a warrant. The burdens of proof on a contested warrantless entry of a home have little to do with the use here of the City's records. The district court was wisely wary."), *cert. denied*, 537 U.S. 1110 (2003); *Piotrowski v. City of Houston*, 237 F.3d 567, 581 (5th Cir. 2001) ("Isolated violations are not the persistent, often repeated, constant violations, that constitute custom and policy as required for municipal section 1983 liability").

[93] *E.g., Burge*, 336 F.3d at 370; *Pineda*, 291 F.3d at 329 & nn. 9-11; *Piotrowski*, 237 F.3d at 581.

[94] *E.g., Burge*, 336 F.3d at 370; *Pineda*, 291 F.3d at 329 & nn. 9-11; *Piotrowski*, 237 F.3d at 581.

[95] *E.g., Burge*, 336 F.3d at 370; *Pineda*, 291 F.3d at 329 & nn. 9-11; *Piotrowski*, 237 F.3d at 581.

405,076 prisoners incarcerated in the Harris County Jail system from 2006 - 2008 constitute no actionable pattern.[96]

Setting aside the pre-suit notification issue, there is simply no evidence of pattern or practice of resistance to significant numbers of inmates' constitutional rights. In fact, the opposite is true. In Grace Chung Becker's March 7, 2008 letter informing Harris County that the DOJ was beginning its CRIPA investigation, she stated that the Civil Rights Division would offer to make recommendations on ways to improve conditions at the Harris County Jail system, when appropriate. Then-Sheriff Thomas and his command staff asked to meet with the Division and their team daily during the inspections to discuss any immediate concerns expressed by the Division. Although the concerns expressed during these meetings implicated no federal constitutional questions, the HCSO responded to the concerns during, between and after the Division's inspections. The Division's own consultants complimented the HCSO professionals' immediate and proactive responses to the recommendations made during the inspection process. After the inspections, the HCSO sent the Division two updates showing initiatives implemented by the HCSO prior to, during and after the July and August 2008 inspections. Similarly, the 34,458 pages of documents and other things produced to the Division show no pattern of constitutional violations.

Sheriff Garcia took office on January 1, 2009, and expeditiously invited peer review from the DOJ's own National Institute of Corrections and other institutions to independently assess the conditions of confinement in the Harris County Jail system and to respond to the recommendations made during the peer review process. Sheriff Garcia proactively reviewed the HCSO's policies and procedures and has already made changes, where appropriate.

The Harris County Commissioners Court has likewise shown no pattern of resistance to inmates' enjoyment of their constitutional rights. The Harris County Commissioners Court has supported the Harris County Sheriff's provision of constitutional conditions of confinement by providing the HCSO with an operating budget of $406,700,000.00, including $234,100,000.00 allotted to jail system operations.

3. No relevant time period

Section 1997b(a)(1)(B)'s notification provision expressly requires the Civil Rights Division to notify Harris County of "the supporting facts giving rise to the alleged conditions and the alleged pattern or practice, *including the dates or time period during which the alleged conditions and pattern or practice of resistance occurred.*" Excluding the 22 episodic acts or omissions claims cited above, the Division failed to articulate any "dates or time period during which the alleged conditions and pattern or practice of resistance [allegedly] occurred." In fact, most of the allegations and "findings" included in the Division's June 4, 2009 letter are objectionable because they reference no relevant time period whatsoever. The Division often couches its allegations in the present tense, so it is unclear whether the Division advocates' allegations relate to what they perceive to be past or present conditions of inmates' confinement.

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[96] *E.g., Burge*, 336 F.3d at 370; *Pineda*, 291 F.3d at 329 & nn. 9-11; *Piotrowski*, 237 F.3d at 581.

4. No identities of persons

Section 1997b(a)(1)(B)'s notification provision expressly requires the Civil Rights Division to notify Harris County "when feasible, the identity of all persons reasonably suspected of being involved in causing the alleged conditions and pattern or practice at the time of the certification." The Division advanced twenty-two (22) incidents which the federal courts would construe as episodic acts or omissions claims,[97] but the Division failed to identify all persons reasonably suspected of being involved in such incidents or otherwise involved in causing any alleged conditions. The Division likewise failed to identify all persons reasonably suspected of otherwise being involved in any alleged conditions or pattern or practice.

5. No date on which the alleged conditions and pattern or practice were first brought to the attention of the Attorney General

Section 1997b(a)(1)(B)'s notification provision expressly requires the Civil Rights Division to notify Harris County of "the date on which the alleged conditions and pattern or practice were first brought to the attention of the Attorney General." The Division's June 4, 2009 letter fails to satisfy this notification requirement.

G. The Civil Rights Division failed to satisfy the pre-suit notification requirements imposed by Section 1997b(a)(1)(C) of CRIPA.

The Civil Rights Division failed to satisfy Section 1997b(a)(1)(C)'s notification provision, which expressly requires notification to Harris County of "the minimum measures which the Attorney General believes may remedy the alleged conditions and the alleged pattern or practice of resistance."[98]

The Division stated that "[i]n order to address the constitutional deficiencies identified above and protect the constitutional rights of the detainees, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice ..."[99] The Division's recommended remedial measures are not based upon constitutional violations or any pattern or practice of constitutional violations, and thus fail to give Harris County the notice required by Section 1997b(a)(1)(C).

The Division's recommended remedial measures amorphously require, "at a minimum," measures in accordance with unspecified, undefined "generally accepted standards of correctional practice," "generally accepted correctional medical standards," "generally accepted standards of correctional health care," "generally accepted correctional mental health standards," "generally accepted health standards" that far exceed minimum constitutional requirements.

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[97] *See e.g., Scott v. Moore*, 114 F.3d 51 (5th Cir. 1997) (en banc); *Hare v. City of Corinth*, 74 F.3d 633 (5th Cir.1996) (en banc).

[98] *See* 42 U.S.C. § 1997b(a)(1)(C).

[99] *See* Letter from Loretta King to Ed Emmett. *supra* note 3, at 20 para. 3 .

H. The Civil Rights Division did not honor its pledge of a fully transparent investigation with regard to inmate interviews.

The Civil Rights Division encouraged full cooperation with their investigation, repeatedly pledging transparency in their investigation. Notwithstanding this pledge, the Division declined to allow Harris County's non-uniformed consultants to silently observe witness interviews.

Harris County opened the doors of its jail facilities, granting the Division's team, including their attorneys, paralegals and consultants, full access to the Harris County Jail system and personnel during their inspections and producing 34,458 pages of documents and other things responding to the Division's requests for production. Shortly before the Division's July 2008 inspections, the HCSO notified the Division that it expected Harris County's consultants to be present during the Division's entire tour of the HCSO and the interviews conducted in the facilities. The Division had no objection to the presence of Harris County's consultants (and uniformed HCSO staff and others) during the Division's interviews of HCSO staff, but declined to allow Harris County's consultants to be present during certain inmate interviews. During the first conversation with the Division's lead counsel on this subject, he explained that the presence of Harris County's consultants during these interviews might result in claims of retaliation and noted that Harris County could interview the inmates after the Division and its consultants concluded their interviews. During a second discussion regarding this subject, when Harris County's counsel explained that Harris County did not plan to have uniformed personnel present during these private inmate interviews, that Harris County's consultants would do nothing more than observe the interviews, and that Harris County believed later interviews by Harris County or its consultants would more likely result in claims of retaliation, the Division's counsel said it was his team's "only chance" to talk with their "witnesses." Harris County was surprised by this statement because Ms. Chung Becker's March 7, 2008 letter notifying Harris County of the investigation assured the County that the Division had not reached any conclusions about the subject matter of the investigation. Harris County re-urged the Division to allow the County's consultants to be present during individual inmate interviews in an attempt to ensure that the process was fair while simultaneously avoiding some, if not many, later claims of retaliation.

The Civil Rights Division advocates, in response, reiterated their commitment to conduct a fair and impartial investigation, noted that the interviews were but one aspect of the fact-finding undertaken to ensure a fair evaluation of jail conditions, and explained that, to the extent they received information from the inmate interviews that raised systemic concerns, they would "identify those issues" to Harris County and request documents from the County to assist them in determining what weight, if any, to give this information.[100] The Division also warned that if Harris County would not permit such interviews, the Division would "take that into consideration" and might "draw appropriate inferences."

While Harris County believed that no negative inferences could logically be drawn from its consultants' silent observation of individual inmate interviews, Harris County indicated that it would not refuse the Division's requests for individual inmate interviews during the Division's

[100] They did neither.

inspections of the Harris County Jail system. Harris County was thus placed in a position where its consultants could not independently (and silently) observe the individual interviews conducted by the Division. Harris County could not immediately and accurately respond to any claims lodged by the inmates during these private interviews. Harris County could not later follow-up on the Division's private interviews with these same inmates for fear that the inmates would later lodge claims of retaliation.

Thereafter, the Division relied upon unsubstantiated inmate complaints in their June 4, 2009 letter. For example, the Division advocates incorrectly base their claims of inadequate delays in receiving mental health care upon unspecified detainees' reports of significant delays when they request care."[101]

I. The Civil Rights Division did not honor its pledge of a fully transparent investigation with regard to the Division's consultants' reports.

Harris County has produced to the Civil Rights Division 34,458 pages of documents and other things. Harris County, in response, repeatedly asked the Civil Rights Division for copies of only one category of documents—the Division's consultants' reports. Despite the Division's repeated claims of a fair, even-handed and transparent investigation, they have produced none of those reports. In their June 4, 2009 letter, the Division employed what their own counsel described during a related conversation as a "carrot and stick approach," stating:

> Assuming there is continued cooperation from the County and the Jail, we would be willing to send our consultants' reports' under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical technical assistance in addressing them.[102]

The import of this paragraph of the Civil Rights Division's letter is clear. Notwithstanding the Division's earlier and repeated claims of transparency, this paragraph informs Harris County that the Division will only produce their consultants' reports if no objections are made to the Division's findings. In other words, the Division has held the reports hostage. This objectionable approach places Harris County in an untenable position. It is not clear which, if any, findings and recommendations actually came from the Civil Rights Division's consultants who actually inspected the Harris County Jail system in July and August 2008 and which findings and recommendations were crafted by the Division's lawyers. The paragraph quoted above includes a disclaimer that can only reasonably be construed to mean that the Division's consultants' findings are *not* memorialized in the Civil Rights Division's June 4, 2009 letter. In addition, the Division's June 4, 2009 letter is in many respects inconsistent with the comments

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[101] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 4.

[102] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 24 para. 1.

made by the Division's consultants during the July and August 2008 inspections and brief-outs. For these reasons, it appears that the Division's consultants' reports have not been produced because they are inconsistent with the Division advocates' findings and conclusions.

Harris County understands the mission of the Civil Rights Division and its Special Litigation Section—to advocate on behalf of institutionalized individuals. CRIPA clearly was enacted to assist the Attorney General in conducting his "litigation program" on behalf of the institutionalized.[103] The Civil Rights Division is even required to submit annual reports to Congress so that Congress will have the opportunity to periodically assess the efficacy and impact of the Division's litigation program.[104] The Division's failure to provide Harris County with the Division's consultants' reports, however, is inconsistent with the Division's repeated pledge of a full, fair and transparent investigation. The Division's failure to provide these reports is also inconsistent with Ms. Chung Becker's March 7, 2008 letter, wherein she noted that "We will also offer to provide recommendations on ways to improve conditions at the facility."[105]

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[103] *See* Senate Report 416, at 9 ("Since 1976 Congress has indicated a desire to assist the Attorney General in conducting his litigation program on behalf of the institutionalized."); *Id.* at 1, *reprinted in* 1980 U.S.C.C.A.N. 787, 789 ("... *Through litigation conducted by the Civil Rights Division*, the Justice Department has participated as amicus curiae or plaintiff-intervenor in more than 25 suits ..."); *Id.* at 1, 3, 16, *reprinted in* 1980 U.S.C.C.A.N. 787, 790, 798 ("Despite the proven effectiveness of the department's efforts, *its litigation program stands threatened* by two recent federal court decisions. ... The Maryland and Montana decisions make clear that without a federal statute clarifying the Attorney General's authority to initiate and to intervene in such suits, the *department's litigative efforts* to protect the institutionalized will be paralyzed. *[CRIPA] provides that authority.* *** *The decisions promise to affect the Attorney General's litigation program* in several important respects."); *Id.* at 9, *reprinted in* 1980 U.S.C.C.A.N. 787, 790 ("Since 1976 Congress has indicated a desire to assist the Attorney General in conducting his *litigation program* on behalf of the institutionalized."); *Id.* at 10, *reprinted in* 1980 U.S.C.C.A.N. 787, 791 ("Since 1971, the *Office of Special Litigation* and Office of Public Accommodations and Facilities *of the Civil Rights Division of the Justice Department* have continued to participate in *Wyatt*-type suits challenging conditions of confinement in state institutions across the nation ..."); *Id.* at 17, *reprinted in* 1980 U.S.C.C.A.N. 787, 799 ("It is clear that without express statutory authority to secure judicial enforcement of constitutional ... rights of the institutionalized, the *Attorney General's litigation program* cannot survive.").

[104] 42 U.S.C. § 1997f ("Report to Congress) ("The Attorney General shall include in the report to Congress on the business of the Department of Justice prepared pursuant to section 522 of Title 28—(1) a statement of the number, variety, and outcome of all actions instituted pursuant to this subchapter including the history of, precise reasons for, and procedures followed in initiation or intervention in each case in which action was commenced; (2) a detailed explanation of the procedures by which the Department has received, reviewed and evaluated petitions or complaints regarding conditions in institutions; (3) an analysis of the impact of actions instituted pursuant to this subchapter, including, when feasible, an estimate of the costs incurred by States and other political subdivisions; (4) a statement of the financial, technical, or other assistance which has been made available from the United States to the State in order to assist in the correction of the conditions which are alleged to have deprived a person of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States; and (5) the progress made in each Federal institution toward meeting existing promulgated standards for such institutions or constitutionally guaranteed minima."). When enacting CRIPA, the House noted that the CRIPA's requirement that the Attorney General "annually report to Congress on the history, procedures, costs and other relevant information about actions brought under this act is designed to ensure that Congress will have the opportunity to assess periodically the efficacy and impact of the Justice Department's litigation program." House Report 897, at 17 (emphasis added).

[105] *See* Letter from Grace Chung Becker, Acting Assistant Attorney Gen., U.S. Dep't of Justice, to Ed Emmett, County Judge, Harris County at 1 para. 3 (Mar. 7, 2008) (on file with author).

The Division's failure to provide Harris County with the Division's consultants' reports is also objectionable because such refusal is inconsistent with Section 1997b(a)(2)(A) of the Act, wherein Congress indicated its intent that the federal government work with state and local jurisdictions to provide technical assistance relating to constitutionally inadequate conditions of confinement.[106] In the paragraph quoted above from the Division's June 4, 2009 letter, the Division advocates expressly noted that their consultants' reports "offer practical technical assistance" in addressing the issues raised by the Division, yet the Division has declined to produce the reports.

V. The Civil Rights Division advocates' findings are inconsistent with the findings made by the DOJ's own National Institute of Corrections, the DOJ's own United States Marshal Service, and other experts.

A. Harris County provides constitutionally adequate conditions of confinement to inmates incarcerated in the Harris County Jail system, and therefore denies the Division's allegations to the contrary.

Harris County objects to the entire "Constitutional Deficiencies" section of the Civil Rights Division advocates' letter because the Division failed to satisfy CRIPA's notification requirements.[107] The Division likewise failed to show that Harris County or any Harris County official or employee subjected significant numbers of Harris County Jail inmates to "egregious or flagrant conditions" which deprived such inmates of their constitutional rights, causing them to suffer grievous harm.[108] The Division further failed to show any alleged pattern or practice of institutional abuse and resistance to a substantial number of HCJ inmates' constitutional rights.[109] Notwithstanding these objections and without waiving same, Harris County submits that it provides constitutionally adequate conditions of confinement to inmates incarcerated in the Harris County Jail system, and denies the Division's allegations to the contrary.

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[106] 42 U.S.C. § Section 1997b(a)(2)(A) (requiring the Attorney General to make "a reasonable good faith effort to consult with the ... chief executive officer and ... chief legal officer of the appropriate ... political subdivision and the director of the institution, or their designees, regarding financial, technical, or other assistance which may be available from the United States and which the Attorney General believes may assist in the correction of such conditions and pattern or practice of resistance").

[107] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-20. *Contra.* 42 U.S.C. § 1997b(a)(1) (1996).

[108] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-20. *Contra* 42 U.S.C. § 1997a(a) (1996); Senate Report 416, at 29.

[109] Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-20. *Contra* 42 U.S.C. § 1997a(a) (1996); Senate Report 416, at 29.

According to the Civil Rights Division:

> As a large urban detention facility, Harris County Jail faces a number of significant problems including a high detainee census and complex funding and logistical challenges. In many ways, the Jail actually performs quite well. Jail policies and procedures provide for a comprehensive detainee housing assignment process, medical sick call procedures, and regular facility maintenance. Staff receive broad training on Jail operations, supervision of detainees, and detainee rights. *Unfortunately, in a number of critical areas, the Jail lacks necessary systems to ensure compliance with constitutional standards.*[110]

Harris County provides constitutionally adequate jail operations-related systems and denies the Civil Rights Division's allegation that the Jail lacks necessary systems to ensure compliance with constitutional standards in a number of critical areas. The HCSO has formulated and implemented Systems Plans in accordance with regulations promulgated by the Texas Commission on Jail Standards, an agency of the State of Texas with jurisdiction over Texas county jails.[111] TEX. GOV'T CODE § 511.001 *et. seq.* The HCSO's Systems Plans cover every aspect of the Jail's operations, including, for example, classification, commissary, inmate correspondence, discipline, education and rehabilitation, emergencies, fire prevention, grievances, health services, inmate rules, library, mental disabilities and suicide prevention, recreation, religious practices, sanitation, telephones and visitation,[112] and far exceed minimum constitutional requirements. Although the HCSO's Systems Plan and the TCJS's approval of such Plan have been produced to the Civil Rights Division,[113] Harris County has found no reference to, or attack upon, the Plan in the Division's letter. When making these unsupported allegations, the Division likewise made no mention of the extensive HCSO policies and procedures that were produced to the Division during its investigation. In fact, Harris County has found almost no references to the HCSO's policies and procedures in the Civil Rights Division's June 4, 2009 letter.[114]

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[110] Letter from Loretta King to Ed Emmett, *supra* note 3, at 3 para. 3 (emphasis added).

[111] The TCJS is responsible for, among other things, the adoption of reasonable rules and procedures establishing minimum standards for the custody, care and treatment of prisoners incarcerated in Texas county jails. Tex. Gov't Code § 511.009(a)(2).

[112] *See, e.g.*, 37 Tex. Admin. Code §§ 273.1 (Health Services), 273.2 (Health Services Plan), 273.4 (Health Records), 273.5 (Mental Disabilities/Suicide Prevention Plan), 273.7 (Tuberculosis Screening Plan), 273.8 (Health Services), 279.1 (Sanitation Plan), 283.1 (Inmate Discipline Plan), 283.2 (Inmate Rules and Regulations), 283.3 (Inmate Grievance Plan), 285.1 (Physical Exercise), 287.1 (Education & Rehabilitation Plan), 291.1 (Inmate Telephone Plan), 291.2 (Inmate Correspondence Plan), 291.3 (Inmate Commissary Plan), 291.4 (Inmate Visitation Plan), 291.5 (Inmate Religious Practices Plan).

[113] *See* Bates 14,948 – 15,020.

[114] In this response, Harris County has made no attempt to specifically cite and thoroughly discuss all relevant policies and procedures that have been produced to the Civil Rights Division.

The Civil Rights Division advocates' systems-related and other findings are inconsistent with the findings made by the DOJ's own National Institute of Corrections, the DOJ's own United States Marshal Service, the Texas Commission on Jail Standards, Advocacy, Inc., and consulting experts John Peters, Ronny Aldridge and Jonathan Roberts.[115]

B. The Civil Rights Division's allegations are inconsistent with the findings issued by the DOJ National Institute of Corrections' technical consultants after completion of their June, 2009 inspection of the Harris County Jail system.

1. Introduction

The National Institute of Corrections ("NIC") is an agency within the United States Department of Justice that, among other things, provides training, technical assistance, information services and policy and program development assistance to federal, state and local corrections agencies.[116]

As part of newly-elected Sheriff Garcia's efforts to improve the quality of services being provided to the citizens of Harris County, Sheriff Garcia invited the Department of Justice's NIC into the Harris County Jail in April of 2009 to conduct a jail assessment and identify areas of possible improvement in jail operations.[117] In response, the NIC engaged "Technical Resource Providers" ("DOJ's NIC consultants") Bill Crout and James Coleman to conduct a Jail System Assessment with the intent of: (1) ensuring that the Harris County jail system is operating safely, securely and efficiently; (2) providing a critical, balanced and non-biased assessment; and (3) making recommendations for incremental improvements to the jail system.[118] Messrs. Crout and Coleman together have more than 75 years of experience in law enforcement and jail operations.[119]

The DOJ's NIC consultants inspected the Harris County Jail system from June 22 - 25, 2009.[120] The DOJ's NIC consultants used American Correctional Association ("ACA") standards and

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[115] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 1 para. 3, at 2 para. 1, at 3 para. 3, at 3 para. 3, at 4 para. 2, at 5 para. 5, at 5 para. 1, at 5 para. 5, at 8 para. 2, at 10 para. 2, at 10 para. 4, at 14 para. 5, at 15 para. 2, at 18 para. 2, at 19 para. 2, at 20 para. 4, at 21 para. 2, at 21 para. 3, at 21 para. 7 .

[116] *See* Overview, http://www.nicic.org/AboutUs (last visited Aug. 20, 2009).

[117] *See* Exhibit 10 (United States Department of Justice—National Institute of Corrections July 2, 2009 Jail System Assessment at 4).

[118] *See* Exhibit 10 at 5, 8.

[119] *See* Exhibit 10 at 5. *See* Exhibits 11 (Curriculum Vitae of William Crout) & 12 (Curriculum Vitae of James Coleman).

[120] Notably, on June 23, 2009, while the DOJ's NIC consultants were on-site inspecting the Harris County jail facilities pursuant to Sheriff Garcia's request, the Civil Rights Division sent Harris County a letter recommending the NIC's technical assistance program to Harris County.

good correctional practices ("community standards") as the benchmark for their peer review project.[121] Following these standards, the DOJ's NIC consultants had high praise regarding the operation of and conditions of confinement in the Harris County Jail system.[122] The DOJ's NIC consultants generally found:

> The Harris County Jail System does an excellent job in performing its mandate to hold inmates in custody pending trial, during trial and if applicable, upon sentencing. The [DOJ's NIC consultants] have noted a number of examples where the HCSO does an exceptional job in providing various services. Other jail systems could look to this jail system to provide example[s] of "best practices" in many areas. Without a doubt, staff at all levels appeared to be dedicate[d], knowledgeable and committed to their profession. This is a good jail system that desires to be even better.[123]

The DOJ's litigation team—the Civil Rights Division—leveled allegations regarding the medical, mental health, protection from harm and environmental issues that are wholly inconsistent with the findings made by the DOJ's technical branch—the National Institute of Corrections—on those same issues.

2. The Civil Rights Division's allegations regarding medical and mental health care are inconsistent with the NIC technical consultants' findings regarding the "constellation" of medical and mental health services offered to inmates incarcerated in the Harris County Jail system.

The DOJ's NIC technical consultants made these observations and findings regarding the "constellation" of medical and mental health care services offered to inmates incarcerated in the Harris County Jail system:

Inmate Processing Center—Medical/Mental Health

> Staff report that significant medical and mental health resources are expended at the "front end" (processing) of the inmates incarceration in an attempt to identify inmates in immediate need of medical/mental health attention. In addition to being individually interviewed by licensed medical staff, inmates receive a chest x-ray to determine the possibility of Tuberculosis. The digital x-rays are immediately screened for significant issues then read by a radiologist in more detail within 24 hours. Inmates with immediate medical/mental health concerns are either immediately examined, or if appropriate, transferred to the 1200 Jail where the medical and mental health clinics are located.[124]

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121 *See* Exhibit 10 at 5.

122 *See,* Exhibit 10.

123 *See* Exhibit 10 at 30.

124 *See* Exhibit 10 at 16.

Inmate Processing Center—Classification

Inmates are interviewed, using a standardized objective classification instrument, to determine their safety/security risks. Inmates are classified as maximum, medium and minimum security. In addition inmates will be sub-categorized by gender, protective custody, and administrative segregation due to high publicity, high violence potential or a history of assaults on staff. Classification staff (with input from medical staff) then determine where to house the inmate in the system.[125]

1200 Baker Street Jail

The six story 1200 Baker Street Jail is located as its name suggests. It is the newest of the three jails in the Harris County Jail System having been constructed in 2003. It contains 4,156 beds arrayed in single, multiple and dormitory cells. This facility contains medical and mental health beds as well as the primary medical infirmary for the jail system. It contains both male and female inmates. Finally, the main headquarters for the Sheriff's Office is located here.[126]

1200 Baker Street Jail—Clinics

One of the area[s] of the jail that most impressed the [DOJ's NIC consultants] was with the clinics. While the [DOJ's NIC consultants] are not medical experts, they do have expertise in jail operations. Jail operations all contain the element of medical services provided to the inmates. Of course, the litmus test that must be given to medical services is that it must provide what services are available in the community.[127]

Providing dental care to inmates is a basic service that jails must provide. Medium and smaller jails will provide this service by sending inmates into the community (escorted by custody staff). This is not only dangerous but very expensive to the counties for staff time, transportation vehicles and dentists' fees. The HCSO has a complete dental clinic where inmates receive these services within the secure perimeter of the facility. The [DOJ's NIC consultants] have rarely seen such a comprehensive array of dental services provided inside the jail. The taxpayers of Harris County also reap the reward because this is a very cost-effective way to provide these services.[128]

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125 *See* Exhibit 10 at 16.

126 *See* Exhibit 10 at 18.

127 *See* Exhibit 10 at 19.

128 *See* Exhibit 10 at 20.

Another medical function that is most often provided by transporting inmates to the community is ophthalmology. Inmates needing prescription eyeglasses can be evaluated within the secure portion of the jail. The [DOJ's NIC consultants] have never seen an ophthalmology office within the jail, but are of the opinion that, like the dental services, provides a very cost-effective and safe way to provide these services.[129]

X-Ray imagery is another basic service that doctors mu[st] have access to in order to do their job. This facility contains state of the art digital x-ray equipment where images [can] be digitally transferred from one office/terminal to another. This provides doctors a much more efficient method for accessing this tool versus the traditional film (which is difficult to store and access). This provides another example of the quantity of medical services being provided to the inmates.[130]

Looking more like a hospital emergency room than a jail clinic, the jail infirmary appears to contain all of the necessary equipment to provide both immediate care to inmates needing medical services.[131]

The infirmary also contains medical beds for those inmates needing this type of housing and care. While this facility will never replace the need for hospital access, care is provided on par with that which is contained in a nursing home environment.[132]

Scattered throughout all of the facilities that the [DOJ's NIC consultants] visited were locked metal boxes where inmates may insert their request for medical services as well as grievance forms. These boxes are frequently accessed by designated staff and the contents reviewed for the most appropriate action.[133]

1200 Baker Street Jail—Mental Health Services

The [DOJ's NIC consultants] visited the mental health section of the jail where the most serious cases of inmates with mental illnesses are cared for and housed. Without getting into a paper on the mentally ill in jails - of which volumes are written, the [DOJ's NIC consultants] observed teams of caring staff working with the most mentally ill in the system.[134]

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129 *See* Exhibit 10 at 20.

130 *See* Exhibit 10 at 20.

131 *See* Exhibit 10 at 21.

132 *See* Exhibit 10 at 21.

133 *See* Exhibit 10 at 21.

134 *See* Exhibit 10 at 21.

> The most impressive feature of the mental health unit, from the [DOJ's NIC consultants'] perspective, was the Crisis Intervention Teams or CITs. There are approximately 45 correctional staff (both blue and white shirts)[135] who have volunteered to work as members of these teams. These staff are provided an additional 112 hours of specialized training in working with mentally ill inmates. Mental health staff describe the CIT personnel as our "eyes and ears" in the units. The [DOJ's NIC consultants] observed a CIT member being used in conjunction with regular mental health staff to "deescalate" the behavior on a mentally ill inmate.[136]
>
> These teams regularly work with mentally ill inmate[s] - they know and understand them as individuals. They learn what "sets them off" and are trained in how to address the problem. They do not replace mental health professionals, but they do replace the custodial staff working with these individuals. What the County receives is a much more efficient and humane way in dealing with the mentally ill in the jail.[137]
>
> 1307 Baker Street Jail—Dialysis Unit
>
> What truly makes this facility remarkable is the dialysis unit that is located within the secure perimeter of the facility. The [DOJ's NIC consultants] have never seen a dialysis unit such as this one located within the walls of the jail. The existence of this unit not only speaks to the constellation of medical services being provided to the inmates, but it addresses many of the cost effective and safety issues previously discussed in connection with the 1200 dental unit.[138]

The allegations made by the Civil Rights Division are inconsistent with these excerpted findings, which were made by technical consultants charged with providing a critical, balanced and non-biased assessment of the Harris County Jail system.[139]

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135 "Blue shirt" refers to a certified peace officer. "White shirt" refers to a detention officer.

136 *See* Exhibit 10 at 22.

137 *See* Exhibit 10 at 22.

138 *See* Exhibit 10 at 25.

139 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14

3. The Civil Rights Division's allegations regarding the HCSO's protection of inmates from suicide are inconsistent with the DOJ's NIC technical consultants' findings regarding this issue.

The DOJ's NIC technical consultants made these observations and findings regarding the HCSO's efforts to protect incarcerated inmates from suicide in the Harris County Jail system:

General Comments and Observations—Suicides

During the initial request for information from the HCSO, the [DOJ's NIC consultants] asked for data on the number of suicides that have occurred since 2001 in the jail system - the 1200, 701, 1307 jails and the IPC. We were extremely surprised to see that there had only been three completed suicides in the downtown housing jails mentioned during this time frame. We thought that there must be some type of mistake made in gathering the data.

During our on-site visit, one of the first issues addressed with Sheriff's staff was to verify the total numbers, which they did. Even though even three suicides are tragic, we were astonished that with a system as large as HCSO, that there had only been three completed suicides during this long period of time. Our experience has shown that even in the best operated jail systems, and even in much smaller jails, it is almost unheard of to only have three completed suicides during a eight and a half [year] period of time. At this point we felt that the jail staff are either doing something extraordinary to prevent the numbers of suicides, or were extremely lucky.

During our on-site visits of the jail facilities, we discovered that there are four primary reasons that HCSO has so few suicides.

- First, medical and mental health care are "front loaded" into the system. This means that high level medical and mental health assessments occur as a part of the booking process. Experience has shown that a majority of suicides occur during this initial 48 hour period of time. At-risk inmates are identified, and appropriate measures taken to prevent self-abuse.

- Secondly, the mental health staff are aggressive in identifying at-risk inmates and providing appropriate preventative measures.

- Thirdly, the Crisis Intervention Team - specially trained custody staff - act as a personnel multiplier in performing the two functions as custody staff and mental health para-professionals. This increases the number of trained staff available to identify at-risk inmates. And

- Fourthly, all custody staff perform frequent "safety checks" (aka cell checks) on all inmates. Inmates exhibiting at risk behavior are quickly identified and referred to mental health.

> As correctional professionals, we know that the number of suicides directly relates to how well a jail system is performing the function of ensuring that the inmates in its care and custody leave the jail in at least as good shape - and often much better - than they were when they entered the system.[140]

The Civil Rights Division's allegations are inconsistent with the NIC technical consultants' findings regarding the suicide issue.[141]

4. The Civil Rights Division's allegations regarding the use-of-force and related issues are inconsistent with the NIC technical consultants' findings regarding these issues.

The DOJ's NIC technical consultants rendered these findings regarding the use of force in the Harris County Jail system:

> Use of Force
>
> As we stated in our scope of work, the [DOJ's NIC consultants] were not on-site to examine any individual cases of misconduct or, for example, deaths in custody. Rather, we focused on systems issues - what are the policies and procedures in place to address various functional areas of the jail. As such, we examined policies, procedures and formats intended to ensure that these policies and procedures are followed. The area of use of force is one such are that we examined.
>
> We found that the policies and procedures regarding the use of force to be well written and meets that "community standard" for such an area in the jail. They are written so that they are easily understandable and the use of various terms are, when necessary, explained in such a way that they are clear to the reader.
>
> We also found that the reporting process for use of force incidents is extremely comprehensive, yet not overly complex. It ensures that each incidence of use of force is examined and tracked at various levels of management to determine whether the incident was within policy and otherwise appropriate, or where it required additional investigation and, if necessary, disciplinary action. We were satisfied that the process currently in place provides the necessary safeguards to ensure that use of force incidents are appropriate.
>
> Use of force incidents in the jail are an unfortunate necessity. We are satisfied that whether to apply the use of force and the appropriate application of force is use, is well documented. However, we caution management to ensure that a

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140 *See* Exhibit 10 at 34-35.

141 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 14

balance is maintained so that staff do not perceive that any "proper application" of force will subject them to a disciplinary process. Where this happens, whether in the jail, or on patrol in the community, incidents that could have been easily de-escalated through a minimal use of force often spin out of control requiring a much larger use of force. We also caution that misconduct by individual custody staff where employee discipline is needed, not be used to revamp the entire system unless this misconduct proves to be a "systems issue." Likewise we would hope that the public and the media be able to differentiate between individual isolated incidents of misconduct - that are appropriately addressed by management, and a broken system.[142]

These findings are inconsistent with the allegations made by the Civil Rights Division.[143]

5. The Civil Rights Division's allegations regarding sanitation and hygiene in the Harris County Jail system are inconsistent with the NIC technical consultants' findings regarding these issues.

The DOJ's National Institute of Corrections' technical consultants made these findings regarding sanitation in the Harris County Jail system:

Inmate Processing Center—Property Storage

Overall, the cleanliness of the facility was very good in spite of its use. While the flow of the facility appears to be fair, the number of inmates frequently overwhelms functional use area. The fact that this facility is working as well as it does, is a testament [to] the dedication of management and line staff who operate it.[144]

1200 Baker Street Jail—Laundry

A critical function that occurs in every jail is the laundry. This is because it is a link in maintaining sanitary conditions in a jail, which in turn results in fewer contagious diseases being transmitted between inmates, and in some cases we have seen in other jails - staff. We observed that all of the washing and drying machines were working. Staff report providing general inmate clothing

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142 *See* Exhibit 10 at 36. *See also Id.* at 22 (re 1200 Baker Street Jail's Inmate Housing) ("In addition, the noise level and tension level [in Inmate Housing] was relatively low. According to documentation, staff conducted frequent "safety checks" of the inmates to ensure safety and security needs."). 28 (re 701 North San Jacinto Jail's Housing) ("The TRPs visited several housing units representing the different types of inmate housing. We found that without exception, these housing areas were clean and well supervised. Inmates did not display tense or aggravated behavior. The noise level, in spite of the hard walls, was relatively low.").

143 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 14-16.

144 *See* Exhibit 10 at 17.

exchanges at least twice a week and every day for inmates who work on crews (kitchen, outside maintenance, cleaning etc.) which meets the "community standards."[145]

1200 Baker Street Jail—Inmate Housing

The [DOJ's NIC consultants] visited several housing units contained within this facility. Without exception, they were extremely clean and well maintained. In addition, the noise level and tension level was relatively low. According to documentation, staff conducted frequent "safety checks" of the inmates to ensure safety and security needs.[146]

1307 Baker Street Jail

Without a doubt, this facility ranks as one of the top five cleanest jails we have ever seen. This does not happen overnight, or ever with concentrated scrubbing over a month - it occurs as an ongoing and continuous process. It is important to the management of the jail for several reasons. First, it maintains a high level of sanitary conditions. Secondly, it sends a strong message to the inmates of the high expectations that staff have for them - it really sets the tone for how professionally the facility is operated.[147]

701 North San Jacinto Street Jail—Laundry

Similar to the other facilities that the [DOJ's NIC consultants] visited, the laundry was well stocked, functional and extremely clean.[148]

701 North San Jacinto Street Jail—Housing

The [DOJ's NIC consultants] visited several housing units representing the different types of inmate housing. We found that without exception, these housing areas were clean and well supervised. Inmates did not display tense or aggravated behavior. The noise level, in spite of the hard walls, was relatively low.[149]

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145 *See* Exhibit 10 at 19.

146 *See* Exhibit 10 at 22.

147 *See* Exhibit 10 at 25.

148 *See* Exhibit 10 at 28.

149 *See* Exhibit 10 at 28.

The allegations made by the Civil Rights Division regarding the sanitation and hygiene issues are inconsistent with these findings made by the DOJ's NIC technical consultants regarding these issues.[150]

6. The Civil Rights Division's allegations regarding the numbers of deaths in custody are inconsistent with the DOJ's NIC technical consultants' observations regarding this issue.

The DOJ's NIC technical consultants made these observations and recommendations regarding the death-in-custody issue:

> It is well documented ... in jails throughout the United States that the inmates jails are receiving today are much sicker, mentally ill, and accused of more serious crimes than the inmate of only a couple of decades ago. Consequently, we are seeing a significant number of "deaths in custody" - where inmates die in jails due to "natural causes."
>
> The [DOJ's NIC consultants] do not have the expertise and background to investigate individual incidents of deaths in custody. What we do have is the knowledge of how these deaths should be documented and investigated by custody staff for the purposes of examining the potential role that custody staff had, if any, in the death.
>
> After review of applicable policies and procedures for deaths in custody, we are satisfied that they are thorough, comprehensive, and clear. They meet, in our opinion, the "community standard" for responding to, reporting and investigating all deaths in custody. That said, we recommend two modifications:
>
> - First, that a section be added to the "Significant Incident Notifications" policy and procedures (Policy #402) that specifies that the Sheriff is notified of all in-custody deaths or serious injuries of inmates as soon as practical by the Detentions Bureau Commander.
>
> - Secondly, we recommend that the HCSO institute a policy, similar to the medical "quality improvement meetings", that are intended to examine all actions taken, or not taken, by custody staff that could have influenced the death. Information from this meeting will then be used to make any corrections in custody policies, procedures or practices that are necessary. County legal staff must be involved in the design and implementation of such a process.[151]

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150 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 18-20.

151 *See* Exhibit 10 at 37.

In sum, the DOJ's National Institute of Corrections consultants, who perform jail assessments for the Department of Justice's technical branch (rather than within the Civil Rights Division's "litigation program"), found that the Harris County Jail system "does an excellent job in performing its mandate to hold inmates in custody pending trial, during trial and if applicable, upon sentencing."[152]

C. The Civil Rights Division's allegations are inconsistent with the findings issued by the DOJ's United States Marshal Service after completion of its July, 2009 inspection of the Harris County Jail system.

The Civil Rights Division's allegations are inconsistent with the DOJ's United States Marshal Service's ("USMS") July 27, 2009 "Detention Facility Investigative Report," which was completed after the USMS most recent assessment of the conditions of confinement in the Harris County Jail system.[153] In this report, the USMS found the Harris County Jail system to be fully compliant with each of the USMS' core detention standards.

The United States Marshal Service is an agency of the United States Department of Justice[154] that, among other things, receives approximately 217,000 federal detainees each year,[155] and "currently houses approximately 58,000 federal detainees each day."[156] About 80 percent of these 58,000 USMS detainees are actually housed in 1,800 state, local and private jails across the country.[157] The remaining detainees are housed in Federal Bureau of Prisons facilities.[158]

The USMS monitors the non-federal facilities that house USMS detainees to help ensure that those facilities are safe and humane, protect detainee statutory rights and protect detainee constitutional rights. In each facility monitored, the USMS reviews the facility's administration/management,[159] health care,[160] security and control,[161] food service,[162]

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[152] *See* Exhibit 10 at 30.

[153] *See* Exhibit 13 (USMS' July 27, 2009 Detention Facility Investigative Report).

[154] *See* US DOJ — About DOJ — Alphabetical List of Agencies, http://www.usdoj.gov/02organizations/02_1.html (last visited Aug. 4, 2009).

[155] U.S. Marshals Fact Sheet, Facts and Figures, http://www.usmarshals.gov/duties/factsheets/2009/facts_figures_0409.pdf (last visited July 31, 2009).

[156] U.S. Marshals Fact Sheet, http://www.usmarshals.gov/duties/factsheets/2009/general_fact_0409.pdf (last visited July 31, 2009); U.S. Marshals Fact Sheet, Prisoner Operations, http://www.usmarshals.gov/duties/factsheets/2009/po_fact_0409.pdf (last visited July 31, 2009).

[157] *Id.*

[158] *Id.*

[159] With regarding to its "administration/management" review, the USMS reviews these "core detention standards": policy development and monitoring; internal inspections and reviews; detainee records; admission and orientation; personal property and monies; detainee releases; and accommodations for the disabled. *See* Exhibit 13 at 12.

staff/detainee communication,[163] safety and sanitation,[164] services and programs,[165] workforce integrity,[166] and detainee discrimination.[167] When assessing facilities housing USMS detainees, the USMS determines whether the facility is compliant,[168] partially compliant,[169] or non-compliant[170] in each of these surveyed areas.[171]

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[160] With regard to its "health care review" review, the USMS reviews these "core detention standards": intake health screening; medical, dental and mental health appraisals; access to routine, chronic and emergency health services; experimental research; response to medical, mental and dental health needs; suicide prevention; detainee hunger strikes; detainee deaths; informed consent/involuntary treatment; and infectious disease. *See* Exhibit 13 at 12.

[161] With regard to its "security and control" review, the USMS reviews these "core detention standards": post orders; permanent logs; security features; security inspections; control of contraband; detainee searches; detainee accountability and supervision; use of force; non-routine use of restraints; tool and equipment control; weapons control; detainee discipline; supervision for special housing; and contingency/emergency plans. *See* Exhibit 13 at 12-13.

[162] With regard to its "food service" review, the USMS reviews these "core detention standards": sanitation requirements; adequate and varied meals; and special diets. *See* Exhibit 13 at 13.

[163] With regard to its "staff/detainee communication" review, the USMS reviews these "core detention standards": staff-detainee communication; diversity training; and detainee grievances. *See* Exhibit 13 at 12.

[164] With regard to its "safety and sanitation" review, the USMS reviews these "core detention standards": fire safety; non-hazardous furnishings; control of dangerous materials; environmental control; clothing and bedding; personal hygiene/well-being; and physical facility and equipment. *See* Exhibit 13 at 12.

[165] With regard to its "services and programs" review, the USMS reviews these "core detention standards": classification, review and housing; religious practices; volunteer work assignments; work assignments and security; juvenile needs; exercise and out-of-cell opportunities; legal materials; legal representation; telephone access; visitation privileges; and detainee mail and correspondence. *See* Exhibit 13 at 12.

[166] With regard to its "workforce integrity" review, the USMS reviews these "core detention standards": staff background and reference checks; staff training, licensing and credentialing; and staff misconduct. *See* Exhibit 13 at 13.

[167] With regard to its "detainee discrimination" review, the USMS reviews this "core detention standard": discrimination prevention. *See* Exhibit 13 at 13.

[168] If the USMS determines that a facility is "compliant" in a surveyed area, the USMS has deemed the facility to have adequate policies, procedures and processes are in place to achieve the standard. *See* Exhibit 13 at 11.

[169] If the USMS finds that a facility is "partially compliant" in a surveyed area, the USMS has found that improvements are necessary, such as additional resources, policy clarifications, process or procedural changes, to fully achieve the standard. *See* Exhibit 13 at 11.

[170] If the USMS finds that a facility is "non compliant" in a surveyed area, the USMS has concluded that adequate policies, procedures and processes are either not in place or not working. *See* Exhibit 13 at 11.

[171] The USMS may also find that a standard is not applicable to the facility, which means that it is not relevant for that facility. *See* Exhibit 13 at 11.

The DOJ's USMS at times incarcerates some of its federal detainees in the Harris County Jail system. Under these circumstances, USMS routinely monitors the conditions of prisoners' confinement in the Harris County Jail system. In 2009, as found in previous inspections, the USMS reviewed each of the areas referenced above and found the Harris County Jail system to be compliant with each of the USMS' core detention standards. The USMS thus determined that the HCSO has adequate policies, procedures and processes in place to achieve each of the standards assessed by the USMS. In accordance with that determination, the USMS continues to incarcerate some of its detainees in the Harris County Jail system.

D. The Civil Rights Division's allegations are inconsistent with the results of the Texas Commission on Jail Standards' 2007 and 2008 inspections of the Harris County Jail system.

Texas law requires the Texas Commission on Jail Standards to, among other things, periodically inspect county jail facilities.[172] To that end, the TCJS conducts, at minimum, an annual inspection of county jail facilities. The TCJS also performs surprise inspections. These inspections are completed to gauge compliance with applicable jail standards related to new construction, existing construction, life safety, admission, release, records and procedures, classification, health services, supervision, staff qualifications, personal hygiene, sanitation, food service, discipline, grievance, exercise, education, library, work assignments, telephone access, correspondence, commissary, visitation, religious practices, variances, remedial orders (if any), complaints, and the jail care system.

Due to the large size and complexity of the Harris County Jail system, the TCJS sends an entire team, usually consisting of five inspectors, to Harris County to conduct their annual inspection. The TCJS team typically spends an entire week on-site inspecting the various facilities, reviewing applicable files and records, and conducting interviews. The inspection concludes with the team conducting a detailed brief-out with the Harris County Sheriff, his Command Staff, and jail administrators.

In 2007 and 2008, the time period ostensibly covered by the Civil Rights Division's findings, the Harris County Jail system successfully passed the annual state jail inspection with no areas of non-compliance. Indeed, the Harris County Jail system have been in full compliance with all applicable state jail standards since April 2007 (for approximately 25 of the last 28 months), and are in full compliance today.[173]

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[172] *See* Tex. Loc. Gov't Code § 351.001 *et seq.*; Tex. Gov't Code § 511.001 *et seq.*; 37 Tex. Admin. Code § 297.1 *et seq.*

[173] In mid-April 2009, the Harris County Jail system failed inspection due primarily to maintenance issues at the 701 North San Jacinto Jail, an excess prisoner count in two court holdover cells in the basement of the 701 Jail, and emergency generator testing and operation issues. Those deficiencies were promptly addressed and the Harris County Jail subsequently passed a surprise state re-inspection conducted in late July 2009.

E. The Civil Rights Division's allegations regarding the number of deaths in custody are inconsistent with Dr. Dwight Steward's findings concerning the mortality rate issue.

The Civil Rights Division advocates alleged that "the number of inmate deaths related to inadequate medical care, described below, is alarming."[174] The Division described five inmate deaths in the medical and mental health care sections of the June 4, 2009 letter. As more fully explained in the medical and mental health sections of this response, there is no support for the conclusion that these deaths were caused by constitutionally inadequate medical or mental health care.

Harris County also denies the Civil Rights Division's unsupported, sensational claim that "the number of inmate deaths ... is alarming." In its June 4, 2009 letter, the Division identified three inmates who allegedly died as a result of inadequate medical care over the 2007-2008 time period. The Division also identified two inmates who allegedly died as a result of inadequate mental health care over the 2006 to 2008 time period.

Harris County asked Dr. Dwight Steward, an expert in statistics and economic analysis,[175] to statistically review, among other things, the contentions made by the Division regarding the mortality rate in the Harris County Jail system.[176] Dr. Steward determined that no statistical evidence supports the Division's allegation that the number of deaths described in the Division's letter is "alarming." Dr. Steward found that the individual incidents identified by the Division do not suggest a statistical pattern of systematic deficiency. Dr. Steward further found that even if the five described deaths were related to inadequate care, the five inmate deaths out of the hundreds of thousands of inmates that the Harris County Jail system incarcerated during the specified time period in no way constituted a statistical pattern of systematic deficiency.

Dr. Steward found that that the three inmate deaths who the Division advocates alleged to have died as a result of inadequate medical care represent 0.0000111 (0.00111%) of the 269,050 inmates who were incarcerated in the Harris County Jail over the 2007-2008 time period. Dr. Steward found that the two inmates who the Division advocates alleged to have died as a result of inadequate mental health care constitute 0.0000049 (0.00049%) of the 405,076 inmates who were incarcerated in the Harris County Jail over the 2006-2008 time period.

Dr. Steward also determined that the number of inmate deaths in custody at the Harris County Jail system is consistent with the number of deaths that occurred at other large jail facilities across the United States. According to Dr. Steward, there was an average of 153 inmate deaths at the five largest comparator jail facilities in the United States during the 2000 to 2006 time period. The Harris County jail facilities experienced 111 deaths in custody during the same time period. In fact, Harris County jail facilities had fewer inmate deaths than four of the five of the

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[174] *See e.g.* Letter from Loretta King to Ed Emmett, *supra* note 3, at 2 para. 2 .

[175] Exhibit 14 (Currriculum Vitae of Dr. Dwight Steward).

[176] Dr. Steward is currently working on a report addressing this and other issues raised in the Civil Rights Division's June 4, 2009 letter. Harris County plans to forward Dr. Steward's report upon its receipt.

comparator jails during the 2000 to 2006 time period.

F. The Civil Rights Division's allegations regarding mental health care in the Harris County Jail system are inconsistent with Advocacy Inc.'s Beth Mitchell's July 22, 2009 observations regarding mental health care in the Jail system.

Advocacy, Incorporated ("Advocacy"), is a protection and advocacy organization created under the Protection and Advocacy for Mentally Ill Individuals ("PAMII") Act.[177] Advocacy is authorized to "pursue administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the State."[178] To that end, Advocacy monitors Texas jail facilities. Advocacy, lead by attorney Beth Mitchell, began focusing its attention on the Harris County Jail system in late 2006, and has continuously monitored the mental health care provided to the prisoners ensconced in the Harris County Jail system since then.

After receipt of the Civil Rights Division's June 4, 2009 findings letter, Ms. Mitchell re-inspected the Harris County Jail system's mental health facilities. After such review, Ms. Mitchell sent the Division advocates the attached July 22, 2009 letter addressing the mental health issues raised by the Division.[179] As Ms. Mitchell noted, Advocacy's relationship with the HCSO moved very quickly from an adversarial to a mutually supportive working relationship resulting in significant improvements for individuals with mental illness housed in the HCJ.[180] In her letter to the Division, Ms. Mitchell explained that the HCSO "has been willing to listen to our concerns and our advice regarding working with and treating persons with mental illness and the HCJ has far exceeded our expectations in implementing recommendations made by our national expert after touring and inspecting the Jail (the tour and inspection was limited to the mental health care)."[181]

Ms. Mitchell also explained Advocacy's opinion that many of the areas that the Division found to be insufficient are the very areas in which the Harris County jail facilities have already made huge strides, and where the Jail "far exceeds the standards of most jails nationally":

> Interestingly, upon review of the DOJ Report, it is Advocacy's opinion that many of the areas that DOJ found to be insufficient are the very areas in which HCJ has

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177 *See* 42 U.S.C. §§ 10801-10851 (West 2005).

178 *Id.* § 10805(a)(1)(B).

179 Exhibit 15 (Advocacy's Beth Mitchell's July 22, 2009 Letter to Loretta King, Acting Assistant Attorney General, United States Department of Justice, Civil Rights Division, regarding the Civil Rights Division's Investigation of the Harris County Jail).

180 Exhibit 15 at 1.

181 Exhibit 15 at 1.

> already made huge strides and where HCJ probably far exceeds the standards of most jails nationally.[182]

Ms. Mitchell outlined some "examples of the major improvements that HCJ has made on a completely voluntarily basis, without the threat of a lawsuit." Ms. Mitchell highlighted these additions to the Harris County Jail system's compliment of psychiatrists and other mental health professional staff:

Positions	2007	2009
Psychiatrists	4 (only one was full-time)	11
Psychologist	2	3
Case managers	8	7
LPHA	10	13
Psych tech	25	34[183]

Ms. Mitchell noted that Harris County hired and gave specialized training to additional detention officers, and stressed that these individuals' training had "already led to a reduction in restraints and altercations":

> Hiring and training 64 Detentions Officers (DO"), all of whom have received an additional 48 hours of specialty training in Mental Health-Crisis Intervention Management. These DO's wear plain clothes instead of the law enforcement uniforms to minimize the intimidation effect sometimes perceived by inmates. The additional training has already led to a reduction in restraints and altercations.[184]

Ms. Mitchell elaborated on Harris County's increases in the range and number of housing options available for persons with mental illness who are incarcerated in the Harris County Jail system:

> HCJ added 24 beds at an offsite psychiatric facility (HCPC) for those inmates whose mental health has significantly deteriorated and can't be treated in a jail setting, making it probably the only jail in the country that utilizes an offsite psychiatric facility to provide care to those inmates who are most in need. HCJ increased its acute psychiatric bed capacity from 51 to 108 at the jail. HCJ added a 12 bed cognitive behavioral therapy unit managed by psychologists and increased the number of beds in their mental health step down units to 148, bringing a total number of beds dedicated solely to mental health care to 280.[185]

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[182] Exhibit 15 at 1.

[183] Exhibit 15 at 2.

[184] Exhibit 15 at 2.

[185] Exhibit 15 at 2.

Ms. Mitchell explained, at length, improvements made by Harris County in the initial identification, evaluation and medication of inmates with mental illness:

> This is one of the main areas that in the past Advocacy would receive numerous complaints from inmates. Now. Advocacy rarely if ever receives complaints about inmates not receiving medications or seeing a psychiatrist upon booking and, when it does, HCJ quickly resolves the issue.
>
> HCJ accomplished this by significantly reorganizing the process through which inmates with mental illnesses are screened, identified and evaluated upon booking. Now, when an inmate is being booked into the HCJ and determined through the initial screening process to have a possible mental health need, they are diverted to the clinic for a higher level of evaluation prior to housing to better determine the appropriate housing location, medication, and evaluation needs of the individual inmate.
>
> This new process has reduced the average time it takes an inmate to see a psychiatrist after intake screening from months to being seen the same day as being booked and it has enabled inmates to receive psychiatric medications after booking in approximately 2 days, compared to what used to be months.[186]

Ms. Mitchell summarized revisions made to the restraint and seclusion policies and procedures for the HCSO's mental health units:

> The Medical Director revised the restraint and seclusion policies and procedures for the mental health units. He requested Advocacy's input when revising these policies and ultimately agreed to implement the restraint and seclusion policies used in Texas' state hospitals which exceed CMS's Conditions of Participation (CoPs) standards regarding the use of restraint and seclusion. Again, something I am sure no other jail has been willing to adopt.[187]

Ms. Mitchell highlighted additional quality assurance components that Harris County has added to the HCSO's mental health program:

> Adding a Utilization Review Manager who provides quality assurance data to Advocacy on a regular basis and has been willing to add fields to the data collection when necessary to address potential areas of concern.[188]

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186 Exhibit 15 at 2.

187 Exhibit 15 at 2-3.

188 Exhibit 15 at 3.

Ms. Mitchell concluded her response to the Civil Rights Division advocates' June 4, 2009 findings by underscoring the "sweeping and substantive changes to the care and treatment of the individuals with mental illness" made by Harris County:

> Advocacy has been in many Texas jails. None of the jails that Advocacy has monitored has taken the initiative, without litigation, to make such sweeping and substantive changes to the care and treatment of the individuals with mental illness. This is not to say that HCJ is perfect, there are still areas that need improvement, but HCJ has been one of the few jails that Advocacy has worked with that is committed to truly making changes that in many cases exceed national standards. Considering all of the institutions that are not willing to make changes on their own, why make a facility that is trying to do the right thing, and in fact has done just that in many areas, feels as if it were all for naught? Advocacy's fear is that this will stifle HCJ strive for perfection and instead leave them at mediocrity since they may now just comply with the conditions of the settlement instead of looking to excel.[189]

The Civil Rights Division's allegations regarding the provision of mental health care in the Harris County Jail system are clearly inconsistent with Advocacy's findings, which are based upon Advocacy's attorneys' and other personnel's routine review, since 2006, of the mental health care provided to prisoners incarcerated in the Harris County Jail system.

F. The Civil Rights Division's allegations regarding the use-of-force and related issues are inconsistent with Dr. John Peters' findings regarding these issues.

Harris County asked Dr. John Peters[190] to accompany the Civil Rights Division advocates' team during their August 2008 inspection of the Harris County Jail system and to review the allegations made by the Division on the use-of-force issue. After participating in the August 2008 inspections and reviewing the Civil Rights Division's June 4, 2009 letter, Dr. Peters issued

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189 Exhibit 15 at 3.

190 Dr. John Peters is a law enforcement consultant who has wide ranging experience in social science research, statistical analysis, training and lesson plan development, and literature reviews, among other areas of expertise. Dr. Peters holds an Associate Degree in Applied Science, Cum Laude, with a certificate in Corrections from Northern Virginia Community College, a Bachelor of Science, Summa Cum Laude, from the University of Baltimore, a Master of Science in Public Relations from Boston University, a Master of Business Administration with Distinction from Babson College, and a PhD from Walden University. Dr. Peters is a former law enforcement patrol officer, deputy sheriff, and law enforcement administrator. As such, he is familiar with the need for and requirements of written policies, rules and procedures in the detention setting, as well as the need to train law enforcement officers about these written policies, rules and procedures. Dr. Peters has provided instructor-level, or Train-the Trainer training throughout North America and England since 1979. Dr. Peters has instructed on such areas as: use of force; expandable baton; straight baton; side-handle baton; tactical handcuffing; tactical flashlight; electronic restraint devices; handgun retention and disarming; unarmed defensive tactics; handling of emotionally disturbed persons; restraint devices; and the prevention of in-custody death. Dr. Peters is also a certified TASER M26, X26, X3, ECD Instructor and a certified TASER armorer. Dr. Peters has taught law enforcement officers throughout the State of Texas for the past three decades and has published over 160 articles and journals. Dr. Peters' very substantial curriculum vita is attached to his report. Exhibit 16.

an extensive report critiquing the Division's methodology and use-of-force findings.[191] Dr. Peters found, among other things, that the HCSO met constitutional standards regarding the use-of-force in the Harris County jail facilities. Dr. Peters noted that the HCSO also exceeded CALEA requirements relating to the development of use-of-force policies for deputies and/or jailers.[192] Dr. Peters found that the uses-of-force deployed by HCSO personnel in the incidents described in the Division's letter were consistent with constitutional and national standards.[193]

Dr. Peters found that the Civil Rights Division failed to identify the constitutional standards and criteria that were allegedly violated by Harris County Jail officers that led to constitutional violations with regard to the use of force. The DOJ's report suggested that any force used which may have been associated with an injury is excessive force. That is not the legal standard."[194]

Dr. Peters performed a statistical analysis of inmate-on-inmate assaults, assaults on Harris County Jail system staff, fighting and use of force incidents. That analysis contradicted the Civil Rights Division's allegation that HCSO officers use hazardous force techniques. In Table 3, on page 20 of his report, Dr. Peters analyzed 2008 and early 2009 data regarding totals for use-of-force incidents, inmate-on-inmate assaults, assaults on staff, and fighting. In the "fighting" category, Dr. Peters counted the number of jail disciplinary reports filed against the inmates who were charged with fighting (one report per inmate). Since it takes two or more inmates to constitute a fight, Dr. Peters noted the number of reports listed does not equal the actual number of fight events.

Dr. Peters' analysis revealed that, when compared to the corresponding overall volume of prisoners admitted into the Harris County Jail, the number of inmate assaults, fights and staff uses-of-force are statistically extremely small. Specifically, Dr. Peters determined that only 0.2933% of the inmates received in 2008 were involved in a staff use-of-force incident. Inmate-on-inmate assaults occurred with regard to only 0.176% of the inmates received in the Harris County Jail system in 2008, and fighting reports were generated only 3.14% (based on the number of fight reports generated) of inmate received in 2008.[195] Dr. Peters found that the extremely low percentages showed great restraint by Harris County Jail staff, and did not support

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[191] Exhibit 16 (Dr. John Peters' August 14, 2009 Report in Response to the U.S. Department of Justice's Investigation of the Harris County Jail & attached Curriculum Vitae).

[192] CALEA standard 1.3, Use of Force, directs law enforcement administrators to develop "A written directive [that] states personnel will use only the force necessary to accomplish lawful objectives." See CALEA, November 2001, pages 1-4. A related CALEA standard, 1.3.4, states: "A written directive governs the use of authorized less-than-lethal weapons by agency personnel." *See* CALEA, November 2001, pages 1-4.

[193] CALEA standard 1.3, Use of Force, directs law enforcement administrators to develop "A written directive [that] states personnel will use only the force necessary to accomplish lawful objectives." See CALEA, November 2001, pages 1-4. A related CALEA standard, 1.3.4, states: "A written directive governs the use of authorized less-than-lethal weapons by agency personnel." *See* CALEA, November 2001, pages 1-4.

[194] *See* Exhibit 16 at 20.

[195] *See* Exhibit 16 at 20.

any implication that HCSO officers use hazardous force techniques and/or engaged in excessive force.[196]

Dr. Peters found that HCSO staff used force consistent with constitutional standards to maintain and/or restore security and/or discipline within the Harris County Jail system. He noted that: "Within the United States ... it is well accepted that a legitimate governmental interest is the need to maintain both discipline and security of inmates who are incarcerated. These form the bases for inmate discipline handbooks, discipline procedures and training correctional officers in the reasonable use of force. The failure of a governmental entity and/or its correctional staff to maintain discipline and keep secure those under its care, custody and control has led to health and safety hazards, incidences of violence between and among inmates, and at the extreme of the continuum murder of inmates and/or staff by other inmates and/or rioting. The Santa Fe (NM) Penitentiary rioting of the last century is one example of where a loss of control led to many inmates' deaths and injuries."[197]

Dr. Peters observed that it is widely known and accepted that the category of prisoner can impact both discipline and security. For example, pre-trial detainees often create more demand for services, present greater security risks, and often are more tense and uncertain. Dr. Peters found that the Harris County Jail staff is keenly aware of the two types of inmates it houses: pre-trial and convicted. Regardless of the inmate category, the HCSO staff must maintain discipline and security. Dr. Peters provided examples of how the HCSO staff help to maintain reasonable discipline and security, such as through the training of jail staff, and through the use of written policies and procedures.[198]

Dr. Peters examined the four use-of force examples identified in the Civil Rights Division's June 4, 2009 letter. In his report, Dr. Peters stated that the use of force deployed by HCJ staff in the incidents identified in the DOJ report was consistent with the maintenance of discipline and control of inmates housed within the Harris County Jail system. Dr. Peters determined that: "HCJ staff used force consistent with constitutional standards to maintain and/or restore security and/or discipline within the HCJ."[199] Dr. Peters found that the four examples of alleged use of excessive force identified by the Civil Rights Division failed to support the Division's claim about hazardous restraint and force techniques on inmates without appropriate guidance or sanction, and failed to establish a pattern of excessive force.[200]

After independently assessing the HCSO Use of Force policies and practices, Dr. Peters strongly disagreed with many of the DOJ's Civil Rights Division's findings. Among other things, Dr. Peters questioned the Civil Rights Division's methodology, the validity and reliability of their

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196 *See* Exhibit 16 at 20 & 21.

197 *See* Exhibit 16 at 21.

198 *See* Exhibit 16 at 21.

199 *See* Exhibit 16 at 21.

200 *See* Exhibit 16 at 22.

information, their leaps to causation, and their conclusions, and stated that the Division's findings did not mirror the current operations of the Harris County Jail system.[201]

H. The Civil Rights Division's allegations regarding the sanitation, hygiene and life safety issues are inconsistent with consultants Ronny Aldridge's and Jonathan Roberts' findings regarding these issues.

Harris County asked Ronny Aldridge and Jonathan Roberts to accompany the Civil Rights Division advocates' team during their July and August 2008 inspections of the Jail, and to review the allegations made by the Division on the sanitation, hygiene and fire safety issues. Messrs. Aldridge and Roberts accompanied Leonard Rice, the Civil Rights Division's sanitation and life safety consultant, during the July and August 2008 inspections. The Civil Rights Division's allegations are inconsistent with consultants Aldridge's and Roberts' findings regarding the sanitation and life safety issues.[202]

Messrs. Aldridge and Roberts disagreed with the Division's conclusions regarding the sanitation issue, finding that the HCSO's washing machines met the TCJS' minimum sanitation standards:

> During the time of the DOJ tour, the jail did have several washing machines that were inoperative which since have been replaced with new ones. At no time while the washing machines were down did the jail fail to meet minimum sanitation standards in accordance with the Texas Administrative Code (TAC) 37-9-259.226.
>
> The jail's laundry facility utilizes Ecolab for the delivery of all chemical products in order to maintain sanitary clothing and linen. All commercial grade washing machines have been programmed to deliver the proper amount of detergent to properly sanitize the detainee clothing and linen. The laundry facilities currently use Tristar L2000 xp detergent and Tristar Destainer (bleach) for cleaning and sanitizing the clothing and linen. The laundry facility also has a "Routine Preventative Maintenance Program" for the washing machines and dryers

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201 See Exhibit 16 at 9-14.

202 Exhibit 17 (Consultants Ronnie Aldridge and Jonathan Roberts' July 24, 2009 Response in regard to the U.S. Department of Justice Investigation of the Harris County Jail). Mr. Aldridge has more than ten years experience in developing written programs in, for example, the areas of lockout/tagout, confined space, and bloodborne pathogens. Mr. Aldridge serves as a Safety Coordinator for the Oklahoma Department of Corrections. As a Safety Coordinator, Mr. Aldridge performs health, fire safety, and sanitation and hygiene audits on approximately 90 facilities every six (6) months and participates in all department pre-American Correctional Association (ACA) audits. Mr. Aldridge also provides training to all Department employees on a wide array of health and safety topics. *See* Exhibit 18 (Consultant Ronny Aldridge's Curriculum Vitae). Mr. Roberts has more than ten years experience in providing consultation and program coordination for environmental, health and safety programs. Much like Mr. Aldridge, Mr. Roberts has many years experience in the correctional area as a manager of the Oklahoma Department of Corrections Safety Administration. As a manager, Mr. Roberts performs health, fire safety and sanitation and hygiene audits on approximately 90 facilities every six (6) months, participates in all department pre-ACA audits and reviews and writes departmental policies and procedures. *See* Exhibit 19 (Consultant Jonathan Roberts' Curriculum Vitae).

> provided by Ecolab. The routine preventative maintenance consists of Ecolab inspecting the jail's laundry facility every month which consist of inspecting the clothing and linen for the following: appearance, feel, odor, staining, wettability, and wrinkling.
>
> The laundry machines, both washers and dryers are also checked monthly to ensure that they are in proper working condition and dispensing the appropriate amount of chemicals to meet above the minimum sanitary standards. The DOJ consultant also made a comment that the water temperature was not hot enough to properly sanitize the clothing and linen. The laundry uses a special detergent specifically formulated to be used with low water temperature washing and during the bleach cycle the water temperature is maintained at a lower temperature as not to degrade the bleach which in turn would lower the disinfection power of the bleach.[203]

Messrs. Aldridge and Roberts disputed the Division's allegations regarding the accessibility of clothing and linens in the Harris County Jail system, explaining:

> The DOJ report also made allegations that the jail did not maintain enough accessible clothing and linen for the number of detainees housed at the facility. This statement is inaccurate; at no time did the DOJ consultant see any detainee without proper clothing or linen. The laundry maintains extra clothing and linen in six (6) storerooms. The laundry exchange teams take large racks filled with clean clothing and linen for exchange and all detainees are offered clean clothing and linen at least weekly in accordance with TAC 37:9-277.2 and TAC 37:9-277.8. There are several empty bins to collect the dirty laundry and when the bins are full with dirty laundry they are covered with disposable plastic covers and transported to the appropriate laundry facility for cleaning. The DOJ consultant actually witnessed this exchange process on one (1) of the housing units and he had no negative comments on the exchange process.[204]

Messrs. Aldridge and Roberts addressed the Division's allegations regarding the Jail's plumbing and mechanical systems, stating:

> During the first site visit the DOJ consultant made allegations regarding the jail's plumbing system, specifically the floor drains in the shower areas that these drains were not well maintained. The jail staff took immediate action in correcting this issue. The jail manually began to clean every drain in the facility and started to use an enzyme based cleaner for the drains. On the second visit, the DOJ consultant praised the jail's staff on how clean the drains were. During the second visit the DOJ consultant did not find a single floor drain that was dirty or unsanitary. In the DOJ report, the jails use of archaic flushable floor drains sued

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203 Exhibit 17 at 3-4.

204 Exhibit 17 at 4.

in the detoxification cells was attacked citing, "Using such grossly inadequate facilities for long periods of time is itself problematic because they are unhygienic." The key words in this sentence is "long periods", the jail does not keep any detoxing detainee in this type of cell any longer than it takes for that detainee to go through the detoxification process. The jail is in full compliance with the use of this type of plumbing to provide a safe cell for detainee's who are going through the detoxification process. According to TAC 37:9.259.236 (2), "Plumbing. Cells shall be provided with one or more vandal resistive flushing floor drains with outside controls, or detention type toilet and lavatory and vandal resistive floor drains. The floor shall be properly pitched to drains. The DOJ report also stated that some of the flushable drains were clogged and back-flushed into the cells when flushed. At no time did we the consultants witness my flushable floor drain back-flush into the cell when used.[205]

Messrs. Aldridge and Roberts also disagreed with the Division's allegations regarding the fire safety issue, stating:

> The jail has adequate fire safety programs outlined in their policies and procedures to ensure the protection of life, these policies and procedures address all components required in the Code of Federal Regulations (CFR), International Fire Code (IFC), and the National Fire Protection Association (NFPA) specifically 29 CFR 1910.38, IFC 404.3.2 and NFPS 101.23.7. Before being assigned a location, all staff are fully trained on the facilities emergency procedures. On August 7, 2008 the DOJ consultant requested that a fire drill be conducted on one of the housing unites and he observed the drill. After the drill was complete, he stated that the drill started off a little slow, but he was extremely impressed with the overall response and commended the entire fleet of staff that participated in the drill. When the group walked out of the housing unit there were approximately 20 fully trained correctional officers (C/O) in full Self Contained Breathing Apparatus (SCBA) ready to conduct a full evacuation of the housing unit if needed. This drill was unplanned and the number C/O's that are required to respond in an emergency situation far exceeds any requirement of state or federal regulations. To have that many staff to be able to put all the necessary equipment on and respond to an emergency situation and to do so in just a few minutes speaks volume about the jail's Fire Safety Programs. The HCJ's Fire Safety Program is one of the best that we have ever seen and the Fire Safety Officers do an impeccable job ensuring that all staff are trained on all types of emergency situations.
>
> The inconsistencies in safety documentation noted by the DOJ consultant were not due to lack of training, but rather errors that were made in the pass on books. This issue was immediately addressed and corrected by the jail. These inconsistencies in documentation at not time were a threat to life safety in the event of an emergency situation. Finally, the DOJ consultant had concerns about

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[205] Exhibit 17 at 4-5.

> appropriate staff did not have adequate access to emergency keys in the event of a failure in the Jail's electronic door control system. The jail's Fire Safety Officer showed the DOJ auditor how the jail would open the doors in case of an electric failure. The DOJ consultant had no negative comments on how the doors would be opened or how the master keys would be accessed for opening the doors in case of an emergency situation.[206]

After individually addressing each of the sanitation, hygiene and fire safety allegations lodged by the Division:

> While the DOJ report contained recommendations on sanitation and life safety, the overall report did not reflect the current level of operation of the HCJ and without the DOJ consultants' reports it is not possible to fully understand the allegations or the recommendations of the claims noted in the report. During both brief-outs the DOJ consultant praised the staff and commented on how well the jail was operated. The issues he had were minor and in no way violated any local, state, or federal regulations. The DOJ consultant also commented on how improved the facilities drains looked in the final brief-out of the second visit and once again commended all the staff for taking a proactive approach to this issue. The HCJ is also inspected by several state agencies at least yearly to ensure that the jail is following all local, state and federal regulations in the areas of sanitation and hygiene and fire safety. The allegations that are made in the DOJ report are in no way reflective of the local, state and federal regulations that the Harris County Jail adheres to. The HCJ has always taken a proactive approach to uncovering and remediating any issue that would adversely affect any offender or staff in a prompt manner. We have inspected many correctional facilities and the HCJ is one of the best operated and maintained jails in relation to fire safety, sanitation and hygiene for the population of detainees that the jail occupies.[207]

In sum, the Civil Rights Division advocates' allegations relating to sanitation, hygiene and fire and life safety are inconsistent with consultants Aldridge and Roberts' findings relating to these issues.

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[206] Exhibit 17 at 4-5.

[207] Exhibit 17 at 5.

VI. Harris County provides constitutionally adequate medical care to inmates incarcerated in the Harris County Jail system.[208]

Harris County objects to the "Medical Care" section of the Civil Rights Division's letter because the Division failed to satisfy CRIPA's notification requirements.[209] The Division likewise failed to come forward with any proof that Harris County or any Harris County official or employee subjected significant numbers of HCJ inmates to "egregious or flagrant conditions" which deprived significant numbers of inmates of their constitutional rights, causing them to suffer grievous harm.[210] The Division further failed to show any alleged pattern or practice of institutional abuse and resistance to a substantial number of HCJ inmates' constitutional rights.[211]

A. Constitutional framework

A pre-trial detainee's medical treatment is scrutinized under the substantive due process guarantees of the Fourteenth Amendment.[212] A convicted prisoner's medical treatment is reviewed under the Eighth Amendment of the Constitution of the United States, which prohibits cruel and unusual punishments.[213] The Fifth Circuit has recognized that "there is no significant distinction between pretrial detainees and convicted inmates concerning basic human needs such as medical care."[214] Under these circumstances, the Fifth Circuit applies the same *Farmer v. Brennan* deliberate indifference standard for assessing the constitutional claims of both pretrial detainees and convicted prisoners under the Eighth Amendment.[215]

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[208] As previously stated, although the Civil Rights Division has repeatedly affirmed its commitment to a transparent and even-handed investigation, it has thus far declined to provide Harris County with its consultants' reports completed after inspection of the Harris County jail facilities. Without Civil Rights Division medical consultant Joseph Fowlkes' report, Harris County cannot reasonably determine which, or to what extent, the Division's medical findings and proposed remedial measures are based upon Dr. Fowlkes' personal observations and recommendations, and which, and to what extent, the findings and proposed remedial measures reflect the Civil Rights Division's advocacy.

[209] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997b(a)(1) (1996).

[210] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

[211] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

[212] *See Bell v. Wolfish*, 441 U.S. 520, 535 (1979).

[213] *E.g., Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Estelle v. Gamble*, 429 U.S. 97, 101-02 (1976); *Palmer v. Johnson*, 193 F.3d 346, 351-52 (5th Cir. 1999).

[214] *Gibbs v. Grimmette*, 254 F.3d 545, 548 (5th Cir. 2001); *Hare v. City of Corinth*, 74 F.3d 633, 643, 650 (5th Cir. 1996) (en banc).

[215] *Gibbs*, 254 F.3d at 548; *Hare*, 74 F.3d at 645 (finding that the *Farmer* deliberate indifference standard is the appropriate standard for all denial of medical care claims under the Eighth and Fourteenth Amendments).

In order to establish a constitutional claim for denial of adequate medical treatment, a prisoner must prove that an official acted with deliberate indifference to a serious medical need.[216] This is a two-part inquiry—one objective and one subjective.[217]

To establish "a serious medical need," a prisoner must prove objectively that he was exposed to a substantial risk of serious harm.[218] "First, the deprivation alleged must be, objectively, 'sufficiently serious'; a [detention] official's act or omission must result in the denial of the minimal civilized measure of life's necessities."[219] Thus, plaintiff must show deliberate indifference to his "serious medical needs" to satisfy this prong.[220]

Second, a plaintiff must establish that the defendant possessed a culpable state of mind – deliberate indifference.[221] The deliberate indifference standard is a subjective inquiry.[222] To act with deliberate indifference, a detention official must both know of and disregard an excessive risk to inmate health or safety.[223] For the official to act with deliberate indifference, he must actually know "that inmates face a substantial risk of serious harm and disregard[] that risk by failing to take reasonable measures to abate it."[224] The official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[225] After perceiving the risk, the official must deliberately fail to act[226] and have the subjective intent to cause harm.[227]

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216 *Estelle*, 429 U.S. at 104-05; *Wilson v. Seiter*, 501 U.S. 294, 303 (1991); *Varnado v. Lynaugh*, 920 F.2d 320, 321 (5th Cir. 1991).

217 *Farmer*, 511 U.S. at 839.

218 *Farmer*, 511 U.S. at 834.

219 *Farmer*, 511 U.S. at 834.

220 *Seiter*, 501 U.S. at 297; *Mendoza v. Lynaugh*, 989 F.2d 191, 193 (5th Cir. 1993).

221 *Farmer*, 511 U.S. at 838 (citing *Seitner*, 501 U.S. at 298).

222 *Farmer*, 511 U.S. at 840-41; *Calhoun v. Hargrove*, 312 F.3d 730, 734 (5th Cir. 2002); *Stewart v. Murphy*, 174 F.3d 530, 534 (5th Cir. 1999).

223 *Farmer*, 511 U.S. at 837.

224 *Farmer*, 511 U.S. at 837, 839. *See also Estelle v. Gamble*, 429 U.S. 97, 106 (1976) (finding that plaintiff must prove that official (1) was "aware of the facts from which an inference of excessive risk to the prisoner's health or safety could be drawn," and (2) "actually drew an inference that such potential for harm existed."); *Gibbs v. Grimmette*, 254 F.3d 545, 549 (5th Cir. 2001) ("To prove deliberate indifference, a pretrial detainee must show that the state official knew of and disregarded an excessive risk to the inmate's health or safety.").

225 *Farmer*, 511 U.S. at 837.

226 *Farmer*, 511 U.S. at 837.

227 *Mace v. City of Palestine*, 333 F.3d 621, 626 (5th Cir. 2003).

The Supreme Court has reaffirmed that "deliberate indifference" is a "*stringent* standard of fault," requiring proof that a government actor disregard a known or obvious consequence of his action.[228] "'Subjective recklessness,' as used in the criminal law, is the appropriate test for deliberate indifference."[229] The deliberate indifference standard permits courts to separate omissions that "amount to an intentional choice" from those that are merely "unintentionally negligent oversight[s]."[230]

To establish deliberate indifference, a pretrial or convicted prisoner must prove that a detention official actually (subjectively) knew of – and disregarded – a substantial risk to the prisoner's health or safety. A plaintiff must demonstrate deliberate indifference to his medical needs by showing that officials "refused to treat him, ignored his complaints, intentionally treated him incorrectly, or engaged in any similar conduct that would clearly evidence a wanton disregard for any serious medical needs,"[231] such as delaying access to medical care and interfering with treatment once prescribed.[232] Mere delay in receiving care is not in and of itself a constitutional violation.[233] Regardless of the length of delay, a plaintiff at a minimum must show deliberate indifference to serious medical needs.[234] Further, delay in medical care can only constitute an Eighth Amendment violation if there has been deliberate indifference that resulted in substantial harm, *i.e.*, lasting complications.[235]

"Deliberate indifference is an extremely high standard to meet."[236] Deliberate indifference is more than mere negligence in providing or failing to provide medical treatment.[237] Unsuccessful medical treatment, ordinary acts of negligence, or medical malpractice do not rise to the level of

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228 *Bd. of the County Comm'rs of Bryan County, Ok., v. Brown*, 520 U.S. 397, 410 (1997); *Southard v. Tex. Bd. of Crim. Justice*, 114 F.3d 539, 551 (5th Cir. 1997).

229 *Farmer*, 511 U.S. at 839-40; *Southard*, 114 F.3d at 551; *Norton v. Dimazana*, 122 F.3d 286, 291 (5th Cir. 1997).

230 *Southard*, 114 F.3d at 551 (quoting *Gonzalez v. Ysleta Indep. Sch. Disc.*, 996 F.2d 745, 756 (5th Cir. 1993) (quoting *Rhyne v. Henderson County*, 973 F.2d 386, 392 (5th Cir. 1992))).

231 *Gobert v. Caldwell*, 463 F.3d 339, 346 & n. 21 (5th Cir. 2006); *Domino v. Tex. Dep't of Crim. Justice*, 239 F.3d 752, 756 (5th Cir. 2001); *Johnson*, 759 F.2d at 1238.

232 *Easter v. Powell*, 467 F.3d 459, 464 (5th Cir. 2006) (emphasis added) (citation omitted).

233 *Easter*, 467 F.3d at 463; *Mendoza v. Lynaugh*, 989 F.2d 191, 195 (5th Cir. 1993); *Wesson v. Oglesby*, 910 F.2d 278, 284 (5th Cir. 1990).

234 *Wilson*, 501 U.S. at 298.

235 *Estelle v. Gamble*, 429 U.S. 97, 105 (1976). *See, e.g.*, *Easter*, 467 F.3d at 464; *Harris v. Hegman*, 198 F.3d 153, 159 (5th Cir. 1999); *Mendoza*, 989 F.2d at 193, 195; *Wesson*, 910 F.2d at 284.

236 *Gobert*, 463 F.3d at 346 & n. 22; *Domino*, 239 F.3d at 756.

237 *See Gibbs v. Grimmette*, 254 F.3d 545, 549 (5th Cir. 2001); *Mendoza v. Lynaugh*, 989 F.2d 191, 193 (5th Cir. 1993); *Williams v. Treen*, 671 F.2d 892, 901 (5th Cir. 1982).

a constitutional violation.[238] The failure to alleviate a significant risk that an official or medical personnel should have perceived, but did not, likewise does not state a constitutional violation.[239] "The subjective intent to cause harm cannot be inferred from a ... failure to act reasonably."[240] To the extent that any inaction may have been negligent, this does not rise to the level of a constitutional violation.[241] An incorrect diagnosis by medical personnel does not state a constitutional violation.[242] The fact that a dose of medication may occasionally be forgotten likewise does not amount to deliberate indifference.[243]

As long as jail medical personnel exercise professional medical judgment, their behavior will not violate a prisoner's constitutional rights.[244] Even if a lapse in professional judgment occurred, any such failure amounts to mere negligence or malpractice, and not deliberate indifference.[245] "Furthermore, the decision whether to provide additional treatment 'is a classic example of a matter for medical judgment.'"[246]

Moreover, active treatment of a prisoner's serious medical condition does not constitute deliberate indifference, even if treatment is negligently administered.[247] The Fifth Circuit has

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238 *E.g., Estelle*, 429 U.S. at 106; *Gibbs*, 254 F.3d at 549; *Domino*, 239 F.3d at 756; *Stewart v. Murphy*, 174 F.3d 530, 534 (5th Cir. 1999) (finding that malpractice of negligent medical care does not rise to the level of deliberate indifference); *Norton v. Dimazana*, 122 F.3d 286, 294 (5th Cir. 1997); *Graves v. Hampton*, 1 F.3d 315, 319 (5th Cir. 1993) ("It is well established that negligent or erroneous medical treatment or judgment does not provide a basis for a § 1983 claim."); *Mendoza*, 989 F.2d at 193 ("It is clear that negligent medical treatment is not a cognizable basis on which to predicate a section 1983 action."); *Varnado v. Lynaugh*, 920 F.2d 320, 321 (5th Cir. 1991); *Johnson*, 759 F.2d at 1238.

239 *Farmer v. Brennan*, 511 U.S. 825, 838 (1994).

240 *Wagner v. Bay City*, 227 F.3d 316, 324 (5th Cir. 2000); *Hare*, 74 F.3d at 649.

241 *Daniels v. Williams*, 474 U.S. at 333-34 (1986).

242 *See, e.g. Harris v. Hegman*, 198 F.3d 153, 159 (5th Cir. 1999); *Mendoza*, 989 F.2d at 195; *Walker*, 967 F.2d at 178; *Wesson v. Oglesby*, 910 F.2d 278, 284 (5th Cir. 1990).

243 *See, e.g. Mayweather v. Foti*, 958 F.2d 91, 91 (5th Cir. 1992) ("Contrary to Mayweather's complaints, the record shows that he received continuous treatment for his back injury despite his incarceration. The treatment may not have been the best that money could buy, and occasionally, a dose of medication may have been forgotten, but these deficiencies were minimal, they do not show an unreasonable standard of care, and they fall far short of establishing deliberate indifference by the prison authorities. Continuing back pain is unpleasant. Its existence does not, however, in and of itself demonstrate that a constitutional violation occurred.").

244 *Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982). *See Hare v. City of Corinth*, 74 F.3d 633 (5th Cir. 1996) (en banc) (discussing *Youngberg*).

245 *See Hegman*, 198 F.3d at 159 (citing *Mendoza*, 989 F.2d at 195).

246 *Gobert v. Caldwell*, 463 F.3d 339, 346 & n.20 (5th Cir. 2006) (citing *Domino v. Tex. Dep't of Crim. Justice*, 239 F.3d 752, 756 (5th Cir. 2001) (quoting *Estelle v. Gamble*, 429 U.S. 97, 107 (1976))).

247 *See Stewart v. Murphy*, 174 F.3d 530, 534 (5th Cir. 1999); *Mendoza*, 989 F.2d at 195; *Varnado v. Lynaugh*, 920 F.2d 320, 321 (5th Cir. 1991).

consistently held that medical records of sick calls, examinations, diagnoses, and medications may rebut allegations of deliberate indifference to serious medical needs.[248] Prisoners are not entitled to "the best that money could buy" regarding medical treatment.[249] Disagreement with a prescribed course of treatment similarly states no constitutional violation.[250] Constitutionally adequate care does not ensure that an inmate will agree with every treatment decision rendered.[251] Disagreements over treatment decisions constitute, at most, claims of malpractice appropriately addressed under state law.

If a constitutional violation is found, then the court must determine whether the governmental entity is liable for that deprivation. To hold a governmental entity for a constitutional violation, a plaintiff must prove: (1) an official policy or custom, of which (2) a final policymaker can be charged with actual or constructive knowledge, and (3) a constitutional violation whose "moving force" is that policy or custom.[252]

B. The HCSO's medical and mental health policies and procedures not only comply with minimum constitutional standards, but also comply with the NCCHC's more stringent "best practice" community standards.

According to the Civil Rights Division:

> The Jail has functional systems in place to provide medical care and treatment to a large population of detainees. These systems include an initial screening process, a more comprehensive health assessment for longer-term detainees, a sick call process, a modern clinic, qualified medical staff, a professional management structure, and mechanisms to obtain outside specialty care. Despite the general quality of such systems, *the Jail fails to provide consistent and adequate care for detainees with serious chronic medical conditions. We found specific deficiencies in the Jail's provision of chronic care and follow-up treatment. These deficiencies, in themselves and when combined with the problems in medical record-keeping and quality assurance discussed below, are serious enough to place detainees at an unacceptable risk of death or injury.*[253]

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248 *See, e.g., Gobert*, 465 F.3d at 347 n. 24; *Banuelos v. McFarland*, 41 F.3d 232, 235 (5th Cir. 1995); *Mendoza*, 989 F.2d at 193-95.

249 *Mayweather v. Foti*, 958 F.2d 91, 91 (5th Cir. 1992).

250 *Gobert*, 463 F.3d at 346 (citing cases); *Gibbs v. Grimmette*, 254 F.3d 545, 549 (5th Cir. 2001); *Stewart*, 174 F.3d at 535; *Norton v. Dimazana*, 122 F.3d 286, 291-92 (5th Cir. 1997); *Spears v. McCotter*, 766 F.2d 179, 181 (5th Cir. 1985); *Young v. Gray*, 560 F.2d 201, 201 (5th Cir. 1977).

251 *See Estelle*, 429 U.S. at 107-108 (1976) (finding that a prison doctor's failure to order an x-ray of the plaintiff's lower back did not state an Eighth Amendment violation).

252 *Pineda v. City of Houston*, 291 F.3d 325, 328 (5th Cir. 2002); *Piotrowski v. City of Houston*, 237 F.3d 567, 578 (5th Cir. 2001).

253 Letter from Loretta King to Ed Emmett, *supra* note 3, at 3 para. 4.

Harris County submits that it provides constitutionally adequate medical care in the Harris County Jail system and challenges each of the above-referenced italicized allegations made by the Civil Rights Division, as discussed below. In addition, the HCSO's medical policies and procedures as well as mental health policies and procedures comply with the NCCHC's "best practice" community standards.

The HCSO's Health Services Division faces a challenging high prisoner census and complex logistical challenges. One of the pervasive concerns with the Civil Rights Division's use of select patient examples (even if taken at face value) to attempt to prove allegations of inadequacy of care is that the Division consistently failed to even determine or document the appropriate denominator for process volume. Far more accurate conclusions can be drawn when incidents noted are compared to the total number of possible incidents. The apparent focus of Division inspections was to examine outlying situations without any concurrent documentation of the usual processes and outcomes. Harris County disputes the conclusion drawn from the examples cited, and strongly disagrees with conclusions based on a predetermined sample without comparison or recognition of those processes which have worked well.

As discussed above, the subjective deliberate indifference standard applies to medical and mental health-related claims. Given the Civil Rights Division's failure to apply the deliberate indifference standard, it appears that the Division is advancing community "best practice" standards as the constitutional standard. When enacting CRIPA, Congress clearly stated its intent that CRIPA was "not intended in any way to empower the Attorney General to determine medical policy."[254] CRIPA's Section 1997i, enacted to further that intent, expressly provides that "[p]rovisions of this subchapter shall not authorize promulgation of regulations defining standards of care." The Division's June 4, 2009 letter clearly and inappropriately bases its findings and proposed remedial relief upon standards that are far more rigorous than the constitutional (deliberate indifference) standard.[255]

It is troubling that the Civil Rights Division made one passing reference to the applicable constitutional standard in its letter,[256] then failed to apply that standard. Instead, they incorrectly based their allegations, conclusions and recommendations upon community "best practice" standards. The Division then went further, failing to even acknowledge that the HCSO's medical and mental health care system conforms to the NCCHC's "best practice" standards. The Division ignored the fact that the HCSO's medical and mental health care systems have been continuously accredited by the NCCHC since 1991. The Division's medical and mental health

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[254] Senate Report 416, at 26 (1990).

[255] While the DOJ can certainly make comparisons to the community's "best practice" standards, it is not authorized under CRIPA to hold those standards out as minimum constitutional standards and base findings and proposed remedial measures upon those standards.

[256] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3 ("Detainees' constitutional rights are violated when prison officials exhibit deliberate indifference to their serious medical needs.") (citing *Estelle v. Gamble*, 429 U.S. 97, 102 (1976)).

care systems-related allegations are all inconsistent with the HCSO's compliance with the NCCHC's best practice standards.[257]

The NCCHC is dedicated to improving health services in jails, prisons and juvenile confinement facilities. Incorporated in 1983, its roots are in the early 1970s as a project of the American Medical Association. NCCHC's leadership in setting standards for health services and improving health care in correctional and detention facilities is widely recognized. The Standards represent NCCHC's recommended requirements for the management of a correctional health services system. The Standards have assisted detention and correctional facilities to "improve the health of their inmates and the communities to which they return; increase the efficiency of their health services delivery; strengthen their organizational effectiveness; and reduce their risk of adverse legal judgments."[258]

The Harris County Jail system is the largest county jail system in the United States to maintain accreditation by the NCCHC. The HCSO's ongoing, continuous accreditation by the preeminent national accrediting agency validates the HCSO's position that it goes beyond minimum constitutional standards and provides care consistent with correctional standards. Accreditation and reaccreditation involve documentation of compliance with standards regulating policies and procedures as well as documented practice. Site surveys are undertaken every three years so that through the NCCHC's external peer review, the jail's system has been scrutinized, reviewed and approved prior to reaccreditation. Such surveys are performed by experts in the field of correctional health care. As the preeminent national accreditation agency overseeing correctional health care, the NCCHC sets the national standards for delivery of health care in jails.

Although HCSO Health Services Director Dr. Michael Seale discussed the HCSO's continuing NCCHC accreditation with Dr. Joseph Fowlkes, the Civil Rights Division's medical consultant, and produced documents pertaining to NCCHC accreditation the Division's advocates pursuant to Dr. Fowlkes' request,[259] the HCSO's continuing compliance with NCCHC standards is not addressed anywhere in the Division advocates' June 4, 2009 letter. Repeated references to the HCSO's alleged failure to comply with "community correctional standards" do not make sense in light of the jail's NCCHC accreditation. Surely the Civil Rights Division is not contending that the NCCHC standards are not constitutional. Surely the Division is not contending that the NCCHC has repeatedly failed to perform adequate reviews. The HCSO's ongoing compliance with nationally-accepted NCCHC standards far exceeds minimum constitutional standards. The Civil Rights Division offers no explanation for this obvious inconsistency.

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257 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 1 para. 3 – 2 para. 1 (re systemic deficiencies and systemic problems), at 3 para. 3 ("lacks necessary systems"), at 3 para. 3 (deficiencies), at 4 para. 2 (deficiencies), at 5 para. 5 (system), at 5 para. 1 (system), at 5 para. 5 (system), at 8 para. 2 (deficiencies in system), at 10 para. 2 (system), at 10 para. 4 (system).

258 *See, e.g.*, STANDARDS FOR HEALTH SERVICES IN JAILS vii (Nat. Comm'n on Corr. Health Care, 2008 ed.).

259 *See* Bates 25,111 – 25,116.

C. Although the Civil Rights Division repeatedly identified "generally accepted medical and mental health standards" as the NCCHC's standards in litigation against other institutions investigated pursuant to CRIPA, the Division has failed to recognize the HCSO's continuing compliance with those "best practice" community standards.

In CRIPA litigation against other jurisdictions, the Civil Rights Division holds the NCCHC standards out as the nation's generally accepted medical and mental health care standards. The Division even references the NCCHC standards in agreements reached with other jurisdictions. For example, in an April 22, 2002 Settlement Agreement between the Civil Rights Division and Nassau County, New York, regarding the Nassau County New York Correctional Center, the parties agreed:

> [Nassau County Correctional Center] shall cause to be developed and/or implemented appropriate written medical policies, procedures, and protocols that include, but are not limited to the following: (1) initial inmate screening and inmate health assessments; (2) staffing levels, necessary credentials and job descriptions; (3) sick call and other access to medical services; (4) distribution and management of medications; (5) emergency care; (6) dental care; (7) mental health care; (8) substance abuse treatment; (9) treatment of individuals with special needs; (10) communicable disease testing and control; (11) women's health care; (12) routine and chronic disease care; (13) medical records; (14) staff training; (15) quality assurance; (16) mortality reviews; (17) inmate education; (18) medical safety and sanitation; (19) suicide prevention; (20) immunization; and (21) medical grievance procedures. *At a minimum, such policies, procedures and protocols shall conform to* Standards of the New York State Commission on Correction ("NYSCOC"), *all "essential" and 85% of the "important" policies of the National Commission on Correctional Health Care ("NCCHC")* and the American Psychiatric Association Standards for Psychiatric Services in Jail and Prisons. *For purposes of this provision, "essential" and "important" policies shall be those so described by the NCCHC."*[260]

In a December 29, 2006 Memorandum Agreement between the DOJ's Civil Rights Division and the State of Delaware, regarding the DOJ's investigation of Delaware State correctional facilities, the DOJ and the State of Delaware agreed:

> *"Generally accepted professional standards" means those industry standards accepted by a significant majority of professionals in the relevant field, and reflected in the standards of care such as those published by the National Commission on Correctional Health Care (NCCHC). DOJ acknowledges that NCCHC has established different standards for jail and prison populations, and that the relevant standard that applies under this Agreement may differ for pretrial and sentenced inmates.* As used in this Agreement, the terms "adequate,"

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[260] Settlement Agreement between the U.S. and Nassau County, N.Y. (April 22, 2002) (on file with author), *available at* http://www.usdoj.gov/crt/split/documents/Nassa_sher_agreem.php (emphasis added).

> "appropriate," and "sufficient" refer to standards established by clinical guidelines in the relevant field. The Parties shall consider clinical guidelines promulgated by professional organizations in assessing whether generally accepted professional standards have been met.[261]

In yet another example, the DOJ's Civil Rights Division entered into a January 14, 2009 Settlement Agreement with King County, Washington, regarding the King County Washington Correctional Facility, wherein the parties agreed that:

> "Generally accepted professional standards" means those industry standards accepted by a significant majority of professionals in the relevant field, and reflected in the standards of care such as those published by the National Commission on Correctional Health Care (NCCHC).[262]

Setting aside the fact that NCCHC standards of care far exceed minimum *constitutional* standards and the fact that CRIPA only gives the Attorney General jurisdiction to investigate "egregious or flagrant conditions" which deprive significant numbers of HCJ inmates' *constitutional* rights, it is incomprehensible that the Division's findings acknowledge the HCSO's continuing accreditation by the NCCHC.

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[261] Memorandum of Agreement between the U.S. Dep't of Justice and the State of Del. Regarding the Delores J. Baylor Women's Corr. Inst., the Del. Corr. Ctr., the Howard Y. Young Corr. Inst., and the Sussex Corr. Inst. at 4-5 (Dec. 19, 2006) (on file with author), *available at* http://www.usdoj.gov/crt/split/documents/delaware_prisons_moa_12-29-06.pdf (emphasis added). In a findings letter issued by the DOJ to the Governor of Delaware regarding the DOJ's investigation of Delaware State correctional facilities that same day, the DOJ stated: "*Generally accepted standards of care* dictate that discharge treatment planning be provided for inmates who have serious mental illness to ensure continuity of care. The State's expert found that its inmate treatment plans fail to address how the patient's care will continue once he or she is released from the DOC facility. NCCHC standards J-E-13 and P-E-13 require jurisdictions to develop discharge planning for inmates with serious mental illness (e.g., medication for a short period of time following release and referrals to community health providers)." Letter from Wan J. Kim, Assistant Attorney Gen., to Ruth Ann Miller, Governor of Del. at 12 (Dec. 29, 2006) (on file with author), *available at* http://www.usdoj.gov/crt/split/documents/delaware_prisons_findlet_12-29-06.pdf.

[262] Settlement Agreement between the U.S. and King County, Wash. at 2 (Jan. 14, 2009) (on file with author), *available at* http://www.usdoj.gov/crt/split/documents/KCCF_Complaint_01-14-09.pdf.

D. Harris County provides constitutionally adequate chronic care to inmates incarcerated in the Harris County Jail system.

1. Introduction

According to the Civil Rights Division:

> Detainees who suffer from chronic medical conditions require assessment and ongoing treatment to prevent the progression of their illnesses. As part of the treatment process, detainees with chronic medical conditions require routine follow up to monitor the progression of their illness and the potentially hazardous effects of medication. *Because of crowding, administrative weaknesses, and resource limits, the Jail does not provide constitutionally adequate care to meet the serious medical needs of detainees with chronic illness.*[263]

Harris County denies the Division's conclusory allegations, which are italicized above, and submits that it provides constitutionally adequate chronic care in the Harris County Jail system. Harris County disagrees that the allegations made by the Division were in any way proven by the patient examples given by the Division. Harris County would also note that the NCCHC has chronic care-related standards and that the HCSO's Medical Division continues to satisfy those standards. The accredited health care system at the Harris County Jail system includes provision of care to those with chronic illness.

According to the Civil Rights Division:

> *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. *Unfortunately, the Jail does not have an assessment process to adequately identify detainees with serious chronic medical conditions.*[264]

Harris County objects to the Division's invocation of the more rigorous "generally accepted standards of correctional medical care," rather than the constitutional (deliberate indifference) standard, in the chronic care section of its letter. Notwithstanding this objection, the Division's report fails to address the fact that the HCSO has been fully compliant with the NCCHC's "J-G-01 Chronic Disease Services" essential standard, and has been accredited and reaccredited since 1991.

Harris County strongly disagrees with the Division's allegation that the Jail does not have an assessment process to adequately identify detainees with serious chronic medical conditions. The Jail has long-standing processes in place which are designed to: (1) screen all incoming detainees during the booking process for medical and mental health issues (including a chest x-

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263 Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 1 (emphasis added).

264 Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 2 (emphasis added).

ray to screen for active tuberculosis); (2) divert patients with affirmative answers on the intake screen to the 1200 Baker clinic's medical and mental health physicians on a 24/7/365 basis so that the physicians determine the need for specialized housing, treatment, assessment and follow-up; (3) rescreen each detainee prior to the fourteenth day of incarceration with a nurse-performed health assessment (including testing for TB, HIV, syphilis)—each reviewed by a physician. Physician review of each Health Assessment form and TB, HIV and syphilis results is completed to ensure appropriate follow-up testing and assessment. Serious medical and mental health issues are identified. Review of the Division's own patient examples clearly shows that chronic medical conditions are routinely identified and followed.

According to the Civil Rights Division:

> In particular, we found that the Jail has delegated screening to nurses who are in need of additional training and more administrative oversight by physicians. For instance, we found assessment forms completed by nursing staff who had not actually completed the assessments.[265]

Harris County objects to the Civil Rights Division's amorphous references to "screening," "nurses" and "nursing staff" who "are in need of additional training and more administrative oversight." Although a more specific reference to "screening" would have been helpful, Harris County believes that the Division is referring to the 14-day Health Assessment process which is performed by Registered Nurses and reviewed by a physician. The nurses had indeed received training prior to the Division's July and August 2008 inspections and received additional training following the inspections in order to remedy perceived deficiencies. In a January 2009 update to the Civil Rights Division, the HCSO reported that all registered nurses had received additional training in conducting thorough physical examinations and had been required to view educational videos regarding the proper completion of physical examinations. The HCSO also reported that a process was implemented requiring the head nurse to visually observe each registered nurse conduct at least one patient's physical examination each week, and to offer education and training regarding any identified deficiencies. The HCSO further reported that each registered nurse performing health assessments is required to participate in annual health assessment training which is reviewed by the Medical Director and Dental Director.[266]

The Civil Rights Division relied upon an isolated incident when making these allegations about the nurses' need for additional training and oversight. One nurse who was observed by both the Civil Rights Division medical consultant and HCSO supervisors to have performed an inadequate assessment was removed from clinical duties, received additional training, was referred to nursing peer review and received disciplinary action for falsifying the assessment. The head nurse function was rearranged so that additional attention could be devoted to monitoring the performance of the 14-day Health Assessments.

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265 Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 2.

266 Bates 31,317-80.

According to the Civil Rights Division:

> We also found that physicians do not routinely see detainees with chronic conditions to assess the status of their health.[267]

Harris County objects to, and disagrees with, this conclusory allegation. Over 10,000 medications are delivered by medication cart nurses alone each and every day in the Harris County Jail. Many of those medications are prescribed for chronic conditions. Again, a more specific reference would have been helpful. The HCSO believes this refers to not having the specific chronic disease management protocols in place as preferred by the consultants. During the Civil Rights Division's inspections, Dr. Michael Seale had several conversations with the Division's consultants regarding the validity and utility of chronic disease management protocols in an acute care setting, such as the Harris County Jail (with a relatively short period of incarceration).[268] Several possible mechanisms were discussed, including one which was being evaluated on a trial basis during the site visits. The Division's medical consultant observed that process and was provided with the intent, approach, and even the actual clinical care forms used. He disagreed with the HCSO's use of nurses to begin the assessment process, but agreed that the HCSO had to find a creative way to manage the thousands of patients with chronic illness who spend hours, days or weeks in the jail system. The Division's consultant did not acknowledge, nor does the Division's June 4, 2009 letter acknowledge, that the patients used as examples in the report often had multiple, short-term incarcerations and therefore any chronic management process would have been difficult to achieve.

According to the Civil Rights Division:

> Jail staff do not conduct periodic surveys of the housing units to identify detainees who may have chronic medical conditions, but who may not necessarily be identified by the normal sick call process or the screening procedures conducted during detainee booking. Such deficiencies result in gaps in the system for identifying detainees with serious chronic medical conditions. For instance, staff may miss some detainees who are degenerating mentally or physically, but who are unable or unwilling to utilize the normal sick call process.[269]

Harris County objects to the Civil Rights Division's proposed "periodic surveys" because there is no constitutional requirement that such surveys be completed. Notwithstanding this objection, and without waiving same, the HCSO is uncertain how this could realistically be achieved given the size of the system and the ongoing turnover of the population. Apparently, the Division is suggesting that jail doctors make cell-by-cell rounds for the purpose of determining whether any inmates with chronic medical needs have not been identified by other means. Is this a wise use of physician resources considering the number of inmates with known conditions requiring

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[267] Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 2.

[268] *See* Exhibit 20 (Dr. Seale's Curriculum Vitae).

[269] Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 2.

treatment? What facts were revealed by the inspection that suggest that the current process (including regular cell counts by detention officers, medication rounds by nurses, and the sick call process) does not identify inmates in this category? The Division's letter did not present any specific examples regarding prisoners who went unidentified during the screening process. Nurses performing triage, health assessment and medication delivery functions are routinely available on each and every housing floor in the jail system to assess prisoners, should a need develop. Assessments can also be generated from other sources such as deputy referrals and calls from family members, attorneys, judges, etc. Periodic surveys of housing areas with less mobility – such as administrative separation areas where there are fewer opportunities to make an outcry – are performed by both medical and mental health personnel consistent with NCCHC standards, specifically to identify prisoners with health issues.

According to the Civil Rights Division:

> *Problems with chronic care assessments are particularly pronounced in the assessment of detainees receiving medications. Generally accepted correctional medical standards* require that once medical staff identify a medical condition, they need to order appropriate medications and then periodically re-assess those medications to determine their effectiveness and to monitor side effects. *The Jail medical staff are not adequately conducting such periodic assessments.* Examples from 2007-2008 include ...[270]

Harris County objects to the Civil Rights Division's reliance upon "generally accepted correctional medical standards," rather than the constitutional (deliberate indifference) standard. Notwithstanding this objection and without waiving same, the HCSO's processes, policies and procedures related to medication delivery and follow-up have been reviewed and approved by the NCCHC. The NCCHC determines "generally accepted correctional medical standards."

Patient follow-up – after physician evaluation – is determined by the physician, based on his/her clinical judgment. During the Civil Rights Division's inspections, as an administrative mechanism to help ensure regular physician assessment of need for follow-up, the UT-Health Science Center Medical Director directed all physicians to include a statement of need for follow-up in the documentation of each future patient encounter. In addition, mental health patients receiving psychotropic medications are reevaluated at the 90-day renewal or as otherwise indicated by psychiatrist order. Blood pressure checks and blood sugar checks are routinely ordered by physicians when clinically appropriate.

The Civil Rights Division summarized what they allege to be three (3) cases (involving Inmates AA – CC) of allegedly inadequate periodic assessments from 2007 and 2008 at page 5 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to periodic assessments. Even assuming that the inmates' assessments were inadequate in those cases, which Harris County expressly denies, three cases out of the 269,050 prisoners

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[270] Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 3 - 5 para. 1.

incarcerated in the Harris County Jail system from 2007 - 2008 constitute no actionable pattern.[271]

2. Inmate AA received constitutionally adequate medical care in the Harris County Jail system.

According to the Civil Rights Division, examples of Jail medical staff's failure to adequately conduct periodic assessments of prisoners' medications from 2007 – 2008 include:

> Detainee AA had a history of hypothyroidism and seizures.[272] Medical staff administered two medications, each of which could have had potentially toxic side effects. After the initial medication order, dosages and blood levels of these medications were not monitored.[273]

Contrary to these allegations, AA's medication order, dosages and blood levels were monitored. It is uncertain which of AA's three incarcerations the Civil Rights Division's allegations refer to.[274] Moreover, it appears that the Civil Rights Division did not recognize that this prisoner was incarcerated on three separate occasions during a relatively short time period.

AA's first incarceration: On May 16, 2008, AA was screened and stated that he took an unknown thyroid medication and an unknown asthma medication. On May 17, 2008, a physician saw AA, and AA told the physician that he had a seizure disorder, but was not taking any medication for seizures at that time. He was prescribed medication for hypothyroidism and an inhaler for asthma. On May 23, 2008, AA left the jail.

AA's second incarceration: During AA's second incarceration, he was held for a period of time longer than nine days, and a blood level of Dilantin was ordered. On June 4, 2008, AA was incarcerated and screened. During screening, AA stated that he had hypothyroidism and a seizure disorder, but did not know the names of his medications. That same day, a physician saw AA and prescribed Dilantin for the seizure disorder, Synthroid for hypothyroidism, and an inhaler for asthma. On July 1, 2008, at the time of medication renewal, AA's orders, including a laboratory request order for a Dilantin blood level, were submitted to a physician for review. The physician, exercising his medical judgment, did not order laboratory studies for thyroid levels. On July 15, 2008, AA left the jail.

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271 *E.g., Burge*, 336 F.3d at 370; *Pineda*, 291 F.3d at 329 & nn. 9-11; *Piotrowski*, 237 F.3d at 581.

272 To protect the identity of the prisoners, the initials used in this response are not the actual prisoners' initials.

273 Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 3 - 5 para. 2.

274 The HCSO's response to the patient examples, included in the medical and mental health care sections of the Civil Rights Division's June 4, 2009 letter, generally reflects its review of the patients' medical records through early August of 2008, when the DOJ made its last inspection.

AA's third incarceration: On August 29, 2008, AA was screened in conjunction with a third incarceration. AA was prescribed Dilantin and Synthroid. On September 6, 2008, AA left the jail.

While we agree that medications should be monitored on an ongoing basis, this prisoner's incarceration length was seven days, forty-two days and nine days, respectively. This prisoner illustrates the challenge of applying chronic disease management requirements to a short-term, dynamically changing population. He simply did not remain incarcerated for more than six weeks. It is unclear whether the Civil Rights Division's consultants' looked at JIMS to determine length of stay. That information is difficult to obtain from the medical record. The Civil Rights Division advocates' statement that "[m]edical staff administered two medications, each of which could have had potentially toxic side effects" is not productive. All medications have potentially toxic side effects. There is no documentation in AA's medical record of any adverse clinical outcome.

3. Inmate BB received constitutionally adequate medical care in the Harris County Jail system.

According to the Civil Rights Division, examples of Jail medical staff's failure to adequately conduct periodic assessments of prisoners' medications from 2007 – 2008 include:

> Detainee BB suffered from a deep venous thrombosis (blood clot) in his lower extremity. Medical staff administered an unsafe dosage of blood thinning medication, placing the detainee at an increased risk of clot formation. Such clots can cause serious medical complications including sudden death. Staff conducted lab tests which showed that the dosage might be unsafe, but then failed to follow up on the test results.[275]

BB received constitutionally adequate medical care while incarcerated in the Harris County Jail system. On April 11, 2008, BB was screened and the screener noted that he had a history of seizures, blood clots, degenerative joint disease, bipolar disorder and schizophrenia. That same day, a medical physician saw BB and prescribed Dilantin, Protonix, Naprosyn, and Coumadin 2.5 mg, to be taken daily. Follow-up for a head laceration was ordered for after five days. A laboratory study for Protime/International Normalized Ratio (to determine level of anticoagulation) was ordered. On April 12, 2008, a psychiatrist saw BB and prescribed medication. On April 16, 2008, blood levels were ordered and drawn. On April 21, 2008, bloodwork for PT/INR was drawn but the proper tube for a PT/INR test was not received by the lab. On April 24, 2008, a physician reviewed the result and ordered a physician appointment. On April 28, 2008, PT/INR was obtained. On May 2, 2008, a physician reviewed and noted the subtherapeutic result. On May 9, 2008, Dilantin was renewed and a Dilantin level was ordered. On June 17, 2008, PT/INR was obtained. On June 20, 2008, a physician reviewed and noted the subtherapeutic result. On June 27, 2008, the physician ordered a repeat PT/INR. On July 2, 2008, the Coumadin was renewed and a PT/INR was ordered. On July 6, 2008, a physician saw BB to evaluate a facial laceration. BB did not describe any leg pain or other signs/symptoms of

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[275] Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 3 - 5 para. 1, 5 para. 3.

blood clotting in the legs. On July 24, 2008, a psychiatrist saw BB in follow-up and adjusted BB's medical regimen. On August 5, 2008, BB's Dilantin was renewed and a Dilantin level was ordered. On August 18, 2008, BB refused venipuncture for PT/INR. A physician's appointment was scheduled for August 22, 2008. On August 19, 2008, however, BB left the jail. No adverse outcomes were documented in the medical record.

The dosage is not inherently clinically "unsafe." Patients require varying dosages of Coumadin to achieve a therapeutic PT/INR result. The initial prescribing dosage, in and of itself, was not inappropriate. Follow-up blood testing was ordered and was reviewed by the UT-Health Science Center Medical Director. Clinical action upon such review is subject to his clinical judgment. There is no indication that any adverse outcome arose as a result of the medical care BB received at the Harris County Jail. This "finding" is nothing more than second guessing of a physician's medical judgment and, even if correct, would not establish a constitutional violation.

This patient illustrates that there is indeed screening for chronic diseases in the Harris County Jail. This example also illustrates that MHMRA psychiatrists perform laboratory testing, perform clinical follow-up, and adjust medication regimens, despite allegations to the contrary elsewhere in the Civil Rights Division advocates' June 4, 2009 letter.

4. Inmate CC received constitutionally adequate medical care in the Harris County Jail system.

According to the Civil Rights Division, examples of Jail medical staff's failure to adequately conduct periodic assessments of prisoners' medications from 2007 – 2008 include:

> Detainee CC had a history of heart failure. Medical staff administered two medications with potentially toxic side effects. Our record review suggests that medical staff did not check CC's blood levels for several months.[276]

CC received constitutionally adequate care while incarcerated in the Harris County Jail system. On December 2, 2007, CC was booked into the Harris County Jail. CC remained incarcerated until his July 10, 2008 transfer to TDCJ-ID. A medical physician saw CC and initially prescribed Digoxin, Coreg, quinapril, Lasix, potassium, Synthroid, Zocor and an albuterol inhaler. CC had physician evaluations over 60 times between December 3, 2007 and June 27, 2008 and never went more than 15 days without a re-evaluation. Quite often, CC had multiple evaluations in the same day. CC was evaluated on December 3, 2007 (twice), December 4, 2007, December 5, 2007, December 6, 2007, December 7, 2007, December 13, 2007, December 21, 2007, December 24, 2007, December 25, 2007, December 26, 2007, January 10, 2008, January 11, 2008, January 22, 2008, January 23, 2008, February 5, 2008, February 6, 2008, February 7, 2008, February 8, 2008 (twice), February 9, 2008, February 12, 2008, February 14, 2008, February 15, 2008 (twice), February 18, 2008 (twice), February 22, 2008, February 25, 2008, February 26, 2008, March 6, 2008, March 10, 2008 (twice), March 11, 2008, March 18, 2008, March 19, 2008, March 25, 2008, March 27, 2008, March 28, 2008, March 31, 2008 (twice), April 5, 2008, April 6, 2008, April 7, 2008, April 14, 2008, April 16,

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[276] Letter from Loretta King to Ed Emmett, *supra* note 3, at 4 para. 3 to 5 para. 1, 5 para. 4.

2008, April 18, 2008, April 20, 2008, April 22, 2008, April 24, 2008, April 25, 2008, April 28, 2008, May 4, 2008, May 7, 2008, May 14, 2008, May 18, 2008, May 21, 2008, May 22, 2008, May 29, 2008, May 31, 2008, June 2, 2008, June 3, 2008, June 11, 2008, June 18, 2008, June 27, 2008 and July 2, 2008, with multiple transfers to LBJ Emergency Center for evaluation, which often resulted in admissions to the hospital for further evaluation (including lab work) and treatment. CC's cardiologist in Galveston was also consulted and an appointment was made for pacemaker evaluation, but CC left for TDCJ-ID before that appointment. CC was also transferred to LBJ Emergency Center multiple times for an evaluation, often resulting in an admission to the hospital for further evaluation, treatment, and laboratory studies.

The Harris County Hospital District ("HCHD") records show that CC had 25 laboratory studies performed during his incarceration in the Harris County jail. In addition, ten laboratory studies were performed at the Harris County Jail. This indicates that laboratory studies were ordered by physicians in accordance with their clinical judgment. All medications can have potentially toxic side effects. There is no clinical indication that any "toxic side effects" were noted during any of CC's clinician visits. Notably, medication effects, both positive and adverse, can also be followed by a clinician's evaluation of the patient and physical findings. There is no indication that any adverse outcome arose as a result of the medical care CC received while incarcerated in the Harris County Jail.

E. Harris County provides constitutionally adequate continuity of care to inmates incarcerated in the Harris County Jail system.

1. Introduction

According to the Civil Rights Division:

> Chronic and some acute medical conditions require appropriate ongoing treatment and continuity of care. Failure to address detainee medical conditions over time can lead to an increased risk in morbidity and mortality. Systems and practices, such as adequate record-keeping and follow-up exams by qualified staff, must be in place to manage the serious medical conditions of detainees during the length of their incarceration. *The Jail does not have a system in place to provide such continuity of care for some of the detainees with the most serious medical conditions.*[277]

Harris County denies the Civil Rights Division's broad, unsupported and incorrect representation highlighted above. Harris County provides inmates incarcerated in the Harris County Jail system with constitutionally adequate continuity of care, and would again emphasize that the HCSO's medical and mental health care policies and procedures have been approved by the NCCHC.

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[277] Letter from Loretta King to Ed Emmett, *supra* note 3, at 5 para. 5.

According to the Civil Rights Division:

> The Jail's medical clinic serves as a makeshift emergency room, stabilizing detainees with acute conditions. This model, however, is problematic in a large urban detention facility with hundreds of sick detainees. Many of the detainees with serious medical conditions cannot be adequately identified or treated solely through an acute care process.[278]

Harris County objects to the allegations in this paragraph of the Civil Rights Division's letter because they are ambiguous and unsupported. Harris County also denies these allegations. Harris County strongly disagrees with the use of the descriptor, "makeshift." The facility was described as having a "modern clinic" earlier in the document. If the consultants had spent sufficient time in the clinic to observe the true spectrum of medical and mental health care delivered, they would have observed the delivery of care to detainees: (1) newly incarcerated; (2) referred to the physicians from the 14-day Health Assessment; (3) referred to the physicians from nursing triage of sick call requests; (4) seen in follow-up by physician order; (5) seen by physicians upon return from the hospital or the hospital emergency center; (6) seen by specialist physicians upon referral from the primary care physicians and yes; and (7) seen on an urgent/emergent basis. Of the two weeks spent on-site at the Harris County Jail, the Civil Rights Division's consultant for the medical operation spent very little time actually observing clinic operations, observing intake screening or observing infirmary operations. It is difficult to understand how a conclusion could be drawn given the lack of actual observation.

The Civil Rights Division's letter ignores the fact that many of the patients in the clinic are seen as a result of routine appointments, referrals and scheduled follow-up appointments. It is not "solely" acute care delivery. In 2008, an average of 1,263 patients were seen each month for routine appointments (not seen as a result of intake screening or referral from the Health Assessment or on an urgent/emergent basis)—which represents approximately 60 patients each business day.

According to the Civil Rights Division's letter:

> In the absence of a chronic care program or other systems for ensuring follow-up care, the sick call process serves as the primary mechanism for the Jail to provide continuity of care. This system is not capable of providing such continuity of care. The sick call process itself is seriously strained due to crowding, staffing limits, and some problematic practices. For instance, we received a number of complaints about delays in care at the Jail's 1200 Baker facility.[279]

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278 Letter from Loretta King to Ed Emmett, *supra* note 3, at 5 para. 6 – 6 para. 1.

279 Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 2.

Harris County objects to the Civil Rights Division advocates' amorphous reference to "some problematic practices," as well as its citation to and reliance upon unsubstantiated complaints.[280] Notwithstanding these objections and without waiving same, no specifics are given in the Division's letter. Timeliness of care delivery – either from the intake screening process, routine sick call requests, or referrals – is monitored by the Quality Improvement Committee and corrective actions are taken (should delays be impending). During the site visits, because of increased patient volume, it was determined that consistently providing a second physician during the night in the 1200 Baker clinic would improve patient flow – the UT-Health Science Center Medical Director committed to such staffing in 2008 on a regular basis. The additional physician resource resolved the concern, and the commitment was communicated to the Civil Rights Division's consultant. Overall, timeliness of care meets NCCHC guidelines.

According to the Civil Rights Division's letter:

> Because of the way care is organized at the Jail, the 1200 Baker housing units seem to be particularly affected by any bottlenecks in access to the main intake clinic, despite the fact that the clinic is also located at 1200 Baker. Because the main clinic also serves as the main intake facility and emergency treatment center, the 1200 Baker detainees must effectively share the same clinic resources as newly admitted detainees, emergency cases, and detainee transfers from other units who require additional medical supervision. This puts a heavy strain on 1200 Baker medical staff and impedes detainee access to care.[281]

While challenging, the concentration of resources at 1200 Baker allows for far more efficient and effective use of personnel, equipment and space. The clinic operates on a 24/7/365 basis and can therefore provide care continually. While "bottlenecks" may be occasionally unavoidable given the periodic influx of detainees new to the system and episodic need to manage clinical urgencies or emergencies, the process is designed to provide continuous access to care, including 24/7 medical physician and psychiatrist support.

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280 "It is well established that a complaint does not amount to a committed act." *Snow v. City of El Paso, Tex.*, 501 F. Supp.2d 826, 833 (W.D. Tex. 2006) (citing *Estate of Davis ex rel. McCully v. City of N. Richland Hills*, 406 F.3d 375, 384 n.45 (5th Cir. 2005) (explaining that the number of complaints bears no relation to ultimate validity). The DOJ amorphously referred to "a number of complaints," and did not identify the number of complaints received or whether they were received from inmates, their lawyers or someone otherwise purporting to act on their behalf. Here, as in *Snow*, the DOJ failed to identify the number of complaints, if any, that were ultimately substantiated and to show that the number of complaints is disproportionately large for a jail the size of the Harris County jail facilities. Here, as in *Snow*, the DOJ failed to place the "number of complaints" in any relevant context from which any reasonable conclusions could be drawn. *See, e.g. Snow*, 501 F. Supp.2d at 833 ("[T]he Court cannot infer a widespread custom, assign knowledge of such custom, or attribute deliberate indifference solely based on the circumstances of Plaintiff's arrest and 104 unsubstantiated excessive force complaints."); *Piotrowski v. City of Houston*, 237 F.3d 567, 581 (5th Cir. 2001) ("A customary municipal policy cannot ordinarily be inferred from single constitutional violations."); *Pineda v. City of Houston*, 291 F.3d 325, 330 (5th Cir. 2002) (refusing to impute knowledge to the municipality based on the numerous offense reports collected because this would amount to *respondeat superior*).

281 Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 2.

According to the Civil Rights Division's letter:

> More generally, the Jail's administrative procedures allow delays in care to be easily overlooked. Jail procedures require that detainees complete forms to request medical care. The Jail disposes of these forms, however, just after they are processed. Once the forms are destroyed, the Jail apparently cannot track detainee requests for medical care in order to determine whether they have been fulfilled.[282]

Harris County denies these contentions and would also note that maintenance of paper forms is not constitutionally required. The Civil Rights Division's letter neglects to mention that given the volume of requests, the HCSO elects to track the requests with the use of a log, which is kept as a record and allows for documentation of requests and correlation with appointment logs. Mental health sick call requests are documented in a computerized log. The sick call request process, as is true of all other Health Services processes, has passed repeated review by the NCCHC.

According to the Civil Rights Division's letter:

> Another peculiar Jail practice involves the process for responding to requests for specialty care. As a matter of routine practice, Jail detainees submit requests for specialty care to a clerk. This process has apparently little or no physician oversight, which means that access to specialty care is not initially reviewed by qualified personnel. This lack of oversight means that individuals who may need more intensive or immediate care receive the same level of attention as those with relatively low priority needs.[283]

Harris County denies the allegations made by the Civil Rights Division advocates in this paragraph of their letter. It is difficult to determine whether the Division advocates were aware of the true specialty clinic referral process. Whether for on-site specialty referrals (OB/Gyn, Infectious Diseases, Orthopedic Surgery or General Surgery) or off-site specialty referrals, each referral is produced on a form with clearly indicated spaces for the referring provider to document the priority of the referral. Each referral is approved by the UT-Health Science Center Medical Director, and is therefore reviewed. Physician oversight is provided.

According to the Civil Rights Division's letter:

> These problems would be troublesome enough for a clinic dealing only with detainees who have acute medical complaints. For detainees with chronic conditions, barriers to care can cause them more difficulties than experienced by those inmates with more typical medical complaints. Detainees with chronic illness may need care to be much more timely and routine than some detainees

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282 Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 3.

283 Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 3.

> with acute conditions. At present, however, the detainees have a difficult time first accessing the clinic, and then receiving continuity of care.[284]

Harris County denies these unsubstantiated and conclusory allegations. The Civil Rights Division's letter does not offer any facts to allow a more specific reply.

According to the Civil Rights Division's letter:

> Detainees with mental illness are an especially high risk group. Other detainees with chronic conditions may at least have the capacity to seek care. Detainees with mental illness, especially those who are acutely psychotic or suicidal, may not even try to use the sick call process to obtain continuing treatment of their conditions. Such detainees may need regular follow-up visits and more consistent access to medical staff.[285]

Harris County objects to these allegations inasmuch as they are speculative and without foundation, and improperly suggest that prisoners with mental illness do not have consistent access to medical staff. Emphasis should be placed on the speculative phrases "may not even try" and "may need ... more consistent access to medical staff." The Civil Rights Division letter provides no specific examples.

Every request that MHMRA receives for service is triaged and prioritized whether received from the inmate, his/her family member, his/her lawyer, the court, chaplain, Detention staff member, or others. Acutely psychotic or suicidal detainees are routinely housed in the jail's mental health units and therefore have 24/7/365 access to mental health professionals. Abnormal behavior exhibited by detainees in general population housing areas is routinely identified by the security staff, who refer either to the mental health professional for triage or to the Mental Health Unit officers staffing the Crisis Intervention Response Team. Prisoners in administrative separation cells are evaluated by medical and mental health staff on a regular basis, consistent with NCCHC standards. The challenge of providing appropriate "outpatient" follow-up care to those detainees with mental illness was in the process of being addressed by the latest revision of the MHMRA annual agreement. The revision was discussed with the Civil Rights Division's consultant so that the Division was aware of upcoming requests. The approval of Commissioners Court in March of 2009 allowed for additional outpatient psychiatrist resource and triage personnel specifically for outpatient follow-up.

The Civil Rights Division advocates cataloged what they allege to be three (3) cases (involving Inmates DD – FF) of allegedly inadequate continuity of medical care from 2007 and 2008 at pages 7 – 8 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to inmates' continuity of care. Even assuming that continuity of medical care was inadequate in those three cases, which Harris County explicitly denies, three

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284 Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 4.

285 Letter from Loretta King to Ed Emmett, *supra* note 3, at 6 para. 4 – 7 para. 2.

cases out of 269,050 prisoners incarcerated in the Harris County Jail system from 2007 - 2008 constitute no actionable pattern.[286]

2. Inmate DD received constitutionally adequate medical care in the Harris County Jail system.

According to the Civil Rights Division, examples of the Jail's failure to provide appropriate follow-up treatment and continuity of care include the following examples from 2007 – 2008 include:

> DD was a 74-year-old detainee with a history of open heart surgery. When DD visited the clinic presenting complaints of incontinence, medical staff failed to give DD a physical exam or take his vital signs. Staff sent DD back to DD's unit. The following day, DD returned to the clinic with incontinence and elevated blood pressure. Clinic staff sent DD to the hospital, where he died shortly thereafter.[287]

Notwithstanding Harris County's objections and without waiving same, Harris County disagrees with the Civil Rights Division advocates' recitation regarding DD's clinical course and conclusions made regarding the adequacy of DD's medical care. The Division's summary grossly misstates DD's clinical course. Late on January 14, 2007, DD underwent intake screening. At that time, DD stated that he took unknown medications for hypertension, high cholesterol and "cardiac." DD reported that he had last taken his medication two weeks before incarceration. At 7:45 a.m. on January 15, 2007, a medical physician evaluated DD. The physician found DD to have elevated blood sugar and prescribed medication for diabetes, a diabetic diet and follow-up blood sugar checks. The physician prescribed three medications for high blood pressure and follow-up blood pressure checks. The physician ordered laboratory studies for cholesterol. At 8:37 p.m. on January 15, 2007, a physician reevaluated DD. The physician noted that nurses stated that DD used diapers. The physician also noted that DD was capable of standing on his own and using a walker. The physician described DD as being in "no apparent distress." On January 16, 2007, a physician again evaluated DD for fecal and urinary incontinence and for being "slow to respond verbally." The physician transferred DD to LBJ Hospital for further evaluation and treatment. DD spent thirty-nine (39) days in the hospital; he did not die "shortly thereafter." The Medical Examiner determined DD's cause of death to be "acute megacolon complicating prolonged hospitalization for treatment of atherosclerotic and hypertensive cardiovascular disease with congestive heart failure."

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286 *E.g., Burge*, 336 F.3d at 370; *Pineda*, 291 F.3d at 329 & nn. 9-11; *Piotrowski*, 237 F.3d at 581.

287 Letter from Loretta King to Ed Emmett, *supra* note 3, at 7 paras. 2-3.

3. Inmate EE received constitutionally adequate medical care in the Harris County Jail system.

According to the Civil Rights Division, examples of the Jail's failure to provide appropriate follow-up treatment and continuity of care include the following examples from 2007 – 2008 include:

> EE had a documented history of diabetes that received inadequate medical attention. When EE complained of symptoms, staff merely prescribed pain medication. Initially, EE complained of leg pain and knee swelling. In response, staff provided EE with pain medication. EE complained again 5 days later about her symptoms. The medical notes were essentially illegible, but apparently staff again just provided pain medication. The detainee complained of her symptoms once more that same day. While waiting to be seen in the clinic, EE collapsed and died shortly afterwards. The documentation suggests that after EE collapsed, staff failed to provide an appropriate emergency response. For instance, the records show that EE had a low blood sugar level at the time of her collapse, but staff failed to respond to the symptoms. Medical records also suggest that the staff did not try to use an automatic emergency defibrillator during the incident.[288]

Harris County disputes the accuracy of the Civil Rights Division advocates' summary regarding EE's care, as well as the conclusions made by the Division regarding the adequacy of EE's medical care.

On September 13, 2007, EE denied any medical problems at intake screening. On September 24, 2007, a physician saw EE. Her blood sugar was 139, and she was prescribed a diabetic diet and follow-up blood sugar checks. On October 20, 2007, a physician reviewed the results of the blood sugar checks (122-175 in the mornings, 93-183 in the afternoons). On October 5, 2007, a physician reevaluated EE and noted her as having "diabetes mellitus—on diet only." On September 27, 2007, EE's Hemoglobin A1c was 6.5%. Follow-up blood sugar checks from October 6 – 8, 2007 ranged from 42-232 in the mornings and 244-279 in the afternoons. A physician reviewed the results and ordered a physician follow-up appointment. On October 15, 2007 a physician saw EE. The physician began Humulin and Regular Insulin and again ordered follow-up blood sugar checks. On November 7, 2007, Hemoglobin A1c was 9%. On November 27, 2007, a physician reviewed this and ordered follow-up blood sugar checks. On December 3, 2007, these were reviewed by a physician. On December 8, 2007, a physician reevaluated EE and prescribed antibiotics. On December 13, 2007, a gynecologist evaluated EE and prescribed medications. That same day, a nurse evaluated EE in response to a sick call request. A physician ordered repeat blood sugar checks and ordered a physician appointment. EE's blood sugar checks ranged from 300-303 in the mornings and 300-340 in the afternoons. At the follow-up appointment, the physician modified EE's insulin regimen and ordered additional follow-up blood sugar checks. On December 27, 2007, a gynecologist saw EE in follow-up, at which time her issues had been resolved. On January 6, 2008, a physician evaluated EE for leg pain after EE reported hearing a "popping noise." EE had had knee surgery five years before.

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[288] Letter from Loretta King to Ed Emmett, *supra* note 3, at 7 para. 2, 7 para. 4.

On examination, EE's kneecap was tender and she was unable to bend the knee. The physician ordered an injection of Toradol for EE, prescribed pain medication, ordered an x-ray and MRI of EE's knee, referred EE to Orthopedic Surgery and scheduled EE for follow-up on January 7, 2008. A nurse gave EE the injection of Toradol. On January 7, 2008, a physician evaluated EE for her complaint of leg pain, noted that EE's left knee was swollen and she had muscle tenderness, and reviewed the x-ray of EE's leg. The physician diagnosed left knee strain and EE was appropriately prescribed Ibuprofen and Flexeril, and was given crutches. On January 12, 2008, a physician reevaluated EE for leg pain. At that time, EE was unable to walk on the affected leg. EE received one dose of Toradol. At 5:40 p.m. that same day, EE presented to a nurse with complaint of leg pain. She said that she wanted another injection of Toradol. She did not have fever. She remained in the medical holdover on the first floor to wait for the physician. At 9:30 pm, the nurses were called to the holdover because EE was not breathing and was unresponsive. CPR was immediately initiated and an ambulance was called. The Houston Fire Department ("HFD"), like the UT and HCSO medical personnel, arrived promptly. According to the HFD's ambulance call record, "patient was on AED and CPR was in progress upon arrival." Per the section labeled "Care Events:" "Chemstrip" was documented as 74 at 21:32 hours. That level of blood sugar did not require any additional intervention.

According to the HCSO's medical records, the radiologist's x-ray was unremarkable. This patient remained afebrile. According to EE's autopsy report, the cause of death is listed as "sepsis due to disseminated staphylococcus aureus bacterial infection of the left knee." A "ruptured 7.1 cm purulent cavity surrounds the left knee." The nature of the overlying skin was not described. EE had a history of left knee reconstructive surgery and pin implantation (2000 or 2001). The extremity exam on the autopsy was described as unremarkable. The autopsy report documented no skin findings or evidence of osteomyelitis.

The Civil Rights Division's use of the phrase "merely prescribed pain medication" does not adequately describe the initial physician's evaluation and is misleading. The Division's letter also fails to document the evaluation of a physician on January 6, 2008, at which time EE received pain medication, an x-ray, a request for MRI from the HCHD, a referral to Orthopedic Surgery and a follow-up appointment. Despite the autopsy diagnosis of sepsis, EE did not have a fever upon her last presentation to the clinic on January 12, 2008.[289]

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[289] Here, as in the other examples included in its letter, the Civil Rights Division raises "acts or omissions," rather than conditions-related claims, which fail to state a constitutional cause of action. Active treatment of a prisoner's serious medical condition does not constitute deliberate indifference. *See Stewart v. Murphy*, 174 F.3d 530, 534-36 (5th Cir. 1999) (finding, in civil rights suit filed by estate and survivors of inmate who died as a result of decubitus ulcers, that physicians who diagnosed and treated inmate for decubitus ulcers were not deliberately indifferent to inmate's serious medical needs and thus did not violate the Eighth Amendment, even though they did not follow recommendation of outside hospital physician and knew nursing staff was not fully complying with their directives). EE's medical records show that medical personnel repeatedly saw and treated EE's medical complaints. To the extent that the DOJ may question the UT physician's diagnosis of EE's medical condition, a medical professional's judgment is not subject to constitutional attack. As long as UT and jail medical personnel exercise professional medical judgment, the exercise of that judgment will not violate a prisoner's constitutional rights. *Youngberg*, 457 U.S. at 322-23 (1982). The Fifth Circuit, sitting *en banc*, indicated in *Hare v. City of Corinth* that Supreme Court decisions clarify that the subjective deliberate indifference standard applies to pretrial detainees' medical deprivation claims.

4. Inmate FF received constitutionally adequate medical care in the Harris County Jail system.

According to the Civil Rights Division, examples of the Jail's failure to provide appropriate follow-up treatment and continuity of care include the following examples from 2007 – 2008:

> FF had a history of cirrhosis. Over several weeks, FF's liver condition worsened, but staff repeatedly failed to respond in a manner consistent with generally accepted correctional medical standards. FF initially presented to the clinic with a complaint of swelling to his legs. Jail staff prescribed blood pressure medication, even though FF blood pressure was normal. FF complained of chest pain and other conditions over the next several weeks. Jail staff repeatedly sent FF to the hospital but repeatedly failed to change his medications, treatment plan, or conduct other appropriate follow-up. For instance, on one of these occasions, a deputy reported that FF was having trouble walking. The staff sent FF to the hospital, and an undated medical note indicates that FF needed fluid removed from his stomach. Again, however, staff did not alter FF treatment plan; nor was there any apparent documentation of vital signs. Approximately one month after his initial complaint, FF died during his last hospital stay. One troubling additional note about this case is that during the period in question, FF apparently spent much of his time at the Jail in a housing unit instead of the infirmary. Given the seriousness of FF medical condition, he needed to be in an infirmary in order to receive the level of care required by generally accepted correctional medical standards. The discontinuity of care and a lack of follow-up by staff are of serious concern in this case.[290]

Harris County objects to the Civil Rights Division's application of the wrong standard to the care provided to this inmate. As previously stated, the "generally accepted correctional medical standard" is a best practice standard, which is more rigorous than the Constitutional (deliberate indifference) standard.

FF underwent intake screening on April 29, 2008 and described a history of cirrhosis/chronic edema, for which he took furosemide and spironolactone. FF was referred to the medical clinic. On April 30, 2008, he was evaluated by a physician for the history of cirrhosis with chronic edema, Hepatitis C, and questionable congestive heart failure. Medications, including spironolactone, Lasix, Lactulose, KCl, Tramadol and Carvedilol and blood pressure checks were prescribed. On May 7, 2008, FF underwent a 14-day health assessment with a reported history of congestive heart failure, hypertension, Hepatitis C infection and cirrhosis. FF described being on medications. On May 14, 2008, a physician reviewed the May 8, 2008 laboratory results. On May 22, 2008, FF was seen by a physician to discuss Hep B & C results. FF stated that he had received no treatment in the past. He described no known complications except cirrhosis. The physician noted that FF's systolic blood pressures during blood pressure checks ranged from 144-167. At that visit, the physician prescribed Accupril for hypertension. FF's medications were renewed by a physician on May 28, 2008. FF was evaluated by a nurse for complaint of

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[290] Letter from Loretta King to Ed Emmett, *supra* note 3, at 7 para. 2, 7 para. 5, 8 para. 1.

urinary discomfort on May 30, 2008 and a physician appointment was scheduled. On June 7, 2008, FF was seen by a physician and described chest pain for one month and dyspnea on exertion, orthopnea and paroxysmal nocturnal dyspnea. FF was noted to be jaundiced. There were no acute changes on EKG. FF was transported to LBJ Hospital. He returned from the hospital on June 10, 2008 with a diagnosis of atypical chest pain. Some laboratory studies from the hospital were still pending at the time of discharge. According to information from the hospital, FF had been ruled out for heart attack. Medications, including Lactulose, were prescribed. FF had another physician evaluation on June 11, 2008; during that evaluation the laboratory report from LBJ Hospital was reviewed with noted improvement in increase in liver function tests as noted at the hospital. A repeat chemistry panel was ordered for June 13, 2008. On June 22, 2008, FF was again evaluated by a physician for "feeling cold and having chest pain." The physician recommended no change in the medication regimen. FF was seen by a physician on June 27, 2008 for increased abdominal girth, jaundice, slurred speech and abdominal pain. FF had developed fluid in the abdomen. His recent laboratory results were reviewed. FF was transported to LBJ Hospital Emergency Center for evaluation and treatment. He returned from the hospital on June 28, 2008. He was evaluated by a physician who ordered that all medications be resumed and that the patient could return to general population. On July 5, 2008 at 1340 hours, the clinic received a call from a deputy that FF was having difficulty walking and breathing. FF was brought to the clinic and was evaluated by a physician. The physician ordered transport of FF to the LBJ Hospital Emergency Center. On July 5, 2008 at 2023 hours, FF was reevaluated by a physician upon return from the hospital. FF's medications were continued and the dosages of spironolactone and Lasix were increased. On July 6, 2008, at 1620 hours, the clinic received a call from a deputy stating that FF was having stomach pains. FF was brought to the clinic and was evaluated by a physician. The physician noted that FF was in "no apparent distress." The physician ordered a chest x-ray and medication was given to FF. On July 6, 2008, at 2246 hours, FF was again evaluated by a physician for complaint of abdominal pain. The physician did not order a change in the medication regimen. On July 8, 2008, FF was evaluated by a physician for complaint of shortness of breath. The physician ordered an adjustment in the medication regimen and provided a pass for an extra pillow. On July 10, 2008, FF was evaluated by a physician for complaint of shortness of breath. On examination, FF's abdomen was noted to be distended and tender and he was transported to LBJ Hospital Emergency Center. FF returned from the hospital on July 11, 2008 and was reevaluated by a physician. The physician ordered that medications be continued as prescribed. On July 15, 2008, FF was evaluated by a physician for complaint of worsening shortness of breath and chest pain. FF's abdomen was noted to be distended. The physician ordered transport to LBJ Hospital Emergency Center. On July 16, 2008, FF returned from the hospital and was evaluated by a physician. Medications were prescribed. On July 19, 2008, FF was evaluated by a physician for complaint of respiratory distress, altered mental status, moaning, and cough. FF was drowsy. His abdomen was distended and a chest x-ray was ordered. The physician ordered transport to LBJ Hospital Emergency Center. FF died sixteen days after admission to LBJ Hospital. On August 4, 2008, the HCSO was notified that FF died at 2356 hours that day. The Medical Examiner determined that FF died of end-stage liver disease due to cirrhosis caused by hepatitis B and C viral infections, as well as chronic ethanolism.

This patient was evaluated by physicians after each hospitalization and the medications, treatment plans and follow-up ordered in each instance were based on each physician's

judgment. Admission to the infirmary and/or alteration of treatment plans can only be performed by a physician. Each physician treating this detainee acted in his/her best medical judgment. Hospitals providing the finest care in the world cannot guarantee a successful outcome. This case was discussed with the UT-Health Science Center Medical Director and the HCSO Health Services Quality Improvement Coordinator, and a new process to monitor patients requiring more than one Emergency Center transport was put into place in an effort to identify those patients best managed in the infirmary setting.[291]

F. Harris County provides constitutionally adequate medical documentation and quality assurance processes for the benefit of inmates incarcerated in the Harris County Jail system.

According to the Civil Rights Division:

> Medical record-keeping and quality assurance are basic components of a clinical practice that is consistent with generally accepted correctional medical standards. These systems help identify and correct potential problems with patient care. Harris County has deficiencies in both areas, and these deficiencies contribute to problems with chronic care and continuity of care.
>
> A complete and adequate medical records system is critical to ensuring that medical staff are able to provide adequate care. The Jail's process for maintaining medical records and processing medical orders often leaves medical records unavailable to nurses and doctors. Medical staff have little or no access to the records when the pharmacy staff are filling out medication orders, because the pharmacy staff have custody of the records when completing those orders. During our fact-gathering, we also found various record-keeping problems such as a lack of compliance with professional record-keeping formats, illegible physician notes, and factually inaccurate documentation. These deficiencies affect the quality of care and the medical staff's ability to meet Constitutional requirements.[292]

Harris County objects to the Civil Rights Division's application of the "generally accepted correctional medical standards" and "professional" record-keeping standards, which are more rigorous than the Constitutional (deliberate indifference) standard. Notwithstanding these objections, Harris County would note that the HCSO has continued to meet the NCCHC's medical-records related standards since 1991, when the HCSO's medical system was first accredited by the NCCHC.

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[291] In any event, FF received constitutionally adequate medical care. The DOJ raises "acts or omissions," rather than conditions-related claims, which again fail to state a constitutional cause of action. Active treatment of a prisoner's serious medical condition does not constitute deliberate indifference, even if treatment is negligently administered. *See, e.g.*, *Stewart v. Murphy*, 174 F.3d 530, 534 (5th Cir. 1999); *Mendoza v. Lynaugh*, 989 F.2d 191, 195 (5th Cir. 1993); *Varnado v. Lynaugh*, 920 F.2d 320, 321 (5th Cir. 1991). "Unsuccessful medical treatment, ordinary acts of negligence, or medical malpractice do not constitute a cause of action under § 1983." *Stewart*, 174 F.3d at 534-36.

[292] Letter from Loretta King to Ed Emmett, *supra* note 3, at 8 paras. 2-3.

Harris County also objects to and disagrees with the Civil Rights Division's conclusory references to deficiencies, inadequacies, unavailability of medical records, various record keeping problems, unspecified lack of compliance with professional record-keeping formats, illegible physician notes and factually inaccurate documentation, which are not supported as required by CRIPA's Section 1997b(a)(1) notification requirements.

Harris County also objects to the Civil Rights Division's failure to mention those aspects of the medical record which are electronic and are always available to the medical staff: the pharmacy system, which documents all current (active) and previous (inactive) medications, the x-ray system and the recent link to the Harris County Hospital District ("HCHD") electronic medical record.

Notwithstanding these objections and without waiving same, the HCSO's medical documentation process suffers from no constitutional infirmity. As previously reported to the Civil Rights Division,[293] the HCSO, in conjunction with the Harris County's Office of Budget and Management, continues to develop and implement the Tracker program to allow for documentation of more complete intake screening, outpatient mental health evaluations and psychiatrist prescriptions. This process is ongoing with continued refinements of the Initial Psychiatric Screening form and modifications to the Orange Sheet information form provided to the court system. The Tracker software also allows for improved monitoring of patient interventions and medication issues.[294]

Ongoing discussions and development and implementation of a formal agreement between the HCSO and the Harris County Hospital District ("HCHD") resulted in a shared database (EpicLink) which gives the clinicians and some administrative staff access to the HCHD's electronic medical record. This development has enhanced continuity of care and is making the process of obtaining outside medical information much more efficient. The project went live on April 1, 2009, and is now used on a regular basis to obtain Hospital District medical information, including Emergency Center information, hospital admission and discharge notes, laboratory and radiographic test results, and procedure results.[295]

A signed agreement was finalized and payment initiated to begin the process of upgrading the pharmacy's Cerner software program, which will provide efficiencies in medication delivery and improve the HCSO's Medical Division's reporting capabilities for on-going quality improvement purposes. Regular design and training meetings are on-going. The updated system is scheduled to go-live in the fall of 2009.[296]

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[293] Bates 31,317-80.

[294] Bates 31,317-80.

[295] Bates 31,317-80 & 34,402.

[296] Bates 34,401.

During the Civil Rights Division advocates' July and August 2008 inspections of the Harris County Jail system, HCSO personnel agreed with the Division's medical consultant that the use of a paper medical record system is extremely challenging given the size and complexity of our system. The HCSO's paper medical record system is challenged by the volume of 130,000 or more prisoners being booked into the Harris County Jail system each year. HCSO medical personnel also discussed with the Division's medical consultant Harris County's ongoing development of computerized systems (including refinements of the existing computerized x-ray system and the computerized pharmacy system) and HCSO's intent to continue to pursue the conversion of their medical records system to an electronic medical record.

Although electronic medical records management is not constitutionally required,[297] the Harris County Commissioners Court approved the HCSO's application for more than six million dollars in stimulus grant funding for development and implementation of an electronic medical record.[298] This application was submitted to the Department of Justice on or about May 18, 2009. Conversion to an electronic record would greatly facilitate access to information, enhance quality improvement efforts and allow for improved continuity of care.[299] With the collaboration of Harris County's Office of Budget and Management, the HCSO, and the Office of Criminal Justice Coordination, a detailed Request for Proposals ("RFP") has been developed. This group will also collaborate in interviewing vendors and potentially selecting and implementing the chosen system. Information has been provided to the HCHD so that the possibility of sharing the HCHD's electronic medical record system ("Epic") can be explored. Should that effort not prove feasible, the RFP has been prepared so that the project can be advertised without undue delay. Until such time, use of a physical paper record in any health care system can result in instances where the medical chart is not available in two places at one time, where handwriting is difficult to read and where inadvertent inaccuracies can occur.

According to the Civil Rights Division:

> As a matter of technical assistance, we should note that correctional facilities often benefit from having an adequate quality assurance process.[300] Such a process can help administrators self-identify and correct any deficiencies. A large facility may have particular difficulty addressing systemic constitutional deficiencies without such a process. The Jail does engage in some effective quality improvement activities in order to track and trend medical-related incidents at the facility. The activities do not, however, include adequate

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297 *See, e.g., Graves v. Arpaio*, No. CV-77-0479-PHX-NVW, 2008 WL 4699770, at *30 (D. Ariz. Oct. 22, 2008).

298 *See* Bates 34,403-38.

299 The DOJ's National Institute of Corrections technical consultants have also recommended that the HCSO continue its efforts to computerize medical records. *See* Exhibit 1 (DOJ's NIC's July 2, 2009 Jail Systems Assessment) at 32.

300 Given the DOJ's "[a]s a matter of technical assistance" preface to this section, it does not appear that the DOJ is alleging that there are any constitutionally-based inadequacies in the HCSO's quality assurance process.

> mechanisms to review and evaluate Jail physicians; nor does the process include mechanisms that could help ensure more consistent and adequate record-keeping. The mortality review process does not include feedback to appropriate physician staff.[301]

Harris County objects to and disagrees with the Civil Rights Division's conclusory allegations that the HCSO's quality improvement ("QI") activities do not include adequate mechanisms to review and evaluate Jail physicians, that QI activities do not include mechanisms that could help ensure more consistent and adequate record-keeping, and that the mortality review process does not include feedback to appropriate physician staff. These allegations are not supported as required by CRIPA's Section 1997b(a)(1) notification requirements.

Harris County would also note that the HCSO has satisfied all NCCHC "best practice" quality assurance-related standards since 1991.

During the Civil Rights Division's medical consultant's inspection, the Quality Improvement Coordinator was praised. Quality Improvement activities are integral to the operation of the Health Services Division and have undergone ongoing review and approval by the NCCHC. The results of mortality review have routinely been shared with the UT-Health Science Center's Medical Director, who in turn communicated with his physicians. These QI discussions with the UT-Health Science Center's Medical Director are routinely documented. The Division's medical consultant praised the quality improvement process but suggested that some assessment of quality of care delivered should be presented in correlation with the quantity of care delivered. Such suggestions by the Division's medical consultant to modify some of the quality improvement tracking processes, add a more robust peer review process and to modify the mortality review process were discussed and implemented.[302]

For example, a clinical activity review form was developed, implemented and revised. The form has been used by medical physicians and psychiatrists for the purpose of providing peer review. Dr. Marcus Guice, the Medical Director for University of Texas-Houston Health Science Center, and Dr. Sylvia Muzquiz, the Medical Director for the MHMRA, have used the form to provide peer review for the on-site medical physicians and psychiatrists, respectively. Specific peer review findings are shared with the individual clinicians. Dr. Muzquiz now has an ongoing role at the HCSO, with specific responsibilities for ongoing peer review and expert supervision of the psychiatrists. As the overall Medical Director for all county MHMRA activities, she brings a global community perspective to the Jail's programs. A general administrative restructuring of the MHMRA jail program has been accomplished: Dr. Muzquiz now provides general administrative oversight. A Lead Psychiatrist position was created and filled by one of the Jail's most experienced psychiatrists. Administrative responsibilities were redefined and implemented for the Mental Health Administrator (Mona Jiles) and the Mental Health Program Director (Robert Simon). A Mental Health Utilization Manager has been added to provide ongoing review of mental health activities, including: monitoring of mental health unit admissions and

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301 Letter from Loretta King to Ed Emmett, *supra* note 3, at 8 para. 4 – 9 para. 1.

302 *See* Bates 31.317-80, 34.400-03.

discharges, review of readmissions, monitoring of progress of patients through the clinical process (crisis resolution stage; stabilization stage; maintenance stage), providing feedback to MHMRA management and psychiatrists, monitoring use of seclusion cells and ensuring appropriate documentation. All forced medication episodes and use of seclusion cells are also reviewed, in detail, by the Mental Health Quality Improvement manager, and are reported to the Quality Improvement Committee. The goal of this reporting mechanism is to determine whether changes in clinical management could prevent future instances of forced medication and/or seclusion. All changes were designed to improve daily oversight and to allow for ongoing specialist peer review.[303]

Quality improvement processes now include review of all detainees who have been sent to the Harris County Hospital District ("HCHD") Emergency Center more than one time during each incarceration in an effort to provide additional review to consider need for ongoing follow-up, need for outside medical records or need for specialized on-site housing.[304]

VII. Harris County provides constitutionally adequate mental health care to inmates incarcerated in the Harris County Jail system.[305]

Harris County objects to the "Mental Health Care" section of the Civil Rights Division's letter because the Division failed to satisfy CRIPA's notification requirements.[306] The Division likewise failed to come forward with any proof that Harris County or any Harris County official or employee has subjected significant numbers of HCJ inmates to "egregious or flagrant conditions" which deprived such inmates of their constitutional rights, causing them to suffer grievous harm.[307] The Division further failed to show any alleged pattern or practice of institutional abuse and resistance to a substantial number of Harris County jail inmates' constitutional rights.[308]

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303 *See* Bates 34,400.

304 *See* Bates 34,401-02.

305 As previously stated, although the Civil Rights Division has repeatedly affirmed its commitment to a transparent and even-handed investigation, it has thus far declined to provide Harris County with its consultants' reports completed after inspection of the Harris County jail facilities. Without the report of Dr. Amanda Ruiz, the Division's mental health consultant, Harris County cannot reasonably determine which, or to what extent, the Civil Rights Division's mental health-related findings and proposed remedial measures are based upon Dr. Ramirez's personal observations and recommendations, and which and to what extent the findings and proposed remedial measures reflect the Civil Rights Division's advocacy.

306 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 9-14. *Contra* 42 U.S.C. § 1997b(a)(1) (1996).

307 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 9-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

308 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 9-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

A. Constitutional Framework

For the constitutional framework relating to mental health care issues, see Section VI(A), *supra*.

B. The HCSO has a range of housing options for prisoners with mental illness.

According to the Civil Rights Division's letter:

> Many of the Jail detainees require mental health care. Approximately 2000 Jail detainees reportedly receive psychotropic medications each day. Of the detainees receiving psychotropic medications, approximately 200 are considered by the Jail to be part of the mental health program. These detainees often cannot be housed in general population because of their mental health condition. The Jail needs a range of housing options to handle such detainees, because detainees with mental illness have very different needs depending on their circumstances. Instead, the Jail only has a limited number of on-site housing options for detainees with mental illness. These basically consist of some single cells and specialized dormitories.[309]

Harris County disagrees with the representations made and conclusions drawn by the Civil Rights Division in this paragraph. It is unclear whether the Civil Rights Division understood the range of housing options available for the provision of mental health care: (1) patients with concurrent medical and mental health issues may be housed in the medical infirmary, where they are followed by a psychiatrist; (2) patients may be housed in the 2C unit, which consists of 70 beds, both single cells and multiple-person group cells; (3) patients may be housed in the 2P unit, which consists of 26 single cells and a nursing station; (4) patients may be housed in the 2P2 unit, which consists of 12 cells dedicated to a cognitive behavioral therapy unit managed by MHMRA psychologists; (5) patients may be housed in the 24-bed Harris County Psychiatric Center unit, which provides mental health hospital-level care; and (6) patients may be housed in the 148 beds of 2B and 2E, which provide "step-down" housing for patients with mental illness under the supervision of Mental Health Unit deputies and mental health staff. The total of 280 mental health-dedicated beds makes the Harris County Jail one of the largest, if not the largest, provider of mental health beds in the state. The Civil Rights Division advocates' conclusion is simply not correct.[310]

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[309] Letter from Loretta King to Ed Emmett, *supra* note 3, at 9 para. 2.

[310] It appears the Houston Chronicle's editorial staff would also disagree with the Civil Rights Division's conclusion. In a July 15, 2009 editorial urging lawmakers to amend outdated Medicaid regulations to open the doors of private hospitals and doctors' offices to a large segment of the mentally ill population who need better treatment options than simply going to jail, Houston Chronicle editors stated: "If you are a mentally ill Houston adult without financial resources, getting arrested and locked up at the Harris County jail may be your quickest route to government-funded treatment. Ever fewer hospital beds and services are available for such patients, and the closing of state institutions has forced thousands of them onto the streets, swelling the ranks of the homeless. For those in need, the jail has become the biggest single provider of mental health care in the area. Unfortunately, it comes with an arrest record." *Denial of care: Archaic Medicaid rule penalizes mentally ill poor adults*, HOUSTON CHRON., July 15, 2009, at B8.

According to the Civil Rights Division:

> Housing practices for detainees with mental illness are problematic. For example, even though the ratio of male to female mental health patients is about 2:1, the number of male single cells to female single cells appears to be 32:1. Thus, female detainees with mental illness are much more likely to be left in inappropriate housing conditions while awaiting care.[311]

Harris County objects to these allegations inasmuch as they are conclusory and speculative and fail to satisfy CRIPA's Section 1997b(a)(1) notification requirements. The Civil Rights Division fails to give specific information about any female inmate in "inappropriate housing conditions." The Division's allegations draw a broad and unwarranted conclusion without supporting documentation. Housing in the variety of mental health units is determined by psychiatrists and is therefore not "inappropriate." The HCSO agrees that more male cells are available to mental health patients than female cells, but this does not necessarily lead to the conclusion that female patients with mental health issues receive inappropriate care. The apparent conclusion that the Harris County Jail is lacking female single cell space and therefore is somehow leading to inappropriate housing is not substantiated.

C. The 1200 Baker Street jail facility's medical clinic does not serve as the HCSO's primary mental health resource.

According to the Civil Rights Division:

> As with medical care generally, the clinic in the 1200 Baker building serves as the primary mental health resource. As noted previously, the 1200 Baker clinic is overwhelmed.[312]

Harris County disagrees with these representations. The HCSO again refers to an earlier comment regarding capacity at the 1200 Baker Street medical clinic. The mental health clinic within the 1200 Baker facility has its own dedicated space and staff and can operate autonomously from the concurrent medical clinics. Other mental health patients are seen elsewhere in the 1200 Baker building and in the 701 San Jacinto building. Given the Division advocates' representations, it is unclear whether they were even aware of those other clinic locations.

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311 Letter from Loretta King to Ed Emmett, *supra* note 3, at 9 para. 3.

312 Letter from Loretta King to Ed Emmett, *supra* note 3, at 9 para. 3.

According to the Civil Rights Division:

> The Jail also has access to some other treatment facilities, such as the Harris County Psychiatric Center (Center), but these facilities have limited resources. For example, the Center can house only 24 Jail detainees.[313]

To the best of the HCSO Health Services staffs' knowledge, the Harris County Psychiatric Center ("HCPC") unit may well be the only mental hospital/jail collaboration in the country. This unit was developed in 2007 to meet the very need discussed by the Civil Rights Division—to present a range of housing and treatment options for patients with mental health needs. The HCPC unit provides mental health hospital-level of care in a therapeutic setting difficult to achieve in a jail. The overall capacity of 280 beds in 2C, 2P, 2B, 2E and HCPC is overlooked by the Civil Rights Division's letter.

As previously explained to the Civil Rights Division, the HCSO, in collaboration with the MHMRA, implemented a new Mental Health New House Clinic in March of 2007 for patients identified as needing mental health services during the booking process. The clinic is staffed by a mental health nurse and psychiatrist 24 hours a day, seven days a week, to evaluate patients and begin treatment early in their incarceration period. This process has improved the provision of care during patients' incarceration and has thus decreased gaps in medication regimens and psychiatrist interactions. This process has also reduced the issue of 21-day court orders by identifying patients with mental disabilities early in their incarceration, medicating them efficiently, and communicating their mental health status to the courts.[314] The HCSO renovated 46 general housing cells into 38 single cells and 8 seclusion cells. One-quarter of the unit is supervised by mental health trained security staff with input from MHMRA-hired psychologists and three-quarters of the unit is managed by HCSO mental health staff with input from MHMRA psychiatrists.[315]

As also explained to the Civil Rights Division, the HCSO entered into a contract with the HCPC in April of 2007 to occupy 24-off-site in-patient beds with incarcerated patients. This process has enabled the HCSO to provide a level of care difficult to achieve within the jail's security setting, allows the inmate patients to receive multidisciplinary care within a therapeutic environment and facilitates intensive psychiatric management.

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313 Letter from Loretta King to Ed Emmett, *supra* note 3, at 9 para. 3.

314 Bates 31.317-80.

315 Bates 31.317-80.

D. Prisoners receive constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail system.

1. Introduction

According to the Civil Rights Division:

> Many of the problems noted previously regarding chronic care and medical care generally also apply to detainees with mental illness. For example, the Jail's process for assessing and treating detainees is focused on acute symptoms and does not adequately identify detainees with serious mental health needs. The mental health clinic functions like a hectic emergency room, and detainees with serious mental health conditions often cannot obtain timely and appropriate care. These deficiencies violate generally accepted correctional mental health standards.[316]

Harris County objects to the Civil Rights Division's invocation of "generally accepted correctional mental health standards," which are more rigorous than the Constitutional (deliberate indifference) standard. Harris County also objects to the Civil Rights Division's conclusory statement that "[m]any of the problems noted previously regarding chronic care and medical care generally also apply to detainees with mental illness." This allegation is not supported as required by CRIPA's Section 1997b(a)(1) notification provision.

Notwithstanding these objections and without waiving same, Harris County disagrees with each of the allegations made by the Civil Rights Division in this paragraph of its report. The Division's allegations are not substantiated and are not supported by documentation in the medical records, by the HCSO's policies and procedures, or by the ongoing review and accreditation by the NCCHC. It appears that the Division advocates did not understand the HCSO's health screening and treatment process. Incoming detainees are all screened for mental health issues (chronic or acute) and abnormal behavior during the booking process. Any detainees with affirmative answers or unusual behavior are sent to the jails' 24/7/365 "Front Door" mental health clinic prior to classification or housing so that a mental health nurse and psychiatrist can evaluate the detainee and determine most appropriate treatment, housing and follow-up. The clinic is not a "hectic emergency room," but has – as its primary focus – the responsibility to see patients referred from intake screening. The issue of urgent and emergent mental health care was also addressed proactively by the Harris County Jail through the development and implementation of the Mental Health Unit – a unit of one Lieutenant, four Sergeants and now more than 150 officers who all have received 112 hours of specialized mental health training. The officers not only assist in the medical clinic, the mental health clinic, the mental health housing units and the HCPC unit, but also intervene during times of detainee urgencies to attempt to de-escalate situations and better manage detainees with mental health issues. The CIRT (Crisis Intervention Response Team) is staffed by two MHU officers on a 24/7/365 basis to respond to such situations. The MHU officers coordinate their activities with the mental health nurse and psychiatrist in the clinic so that mental health urgencies and

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[316] Letter from Loretta King to Ed Emmett, *supra* note 3, at 9 para. 4 – 10 para. 1.

emergencies can be better managed with as little disruption to the clinic as possible. Adding psychiatrist support to the mental health units (three psychiatrists dedicated to providing care to 2C and 2P with daily – including weekends and holidays – rounds) has also minimized the need of the clinic to manage urgent situations on the unit. Finally, additional psychiatrist support has been added so that a psychiatrist is assigned to be responsible for the management of urgencies and emergencies on a rotational basis, so that those patients can be evaluated elsewhere in the system, therefore minimizing impact on the clinic. Harris County strongly disagrees with the Civil Rights Division's allegation that "[t]hese deficiencies violate generally accepted correctional mental health standards." The policies, procedures and practices of the mental health operation in the Harris County Jail have been approved by the NCCHC.

According to the Civil Rights Division:

> As a practical matter, while the general medical clinics can meet the serious acute care needs of many detainees, the mental health system does not adequately address the serious mental health care needs of detainees. Mental health policies designed to cover a range of conditions exist, but overwhelmed staff often do not implement them as written. A host of serious mental health conditions cannot be adequately handled at the Jail because of significant housing and treatment limitations. While the Jail devotes additional resources to dealing with the most acutely suicidal, even the basic care and supervision of the most seriously mentally ill appears inadequate.[317]

Harris County objects to the Civil Rights Division's broad, sweeping conclusory statements, made without the support statutorily required under 42 U.S.C. § 1997b(a)(1). Notwithstanding these objections and without waiving same, Harris County agrees that the HCSO's general medical clinics meet the serious acute needs of prisoners incarcerated in the Harris County Jail system, agrees that the HCSO has implemented mental health policies covering a wide range of conditions, and agrees that additional resources are devoted to dealing with the most acutely suicidal. Harris County disagrees with each other allegation made – and conclusion drawn – by the Civil Rights Division in this paragraph of its report.

According to the Civil Rights Division:

> The Jail's written policies include a process for screening and prioritizing detainees with serious mental illness, but in practice, the Jail does not adequately treat detainees based on the seriousness of their condition. The Jail staff classify requests for mental health care into four basic categories. Category 1 includes detainees who are acutely suicidal or have expressed homicidal complaints. Category 2 includes detainees who have expressed some suicidal ideation but have not indicated imminent action. Category 3 includes detainees with medication issues. Category 4 includes detainees who need to see a case manager. Because of limitations on facility housing, staffing, and treatment options, the Jail can only address detainees in Category 1. Other detainees must

[317] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 2.

wait for treatment, often for significant periods of time, if they receive mental health treatment at all.[318]

Harris County provides constitutionally adequate access to mental health care to prisoners incarcerated in the Harris County Jail system. Here, as above, Harris County objects to the Civil Rights Division's broad, sweeping, conclusory statements, made without the support statutorily required under 42 U.S.C. § 1997b(a)(1). Notwithstanding these objections and without waiving same, Harris County agrees that the HCSO's written policies include a process for screening and prioritizing prisoners with serious mental illness. Harris County disagrees with the balance of the Division advocates' representations in this paragraph of their letter.

This paragraph of the Civil Rights Division advocates' letter is inherently contradictory. If the Division advocates are representing that the HCJ is not treating detainees based on the seriousness of their conditions, why then do they document the fact that the Harris County Jail uses a triage classification system based on seriousness of condition? The Division advocates again use the unsubstantiated allegation of limited housing, staffing and treatment options. Challenges in the provision of routine mental health care were discussed with the Division's consultants, including specific discussions to show resource reallocation to "outpatient" mental health care as well as proposed (now approved) changes in the MHMRA agreement to provide additional "outpatient" case manager and psychiatrist support.

The Civil Rights Division's claims that "[b]ecause of limitations on facility housing, staffing, and treatment options, the Jail can only address detainees in Category 1" and that "[o]ther detainees must wait for treatment, often for significant periods of time, if they receive mental health treatment at all" lack foundation. There are two main mechanisms in place for mental health patients to be seen:

1. Initial contact with the detainee is during the booking process into the jail. Patients reporting any mental health issues to security and/or medical staff during the booking process or those who present with unusual behavior are referred to the Front Door Clinic for follow-up evaluation by a mental health nurse and psychiatrist 24/7/365. No categorization is performed (with the exception of determining emergent need) in that all patients with identified mental health issues are sent to the clinic for evaluation, regardless of severity.

2. Once housed, detainees/patients may be seen as a result of submitting a request for services. Requests for a patient may also be submitted by HCSO staff, family members, lawyers and others who may be interested in a patient's welfare. Each referral for service is triaged by masters-level licensed staff and is prioritized according to the categories listed:

   Category 1—includes the following: patients who are acutely suicidal or homicidal or presenting with imminent threats of harm, those acutely

[318] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 3.

> psychotic or delusional, those aggressive as a result of mental health issues, and those reporting possible adverse reactions to medications.
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> Category 2—includes the following: patients voicing thoughts of suicide or homicide, but no imminent plan of action, patients reported to be exhibiting behavior that may be disruptive to the housing unit and there is a concern it may be directly related to mental health issues, and patients referred by medication cart nurse for non-compliance issues.
>
> Category 3—includes the following: patients requesting medication and patients requesting follow-up contact for other reasons.
>
> Category 4—includes the following: patients on medication who present with one of the problems listed in the above three categories.

The HCSO categorically denies the statement that patients triaged and characterized as being in Categories 2-4 do not receive treatment. As discussed above, additional resources were in place prior to the time of the Civil Rights Division's July and August 2008 inspections and additional resources were put into place following the modification of the MHMRA agreement in March of 2009 to create additional LPHA[319] screening and psychiatrist support for triage, evaluation and treatment of outpatients. The Division advocates' letter misrepresents the situation and ignores the process in place.

According to the Civil Rights Division:

> Given that mental health staff received about 17,000 requests in 2007, the existing system for allocating mental health resources is inadequate. The Jail does not provide access to mental health care for many inmates with serious needs. Examples from 2007-2008 include ...[320]

Harris County objects to this paragraph of the Civil Rights Division's letter because it is not supported with notification as required by 42 U.S.C. § 1997b(a)(1) and is conclusory. Notwithstanding these objections and without waiving same, Harris County provides constitutionally adequate access to mental health care to prisoners incarcerated in the Harris County Jail system. Harris County denies the Division's allegation that the jail does not provide access to mental health care for many inmates with serious needs, and submits that the examples cited by the Division advocates do not support the conclusion for which they are asserted.

Sweeping changes were implemented in 2007 and 2008. The Civil Rights Division was provided with the plan (which included adding the HCPC unit, converting a housing unit to mental health housing (2P), developing and training the deputies of the Mental Health Unit, developing and implementing the Front Door psychiatric clinic, developing and implementing a

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[319] An LPHA is a Licensed Practitioner of the Healing Arts.

[320] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 4.

performance-measure based MHMRA agreement, hiring a Mental Health Quality Improvement Coordinator, modifying the mental health triage process, hiring additional psychiatrists, etc.). The Civil Rights Division simply ignores the progress made prior to their July and August 2008 inspections and the proposed improvements awaiting agreement renewal and Commissioners Court approval (information which was provided to the DOJ in Harris County's ongoing updates).[321]

The Civil Rights Division advocates cited what they allege to be six (6) cases (involving Inmates GG – LL) of inadequate access to mental health treatment from 2007 – 2008 at pages 10 – 12 of their June 4, 2009 letter. The Division failed to notify Harris County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to access to mental health treatment. Even assuming the mental health treatment to have been inadequate in those six cases, which Harris County specifically denies, six cases out of the 269,050 prisoners incarcerated in the Harris County Jail system from 2007 - 2008 constitute no actionable pattern.[322]

2. Inmate GG received constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail.

According to the Civil Rights Division, examples showing that the Jail does not provide access to mental health care for many inmates with serious needs include:

> GG entered the facility with a mental health history. At the time, GG apparently was withdrawing from alcohol, but staff failed to provide appropriate medication and initial intervention. Five days later, someone observed GG in his cell, with blood seeping out under the door. Security arrived, and they discovered that GG had lacerated his hand and appeared to be hallucinating. Staff transferred GG to the infirmary, but they did not complete an initial psychiatric assessment until five days later. Staff discharged GG two days later.[323]

The Division's recitation regarding Inmate GG's access to mental health treatment constitutes a complete misunderstanding of the facts.

On July 6, 2008, Inmate GG underwent intake screening and denied any medical or mental health issues. On July 8, 2008, GG apparently developed symptoms while in court, including numbness in his legs, arm and back. GG was promptly brought to the clinic for a physician evaluation. At the clinic, GG reported: "It's all stress related." GG was promptly referred to a psychiatrist. That same day, the psychiatrist evaluated GG and determined that he had an anxiety disorder which did not require medication. GG denied any suicidal ideation. On July 10, 2008, GG became disoriented and developed hallucinations and was again brought to see a

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321 *E.g,* Bates 34,400-03.

322 *E.g., Burge,* 336 F.3d at 370; *Pineda,* 291 F.3d at 329 & nn. 9-11; *Piotrowski,* 237 F.3d at 581.

323 Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 4 – 11 para. 1.

physician. The physician determined that GG was withdrawing from some substance and admitted him to the jail's medical infirmary. On July 11, 2008, while in the infirmary, GG cut his wrist and neck. A physician immediately treated him. An IV was started and GG was transported to Lyndon B. Johnson ("LBJ") Hospital's Emergency Center. On July 16, 2008, GG returned from the hospital and was reevaluated by a medical physician and mental health and readmitted to the jail's infirmary with orders for psychotropic medications. On July 17, 2008, GG was again evaluated by a medical physician and psychiatrist. On July 18, 2008, GG was medically cleared by the medical physician and transferred to the jail's mental health unit by a psychiatrist.

Contrary to the Civil Rights Division's letter, GG was seen by a psychiatrist the same day the complaint was made. He returned from court, indicated that his physical reactions were directly related to stress and was appropriately referred to a psychiatrist. There was no delay in offering mental health treatment. There was no report of mental health history upon admission as per intake screening, and there was no history of formal mental health treatment prior to GG's incarceration. The lacerations to GG's hand and neck occurred *while he was in the infirmary*. The Division's letter would cause a casual reader to conclude that GG was discharged into the jail's general population two days after he was placed in the infirmary. In fact, GG was appropriately transferred to the *mental health unit* when he was discharged from the infirmary. While the Division may disagree with the professional judgments of the physician and psychiatrist who treated GG, there is no evidence that those judgments were medically incorrect and it certainly does not mean that his constitutional rights were violated.

3. Inmate HH received constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail.

According to the Civil Rights Division, examples showing that the Jail does not provide access to mental health care for many inmates with serious needs include:

> HH's medical record suggested that he had a history of not eating, but staff did not initially refer him to a psychiatrist for assessment. After six months in the Jail, HH complained of depression, and staff finally referred HH to a psychiatrist. Mental health staff, however, did not conduct an initial psychiatric evaluation until three weeks after HH complained of depression. Mental health staff noted that HH appeared to be depressed. During the next two months, HH received medication but did not see a psychiatrist. HH ended up in an altercation and had to be placed in isolation. Two days later, he began vomiting blood. At the time of our tour, HH had been housed in administrative separation for more than 18 months and had been involved in various altercations with staff. Given the nature of HH mental health condition, the Jail's delays in providing mental health treatment and evaluation likely contributed to HH's continuing mental decline and behavioral disturbances.[324]

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[324] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 4. 11 para. 2.

Harris County objects to this paragraph of the Civil Rights Division advocates' report, which inaccurately summarizes HH's course of treatment and ends with a conclusion that lacks foundation and is legally and factually erroneous.

On October 7, 2006, Inmate HH underwent intake screening and denied any medical or mental health issues. On October 16, 2006, HH underwent a fourteen-day Health Assessment and denied any medical or mental health issues. At that time, HH weighed 240 pounds. On September 6, 2007, HH complained of extremity pain, but declined to see a physician for that complaint. On October 16, 2007, HH underwent an annual Health Assessment and denied any medical or mental health issues. At that time, HH weighed 273 pounds. On November 19, 2007, a physician evaluated HH for a skin condition. On November 29, 2007, a physician again evaluated HH for a skin condition. At the November 29, 2007 physician evaluation, HH was noted to have an elevated blood pressure. Blood pressure checks were ordered by the physician. On December 5, 2007, a physician saw HH for a follow-up appointment for high blood pressure and prescribed HCTZ for high blood pressure. On December 31, 2007, a physician saw HH for a follow-up appointment regarding his high blood pressure. On January 25, 2008, a physician evaluated HH for a skin condition. On January 28, 2008, a physician saw HH for follow-up regarding high blood pressure and adjusted HH's medication regimen. On March 3, 2008, a physician saw HH for follow-up regarding his high blood pressure and noted that HH "refuses to lose weight or go on low salt diet." At that point, HH weighed 286 pounds. The physician added a prescription for Norvasc. On April 10, 2008, a physician evaluated HH for an ingrown toenail. On April 17, 2008, May 2, 2008 and May 19, 2008, physicians saw HH for a follow-up of his ingrown toenail. On May 19, 2008, an LPHA assessed HH in administrative separation, and referred him to a psychiatrist for evaluation of possible depression secondary to having been incarcerated for nineteen months. On June 9, 2008, a psychiatrist evaluated HH for chief complaint of "I can't take it." HH described symptoms of depression and anxiety. The psychiatrist prescribed Abilify, Lexapro and Seroquel. On July 11, 2008, a psychiatrist renewed those psychotropic medications. On July 31, 2008, a medical physician evaluated HH following an altercation. Later that same day, HH became dizzy and was evaluated for the second time that day. According to a nurse's notes, HH did not want to eat and declined dinner that evening. On August 1, 2008, a medical physician saw HH for a follow-up. On August 2, 2008, HH was again brought to the medical clinic. According to the nurse's notes: "Vomiting with blood/upset stomach. No evidence of any vomiting, states vomiting times one today. Patient states he forced himself to throw up, states hasn't eaten anything today, was in deputy altercation two days ago." According to the physician's notes: "Patient put his finger down his throat to make him throw up, no complaint of nausea/vomiting, only had an upset stomach earlier but now resolved. No abdominal pain now. No history of peptic ulcer disease and not on any meds which will cause gastrointestinal bleeding." On August 9, 2008, a physician reassessed HH for complaints of nausea, vomiting and diarrhea, and prescribed medication for gastroenteritis. On August 27, 2008, an LPHA reassessed HH in response to his questions about his medications and referred HH to a psychiatrist. On September 8, 2008, a psychiatrist reevaluated HH. HH complained that he was having difficulty falling asleep and was having "mood surges." The psychiatrist increased HH's dosage of Seroquel. On October 7, 2008, a medical physician reevaluated HH and adjusted his dosage of his antihypertensive medication. On October 8, 2008, a psychiatrist renewed HH's psychotropic medications. On October 9, 2008, HH underwent a second annual Health Assessment. During this Health Assessment, HH described a history of high blood

pressure, for which he was taking Lotensin and Norvasc. HH also described a history, since 2007, of depression, for which he was taking Seroquel, Lexapro and Abilify. During this Health Assessment, HH weighed 275 pounds. On October 22, 2008, an LPHA again assessed HH, and a psychiatrist again assessed HH and again adjusted his dosage of Seroquel.

Contrary to the Civil Rights Division's letter, HH's medical record does not "suggest" that HH "had a "history of not eating." Aside from the short time period documented in the medical record (which was diagnosed and treated as gastroenteritis), there is no indication that HH was not eating. In fact, serial health assessments show that HH's weight increased during his incarceration. The physicians also counseled HH about his overuse of commissary foods, which interfered with his medication regimen for blood pressure. HH's medical record likewise reveals no evidence that HH experienced "continuing mental decline." The conclusion that delays in mental health treatment contributed to his behavioral problems is simply speculation.

4. Inmate II received constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail.

According to the Civil Rights Division, examples showing that the Jail does not provide access to mental health care for many inmates with serious needs include:

> II entered the Jail with a history of seizures, but apparently did not receive seizure medications at intake. II experienced a seizure 19 days after arrival at the Jail. II also had a history of cutting. There was no follow-up on this psychiatric issue at all.[325]

Harris County disagrees with the accuracy of the Civil Rights Division's recitation of Inmate II's access to and course of mental health treatment in the Harris County Jail system, as well as the unsupported conclusions reached by the Division. II had multiple incarcerations in 2007 and 2008 and it is unclear as to which incarceration the Division is referring. II was incarcerated from February 28 – March 1, 2007, from March 28 – June 2, 2007, from July 20 – August 31, 2007, from September 19 – November 1, 2007, from February 23 – November 19, 2008, and from December 5 – December 9, 2008.

Inmate II's first incarceration: On March 1, 2007, a physician evaluated II, prescribed Dilantin and referred her to the MHMRA. That same day, a psychiatrist evaluated II. She was released from custody on March 1, 2007.

Inmate's II's second incarceration: When incarcerated on March 28, 2007, II reported that she was pregnant and had not been taking her Dilantin in the free world. II was referred to MHMRA and to the HCSO's Obstetrics and Gynecology ("OB/Gyn") Clinic. II declined the OB/Gyn Clinic visit. Serum pregnancy testing showed that II was not pregnant. On April 3, 2007, a psychiatrist evaluated II and prescribed psychotropic medications. On May 26, 2007, a medical physician reevaluated II and prescribed Dilantin. She was released from custody on June 2, 2007.

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[325] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 4, 11 para. 3.

Inmate II's third incarceration: On July 20, 2007, a medical physician evaluated Inmate II, prescribed Dilantin and referred her to MHMRA. On July 22, 2007, a psychiatrist evaluated II and prescribed psychotropic medications. On August 20, 2007, II's Dilantin orders were renewed and a laboratory test was ordered to determine a Dilantin level in the blood. II was released from custody on August 31, 2007.

Inmate II's fourth incarceration: On September 20, 2007, a medical physician evaluated II, prescribed Dilantin and referred her to MHMRA. On September 21, 2007, II refused mental health evaluation. On October 3, 2007, MHMRA re-approached II. On October 3, 2007, II underwent screening by a LPHA, who noted bipolar disorder and referred II to a psychiatrist. The LPHA noted the history of self-mutilation. On October 19, 2007, the clinic was called to evaluate II for a report of non-witnessed seizure activity. When the nurse arrived at the housing floor to transport II, she was alert and no seizure activity was noted. A medical physician evaluated II and made no change in the medication regimen. On October 22, 2007, an LPHA followed-up subsequent to a psych referral. II was again referred to a psychiatrist. She was released from custody on November 1, 2007.

Inmate II's fifth incarceration: On February 23, 2008, a medical physician evaluated II and prescribed Dilantin. On February 24, 2008, a psychiatrist evaluated II and prescribed psychotropic medications. II again denied any plans to harm herself or others.

On March 12, 2008, the clinic received a call from a Deputy regarding possible seizure. The nurse noted upon arrival to the housing floor that Inmate II was alert, talking, had no seizure activity, and walked to stretcher. Per the physician's evaluation on March 12, 2008: the patient was not postictal and had no injuries. The "patient thinks tonight's events might have been an anxiety attack." The physician ordered that the medications be continued as prescribed. On March 19, 2008, the clinic received a call from a Deputy regarding possible seizure. The nurse noted upon arrival to the housing floor that the patient was alert, oriented, speaking and showed no seizure activity. Per the nursing notation: "Upon arrival to clinic, claims OK and refused medical treatment." On March 20, 2008, II's psychotropic medications were reordered by a psychiatrist. On March 25, 2008, II's order for Dilantin was renewed by a medical physician. On June 12, 2008, II's psychotropic medications were reordered by a psychiatrist. On June 23, 2008, II's order for Dilantin was renewed by a medical physician. On July 30, 2008, the clinic received a call from a Deputy for unknown reason. The nurse noted, upon her arrival to the housing floor, that II was sitting at a table and was alert and oriented. II stated that she was "upset and anxious." Per the physician evaluation on July 30, 2008: "Patient brought down after brief episode of loss of consciousness this evening....patient feels like she might have a seizure...." II was transported to the LBJ Hospital Emergency Center. On July 31, 2008, II returned from LBJ Hospital and was reevaluated by a medical physician. The physician noted that II was alert, oriented, pleasant, and cooperative. The physician ordered that the Dilantin be continued. On August 27, 2008, II was seen by a psychiatrist and her psychotropic medication regimen was adjusted. On September 18, 2008, II's order for Dilantin was renewed. On September 24, 2008, II's orders for psychotropic medications were renewed by a psychiatrist. On October 4, 2008, the clinic received a call from a Deputy for unknown reason. The nurse noted upon arrival to the housing floor that II was alert and oriented, had no incontinence, and

ambulated without difficulty. II stated that she was not getting up for morning medication. There was no witnessed seizure. II was evaluated by a physician on October 4, 2008, and per physician order was given a dose of Dilantin in the clinic by a nurse. The physician adjusted the Dilantin regimen and ordered a Dilantin blood level. She was released from custody on November 19, 2008.

Inmate II's sixth incarceration: On December 6, 2008, a medical physician evaluated Inmate II and prescribed Dilantin. That same day, a psychiatrist evaluated II and prescribed psychotropic medications. II again denied any plans to harm herself or others. II was evaluated by a physician for an abscess on December 11, 2008. II was evaluated by a nurse for follow-up of the abscess on December 16, 2008. The wound had healed. II was released from custody on December 17, 2008.

Here, as in several other "examples" memorialized in the Civil Rights Division's letter, the letter misrepresents the medical care provided. Inmate II was prescribed the anti-seizure medication Dilantin during each of her incarcerations. Whether she suffered a seizure while in the jail is not as certain as the Division suggests. As discussed above, LPHAs and psychiatrists repeatedly evaluated II and determined follow-up as clinically indicated in their own judgment. There is also no evidence that II cut herself or engaged in self-mutilation in any of the six referenced incarcerations in the Harris County Jail system.

5. Inmate JJ received constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail system.

According to the Civil Rights Division, examples showing that the Jail does not provide access to mental health care for many inmates with serious needs include:

> JJ served time in the Jail on multiple occasions. Staff medicated JJ without following generally accepted correctional medication standards. Without an initial screening, the Jail staff involuntarily medicated JJ and housed him in the mental health department's acute treatment cellblock. Staff then repeatedly treated JJ with both anti-psychotic and mood-stabilizing medications without adequate laboratory studies or proper monitoring, placing the detainee at risk of sudden death.[326]

The name and Systems Person Number ("SPN") provided by the Civil Rights Division do not match. There are at least seven individuals with that name in JIMS. The patient's file associated with the provided SPN does not match clinically with the representations proffered by the Division advocates. The inmate with the SPN provided by the DOJ was incarcerated multiple times during the 2007-2008 period, including June 9 – 29, 2007, October 23 – November 19, 2007, January 30 – March 11, 2008, March 16 – April 17, 2008, May 4 – July 21, 2008 and November 17 – December 17, 2008. The following discussion is based on the SPN provided.

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[326] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 4, 11 para. 4.

JJ's first incarceration: On June 9, 2007, Inmate JJ was incarcerated and underwent intake screening. JJ denied any medical or mental health issues but exhibited "unusual behavior" and was referred to the HCSO's mental health clinic. On June 10, 2007, a psychiatrist evaluated JJ and prescribed Risperdal, Depakot ER and Cogentin. Valproate acid blood level and blood chemistry lab tests were ordered. Nineteen days later, JJ was released from the Harris County Jail.

JJ's second incarceration: On October 23, 2007, Inmate JJ was incarcerated and underwent intake screening. JJ denied any medical or mental health issues but exhibited "unusual behavior (talking to self)." On October 24, 2007, a psychiatrist evaluated JJ, prescribed Zydis and Invega and recommended consideration of transfer of JJ to the HCPC unit when a bed became available. JJ was released from jail twenty-six days later.

JJ's third incarceration: On January 30, 2008, Inmate JJ was incarcerated and underwent intake screening. JJ denied any medical or mental health issues but the screening nurse noted that he had been taking "unknown MHMRA meds" and referred him to the HCSO's mental health clinic. On January 31, 2008, a psychiatrist evaluated JJ and prescribed Risperdal, Depakote ER and Cogentin. Valproate acid level, chemistry profile, complete blood count and liver function lab tests were ordered. On February 12, 2008, a psychiatrist saw JJ in follow-up and laboratory tests were ordered. On February 26, 2008, a psychiatrist had a follow-up visit with JJ. The psychiatrist adjusted JJ's medication regimen, ordered laboratory tests, and admitted JJ to the HCSO's on-site mental health unit. JJ was released from the Harris County Jail facilities fourteen days later.

JJ's fourth incarceration: On March 16, 2008, Inmate JJ was incarcerated and underwent screening. The intake screening nurse noted that JJ was "talk[ing] to self, mumbling" and that he had last taken his medications on March 11, 2008, and referred JJ to the HCSO's mental health clinic. On March 26, 2008, a psychiatrist evaluated JJ. According to the psychiatrist's note, JJ "was seen by a MHMRA LPHA on 3/21/08, was non-compliant with his medications." The psychiatrist admitted JJ to the HCSO's on-site mental health unit and prescribed Risperdal, Depakote ER and Cogentin. That same day (March 26, 2008), a psychiatrist on the HCSO's mental health unit evaluated JJ and modified his medication regimen to include Invega and Klonopin. The psychiatrist discontinued JJ's Risperdal. On March 27, 2008, a psychiatrist gave a prn order for Abilify and Ativan. On March 28, 2008, JJ was again evaluated by a psychiatrist. The psychiatrist adjusted JJ's Invega and Depakote dosages and discontinued JJ's prescriptions for Cogentin and Klonopin. The psychiatrist also ordered a blood count, a chemistry profile, a thyroid stimulating hormone blood test and a valproate acid level blood test. The psychiatrist also ordered Ativan as a prn dose for agitation. On April 2, 2008, a psychiatrist evaluated JJ and the ordered medications were continued. On April 9, 2008, a psychiatrist evaluated JJ, adjusted JJ's Invega dosage and discontinued his other ordered medications. On April 14, 2008, a psychiatrist evaluated Inmate JJ. The psychiatrist added Lexapro to JJ's regimen, adjusted his Invega dosage to 15 milligrams daily and continued his previously ordered medications. According to the psychiatrist's note: "15 mg/day outside of FDA labeling but tested in the FDA registration trials." On April 17, 2008, JJ was released from jail.

JJ's fifth incarceration: On May 5, 2008, Inmate JJ underwent intake screening. JJ denied any medical or mental health issues but was noted by the nurse to be talking to himself, and was referred to the mental health clinic. That same day, JJ refused to see the psychiatrist. On May 14, 2008, a psychiatrist evaluated JJ, ordered laboratory tests and prescribed Invega, Depakote ER and Lexapro. On May 25, 2008, JJ was brought to the clinic after an altercation. A psychiatrist reevaluated JJ and prescribed a dose of Invega, Geodon and Benadryl, which were given to JJ in the clinic. The psychiatrist also prescribed Geodon and Benadryl as a q 4 hour IM injection with daily dosage limits. JJ was transferred to the HCSO's on-site step-down Mental Health Unit. On May 26, 2008, a psychiatrist again evaluated JJ for disruptive behavior and ordered a one-time dose of Ativan and Depakote ER. On June 17, 2008, a psychiatrist renewed JJ's orders for Depakote ER, Lexapro and Invega. On July 10, 2008, JJ was brought to the clinic for evaluation of aggressive behavior. A psychiatrist evaluated JJ, gave him a dose of Abilify, Ativan and Benadryl in the clinic and admitted him to the HCSO's on-site mental health unit with ongoing orders for Invega and Depakote ER. On July 11, 2008, the mental health unit's psychiatrist evaluated JJ, discontinued Lexapro and continued the Invega and Depakote. On July 13, 2008, a psychiatrist evaluated JJ and continued his medications. On July 15, 2008, a psychiatrist reevaluated JJ and noted that JJ was "improving with better medication compliance." On July 18, 2008, a psychiatrist reevaluated JJ and renewed JJ's orders for Depakote ER and renewed and increased the dosage of Invega. According to the psychiatrist's note: "will increase Invega, watch for extrapyramidal signs, check valproate acid level." On July 21, 2008, JJ was released from the jail.

The Civil Rights Division's letter is oversimplified and misleading. Inmate JJ was screened during the multiple incarcerations and received multiple evaluations by psychiatrists. Blood work was frequently ordered by the psychiatrists, and it appears that the one episode where the FDA recommended dosage was exceeded, that episode was noted by the psychiatrist. JJ was clearly monitored frequently. The assertion that JJ was put at risk of sudden death is complete hyperbole. Inmate JJ received constitutionally adequate access to mental health care in the Harris County Jail system.

6. Inmate KK received constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail system.

According to the Civil Rights Division, examples showing that the Jail does not provide access to mental health care for many inmates with serious needs include:

> KK was identified as bipolar upon admission. Psychiatry did not see KK for nearly a month, and KK received no medication for his illness until about six weeks after his admission. In the interim, KK was involved in altercations on four occasions, resulting in the fracture of his arm. Staff renewed KK's medication order over this period without further patient examination by a psychiatrist. Even after KK's altercations, there appears to have been little follow-up by staff to deal with KK's mental health symptoms.[327]

[327] Letter from Loretta King to Ed Emmett, *supra* note 3, at 10 para. 4, 11 para. 5. 12 para. 1.

Inmate KK received constitutionally adequate access to mental health care in the Harris County Jail system. Harris County denies each of the allegations made by the Civil Rights Division in this paragraph of their June 4, 2009 letter. The Division's letter again misrepresents the facts. Inmate KK had multiple physician evaluations and multiple MHMRA evaluations.

On April 6, 2008, Inmate KK was booked into the Harris County Jail and underwent intake screening. KK denied any mental health issues. KK admitted to use of heroin. That same day, a medical physician evaluated KK and admitted him to the HCSO's medical infirmary for detoxification. KK's four-day detoxification process was unremarkable. On April 10, 2008, KK told medical providers of a history of depression, bipolar disorder and attention deficit disorder. On April 10, 2008, KK was referred to MHMRA and, on April 21, 2008, underwent screening by LPHA. KK reported that he had last taken psychotropic medications six months before the evaluation. On April 27, 2008, a physician evaluated KK following an altercation with hand injury. On May 1, 2008, a psychiatrist evaluated KK and prescribed psychotropic medications. On May 16, 2008, an MHMRA LPHA evaluated KK. On May 23, 2008, KK was again seen by a physician following an altercation with hand injury. On May 29, 2008, a psychiatrist renewed KK's psychotropic medications. On June 1, 2008, an MHMRA LPHA evaluated KK. On June 3, 2008, a physician evaluated KK following an altercation with injury to his nose. On June 11, 2008, an orthopedist in the HCSO's on-site Orthopedic Clinic evaluated KK. On June 24, 2008, surgery was performed on KK at LBJ Hospital to repair an arm fracture. On July 7, 2008, KK was seen at LBJ Hospital as an outpatient for follow-up. On July 11, 2008, a medical physician saw KK in follow-up in the HCSO's clinic. On August 13, 2008, a medical physician saw and treated KK for self-sustained injuries to his wrist. According to the physician's note: "States he cut his wrist for several situational reasons, not to take his life." KK was transferred to LBJ Hospital for treatment. That same day (August 13, 2008), KK returned to the Harris County Jail and an orthopedist in the HCSO's Orthopedic Clinic saw KK in follow-up. That same day, an MHMRA LPHA also evaluated KK. On August 22, 2008, a psychiatrist evaluated KK. On September 3, 2008, an orthopedist saw KK in follow-up.

KK was not identified as bipolar until four days after he was admitted to the jail. He was prescribed psychotropic drugs 20 days later, after being evaluated by a psychiatrist. He was involved in only one altercation before he was prescribed medications. The suggestion that KK would not have been involved in any altercations if he had been properly medicated is proven wrong by the fact that he was involved in three altercations after being administered medications. It is noteworthy that elsewhere in the report the Civil Rights Division accuses the HCSO of utilizing medications as "chemical restraints," yet criticizes HCSO for not doing so in the case of KK. In at least one instance (*see* the case of OO, *infra.*), the Division contends that administering medications caused the inmate to be involved in altercations in the jail.

7. Inmate LL received constitutionally adequate access to mental health treatment while incarcerated in the Harris County Jail.

According to the Civil Rights Division, examples showing that the Jail does not provide access to mental health care for many inmates with serious needs include:

> During intake, LL reported a mental health history that included risk factors for suicide. The Jail staff did not refer LL to mental health services. Approximately 3 weeks later, LL lacerated his neck.[328]

The Division's letter is again inaccurate. Inmate LL did not report a mental health history at intake screening. LL was incarcerated in the Harris County Jail system from May 24 – July 22, 2008. On May 24, 2008, during his intake screening, LL denied any mental health issues. He only stated that he took over-the-counter Prevacid, presumably for gastric upset. On June 1, 2008, during his fourteen-day Health Assessment, LL again denied any mental health issues. On June 23, 2008, LL cut his own neck. A medical physician promptly evaluated LL and sent him to LBJ Hospital for treatment. On June 24, 2008, LL returned from the hospital, evaluated by a medical physician and referred to MHMRA. That same day, a psychiatrist evaluated LL and noted that LL had "no prior psychiatric history." During that June 24, 2008 evaluation, LL first reported symptoms of anxiety and depression since his incarceration. The psychiatrist admitted LL to the HCSO's mental health unit and prescribed psychotropic (anxiolytic) medication.

E. Prisoners receive constitutionally adequate mental health treatment orders and psychotropic medications as prescribed while incarcerated in the Harris County Jail.

1. Introduction

According to the Civil Rights Division:

> In a large urban detention center with a heavy mental health caseload, staff need to have access to a variety of treatment resources. Such resources include an array of different types of therapy, medication, and intensive supervision in order to address different types of mental illness, and varying levels of patient acuity.
>
> Jail mental health staff have access to some mental health resources, but those resources are not sufficient given the size of the mental health caseload. The Jail has few treatment program options available for detainees with mental illness. The Jail uses medications, additional staff monitoring, and some structured housing for detainees with mental illness. For most mental health conditions, the primary intervention is a medication order, often with inadequate follow-up even for the most seriously ill. Indeed, once medical staff prescribe medications, they often cannot or do not routinely follow-up on those detainees unless the detainees themselves request care. This is a substantial departure from generally accepted correctional standards. Notably, detainees also reported that there are significant delays when they request care.
>
> In our document review, some of the treatment orders appeared to depart significantly from generally accepted professional mental health standards. Some of these orders suggest that staff may be utilizing medications in a clinically

[328] Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 2.

inappropriate or unsafe manner. Examples of improper chemical restraints and unsafe medication practices during the period from 2006-2008 include the following:[329]

Harris County denies each of the allegations made and conclusions drawn by the Civil Rights Division the second and third paragraphs, above. None of these conclusory and speculative representations are supported as required by CRIPA's Section 1997b(a)(1)'s notification provisions.

Harris County objects to the Civil Rights Division's application of the "generally accepted correctional medical standards" and "generally accepted professional mental health standards," which are more rigorous than the Constitutional (deliberate indifference) standard. Notwithstanding this objection and without waiving same, the HCSO's policies, procedures and practices have been reviewed and approved by the NCCHC. Correctional standards are indeed being met. The need for additional treatment options was met by the development and implementation of the HCPC unit.

Harris County also objects to the Civil Rights Division's citation to and reliance upon detainees' anecdotal, undocumented and unsubstantiated complaints.[330] There was apparently no effort made to compare the complaints to inmate medical records, which could easily have been done.

Contrary to the Civil Rights Division's general allegations, the Harris County Commissioners Court allocated additional resources to the HCSO's mental health program through expansion of the MHMRA contract in March of 2009. When alleging that the Jail has few treatment program options available for detainees with mental illness, for example, the Civil Rights Division fails to mention the programs available at the Harris County Psychiatric Center, a true inpatient mental health hospital. The Jail uses medications, additional staff monitoring, and more than "some" structured housing for detainees with mental illness. The Jail uses acute units, step down units and the HCPC unit.

Harris County denies the Civil Rights Division's allegation that "[f]or most mental health conditions, the primary intervention is a medication order, often with inadequate follow-up even for the most seriously ill" This allegation ignores the fact that psychiatrists evaluate the need for specialized housing units, including HCPC, with treatment programs. The majority of detainees prescribed psychotropic medications are housed in the general population, just as they would be living in the free world—not in an acute psychiatric unit.

The Civil Rights Division advocates detailed what they allege to be five (5) cases (involving Inmates MM – QQ) of "improper chemical restraints and unsafe medication practices" from 2006 – 2008 at pages 12 – 14 of their June 4, 2009 letter. The Division failed to notify Harris

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329 Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 paras. 3-5.

330 *Snow v. City of El Paso, Tex.*, 501 F. Supp.2d 826, 833 (W.D. Tex. 2006) (citing *Estate of Davis ex rel. McCully v. City of N. Richland Hills*, 406 F.3d 375, 384 n.45 (5th Cir. 2005)); *Piotrowski v. City of Houston*, 237 F.3d 567, 579 (5th Cir. 2001); *Pineda v. City of Houston*, 291 F.3d 325, 330 (5th Cir. 2002).

County of any supporting facts showing a pattern or practice of resistance to a significant number of inmates' constitutional rights with regard to the use of "improper chemical restraints and unsafe medication practices." Even assuming improper chemical restraints and unsafe medication practices in those five cases, which Harris County expressly denies, five cases out of 405,076 prisoners incarcerated in the Harris County Jail system from 2006 - 2008 constitute no actionable pattern.[331]

2. Inmate MM was not subjected to chemical restraints or medication practices that violated his constitutional rights.

According to the Civil Rights Division, examples of improper chemical restraints and unsafe medication practices during the period from 2006 – 2008 include:

> MM was in an acute psychotic state for nearly two weeks before he died. At intake, staff prescribed medications but they were never dispensed. As MM became increasingly uncooperative, staff injected MM with an intramuscular drug. Medical records suggest significant problems with basic medication documentation and staff approaches to medication noncompliance. Soon after MM was injected, MM's breathing grew shallow, and he became unresponsive. MM died shortly afterwards.[332]

Here, as throughout this response, Harris County objects to the Civil Rights Division's improper application of "generally accepted professional mental health standards," which are more rigorous than the applicable constitutional (subjective deliberate indifference) standard.[333] Harris County also objects to the Division's inaccurate recitation of the course of MM's treatment, as well as the conclusions made by the Civil Rights Division in this paragraph of its letter. Notwithstanding these objections and without waiving same, MM received constitutionally adequate access to mental health care in the Harris County Jail system, and was not subjected to chemical restraints or medication practices that violated his constitutional rights.

MM was incarcerated from December 31, 2005 until January 13, 2006, before many of the structural and procedural changes in the delivery of mental health care were developed and implemented at the HCSO. This period predates the formation of the Executive Director of Health Services position, predates the development of the performance measure-based MHMRA contract, predates the HCSO's acquisition of responsibility for provision and supervision of psychiatric technicians and nurses, predates the formation of the Mental Health Quality Improvement Coordinator position, predates the development and implementation of the Front Door Clinic and predates the restructuring of mental health services policies and procedures. The events, as described below, should therefore not be interpreted in light of current practices, policies or procedures.

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331 *E.g., Burge,* 336 F.3d at 370; *Pineda,* 291 F.3d at 329 & nn. 9-11; *Piotrowski,* 237 F.3d at 581.

332 Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 5 – 13 para. 1.

333 Letter from Loretta King to Ed Emmett, *supra* note 3. at 12 para. 5.

At intake screening on December 31, 2005, MM was identified as having a bipolar disorder and was given Zyprexa. He was referred to MHMRA at that time. On January 5, 2006, a psychiatrist evaluated MM and prescribed Zyprexa. At 19:20 hours on January 12, 2006, a nurse noted that MM had been involved in an altercation. MM was sent to the medical clinic for evaluation. No psychiatrist was routinely working in the clinic at that time of day at that time. At 19:25 hours on January 12, 2006, another nursing note indicated that MM had been evaluated by a MHMRA screener who stated that she would re-evaluate MM on January 13, 2006. MM was evaluated by a medical physician, who documented an "event of psychotic behavior." The medical physician contacted Dr. Michael Seale and discussed MM's care. Dr. Seale approved the use of a medical infirmary cell until such time that MHMRA could evaluate MM. The medical physician was able to medicate MM with Zyprexa. On January 13, 2006, MM attacked the medical physician during rounds. MM was not moved from the medical infirmary cell. Later, on January 13, 2006, a psychiatrist evaluated MM and ordered a transfer to the HCSO's on-site mental health unit with assaultive precautions. The psychiatrist ordered medications to be given upon arrival to the unit: Haldol 10 mg, Ativan 2 mg and Benadryl 25 mg. Given MM's history of assaultive behavior, the HCSO's Emergency Response Team ("ERT") extracted him from the medical cell. The extraction involved an altercation, including the use of a Taser. Dr. Seale assessed MM immediately after extraction. Aside from a scant amount of nasal bleeding, MM appeared to have no injuries and was alert and verbally responsive. MM was transported to the second floor mental health unit. Upon arrival to the unit, MM received the injection as ordered by a psychiatrist. Shortly thereafter, MM was noted to have a thready pulse and shallow breathing. The ERT transported MM back to the clinic, where CPR was initiated. Narcan was given without effect. Houston Fire Department ambulance crew arrived, assumed the code and transported MM to St. Joseph's Hospital Emergency Center. MM expired at the hospital at 16:17 hours. The Medical Examiner determined that the cause of death was not related to the injection as implied by the Civil Rights Division advocates' letter, but instead was a result of Excited Delirium.

The assertion that the prescribed medications were never dispensed is untrue. The injections following MM's extraction from his cell were ordered by a licensed medical professional. The Civil Rights Division offers no explanation to rebut the Medical Examiner's determination of the cause of death. Instead, the Division assumes a relationship between the psychiatrist's medication orders and MM's death solely because of temporal proximity.

3. Inmate NN was not subjected to chemical restraints or medication practices that violated his constitutional rights.

According to the Civil Rights Division, examples of improper chemical restraints and unsafe medication practices during the period from 2006 – 2008 include:

> NN spent the better part of a year in a State Hospital. NN was found not competent and not restorable. For some reason, he was sent back to the Jail. Despite his competency status, Jail staff nevertheless placed the detainee in general housing and allowed him to keep various medications on his person. NN was not a good candidate for self-medication. NN appeared to suffer a seizure

> and he was sent to the clinic. The clinic staff suspected the detainee was "sleepy" due to his psychotropic medications. They released the detainee from the clinic, and he died shortly afterwards.[334]

NN was not subjected to improper chemical restraints or unsafe medication practices. NN received constitutionally adequate access to mental health care in the Harris County Jail system. The Civil Rights Division has misrepresented the actions taken in the medical clinic on December 23, 2007. NN remained in the clinic with serial vital signs and IV hydration. He was observed by the medical physicians to go into respiratory arrest and CPR was promptly initiated.

Inmate NN's clinical course was not typical. On December 14, 2007, NN was released from Rusk State Hospital.[335] A Rusk State Hospital psychiatrist prescribed NN's medications, including Clonidine, Diltiazem, FeSO4, HCTZ, Lithium, Zyprexa, and Klonopin (all for seven-day duration and all non-keep-on-person)[336] before NN returned to the Harris County Jail so that they would be continued without delay. NN was initially housed in 2B, the mental health step-down unit. However, upon admission to the jail, NN's screening chest x-ray was abnormal. Given the abnormal x-ray, a medical physician evaluated NN on December 15, 2007 and admitted him to the medical infirmary for respiratory isolation. The medical physician's December 17, 2007 discharge orders indicated "discharge to MHMRA housing." The medical nurse in the infirmary apparently inadvertently sent through a routine housing transfer request, and NN was discharged instead to general population. That housing location allowed for keep-on-person medication status. On December 18, 2007, a MHMRA case manager assessed NN and was aware of his housing status and did not transfer him to a mental health unit. The keep-on-person medication issue was not addressed. According to the MHMRA manager's note: "[M]et with [NN] to follow up with him to let him know that I will change his medication from 2B2 to 6C2. [NN] reported no problems and did not want to go to a tank with restrictions ... [L]et him know that he may get moved to 2B2 due to him return incompetent to stand trial." The HCSO's medication cart nurses and pharmacy personnel would not be aware of a patient's competence unless a specific physician's order was written to dictate non-keep-on-person status. On December 23, 2007, NN signed for receipt of the keep-on-person diltiazem. According to a nursing notation made at 07:45 hours that same morning: "Received a call from Deputy that inmate was having a seizure. Arrived on floor with stretcher. Inmate lying on low bunk by door. No seizure activity noted. Patient disoriented with slurred speech. Inmate put on stretcher and

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[334] Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 5, 13 para. 2.

[335] The court that presided over NN's criminal proceedings and committed him to Rusk State Hospital ("committing court") issued a bench warrant ordering NN's return for further proceedings, and appointed counsel to represent NN. NN was bench-warranted back to the Harris County Jail in accordance with the committing court's order. At defense counsel's request, NN's next appearance before the committing court was scheduled for January 18, 2008.

[336] On December 5, 2007, the Rusk State Hospital issued a report to the court opining, among other things, upon NN's clinical disposition. According to the treating physician and treatment team, NN: "has reached maximum hospital benefit and DOES NOT REQUIRE FURTHER INPATIENT TREATMENT at this time. It is further the opinion of the treating physician and treatment team that he can be safely and effectively treated on an outpatient basis with the provision of adequate psychiatric services." In other words, NN's treating physician and treatment team found, on December 5, 2007, that NN could safely take his own medications.

brought to clinic for physician evaluation." According to the physician's notation, NN was: "Incoherent, sleepy, found responsive but very sleepy. Snoring, sleeping, difficult to arouse." At 08:20 hours, the physician ordered an IV and documented "[n]o change in blood pressure with normal saline bolus." At 08:45 hours, the physician noted: "BP recheck 90/62. Extreme sedation—probable need to adjust psychotropic meds. To [psychiatrist] for medication evaluation and adjustment." At 09:25 hours, the physician noted: "... No pulse, respiration found—CPR started." The automated external defibrillator was applied. NN was intubated and received resuscitation medications. CPR was continued until Houston Fire Department ambulance arrived and transferred NN to the hospital. That same day, NN died of acute diltiazem toxicity.

On December 26 and 27, 2007, the access to medication issue was reviewed as a part of the HCSO Internal Quality Improvement Death Review process. At that time discussions were held with MHMRA administration regarding the need for the case managers to make a full assessment including medications, given that they may be the provider with the most global information about the patient and that they assess each state hospital returnee. Discussions were also held with MHMRA psychiatrists. The medication prescribing practice was changed at that time to require non-keep-on-person medication status for all medications when writing initial medication orders for patients upon return from the state hospitals, regardless of housing location. The housing decision and related keep-on-person status were, at worst, due to negligence rather than any unconstitutional deprivation.

4. Inmate OO was not subjected to chemical restraints or medication practices that violated his constitutional rights.

According to the Civil Rights Division, examples of improper chemical restraints and unsafe medication practices during the period from 2006 – 2008 include:

> A Jail psychiatrist diagnosed OO with schizoaffective disorder (a situation where both mood and schizophrenic symptoms exist). OO also had a history of mental illness. OO mental health deteriorated, and staff repeatedly renewed his medications without having him seen again by a psychiatrist. OO ended up in two altercations, including one in which he struck a deputy.[337]

Harris County disagrees with the Civil Rights Division's recitation of OO's course of treatment, denies the Division's contention that OO was subjected to improper chemical restraints or unsafe medication practices, and denies the Division's inference that OO's psychiatric care somehow caused him to be in two altercations. Notwithstanding these objections and without waiving same, OO received constitutionally adequate access to mental health care in the Harris County Jail system.

The Civil Rights Division's letter is oversimplified and draws conclusions which are not based on facts documented in Inmate OO's medical record. Psychiatric evaluations by screeners, LPHAs, and psychiatrists are not even mentioned in the Civil Rights Division's letter.

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[337] Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 5, 13 para. 3.

On January 12, 2007, Inmate OO underwent intake screening and stated that he took Depakote. OO was referred to MHMRA. This event preceded the March 2007 implementation of the Front Door mental health clinic. On January 26, 2007, OO underwent a fourteen-day Health Assessment. During that assessment, OO first described a history of schizophrenia and history of hypertension. OO was referred to the medical clinic and to MHMRA. On January 26, 2007, a medical physician evaluated OO. An EKG was performed and the physician prescribed two antihypertensive medications. OO was referred to MHMRA. On February 11, 2007, OO was evaluated by a psychiatrist, who prescribed Zyprexia, Depakote ER and Klonopin. On February 19, 2007, a psychiatrist reevaluated OO and continued his medications. On March 7, 2007, a psychiatrist renewed OO's psychotropic medications for a 90-day period. On April 15, 2007, a medical physician saw OO following an altercation. On April 24, 2007, a physician evaluated OO for hypertension and medication compliance. On June 1, 2007, a psychiatrist renewed OO's psychotropic medications for 90 days. The psychiatrist ordered labwork, including a valproic acid level. On June 15, 2007, a psychiatrist documented review of the labwork results. On June 19, 2007, OO was seen for follow-up of hypertension, and an additional antihypertensive medication was ordered. On June 21, 2007, a MHMRA screener evaluated OO. On June 26, 2007, a medical physician saw OO for antihypertensive medication compliance issues. On September 4, 2007, OO's psychotropic medications were renewed for 90 days. On September 10, 2007, OO was seen for follow-up of hypertension. On September 10, 2007, a MHMRA LPHA evaluated OO. On October 25, 2007, a psychiatrist evaluated OO after an altercation and adjusted OO's Depakote dosage, discontinued OO's Zyprexa, and Klonopin and ordered Zydis. On December 24, 2007, a medical physician evaluated OO for a complaint of back pain. On January 3, 2008, a physician saw OO in follow-up for hypertension. On January 9, 2008, OO underwent an annual Health Assessment. On January 18, 2008, OO's psychotropic medications were renewed for 90 days. A Depakote level was ordered. A physician noted that the Valproic acid level was therapeutic on January 28, 2008. On February 13, 2008, a MHMRA LPHA evaluated OO. On February 25, 2008, a psychiatrist evaluated OO. Klonopin was ordered and a Depakote level and liver function tests were ordered. On March 3, 2008, a physician saw OO in follow-up for hypertension. On March 11, 2008, a psychiatrist reviewed the results of the laboratory studies ordered on February 25, 2008. Liver function tests were unremarkable and Valproic acid level was therapeutic. On March 24, 2008, a psychiatrist renewed OO's psychotropic medications for 90 days. On June 29, 2008, a medical physician saw OO for mouth pain. On June 20, 2008, a psychiatrist renewed OO's psychotropic medications for 90 days. OO was evaluated by MHMRA screeners while in administrative separation 15 times between July 4, 2008 and August 27, 2008. More specifically, OO was evaluated on July 4, 2008, July 8, 2008, July 9, 2008, July 14, 2008, July 16, 2008, July 23, 2008, July 25, 2008, July 28, 2008, August 4, 2008, August 5, 2008, August 11, 2008, August 15, 2008, August 19, 2008, August 22, 2008 and August 27, 2008. On August 27, 2008, a medical physician saw OO for gastrointestinal distress. OO was evaluated by MHMRA screeners while in administrative separation on August 29, September 3, and September 11, 2008. On September 18, 2008, a psychiatrist renewed OO's psychotropic medications for 90 days. On September 23, 2008, a MHMRA screener evaluated OO while he was in administrative separation. On September 24, 2008, laboratory results returned indicating that the patient's liver function tests were unremarkable and that the Valproic acid level was therapeutic. On September 27, October 2, October 22, October 25, and October 30, 2008, MHMRA screeners evaluated OO while he was in administrative separation. On

October 31, 2008, a medical physician saw OO for a complaint of constipation with bleeding. On November 1 and 5, 2008, MHMRA screeners evaluated OO while he was in administrative separation. On November 6, 2008, a medical physician saw OO for a complaint of gastrointestinal distress. On November 8, 12, and 15, 2008, MHMRA screeners evaluated OO while he was in administrative separation. On December 12, 2008, OO's psychotropic medications were renewed.

5. Inmate PP was not subjected to chemical restraints or medication practices that violated his constitutional rights.

According to the Civil Rights Division, examples of improper chemical restraints and unsafe medication practices during the period from 2006 – 2008 include:

> PP reported a history of seizures. PP suffered at least one seizure in the Jail, but according to the Jail's medical records, there was no proper follow-up. Medical staff placed PP on four benzodiazepines, but not a long-term anti-convulsant. This suggests that the purpose of the medications prescribed was more likely to sedate the inmate, rather than to treat his seizures.[338]

Harris County disagrees with the Civil Rights Division's summary of the course of PP's treatment, as well as the conclusions drawn by the Division. PP received constitutionally adequate access to mental health care in the Harris County Jail system, and was not subjected to chemical restraints or medication practices that violated his constitutional rights. The Division's letter misrepresents and grossly oversimplifies Inmate PP's medical course. PP had multiple incarcerations during 2007 and 2008, including incarcerations from March 24 – June 1, 2007, June 13 – July 19, 2007, April 13 – May 25, 2008 and May 26 – July 7, 2008. There is no documentation supporting seizure activity during PP's incarceration in the Harris County Jail, with the exception of a self-report of a seizure that allegedly occurred during housing in an outside facility.

The benzodiazepine used on three of the four separate occasions was Ativan, prescribed in a tapering fashion to treat the symptoms of detoxification. One use of benzodiazepine was the prescription of Klonopin. Klonopin is indicated for use in seizure disorder treatment.

PP's first incarceration: On March 25, 2007, Inmate PP underwent intake screening and described history of seizures and use of Xanax. On March 25, 2007, PP was seen by a medical physician and admitted to the jail's medical infirmary and prescribed detoxification protocol medications, including Ativan taper (a benzodiazepine). PP's infirmary course was unremarkable and, on March 28, 2007, PP was discharged to general population. On June 1, 2007, PP was released from jail. No seizure activity was documented during this incarceration.

PP's second incarceration: On June 13, 2007, PP underwent intake screening. According to the screening form, PP was "having hard time staying awake, [had] slurred speech, [and was] unable to answer questions." PP was referred to the medical clinic. On June 14, 2007, PP was

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[338] Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 5, 13 para. 4.

evaluated by a medical physician. At that time, PP told the physician that he had high blood pressure, for which he took Clonidine, and chronic back pain, for which he took Elavil and Vicodin. PP denied alcohol or drug use. The physician noted that PP was in "no apparent distress" and documented an unremarkable physical examination. Medication was prescribed for hypertension and blood pressure checks were ordered. An anti-inflammatory medication was prescribed for back pain. PP was not prescribed a benzodiazepine. On July 19, 2007, PP was released from jail. No seizure activity was documented during this incarceration.

PP's third incarceration: On April 13, 2008, PP underwent intake screening. He stated that he was taking these medications: Oxycontin, Soma, Xanax, Phenobarbital and Clonidine. On April 14, 2008, a medical physician evaluated PP and admitted him to the jail's medical infirmary for detoxification. He was prescribed a taper of Ativan (a benzodiazepine) for detoxification. Additionally, PP was noted to have an infection of his hand. An x-ray, dressing changes, and antibiotics were also prescribed. On April 15, 2008, the infirmary physician performed an incision and drainage of the hand infection and prescribed intravenous antibiotics. PP's infirmary course was unremarkable and he was discharged to the general population on April 18, 2008. On April 22, 2008, a psychiatrist evaluated PP and prescribed psychotropic medication. No benzodiazepine was prescribed. On May 14, 2008, a medical physician prescribed prophylactic medication to PP for a history of TB skin test conversion. On May 21, 2008, PP's psychotropic medications were renewed by a psychiatrist. On May 25, 2008, PP was released from jail. No seizure activity was documented during this incarceration.

PP's fourth incarceration: On May 26, 2008, PP underwent intake screening. He stated that he had history of seizure disorder, had eye trauma and dizziness, and was taking Xanax. On May 26, 2008, a medical physician evaluated PP and prescribed Klonopin (a benzodiazepine) for the seizure disorder, Vicodin for pain and a Librium taper (a benzodiazepine) for Xanax withdrawal. P was transferred to an outside facility for housing from June 18 – July 4, 2008. Upon return on July 4, 2008, a medical physician evaluated PP and prescribed Klonopin (a benzodiazepine) for seizure disorder. On July 6, 2008, a nurse evaluated PP for triage of a complaint of seizure disorder. He told the nurse at that time that his last seizure had occurred one week before. The nurse referred PP to the medical clinic. However, on July 6, 2008, PP left the jail.

6. Inmate QQ was not subjected to chemical restraints or medication practices that violated her constitutional rights.

According to the Civil Rights Division, examples of improper chemical restraints and unsafe medication practices during the period from 2006 – 2008 include:

> QQ required treatment for seizures. QQ experienced a series of seizures, but on at least two clinic visits, documentation suggests that QQ's chart was unavailable to the staff during the exams. This resulted in a number of delays in care despite QQ's repeated seizures.[339]

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[339] Letter from Loretta King to Ed Emmett, *supra* note 3, at 12 para. 5, 13 para. 5, 14 para. 1.

Notwithstanding these objections and without waiving same, the Civil Rights Division's letter is oversimplified and misleading and fails to indicate the ongoing, coordinated and effective care this patient received. The medical record does not indicate that there was *any* delay in care at *any* point in this patient's complicated medical course and does not substantiate the Division's claim that QQ's chart was unavailable on at least two occasions. QQ received constitutionally adequate access to mental health care in the Harris County Jail system, and was not subjected to chemical restraints or medication practices in violation of her constitutional rights.

During intake screening on July 9, 2008, QQ described a history of seizures for which she took Depakote. On July 9, 2008, a medical physician saw QQ and prescribed Depakote. QQ was given her first dose of Depakote while in the clinic. A lab test for Depakote blood level was ordered for July 16, 2008. On July 12, 2008, QQ was again seen by a physician and stated that she was not regularly receiving the medication. The physician gave QQ a dose of Depakote in the clinic and continued the medication order. On July 14, 2008, QQ had a seizure and was brought to the clinic. Upon evaluation by a physician, the physician increased the Depakote dosage. On July 27, 2008, QQ was found on the floor in her housing unit. QQ was brought to the medical clinic and evaluated by a physician. She was drowsy and found to have a fever, and was transferred to the LBJ Hospital's Emergency Center for further evaluation and treatment. She returned from the hospital and was re-evaluated by a physician on July 29, 2008. According to the documentation, QQ felt much better, with the exception of pain at the site of lumbar puncture performed at the hospital. The physician discontinued QQ's Depakote, prescribed Dilantin, requested a LBJ Neurology Clinic consultation, and ordered laboratory studies including a Dilantin level and blood pressure checks for follow-up. On July 31, 2008, QQ had another witnessed seizure and was reevaluated by a medical physician. The physician ordered that the Dilantin be continued and that Depakote be added. On August 1, 2008, QQ was seen in the jail's on-site OB/Gyn Clinic. On August 5, 2008, QQ had a seizure and was brought to the medical clinic. She was again evaluated by a physician, who reordered the Dilantin, ordered a Depakote level, ordered a follow-up Dilantin level on August 12, 2008, and ordered a follow-up appointment for August 19, 2008. On August 13, 2008, QQ was seen by the jail's OB/Gyn Clinic for follow-up. On August 15, 2008, a physician saw QQ for a skin condition. On August 16, 2008, a physician saw QQ for an allergic reaction. On August 17, 2008, a physician saw QQ for fever and increased rash, thought by the physician to be secondary to one of her medications. QQ was transferred to the LBJ Hospital Emergency Center for further evaluation and treatment. On August 17, 2008, QQ returned from the hospital with a diagnosis of viral syndrome. A physician evaluated QQ and adjusted her Dilantin dosage. QQ was admitted to the jail's on-site medical infirmary for observation. On August 18, 2008, while in the infirmary, QQ's rash progressed and she was again transferred to LBJ Hospital. On August 19, 2008, the infirmary physician documented a phone call with a LBJ Hospital Emergency Center physician and noted that LBJ Dermatology made a diagnosis of Stevens-Johnson Syndrome, requiring burn hospital expertise, so the patient had been transferred to the Burn Unit at the University of Texas Medical Branch at Galveston. On August 26, 2008, QQ returned from the hospital and was evaluated by a physician and admitted to the jail's medical infirmary. According to physician, Dermatology felt that Dilantin may have precipitated the Stevens-Johnson Syndrome and recommended discontinuing both Dilantin and Depakote, using Keppra instead. The physician ordered Keppra. UTMB recommendations were followed. Prior to QQ's August 27, 2008 transfer to TDCJ-ID, a medical summary was prepared and faxed to TDCJ-ID's transport coordinator.

F. Prisoners receive constitutionally adequate suicide protection while incarcerated in the Harris County Jail system.

1. Introduction

According to the Civil Rights Division:

> In general, a comprehensive system for providing adequate mental health care should also include policies, procedures and practices to prevent detainee suicides. Because suicide prevention is itself an important legal concern, we note specifically that the Jail has a number of conditions that are dangerous for suicidal detainees.[340]

Harris County disputes the Division's characterization of its suicide prevention measures as "inadequate," and denies the Division's allegation that the Harris County Jail has a number of conditions that are dangerous for suicidal inmates. The Division's conclusions are broad, ill-defined and unsubstantiated, and are inconsistent with the DOJ's own NIC consultants' findings.[341] The National Institute of Corrections' consultants' findings reflect the HCSO's dedication to the protection of inmates from harm, including protection from suicide. Notwithstanding its immense detainee population, the Harris County Jail has historically had very few suicides. There is a reason for that. The HCSO's Health Services Division has a comprehensive system for providing adequate mental health care, including policies, procedures and practices to prevent detainee suicides. The Health Services Division's policies, procedures and practices not only conform to minimum constitutional requirements, but have also passed the NCCHC's more rigorous "best practices" accreditation standards since 1991.

In coordination with medical and mental health officials, the HCSO has developed and implemented an extensive suicide prevention plan that has been approved by the Texas Commission on Jail Standards.[342] This plan includes, among other things, procedures for intake screening to identify inmates who are mentally disabled and/or potentially suicidal and procedures for referrals to available mental health officials; procedures for communication of information relating to inmates who are mentally disabled and/or potentially suicidal; procedures for the assignment of inmates who are mentally disabled and/or potentially suicidal to appropriate housing; procedures for adequate supervision of inmates who are mentally disabled and/or potentially suicidal and procedures for documenting supervision; procedures for staff intervention prior to the occurrence of a suicide and during the progress of a suicide attempt, or

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340 Letter from Loretta King to Ed Emmett, *supra* note 3, at 14 para. 2.

341 *See* Exhibit 10 at 34-35. The Civil Rights Division's conclusions are also inconsistent with statements they made in other sections of their June 4, 2009 letter. The Division stated, for example, that: "The Jail has already adopted a number of useful strategies for dealing with detainees who are dangerous to themselves or others. These strategies include an objective classification process for deciding where to house detainees and contracts with outside facilities to handle crowding pressure." Letter from Loretta King to Ed Emmett, *supra* note 3, at 17 para. 2.

342 Bates 14,948, 15,001-06, 15,019.

serious deterioration of mental condition; procedures for reporting completed suicides to appropriate outside authorities and family members; procedures for follow-up review of policies by the HCSO and mental health and medical officials following all attempted or completed suicides; and provisions for staff training concerning the recognition, supervision, documentation and handling of inmates who are mentally disabled and/or potentially suicidal.[343]

2. Video surveillance, supervision and physical fixtures

According to the Civil Rights Division:

> First, the Jail lacks adequate video surveillance and supervision in various holding areas. Some of the cells used for housing newly arrested detainees include unsafe physical fixtures (e.g.. exposed bars) that can be used to facilitate suicide. While the Sheriff's Department was in the process of retrofitting these cells during our tour, such efforts need to be broadened. Many of the mental health holding areas throughout the Jail appear to be clinically inappropriate. For instance, padded rooms in administrative separation and maximum security units are difficult to supervise and the conditions are so stark, they can cause a detainee with mental illness to degenerate.[344]

Harris County objects to and denies the Division's ambiguous allegation that the Jail "lacks adequate video surveillance and supervision in various holding areas," and would also note that video surveillance is not constitutionally or statutorily required.

It is unclear what the Division means when stating that "[s]ome of these cells used for housing newly arrested detainees include unsafe physical fixtures (e.g., exposed bars) that can be used to facilitate suicide." If the Division is referring to the holdover cells at the HCSO's substations, the HCSO's Plexiglas project has been completed. Prior to the Division's July and August 2008 inspections, the HCSO was in the process of retrofitting the cell doors at the Clay Road substation, installing Plexiglas between the bars and the holding cells.[345] Later, the HCSO received and completed installation of Plexiglas at its Cypresswood Jail.[346] There are no bars in the downtown HCSO Inmate Processing Center facility. It is also unclear what the Division means by their allegation that "these efforts need to be broadened." Harris County's research has yielded no constitutional or other authority that prohibits a jail facility from incarcerating inmates behind exposed bars. If the Division intends these comments to be suggestions for improvement, rather than findings of unconstitutional deprivations, the Division should say so.

The Civil Rights Division generally alleges that "many" of the mental health holding areas throughout the Jail "appear" to be clinically inappropriate, and complain that the padded rooms

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343 *See* 37 Tex. Admin. Code § 273.5.

344 Letter from Loretta King to Ed Emmett, *supra* note 3, at 14 para. 3.

345 Bates 31,317-80.

346 Bates 31,317-80.

are stark and difficult to supervise. It is unclear which cells the Division might be referring to in this statement. Clinical mental health holding cells do not exist, *per se*. Padded seclusion cells are located within the mental health units, but are only utilized under a psychiatrist's direction and only with strictly defined procedures—all of which are reviewed on an ongoing basis by the Mental Health Quality Improvement Coordinator. All prisoners in administrative separation cells are evaluated on a regular basis (in compliance with NCCHC standards) in order to ensure that each prisoner has access to care. The segregation and security units are designed to temporarily house prisoners who are combative, under the influence of illicit drugs, suffering through withdrawal, experiencing psychotic episodes, or suicidal. They are padded, outside distractions of all kinds are minimized, the lighting is adjusted to reduce anxiety, and all manner of things the prisoner could use to harm himself are removed. The Civil Rights Division does not make any suggestions about what can be done to make the units less stark and – at the same time – serve their intended purposes.

3. Prisoners' access to mental health care

According to the Civil Rights Division:

> Second, the detainees' generally limited access to mental health care can be especially dangerous for suicidal detainees, since suicidal detainees may not be particularly inclined to seek care on their own. Thus, adequate screening and pro-active efforts to identify and treat suicidal detainees are necessary to ensure compliance with minimum standards of care.[347]

Emphasis should be placed on "can be" and "may not." No specific examples are given. Harris County disagrees with the Civil Rights Division's allegation that only "limited" access to mental health care is given. As stated above, the Civil Rights Division's letter ignores the multiple processes in place to provide access to care, including: intake screening, the Front Door Clinic, triage of sick call requests, the Crisis Intervention Response Team, availability of psychiatrists for evaluation and treatment of urgent/emergent issues as well as routine outpatient appointments.

Harris County objects to the Civil Rights Division's application of amorphous "minimum standards of care," rather than the constitutional (deliberate indifference) standard. In *Domino v. TDCJ-ID,* for example, an inmate/psychiatric patient expressed suicidal ideations and a psychiatrist returned him to his cell after a five-minute examination. The inmate committed suicide two and a half hours later. Explaining that the deliberate indifference standard is an extremely high standard to meet, the Fifth Circuit reversed the district court's denial of a TDCJ-ID's psychiatrist's motion for summary judgment and rendered judgment in his favor:

> Deliberate indifference is an extremely high standard to meet. It is indisputable that an incorrect diagnosis by prison medical personnel does not suffice to state a claim for deliberate indifference. ... Rather, the plaintiff must show that the officials "refused to treat him, ignored his complaints, intentionally treated him

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[347] Letter from Loretta King to Ed Emmett, *supra* note 3, at 14 para. 4.

> incorrectly, or engaged in any similar conduct that would clearly evince a wanton disregard for any serious medical needs." ... Furthermore, the decision whether to provide additional medical treatment "is a classic example of a matter for medical judgment." ... And, "the failure to alleviate a significant risk that [the official] should have perceived, but did not," is insufficient to show deliberate indifference. Suicide is inherently difficult for anyone to predict, particularly in the depressing prison setting. ... Reddy presented evidence that Domino had been a difficult, often uncooperative patient and concluded that Domino was threatening suicide to obtain secondary gain. He did not believe the threat was genuine. Reddy's diagnosis was wrong. But, as stated above, an incorrect diagnosis does not amount to deliberate indifference.[348]

Harris County agrees that adequate screening and pro-active efforts to identify and treat suicidal detainees are necessary to ensure compliance with minimum standards of care. The HCSO's policies, procedures, and practices, regarding suicide prevention, have been reviewed and approved by the Texas Commission on Jail Standards and by the NCCHC, and thus satisfy more than minimum constitutional requirements.

VIII. Harris County provides constitutionally adequate protection from the use of excessive force against inmates incarcerated in the Harris County Jail system.[349]

Harris County objects to the "Excessive Use of Force" section of the Civil Rights Division's letter because the Division failed to satisfy CRIPA's notification requirements.[350] The Division likewise failed to come forward with any proof that Harris County or any Harris County official

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[348] *Domino v. Tex. Dep't of Crim. Justice*, 239 F.3d 752, 756 (5th Cir. 2001) (internal citations omitted). *See, e.g., Farmer*, 511 U.S. at 837 ("[T]he official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."); *Jacobs v. W. Feliciana Sheriff's Dep't*, 228 F.3d 388, 395 (5th Cir.2000) ("[T]o be considered deliberately indifferent to a known suicide risk, an officer's acts must constitute at least more than a mere 'oversight'"); *Hare v. City of Corinth ("Hare II")*, 74 F.3d 633, 649 (5th Cir.1996) (en banc) ("To establish a constitutional violation, a plaintiff must show that prison or jail officials were subjectively aware of a substantial risk of serious harm and failed to take reasonable measures to abate that risk."); *Evans v. City of Marlin*, 986 F.2d 104, 107 (5th Cir. 1993) (finding failure to provide adequate protection against a prisoner's *known* suicidal impulses is constitutionally actionable); *Burns v. City of Galveston*, 905 F.2d 100, 104 (5th Cir. 1990) (finding that detentions personnel are not required to "unerringly detect suicidal tendencies" and that "the failure to train custodial officials in screening procedures to detect latent suicidal tendencies does not rise to the level of a constitutional violation

[349] As previously stated, although the DOJ's Civil Rights Division has repeatedly affirmed its commitment to a transparent and even-handed investigation, it has thus far declined to provide Harris County with its consultants' reports completed after inspection of the Harris County jail facilities. Without Civil Rights Division consultant Manuel Romero's report, Harris County cannot reasonably determine which, or to what extent, the Civil Rights Division's protection from harm-related findings, including the use-of-force and prisoner population related findings, as well as proposed remedial measures, are based upon Mr. Romero's personal observations and recommendations, and which, and to what extent, findings and proposed remedial measures reflect the Civil Rights Division's advocacy.

[350] *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997b(a)(1) (1996).

or employee subjected significant numbers of HCJ inmates to "egregious or flagrant conditions" which deprived significant numbers of inmates of their constitutional rights, causing them to suffer grievous harm.[351] The Division further failed to show any alleged pattern or practice of institutional abuse and resistance to a substantial number of Harris County Jail inmates' constitutional rights.[352]

A. Constitutional framework

Detention officers confronted with a disturbance "must balance the threat unrest poses to inmates, ... workers, administrators, and visitors against the harm inmates may suffer if guards use force."[353] "Despite the weight of these competing concerns, corrections officials must make their decisions 'in haste, under pressure, and frequently without the luxury of a second chance.'"[354] Under these circumstances, the Supreme Court found the deliberate indifference standard to be inappropriate when authorities use force when responding to a disturbance in a detention facility.[355] In other words, the Court found that a plaintiff needs to show a greater degree of culpability than "deliberate indifference" in order to prove an excessive force allegation.

The Supreme Court determined that "the question whether the measure taken inflicted unnecessary and wanton pain and suffering ultimately turns on 'whether force was applied in a good faith effort to maintain or restore discipline or maliciously and sadistically for the very purpose of causing harm.'"[356] Whether a disturbance "is a riot or a lesser disruption, corrections officers must balance the need 'to maintain or restore discipline' through force against the risk of injury to inmates."[357] Both situations "may require [officers] to act quickly and decisively," and both implicate the principle that detention officers "should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security."[358] The Court held that whenever detention officers stand accused of using excessive physical force in violation of the Cruel and Unusual Punishments Clause, the "core judicial inquiry is ... whether force was

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351 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

352 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

353 *Hudson v. McMillian*, 503 U.S. 1, 6 (1992).

354 *Hudson*, 503 U.S. at 6 (citing *Whitley v. Albers*, 475 U.S. 320 (1986)).

355 *Hudson*, 503 U.S. at 6.

356 *Hudson*, 503 U.S. at 6 (citing *Whitley v. Albers*, 475 U.S. 312, 320-21 (1986)).

357 *Hudson*, 503 U.S. at 6.

358 *Hudson*, 503 U.S. at 6 (citing *Whitley*, 475 U.S. at 321-22 (1986)).

applied in a good-faith effort to maintain or restore discipline, or maliciously and sadistically to cause harm."[359]

In determining whether the use-of-force was "wanton and unnecessary," the Supreme Court stressed the propriety of evaluating the need for application of force. the relationship between that need and the amount of force used, the threat "reasonably perceived by the responsible officials," and "any efforts made to temper the severity of a forceful response."[360]

The Supreme Court also explained that the extent of injury suffered by a prisoner is one factor that may suggest "whether the use-of-force could plausibly have been thought necessary" in a particular situation, "or instead evinced such wantonness with respect to the unjustified infliction of harm as is tantamount to a knowing willingness that it occur."[361] The Court found that the absence of serious injury is therefore relevant to the Eighth Amendment inquiry. "but does not end it."[362] The Court noted that not every "malevolent touch by a prison guard gives rise to a federal cause of action."[363] and concluded that the Eighth Amendment's prohibition of "cruel and unusual" punishments "necessarily excludes from constitutional recognition *de minimis* uses of physical force, provided that the use-of-force is not of a sort "'repugnant to the conscience of mankind.'"[364]

Whether advanced by a pretrial detainee or convicted prisoner, a claim alleging excessive force by a law enforcement officer is examined under this same standard.[365] The central inquiry is "whether force was applied in a good-faith effort to maintain or restore discipline, or maliciously and sadistically to cause harm."[366]

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359 *Hudson,* 503 U.S. *at* 6-7. In so holding, the Court noted that the extension of *Whitley's* "'unnecessary and wanton infliction of pain' standard to all allegations of excessive force works no innovation." *Hudson*, 503 U.S. at 7.

360 *Hudson,* 503 U.S. *at* 7.

361 *Hudson,* 503 U.S. *at* 7 (citing *Whitley*, 475 U.S. at 321).

362 *Hudson,* 503 U.S. *at* 7.

363 *Hudson,* 503 U.S. *at* 7 ("Not every push or shove, even if it may later seem unnecessary in the peace of a judge's chambers, violates a prisoner's constitutional rights")).

364 *Hudson,* 503 U.S. *at* 9-20 (citing *Whitley*, 475 U.S. at 327).

365 *E.g.*, *United States v. Daniels*, 281 F.3d 168, 179 (5th Cir. 2002).

366 *Valencia v. Wiggins*, 981 F.2d 1440, 1447-49 (5th Cir. 1993), *cert. denied*, 509 U.S. 905 (1993) (citing *Hudson v. McMillian*, 503 U.S. 1 (1992); *Whitley v. Albers*, 475 U.S. 312 (1986)).

B. Harris County provides a constitutionally adequate system for deterring the use of excessive force and for managing a large prisoner population.

According to the Civil Rights Division:

> We evaluated the Jail's detainee supervision procedures, security classification process, housing practices, grievance procedures, disciplinary process, and training program. We found that many Jail policies and practices are consistent with minimum correctional standards. Yet, at the same time, we also found some significant and often glaring operational deficiencies. For security matters in particular, the Jail lacks: (1) a minimally adequate system for deterring excessive use-of-force. and (2) an adequate plan for managing a large and sometimes violent detainee population.[367]

Harris County denies the Civil Rights Division's allegations that the jail has "some significant and often glaring operational deficiencies," that the jail "lacks a minimally adequate system for deterring excessive use of force," and that the jail "lacks an adequate plan for managing a large and sometimes violent detainee population."

Experts in the field of Corrections, including experts recently sent to Harris County by the DOJ's own National Institute of Corrections to provide technical assistance, have examined the HCSO's Use of Force policies and post-incident review process, and found them to be comprehensive, sound and consistent with community corrections standards. According to the DOJ NIC consultants' report issued July 2, 2009:

> We found that the policies and procedures regarding the use of force to be well written and meets that "community standard" for such an area in the jail. They are written so that they are easily understandable and the use of various terms are, when necessary, explained in such a way that they are clear to the reader.
>
> We also found that the reporting process for use of force incidents is extremely comprehensive, yet not overly complex. It ensures that each incidence of use of force is examined and tracked at various levels of management to determine whether the incident was within policy and otherwise appropriate, or where it required additional investigation and, if necessary, disciplinary action. We were satisfied that the process currently in place provides the necessary safeguards to ensure that use of force incidents are appropriate.[368]

In compliance with HCSO policies and Commission on Accreditation for Law Enforcement Agencies ("CALEA") standards, all HCSO use-of-force incidents are reviewed by supervisors to determine if the force used by staff was appropriate and justified in accordance with Department

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367 Letter from Loretta King to Ed Emmett, *supra* note 3, at 14 para. 5 (June 4, 2009).

368 *See* Exhibit 1 (DOJ's NIC's July 2, 2009 Jail System Assessment) at p. 36.

policies and state law. If the HCSO determines that the force used was unjustified and/or excessive, corrective action is taken (*i.e.*, suspension, termination, potential referral to the District Attorney's Office, etc.). In this manner, employees are directly deterred from using excessive force. In addition, the HCSO enters all Use of Force incidents into a "Personnel Early Warning System" (PEWS) database that allows supervisors to reference every employee's use-of-force history. If supervisors detect a pattern or trend that causes concern, the supervisors are able to initiate proactive measures to address the potential issue (*i.e.*, documented counseling letter, additional training, etc.). HCSO employees are keenly aware that their use-of-force history is being captured, maintained and referenced by supervisors.

The HCSO utilizes numerous methods to manage the inmate jail population. The basic design of the inmate housing units and associated duty stations allows staff to view directly into the cellblocks at all times. The HCSO conducts security checks, cell searches, searches of inmates, and monitors areas via video to enhance inmate management and facility security. In addition, the HCSO manages the jail population by issuing and enforcing rules documented in the Inmate Handbook (a booklet distributed to every inmate during intake processing). The HCSO operates a Disciplinary Court within each jail facility to fairly issue out sanctions (loss of privileges, placement in disciplinary separation, loss of good time credit, etc.) when inmates violate the rules of the institution. When warranted, the HCSO also files additional criminal charges against inmates if they violate the law while in the jail. Inmate management is also enhanced by the comprehensive training the HCSO provides its jail staff, to include HCSO New Employee Orientation Training and state-mandated Jail School. The HCSO proactively, successfully manages the inmate population of the Harris County Jail system.

C. Harris County's use-of-force policies are constitutionally adequate.

According to the Civil Rights Division:

> We have serious concerns about the use of force at the Jail. The Jail's use of force policy is flawed in several regards. First, neither written policy nor training provide staff with clear guidance on prohibited use of force practices. For example, Harris County Jail does not train staff that hogtying and choke holds are dangerous, prohibited practices.[369]

Without arguing over whether chokeholds are always dangerous, prohibited practices, Harris County disagrees with the allegations made and conclusions reached by the Civil Rights Division in this paragraph of the Division's June 4, 2009 letter. Contrary to these allegations, the HCSO's policies and training provide guidance regarding certain prohibited use-of-force practices.[370] Numerous sections of the 2008 HCSO Policy Manual and the 2009 HCSO Policy Manual identify and strictly prohibit certain use-of-force ("UOF") actions.[371] For example, both 2008

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[369] Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

[370] Harris County is also constrained to object to any conclusions reached regarding the training afforded HCSO staff inasmuch as the DOJ has neither requested nor received training records relating to HCSO employees.

[371] As previously noted, Sheriff Adrian Garcia took office on January 1, 2009. The DOJ has not requested copies of any of the policies and procedures established under Sheriff Garcia's administration.

and 2009 HCSO policies expressly prohibit hog-tying of prisoners,[372] expressly prohibit the firing of warning shots,[373] and expressly prohibit the use of chemical weapons on prisoners exhibiting only verbal and/or passive resistance to authority.[374]

It is fair to say that the HCSO's 2008 policies prohibited the use of deadly force, including the compression of a person's neck in a manner that could result in death or serious bodily injury, unless the circumstances justified the use of deadly force under state law. HCSO policy states that the "[u]se of deadly force must be in accordance with all applicable State and Federal laws." HCSO policy also states that an employee or staff member "is justified in using deadly force against another when and to the degree the deputy reasonably believes the action is in defense of human life, including the deputy's own life, or in defense of any person in imminent danger of serious physical injury." Section 9.01 of the Texas Penal Code and HCSO policy define deadly force as force that is intended or known by the actor (person) to cause, or in the manner of its use or intended use is capable of causing, death or serious bodily injury. Compressing a person's neck in a manner intended or known to cause, or capable of causing, death or serious bodily injury would thus be considered deadly force and, in accordance with HCSO policy and state law, would only be permissible when the use of deadly force is justified. That being said, Sheriff Garcia's 2009 Detention Command Use-of-Force Bureau Policy expressly prohibits such neck compressions in uses-of-force unless the circumstances faced by the officer would justify the use of deadly force in accordance with state law.[375]

While HCSO policy and training guide officers in determining the appropriateness of the use-of-force and use-of-force techniques, officers also look to state law regarding use-of-force issues. The authority to use force, including deadly force, is conferred under state and constitutional law and is highly dependent upon the *circumstances* in which the force is used.[376] The Texas Penal Code provides guidelines for when a detention officer's use-of-force is lawful. "Knowing the innate danger in maintaining a correctional facility, the legislature grants correctional officers the right to use reasonable force against an inmate to maintain their own safety, the safety of others, or the security of the [facility] as a whole."[377] Section 9.53 of the Texas Penal Code, entitled "Maintaining Security in Correctional Facility," statutorily authorizes a HCSO deputy or jailer to

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372 *See* 2008 Policy Manual at Chapter III, Section 3.0 (D)(2) (Procedures for Use of Less than Lethal Impact and Restraining Devices). *See also* 2009 Policy Manual at 502.1(1)(D)(2) (Less than Lethal Impact and Restraining Devices). In fact, HCSO policies have prohibited hog-tying for approximately ten or more years.

373 *See* 2008 Policy Manual at Chapter III, Section 1.0 (A)(15) (Use of Force). *See also* 2009 Policy Manual at 501.1(1)(A)(15) (Use of Force)).

374 *See* 2008 Policy Manual at Chapter III, Section 3.1(E) (Use of Chemical Weapons). *See also* 2009 Policy Manual at 504.1 (Use of Chemical Weapons)).

375 HCSO Detention Bureau Policy, Directive 09-001, *Use of Force Policy*, effective 8-14-09, revised 8-19-09.

376 HCSO policies reference and incorporate Sections 9.51 (entitled "Arrest and Search") and 9.52 (entitled "Prevention of an Escape from Custody") of the Texas Penal Code. *See* OPM Chapter III, Section 1.0 *Use of Force* (A)(7). *See also* NPM Policy 501.1 *Use of Force.*

377 *Hall v. State*, 158 S.W.3d 470, 475 (Tex. Crim. App. 2005).

use reasonable force to defend himself or the safety of others, and to use force "when and to the degree" that the officer "reasonably believes the force is necessary to maintain the security" of the Harris County Jail system:

> An officer or employee of a correctional facility is justified in using force against a person in custody when and to the degree the officer or employee reasonably believes the force is necessary to maintain the security of the correctional facility, the safety or security of other persons in custody or employed by the correctional facility, or his own safety or security.[378]

The HCSO's policies provide, for example, that:

> When it becomes necessary to use force in making an arrest or restraining a prisoner, the Deputy shall use only that degree of force necessary under the circumstances. In every arrest or incident in which force is used, the facts surrounding such arrest and/or the use of force shall be fully set forth in a written report to be submitted by the Deputy to the appropriate supervisor by the end of the employee's duty shift.[379]

Although the HCSO policies expressly prohibit some actions, it is not reasonable to expect any law enforcement agency to prohibit use-of-force techniques that would be reasonable under the circumstances faced by the officer. An officer responds to the circumstances presented and must immediately determine what force is reasonable *under those circumstances* to defend himself and, at times, others. The HCSO has policies that permit the use of potentially deadly force in limited circumstances. The HCSO's use-of-force policies, practices and training are consistent with state law and conform to constitutional requirements. The HCSO use-of-force policies describe when the use of deadly force is permissible, directly prohibit excessive use of force against prisoners, require that all use of force incidents be documented, and require that an employee report any incident in which they observe other employees using excessive force.[380] These policies are reinforced through on-the-job training.

John Peters, Jr., Ph.D.,CLS, an expert in the field of Corrections, reviewed the HCSO use-of-force policies and concluded: "In my professional opinion, coupled with my education, training, and experience, Harris County and/or Sheriff Thomas met and/or exceeded national policy recommendations and/or requirements regarding policies, procedures, and rules governing their employees' use-of-force prior to the on-site visit by the DOJ."[381]

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378 Tex. Pen. Code § 9.53.

379 *See* 2008 Policy Manual at Chapter II, Section 1.3(B) (Conduct in Making Arrests or Towards a Prisoner). *See also* 2009 Policy Manual at Policy 302(II)(E)(2) (Conduct in Making Arrests or Towards a Prisoner).

380 *See, e.g.,* 2008 Policy Manual at Chapter II, Section 1.3(B); Chapter III, Section 1.0. *See also* 2009 Policy Manual at Policy 302 & 501.

381 *See* Exhibit 16 at 9.

A copy of the HCSO approved use-of-force policy is issued to each deputy, and these policies are available to all employees via the Departmental intranet.[382] HCSO policy mandates that all new employees are issued HCSO Policies, Procedures and Directives.[383] All newly employed personnel are required by policy to attend "New Employee Orientation" for the purpose of reviewing Sheriff's Office Policy and Procedures and Personnel Regulations.[384] All newly hired Deputy and Civilian Detention Officer personnel are required to attend and successfully complete Detention Officer Training to obtain a Texas County Jailer's License. This training includes instruction on legal aspects relating to the operation of a county jail and the proper handling of prisoners, as well as instruction concerning the Harris County Sheriff's Office "Department Manual." By policy, all officers receive annual in-service training on Use-of-force policies. This annual training is documented, and records are maintained by the HCSO Academy. In addition, HCSO's "New Employee Orientation" and state-mandated "Basic Jail School" training classes include basic training in use-of-force defensive tactics and control techniques. Deputies assigned to the jail also received UOF training during the Basic Peace Officer Training course at the HCSO Academy.

D. Harris County's review of use-of-force incidents is constitutionally adequate.

1. Introduction

According to the Civil Rights Division:

> ... Indeed, we found a significant number of incidents where staff used inappropriate force techniques, often without subsequent documented investigation or correction by supervisors. ...[385]

Harris County objects to and denies these ambiguous and conclusory allegations, each of which is made without the support required by 42 U.S.C. § 1997b(a)(1). The Civil Rights Division did not explain what it meant by "a 'significant number' of incidents," or what it meant by "inappropriate force techniques." The Division did not support their allegations with evidence actually demonstrating the proposition asserted—that they found a statistically "significant number of incidents where staff used inappropriate force techniques, often without subsequent documented investigation or correction by supervisors."

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382 *See* 2008 Policy Manual at Chapter III, Section 1.0(G) (Use of Force). *See also* 2009 Policy Manual at 501.1(I)(G) (Use of Force Training).

383 *See* 2008 Policy Manual at Chapter IV, Section 11.0(C)(2)(f) (County Property). *See also* 2009 Policy Manual at 241 (County Property). Sheriff Garcia's 2009 Policy Manual also advises employees that all Departmental policies are available to employees on the intranet. *See* 2009 Policy Manual at 241 (County Property).

384 *See* 2008 Policy Manual at Chapter II, Section 2.4(D)(5) (Application and Hiring Process). *See also* 2009 Policy Manual at 201 (Application and Hiring Process).

385 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

Besides "hogtying" and "choke holds," the Civil Rights Division did not specify force techniques which they apparently allege to be "inappropriate" under any circumstances, including circumstances where the use of deadly force would be appropriate. In 2008, the HCSO booked approximately 134,000 inmates into the Harris County Jail, yet the Civil Rights Division cites only five UOF incidents in its letter.[386] Of the five UOF incidents mentioned in the Civil Rights Division advocates' letter, two allegedly involved choke holds and none involved hogtying.[387] The Division's statistics do not support the proposition for which they are advanced. The Division's conclusory allegations clearly fail to satisfy CRIPA's notification requirements.

The Civil Rights Division also claims that these force techniques were "often" used "without subsequent documented investigation or correction by supervisors." Harris County does not know what the Division means by "often." In any event, the HCSO has historically investigated all complaints alleging excessive use-of-force and documents all uses of force in accordance with CALEA standards. HCSO policy documents the process by which all complaints, including allegations of excessive force, are investigated.[388] In addition, Harris County Jail inmates have the ability to file a complaint through the Inmate Grievance Board.

In May of 2008, the Office of Inspector General ("OIG") was created in the HCSO with the objective of providing additional independent oversight regarding all facets of Detention Command operations. The OIG Command was structured into two operational divisions, including the Investigative Division and the Compliance and Inspection Division.[389] OIG's Investigative Division was formed to investigate complaints and alleged policy violations involving HCSO employees assigned to the Detention Command. OIG's mission was to provide independent, fair, unbiased, factually accurate and complete investigative reports to the HCSO Command staff for review and final disposition. When necessary, OIG investigators work with the Harris County District Attorney's Public Integrity Division to prosecute employees who violate the law. Prior to the Civil Rights Division's inspections, the OIG Investigative Division initiated the process of independently reviewing complaints filed against Detention Command personnel.[390]

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386 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009). Even assuming that these incidents demonstrated constitutional violations, which Harris County denies, they fail to reflect a pattern of "egregious and flagrant conditions" that has deprived significant numbers of HCJ inmates' constitutional rights, violating their constitutional rights and causing them to suffer grievous harm, all pursuant to a pattern of resistance to the full enjoyment of their constitutional rights necessary for federal intrusion into the administration of the Harris County jail facilities. The Civil Rights Division has likewise failed to demonstrate any element of proof necessary to hold Harris County liable for a constitutional violation.

387 And, as noted above, hogtying has been expressly prohibited by HCSO policy for ten or more years.

388 *See* 2008 Policy Manual at Chapter II, Section 1.10 (Internal Investigation). *See also* 2009 Policy Manual at 231 (Internal Investigations).

389 Compliance and Inspection Division personnel are now assigned to the Detention Command.

390 *See* 2008 Policy Manual at Chapter II, Section 1.10 (Internal Investigation). *See also* 2009 Policy Manual at 231 (Internal Investigations).

The HCSO recognized that the Jail's use-of-force documentation and review process could be enhanced in order to provide more transparency and oversight, and the OIG Division worked closely with the Harris County Attorney's Office to augment documentation and review criteria for all use-of-force incidents within the HCSO Detention Command.[391] In November of 2008, the HCSO added another layer of review by creating the "Use-of-Force Review Section" in its Office of Inspector General. The augmented documentation criteria and review protocols were implemented on November 12, 2008.[392] Under these protocols, extensive documentation must be submitted with all use-of-force reports completed within the Detention Command.[393] This documentation includes, for example, use-of-force-related coversheet, report, supplemental reports, subject statement, witness statements, and photographs.[394] The OIG use-of-force Review Section reviews all jail UOF incidents and, after cross-checking that information against additional information, including inmate medical records, disciplinary statements, grievances and the like, provides an independent, informed assessment of whether the amount of force used by staff was appropriate and justified.[395] Any incident deemed questionable is referred for additional investigation. The OIG also created a use-of-force database that allows for electronic tracking and recording of all jail-related use-of-force incidents, and proactively sought applicable training for OIG staff members in investigative techniques.[396]

In 2008, the HCSO OIG and Internal Affairs Division ("IAD") were separate Commands. In early 2009, newly-elected Sheriff Adrian Garcia combined these two investigative/oversight commands and nearly doubled their size, from twenty-four to forty-seven employees.

In addition, all IAD cases alleging excessive UOF are reviewed by Command Staff Bureau Majors for their findings and disposition.

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391 *See* Bates 31,323, 31,376-80.

392 *See* Bates 31,323, 31,376-80.

393 *See* Bates 31,376-80.

394 *See* Bates 31,376-80.

395 The enhanced HCSO Use of Force documentation requirements and review protocols were established and implemented on November 12, 2008. *See* Bates 31,376-80. *See also* HCSO Office of Inspector General Policy, Directive OIG.001, Use of Force Required Documentation—Review Criteria / Process, effective 8-4-09.

396 *See* Bates 31,323.

According to the Civil Rights Division:

> Second, use of force policies fail to distinguish between planned use of force (e.g., for extracting a detainee from a cell) and unplanned use of force (e.g., when responding to a fight). In many planned use of force situations, staff should be consulting with supervisors, and possibly medical staff, before using force.[397]

The HCSO has a Department UOF policy for all UOF events, along with a specific "planned" UOF policy within the Detention Command. All "unplanned" UOF incidents are covered by Bureau and Department UOF policies. The "planned" UOF incidents in the jails currently fall within the Detention Command Containment Team (DCCT) bureau policy that was created in May of 2008. Prior to that, the jails relied upon the HCSO Emergency Response Team ("ERT") to conduct planned UOF events. Jail personnel assigned to the DCCT and ERT teams receive specialized training and access to additional protective equipment.

According to the Civil Rights Division:

> Third, Jail policies do not provide for routine videotaping of use of force.[398]

The Civil Rights Division has proffered no authority supporting the proposition that routine videotaping of uses-of-force is either constitutionally or statutorily required. That being said, the HCSO has routinely photographed inmates following UOF incidents since November of 2008, and has updated the HCSO policies and obtained video equipment for use during planned uses-of-force.[399]

According to the Civil Rights Division:

> Fourth, the Jail does not have an appropriate administrative process for reviewing use of force. Jail policy does not clearly require the individual using force to file a use of force report; nor does Jail policy provide for routine, systematic collection of witness statements. Instead, they appear to rely excessively on officer statements to determine what happened during an incident. While Jail staff were helpful and willing to assemble use of force documents requested by our review team, we found it troubling that the Jail did not collect such documents as a matter of course. In other words, use of force occurs at the Jail without adequate review, and Jail data regarding use of force levels cannot be considered reliable. We believe that the incidents noted during our review may only reflect part of what is really occurring within the facility.[400]

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397 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

398 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

399 HCSO Detention Bureau Policy, Directive 09-002, *Videotaping Planned Use of Force Events*, effective 8-14-09, revised 8-19-09.

400 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009). Harris County also takes issue with and denies the Civil Rights Division's speculative and reckless observation, in this same paragraph,

Harris County denies these inaccurate and misleading allegations. The HCSO previously had a process for documenting and reviewing uses-of-force. This process pre-dates the creation of the OIG. In the past, HCSO's policies required every use-of-force incident be documented. More recently, the HCSO has reinforced and enhanced its policies by specifically identifying the documents, photographs and other materials to be included in each use-of-force reporting packet. The HCSO's use-of-force policy, then as now, specifically requires that all use-of-force incidents must be documented, with all associated reports forwarded for post-incident assessment and review.

To the extent that the Civil Rights Division is alleging that the HCSO policy does not provide for the routine, systematic collection of witness statements, the Division errs. Harris County would also refer the Civil Rights Division to the update produced on January 9, 2009.[401] In that update, the HCSO reported that it had substantially augmented its use-of-force review process in 2008, imposing significantly more reporting obligations and review and cross-checks to ensure the thorough review of use-of-force incidents.[402]

HCSO policy mandates that all incidents involving the use-of-force must be documented in HCSO reports by the involved employee, reviewed by the immediate supervisor, and forwarded to the respective Division Commander.[403] As previously stated, HCSO policies expressly provide that "[w]hen it becomes necessary to use force in making an arrest or restraining a prisoner, the Deputy shall use only that degree of force necessary under the circumstances. In every arrest or incident in which force is used, the facts surrounding such arrest and/or the use of force shall be fully set forth in a written report to be submitted by the officer to his or her appropriate supervisor by the end of the employee's duty shift."[404]

HCSO policy requires Division Commanders to review these Use of Force reports to determine whether there is a need for training, counseling, or further administrative review. HCSO policy provides that unauthorized or indiscriminate use of physical force may result in disciplinary action being taken against an employee. The Division Commander must also submit an annual report detailing any UOF patterns or trends which may require additional training, equipment or policy modification.

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that "[w]e believe that the incidents noted during our review may only reflect part of what is really occurring within the facility." *Id.*

401 *See* Bates 31,317-80.

402 *See* Bates 31,320, 31,323, 31,376-80.

403 *See* 2008 Policy Manual at Chapter III, Section 1.0(E) (Reporting Use of Force). *See also* 2009 Policy Manual at 501.1 (Use of Force).

404 *See* 2008 Policy Manual at Chapter III, Section 1.3(B) (Conduct in Making Arrests or Towards at Prisoner). *See also* 2009 Policy Manual at 302(II)(E)(2) (Conduct in Making Arrests or Towards a Prisoner)). Detention Command UOF Bureau Policies (DOC 07.001.00) also require jail personnel to submit UOF reports prior to the end of their duty shift.

According to the Civil Rights Division:

> As a result of systemic deficiencies including a lack of appropriate policies and training, the Jail exposes detainees to harm or risk of harm from excessive use of force. In a particularly troubling January 2008 case, staff applied a choke hold to a detainee, who subsequently died. The autopsy report identified the manner of death as homicide. ...[405]

Harris County objects to and denies the Division's ambiguous and non-specific contention that there are "systemic deficiencies including a lack of appropriate policies and training" that allegedly "exposes detainees to harm or risk of harm from excessive use of force." These allegations have no legal or factual basis and are frivolous, unreasonable and without foundation.[406]

It is also troubling that the Division alleges training deficiencies without specificity and without application of any relevant legal principles. In *Canton v. City of Ohio*, the Supreme Court held that the inadequacy of police training, if any, is constitutionally actionable only where the failure to train amounts to deliberate indifference to the rights of individuals with whom the police come into contact:

> We hold today that the inadequacy of police training may serve as the basis for § 1983 liability only where the failure to train amounts to deliberate indifference to the rights of persons with whom the police come into contact.
>
> * * *
>
> In resolving the issue of a city's liability, the focus must be on adequacy of the training program in relation to the tasks the particular officers must perform. That a particular officer may be unsatisfactorily trained will not alone suffice to fasten liability on the city, for the officer's shortcomings may have resulted from factors other than a faulty training program. ... It may be, for example, that an otherwise sound program has occasionally been negligently administered. Neither will it suffice to prove that an injury or accident could have been avoided if an officer had had better or more training, sufficient to equip him to avoid the particular injury-causing conduct. Such a claim could be made about almost any encounter resulting in injury, yet not condemn the adequacy of the program to enable officers to respond properly to the usual and recurring situations with which they must deal. And plainly, adequately trained officers occasionally make mistakes; the fact that they do says little about the training program or the legal basis for holding the city liable.

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405 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2 (June 4, 2009).

406 *See Johnson v. State of Florida*, 348 F.3d 1334, 1349 (11th Cir. 2003).

> Moreover, for liability to attach in this circumstance the identified deficiency in a city's training program must be closely related to the ultimate injury. Thus in the case at hand, respondent must still prove that the deficiency in training actually caused the police officers' indifference to her medical needs. ... Would the injury have been avoided had the employee been trained under a program that was not deficient in the identified respect? Predicting how a hypothetically well-trained officer would have acted under the circumstances may not be an easy task for the factfinder, particularly since matters of judgment may be involved, and since officers who are well trained are not free from error and perhaps might react very much like the untrained officer in similar circumstances. But judge and jury, doing their respective jobs, will be adequate to the task.
>
> To adopt lesser standards of fault and causation would open municipalities to unprecedented liability under § 1983. In virtually every instance where a person has had his or her constitutional rights violated by a city employee, a § 1983 plaintiff will be able to point to something the city "could have done" to prevent the unfortunate incident. ... Thus, permitting cases against cities for their "failure to train" employees to go forward under § 1983 on a lesser standard of fault would result in *de facto respondeat superior* liability on municipalities-a result we rejected in *Monell* ... It would also engage the federal courts in an endless exercise of second-guessing municipal employee-training programs. This is an exercise we believe the federal courts are ill suited to undertake, as well as one that would implicate serious questions of federalism. ...
>
> Consequently, while claims such as respondent's-alleging that the city's failure to provide training to municipal employees resulted in the constitutional deprivation she suffered-are cognizable under § 1983, they can only yield liability against a municipality where that city's failure to train reflects deliberate indifference to the constitutional rights of its inhabitants.[407]

The Division has essentially second-guessed the HCSO's training program without any analysis of the HCSO's training program or discussion or application of the deliberate indifference standard.

Regarding the Civil Rights Division's citation to the January 2008 use-of-force incident, Harris County submits that the Division made no attempt to fairly recite the hotly contested facts and circumstances revealed during the HCSO's investigation of that incident. The HCSO informed the Division advocates that the officer involved in that use-of-force was fired from employment with the HCSO and referred to the Harris County District Attorney's Office for prosecution, but

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[407] *City of Canton, Ohio v. Harris*, 489 U.S. 378, 388, 390-92 (1989) (citations omitted). *See also Bd. of County Com'rs of Bryan County v. Brown*, 520 U.S. 397, 404 (1997) ("As our § 1983 municipal liability jurisprudence illustrates, however, it is not enough for a § 1983 plaintiff merely to identify conduct properly attributable to the municipality. The plaintiff must also demonstrate that, through its *deliberate* conduct, the municipality was the 'moving force' behind the injury alleged. That is, a plaintiff must show that the municipal action was taken with the requisite degree of culpability and must demonstrate a direct causal link between the municipal action and the deprivation of federal rights.") (emphasis in original).

no mention of these facts is made in the Division's letter. A Harris County Grand Jury no-billed the involved officer on the offenses of criminally negligent homicide and manslaughter.[408] The Grand Jury indicted the involved officer for tampering with a governmental record. The officer pled guilty to and received deferred adjudication for that offense. The HCSO sergeant charged with responsibility for supervising the officer involved in the incident was also demoted, but no mention of any of these facts appears in the Division's letter.

According to the Civil Rights Division:

> ... Our review of the Jail's records suggests that such improper force technique is being used with troubling frequency. For instance, our consultant found a pattern of such incidents when reviewing use of force reports dated from January through June 2008. These incidents included the following: ...[409]

Harris County objects to the Civil Rights Division's wholly speculative observation that its review of the Jail's records "suggests that such improper force is being used with troubling frequency." It is not at all clear what the Division means by "suggests," "such improper force," "being used with troubling frequency," or a "pattern of such incidents." Harris County must also note that although the Division has repeatedly characterized its investigation as fully "transparent," the Division has repeatedly failed to honor Harris County's verbal and written requests for the Division's consultants' reports. Under these circumstances, it is virtually impossible to review and analyze the consultants' actual observations and findings, and compare them to the allegations made by the Division.

Approximately 405,076 inmates were received over the past three years in the Harris County Jail, yet the Civil Rights Division advocates cite five unrelated use-of-force incidents, each involving different force techniques applied to wholly different circumstances to allegedly support a pattern of a similar but unspecified "improper force technique." The Division's allegations clearly fail to satisfy CRIPA's Section 1997b(a)(1) notification provision. The Division's allegations also fail to demonstrate any evidence of "egregious or flagrant conditions" which deprive a significant number of inmates to constitutional violations, causing them "to suffer grievous harm." These allegations likewise fail to show that "such deprivation is pursuant to a pattern or practice of resistance to the full enjoyment" of inmates' constitutional rights.

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408 The Harris County Medical Examiner classifies a decedent's manner of death as natural, accident, homicide, suicide, undetermined or pending investigation. The Harris County Medical Examiner's Office generally explains its "Homicide" designation to the public as follows: "Homicide – 'occurs when death results from... an injury or poisoning or from '...a volitional act committed by another person to cause fear, harm, or death. Intent to cause death is a common element but is not required for classification as homicide.' Homicide is when a person is killed by one or more persons. This is different than murder. Murder is the unlawful taking of a human life by another, especially with premeditated malice. For example, if a police officer kills someone in the line of duty, it is considered a homicide, but not necessarily a murder. All murders are homicides, but not all homicides are murders." Harris County Medical Examiner's Office – Cause and Manner of Death, http://www.co.harris.tx.us/ME/cause.aspx (last visited July 28, 2009).

409 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2 (June 4, 2009).

Harris County also finds it troubling that the Civil Rights Division fails to acknowledge that most uses-of-force result from the aggressive actions of a combative or belligerent inmate. In the examples that follow, the Division makes no effort to even outline the inmates' actions that precipitated the uses-of-force in question, let alone hold the inmates responsible for the actions prompting the officers to defend themselves and maintain jail security.

2. Inmate RR was not subjected to an improper force technique.

According to the Civil Rights Division, use-of-force incidents "suggest[ing] that such improper force technique" was "being used with troubling frequency" included the following:

> An officer reported that he "grabbed inmate RR by the front of his jumpsuit top and the back of his neck and forcibly placed inmate RR on the ground. Once on the ground, I continued to apply pressure to inmate RR's neck and placed my right knee in the small of his back."[410]

Here is what actually happened. While conducting a visual inspection of a cellblock on May 25, 2008, a HCSO pod deputy noticed that inmates had created a curtain from trash bags and placed it inside the shower area of the cellblock. This curtain obstructed HCSO employees' view into the cellblock and thus presented a security issue. Using the intercom, the pod deputy twice ordered the inmates to remove the curtain from the shower area. The inmates ignored these orders. The pod deputy then directly ordered RR to remove the curtain from the shower area. RR began to protest, questioning why he had to remove the curtain and complaining that he was not located closest to the curtain. The pod deputy again ordered RR to remove the curtain and to bring it out to the safety vestibule. RR complied. In the safety vestibule, the pod deputy told RR that he was not authorized to question any lawful order given to him by a staff member. RR became belligerent, turned his back to the officer and headed back into the cellblock. The pod deputy stopped RR and ordered him to face the wall. RR refused to face the wall, turned toward the pod deputy, began to raise his voice, "stared [the pod deputy] straight in the eye," clenched his fist, and again began to aggressively ask why the pod deputy had not asked someone closer to the shower area to remove the curtain. The pod deputy ordered RR to place his hands behind his back two more times. Both orders were ignored. Another officer observed RR's aggressive behavior and called for assistance. The floor sergeant and two additional officers arrived on the scene. The pod deputy again ordered RR to place his hands behind his back. RR again ignored the pod deputy's order. The pod deputy grabbed RR by the front of his jumpsuit top and the back of his neck and forcefully placed RR on the ground. On the ground, the pod deputy continued to apply pressure to the back of RR's neck, placed his right knee in the small of RR's back and, using his other hand, placed RR's left arm behind RR's back while another officer placed RR's right arm behind RR's back. RR gave no further resistance and allowed himself to be handcuffed.[411]

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410 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2, 16 para. 1 (June 4, 2009).

411 Bates 26,480.

RR was offered the opportunity to and gave a statement regarding the incident. In that statement, RR admitted that he "was ask[ed] to put [his] hands behind [his] back and [he] didn't." In that same statement, RR made no claim about any alleged injuries.[412]

Although RR appeared to have sustained no injuries during the incident, he was escorted to the clinic for evaluation as a precautionary measure in accordance with HCSO policy. At the clinic, RR refused treatment. The nurse who witnessed RR's refusal of medical treatment noted that RR had no visible signs of injury and made no verbal complaints of injury.[413]

RR filed no grievance relating to this incident.

RR was administratively charged with resisting restraint in violation of Section 1104 of the Inmate Handbook. Although RR admitted to resisting restraint in his statement, he pled not guilty to the charge before the Disciplinary Committee. The Committee found RR guilty of the charge and RR temporarily lost visitation and commissary privileges.

Harris County objects to the Civil Rights Division's ambiguous recitation of this use-of-force incident. The Division does not attempt to explain the incident itself or any facts or circumstances surrounding the take-down. What role did the inmate play in the incident? What, if anything, does the Division believe to be constitutionally deficient about the technique used by the pod deputy to take-down this inmate and to control his subsequent movements? After the take-down, what else was happening on the ground? For example, the Division's excerpt of the incident leaves out any mention of the fact that while the pod deputy was attempting to restrain and control RR's movement on the ground with only one hand somewhere on the back of RR's neck and a knee in the small of RR's back, that same pod deputy was using his other hand to move RR's left arm behind RR's back so RR could be handcuffed. At that same time, another officer was moving RR's right arm behind RR's back for the same purpose—to handcuff him. Is the Division suggesting that any pressure applied with one hand at an unspecified location on the back of an inmate's neck constitutes a choke hold and further constitutes the excessive use-of-force in violation of the Constitution? Is the Division suggesting that an officer may not constitutionally touch an inmate anywhere on the back of his neck while attempting to control and cuff him? And what injuries did the inmate allegedly suffer as a result of the control technique used by pod deputy? None.

In this case, the force used was appropriate to the need to maintain or restore discipline. There is no evidence that it was applied maliciously or sadistically for the purpose of causing harm. In fact, by all accounts the inmate was not harmed at all. It cannot be disputed that an officer in charge of a detention facility may constitutionally restrain an inmate who refuses to comply with his lawful orders. None of the force applied against RR exceeded what was necessary to accomplish that purpose.

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412 Bates 26,483.

413 Bates 26,481.

The Civil Rights Division alleges that when reviewing use-of-force incidents, supervisors do not have ready access to important evidence and "appear to rely excessively on officer statements to determine what happened during the incident."[414] This incident, like each of the other three incidents cataloged by the Division, does not support the Division's allegations. When reviewing the incident, the sergeant had the involved pod deputy's statement, two other officers' statements, Inmate RR's statement and extensive photographs of RR from numerous vantage points. The sergeant also interviewed RR regarding the incident. During that interview, RR admitted that he physically resisted the pod deputy because he was angry. During that same interview, RR reported that he was not injured and that he refused treatment at the clinic.[415]

This incident shows that the involved officer used the least amount of force necessary under the circumstances to control an angry, resisting inmate. This incident also demonstrates that the HCSO immediately provided the inmate with access to medical care, and that the sergeant timely and appropriately reviewed the incident.

3. Inmate SS was not subjected to an improper force technique.

According to the Civil Rights Division, use-of-force incidents "suggest[ing] that such improper force technique" was "being used with troubling frequency" included the following:

> An officer used both a headlock and multiple strikes to SS's rib cage.[416]

Here is what actually happened. On May 11, 2008, an officer rushed into a cellblock to break up a fist-fight between SS and another inmate. The officer ordered the two inmates to stop fighting. Both inmates continued to fight. SS became combative and swung at the officer, attempting to strike him. SS missed. The officer then pushed SS away from him. SS then became more combative and approached the officer with two closed fists. Defending himself, the officer hit SS with a closed fist on the left side of his face. SS attempted to strike the officer again, at which point the officer placed him in a headlock to subdue and restrain him. At that point, the involved officer and an assisting officer were able to handcuff SS and SS's resistance effectively ended.[417]

Contrary to the Division's recitation regarding this incident, there is no mention in any report or in SS's statement about any strikes to SS's rib cage or about "multiple" strikes to any part of SS's body. Instead, reacting to SS's attack, the officer pushed SS, struck him once and was finally able to subdue him through placement in a headlock. SS showed no signs of injury. The other inmate was bleeding from his nostril. Both inmates were escorted to the clinic for

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414 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

415 Bates 26,479.

416 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2, 16 para. 2 (June 4, 2009).

417 Bates 28,866.

assessment. Approximately forty minutes after the incident, SS refused medical treatment in the clinic.[418]

Both inmates wrote statements about the incident. SS included no claims against the officer in his statement, and instead focused on the fight with the other inmate.[419] SS filed no grievance relating to this incident.

Both inmates were administratively charged with fighting in violation of Section 1105 of the Inmate Handbook. SS pled guilty to both the fighting and assaulting staff member charges and temporarily lost visitation and commissary privileges.

Harris County objects to the Civil Rights Division's inaccurate and ambiguous recitation of this use-of-force incident. As previously noted, no report mentions, and no statement alleges, that any officer made any strikes to SS's rib cage. Here, as in each of the referenced use-of-force incidents, the Division failed to explain the incident itself or the facts and circumstances giving rise to the use-of-force. Here, as in each UOF incident cited by the Division, no context is given. Surely the Division is not contending that a headlock is constitutionally impermissible, or that an officer who defends himself against inmate aggression has violated the Constitution. The reality is that many jail prisoners are very dangerous people and the Constitution allows officers to protect themselves when necessary.

The Civil Rights Division claims that when reviewing use-of-force incidents, supervisors do not have ready access to important evidence and "appear to rely excessively on officer statements to determine what happened during the incident."[420] This investigation of this incident does not support these contentions. The reviewing sergeant had the involved officer's statement and the statements written by the two inmates. The sergeant also knew that SS made no complaints of injuries at the time of the incident. The sergeant knew that SS had been taken to the clinic as a precautionary measure, and had been released by the clinic.

This incident shows that the involved officer used the least amount of force necessary under the circumstances to control an attacking inmate. This incident also shows that the HCSO immediately provided the inmate with access to medical care, and that the sergeant timely and appropriately reviewed the incident.

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418 Bates 28,866, 28872.

419 Bates 28,866.

420 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

4. Inmate TT was not subjected to an improper force technique.

According to the Civil Rights Division, use-of-force incidents "suggest[ing] that such improper force technique" was "being used with troubling frequency" included the following:

> Officers "grab[bed] the front of [TT's] shirt and place[d] him on the wall to gain control of the incident.[421]

Here is what actually happened. On April 7, 2008, TT refused an officer's repeated orders to make his bed. When the officer and his sergeant entered the cell to confiscate TT's bed linens and towel, TT refused the officer's order to hand over the towel. When the officer attempted to take the towel from TT, TT quickly and aggressively pulled it away with a swinging motion and assumed a combative stance. The officer perceived TT to be an immediate threat to his safety and quickly responded by grabbing the front of TT's shirt and placing him against a wall. The officer then obtained the towel and released TT.[422]

TT did not complain of injuries at the scene of the incident, but was immediately escorted to the jail clinic as a precautionary measure.[423] A nurse triaged TT and TT complained of pain. Approximately two hours after the use-of-force incident, a UT physician examined TT. Clinic staff advised they observed no injuries to TT. At the clinic, TT's hand and wrist were x-rayed as a precautionary measure to rule out any fractures, and TT was given Ibuprofen. The radiologist reviewed and reported TT's x-ray results approximately three hours later, finding no fractures.[424]

Harris County objects to the Civil Rights Division advocates' amorphous one-sentence recitation of this use-of-force incident. Here, as in the other referenced incidents offered to illustrate an unspecified improper force technique, the Division does not explain the facts and circumstances leading to and culminating in the use-of-force. Surely the Division is not contending that the officer's open hand control technique violated this inmate's constitutional rights. Surely the Division is not contending that an officer violates the Constitution by grabbing an inmate by the front of the shirt and placing him against the wall in order to gain control of an incident. Placement against a wall is commonly and appropriately used throughout the law enforcement profession to gain control of a situation.

The Civil Rights Division claims that when reviewing use-of-force incidents, supervisors do not have ready access to important evidence and "appear to rely excessively on officer statements to determine what happened during the incident."[425] This incident does not support these contentions. When reviewing the incident, the sergeant knew the results of TT's visit to the

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421 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2, 16 para. 3 (June 4, 2009).

422 Bates 28,941.

423 Bates 28,941.

424 Bates 28,935-46.

425 Letter from Loretta King to Ed Emmett. *supra* note 3, at 15 para. 1 (June 4, 2009).

clinic, right down to the name of the UT physician who examined and released TT back to his cellblock. TT declined to write a statement on his own behalf and apologized for his aggressive behavior. TT filed no grievance relating to the incident. TT was administratively charged with refusing to obey an order in violation of Rule 2305 of the Inmate Handbook. TT pled guilty to that charge and temporarily lost visitation and commissary privileges.

This incident demonstrates that the involved officer used the least amount of force necessary under the circumstances to control a belligerent inmate, that the inmate received immediate access to and was given appropriate medical care, and that the incident was timely and properly reviewed by the sergeant on duty. Rather than being an example of excessive force, this incident is a perfect example of an officer using only the amount of force necessary under the circumstances.

5. Inmate UU was not subjected to an improper force technique.

According to the Civil Rights Division, use-of-force incidents "suggest[ing] that such improper force technique" was "being used with troubling frequency" included the following:

> Officers used force on UU that resulted in a laceration requiring eleven staples to the scalp. Yet, the use of force incident was not reported by either of the officers who applied the force. Instead, another officer initiated the "inmate offense report."[426]

Here is what actually happened. On May 13, 2008, UU caused a disturbance in the housing pod after returning from visitation highly upset. UU was yelling and punching the walls with his fists. An officer attempted to communicate with UU via intercom to calm him down, but UU did not respond. The officer called for assistance to investigate the disturbance. When additional officers entered the cellblock to question UU about his behavior, he became verbally aggressive and threatening, raising his hands and saying "Come on ... Come on." An officer restrained UU, handcuffed him and escorted him into the cell dayroom area. While handcuffed in the dayroom, UU attempted to head-butt one of the officers. The officer acted instinctively by pushing UU away, which caused UU to strike his head and shoulder on the cell door and resulted in the laceration to UU's head. UU was immediately escorted to the Jail's medical clinic for treatment.[427] UU was triaged and examined and treated by a UT physician approximately twenty minutes after the incident. UU received sutures, and returned to the clinic ten days later for removal of the stitches.[428]

UU filed no internal grievance relating to the incident. UU was administratively charged with assaulting a staff member (a violation of Rule 1103 of the Inmate Handbook) and, on May 28, 2008, pled guilty to that charge and temporarily lost visitation and commissary privileges.

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426 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 2, 16 para. 4 (June 4, 2009).

427 Bates 30,906.

428 Bates 30,908-13.

Harris County objects to the Civil Rights Division's ambiguous and misleading recitation regarding this incident. Here, the Division cited the inmate's injuries, but failed to fairly describe, or even attempt to describe, the incident culminating in the injury. The Division cataloged this incident under incidents "suggest[ing] that such improper force technique" was "being used with troubling frequency," but failed to make any mention of the force technique that caused the injury—an officer's defensive push. Surely the Division is not contending that under these circumstances a push is an inappropriate use-of-force technique. Surely the Division is not contending that the officer's open hand control technique was unconstitutional. An officer is obviously constitutionally authorized to protect himself from attack by a combative inmate who was trying to head-butt him.

This incident also fails to support the Civil Rights Division's claims that when reviewing use-of-force incidents, supervisors do not have ready access to important evidence and "appear to rely excessively on officer statements to determine what happened during the incident."[429] The sergeant on duty interviewed Inmate UU twice about the incident. During the interviews, UU gave conflicting statements regarding the incident. When reviewing the incident and completing the use-of-force report, the sergeant not only interviewed the involved officers and the inmate, but was obviously well aware of UU's injuries, expressly noting on the use-of-force report that UU received "stitches to the right side of forehead/abrasions on knuckles."[430]

This incident illustrates that the officer used the least amount of force necessary under the circumstances to control a volatile inmate, that the inmate received immediate and appropriate medical care, and that the incident was expeditiously and appropriately reviewed by the sergeant on duty. The use of force was clearly not initiated maliciously or sadistically to cause the inmate harm.

According to the Civil Rights Division:

> These and other similar incidents suggest that staff use hazardous restraint and force techniques without appropriate guidance or sanction. In some cases, medical records confirm that detainees may have suffered notable injuries, such as lacerations to the scalp or eye. Notably, when force was investigated by supervisors, it appears that the supervisors often determined that staff's use-of-force was appropriate without obtaining independent medical review or multiple witness statements.[431]

Harris County objects to, and denies, these conclusory allegations, each of which was made without the support mandated by CRIPA's Section 1997b(a)(1) notification provisions. And, as previously stated, the HCSO created the OIG Use-of-force Review Section in 2008. All relevant

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429 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1 (June 4, 2009).

430 Bates 30,905.

431 Letter from Loretta King to Ed Emmett, *supra* note 3, at 16 para. 5 (June 4, 2009).

documentation/information, including the medical records and witness statements referenced above, is obtained and reviewed by the OIG UOF Review Section prior to a determination as to whether the UOF was appropriate and justified.[432]

According to the Civil Rights Division:

> At the time of our inspection, the Jail was already making some effort to improve use of force reviews. At the time of our tour, the Office of the Inspector General was in the early stages of developing a use of force review process. We also understand that the Jail continues expanding this process in ways that may address some of the concerns noted in this letter. Nevertheless, work must continue in this area before we can conclude that the Jail meets minimum constitutional standards.[433]

Harris County agrees that the HCSO was continuing its efforts to improve its use-of-force reviews at the time of the Civil Rights Division's July and August, 2008 inspections. Since then, the HCSO has continued to review and implement improvements in its use-of-force reviews.

Harris County does not know what the Civil Rights Division advocates mean by their ambiguous comment that "work must continue in this area before we can conclude that the Jail meets minimum constitutional standards," and objects to and denies this comment.

After independently assessing the HCSO Use of Force policies and practices, corrections expert John G. Peters, Jr., Ph.D., CLS, strongly disagreed with many of the Civil Rights Division's findings.[434] Among other things, Dr. Peters questioned the Civil Rights Division's methodology, the validity and reliability of their information, their leaps to causation, and their conclusions, and stated that the Division's findings did not mirror the current operations of the Harris County Jail. Dr. Peters advised that the HCSO met, or exceeded, national policy recommendations and/or requirements regarding policies, procedures, and rules governing use-of-force by employees. In order to clarify the underlying basis for the Division's findings and recommended remedial actions, Harris County has repeatedly requested access to the Civil Rights Division's consultants' reports. To date, the Division has declined to produce those reports.

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432 Bates 31,323; 31,376-31,380.

433 Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 6 (June 4, 2009).

434 Exhibit 16.

IX. Harris County's Prisoner Population Numbers

The Civil Rights Division does not allege that the Harris County Jail system is unconstitutionally overcrowded.

A. Constitutional framework

Overcrowding of persons in custody is not *per se* unconstitutional.[435] Convicted prisoners' overcrowding claims are reviewed under the Eighth Amendment. Conditions that cannot be said to be cruel and unusual under contemporary standards are not unconstitutional under the Eighth Amendment. To the extent that such conditions are restrictive and even harsh, they are part of the penalty that criminal offenders pay for their offenses against society.[436] It is well settled that "the Constitution does not mandate comfortable prisons," and that the conditions of convicted prisoners' confinement may be "restrictive and even harsh."[437]

Pretrial detainees overcrowding claims are analyzed under the Fourteenth Amendment.[438] The Constitution "is not concerned with a *de minimus* level of imposition on pretrial detainees."[439] Thus, pretrial detainees' Fourteenth Amendment rights are not violated unless they are "subjected to conditions of confinement that constitute punishment which are not reasonably related to a legitimate government objective."[440] Under *Bell v. Wolfish*:

> [I]f a particular condition or restriction of pretrial detention is reasonably related to a legitimate governmental objective, it does not, without more, amount to "punishment." ... Conversely, if a restriction or condition is not reasonably related to a legitimate goal—if it is arbitrary or purposeless—a court permissibly

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435 *Rhodes v. Chapman,* 452 U.S. 337, 347-50 (1981). In *Rhodes v. Chapman*, the Supreme Court held that double celling at the Southern Ohio Correctional Facility, made necessary by the unanticipated increase in prison population, that did not lead to deprivations of essential food, medical care, or sanitation, or increase violence among inmates or other conditions intolerable for prison confinement, did not constitute cruel and unusual punishment in violation of the Eighth Amendment. *Rhodes v. Chapman*, 452 U.S. 337, 347-348 (1981).

436 *Rhodes v. Chapman,* 452 U.S. 337, 347 (1981).

437 *Rhodes,* 452 U.S. 337 at 347, 349 ("But the Constitution does not mandate comfortable prisons, and prisons of SOCF's type, which house persons convicted of serious crimes, cannot be free of discomfort. Thus, these considerations properly are weighed by the legislature and prison administration rather than a court."); *Hernandez v. Velasquez,* 522 F.3d 556, 560 (5th Cir. 2008).

438 The appropriate standard to apply in analyzing constitutional challenges by pretrial detainees depends on whether the alleged unconstitutional conduct is a "condition of confinement" or "episodic act or omission." *See Scott v. Moore,* 114 F.3d 51, 53 (5th Cir. 1997) (en banc). The courts have classified cases alleging "overcrowding" as conditions-of-confinement cases. *E.g., Collins v. Ainsworth,* 382 F.3d 529, 540 (5th Cir. 2004) (recognizing that overcrowded conditions for pretrial detainees are not unconstitutional unless they are unduly punitive).

439 *Bell v. Wolfish,* 441 U.S. 520, 535 (1979).

440 *Collins,* 382 F.3d at 540 (5th Cir. 2004) (citing *Bell,* 441 U.S. at 535).

> may infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees *qua* detainees.[441]

"[T]his test is deferential to jail rulemaking; it is in essence a rational basis test of the validity of jail rules."[442] Pretrial detainees' due process rights are thus violated only when they are subjected to conditions of confinement that constitute punishment which is not reasonably related to a legitimate governmental objective.[443]

B. Harris County continues to explore and implement innovative measures to address Harris County's prisoner population numbers.

1. Introduction

According to the Civil Rights Division:

> With a population approaching 10,000 detainees, the Jail is one of the largest detention facilities in the country. The Texas Jail Commission's decision to grant the County waivers to house approximately 2000 detainees more than the Jail's original design capacity is concerning on its face. At the same time, however, a large detainee population, even if over design capacity, does not itself necessarily violate minimum legal standards. Moreover, the Sheriff's Department has adopted a number of measures to alleviate crowding issues, such as transferring detainees to outside facilities and providing "portable bunks." Conditions would likely be much worse if the detainees at outside contract facilities had to be housed in the Houston Jail complex. The Sheriff's Department is clearly trying to

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441 *Collins,* 382 F.3d *at* 540 (quoting *Bell,* 441 U.S. at 539).

442 *Collins,* 382 F.3d *at* 540 (citing *Hare v. City of Corinth, Miss.,* 74 F.3d 633, 646 (5th Cir. 1996) (describing *Bell* test)).

443 *Collins,* 382 F.3d *at* 540. In determining whether detention facility officials had a punitive purpose in imposing the condition at issue, the courts analyze whether the detainee was singled out and treated differently as a form of punishment. *See e.g., Walker v. Jackson,* No. 5:08cv147-JMR, 2009 WL 1768547, 9 (S.D. Miss. June 23, 2009) (rejecting detainee's denial of recreation and newspaper claims given no evidence of punitive intent). Absent some indication of punitive intent, the courts have found that detainees' allegations fail to create a genuine issue as to whether detention officials' violated their constitutional rights. *See e.g., Walker v. Jackson,* No. 5:08cv147-JMR, 2009 WL 1768547, 9 (S.D. Miss. June 23, 2009) (rejecting detainee's denial of recreation and newspaper claims). The courts also review the length of the detainee's period of confinement. In one recent conditions case, for example, a detainee who was incarcerated for a two-week period in the Wilkinson County, Mississippi Jail filed a civil rights suit, alleging that jail personnel denied him recreation, newspapers, clean sheets, clean towels, soap, and nutritionally balanced and adequately-portioned food during his two week stay in the jail. The district court found that the detainee's claims failed to rise to the level of a constitutional deprivation. *See e.g., Walker v. Jackson,* No. 5:08cv147-JMR, 2009 WL 1768547, 9-10 (S.D. Miss. June 23, 2009). The court underscored the short duration of the alleged deprivation, stating that "such a temporary inconvenience is not the kind of extreme deprivation that amounts to punishment." *See e.g., Walker,* 2009 WL 1768547, at *10. The court deferred to the jail administrators overseeing the detainee's confinement, observing that the daily management of detention operations "is best left to the knowledge and expertise" of the administrators. *Walker,* 2009 WL 1768547, at *10 (citing *Rhodes v. Chapman,* 452 U.S. 337, 349 (1981)).

> manage its population, and we acknowledge its efforts. While crowded conditions may not, in and of themselves, violate the Constitution, we are compelled to raise our concerns here because (1) the Jail's crowded conditions currently exacerbate many of the constitutional deficiencies identified in this letter:[444] and (2) the Jail needs a more comprehensive, systemic approach to dealing with a large and growing Jail population.[445]
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> * * *
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> More generally, while clearly the use of outside facilities and other tactics have helped to alleviate some of the population pressures at the Jail, it is less clear whether the Jail actually has a workable long-term plan for dealing with the types of systemic problems noted in this letter, especially in light of potential population growth. The County is reportedly working to address many of the specific issues raised in this letter, but at this early remedial stage, it is difficult to determine how much progress will eventually be made. For instance, if the Jail increases staff, but then the Jail population simultaneously increases, those staff could quickly become overwhelmed. In other words, when dealing with crowding and its effects on security, medical care, and various Jail operations, the Sheriff's Department should evaluate issues and remedies in a systemic manner. Otherwise, it may be much more difficult to resolve deficiencies in a complete and long-term manner.[446]

It is not clear what the Civil Rights Division means by its reference to "minimum legal standards." The Division recognizes that a prisoner population that exceeds a jail's design capacity "does not itself necessarily violate" "minimum legal standards," and does not allege that the Harris County Jail system is unconstitutionally overcrowded.

In any event, no authority would support the proposition that the design capacity of a detention facility would necessarily the same as its constitutional or state-mandated capacity. In the event that the Division is referring to minimum state standards, Texas law permits a Texas county jail's prisoner population to exceed the jail's design capacity under circumstances more fully discussed below.

Harris County disagrees with the Civil Rights Division's representation that the Jail "needs a more comprehensive, systemic approach to dealing with a large and growing Jail population." As the Division readily acknowledged, Harris County has adopted a number of measures to manage the Harris County Jail's prisoner population. These measures include, but are not limited to, the provision of portable beds in the Harris County Jail system, the transfers of

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444 Harris County denies the Civil Rights Division's unsupported allegation that "[t]he Jail's crowded conditions currently exacerbate many of the constitutional deficiencies identified in this letter" inasmuch as the Division advocates have identified no constitutional deficiencies in the Harris County jail facilities.

445 Letter from Loretta King to Ed Emmett, *supra* note 3, at 16 para. 7, at 17 para. 1 (June 4, 2009).

446 Letter from Loretta King to Ed Emmett, *supra* note 3, at 18 para. 2 (June 4, 2009).

inmates to outside facilities in and out of state and the recent approval, by the Harris County Commissioner's Court, of additional contracts to transfer qualifying prisoners to other detention facilities. Other measures undertaken by Harris County since 2002 follow.

2. Planned Central Processing Center

In 2002, Harris County, the City of Houston, the Harris County Sheriff's Office and the Houston Police Department formed an Executive Committee and a Technical Committee to develop a plan to build a Central Processing Center ("CPC") facility that would allow the City and County to consolidate their separate jail operations. This merger would have eliminated duplicative prisoner processing, improved efficiency and allowed the City of Houston to eventually close its jails. Harris County hired an architect team to develop a facility space program for the project and purchased land adjacent to the existing county jails as a potential site for the new building.

In September of 2003, a project report was developed and distributed. Prior to moving the project into its design phase, Harris County expanded the scope of the project to include the identification of future Harris County Jail needs and to incorporate them into the CPC capital improvement project. To that end, a new study was initiated and the final report was issued in June of 2006. In late 2006 and early 2007, agreements between the City and County were drafted that addressed financial, operational and administrative issues related to the merger of all City and County jail operations.

In November of 2007, the CPC project was presented to Harris County voters in the form of a $195,000,000.00 bond election. The total estimated cost of the project was $245,000,000.00, with the County's cost at $213,000,000.00 and the City of Houston contributing $32,000,000.00 for the County to direct-book City prisoners. The new facility would have included a modern prisoner processing component designed to efficiently process up to 240,000 prisoners annually, two floors dedicated to the expansion of the HCSO's medical and mental health services, 2,500 more inmate housing beds, and dedicated space for female prisoners. The new facility would have met all City and County jail needs through the year 2025. Unfortunately, the CPC bond election was not approved by Harris County voters.

In June of 2008, Harris County developed a new CPC project plan that included four options for consideration, ranging in total cost from $171,000,000.00 to $256,000,000.00, including $38,000,000.00 from the City of Houston.[447] The CPC options included the original prisoner processing component, a reduced health services component, and approximately 993 to 2,193 jail beds. These CPC options remain under consideration by Harris County. Harris County and City of Houston officials together with the Harris County Sheriff's Office have been holding meetings and are still committed to this project.

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[447] The City's costs increased as a result of inflation, higher projected construction costs and other costs associated with the delay of the project as a result of the bond failure.

3. Prisoner Population Variances

Since July 2006, as the Harris County Jail's prisoner population grew, the HCSO has worked with the Texas Commission on Jail Standards to safely increase local housing capacity by adding temporary beds in the jail facilities.[448] The TCJS is charged with the reasonable enforcement of state-mandated minimum standards relating to the construction, equipment, maintenance, operation, personnel, programs, services and for the custody, care and treatment of inmates incarcerated in county facilities.[449] The TCJS is empowered to grant an application for a variance if the party filing an application for variance shows clear justification for the variance and it does not reasonably appear to the TCJS that the variance requested would permit or create unhealthy, unsanitary, or unsafe conditions or otherwise jeopardize the security or supervision of inmates or the programs and services required by law or rule of the commission.[450]

The TCJS has granted or, at times, partially granted the HCSO's requests for prisoner population-related variances in accordance with its determination that the HCSO was managing its prisoner population responsibly and that the approved variance would not permit or create unhealthy, unsanitary or unsafe conditions or otherwise jeopardize the security or supervision of inmates or the programs and services required by law or rule of the commission. In 2008, for example, the TCJS granted the HCSO a variance totaling 2,064 temporary beds. In August 2008, the HCSO voluntarily relinquished 224 varianced beds because the prisoner population numbers did not support the higher variance. This year, the TCJS reduced the variance to 1,612 beds.

To proactively safeguard internal safety and security, limit inmate crowding and reduce the potential for significant maintenance, sanitation and health issues, the HCSO, with the TCJS' approval, developed a strategy to safely deploy temporary beds by proportionally regulating them by jail facility and cellblock configuration. By spreading the temporary beds throughout the entire jail system, no one housing unit becomes overburdened.

The managed, safe deployment of these temporary beds has been in effect since 2006. The number of approved temporary beds has increased and decreased, sometimes at the HCSO's request and sometimes by order of the TCJS.[451] As of August 2009, the TCJS has authorized the HCSO to deploy up to 1,612 temporary beds (17% above design housing capacity) in the Harris County Jail system. These temporary beds may only be deployed in the following manner:

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[448] Prisoners have no constitutional right to an elevated bed. *Mann v. Smith,* 796 F.2d 79, 85-86 (5th Cir. 1986).

[449] 37 Tex. Admin. Code § 299.1 (citing Tex. Loc. Gov't Code § 351.001, *et seq.*; Tex. Gov't Code § 511.001, *et seq.*).

[450] 37 Tex. Admin. Code § 299.4.

[451] In May of 2009, for example, the TCJS eliminated 228 variance beds from the sixth and seventh floor of the 701 North San Jacinto Jail because of mechanical problems found with the intercoms on those floors during the TCJS's inspections. The HCSO repaired the intercoms and passed the TCJS' July 2009 surprise re-inspection of the jail facilities, but has not requested another variance for return of the 228 temporary beds.

TABLE #1: CURRENT VARIANCE (TEMPORARY BEDS) BY JAIL FACILITY

By Facility		
701 Jail	Variance Not To Exceed:	660 Inmates
1200 Jail (Housing)	Variance Not To Exceed:	888 Inmates
1307 Jail	Variance Not To Exceed:	50 Inmates
1200 Jail (Medical)	Variance Not To Exceed:	14 Inmates
Total		**1,612 Inmate beds**

TABLE #2: CURRENT VARIANCE (TEMPORARY BEDS) BY CELLBLOCK CONFIGURATION

By Cellblock	*Design Capacity*	*Approved Variance*
Dormitory Cells	48	+10
Dormitory Cells	24	+8
Single Occupancy Cellblocks	24	+8
Medical	108	+14

Although the HCSO currently has a variance totaling 1,612 beds, it deploys a considerably smaller number of these beds. For example, on August 5, 2009, the HCSO deployed a total of 839 temporary beds in the entire jail system. The HCSO uses the "float" (the difference between the total number of beds that are available for use system-wide and the number of beds that are actually used) to compensate as hundreds of inmates are booked into, and released from, the Harris County Jail system each day. The "float" essentially allows the HCSO Classification Section to safely adjust to variations in the size, makeup and movement of the jail population without ever exceeding the state-approved bed variance. The Classification Section keeps track of and reports actual bed usage each day to ensure that the HCSO does not exceed its facility-wide or cellblock-specific variances.

4. Transfers of Prisoners to Other Detention Facilities

Since 2007, Harris County has also transferred inmates to private contract jails in Louisiana. During the 2008 – 2009 fiscal year, Harris County expended $15,400,000.00 to house inmates in these private contract jail facilities.

In addition, Sheriff Garcia recently asked for Commissioners Court approval to enter into agreements with several Texas county jails to transfer and incarcerate Harris County jail inmates in those facilities, and to thus decrease Harris County Jail system prisoner population numbers, overtime costs and transportation costs. On August 11, 2009, the Harris County Commissioners

Court unanimously approved Sheriff Garcia's proposal and Harris County entered into interlocal agreements totaling $16,504,935.00 with Newton, Bowie, Dickens and Jefferson Counties.[452] It is expected that the Commissioners Court will, on August 25, 2009, approve additional interlocal agreements totaling $3,276,788.00 for that purpose with San Jacinto County and McLennan County.[453]

5. Allocation of Additional Funding for HCSO Employee Overtime

As previously stated, the Harris County Commissioners Court provided HCSO with an operating budget of $406,700,000.00 during the 2008 – 2009 fiscal year. Of that total budget, $234,100,000.00 is allotted to jail system operations. While the HCSO continues in its efforts to attract and hire qualified detention personnel. prisoner population numbers have required the expenditure of approximately $39,400,000.00 in employee overtime costs during the 2008 – 2009 fiscal year to meet TCJS-mandated staffing levels within the Jail. Meanwhile, the HCSO has continued its aggressive efforts to hire qualified detention personnel. Between January 1 and August 1 of this year, the HCSO hired a net total of 158 additional detention officers.[454]

6. Creation of a Public Defender Office

On April 8, 2008, at the request of Commissioner Lee, the Commissioners Court directed Management Services to study and make recommendations regarding the feasibility of establishing a Public Defender Office in Harris County. On September 18, 2008, at mid-year budget review, Management Services outlined, for the Commissioners Court, a potential phased-in approach in establishing a Public Defender Office, including the preparation of a proposed model that could be adapted upon receipt of outside organizations' proposals; the identification of members of a possible study team; later presentation by the study team of a recommended plan to Commissioners Court; public hearings; and adjustments, after the public hearings, to the plan. Commissioners Court anticipates that further action will be taken on the Public Defender Office plan on or about September 29, 2009, during mid-year budget review.

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[452] *See* Exhibits 1 ($6,538,610 interlocal agreement between Newton County, Texas and Harris County, Texas to detain, care and transport up to 872 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options), 2 ($4,106,250 interlocal agreement between Bowie County, Texas and Harris County, Texas to detain, care and transport up to 500 adult inmates from August 11, 2009 to February 28. 2010 with annual renewal options), 3 ($3,285,000 interlocal agreement between Dickens County. Texas and Harris County, Texas to detain, care and transport up to 400 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options) & 4 ($2,575,075 interlocal agreement between Jefferson County, Texas and Harris County, Texas to detain, care and transport up to 376 adult inmates from August 11, 2009 to February 28, 2010 with annual renewal options).

[453] It is expected that the Harris County Commissioners Court will, on August 25, 2009, approve a $574,875 interlocal agreement between San Jacinto County and Harris County. Texas to detain, care and transport up to 70 adult inmates from August 25, 2009 to February 28, 2010 with annual renewal options. It is expected that Commissioners Court will approve, on that same day, a $2,701,913 interlocal agreement between McLennan County and Harris County to detain, care and transport up to 329 adult inmates from August 25, 2009 to February 28, 2010 with annual renewal options.

[454] Between January 1, 2009 and August 1, 2009, the HCSO hired 229 detention officers. During that same time period, 71 detention officers left their employment with the HCSO.

7. Justice Management Institute's Study of the Local Criminal Justice System

In September, 2008, the Harris County Commissioners Court contracted with the Justice Management Institute (JMI) to conduct a study of the criminal justice system in Harris County and to make recommendations for improvements to the criminal justice system, including actions that could be taken to help reduce Harris County's prisoner population. In the first phase of its study, JMI sought to accomplish three goals, including: (1) the development of baseline information about the current situation and recent trends with respect to criminal justice system operations; (2) the identification of system strengths and key issues that warrant further investigation and possible development of alternative processes; and (3) the formulation of plans regarding further research and consideration of alternative processes that can improve justice system operations and reduce or contain the costs of system operations.[455] As part of its study, JMI explored possible ways to reduce the jail population to a level that would avoid the need for construction of new jail facilities or for continued outsourcing of jail inmates to privately run facilities outside Harris County.[456]

In February, 2009, the JMI team began its on-site work. On June 23, 2009, the Commissioners Court accepted JMI's study, entitled "Harris County Criminal Justice System Improvement Project – Preliminary Report."[457] The preliminary report acknowledged Harris County's strengths, including, for example, its "highly efficient" front-end case processing with initial stages of the pretrial process able to move quickly, allowing probable cause determinations to typically be made within twelve hours of arrest through the presence of an on-duty officer/magistrate.[458] According to JMI: "We know of no other urban criminal justice system that handles the early stages of cases more efficiently."[459]

JMI cited other strengths of Harris County's criminal justice system, including, for example; (1) well-established county-level institutions, including the courts, the District Clerk's Office, the District Attorney's Office, the defense bar, the Sheriff's Office, and the County Attorney's Office; (2) the District Attorney's highly efficient "around the clock" intake process; (3) the Pretrial Services Agency's excellent procedures for and job in gathering information about newly arrested persons which, among other things, is immediately and directly relevant to the courts' review of bond and pretrial release-related decisions; (4) the Medical Examiner's Office's highly experienced staff and nationally recognized forensic testing and other crime lab work; (5)

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455 *See* Exhibit 5 at 1 (JMI's June 17, 2009 preliminary report regarding the Harris County Criminal Justice System Improvement Project).

456 *See* Exhibit 5 at 2 (JMI's June 17, 2009 preliminary report regarding the Harris County Criminal Justice System Improvement Project).

457 *See* Exhibit 6 (Harris County Commissioners Court's June 23, 2009 Order).

458 *See* Exhibit 5 at 6.

459 *See* Exhibit 5 at 6.

the Harris County Commissioners Court's progress toward improvements in indigent defense services through the development of a Public Defender Office and in formulating plans for a specialized unit of qualified defense lawyers who could handle cases in the County Criminal Courts that involve defendants with indicated mental illness or mental retardation; (6) the availability to the courts and other system practitioners, through the Justice Information Management System ("JIMS"), of extensive, timely and reliable information regarding cases, defendants and caseloads; (7) the Administrative Offices of the County Criminal Courts at Law's and district courts' progress in developing a web-based system for obtaining and analyzing information regarding defendants, cases and overall caseloads; (8) the District Clerk's Office's significant strides in introducing new technology into the operations of that office; (9) progress made by the Community Supervision and Corrections Department in its capacity to supervise offenders using evidence-based practices; (10) criminal justice system leaders' openness to improvements in the operation of the criminal justice system; and (11) Harris County government's support for innovation and improvement of the criminal justice system.[460]

While the study acknowledged the County's many strengths, it set forth four major themes: (1) the over-reliance of society and the criminal justice system on the Jail as a resource for handling persons whose law-breaking is a result of substance abuse and/or mental illness; (2) the over-reliance on "costly and inefficient" paper-based records and "outdated" computer systems; (3) the lack of capacity for analyses of operations and performance necessary for justice system planning and resource allocation; and (4) the continuing need for coordination among interrelated county agencies involved in and affected by criminal justice processes.[461]

JMI made twenty-eight (28) recommendations for reducing the jail population and improving criminal justice processes.[462] JMI recommended, among other things, the establishment of a criminal justice coordinating council or similar entity with responsibility for policy development and oversight of improvement initiatives for the criminal justice system. JMI recommended that the council include the leaders of agencies involved in or affected by the County's criminal justice operations. JMI recommended that the Commissioners Court appoint a Criminal Justice Coordinator and establish a staff unit in support of the council for policy development, research and analyses of information for planning, budgeting and resource allocation.

On June 23, 2009, the Harris County Commissioners Court accepted JMI's report with recommendations for reductions in jail population involving improvement initiatives for the criminal justice system, and directed Management Services to prepare a suggested order for consideration at the Commissioners Court's July 14, 2009 meeting that would enable the County to begin moving forward on JMI's recommendations. .

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460 *See* Exhibit 5 at 6-8.

461 *See* Exhibit 5 at 2.

462 *See* Exhibit 5.

8. Creation of the Harris County Criminal Justice Coordinating Council

On July 14, 2009, in accordance with JMI's findings and recommendations, the Harris County Commissioners Court unanimously voted to create the Harris County Criminal Justice Coordinating Council ("CJC" or "Council"), composed of eleven (11) elected officials: the District Attorney, District Clerk, Sheriff, County Attorney, Administrative Judge of the District Courts, Administrative Judge of the Criminal Trial Division of the District Courts, Presiding Judge of the County Criminal Courts, Presiding Judge of the sixteen (16) Justices of the Peace Courts, a Constable to represent the eight constables, and two members of Commissioners Court.[463] The Commissioners Court designated the Council as the focal point for efforts to improve the criminal justice system and seek reductions in the Harris County Jail prisoner population.

The Harris County Commissioners Court also created the Office of Criminal Justice Coordination ("OCJC"),[464] and directed the OCJC to support the Council in policy development, research, and analyses of information for planning, budgeting, and resource allocation.[465]

On July 28, 2009, the Commissioners Court unanimously ordered that Commissioners El Franco Lee and Sylvia Garcia be designated for service on the Council.[466] On August 20, 2009, the Council held its first meeting, chaired by Commissioner Lee. Barry Mahoney, the President of JMI, reviewed the JMI report and recommendations with Council members, including Harris County Constable (Precinct 1) Jack Abercia (representing the eight Constables), Harris County Justice of the Peace (Precinct 2, Place 1) Jo Ann Delgado (representing the sixteen Justices of the Peace), Harris County Sheriff Adrian Garcia, Harris County Commissioner Sylvia Garcia, Judge Joseph ("Tad") Halbach (Administrative Judge of the Civil District Courts), Judge Jean Hughes (Presiding Judge of the Harris County County Criminal Courts), Harris County District Clerk Loren Jackson, Harris County Commissioner El Franco Lee, Harris County District Attorney Pat Lykos, Harris County Attorney Vince Ryan and Judge Debbie Mantooth Stricklin (Administrative Judge of the Criminal District Courts). The Committee established its working committees and priorities. It is expected that reducing the jail population will be the Council's highest priority.[467]

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[463] *See* Exhibit 7 (Harris County Commissioners Court's July 14, 2009 Order).

[464] *See* Exhibit 7. The Commissioners Court designated former Harris County Criminal District Judge Caprice Cosper as the director of the OCJC, and designated Clarissa Stephens as the Deputy Director of the OCJC.

[465] *See* Exhibit 7.

[466] *Exhibit 8* (Commissioners Court's July 28, 2009 Order).

[467] *Exhibit 9* (Harris County Criminal Justice Coordinating Council's August 20, 2009 Agenda with attachments).

9. Sheriff Garcia's Enhancements to the HCSO's Internal Classification System

In February 2009, Sheriff Adrian Garcia initiated an internal study to identify improvements that could be made to help reduce the prisoner population in the Harris County Jail. That research revealed that over 1,100 temporary beds were being used in the high-security jails, while more than 350 beds at the minimum security jails were being underutilized. This study concluded that improvements in the state-approved inmate classification system would allow the HCSO to safely identify more minimum security inmates and optimize cellblock usage throughout the entire jail system. To that end, the study recommended allowing the HCSO to more thoroughly consider the severity of each inmate's out-of-county detainers and cases before raising the inmate's custody risk-level. In May 2009, Sheriff Garcia proposed these classification improvements to the TCJS. In June 2009, the HCSO obtained state-approval to implement the proposed changes. As of August 19, 2009, the number of inmates classified as minimum security in the jail system had grown from 1,851 to 2,746. The safe identification of many more minimum security inmates has allowed the HCSO to recapture the use of more than 350 previously under-utilized minimum-security inmate beds and, by diverting more inmates to the minimum security jails, helped reduce crowding in the higher-security jails. Through its internal classification system, the HCSO continues to proactively manage the inmate population to safely optimize bunk usage and reduce jail crowding.

10. District Attorney Patricia Lykos' Institution of Direct Intervention using Voluntary Education Restitution and Treatment Program

On August 1, 2009, Harris County District Attorney Patricia Lykos instituted a new Direct Intervention using Voluntary Education Restitution and Treatment ("DIVERT") program. The DIVERT program is intended to add to the exceptional efforts already underway in the Harris County community to reduce the incidents of intoxicated drivers and the devastating loss of lives of innocent members of the community as a result of the automobile crashes that are occurring at an alarming rate.

In reviewing DWI disposition statistics over the past eight years, it was observed that the percentage of defendants receiving court-supervised treatment dropped from forty-five (45%) percent in 2000 to twenty-two (22%) in 2007. Knowing that eighty (80%) percent of defendants who receive treatment do not return, it was obvious that the reduction of treatment of first offender DWI defendants was counterproductive to the goal of reducing DWI recidivism.

The Harris County District Attorney's DIVERT constitutes the postponement of prosecution in first offender Class B Misdemeanor DWI cases. Upon any person qualified as being eligible for the program, subject to the successful completion of treatment conditions imposed, based upon a thorough evaluation of the defendant, the offense may ultimately be expunged from the defendant's criminal history. The potential of expunction has served as the motivation for a greater percentage of first offender DWI defendants to received treatment, thereby increasing the expectation of their not committing future DWI offenses in the future. The time period of

supervision shall not exceed two years. All fees and costs are paid by the participant and no participant will be excluded for inability to pay fees or costs.

DIVERT is designed to: (1) reduce the instance of repeat arrest for driving while intoxicated through mandatory evidence based treatment and supervision; (2) raise community awareness of consequences of Driving While Intoxicated; (3) minimize court appearances during the disposition period; (4) impose conditions based upon the evaluation of each offender; (5) afford the Defendants the opportunity to accept responsibility for their conduct; and (6) assure supervision criteria uniformly applied to all Defendants; and (7) impact the jail overcrowding issue by reducing recidivism; and by recommending PTR bonds for any defendant in jail who qualifies for the program.

11. Harris County's Development of Veteran's Court

The Veterans Administration and the Success through Addiction Recovery ("Star") Court have been working cooperatively to establish a "Veterans Court" in October of 2009 that will begin accepting and attempting to divert nonviolent offenders who have a military background from the courts and, concomitantly, the Harris County Jail facilities. It is anticipated that Veterans Court will function much like a Star Court. The STAR program provides treatment and individualized supervision as an alternative to incarceration. Such programs are more cost effective than traditional incarceration, because they help to reduce recidivism.

C. Contrary to the Civil Rights Division's allegations, violence does not "break out frequently" in the Harris County Jail system.

According to the Civil Rights Division:

> Jail crowding affects multiple Jail systems. For instance, it impedes detainee access to medical care, indirectly affects detainee hygiene, and reduces the staff's ability to supervise detainees in a safe manner. How the Jail handles inmate supervision and violence illustrates some of the complexities associated with overcrowding. The Jail has already adopted a number of useful strategies for dealing with detainees who are dangerous to themselves or others. These strategies include an objective classification process for deciding where to house detainees and contracts with outside facilities to handle crowding pressure. Despite such strategies; the Jail is so large, violence still breaks out frequently. In one recent ten month period, the Jail reported over 3000 fights, and 17 reported sexual assaults. Also, as discussed above in the mental health section of this letter, the Jail has had particular difficulty managing violent detainees with behavioral and mental health issues. Because crowding makes it difficult to supervise detainees and prevent violence, additional Jail staffing or more jail diversion programs could reduce the risk of detainees coming to harm in the facility.[468]

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[468] Letter from Loretta King to Ed Emmett, *supra* note 3, at 17 para. 2 (June 4, 2009).

Harris County agrees that the HCSO has adopted a number of useful strategies designed for the purpose of dealing with inmates who are dangerous to themselves or others, including the strategies referenced above. Harris County objects to and denies the balance of the allegations in this paragraph of the Civil Rights Division's letter. The allegations are ambiguous, conclusory, speculative, inaccurate and without foundation. In addition, the allegation that the Jail "reported over 3000 fights and 17 reported sexual assaults" in "one recent time period" does not specify the relevant time period or the report from which the allegations are drawn.

Harris County denies that "violence breaks out frequently" in the Harris County Jail system. This claim is not supported by any evidence and, as discussed above, is contradicted by the DOJ's own National Institute of Corrections technical consultants. Harris County denies that the HCSO reported 3000 fights during the unspecified "recent ten month period" noted by the Civil Rights Division. The Division's conclusion (that "violence still breaks out frequently" in the jail) is not supported by their vague allegation that "[i]n one recent ten month period, the Jail reported over 3000 fights." The Division failed to fairly review the underlying incidents that were categorized under the "fights" column of the report from which they drew the 3000 number. The Division, for example, failed to review the nature and severity of the altercations, whether any weapons were involved in the altercation, and whether (and to what extent) any injuries were sustained in the altercation. The Division also misinterpreted the report from which they took the 3,000 number. The report included the number of inmates charged with violating the jail rule against fighting, not the number of fights. Since at least two inmates would have participated in each altercation, there were at most 1,500 altercations over the ten-month time period (during which approximately 110,000 inmates were received at the Harris County Jail system). Statistically, very few inmates are involved in fights in the Harris County Jail facilities.

Harris County also objects to the Civil Rights Division's reference to "17 reported sexual assaults" over the same unspecified ten month period to support their conclusion that "violence breaks out frequently" in the Harris County Jail system. The Division's citation to the 17 reported sexual assaults does not support the proposition for which it was asserted—that violence must break out frequently in the jail because 17 reports of sexual assault were made. A report does not constitute a committed act. Had the Division inquired as to the results of the investigations of the 17 reported sexual assaults, that inquiry would have revealed that there were not 17 *substantiated* sexual assaults over that unspecified ten-month period (during which approximately 110,000 inmates were received in the jail facilities). In 2008, for example, twelve inmates (out of the 134,000 prisoners received in the jail facilities in 2008) reported inmate-on-inmate non-consensual sexual acts. All outcries of sexual misconduct or assault are investigated in accordance with HCSO policy. Of the twelve reported 2008 incidents, one was substantiated, four were unsubstantiated and seven were determined to be unfounded after investigation. Statistically, an infinitesimal number of inmates are involved in inmate-on-inmate non-consensual sexual acts.

The Division alleges that "[t]he Jail has had particular difficulty managing violent detainees with behavioral and mental health issues." As stated above, Harris County has been extremely proactive in its response to the challenge of managing the care of "violent detainees with behavioral and mental health issues." The interjection of the Mental Health Unit ("MHU")

officers, whether through the deployment of the CIRT or through the ongoing supervision of MHU officers in the medical/mental health clinic and the medical/mental health infirmary units, was expressly designed to more appropriately manage detainees with mental health issues. In addition, the development of a more diverse range of housing options for prisoners with mental illness has lead to more appropriate housing environments which in turn has lead to more appropriate management of behavior. Finally, the development of 2P (which was remodeled at a cost of approximately $800,000.00), including the Cognitive Behavioral Therapy unit, was designed specifically to help manage the behavior of detainees with behavioral and/or mental health issues.

The Civil Rights Division asserts that "[b]ecause crowding makes it difficult to supervise detainees and prevent violence, additional Jail staffing or more jail diversion programs could reduce the risk of detainees coming to harm in the facility." The Division does not explain what it means by "additional Jail staffing or more jail diversion programs." The HCSO's staffing and supervision programs meet constitutional standards relating to the supervision of inmates in jail facilities. The HCSO's staffing ratios have been approved by the TCJS,[469] and have been produced to the Division. The HCSO's personal observation and supervision of inmates exceeds the minimum requirements set forth by the State of Texas.[470] In any event, there is no evidence of any pattern of incidents which are causally linked to the prisoner population numbers in the Harris County Jail system. The Division has not alleged or shown that Harris County or any person acting on behalf of Harris County, is subjecting significant numbers of Harris County Jail inmates to "egregious or flagrant conditions" which deprive such inmates of their Constitutional rights, causing such inmates to suffer grievous harm, all pursuant to a pattern or practice of resistance to the inmates' enjoyment of their constitutional rights.

D. Contrary to the Civil Rights Division's allegations, the HCSO does not have only "limited options to address violence and other serious incidents" and is not compelled to "rely heavily on more cumbersome criminal prosecutions to deal with violent incidents."

According to the Civil Rights Division:

> Managing a large population is a complex problem, and requires both short-term administrative approaches and long-term strategies. *For instance, changes to administrative processes and better technology can help alleviate violence and supervision problems associated with crowding. The Jail staff have limited options to address violence and other serious incidents through internal administrative and supervisory mechanisms. At the time of our tour, the Jail did not have the ability to routinely investigate violent incidents. Instead, the Jail staff had to rely heavily on more cumbersome criminal prosecutions to deal with such incidents.* In such a large facility, criminal prosecutions may not be a sufficient deterrent to violence. *More structured administrative procedures for*

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469 *See* 37 Tex. Admin. Code § 275.4.

470 *See* 37 Tex. Admin. Code § 275.1.

reviewing incidents, identifying dangerous inmates, and correcting hazardous situations are needed.[471]

Harris County objects to and denies the conclusory, speculative, unsupported and utterly baseless allegations made by the Civil Rights Division advocates in each italicized sentence of this paragraph of their June 4, 2009 letter. The Division labels incidents involving inmates as "violent" without articulating the support required under CRIPA's notification provisions. The Division has provided Harris County with no relevant time period, no incidents and no specifics. What "violent" incidents are the Division advocates talking about? Here, as in every paragraph of this section of the Division's letter, the Division advocates don't cite even one failure-to-protect incident allegedly arising as a result of prisoner population numbers. Here, as in every paragraph of this section of the Division's letter, the Division advocates allege no specific constitutional violations, no egregious or flagrant violations of a significant number of inmates' constitutional rights, no serious harm to a significant number of inmates (or even one inmate) resulting from constitutional violations, and no pattern or practice of resistance to the protection of inmates' constitutional rights.

The HCSO's Internal Affairs Division investigates major incidents in the jail facilities. Since Sheriff Garcia took office, he substantially increased the staff in his Internal Affairs/Office of Inspector General Bureau. Contrary to the conclusory allegations made by the Civil Rights Division, only 201 of the 25,087 internal disciplinary cases submitted to the HCSO's Disciplinary Committee in 2008 were serious enough to be referred to the Harris County District Attorney's Office for possible prosecution. Less than one percent (0.008%) of the 2008 internal disciplinary cases were referred to the District Attorney's Office for possible criminal prosecution.

There are good reasons for the low number of referrals for state prosecution. The overwhelming majority of the internal disciplinary cases only involved simple jail rule violations, rather than potential criminal law violations. The HCSO has a detailed, comprehensive state-approved "Inmate Disciplinary Plan" governing the conduct and review of the conduct of inmates under the Sheriff's care, custody and control.[472] The Plan is a management tool providing a means of governing the conduct of inmates and providing clear and exclusive procedures for staff members to follow for the discipline of inmates. The Plan provides for the firm, fair and consistent application of jail rules and regulations, which are published in the Inmate Handbook and provided to each inmate during the booking process.[473] The HCSO has guidelines for inmate conduct which allows for the generation of inmate offense reports, administrative hearings to provide due process and, when applicable, imposition of sanctions relating to minor and major infractions of jail rules. Information regarding significant incidents involving prisoners is communicated through the use of pass-on books and "Significant Events Bulletins."[474] In

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471 Letter from Loretta King to Ed Emmett, *supra* note 3, at 17 para. 3 (June 4, 2009) (emphasis added).

472 *See* 37 Tex. Admin. Code § 283.1 ("Inmate Disciplinary Plan").

473 *See* 37 Tex. Admin. Code § 283.2 ("Inmate Rules and Regulations).

474 *See e.g.*, Bates 14,251 (Significant Events Bulletin policy).

addition, monthly and yearly statistics are generated regarding trends in inmate behavior.[475] The HCSO's Disciplinary personnel work closely with Classification for the purpose of identifying inmates who are prone to anti-social or violent behavior and who require specialized, protective or exclusionary housing. The HCSO's Disruptive Groups Unit ("DGU") also identifies gang members in the jail so that appropriate decisions regarding housing can be made.

E. Contrary to the Civil Rights Division's allegations, the HCSO has procedures in place to distinguish between disturbances caused by prisoners with mental illness and disturbances caused by others.

According to the Civil Rights Division:

> *The Jail also did not have procedures in place that could more appropriately distinguish between disturbances caused by detainees with mental illness and other detainees.* The response to the former often needs to be more nuanced in order to avoid exacerbating the detainees' mental illnesses and to ensure fairness. *Instead of referring detainees for structured treatment, the Jail staff instead often have to rely on placing detainees with mental illness in isolation.* Isolation can actually make a detainee with mental illness worse and is not as therapeutic as a properly designed, dedicated treatment unit.[476]

Harris County objects to and denies each of the highlighted allegations made by the Civil Rights Division in this paragraph of their June 4, 2009 letter. The Division again failed to support their allegations with the support statutorily required by CRIPA's Section 1997b(a)(1) notification provisions.

Harris County denies the Civil Rights Division's ambiguous, conclusory and baseless claim that "[t]he Jail also did not have procedures in place that could more appropriately distinguish between disturbances caused by inmates with mental illness and other detainees." All personnel assigned to the Mental Health Unit must take a forty hour "Mental Health Officer Course." That course is open to all employees of the HCSO, and many employees outside the Mental Health Unit have taken advantage of the opportunity to take that course.

In accordance with state law, the HCSO requires all of its licensed peace officers to complete a sixteen hour statewide education and training program on de-escalation and crisis intervention techniques to facilitate interactions with persons with mental impairments.[477] Although the State imposes no Crisis Intervention Training ("CIT")-related training requirements upon detention officers, the HCSO requires all Detention personnel, including licensed peace officers and detention officers, to take a twenty-four hour CIT course. This training assists officers in identifying inmates who have intellectual disabilities and teaches the officers techniques leading

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[475] These statistics track events, not the number of inmates charged.

[476] Letter from Loretta King to Ed Emmett, *supra* note 3, at 17 para. 3, at 18 para. 1 (June 4, 2009) (emphasis added).

[477] *See* Tex. Occ. Code § 1701.253(j).

to more rapid and successful de-escalation during disturbances and confrontations involving these inmates.[478]

The HCSO has established standard operating procedures designed to ensure that all Detention employees have a working knowledge of the mental health resources available for utilization in making certain all inmates afflicted with mental illness in the custody of the HCSO are treated appropriately and professionally, and all mental health issues are addressed by a mental health provider and/or specialist in a timely fashion.[479]

All personnel are responsible to observe each inmate in custody for symptoms commonly experienced by persons with mental illness. Personnel are taught that professionalism, respect, reassurance, calm and directness are necessary attributes for stabilizing mental health crises. They are taught that a hostile and disrespectful approach toward a person in mental health crisis often exacerbates the crisis and elicits a mutual response. They are taught to maintain on-going, direct communication with the inmate and to refrain from engaging in extraneous conversations with others, especially conversations which could be construed as disparaging, demeaning or ridiculing. They are taught to refrain from trickery and deception. They are taught to avoid using unnecessary intimidation or threatening gestures. They are taught that crowding an excessive number of personnel around the inmate may elicit an adverse, defensive and possibly assaultive response. They are taught to always maintain a reasonably safe distance, to avoid touching the inmate unless necessary, and to remove all objects which the inmate could use to harm him/herself or others. They are taught to use one primary communicator with whom the most favorable rapport can be established.[480]

The Mental Health Unit-Crisis Intervention Team ("MHU-C.I.R.T.") is available for call-out throughout the Jail Commands when specific criteria are present indicating that an inmate mental health crisis exists. The Crisis Intervention Response Team is called out when a serious situation involving an inmate exhibiting abnormal behavior or behaviors believed to be symptomatic of a mental illness: (1) appears likely to result in imminent bodily harm to any person; (2) is not diffusible by way of verbal efforts of on-scene Detention housing personnel; (3) is approaching, but has not yet reached a threshold necessitating the immediate use of physical force; and (4) time permits for the deployment and arrival of MHU-C.I.R.T. personnel.[481]

When C.I.R.T. personnel arrive on the scene, detention personnel are required (among other things) to: (1) clear the area of other inmates to the extent possible; (2) ensure the area is free of any loose objects that could be used by the inmate as a weapon; (3) ensure that an unobstructed

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478 Mental Health Unit and medical security personnel qualify for incentive pay by completing, among other requirements, a twenty-four hour course in Intermediate Crisis Intervention, a forty hour Mental Health Peace Officer Certification course, an eight hour course in Suicide Detection and Prevention in Jail, a sixteen hour course in Use of Force in a Jail Setting, and a twenty-four hour course in "Mandt System: Conceptual/Relational" theory.

479 *E.g.*, Bates 14,147-14,154.

480 *E.g.*, Bates 14,148.

481 Bates 14,147.

route remains available for personnel to quickly exit the area of intervention should it become necessary to do so; (4) temporarily relinquish jurisdiction of the scene to allow MHU personnel to employ mental health crisis intervention strategies; (5) maintain a physical presence at a distance sufficient to allow for semi-private dialogue between the inmate and MHU-C.I.R.T. personnel, while not compromising detention personnel's ability to physically respond should it become necessary to do so; (6) allow MHU-C.I.R.T. personnel to conduct de-escalation and stabilization strategies without unnecessary verbal and non-verbal interruptions; (7) provide assistance to MHU-C.I.R.T. personnel when requested and/or necessary; (8) maintain the safety and security of all persons in the immediate area within and around the location of intervention; (9) and following successful mental health crisis intervention and MHU-C.I.R.T.'s departure, continue to follow recommended CIT protocols to avoid and/or minimize the potential for reoccurring mental health crises.[482]

After any MHU-C.I.R.T. intervention, the team provides an assessment of the outcome, circumstances, available options and recommendations to detention personnel.[483]

Another tool employed by the HCSO's jail staff that benefits inmates with possible mental health issues is the "Referral for Psychiatric Screening." Personnel who observe behavior indicative of a mental health issue are required to document the conduct observed on an In-house report and a "Referral for Psychiatric Screening" and to submit such reports to the on-duty watch commander, Classification, disciplinary, the clinic and to the Mental Health Unit.[484]

When completing Inmate Offense Reports ("IOR"), personnel also note possible mental health issues on the IOR itself. When an inmate is referred to the HCSO's Disciplinary Committee for review of alleged administrative violations of the Inmate Handbook, the Disciplinary Committee receives a copy of the IOR, which essentially functions as a charging document. When performing its review of administrative charges, the Disciplinary Committee considers the possible need for Mental Health Unit ("MHU") intervention. In addition, the Disciplinary Committee uses a HCSO computer system that tracks whether the inmate appearing before the Committee has had any previous MHU interventions. This allows the Disciplinary Committee to remain apprised of these inmates' backgrounds and, to the extent sanctions are appropriate under the circumstances, to formulate fair, balanced and objective sanctions. When reviewing administrative disciplinary charges lodged against an inmate, the Disciplinary Committee routinely dismisses or gives special consideration to inmates who are identified as having mental health issues.

Harris County also denies the Civil Rights Division's conclusory allegation that "[i]nstead of referring detainees for structured treatment, the Jail staff instead often have to rely on placing detainees with mental illness in isolation." Citation of specific instances would be helpful to allow review of the specific situation. Harris County presumes that when the Division refers to

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482 *E.g.*, Bates 14,154.

483 *E.g.*, Bates 14,152.

484 *E.g.*. Bates 14,149-50.

"isolation," they are referring to administrative separation, rather than the use of a clinical seclusion cell as ordered by a psychiatrist on a time-limited basis.

As mentioned above, mental health professionals regularly evaluate all detainees in administrative separation as per NCCHC standards.[485] The Division's letter ignores the fact that the HCSO proactively developed the Mental Health Unit so that security staff with mental health training would be available not only to provide security in the medical and mental health clinic and housing areas but also provide (through the Crisis Intervention Response Team) an opportunity for assessment of "disturbances" from both security and mental health perspectives. The MHU process was designed specifically to "avoid exacerbating the detainees' mental illnesses." The use of isolation cells in the mental health units is strictly controlled: admission to the cells is only upon physician order, documented nursing monitoring of patients is required, release from seclusion is required once a behavioral target is achieved. continuation of the seclusion beyond four hours must be ordered by a physician and continuation of the seclusion beyond eight hours must be ordered by a physician after a face-to-face evaluation. Each use of seclusion is monitored by the MHMRA Utilization Review Manager and by the HCSO Mental Health Quality Improvement Coordinator. Use of seclusion cells is reported at the regular Quality Improvement Committee meetings. Review of psychiatrist orders and justification for seclusion is provided by the MHMRA Medical Director and Forensic Lead Psychiatrist.

F. Contrary to the Civil Rights Division's allegations, the HCSO staff exercises control over contraband.

According to the Civil Rights Division:

> Other administrative deficiencies include a lack of staff control over hazardous contraband (e.g., detainee razors) ...[486]

Harris County objects to and denies this ambiguous, conclusory allegation, which was made without the support mandated by CRIPA's Section 1997b(a)(1) notification provisions.

State standards require the HCSO to provide indigent inmates with shaving implements.[487] Prior to the Civil Rights Division's July and August, 2008, inspections of the Harris County Jail system, the HCSO issued disposable shaving razors to the inmates upon intake and sold disposable razors in commissary. Although there is no constitutional or statutory prohibition against the sale of disposable razors to or the possession of such razors by inmates, Civil Rights Division sanitation consultant Leonard Rice recommended against these practices. Notwithstanding the lack of any pattern of incidents that would fairly support the conclusion that the HCSO "lacks control" over razors, the HCSO stopped selling razors to inmates and implemented a time consuming and costly new razor procedure in accordance with Mr. Rice's

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485 *See* JE-09, "Segregated Inmates," 2008 NCCHC Standards for Health Services in Jails.

486 Letter from Loretta King to Ed Emmett, *supra* note 3, at 18 para. 1 (June 4, 2009).

487 *See* 37 Tex. Admin. Code § 277.4 ("Personal Hygiene").

recommendation. Harris County now purchases all razors, distributes them to inmates on a regular basis, collects the razors approximately two hours after delivery, accounts for each razor, examines the condition of each razor to determine whether any razor blade is missing and disposes of the razors as biohazard waste products, all at great cost to the Harris County taxpayers.[488] The HCSO reported this change in its policies and procedures to the Civil Rights Division advocates on January 9, 2009, but the Division advocates failed to make any mention of this fact in their June 4, 2009 letter.[489]

In accordance with TCJS' minimum jail standards, HCSO personnel search items brought into the security perimeter of the Harris County jail facilities for contraband. HCSO personnel search inmates who leave the security perimeter of the jail facilities for contraband before the inmates reenter the security perimeter. HCSO personnel conduct regular and irregular searches of the jail facilities. These searches are timed so that they cannot be anticipated by the inmates, and are all conducted for the purpose of protecting HSO Detention personnel and the inmates incarcerated in the Harris County Jail system.[490] It must also be noted that during the course of the Civil Rights Division's July and August 2008 inspections, Manuel Romero, the Division's corrections consultant, complimented the HCSO on its search procedures.

G. Contrary to the Civil Rights Division's allegations, the HCSO maintains a disciplinary process that protects witness confidentiality.

According to the Civil Rights Division:

> Other administrative deficiencies include ... a disciplinary process that lacks safeguards to protect witness confidentiality.[491]

What does the Civil Rights Division mean by their general allegation that the HCSO's disciplinary process "lacks safeguards to protect witness confidentiality"? Harris County objects to and denies this conclusory allegation, which was made without the support mandated by CRIPA's Section 1997b(a)(1) notification provisions and which has never previously been raised as a concern by either the Civil Rights Division or its consultants.

Contrary to the Civil Rights Division's allegation, the HCSO's disciplinary process provides safeguards to protect witness confidentiality. In accordance with the State's regulatory scheme,[492] the HCSO's Systems Plan provides for the disclosure of evidence against inmates

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488 Bates 31,357, 31,317-80.

489 Bates 31,323 (summary of razor policy and procedures), 31,357-59 ("Razor Distribution Policy"), 31,361 ("Razor Distribution Flowchart"), 31,363 (Inmate Razor Distribution Notification), 31,365-66 (Razor distribution forms).

490 *See* 37 Tex. Admin. Code § 275.6 ("Searches for Contraband").

491 Letter from Loretta King to Ed Emmett, *supra* note 3, at 18 para. 1 (June 4, 2009).

492 See 37 Tex. Admin. Code § 283.1(3)(E) ("[P]rovisions shall be made for the disclosure of the evidence against the person charged with the violation, *although confidential informants may be protected.*") (emphasis added).

charged with violations of the Harris County Jail system rules governing inmate conduct.[493] Confidential informants may be protected in accordance with this same statutory scheme.[494] Although statements from inmates witnessing alleged violations are commonly read to or summarized for the accused inmate during internal disciplinary hearings, the names of the inmates making these statements are not revealed to the accused. To that end, Section V(C)(2)(e) of the Inmate Discipline Plan expressly explains that disciplinary hearings are an administrative process and that inmates have no right to cross examine or confront witnesses and/or their accuser.

Provisions are also made for administratively charged inmates to be heard in person and to present documentary defensive evidence and witnesses on his or her own behalf when not unduly hazardous to institutional safety and security goals.[495]

The Civil Rights Division's allegations regarding the inmate disciplinary system are inconsistent with the DOJ's own NIC technical consultants' findings:

> One method used by jail experts to determine the relative quality of jail management is what process[es] are in place to ensure that inmates can communicate with the supervision and management of the facility. This inmate grievance process is an excellent way for managers to assess the health of the jail. Inmates who grieve a particular process or individual within the jail may provide the manager with warning that these process or individuals need to be reviewed.
>
> Similarly, the issue of inmate discipline reveals the degree of due process afforded. Where inmates believe that the process is fair and impartial, they are more likely to [be] more easily supervised.
>
> The [DOJ's NIC consultants] have seen few jail systems that have as good of an inmate disciplinary system as Harris County Sheriff's Office. Inmates who have administrative action imposed upon them for violating the jail's rules are afforded significant "due process" before the sanctions are applied. This system utilizes a room, not unlike a court room, to hear the defense of the inmates, together with any witnesses that the inmate may produce. A lieutenant serves as the hearing officer and their decision may be appealed up to the Detention Bureau Commander whose decision is final. Significantly, the lessons learned from this process are also used in the training of custody staff.[496]

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493 *See* Bates 14,964, 14,966 & 15,019-20 (HCSO's Detention Command's Systems Plan).

494 *See* Bates 14,964, 14,966 & 15,019-20 (HCSO's Detention Command's Systems Plan). *See, e.g.*, Bates 12,911 (Inmate Handbook) ("Provisions shall be made for the disclosure of the evidence against the person charged with the violation, although confidential informants may be protected.").

495 *See* Bates 14,964, 14,966 & 15,019 (HCSO's Detention Command's Systems Plan). *See also* TEX. ADMIN. CODE § 283.1(3)(F) & (G).

496 *See* Exhibit 1 (DOJ's NIC's July 2, 2009 Jail Systems Assessment) at 24.

The Civil Rights Division's allegations are also inconsistent with the compliments made about the HCSO's disciplinary process by the Division's own corrections consultant, Mr. Romero, during the July/August 2008 inspections and the brief-out held at the end of the inspections.

H. Contrary to the Civil Rights Division's allegations, physical plant and technology issues do not affect Jail staff's ability to provide constitutionally adequate supervision in the Harris County Jail system.

According to the Civil Rights Division:

> Similarly, physical plant and technology issues affect the Jail staff's ability to supervise housing areas. The four main facilities do not have video surveillance in critical areas. The satellite facilities also lack adequate video surveillance.[497]

Harris County objects to and denies the vague, conclusory and unsupported allegations in this paragraph of the Civil Rights Division's letter. It is not clear what the Division means by "physical plant and technology issues." Video surveillance only? If so, video surveillance in what "critical areas"?

Video surveillance is neither required by the United States Constitution nor State law.[498] In fact, the Texas Legislature extensively studied then declined to enact any state-imposed video requirement applicable to Texas county jails.[499] The State of Texas requires that jail facilities "shall have an established procedure for visual, face-to-face observation of all inmates by corrections officers at least once every hour" and that "[o]bservation shall be performed at least every 30 minutes in areas where inmates known to be assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior are confined."[500]

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[497] Letter from Loretta King to Ed Emmett, *supra* note 3, at 18 para. 1 (June 4, 2009).

[498] It does not appear that the Civil Rights Division is arguing that video surveillance is constitutionally required. If the Division is making this argument, it has failed to justify it with the support required by CRIPA's notification provision. If the Division is making this argument, it has also failed to connect the lack of video surveillance to any constitutional violation, let alone egregious and flagrant violations of significant numbers of inmates' constitutional rights, causing significant numbers of inmates to suffer grievous harm, all pursuant to a pattern or practice of resistance to those inmates' constitutional rights.

[499] The Texas legislature directed the TCJS to study and report to the legislature the feasibility of installing and operating in county jails video camera surveillance systems that would record images in each jail corridor, solitary confinement cell, suicide watch cell, kitchen and dining area and other common areas of the jails. Tex. Loc. Gov't Code § 351.106. After the TCJS completed its study and submitted its report to the legislature, Section 351.016 expired of its own terms, and the legislature imposed no surveillance requirements upon Texas counties.

[500] 37 Tex. Admin. Code § 275.1 ("Regular Observation by Corrections Officers"). *See also* Tex. Admin. Code § 275.4 ("Staff"). "Closed circuit television may be used, but not in lieu of the required personal observation." 37 Tex. Admin. Code § 275.1 ("Regular Observation by Corrections Officers"). Video surveillance is conducted in the HCSO's Inmate Processing Center.

When considering the need for additional video surveillance, Harris County agrees that it is important to consider the design of the physical plant. Physical plant and technology issues do not affect Jail staff's ability to provide constitutionally adequate supervision in the Harris County Jail system. In accordance with State law, the HCSO has established procedures for visual, face-to-face personal observation of the inmates who are incarcerated in the Harris County Jail system. Officers monitor detainees in accordance with Texas law during the short time periods detainees are held at the substations. The downtown jail facilities are designed so that jail staff assigned to the housing units actually view directly into the housing cellblocks (direct observation). HCSO personnel are either in the cellblocks or in duty stations a few feet away from inmates, directly observing and supervising inmates in accordance with Texas law.

The Harris County Jail system already possesses extensive video surveillance in numerous areas. In addition, the HCSO upgraded the video surveillance system at the Inmate Processing Center in 2005. The IPC video is now digitally recorded and stored. The Harris County Sheriff's Office is also in the process of upgrading the security system at the 701 N. San Jacinto Jail. The contract has already been awarded and the contractor has staff on site conducting preliminary work. The HCSO anticipates that during or around April of 2010, the HCSO will begin shutting down one floor, or half a floor, at a time so that work inside the cellblocks can be completed by the contractor. This upgrade will include a new intercom system and video surveillance system consisting of 355 cameras located throughout the building. The cameras will be digitally recorded to the Sheriff's Office server.

X. Harris County provides constitutionally adequate sanitation and fire and life safety for the benefit of inmates incarcerated in the Harris County Jail system.[501]

Harris County objects to the "Sanitation and Life Safety" section of the Civil Rights Division's letter because the Division failed to satisfy CRIPA's notification requirements.[502] The Division likewise failed to come forward with any proof that Harris County or any Harris County official or employee subjected significant numbers of HCJ inmates to "egregious or flagrant conditions" which deprived significant numbers of inmates of their constitutional rights, causing them to suffer grievous harm.[503] The Division further failed to show any alleged pattern or practice of institutional abuse and resistance to a substantial number of Harris County Jail inmates' constitutional rights.[504]

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501 As previously stated, although the DOJ's Civil Rights Division has repeatedly affirmed its commitment to a transparent and even-handed investigation, it has thus far declined to provide Harris County with its consultants' reports completed after inspection of the Harris County jail facilities. Without Civil Rights Division consultant Leonard Rice's report, Harris County cannot reasonably determine which, or to what extent, the Civil Rights Division's sanitation and life safety-related findings and proposed remedial measures are based upon Mr. Rice's personal observations and recommendations, and which, and to what extent, the findings and proposed remedial measures reflect the Civil Rights Division's advocacy.

502 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997b(a)(1) (1996).

503 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

504 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 3-14. *Contra* 42 U.S.C. § 1997a(a) (1996).

A. Constitutional framework

The Constitution does not require that inmates be housed in comfortable detention facilities, but does require that inmates be afforded "humane conditions of confinement."[505] Conditions of confinement claims filed by convicted prisoners must satisfy tests for both objective and subjective components.[506] To establish an Eighth Amendment violation regarding conditions of confinement, an inmate must first demonstrate that the deprivation was sufficiently serious. In other words, the inmate must establish that an official's act or omission resulted in the denial of "the minimal civilized measure of life's necessities."

For the objective component, "extreme deprivations are required to make out a conditions-of-confinement claim."[507] A plaintiff must demonstrate that he suffered an extreme deprivation of a "minimal civilized measure of life's necessities."[508] The Supreme Court has noted that "the length of confinement cannot be ignored. ... A filthy, overcrowded cell ... might be tolerable for a few days and intolerably cruel for weeks or months."[509] Although admittedly unpleasant, short term sanitation restrictions do not state a constitutional violation.[510] The Civil Rights Division has not alleged that even one inmate has suffered an extreme deprivation of any "minimal civilized measure of life's necessities."[511] The Division's vague and speculative sanitation, hygiene and fire and life safety-related allegations do not objectively show a sufficiently extreme deprivation to even satisfy the first (objective) component of a conditions of confinement claim.[512]

The inmate must also prove that the official possessed a sufficiently culpable state of mind.[513] The inmate must prove that the official acted with deliberate indifference to inmate health or safety.[514] Deliberate indifference is established by showing that officials were aware of facts

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505 *Farmer v. Brennan*, 511 U.S. 825 (1994).

506 *See Hudson v. McMillian*, 503 U.S. 1, 8 (1992) (Eighth Amendment).

507 *Hudson*, 503 U.S. at 9.

508 *Wilson v. Seiter*, 501 U.S. 294, 304 (1991).

509 *Hutto v. Finney*, 437 U.S. 678, 686-87 (1978) (Eighth Amendment); *Smith v. Copeland*, 87 F.3d 265, 269 (8th Cir. 1996) (finding no Eighth Amendment violation when prisoner was exposed for four days to raw sewage from an overflowed toilet in his cell).

510 *Whitnack v. Douglas County*, 16 F.3d 954, 958 (8th Cir. 1994).

511 *See Wilson*, 501 U.S. at 304.

512 *Davis v. Scott*, 157 F.3d 1003, 1006 (5th Cir. 1998) (Eighth Amendment); *Daigre v. Maggio*, 719 F.2d 1310, 1312 (5th Cir. 1983) (Eighth Amendment).

513 *Farmer v. Brennan*, 511 U.S. 825 (1994).

514 *Farmer*, 511 U.S. at 847; *Herman v. Holiday*, 238 F.3d 660, 664 (5th Cir. 2001).

from which an inference of excessive risk to inmate's health or safety could be drawn; and that they actually drew an inference that such potential for harm existed.[515]

Pretrial detainees retain a due process right against "particular restrictions and conditions accompanying pretrial detention [that] amount to punishment in the constitutional sense of that word."[516] Where confinement is temporary, conditions will ordinarily not give rise to a constitutional deprivation.[517] "Jails must provide only reasonably adequate hygiene and sanitation conditions."[518]

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[515] *Farmer*, 511 U.S. at 847; *Herman*, 238 F.3d at 665.

[516] *Bell v. Wolfish*, 441 U.S. 520, 538 (1979); *Hare v. City of Corinth*, 74 F.3d 633, 639-43 (5th Cir. 1996) (en banc); *Hare v. City of Corinth, Miss.*, 74 F.3d 633, 643 (5th Cir. 1996) ("[W]e reject the suggestion that the choice between the *Bell* test and a deliberate indifference standard turns on whether a pretrial detainee's claim is framed as a denial of medical care or a failure to protect: we conclude that both medical care and failure-to-protect cases should be treated the same for purposes of measuring constitutional liability. ... [T]he *Bell* test retains vitality only when a pretrial detainee attacks general conditions, practices, rules, or restrictions of pretrial confinement. When, by contrast, a pretrial detainee's claim is based on a jail official's episodic acts or omissions, the *Bell* test is inapplicable, and hence the proper inquiry is whether the official had a culpable state of mind in acting or failing to act. Third, we adopt a standard of deliberate indifference as the measure of culpability for such episodic acts or omissions. We emphasize that our use of a deliberate indifference standard does not scale back the constitutional rights of pretrial detainees. This is so because a proper application of *Bell's* reasonable-relationship test is functionally equivalent to a deliberate indifference inquiry. Finally, we turn to the question whether to apply an objective or subjective definition of deliberate indifference. Finding no constitutionally significant distinction between the rights of pretrial detainees and convicted inmates to basic human needs, including medical care and protection from violence or suicide, we conclude that a state jail official's constitutional liability to pretrial detainees for episodic acts or omissions should be measured by a standard of subjective deliberate indifference as enunciated by the Supreme Court in *Farmer*.").

[517] *E.g.*, *Walker v. Jackson*, No. 5:08cv147-JMR, 2009 WL 1768547, at *10 (S.D. Miss. June 23, 2009). In *Walker v. Jackson*, for example, the United States District Court for the Southern District of Mississippi dismissed a civil rights plaintiff's conditions-related claims, explaining: "Plaintiff's allegations concerning the denial of clean sheets, soap, and clean towels for a two week period also fail to rise to the level of a constitutional deprivation. *Such a temporary inconvenience is not the kind of extreme deprivation that amounts to punishment.*" *Id.* (emphasis added). In *Lawrence v. Owens*, the United States District Court for the Eastern District of Pennsylvania observed: "At the outset, we note that in this day of prison overcrowding, prison officials are presented with the Herculean task of housing more inmates than their facilities were designed to accommodate. Problems of prison overcrowding sometimes require that prison officials house prisoners in temporary holding areas until arrangements for permanent housing assignments can be made. *As these areas are to be used to house prisoners only temporarily, conditions of confinement in such areas may often be uncomfortable or undesirable. Where confinement to those areas is temporary, however, the conditions will ordinarily not give rise to a federal cause of action.*" *See e.g.*, *Lawrence v. Owens*, No. 87-0898, 1987 WL 12753, 1 (E.D. Pa. June 18, 1987) (not design. for publication) (emphasis added). *See also Matthews v. Corrections Corp. of America*, No. No. 08-CV-0921; SEC. P., 2009 WL 775092, 4 (W.D. La. Mar. 24, 2009) (citing *Hutto v. Finney*, 437 U.S. 678, 686-87 (1978) ("[T]he length of confinement cannot be ignored in deciding whether the confinement meets constitutional standards. A filthy, overcrowded cell ... might be tolerable for a few days and intolerably cruel for weeks or months."); *Davis v. Scott*, 157 F.3d 1003, 1006 (5th Cir.1998) (finding no Eighth Amendment violation where inmate was kept in filthy cell for only three days and was given cleaning supplies)).

[518] *Burton v. Cameron County*, 884 F.Supp. 234, 241 (S.D. Tex. 1995) (citing *Green v. Ferrell*, 801 F.2d 765, 771 (5th Cir.1986)).

B. Harris County provides constitutionally adequate sanitation and hygiene, including constitutionally adequate laundry facilities, bedding, clothing and mattresses, in its jail facilities.

According to the Civil Rights Division:

> The Jail buildings are generally modern and adequately maintained. Staff receive training on a variety of emergency procedures. The Jail lacks, however, certain necessary structured maintenance, sanitation, and fire safety programs. Given stresses upon Jail infrastructure crowding, the lack of such programs raises concerns about sanitation and fire safety in the Jail.[519]

Harris County agrees that its jail facilities are generally modern and well-maintained and that staff receive training on a variety of emergency procedures. Harris County denies that its jails lack "necessary structured maintenance, sanitation and fire safety programs," denies that "the lack of such programs raises concerns about sanitation and fire safety in the Jail," and submits that Harris County provides constitutionally adequate sanitation, hygiene and life safety in the Harris County Jail system. And, as discussed more fully below, the Civil Rights Divisions "concerns" are insufficient under CRIPA and its legislative history to support federal intrusion into this area of the Jail's operations.

According to the Civil Rights Division:

> While the Jail generally appeared to be clean and many systems seemed to be well-maintained, certain deficiencies in the Jail's hygiene practices and maintenance programs expose detainees to an unacceptable risk of injury, disease, or other harm. Jail crowding contributes to these deficiencies.
>
> First, the Jail does not have systems in place to ensure adequate detainee personal hygiene. For example, the facility's laundry facilities and procedures are currently inadequate given the size of the Jail population. As a general matter, the Jail does not even have a "par level" of clothing or linen available for detainees. In other words, the Jail does not maintain enough accessible clothing or linen on-hand for the number of detainees housed at the facility. Moreover, the laundry operation does not meet minimum sanitary standards. The laundry operation does not properly wash and sanitize clothing. The laundry has only a few machines, and a number of those were inoperative during our tour. The staff also use a variety of inconsistent, and often inadequate, schedules and procedures for handling and cleaning laundry. As a result, we found a significant amount of unsanitary bedding, clothing, and mattresses throughout the facility. Such unsanitary conditions can expose detainees to a serious risk from infectious disease.[520]

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519 Letter from Loretta King to Ed Emmett, *supra* note 3, at 18 para. 3 (June 4, 2009).

520 Letter from Loretta King to Ed Emmett, *supra* note 3, at 19 paras. 1-2 (June 4, 2009).

Harris County agrees that its jail facilities are generally clean and well maintained. Harris County denies the Civil Rights Division's conclusory, speculative and unsupported allegation that the Jail's hygiene practices and maintenance programs expose detainees to an unacceptable risk of injury, disease, or other harm.[521] Speculative, unsupported allegations of potential risk do not confer the Attorney General with standing to pursue or file suit under CRIPA. Harris County also denies each of the Civil Rights Division's other hygiene, laundry and sanitation-related allegations.

The HCSO's Sanitation Plan and sanitation satisfy all constitutional requirements. The HCSO's Sanitation Plan also conforms to the State of Texas' regulatory standards and has been approved by the Texas Commission on Jail Standards.[522] The HCSO's Sanitation Plan clearly outlines policies and procedures regarding cellblock inspections, standards of cleanliness and hygiene, issuance of cleaning supplies and products, cleaning schedules and infectious disease control. The HCSO has an inspection team dedicated to audit the jail facilities to meet and exceed the TCJS's sanitation requirements, and to enforce compliance with department sanitation-related regulations. The HCSO not only takes the health and hygiene of its inmates seriously, but insists that each inmate be held accountable for his or her personal hygiene as well as the cleanliness of his/her immediate living area and general living quarters.

The HCSO's policies and procedures concerning inmate clothing, personal hygiene, bedding and mattresses comport with constitutional standards. These policies and procedures also satisfy the State of Texas' standards regarding prisoners' clothing, personal hygiene and bedding. TCJS Minimum Jail Standards ("TCJS regulations" or "TCJS standards") provide that "[a] change of clothing shall be furnished at least once a week unless work, climatic conditions, illness, or other factors necessitate more frequent exchange to assure cleanliness."[523] The HCSO exceeds these standards, generally providing inmates with two changes of laundered clothing per week. Depending upon their job assignment, inmate workers receive a new change of clothing daily (or as needed) in all jail facilities. Inmates in certain educational programs, like paint and body, welding and culinary school, also receive a new change of clothing daily.

TCJS regulations provide that "[i]nmates held over 48 hours who are unable to supply themselves with personal care items, because of indigency, shall be furnished the following: (1) toothbrush; (2) toothpaste or toothpowder; (3) soap; (4) comb; and (5) shaving implements."[524] The HCSO complies with these regulations.

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521 When enacting CRIPA, Congress clearly did not intend to grant the DOJ authority to file or intervene in civil rights suits based upon speculative allegations of risks of injury, disease or other harm.

522 The HCSO produced its Systems and Sanitation Plans, as well as its sanitary and laundry-related policy and procedures to the DOJ. Bates 14,231 (Sanitation Plan), 15,102 (System Plan re sanitation), 13,439 (Laundry Manual), 31,322 (laundry initiatives). *See also* Bates 15,019 (TCJS's approval of HCSO's Sanitation Plan). *Contra* 37 Tex. Admin. Code §§ 279.1 & 279.2 (Sanitation Plan-related regulations).

523 *See* 37 Tex. Admin. Code § 277.2 ("Laundering").

524 *See* 37 Tex. Admin. Code § 277.4 ("Personal Hygiene").

TCJS regulations provide that "[a] standard issue of bedding and linens to each inmate to be detained overnight shall include, but shall not be limited to, the following clean, safe, and serviceable items: (1) one mattress; (2) one sheet or mattress cover; (3) one towel; (4) one blanket, or more depending upon climatic conditions."[525] The HCSO meets these requirements.

TCJS regulations provide that "[w]ashable items such as sheets, towels, and mattress covers shall be exchanged for clean replacements at least once each week, or more often if necessary," and that [b]lankets shall be laundered or dry cleaned at least every three months or more often if necessary."[526] The HCSO meets these standards.

TCJS regulations provide that "[m]attresses shall be swept, aired, sprayed with a nontoxic disinfectant and stored off the ground prior to reissue.[527] The HCSO satisfies these requirements.

Harris County denies the Civil Rights Division's laundry-related allegations regarding the HCSO's laundry facilities, operations and procedures. Harris County's laundry facilities, operations and procedures are constitutionally adequate and satisfy state standards.

Harris County disagrees with the Civil Rights Division's allegation that the Jail "does not maintain enough accessible clothing or linen on-hand for the number of detainees housed at the facility," and to any inference that "par-level" reserves are constitutionally (or even statutorily) required. The HCSO maintains a "float" in order to perform laundry exchanges. For example, the HCSO keeps a minimum of 3,000 – 4,000 extra jumpsuits on hand for contingency use. The jails continuously change out "clean for dirty" jumpsuits and linens. As the "clean for dirty" laundry exchange takes place, inmates take full carts of dirty items downstairs to be laundered, keeping a steady flow of clean jumpsuits and linen injected into the exchange process. In addition, the HCSO maintains a large supply of new laundry items in stock. For example, on July 2, 2009, the HCSO had approximately 19,872 sheets, 2,177 shirts, and 4,997 pants in the new supply stock. The HCSO also has the ability to order new laundry items as needed, subject to vendor availability.

The Civil Rights Division ambiguously alleges that they found "a significant amount" of unsanitary bedding, clothing, and mattresses throughout an unspecified facility. Harris County denies this amorphous and unsupported allegation. With regard to mattresses, the HCSO would note that torn mattresses are discarded because of possible sanitation issues and that all other mattresses are sanitized prior to the time they are re-issued to incoming inmates.

The HCSO's laundry operations were designed by industry professionals and are constitutionally sufficient. Harris County disagrees with the Civil Rights Division's contentions that the laundry "has only a few machines" and that an unspecified "number" of those "few machines" were

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525 *See* 37 Tex. Admin. Code § 277.8 ("Bedding and Linens").

526 *See* 37 Tex. Admin. Code § 277.9 ("Laundering of Bedding and Linens").

527 *See* 37 Tex. Admin. Code § 277.10 ("Mattresses").

inoperative during their inspections. The three Harris County Jail laundry facilities located at the 1200 Baker Street, 1307 Baker Street and 701 North San Jacinto jail locations have two 250-pound capacity washing machines, eleven 135-pound capacity washing machines, two 125-pound capacity washing machines and one 85-pound capacity washing machine; eleven 170-pound capacity dryers (with nine 120-pound capacity dryers on order to replace five of the 170-pound capacity dryers) and three 140-pound capacity dryers; industrial scales to weigh the laundry; automated detergent and bleach dispensers for the washing machines, commercial grade lint removal systems; numerous bins, carts, buggies, shelves and stainless steel tables to move and fold laundry: and six storerooms for laundry supplies. The laundry section keeps extra inmate uniforms, inmate undergarments, inmate sheets, inmate towels, and inmate blankets, as well as cleaning supplies, in the six storerooms.

Prior to the Civil Rights Division's July and August 2008 inspections, the HCSO ordered new washers and dryers to replace machines in the 701 North San Jacinto jail's laundry facilities, and made necessary alterations to plumbing and electric systems to accommodate those machines. Although Leonard Rice, the Division's sanitation consultant, did not support the replacement of the machines with a greater number of smaller-sized machines, larger machines would not physically fit in the elevator for transport to the basement of the facility. The new washing machines were installed and in use by the end of August of 2008.

The HCSO's laundry operations properly wash and sanitize clothing. Ecolab's Institutional Division has provided and continues to provide the HCSO with proper chemical delivery systems and products to sanitize laundry. The laundry is chemically sanitized with commercial grade detergent (TRI-STAR L-2000 XP) and concentrated chlorine bleach. These products were intended to be used to sanitize laundry at lower temperatures. Mr. Rice, the Civil Rights Division's consultant, preferred sanitation of clothing with extreme hot water temperatures but the detergent and bleach currently in use sanitizes the laundry with cooler temperatures. In fact, hot water would degrade the ability of the detergent to properly sanitize laundry. The advantage of using these products instead of relying upon extremely hot water is that Harris County can sanitize laundry regardless of the status of the boilers. Commercial grade washing machines have been programmed to maximize the use of these chemical products. Ecolab dispensers are in proper working order and provide adequate amounts of product during wash cycles. All Ecolab dispensers have an alarm system that notifies the user if no product is being dispensed.

During the Civil Rights Division's July and August, 2008 inspections of the Harris County Jail system, their consultant did not find a cross-contamination problem. Mr. Rice did question whether laundry handling procedures left that possibility open, explaining that when dirty laundry was removed from the wheeled buggies, workers might cross-contaminate laundry in the event they forgot to disinfect the buggy before it moved through the line to receive clean items. Mr. Rice suggested different colored buggies for clean and dirty laundry. The HCSO welcomed this precautionary recommendation and immediately purchased color-coded carts to ensure that clean and dirty laundry is kept in separate carts to negate the possibility of cross-contamination. Green laundry carts are only used for clean laundry. The other carts are only used for dirty laundry. Carts holding dirty laundry have lids. The HCSO requires that carts and folding tables

be disinfected at least once per shift. The HCSO also changed its laundry procedures at the 1200 Baker Street Jail to require dirty laundry to be brought into the laundry by a separate door.[528]

Inmate workers, under the direction of HCSO employees, place plastic gloves over their hands and move the dirty laundry bins onto scales to weigh the loads before placing them in the commercial grade washing machines. Once the dirty laundry is loaded into the washing machines, the empty bin is disinfected and placed in an area for reuse for other dirty clothes. The disposable plastic cover is then discarded after each use and a new cover is placed for re-use. Inmate workers are required to wear protective gloves while moving soiled laundry items.

Clean laundry is removed from the dryers and placed on very large stainless steel tables. The laundry is sorted and folded and placed on racks in preparation for more prisoner laundry exchanges. The stainless steel tables and the racks are disinfected at least once per shift.

Laundry exchange teams take large racks filled with clean folded prisoner uniforms, undergarments and rolls of prisoner sheets and towels, along with several empty bins to collect dirty laundry, to the prisoner housing areas on a daily basis. As the clean laundry is exchanged for dirty laundry, the full dirty laundry bins are covered with disposable plastic covers and brought to the respective laundry for that particular jail facility

All surfaces, including floors, walls, machinery, office window seals, windows, etc., in the laundry areas are cleaned daily. The lint screens in the dryers are cleaned at the beginning of every shift.

Harris County denies the Civil Rights Division's allegation that the Jail "does not maintain enough accessible clothing or linen on-hand for the number of detainees housed at the facility." On the contrary, the HCSO maintains enough accessible clothing and linen on hand for the number of prisoners confined in the Harris County Jail. The HCSO does a "par-level," one-for-one exchange of inmate clothing.

The HCSO has found that female inmates often decline to exchange their undergarments, preferring instead to wash and hang them in their cellblocks. The HCSO, in response, established a new Security Towel Hooks policy and procedure and equipped each female housing area in its downtown jail facilities with stainless steel safety clothing hooks to provide a sanitary means of hanging laundered undergarments to dry.[529] Mr. Rice examined the county-issued undergarments and a photograph of the clothing hooks and approved of both.

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528 Bates 31,317-31,380.

529 Bates 31,318-24, 31,367-74.

C. Harris County provides constitutionally adequate grooming equipment to inmates incarcerated in the Harris County Jail.

According to the Civil Rights Division:

> Another example of poor hygiene practices involves detainee grooming and shaving equipment. The Jail's barbers practice their trade in an unhygienic manner. Clipper blades, guards, and supply boxes appeared to be dirty and had not been cleaned between uses. Detainee barbers did not keep their equipment in disinfectant solutions.[530]

Harris County provides constitutionally adequate and hygienic grooming equipment to inmates incarcerated in the Harris County Jail system.[531] During the Civil Rights Division's July 2008 inspection, Mr. Rice and HCSO personnel found hair clippings in the inmate barbers' box at the 1200 Baker Street Jail facility. While this presents no constitutional question, the officers who manage the barber shops now frequently check the barbers' boxes for hair clippings. The inmate barbers have at their disposal canned Oster disinfecting spray to sanitize hair cutting tools. Although the disinfecting spray meets state regulations relating to the sanitation of barbers' hair cutting tools[532] and presents no federal constitutional question, a liquid disinfectant is now also used to sanitize hair cutting tools. Laminated copies of the state standards are posted in each barber shop.[533] Inmates are under orders to obey the state standards, and frequent checks are made to ensure compliance with state standards.

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[530] Letter from Loretta King to Ed Emmett, *supra* note 3, at 19 para. 3 (June 4, 2009).

[531] The HCSO's Sanitation Plan expressly provides that: (a) Inmates shall be allowed access to an inmate barber by submitting an "Inmate Request Form" to staff personnel ...; (b) All instruments and tools must be sanitized after each client with an approved disinfecting spray or bleach solution as stated in Title 16 of the Texas Administrative Code, Chapter 82.101. The implement or tool is not considered sanitized if all visible hair and debris is not removed prior to disinfecting spray being applied.; (c) All clean and disinfected implements and materials when not in use shall be stored in a clean, dry, debris-free environment including but not limited to drawers, cases, tool belts, rolling trays, or hung from hooks. They must be stored separate from soiled implements and materials. Non-barber related supplies must be stored in separate drawers or locations.; (d) A container of liquid disinfectant shall be located at each barber chair or station in a barber establishment to be used to disinfect combs, brushes, scissors or other equipment which may be safely immersed in a liquid disinfectant.; (e) Floors in barber establishments shall be thoroughly cleaned each day. All hair cuttings shall be removed as soon as practicable.; (f) Clean towels shall be used on each client.; (g) Soiled towels shall be removed after use on each client and deposited in a suitable receptacle." Bates 14,235–36 (1200 Baker Street Jail's Standard Operating Procedures); Bates 14,551-52 (701 North San Jacinto Jail's Standard Operating Procedures).

[532] *See* 16 Tex. Admin. Code § 82.101 ("Health and Safety Standards—Department—Approved Disinfectants").

[533] *See* 16 Tex. Admin. Code §§ 82.100 ("Barbers—Health and Safety Definitions"), 82.101 ("Health and Safety Standards—Department—Approved Disinfectants"), 82.102 ("Health and Safety Standards—General Requirements").

D. Harris County provides constitutionally adequate shaving equipment to inmates incarcerated in the Harris County Jail.

According to the Civil Rights Division:

> Another example of poor hygiene practices involves detainee grooming and shaving equipment. ... As discussed previously in this letter's section on protection from harm, razor blades are not well controlled in the facility. The availability and use of dirty, shared razors and blades is a serious risk, both in terms of disease transmission and as a security matter.[534]

Harris County provides constitutionally adequate and hygienic shaving equipment to inmates incarcerated in the Harris County Jail system, and denies the Civil Rights Division's unsupported allegations that "razor blades are not well controlled in the facility" and that "dirty, shared razors and blades" are available or in use. Here, as above, the Civil Rights Division cited no incidents and failed to otherwise support these conclusory allegations as required by CRIPA's notification provisions.

As stated above, Texas regulations require the HCSO to provide indigent inmates with shaving implements.[535] Although there is no constitutional or statutory prohibition against the sale of razors to or the possession of disposable razors by inmates, Civil Rights Division sanitation consultant Leonard Rice recommended against these practices. Notwithstanding the lack of *any* pattern of incidents that would fairly support the conclusion that "razor blades are not well controlled in the facility," the HCSO stopped selling disposable razors to inmates and implemented a time consuming and costly new razor procedure in accordance with Mr. Rice's recommendation. Harris County now purchases all razors, distributes them to inmates on a regular basis, collects the razors approximately two hours after delivery, accounts for each razor, examines the condition of each razor to determine whether the razor blade is missing, and disposes of the razors as biohazard waste products, all at great cost to the Harris County taxpayers.[536] Harris County reported this change in procedure to the Civil Rights Division advocates on January 9, 2009, but, as noted above, the Civil Rights Division ignored this fact when advancing this conclusory, unsupported allegation against Harris County.[537]

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534 Letter from Loretta King to Ed Emmett, *supra* note 3, at 19 para. 3 (June 4, 2009).

535 *See* 37 Tex. Admin. Code § 277.4 ("Personal Hygiene").

536 Bates 31,357, 31,317-80.

537 Bates 31,323 (summary of razor policy and procedures), 31,357-59 ("Razor Distribution Policy"), 31,361 ("Razor Distribution Flowchart"), 31,363 (Inmate Razor Distribution Notification), 31,365-66 (Razor distribution forms).

E. Harris County provides constitutionally adequate plumbing and mechanical systems in the Harris County Jail.

According to the Civil Rights Division:

> Finally, the Jail's plumbing and mechanical systems require improved maintenance in order to ensure hygienic conditions in certain housing units. While most of the Jail is properly maintained, *the Jail's population size and gaps in the Jail's maintenance program result in unsanitary conditions in the intake and mental health units, where the Jail utilizes archaic flushable floor drains, essentially holes in the floor, instead of toilets. Using such grossly inadequate facilities for long periods of time is itself problematic because they are unhygienic. Moreover, when we tested some of the drains, they back-flushed into the cells. Elsewhere throughout the Jail, we found drains clogged with significant accumulations of debris.*[538]

Maintenance is a constant struggle in the Harris County Jail system, especially given the fact that inmates sometimes vandalize showers and toilets and otherwise destroy County property.[539] Notwithstanding this unfortunate fact, Harris County provides plumbing and mechanical systems in the jail facilities that meet both constitutional and state standards, and disagrees with the italicized allegations made by the Civil Rights Division in this paragraph of their letter.

The Civil Rights Division states that the Jail uses "archaic flushable floor drains, essentially holes in the floor, instead of toilets," in the intake and mental health units.[540] The HCSO is statutorily required to maintain, and does maintain, detoxification cells for temporary detention of inmates during the detoxification process.[541] The State of Texas' TCJS requires that these safety cells be constructed of "durable and easily cleaned" floor, wall, door and ceiling material, and be constructed in such a manner to "resist vandalism," "facilitate supervision of the cell area," and "materially reduce noise."[542] The TCJS requires that these safety cells "shall be provided with one or more vandal resistive flushing floor drains with outside controls, or detention type toilet and lavatory and vandal resistive floor drains," and that the floors of these cells "be properly pitched to drains."[543] The TCJS imposes these requirements to protect inmates

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538 Letter from Loretta King to Ed Emmett, *supra* note 3, at 19 para. 4 – 20 para. 1 (June 4, 2009) (emphasis added).

539 *See* Bates 14,231 (Sanitation Plan), 15,102 (System Plan re Sanitation), 14,078–80 (biohazard policy re contaminated laundry), 14,119 (laundry).

540 The Civil Rights Division's complaint relating to the HCSO's use of flushable floor drains in certain holding cells appears to be inconsistent with the Division's position, in the "Inadequate Suicide Prevention" section of their letter, that some of the cells used for housing newly arrested detainees include unsafe physical fixtures. *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 14 para. 3 (June 4, 2009).

541 *See* 37 Tex. Admin. Code § 259.236 ("Detoxification Cells").

542 *See* 37 Tex. Admin. Code § 259.236(2), (4) & (5) ("Detoxification Cells").

543 *See* 37 Tex. Admin. Code § 259.236(2) ("Detoxification Cells").

from harming themselves and destroying taxpayer-supported detention facilities during the detoxification process. These cells are used on a temporary, as-needed basis. As Leonard Rice, the Civil Rights Division's sanitation consultant, acknowledged during the Division's August 8, 2008 brief-out, these cells are infrequently used.

In addition, TCJS regulations provide that a jail facility "may contain one or more single occupancy cells for the temporary housing of violent persons."[544] With regard to plumbing in "violent cells," TCJS regulations expressly provide that "[f]lushing type floor drains with outside controls shall be provided."[545] TCJS regulations also require that "violent cells shall include" fire resistive and nontoxic padding that completely covers walls, floor and bench "to protect the inmate from self injury."[546] These regulations were promulgated to protect inmates from self injury and to protect taxpayer-funded property.

There are a total of twenty-three cells with vandal resistive flushing floor drains, including three cells at Intake in the Inmate Processing Center, four cells in high security areas in the 701 North San Jacinto Jail, sixteen cells in the Health Services area of 1200 Baker. While the time an inmate spends in these cells depends upon the circumstances, an inmate generally spends less than four hours in these cells. The vandal resistive flushing floor drains are routinely cleaned by special detail and, contrary to the Civil Rights Division's allegations, are hygienic. The HCSO uses a disinfectant cleaner followed by application of "Consume," which is consistent with Mr. Rice's recommendation that the HCSO use an enzyme-based cleaner. The HCSO continues to meet state jail standards relating to the maintenance and sanitation of these cells.

The Civil Rights Division generally alleges that when they tested "some" unspecified drains in unspecified locations in unspecified jail facilities, they "back-flushed into the cells." Although Mr. Rice raised a concern that these cell drains might possibly back-flush, his concern was never realized.[547] HCSO employees, attorneys and consultants accompanied Civil Rights Division attorneys, paralegals and Mr. Rice throughout their inspections of the Harris County Jail system and observed no drains that back-flushed into the cells. In fact, it is fair to say that no representatives of either Harris County or the Civil Rights Division observed any drain back flush into any cell, in any jail location, during any testing process during the Civil Rights Division's July and August 2008 inspections.

The Civil Rights Division generally alleges that they found "drains clogged with significant accumulations of debris" at unspecified locations "elsewhere" throughout an unspecified facility.

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544 37 Tex. Admin. Code § 261.334 ("Violent Cells").

545 37 Tex. Admin. Code § 261.334(2) ("Violent Cells—Plumbing").

546 37 Tex. Admin. Code § 261.334(4) ("Violent Cells—Padding").

547 HCSO personnel believe that the Civil Rights Division may have misinterpreted Mr. Rice's stated concern regarding this potential back-flushing issue to mean that he actually witnessed a drain back-flush into a cell. That simply did not happen during the inspection. Since the Civil Rights Division advocates have declined to give Harris County Mr. Rice's report, Harris County has had no opportunity to compare Mr. Rice's actual findings to the Civil Rights Division's June 4, 2009 letter.

Harris County does not believe this to be a fair representation regarding what was actually observed during the Civil Rights Division's July and August 2008 inspections. It is fair to say that Civil Rights Division attorneys, personnel and Mr. Rice, as well as HCSO employees and their attorneys and consultants, saw some debris in a few drains. It is also fair to say that inmates do at times discard their refuse in drains, rather than in garbage cans. The drains are easily cleaned when the cells are cleaned.

During the Civil Rights Division's July 2008 inspection, Mr. Rice recommended that the HCSO consider using an enzyme-based product to clean drains in the jail facilities, rather than a different recently-purchased product. Shortly thereafter, Mr. Rice inspected the medical facilities at 1200 Baker, found the drains there to be spotless, and learned that a deputy was using Spartan Consume Enzymes on those drains. Mr. Rice repeatedly complimented the deputy regarding the sanitary conditions of the floor drains in the medical area and told him he should receive a commendation from the Sheriff. In response, HCSO immediately purchased and implemented use of this cleaning product in all downtown jail facilities.[548] Between the July and August 2008 Civil Rights Division inspections, new drains were installed in the Inmate Processing Center, and those drains are also being cleaned with Spartan Consume Enzymes.

F. Harris County provides constitutionally adequate fire safety in the Harris County Jail.

According to the Civil Rights Division:

> The Jail is a modern facility with a number of fire safety features, such as alarm systems and fire suppression equipment. The main problem with the Jail's fire safety program is that staff training and oversight appear to be inadequate. During our site inspection, we found inadequate numbers of personnel trained to perform emergency tasks. ...[549]

Harris County agrees that the jail facilities are modern facilities with many fire safety features, including, among other things, alarm systems, fire suppression equipment, emergency flashlights, Scott Air Packs, Emergency evacuation chairs, smoke evacuation systems, fire extinguishers located throughout the buildings, Fireworks software, suicide cut-down tools and emergency evacuation keys. Harris County's fire safety-related training and oversight meet both constitutional and state standards.[550]

The Civil Rights Division advocates generally allege that fire safety-related staff training and oversight "appear to be inadequate" and that they found "inadequate numbers of personnel trained to perform emergency tasks." Harris County objects to and disagrees with these

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548 Bates 31,317-80.

549 Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 2 (June 4, 2009).

550 *See, e.g.*, 37 Tex. Admin. Code §§ 263.1 – 263.90 (including "Life Safety Rules" applicable to Texas jails). *See also* Bates 12,729-813 (Emergency Plans for Detention Operations); 14,971 (Emergency Plan—System Plan); 14,982 (Fire Plan); 31,318, 31,336 (Emergency Cut-down tools).

ambiguous, speculative and unsupported allegations, and would note that the Division's Sanitation and Life Safety consultant, Leonard Rice, specifically raised no Fire Life Safety training-related complaints during the Division's August 2008 brief-out.

Inadequacies in training may serve as a basis for governmental liability only where the failure to train amounts to deliberate indifference to the rights of persons.[551] Although the Civil Rights Division advocates generally allege that staff training appears to be inadequate, they have never requested or reviewed the HCSO's Fire Life Safety-related training records. When speculating about the adequacy of the HCSO's Fire Life Safety-related training, they did not address or apply the deliberate indifference standard.

During New Employee Orientation, all HCSO employees must complete a five hour Basic Fire Safety training course. Every person who works in the Harris County Jail on a full-time or temporary basis must complete a basic Fire Safety course. The HCSO also has three full-time Fire Safety Officers with extensive fire and life safety training and teaching credentials.[552] HCSO Fire Safety Officers have compiled a rigorous training program that exceeds the State's fire and life safety requirements.[553] This program includes, for example, these compulsory courses:

> Basic Fire Life Safety for New Employees: This course concentrates on fundamental policy and procedures in emergency situations unique to the detention environment. This includes a strong focus on the proper use of emergency equipment. All detention personnel are trained in this subject immediately upon employment (during New Employee Orientation) and before being assigned to their work area in accordance with TCJS regulations.[554]
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> Intermediate Fire Life Safety: This course is conducted during the required Basic County Corrections course. It is scenario-based, taking the HCSO personnel

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551 *E.g., City of Canton, v. Harris*, 489 U.S. 378, 385-87 (1989).

552 The three personnel currently assigned to the HCSO Fire Safety Office have extensive experience in fire fighting, arson investigation, building inspections, policy and procedure development and training development. Each of these employees possess 478 or more training hours in basic structural fire fighting; ninety (90) or more training hours in Arson Investigation with Cause and Detection; forty (40) training hours in OSHA COSS (Certified Occupational Safety Specialist); forty (40) training hours in Texas Commission on Law Enforcement Officer Standards and Education ("TCLEOSE") Instructor Development; fifty (50) training hours in National Fire Protection Association Fire Instructor I; twenty-four (24) training hours in National Fire Protection Association Fire Safety 101; forty (40) or more training hours in National Incident Management System (NIMS); and twenty-four (24) or more training hours regarding Americans with Disabilities Act. The HCSO's Fire Safety Training Coordinator is certified by: (1) the Texas Department of Health as an Emergency Medical Services Instructor/Examiner; (2) by TCLEOSE in Instructor Development: and (3) by the Texas Commission on Fire Protection (as Instructor I Fire Fighting /Fire Protection). The HCSO's other safety officers hold certifications by, for example, the State Fireman's and Fire Marshal's Association of Texas as Level 1 instructors in Basic Fire Fighting.

553 *See, e.g.*, 37 Tex. Admin. Code §§ 263.1 – 263.90 (including "Life Safety Rules" applicable to Texas jails).

554 *See, e.g.*, 37 Tex. Admin. Code § 263.41 ("Training and Drills").

through hours of hands-on practical training. Utilizing various emergency equipment, detention personnel conduct search and rescue in a zero visibility smoke-filled room, complete extinguishment, and extricate non-ambulatory persons from a multi-story structure. Personnel must demonstrate proficiency using and maintaining all emergency equipment found in the detention facilities. This equipment includes the Scott 2.2 air pack, the Stryker evacuation stair chair, the suicide cut-down tool, the emergency keys used in the detention environment and the ABC fire extinguisher.

Advanced Fire Life Safety for Supervisors: This course concentrates on fire code issues commonly encountered in the detention environment. Supervisors are taught to recognize fire code violations and to correct and/or resolve these violations. During this course, supervisors also must show proficiency using and maintaining all emergency equipment, such as Scott 2.2 air pack, the Stryker evacuation stair chair, the suicide cut-down tool, the emergency keys used in the detention environment and the ABC fire extinguisher. This allows all supervisors to keep their subordinates proficient as well. There is also an in-depth overview of supervisors' responsibility during an emergency situation.

Fire Life Safety Update: This course available to all HCSO personnel, to include personnel not regularly assigned to the Detention Bureau. This training encompasses all facets of fire life safety including fire emergencies, evacuation routes and policy, and location and use of all emergency equipment. It should be noted that personnel working in the jail, but not regularly assigned to the detention bureau (*e.g.* patrol deputies working overtime in the jail), are required to carry a card indicating that they have completed this training. This card requires quarterly renewal and personnel must receive continuing education training to obtain another card.

Quarterly Fire Life Safety Training: This required training satisfies TCJS-mandated quarterly training for all jail personnel to include fire, emergency, evacuation drills and location and use of equipment.[555] This quarterly training also focuses on policy and procedure-related updates.

HCSO Fire Safety Officers also offer these non-compulsory and special training courses:

Civilian Fire Life Safety: This block of instruction is offered as continuing education for civilian personnel working in the detention environment. This course allows the civilian working in the secure area to have procedural knowledge in responding to all emergency situations.

Fire Safety Emergency Responder: This block of instruction is purely hands-on scenario-based training that requires personnel to react immediately and appropriately when faced with an emergency. Personnel are placed in the jail

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555 *See, e.g.*, 37 Tex. Admin. Code § 263.41 ("Training and Drills").

> setting, given emergency equipment and then faced with several scenarios. The instructor observes the student's response, evaluates that response and provides feedback to ensure that the student can actually apply what was learned in class.
>
> Specialized training is created and offered as situations dictate and is conducted by HCSO Fire Safety Officers. This training can be as simple as conducting tours with new supervisory personnel or as advanced as curriculum development and course instruction.

In 2008, HCSO personnel completed approximately 10,660 total detention-related, Fire Life Safety training hours.

In addition to this training, several informational publications produced by the Fire Safety Training Coordinator have been placed on the HCSO's intranet to provide all HCSO personnel with basic information regarding life safety issues arising in the jail facilities. These publications include, for example, a four-page pictorial booklet explaining the emergency equipment located in the Harris County Jail system. Another example publication is a four-page pictorial booklet discussing the proper application of the Scott Air pack.

According to the Civil Rights Division:

> ... The Jail has a level of constant staff turnover that makes it difficult to ensure that there are fully trained staff on duty in the housing units. As a result, when we randomly questioned staff about emergency procedures, we found that a number of them did not know how to use emergency equipment or how to respond during a drill. ...[556]

Harris County disagrees with the Civil Rights Division's allegation that the Jail "has a level of constant staff turnover that makes it difficult to ensure that there are fully trained staff on duty at the housing units." Harris County also denies the Civil Rights Division's assertion that "[w]hen we randomly questioned staff about emergency procedures, we found that a number of them did not know how to use emergency equipment or how to respond during a drill."

The Civil Rights Division advocates' complaints about the staff's level of training is primarily based upon two incidents occurring during their July and August 2008 inspections.[557] In the first incident, an employee fumbled while locating a pressure gauge on an air tank. In the second incident, a jailer who was the first person to arrive during a fire drill appeared to be confused by the hypothetical scenario described by Mr. Rice, the Division's consultant. Mr. Rice, however, acknowledged that he was impressed by the large turnout of personnel armed with appropriate equipment. Harris County has fully trained staff on duty in all of the housing units.

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556 Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 2 (June 4, 2009).

557 Harris County also objects to the Civil Rights Division advocates' improper reliance upon two employees' anecdotal responses to questions to support their claims in this section of their June 4, 2009 letter.

According to the Civil Rights Division:

> We also discovered inconsistencies in safety documentation that further suggest a lack of staff training.[558]

Harris County objects to the Civil Rights Division advocates' ambiguous references to "inconsistencies in safety documentation," as well as their speculative, baseless conclusion that these unspecified "inconsistencies in safety documentation" allegedly "suggest a lack of staff training."

During the brief-out, Mr. Rice stated that he found inconsistent documentation regarding equipment inspections on newly-implemented HCSO pass-on logbooks.[559] Mr. Rice did not fault fire and life safety training.[560] Employees are required to inspect the emergency equipment in their work area each shift and record the results of their inspection in their duty station's pass-on logbooks. All emergency equipment found in the detention environment, including but not limited to the Scott 2.2 air pack, ABC fire extinguishers,[561] emergency keys, suicide cut-down tools and flash lights, are inspected as required by HCSO policy to ensure all are in good working order. This HCSO inspection requirement goes well beyond inspection requirements imposed by federal, state and local regulations. Mr. Rice observed that the HCSO's inspection requirements exceed all applicable standards. Mr. Rice noted that the HCSO need not inspect the fire extinguishers and Scott Air Packs every shift and need not record, in the pass-on books, the results each shift of those HCSO's checks. Mr. Rice recommended that monthly fire inspection results be recorded on the fire extinguishers themselves, rather than on the pass-on books.

Although it is not at all clear from their June 4, 2009 letter, the Civil Rights Division advocates may also be referring to notations describing the amount of air in the Scott air packs in the new pass-on logbooks. HCSO personnel inspect the Scott air packs, as well as suicide cut-down tools, POD keys, flashlights, AED, smoke detectors, sprinkler heads and fire panel, during each of the three shifts covering every twenty-hour (24) hour time period and record the results of their inspections in pass-on logbooks. HCSO sergeants monitor the pass-on logbooks in an effort to ensure, among other things, that HCSO personnel record the results of their inspections. Mr. Rice was not satisfied with personnel's notations of "Full" in the pass-on logs even though the word "Full" appears on the Scott air pack's gauge when personnel checked the air pack and

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558 Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 2 (June 4, 2009).

559 Pass-on logbooks are used for the purpose of passing pertinent information on between personnel on different shifts. New pass-on logbooks imposing more detailed requirements upon employees were distributed to all detention facilities in June of 2008.

560 The HCSO Fire Safety Office maintains a thorough database of all Fire and Life Safety training given throughout the year but, as previously indicated, no request was made by the Civil Rights Division for this documentation.

561 Prior to the DOJ's Civil Rights Division's July 2008 inspections, the HCSO Fire Safety Officer also created and implemented training relating to monthly inspections of the fire extinguishers located in all areas of the Harris County jail facilities.

that same word is the manufacturer's recommended verbiage. The Fire Safety Office immediately responded to Mr. Rice's concerns by creating a training sheet and retraining all personnel to record the number "2000" (referring to 2000 pounds of pressurized air in the air bottle) when "Full" appears on the Scott air pack's gauge. The pass-on logbooks were also modified, and employees no longer record the word "Full" in the pass-on books.

According to the Civil Rights Division:

> ... *Finally, we found that the Jail staff did not have adequate access to emergency keys in the event of a failure in the Jail's electronic door control system.* Commendably, the Sheriff's Department immediately took a number of steps to address our fire safety concerns. Importantly, these efforts should be incorporated into ongoing, system-wide safety reviews.[562]

Prior to the Civil Rights Division's inspections, the HCSO complied with all code requirements regarding the placement and location of emergency keys on all floors incarcerating inmates, and thus disagrees with the highlighted sentence in this paragraph of the Civil Rights Division's letter. Mr. Rice recommended that the HCSO add additional keys in certain specified locations on the housing floors. The HCSO welcomed this safety-related suggestion, and immediately added the additional keys at specified locations on all housing floors between the July and August 2008 DOJ inspections.[563] Mr. Rice was well satisfied with the HCSO's pro-active efforts, specifically noting during the August 2008 brief-out that the HCSO staff were quite receptive to each of the suggestions he made to ensure a more thorough and efficient inspection process.

XI. Harris County's response to the Civil Rights Division's "Recommended Remedial Measures"

A. Objections

According to the Civil Rights Division:

> In order to address the constitutional deficiencies identified above and protect the constitutional rights of detainees, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice: ...[564]

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because the Division has shown no constitutional deficiencies in the Harris County Jail system.

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562 Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 2 (June 4, 2009) (emphasis added).

563 *See* Bates 31,322. The HCSO also instituted other measures more specifically described in the January 9, 2009 update to the DOJ for rapid access to needed keys during emergencies. *Id.*

564 Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 3 (June 4, 2009).

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because the Division seeks to require conformity with non-specific "generally accepted professional standards of correctional practice," rather than with minimum constitutional standards.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures regarding medical care and mental health care in Section IV of the Division's June 4, 2009 letter because the HCSO's Health Services Division provides medical and mental health care that is and has been accredited by the NCCHC since 1991.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because the Division further seeks to impose medical and mental health-related remedial measures based upon "generally accepted correctional medical standards" and "generally accepted correctional mental health standards";[565] use-of-force investigation-related remedial measures based upon "generally accepted correctional standards";[566] and hygiene-related remedial measures based upon "generally accepted health standards,"[567] rather than upon minimum constitutional standards.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because CRIPA grants the Attorney General limited authority to review the HCSO's compliance with minimum federal constitutional standards. The Division's authority does not extend to allow it to find so-called constitutional violations based upon non-specific "generally accepted" community standards of care, rather than minimum constitutional standards, and to then call for "minimum remedial relief." As previously explained, Harris County is thus constrained to object to what appears to be an improper attempt to assume superintendence of the "administration" of the Harris County Jail system, an area in which the Attorney General has no authority and the federal courts will not venture.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because there is no evidence that HCSO officials, employees or others acting on their behalf have subjected or are subjecting any inmates, let alone a substantial numbers of inmates, to "egregious or flagrant conditions" which deprive such inmates of their federal constitutional rights, causing them to suffer grievous harm, and that such deprivations are pursuant to a pattern or practice of resistance to the inmates'

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565 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 4 (generally accepted correctional medical standards); *Id.* at 20 para. 5 – 21 para. 1 (generally accepted correctional medical standards and generally accepted correctional medical standards); *Id.* at 21 para. 7 – 22 para. 1 (generally accepted standards of correctional health care); *Id.* at 22 para. 3 (generally accepted correctional mental health standards).

566 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 9 – 23 para. 1 (generally accepted correctional standards).

567 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 4 (generally accepted health standards).

enjoyment of such rights. Under these circumstances, no remedial relief is warranted or even authorized under CRIPA.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because after making findings they know to be inaccurate, they have, in several instances, recommended that Harris County implement policies and procedures that, as the Division well knows, have already been implemented by the HCSO.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because, to the extent not already in effect, the Division's recommended changes in policies and procedures are premised upon the faulty presumption that the policies and procedures in place during the relevant time period were constitutionally deficient.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter because such recommendations are ambiguous.

Harris County objects to the Civil Rights Division advocates' recommended minimum remedial measures in Section IV of the Division's June 4, 2009 letter insofar as the implementation of the Division advocates' recommendations would elevate the Harris County taxpayers' burden to "ensure," under threat of lawsuit, conditions of confinement that far exceed minimum constitutional requirements.

B. Medical Care

1. Response to the Civil Rights Division's first recommendation

According to the Civil Rights Division:

> The Jail should develop a chronic care program consistent with generally accepted correctional medical standards. This program should include a process that will identify detainees who should be enrolled in a chronic care program; a roster of detainees enrolled in the program; a schedule of medical visits for each detainee enrolled in the program; a system for determining which diagnostic tests will be required for each chronic condition; and record-keeping which includes documentation of lab work and medical orders.[568]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCJ medical program, including the management of chronic medical issues, has been reviewed and has received ongoing re-accreditation by the NCCHC. During the brief-out, the Civil Rights Division's medical consultant acknowledged that his recommendations

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[568] Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 4 (June 4, 2009).

regarding chronic care were at least in part based upon anticipated future standards, as opposed to current NCCHC standards. As discussed with the Division's medical consultant, the HCJ already has refined its chronic care program in anticipation of the then upcoming new NCCHC standards. The HCSO will continue to address the needs of chronic care patients in the proper perspective of the frequent short length of stay and recidivism seen in the jail population in compliance with NCCHC standards. Eventual development and implementation of the electronic medical record will be invaluable in enhancing the HCSO's record-keeping.

2. Response to the Civil Rights Division's second recommendation

According to the Civil Rights Division:

> The Jail should update and improve the medical and mental health quality assurance and training programs to ensure compliance with generally accepted correctional medical standards. These improvements should include additional internal self-auditing to ensure that staff conduct appropriate assessments, provide timely treatment, and document care in a manner consistent with generally accepted correctional medical standards.[569]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO has and intends to continue to maintain compliance with NCCHC standards, including those standards relating to quality improvement. This process already includes comprehensive medical and mental health quality improvement processes, including internal self-auditing. Processes to refine the professional peer review program, including oversight of medical physician activity by the UT-Health Science Center Medical Director and oversight of psychiatrist activity by both the MHMRA Medical Director and the Forensic Lead Psychiatrist are already in place. Addition of a mental health Utilization Review Manager has improved the HCSO's ability to monitor mental health unit admissions and inpatient care.

3. Response to the Civil Rights Division's third recommendation

According to the Civil Rights Division:

> The Jail should develop a system to monitor the effects of medications and to ensure appropriate follow-up for detainees with serious medical or mental health conditions.[570]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO implemented new processes during the Civil Rights Division's site visits to further enhance the ability to provide follow-up. MHMRA, as a part of its agreement revision in

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569 Letter from Loretta King to Ed Emmett, *supra* note 3, at 20 para. 5, at 21 para. 1 (June 4, 2009).

570 Letter from Loretta King to Ed Emmett, *supra* note 3, at 21 para. 2 (June 4, 2009).

March of 2009, specifically added both LPHA and psychiatrist resources to address the then anticipated upcoming change in NCCHC standards to require medication follow-up.

4. Response to the Civil Rights Division's fourth recommendation

According to the Civil Rights Division:

> The Jail should develop a system to track sick call requests and identify barriers to timely access to medical or mental health care. Sick call requests need to be triaged by appropriate personnel to ensure appropriate and timely access to medical care.[571]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO already has a robust sick call request system in place which is compliant with all NCCHC standards. Sick call requests are logged and appointments are scheduled by health care professionals within the time frames required by the NCCHC. The medical and mental health Quality Improvement Coordinators monitor the sick call request and appointment systems on a regular basis and report at the regularly scheduled Quality Improvement Committee meetings.

5. Response to the Civil Rights Division's fifth recommendation

According to the Civil Rights Division:

> The Jail should ensure that medical consultation and specialty services receive physician oversight.[572]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO specialty referral system already has physician oversight and is compliant with NCCHC standards. Recent access to the Harris County Hospital District's electronic medical record system, including the ability to input consultation and specialty services requests directly into the HCHD system, improves communication and allows for better documentation.

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571 Letter from Loretta King to Ed Emmett, *supra* note 3, at 21 para. 3 (June 4, 2009).

572 Letter from Loretta King to Ed Emmett, *supra* note 3, at 21 para. 4 (June 4, 2009).

6. Response to the Civil Rights Division's sixth recommendation

According to the Civil Rights Division:

> The Jail should employ sufficient qualified staff to ensure detainees have adequate access to medical and mental health care.[573]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO's medical and mental health staffing meets NCCHC requirements. Use of temporary agency support for nursing and other health care areas augments staffing resources.

C. Mental Health Care

1. Response to the Civil Rights Division's first recommendation

According to the Civil Rights Division:

> The Jail should create a mental health program that will allow the Jail to identify, treat, and monitor detainees with chronic mental illness. As part of this development process, responsible Jail personnel may wish to consider evaluating mental health programs in a variety of outside institutions and adopt useful policies and procedures from appropriate models.[574]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCJ already has a mental health program that identifies, treats and monitors patients with mental illness. As presented to the DOJ, augmentation of resources designed specifically to monitor patients on chronic psychotropic medication has been performed which allows for additional chronic mental illness management. The HCJ mental health program, as a part of the overall HCJ medical/mental health program, has been reviewed and accredited by the NCCHC.

2. Response to the Civil Rights Division's second recommendation

According to the Civil Rights Division:

> The Jail should continue with efforts to assess the mental health caseload in the facility, and develop a variety of housing and treatment options to address the needs of the mentally ill. This system will need to organize treatment options so that the Jail can deal with those across the entire spectrum of care. The Jail's mental health treatment policies need to meet generally accepted standards of

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573 Letter from Loretta King to Ed Emmett, *supra* note 3, at 21 para. 5 (June 4, 2009).

574 Letter from Loretta King to Ed Emmett, *supra* note 3, at 21 para. 6 (June 4, 2009).

> correctional health care. These policies should provide for the development of individual treatment plans and timely access to levels of care appropriate to detainees' mental health needs. Such care should address detainees who are stable and can be housed in general housing, detainees who are highly unstable and require intensive supervision, detainees who are stable but may require step-down services before returning to general population, detainees who are actively suicidal, and detainees who are at risk of suicide but may not have expressed an immediate intent to commit suicide.[575]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. A variety of housing and treatment options already exist in the jail—from inpatient psychiatric hospital care, to on-site mental health infirmary care, to on-site step-down unit care, to follow-up as outpatients in general population, detainees in the HCJ receive a spectrum of care. The treatment policies do meet NCCHC standards of correctional care. Timely access to appropriate levels of care, as required by the NCCHC, is provided and monitored by both MHMRA and HCSO quality improvement personnel. All patient transfers from acute units to step-down units to general population are determined by mental health care personnel based on clinical need.

3. Response to the Civil Rights Division's third recommendation

According to the Civil Rights Division:

> Restraints should not be used as punishment, for the convenience of staff, or in lieu of treatment. The Jail should provide a variety of psycho-therapeutic treatment options and adopt appropriate safeguards to avoid the inappropriate use of chemical sedation.[576]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. Restraints are not used as punishment, for the convenience of staff or in lieu of treatment. The Civil Rights Division's report failed to give an example of inappropriate use of restraints. The allegation of overuse of medication with the implication of use of chemical restraint was not substantiated. A variety of treatment options are provided. Safeguards are already in place including policies, procedures and practices, determining use of seclusion cells, chronic involuntary medication and use of involuntary medication in an emergent situation in compliance with 2008 NCCHC Standards for Health Services in Jails: J-I-01, "Restraint and Seclusion," and J-I-02, "Emergency Psychotropic Medication."

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575 Letter from Loretta King to Ed Emmett, *supra* note 3, at 21 para. 7, at 22 para. 1 (June 4, 2009).

576 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 2 (June 4, 2009).

4. Response to the Civil Rights Division's fourth recommendation

According to the Civil Rights Division:

> The Jail should implement policies for monitoring detainees at risk of suicide that meet generally accepted correctional mental health standards. The Jail should retrofit cells used for suicidal detainees or detainees requiring intensive supervision. The Jail should eliminate fixtures that can be used to facilitate suicide (e.g., exposed bars or bath fixtures) while at the same time avoid creating a non-therapeutic environment (e.g., bare cells or extensive use of isolation for psychotic detainees).[577]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCJ's policies relating to suicide prevention meet NCCHC and TCJS standards. As discussed more fully above, the NIC's technical consultants recently issued findings that are fundamentally inconsistent with the Division's findings on suicide prevention issue.[578] Detainees with suicidal ideation are admitted to the jail's mental health infirmary units under suicide precautions and are monitored by the jail's mental health staff. Only a psychiatrist can remove a patient from suicide precautions. Use of seclusion cells for psychotic detainees is governed by strict policies and procedures and is monitored by mental health quality improvement personnel.

5. Response to the Civil Rights Division's fifth recommendation

According to the Civil Rights Division:

> The Jail should include mental health staff and administrators as part of medical quality assurance and other administrative management processes.[579]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. Mental health staff and administrators have always been involved in administrative management processes, including participation in the quarterly Health Services Senior Staff meetings. The HCSO, long before the Civil Rights Division's site visits, hired an experienced Mental Health Quality Improvement Coordinator to augment the mental health quality assurance process. The Coordinator participates in ongoing quality improvement activities and presents at the quarterly Quality Improvement Committee meetings. He reports directly to the Executive Director of Health Services. In addition, MHMRA provides a Utilization Review Coordinator and provides peer review of psychiatrist activity.

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577 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 3 (June 4, 2009).

578 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 14.

579 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 4 (June 4, 2009).

D. Protection from Harm

1. Response to the Civil Rights Division's first recommendation

According to the Civil Rights Division:

> The Jail should ensure that there are a sufficient number of adequately trained staff on duty to supervise detainees and to respond to serious incidents.[580]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO has a sufficient number of adequately trained staff on duty to supervise inmates and to respond to serious incidents. The HCSO's staffing, training and supervision meet federal constitutional, as well as state, standards. Between January 1 and August 1 of this year, the HCSO hired a net total of 158 additional detention officers, and the HCSO continues to utilize overtime to supplement jail staffing levels as necessary. In addition, the HCSO operates a modern training academy, conducts numerous mandated (such as state-required Jail School) and voluntary training programs, and maintains a comprehensive Career Development section that retains the TCLEOSE training records of all HCSO employees. The HCSO will continue its aggressive efforts to attract, hire and train qualified detention personnel.

2. Response to the Civil Rights Division's second recommendation

According to the Civil Rights Division:

> The Jail should prohibit the use of chokeholds and hogtying.[581]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. The HCSO policies have prohibited "hog-tying of prisoners" for ten or more years.[582] It is fair to say that the HCSO's 2008 policies prohibited the use of deadly force (i.e. compression of a person's neck in a manner that could result in death or serious bodily injury) unless the circumstances justified the use of deadly force under state law. Sheriff Garcia's 2009 Detention Command Use-of-Force bureau policy explicitly prohibits such neck compressions in uses-of-force unless the circumstances faced by the officer would justify the use of deadly force in accordance with state law.[583]

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580 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 5 (June 4, 2009).

581 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 6 (June 4, 2009).

582 *See* 2008 Policy Manual at Chapter III, Section 3.0 (D)(2) (Procedures for Use of Less than Lethal Impact and Restraining Devices). *See also* 2009 Policy Manual at 502.1(1)(D)(2) (Less than Lethal Impact and Restraining Devices). In fact, HCSO policies have prohibited hog-tying for approximately ten or more years.

583 HCSO Detention Bureau Policy, Directive 09-001, *Use of Force Policy*, effective 8-14-09, revised 8-19-09.

3. Response to the Civil Rights Division's third recommendation

According to the Civil Rights Division:

> The Jail should increase video surveillance in critical housing areas and alter staffing patterns to provide additional direct supervision of housing units.[584]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. In addition to the objections lodged above, Harris County objects to this recommendation because it is ambiguous. It is not clear what the Civil Rights Division means by "increase video surveillance in critical housing areas," or by "alter staffing problems to provide additional direct supervision of housing units."

The Harris County Jail system already possesses extensive video surveillance in numerous areas. While most cameras in the jails are simply monitored, the HCSO upgraded the video surveillance system at the Inmate Processing Center in 2005 so that the IPC video is now digitally recorded and stored. In addition, the Harris County Sheriff's Office is in the process of upgrading the security system at the 701 N. San Jacinto Jail. This upgrade will include a new intercom system and video surveillance system consisting of 355 cameras located throughout the building. The cameras will be digitally recorded to the Sheriff's Office server. Neither the Constitution nor State law, however, requires video surveillance. In fact, after extensively studying the video surveillance issue, the Texas legislature declined to statutorily impose this requirement upon Texas counties.

The HCSO jail staffing deployment meets, and often exceeds, state standards. These staff members properly supervise inmates in all the housing units. In fact, the Harris County jail facilities are designed in such a way that jail staff actually view directly into the housing cellblocks from their assigned duty stations.

4. Response to the Civil Rights Division's fourth recommendation

According to the Civil Rights Division:

> The Jail should develop and implement policies and procedures to improve control over razors or other dangerous items.[585]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as

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584 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 7 (June 4, 2009).

585 Letter from Loretta King to Ed Emmett, *supra* note 3, at 22 para. 8 (June 4, 2009). In addition to the objections lodged above, Harris County objects to this recommendation because it is ambiguous. What does the Civil Rights Division mean by "other dangerous items"?

follows. The HCSO controls the introduction of razors and "other dangerous items" through searches of prisoners and cells. Searches have been, and are routinely, conducted as a matter of course for the protection of inmates as well as staff members. The policies and procedures implemented by the HCSO obviously control "razors and other dangerous items" in the Harris County Jail system. The Civil Rights Division advocates failed to support their "lack of control over razors or other dangerous items" allegations and recommended "minimum remedial relief" with citations to any incidents or pattern of incidents involving "razors or other dangerous items" in the Harris County jail facilities.

As stated above, Texas standards require the HCSO to provide indigent inmates with shaving implements.[586] Prior to the Civil Rights Division's July and August, 2008, inspections of the Harris County Jail system, the HCSO issued disposable razors to the inmates. Although there is no constitutional or statutory prohibition against the sale of disposable razors to, or the possession of, disposable razors by inmates, Division sanitation consultant Leonard Rice recommended against these practices. Notwithstanding the lack of *any* pattern of incidents that would fairly support the conclusion that the HCSO "lack control" over shaving razors, the HCSO stopped selling these razors to inmates and implemented a time consuming and costly new shaving procedure in accordance with Mr. Rice's recommendation. Harris County now purchases all disposable razors, distributes them to inmates on a regular basis, collects the razors approximately two hours after delivery, accounts for each razor, examines the condition of each razor to determine whether any razor blade is missing and disposes of the razors as biohazard waste products, all at great cost to the Harris County taxpayers.[587]

Harris County reported this change in procedure to the Division on January 9, 2009, but no mention of this fact is made in the Division's June 4, 2009 letter.[588] In fact, this change in policies and procedures is ignored in both the Division's findings and recommendations. The Division advocates represent that the HCSO has "no control" over razors, and recommend that the HCSO implement changes in policy and procedures that the Division advocates know to have already been implemented.[589] Then, after making findings the Division advocates know to be inaccurate and recommending changes in policies and procedures the Division advocates know to have already been made, they generally and amorphously state: "Since we toured, the County has reported that it has adopted a number of improvements, many of which appear to be designed

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586 *See* 37 Tex. Admin. Code § 277.4 ("Personal Hygiene").

587 Bates 31,357, 31,317-80.

588 Bates 31,323 (summary of razor policy and procedures), 31,357-59 ("Razor Distribution Policy"), 31,361 ("Razor Distribution Flowchart"), 31,363 (Inmate Razor Distribution Notification), 31,365-66 (Razor distribution forms).

589 Letter from Loretta King to Ed Emmett, *supra* note 3, at 18 para. 1 ("Other administrative deficiencies include a lack of staff control over hazardous contraband (*e.g.*, detainee razors)."), at 19 para. 3 ("As discussed previously in this letter's section on protection from harm, razor blades are not well controlled in the facility. The availability and use of dirty, shared razors and blades is a serious risk, both in terms of disease transmission and as a security matter."), at 22 para. 8 ("The Jail should develop and implement policies and procedures to improve control over razors or other dangerous items.") (June 4, 2009).

to address issues raised during our exit interviews. We appreciate the County's pro-active efforts."[590]

5. Response to the Civil Rights Division's fifth recommendation

According to the Civil Rights Division:

> The Jail should develop and implement additional policies and procedures for the investigation of serious incidents, including excessive use of force and detainee-on-detainee violence. These policies and procedures should include administrative responses to violence and a detainee disciplinary process conducted in a confidential manner. They should also include routine interview and document collection procedures that will allow investigators to complete their inquiries in an objective manner consistent with generally accepted correctional standards.[591]

In addition to the objections lodged above, Harris County objects to these recommendations because they are ambiguous. Notwithstanding these objections, Harris County has extensive policies and procedures relating to the investigation of use of force incidents. The HCSO has historically investigated all serious incidents, including allegations of excessive use of force and altercations in the jail, and will continue to do so. To facilitate that effort, the HCSO created the Office of Inspector General in May 2008. The OIG was created with the objective of providing additional independent oversight of Detention Command operations. Specifically, the OIG's Investigative Division was formed to investigate complaints and alleged policy violations involving HCSO employees assigned to the Detention Command. OIG's mission is to provide independent, fair, unbiased, factually accurate and complete investigative reports to the HCSO Command staff for review and final disposition. When necessary, OIG investigators work with the Harris County District Attorney's Public Integrity Division to prosecute employees who violate the law. Prior to the DOJ's inspections, the OIG Investigative Division initiated the process of independently reviewing complaints filed against Detention Command personnel.[592]

The HCSO recognized that the Jail's UOF documentation and review process could be enhanced in order to provide more transparency and oversight, and the OIG Division worked closely with the Harris County Attorney's Office to augment documentation and review criteria for all use-of-force incidents within the HCSO Detention Command.[593] In November of 2008, the HCSO created the "Use-of-Force Review Section" in its Office of Inspector General. Documentation criteria and review protocols were implemented on November 12, 2008.[594] Under these

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590 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 7.

591 Letter from Loretta King to Ed Emmett. *supra* note 3, at 22 para. 9, at 23 para. 1 (June 4, 2009).

592 *See* 2008 Policy Manual at Chapter II, Section 1.10 (Internal Investigation). *See also* 2009 Policy Manual at 231 (Internal Investigations).

593 *See* Bates 31,323, 31,376-80.

594 *See* Bates 31,323, 31,376-80.

protocols, extensive documentation must be submitted with all UOF reports completed within the Detention Command.[595] This documentation includes, for example, use-of-force-related coversheet, report, supplemental reports, subject statement, witness statements, and photographs.[596] The OIG UOF Review Section reviews all jail UOF incidents and, after cross-checking that information against additional information, including inmate medical records, disciplinary statements, grievances and the like, provides an independent, informed assessment of whether the amount of force used by staff was appropriate and justified.[597] Any incident deemed questionable is referred for additional investigation. The OIG also created a use-of-force database that allows for electronic tracking and recording of all jail-related use-of-force incidents, and proactively sought applicable training for OIG staff members in investigative techniques.[598]

The HCSO's substantial augmentation of its use-of-force reporting and review procedures was implemented in November of 2008, and Harris County supplied the Civil Rights Division with the updated procedures on January 9, 2009. The Civil Rights Division advocates, however, failed to specifically acknowledge these enhancements when alleging that "use of force occurs at the Jail without adequate review" and when making the recommendations in this section of their recommended minimum remedial measures.[599]

In addition, Sheriff Adrian Garcia combined the Internal Affairs Division with the Office of Inspector General in early 2009 and nearly doubled the number of staff assigned to OIG (from 24 to 47).

The HCSO utilizes numerous methods to manage the inmate jail population. The basic design of the inmate housing units and associated duty stations allows staff to view directly into the cellblocks at all times. The HCSO conducts security checks, cell searches, searches of inmates, and monitors areas via video to enhance inmate management and facility security. In addition, the HCSO manages the jail population by issuing and enforcing rules documented in the Inmate Handbook (a booklet distributed to every inmate during intake processing). The HCSO operates a Disciplinary Court within each jail facility to fairly issue out sanctions (loss of privileges, placement in disciplinary separation, loss of good time credit, etc.) when inmates violate the rules of the institution. Through the jail disciplinary hearing process and enforcement of institutional rules, the HCSO already possesses an administrative mechanism to respond to disruptive behavior. The HCSO disciplinary process is conducted in accordance with State law, and suffers from no constitutional infirmity.

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595 *See* Bates 31,376-80.

596 *See* Bates 31,376-80.

597 The enhanced HCSO Use of Force documentation requirements and review protocols were established and implemented on November 12, 2008. *See* Bates 31,376-80. *See also* HCSO Office of Inspector General Policy, Directive OIG.001, Use of Force Required Documentation—Review Criteria / Process, effective 8-4-09.

598 *See* Bates 31,323.

599 *See* Letter from Loretta King to Ed Emmett, *supra* note 3, at 15 para. 1, at 15-16, at 22 para. 5 – 23 para. 1.

When warranted, the HCSO also files additional criminal charges against inmates if they violate the law while in the jail. Inmate management is also enhanced by the comprehensive training the HCSO provides its jail staff, to include HCSO New Employee Orientation Training and state-mandated Jail School. The HCSO proactively. successfully manages the inmate population of the Harris County Jail.

6. Response to the Civil Rights Division's sixth recommendation

According to the Civil Rights Division:

> The Jail should alter its procedures for cell extractions and other use of force situations to ensure that staff are utilizing appropriate force techniques. Such alterations should include routine videotaping of planned use of force.[600]

Harris County objects to these recommendations because they are ambiguous. Subject to each of the objections made here and above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. Videotaping is not constitutionally required or required by Texas law. In fact, as stated above, the Texas legislature studied, considered and rejected a statutory videotaping requirement. Nonetheless, Sheriff Garcia has changed his policies, establishing protocols for the videotaping and electronic preservation of all planned use-of-force events, cell extractions, or other significant incidents involving uncooperative inmates, whenever time and circumstances permit.[601]

It must also be noted that the HCSO has specially trained and equipped staff to perform cell extractions and respond to disturbances in the jail (the HCSO Detention Command Containment Team and the HCSO Emergency Response Team). The Division's corrections consultant, Manuel Romero, saw the Containment Team perform the search process during the 2008 inspections of the Harris County Jail system, and complimented their work.

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600 Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 2 (June 4, 2009).

601 HCSO Detention Bureau Policy, Directive 09-002, *Videotaping Planned Use of Force Events*, effective 8-14-09, revised 8-19-09.

E. Sanitation and Life Safety

1. Response to the Civil Rights Division's first recommendation

According to the Civil Rights Division:

> The Jail should develop and implement a long-term plan for addressing Jail crowding and population growth.[602]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows. Harris County has taken numerous initiatives to proactively manage the jail population. For example, the HCSO has worked with the Texas Commission on Jail Standards to safely increase jail housing capacity by safely adding temporary (portable) beds into existing cellblocks. Since 2007, Harris County has contracted with private jail facilities in Louisiana to house excess Harris County inmates. This proactive diversion of inmates out of the Harris County Jail system has enabled the HCSO to safely manage the jail population and limit local crowding. In November 2008, Harris County hired the Justice Management Institute (JMI) to study the Harris County Criminal Justice System and make recommendations to help reduce jail crowding. Harris County received that report in June 2009 and has already formed a Criminal Justice Coordinating Council to act on the JMI recommendations. This Council, which had its first meeting on August 20, 2009, should allow Harris County to successfully reduce its current jail population, and to proactively regulate future jail population growth. In June 2009, with the approval of the Texas Commission on Jail Standards, Sheriff Adrian Garcia implemented enhancements in the jail inmate classification assessment process. These enhancements have allowed the HCSO to safely identify more minimum security inmates, which in turn allows the HCSO to more fully utilize its minimum security jails and divert inmates away from the more crowded high-security jails. Harris County continues to proactively manage its jail population.

2. Response to the Civil Rights Division's second recommendation

According to the Civil Rights Division:

> The Jail should develop and implement policies and procedures to improve detainee hygiene to a level consistent with generally accepted health standards. The Jail should specifically improve laundry practices and facilities to ensure that the Jail can adequately wash and sanitize detainee laundry. The Jail should also maintain, at all times, a sufficient supply of sanitary bedding, linen, clothing, razors, and other hygiene materials.[603]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as

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602 Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 3 (June 4, 2009).

603 Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 4 (June 4, 2009).

follows. Harris County jail facilities are generally clean and well maintained, and the HCSO's Sanitation Plan and sanitation satisfy all state and constitutional requirements. In addition, Harris County's laundry facilities, operations and procedures are constitutionally adequate and satisfy state standards.

The HCSO continues to maintain a sufficient supply of sanitary bedding, linen, clothing, razors and other hygiene materials. For example, the HCSO keeps a minimum of 3,000 – 4,000 extra jumpsuits on hand for contingency use. The jails continuously change out "clean for dirty" jumpsuits and linens. As the "clean for dirty" laundry exchange takes place, inmates take full carts of dirty items downstairs to be laundered, keeping a steady flow of clean jumpsuits and linen injected into the exchange process. In addition, the HCSO maintains a large supply of new laundry items in stock. For example, on July 2, 2009, the HCSO had approximately 19,872 sheets, 2,177 shirts, and 4,997 pants in the new supply stock. The HCSO also has the ability to order new laundry items as needed, subject to vendor availability.

The three Harris County Jail laundry facilities located at the 1200 Baker Street, 1307 Baker Street and 701 North San Jacinto jail locations have two 250-pound capacity washing machines, eleven 135-pound capacity washing machines, two 125-pound capacity washing machines and one 85-pound capacity washing machine; eleven 170-pound capacity dryers (with nine 120-pound capacity dryers on order to replace five of the 170-pound capacity dryers) and three 140-pound capacity dryers; industrial scales to weigh the laundry; automated detergent and bleach dispensers for the washing machines, commercial grade lint removal systems; numerous bins, carts, buggies, shelves and stainless steel tables to move and fold laundry; and six storerooms for laundry supplies. The laundry section keeps extra inmate uniforms, inmate undergarments, inmate sheets, inmate towels, and inmate blankets, as well as cleaning supplies, in the six storerooms. The HCSO replaced the older washing machines in the 701 North San Jacinto Jail in August 2008 (after the DOJ's last site inspection). The HCSO will continue to replace older equipment, as needed, and adequately wash and sanitize prisoner laundry.

3. Response to the Civil Rights Division's third recommendation

According to the Civil Rights Division:

> The Jail should increase staff training to ensure that staff is prepared to implement emergency procedures and operate emergency equipment the event of an emergency. Jail supervisors shall periodically test and drill staff on their knowledge of emergency procedures, and provide corrective instruction as part of a Jail-wide safety program. The Jail should continue with its ongoing effort to develop a qualified Jail safety team to help conduct staff training and oversee facility safety programs.[604]

Subject to each of the objections made above, as well as the other objections made throughout this response, Harris County responds to this recommended "minimum" remedial measure as follows.

---

[604] Letter from Loretta King to Ed Emmett, *supra* note 3, at 23 para. 4 (June 4, 2009).

The Harris County Sheriff's Office maintains adequate staffing levels throughout all Harris County jail facilities in accordance with applicable state and federal laws. The personnel assigned to jails undergo comprehensive training on emergency procedures, fire and life safety procedures and the operation of emergency equipment. This training occurs in the three-week New Employee Orientation Class and the six-week Jail School. The HCSO also conducts practical exercises and regular and irregular drills, to maintain a state of readiness. The Texas Commission on Jail Standards' staff also conducts emergency drills in all Harris County jail facilities during their inspections.

Harris County operates modern jail facilities with many fire safety features, including, among other things, alarm systems, fire suppression equipment, emergency flashlights, Scott Air Packs, Emergency evacuation chairs, smoke evacuation systems, fire extinguishers located throughout the buildings, Fireworks software, suicide cut-down tools and emergency evacuation keys. The HCSO also has three full-time Fire Safety Officers who oversee Harris County's fire safety-related training in the jails. The HCSO fire and safety staffing, training and oversight meet both constitutional and state standards.[605]

XII. Conclusion

Although we strongly disagree with the allegations lodged by the Civil Rights Division advocates, we hope to continue working with the Division in an amicable and cooperative fashion. As noted in your June 4, 2009 letter, Harris County continues to proactively adopt improvements which ultimately inure to the benefit of prisoners incarcerated in the Harris County Jail system. We would welcome the opportunity to sit down with you and more thoroughly address your letter and our response.

Respectfully submitted,

VINCE RYAN
HARRIS COUNTY ATTORNEY

J. MARCUS HILL
FIRST ASSISTANT COUNTY ATTORNEY

[605] *See, e.g.*, 37 Tex. Admin. Code §§ 263.1 – 263.90 (including "Life Safety Rules" applicable to Texas jails). *See also* Bates 12,729-813 (Emergency Plans for Detention Operations); 14,971 (Emergency Plan—System Plan); 14,982 (Fire Plan); 31,318, 31,336 (Emergency Cut-down tools).

TERENCE O'ROURKE
SPECIAL COUNSEL

JOHN ODAM
SPECIAL ASSISTANT COUNTY ATTORNEY

LISA R. HULSEY
CHIEF, APPELLATE DIVISION
1019 Congress, Fifteenth Floor
Houston, Texas 77002
(713) 755-7110 (telephone)
(713) 755-8924 (facsimile)
Lisa.Hulsey@cao.hctx.net

cc: Adrian Garcia
Harris County Sheriff
1200 Baker Street
Houston, Texas 77002

Honorable Ed Emmett
Harris County Judge
1001 Preston, Suite 911
Houston, Texas 77002

El Franco Lee
Commissioner Precinct 1
1001 Preston, 9th Floor
Houston, Texas 77002

Sylvia R. Garcia
Commissioner Precinct 2
1001 Preston, Room 950
Houston, Texas 77002

Steve Radack
Commissioner Precinct 3

1001 Preston, 9th Floor
Houston, Texas 77002

Jerry Eversole
Commissioner Precinct 4
1001 Preston, 9th Floor
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Jack Abercia
Harris County Constable Precinct 1
1302 Preston, 3rd Floor
Houston, Texas 77002

Ann Delgado
Justice of the Peace
Precinct 2, Place 1
10851 Scarsdale
Houston, Texas 77089

Hon. James J. ("Tad") Halbach
Administrative Judge of the District Courts
201 Caroline, 14th Floor
Houston, Texas 77002

Hon. Jean Spradling Hughes
Presiding Judge of the Harris County Criminal Court #15
1201 Franklin, 11th Floor
Houston, Texas 77002

Loren Jackson
Harris County District Clerk
201 Caroline, 4th Floor
Houston, Texas 77002

Pat Lykos
Harris County District Attorney
1201 Franklin, 6th Floor
Houston, Texas 77002

Hon. Debbie Mantooth Stricklin
Administrative Judge of the 180th District Court
1201 Franklin, 18th Floor
Houston, Texas 77002

1001 Preston, 9th Floor
Houston, Texas 77002

Jerry Eversole
Commissioner Precinct 4
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Harris County District Attorney
1201 Franklin, 6th Floor
Houston, Texas 77002

Hon. Debbie Mantooth Stricklin
Administrative Judge of the 180th District Court
1201 Franklin, 18th Floor
Houston, Texas 77002

The Honorable Tim Johnson, Esq.
United States Attorney
Southern District of Texas
P.O. Box 61129
Houston, TX 77208

Exhibit 1

Kelly E. Johnson, C.P.M., C.P.C.M.
Harris County Purchasing Agent

August 4, 2009

Commissioners Court
Harris County, Texas

RE: Interlocal Agreement

Members of Commissioners Court:

Please approve the attached Order authorizing the County Judge to execute the attached Agreement for the following:

Description:	Detention, Care and Transport of up to 872 Adult Inmates for the Harris County Sheriff's Office
Vendor:	Newton County, Texas
Term:	August 11, 2009 through February 28, 2010 with annual renewal options
Amount:	$6,538,610
Reviewed by:	X Sheriff's Office X Harris County Purchasing

A purchase order will be issued upon Commissioners Court approval.

Vote of the Court:	Yes	No	Abstain
Judge Emmett			
Comm. Lee			
Comm. Garcia			
Comm. Radack			
~~Comm. Eversole~~			

Sincerely,

Kelly E. Johnson
Purchasing Agent

MB
MAB/rml
Attachments
cc: Sheriff's Office
Vendor

US - original + 3 copies
Pur - original + 3 copies
Aud - original + 1 copy
Sheriff - copy

Presented to Commissioner's Court
AUG 11 2009
APPROVE
Recorded Vol_____ Page_____

FOR INCLUSION ON COMMISSIONERS COURT AGENDA AUGUST 11, 2009

1001 Preston, Suite 670, Houston, TX 77002 Tel 713-755-5036 Fax 713-755-6695

INTERLOCAL COOPERATION AGREEMENT

This Agreement is made by and entered into between Newton County, Texas (hereinafter "Contractor") and Harris County, Texas (hereinafter "Harris County") on the date indicated below.

WHEREAS, Harris County is seeking to provide for the housing and care of certain inmates incarcerated or to be incarcerated in its jail, and

WHEREAS, Contractor currently has the jail capacity and the ability to provide housing and care for such inmates, and

WHEREAS, both parties are political subdivisions of the State of Texas authorized to enter into an Interlocal Cooperation Agreement for such detention services pursuant to Chapter 791 of the Government Code (Vernon's 1992) (formerly Article 4413(32c), Tex. Rev. Civ. Stat.), and

WHEREAS, Harris County and the Contractor desire to enter into an agreement pursuant to which the Contractor will provide housing and care for certain inmates incarcerated or to be incarcerated in the County's jail.

NOW, THEREFORE, in consideration of the promises, covenants and agreements contained herein, the parties hereto mutually agree as follows:

ARTICLE I

DETENTION SERVICES

1.01 **HOUSING AND CARE OF INMATES:** Contractor agrees to accept, and provide for the secure custody, care and safekeeping of inmates of the County in accordance with state and local law, including the minimum standards promulgated by the Texas Commission on Jail Standards. The Contractor shall provide housing, care, meals, and routine medical services for such inmates on the same basis as it provides for its own inmates confined in its own jail subject to the terms and conditions of this Agreement.

1.02 **MEDICAL SERVICES:** The per day rate under this agreement covers only routine medical services such as on-site sick call (when provided by on-site staff) and non-prescription, over-the-counter/non-legend and routine drugs and medical supplies. The per day rate does not cover medical/health care services provided outside of the Contractor's facility or by other than facility staff, prescription drugs and treatments, or surgical, optical and dental care, and does not include the costs associated with any hospitalization of an inmate. The County shall pay the Contractor an amount equal to the amount the Contractor is required to expend for medical services and shall pay the County approved drug formulary rates for prescription drugs other than those routine medical services provided for by the per day rate. When it becomes necessary for an inmate to be hospitalized, the Contractor shall contact the County, through its Sheriff or designated representative, as soon as possible to inform the County of the fact that the inmate has been, or is to be, hospitalized and of the nature of the illness or injury that has required the hospitalization.

The Contractor shall submit invoices for such medical services along with its regular monthly billings for detention services, and such invoices shall be paid on the same terms as the regular monthly billing.

The Contractor has the right to arrange for the hospital or health care provider to bill the County directly for the costs of the hospitalization and/or medical care, rather than the Contractor paying the costs and billing the same to the County. If the hospital or health care provider refuses to bill the County directly, the County shall reimburse the Contractor for such costs within forty-five (45) business days of

receipt of an invoice from the Contractor therefor, which invoice may be delivered personally, by facsimile, by mail or by other reliable courier.

1:03 **MEDICAL INFORMATION:** If the Contractor deems it necessary pursuant to the HIPAA regulations (codified at 45 CFR Parts 160 and 164), Harris County shall provide the Contractor with medical information for all inmates sought to be transferred to the Contractor's facility under this agreement, including information regarding any special medication, diet or exercise regiment applicable to each inmate.

1:04 **TRANSPORTATION AND OFF-SITE SECURITY:** The Contractor agrees to provide one (1) guarded round-trip inmate transports per week of up to forty (40) inmates per transport at its expense for Harris County. Additional weekly transports will be billed to Harris County at the rate of $28.57 per hour per officer.

Contractor will provide stationary guard services $28.57 per hour per guard as requested or required by the circumstances or by law for inmates admitted or committed to an off-site medical facility. Harris County shall compensate the Contractor for the actual cost of said guard services to the Contractor, which shall be billed by the Contractor along with the regular monthly billing for detention services.

The Contractor is responsible for the transport of its inmates from the Contractor's facility to the Texas Department of Criminal Justice, Institutional Division.

1.05 **SPECIAL PROGRAMS:** The per day rate set out in this agreement only covers basic custodial care and supervision and does not include any special educational, vocational or other programs. The parties may agree by a written amendment to this agreement, or by separate agreement, for the provision of special programs for the consideration and under the terms mutually agreed to by the parties.

1.06 **LOCATION AND OPERATION OF FACILITY:** The Contractor shall provide the detention services described herein at the Newton County Jail in Newton, Texas,

ARTICLE II

FINANCIAL PROVISIONS

2.01 **PER DIEM RATE:** The per diem rate for detention services under this agreement is Forty-two dollars and twenty five cents ($42.25) per man day. This rate covers one inmate per day up to a maximum, not to exceed number of 872 adult beds. Harris County shall only contract the detention services under this agreement as needed, and as qualified inmates are identified through the classification process. At no time shall Harris County commit to a minimum number of inmate man-days. Any portion of any day shall count as a man-day under this agreement, except that Harris County may not be billed for two days when an inmate is admitted one evening and removed the following morning. In that situation, the Contract will bill for the day of arrival, but not for the day of departure.

2.02 **BILLING PROCEDURE:** Contractor shall submit an itemized invoice for the services provided each month to Harris County, in arrears, invoices will be submitted to the officer of Harris County designated to receive the same on behalf of Harris County. Harris County shall make payment to the Contractor within thirty (30) days after receipt of a County approved invoice. Payment shall be in the name of Newton County, Texas and shall be remitted to:

Newton County Auditor
110 Court Street
Newton, Texas 75966

Amounts which are not timely paid in accordance with the above procedure shall bear interest at the lesser of the annual percentage rate of 1%, or the maximum legal rate applicable thereto, which shall be a

contractual obligation of Harris County under this agreement. County further agrees that the Contractor shall be entitled to recover its reasonable and necessary attorney's fees and costs incurred in collection of amounts due under this agreement.

ARTICLE III

TERM OF AGREEMENT

3.01 **INITIAL TERM:** The Initial Term of this agreement is from the date of execution of this agreement by both parties through February 28, 2010.

3.02 **RENEWALS:** This agreement maybe renewed, after the Initial Term annually by mutual agreement of the parties. In the event that the parties seek to renew this agreement at the end of the primary term or any renewal period, the per diem rate for detention services shall be at the rate negotiated by the parties for such renewal period. The terms, conditions and rates with regard to any renewal period shall be as mutually agreed between the parties, and as approved by the commissioners courts of the respective parties.

3.03 **TERMINATION:** This agreement shall terminate at the end of the primary term or of any renewal term unless renewed pursuant to Section 3.02. In addition, this agreement may be terminated upon sixty (60) days written notice by either party delivered to the officer specified herein by the other party to receive notices. This agreement will likewise terminate upon the happening of an event that renders performance hereunder by the Contractor impracticable or impossible, such as severe damage to or destruction of the facility or actions by governmental or judicial entities which create a legal barrier to the acceptance of any of Harris County's inmates.

ARTICLE IV

ACCEPTANCE OF INMATES

4.01 **COMPLIANCE WITH LAW:** Nothing herein shall create any obligation upon the Contractor to house Harris County's inmates where the housing of said inmates will, in the opinion of the Contractor's Sheriff, raise the population of the facility above permissible numbers of inmates allowed by law, or will, in the Sheriff's opinion, create a condition of overcrowding or create conditions which endanger the life and/or welfare of personnel and inmates at the facility, or result in possible violation of the constitutional rights of the inmates housed at the facility. At any time that the Contractor's Sheriff determines that a condition exists at the Contractor's facility necessitating the removal of Harris County's prisoners, or any specified number thereof, Harris County shall, upon notice by the Contractor's Sheriff to the Sheriff of Harris County, immediately (within forty-eight (48) hours) remove said prisoner from the facility.

4.02 **ELIGIBILITY FOR INCARCERATION AT FACILITY:** The only inmates of Harris County eligible for incarceration are those inmates eligible for incarceration in the facility in accordance with the state standards under both the Jail Commission approved custody assessment system in place at Harris County's jail and pursuant to the custody assessment system in place at the Contractor's facility.

4.03 **RESERVATION WITH REGARD TO ACCEPTANCE OR CONTINUED INCARCERATION OF INDIVIDUAL INMATES:** Contractor reserves the right for its Sheriff or his designated representative to review the background of all inmates sought to be transferred to the Contractor's facility, and Harris County shall cooperate with and provide information requested regarding any inmate by the Contractor's Sheriff. The Contractor reserves the right to refuse acceptance of any prisoner of Harris County. Likewise, if any inmate's behavior, medical or psychological condition, or other circumstances of reasonable concern to the Contractor's Sheriff makes the inmate unacceptable for continued incarceration in Contractor's facility in the opinion of the Contractor's Sheriff, the county will be

requested to remove said inmate from the facility, and shall do so immediately (within forty-eight (48) hours) upon the request of the Contractor's Sheriff. Inmates may also be required to be removed from the facility when their classification changes for any purpose, including long-term medical segregation.

4.04 **INMATE SENTENCES:** Contractor shall not be in charge or responsible for the computation or processing of inmates time of confinement, including, but not limited to, computation of good time awards/credits and discharge dates. All such computations and recordkeeping shall continue to be the responsibility of Harris County. It shall be the responsibility of Harris County to notify the Contractor of any discharge date for an inmate at least ten (10) days before such date. The Contractor will release inmates of Harris County only when such release is specifically requested in writing by the Sheriff of Harris County. However, it is agreed that the preferred and usual course of dealing between the parties shall be for the Contractor to return inmates to Harris County facility shortly before their discharge date, and for Harris County to discharge the inmate from its own facility. Harris County accepts all responsibility for the calculations and determinations set forth above and for giving Contractor notice of same, and to the extent allowed by law, shall indemnify and hold the Contractor harmless for all liability or expenses of any kind arising therefrom. Harris County is responsible for all paperwork, arrangements and facilitation of inmates to be transferred and the Contractor shall be responsible for the transportation and delivery of Harris County inmates to the Texas Department of Criminal Justice, Institutional Division.

ARTICLE V

MISCELLANEOUS

5.01 **BINDING NATURE OF AGREEMENT:** This agreement is contractual and is binding upon the parties hereto and their successors, assigns, and representatives.

5.02 **NOTICE:** All notices, demands, or other writings may be delivered by either party hereto to the other by United States Mail or other reliable courier at the following address:

To Contractor:
Newton County Auditor
110 Court Street
Newton, Texas 75966

To County:
Harris County
Attn: Ed Emmett, County Judge
1001 Preston, Suite 911
Houston, TX 77002

With a copy to:
Harris County Purchasing Agent
1001 Preston, Suite 670
Houston, TX 77002

The address to which any notice, demand, or other writing may be delivered to any party as above provided may be changed by written notice given by such party as above provided.

5.03 **AMENDMENTS:** This agreement shall not be modified or amended except by a written instrument executed by the duly authorized representatives of both parties and approved by commissioners courts of the respective parties hereto.

5.04 **PRIOR AGREEMENTS:** This agreement contains all of the agreements and undertakings, either oral or written, of the parties with respect to any matter mentioned herein. No prior agreement or understanding pertaining to any such matter shall be effective.

5.05 **CHOICE OF LAW AND VENUE:** The law which shall govern this agreement is the law of the State of Texas. All consideration to be paid and matters to be performed under this agreement

are payable and performable in Newton, Newton County, Texas, and venue of any dispute or matter arising under this agreement shall lie in a district court of Harris County, Texas.

5.06 **APPROVALS:** This agreement must be approved by the Commissioners Court of Harris County and the Commissioners Court of the Contractor in accordance with the Interlocal Cooperation Act.

5.07 **FUNDING :** Prior to the execution of this agreement, Contractor has been advised by Harris County, and Contractor clearly understands and agrees, such understanding and agreement being of the absolute essence to this contract, that Harris County shall have available the total maximum sum of ***$6,538,610.00*** specifically allocated to fully discharge any and all liabilities which may be incurred by Harris County, including any and all costs for any and all things or purposes, ensuing under or out of this agreement, irrespective of the nature thereof, and notwithstanding any word, statement or thing contained in or inferred from the preceding provisions of this agreement which might in any light by any person be interpreted to the contrary. Harris County's liability for payment under the terms and provisions of this agreement is limited to such sum, plus additional amounts of funds from time to time certified available pursuant to Tex. Loc. Gov't Code Ann, §§111.031 - 111.093, as amended, for the purpose of satisfying Harris County's obligations under the terms and conditions of this agreement.

Signature and Execution:

HARRIS COUNTY, TEXAS

By: Ed Emmett
Ed Emmett, Harris County Judge (As Authorized and Approved by the Harris County Commissioners Court
Dated AUG 11 2009

NEWTON COUNTY, TEXAS

By: Truman Dougharty
Truman Dougharty, Newton County Judge (As Authorized and Approved by the Newton County Commissioners Court
Dated 7-29-09

APPROVED AS TO FORM:
VINCE RYAN, County Attorney

Portia Poindexter
Portia Poindexter, Assistant County Attorney

Misti Spacek
Criminal District Attorney

Harris County Sheriff
Date Approved: 8/1/09

Newton County Sheriff
Date Approved: 07 29 2009.

ATTEST:

Mary Cobb
Newton County Clerk

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

The Commissioners Court of Harris County, Texas, convened at a meeting of said Court at the Harris County Administration Building in the City of Houston, Texas, on the ____ day of AUG 1 1 2009, 2009 with the following members present, to-wit:

Ed Emmett	County Judge
El Franco Lee	Commissioner, Precinct No. 1
Sylvia García	Commissioner, Precinct No. 2
Steve Radack	Commissioner, Precinct No. 3
~~Jerry Eversole~~	~~Commissioner, Precinct No. 4~~

and the following members absent, to-wit: Eversole, constituting a quorum, when among other business, the following was transacted:

ORDER AUTHORIZING EXECUTION OF AN INTERLOCAL COOPERATION AGREEMENT BETWEEN HARRIS COUNTY AND NEWTON COUNTY

Commissioner Lee introduced an order and made a motion that the same be adopted. Commissioner Garcia seconded the motion for adoption of the order. The motion, carrying with it the adoption of the order, prevailed by the following vote:

Vote of the Court	Yes	No	Abstain
Judge Emmett	☑	☐	☐
Comm. Lee	☑	☐	☐
Comm. García	☑	☐	☐
Comm. Radack	☑	☐	☐
~~Comm. Eversole~~	☐	☐	☐

The County Judge thereupon announced that the motion had duly and lawfully carried and that the order had been duly and law-fully adopted. The order thus adopted follows:

Recitals

1. Harris County desires to contract with Newton County for the detention, care, and transport of up to 872 adult inmates detained by the Harris County Sheriff.

2. Harris County and Newton County desire to enter an agreement pursuant to Texas Gov't Code Ch. 791, ("the Interlocal Cooperation Act") authorizing local governments to purchase of services, provided that the services are authorized by the governing body of the counties, the services are payable from the current revenues of the purchasing party,

Presented to Commissioner's Court

AUG 1 1 2009

APPROVE_____

and they are for an amount that fairly compensates the performing part for the services or functions performed.

3. Newton County is capable of providing and willing to provide the services in the Interlocal Cooperation Agreement.

Now therefore be it Ordered by the Commissioner Court of Harris County:

1. That the recitals set forth in this Order are true and correct.

2. That Harris County Judge Ed Emmett be, and he is hereby, authorized to execute an Interlocal Cooperation Agreement between Harris County and Newton County providing for the detention, care, and transport of up to 872 adult inmates detained by the Harris County Sheriff, from this date through February 28, 2010 with the option to renew the agreement for additional one (1) year terms thereafter, and at a cost not to exceed ***$6,538,610.00***.

3. All Harris County officials and employees are authorized to do any and all things necessary or convenient to accomplish the purpose of this Order.

Exhibit 2

Kelly E. Johnson, C.P.M., C.P.C.M.
Harris County Purchasing Agent

August 4, 2009

Commissioners Court
Harris County, Texas

RE: Interlocal Agreement

Members of Commissioners Court:

Please approve the attached Order authorizing the County Judge to execute the attached Agreement for the following:

Description: Detention, Care and Transport of up to 500 Adult Inmates for the Harris County Sheriff's Office

Vendor: Bowie County, Texas

Term: August 11, 2009 through February 28, 2010 with annual renewal options

Amount: $4,106,250

Reviewed by: X Sheriff's Office X Harris County Purchasing

A purchase order will be issued upon Commissioners Court approval.

Vote of the Court:	Yes	No	Abstain
Judge Emmett	✓		
Comm. Lee			
Comm. Garcia			
Comm. Radack			
Comm. Eversole			

Sincerely,

Kelly E. Johnson
Purchasing Agent

MB MAB/rml
Attachments
cc: Sheriff's Office
Vendor

Presented to Commissioner's Court
AUG 11 2009
APPROVE L/G
Recorded Vol____ Page____

FOR INCLUSION ON COMMISSIONERS COURT AGENDA AUGUST 11, 2009

1001 Preston, Suite 670, Houston, TX 77002 Tel 713-755-5036 Fax 713-755-6695

INTERLOCAL COOPERATION AGREEMENT

This Agreement is made by and entered into between Bowie County, Texas (hereinafter "Contractor") and Harris County, Texas (hereinafter "Harris County") on the date indicated below.

WHEREAS, Harris County is seeking to provide for the housing and care of certain inmates incarcerated or to be incarcerated in its jail, and

WHEREAS, Contractor currently has the jail capacity and the ability to provide housing and care for such inmates, and

WHEREAS, both parties are political subdivisions of the State of Texas authorized to enter into an Interlocal Cooperation Agreement for such detention services pursuant to Chapter 791 of the Government Code (Vernon's 1992) (formerly Article 4413(32c), Tex. Rev. Civ. Stat.), and

WHEREAS, Harris County and the Contractor desire to enter into an agreement pursuant to which the Contractor will provide housing and care for certain inmates incarcerated or to be incarcerated in the County's jail.

NOW, THEREFORE, in consideration of the promises, covenants and agreements contained herein, the parties hereto mutually agree as follows:

ARTICLE I

DETENTION SERVICES

1.01 **HOUSING AND CARE OF INMATES:** Contractor agrees to accept, and provide for the secure custody, care and safekeeping of inmates of the County in accordance with state and local law, including the minimum standards promulgated by the Texas Commission on Jail Standards. The Contractor shall provide housing, care, meals, and routine medical services for such inmates on the same basis as it provides for its own inmates confined in its own jail subject to the terms and conditions of this Agreement.

1.02 **MEDICAL SERVICES:** The per day rate under this agreement covers only routine medical services such as on-site sick call (when provided by on-site staff) and non-prescription, over-the-counter/non-legend and routine drugs and medical supplies. The per day rate does not cover medical/health care services provided outside of the Contractor's facility or by other than facility staff, prescription drugs and treatments, or surgical, optical and dental care, and does not include the costs associated with any hospitalization of an inmate. The County shall pay the Contractor an amount equal to the amount the Contractor is required to expend for medical services and shall pay the County approved drug formulary rates for prescription drugs other than those routine medical services provided for by the per day rate. When it becomes necessary for an inmate to be hospitalized, the Contractor shall contact the County, through its Sheriff or designated representative, as soon as possible to inform the County of the fact that the inmate has been, or is to be, hospitalized and of the nature of the illness or injury that has required the hospitalization.

The Contractor shall submit invoices for such medical services along with its regular monthly billings for detention services, and such invoices shall be paid on the same terms as the regular monthly billing.

The Contractor has the right to arrange for the hospital or health care provider to bill the County directly for the costs of the hospitalization and/or medical care, rather than the Contractor paying the costs and billing the same to the County. If the hospital or health care provider refuses to bill the County directly, the County shall reimburse the Contractor for such costs within forty-five (45) business days of

receipt of an invoice from the Contractor therefor, which invoice may be delivered personally, by facsimile, by mail or by other reliable courier.

1:03 **MEDICAL INFORMATION:** If the Contractor deems it necessary pursuant to the HIPAA regulations (codified at 45 CFR Parts 160 and 164), Harris County shall provide the Contractor with medical information for all inmates sought to be transferred to the Contractor's facility under this agreement, including information regarding any special medication, diet or exercise regiment applicable to each inmate.

1:04 **TRANSPORTATION AND OFF-SITE SECURITY:** The Contractor agrees to provide one (1) guarded round-trip inmate transport per week of up to forty (40) inmates per transport at its expense for Harris County. Additional weekly transports will be billed to Harris County at the rate of $28.57 per hour per officer.

Contractor will provide stationary guard services $28.57 per hour per guard as requested or required by the circumstances or by law for inmates admitted or committed to an off-site medical facility. Harris County shall compensate the Contractor for the actual cost of said guard services to the Contractor, which shall be billed by the Contractor along with the regular monthly billing for detention services.

The Contractor is responsible for the transport of its inmates from the Contractor's facility to the Texas Department of Criminal Justice, Institutional Division.

1.05 **SPECIAL PROGRAMS:** The per day rate set out in this agreement only covers basic custodial care and supervision and does not include any special educational, vocational or other programs. The parties may agree by a written amendment to this agreement, or by separate agreement, for the provision of special programs for the consideration and under the terms mutually agreed to by the parties.

1.06 **LOCATION AND OPERATION OF FACILITY:** The Contractor shall provide the detention services described herein at Bowie County Correction Center in Texarkana, Texas.

ARTICLE II

FINANCIAL PROVISIONS

2.01 **PER DIEM RATE:** The per diem rate for detention services under this agreement is Forty-Two dollars ($42.00) per man day. This rate covers one inmate per day up to a maximum, not to exceed number of 500 adult beds. Harris County shall only contract the detention services under this agreement as needed, and as qualified inmates are identified through the classification process. At no time shall Harris County commit to a minimum number of inmate man-days. Any portion of any day shall count as a man-day under this agreement, except that Harris County may not be billed for two days when an inmate is admitted one evening and removed the following morning. In that situation, the Contract will bill for the day of arrival, but not for the day of departure.

2.02 **BILLING PROCEDURE:** Contractor shall submit an itemized invoice for the services provided each month to Harris County, in arrears, invoices will be submitted to the officer of Harris County designated to receive the same on behalf of Harris County. Harris County shall make payment to the Contractor within thirty (30) days after receipt of a County approved invoice. Payment shall be in the name of Bowie County, Texas and shall be remitted to:

Bowie County Auditor
PO Box 248
New Boston, TX 75570

Amounts which are not timely paid in accordance with the above procedure shall bear interest at the lesser of the annual percentage rate of 1%, or the maximum legal rate applicable thereto, which shall be a contractual obligation of Harris County under this agreement. County further agrees that the Contractor

shall be entitled to recover its reasonable and necessary attorney's fees and costs incurred in collection of amounts due under this agreement.

ARTICLE III

TERM OF AGREEMENT

3.01 **INITIAL TERM:** The Initial Term of this agreement is from the date of execution of this agreement by both parties through February 28, 2010.

3.02 **RENEWALS:** This agreement maybe renewed, after the Initial Term annually by mutual agreement of the parties. In the event that the parties seek to renew this agreement at the end of the primary term or any renewal period, the per diem rate for detention services shall be at the rate negotiated by the parties for such renewal period. The terms, conditions and rates with regard to any renewal period shall be as mutually agreed between the parties, and as approved by the commissioners courts of the respective parties.

3.03 **TERMINATION:** This agreement shall terminate at the end of the primary term or of any renewal term unless renewed pursuant to Section 3.02. In addition, this agreement may be terminated upon sixty (60) days written notice by either party delivered to the officer specified herein by the other party to receive notices. This agreement will likewise terminate upon the happening of an event that renders performance hereunder by the Contractor impracticable or impossible, such as severe damage to or destruction of the facility or actions by governmental or judicial entities which create a legal barrier to the acceptance of any of Harris County's inmates.

ARTICLE IV

ACCEPTANCE OF INMATES

4.01 **COMPLIANCE WITH LAW:** Nothing herein shall create any obligation upon the Contractor to house Harris County's inmates where the housing of said inmates will, in the opinion of the Contractor's Sheriff, raise the population of the facility above permissible numbers of inmates allowed by law, or will, in the Sheriff's opinion, create a condition of overcrowding or create conditions which endanger the life and/or welfare of personnel and inmates at the facility, or result in possible violation of the constitutional rights of the inmates housed at the facility. At any time that the Contractor's Sheriff determines that a condition exists at the Contractor's facility necessitating the removal of Harris County's prisoners, or any specified number thereof, Harris County shall, upon notice by the Contractor's Sheriff to the Sheriff of Harris County, immediately (within forty-eight (48) hours) remove said prisoner from the facility.

4.02 **ELIGIBILITY FOR INCARCERATION AT FACILITY:** The only inmates of Harris County eligible for incarceration are those inmates eligible for incarceration in the facility in accordance with the state standards under both the Jail Commission approved custody assessment system in place at Harris County's jail and pursuant to the custody assessment system in place at the Contractor's facility.

4.03 **RESERVATION WITH REGARD TO ACCEPTANCE OR CONTINUED INCARCERATION OF INDIVIDUAL INMATES:** Contractor reserves the right for its Sheriff or his designated representative to review the background of all inmates sought to be transferred to the Contractor's facility, and Harris County shall cooperate with and provide information requested regarding any inmate by the Contractor's Sheriff. The Contractor reserves the right to refuse acceptance of any prisoner of Harris County. Likewise, if any inmate's behavior, medical or psychological condition, or other circumstances of reasonable concern to the Contractor's Sheriff makes the inmate unacceptable for continued incarceration in Contractor's facility in the opinion of the Contractor's Sheriff, the county will be requested to remove said inmate from the facility, and shall do so immediately (within forty-eight (48)

hours) upon the request of the Contractor's Sheriff. Inmates may also be required to be removed from the facility when their classification changes for any purpose, including long-term medical segregation.

4.04 **INMATE SENTENCES:** Contractor shall not be in charge or responsible for the computation or processing of inmates time of confinement, including, but not limited to, computation of good time awards/credits and discharge dates. All such computations and recordkeeping shall continue to be the responsibility of Harris County. It shall be the responsibility of Harris County to notify the Contractor of any discharge date for an inmate at least ten (10) days before such date. The Contractor will release inmates of Harris County only when such release is specifically requested in writing by the Sheriff of Harris County. However, it is agreed that the preferred and usual course of dealing between the parties shall be for the Contractor to return inmates to Harris County facility shortly before their discharge date, and for Harris County to discharge the inmate from its own facility. Harris County accepts all responsibility for the calculations and determinations set forth above and for giving Contractor notice of same, and to the extent allowed by law, shall indemnify and hold the Contractor harmless for all liability or expenses of any kind arising therefrom. Harris County is responsible for all paperwork, arrangements and facilitation of inmates to be transferred and the Contractor shall be responsible for the transportation and delivery of Harris County inmates to the Texas Department of Criminal Justice, Institutional Division.

ARTICLE V

MISCELLANEOUS

5.01 **BINDING NATURE OF AGREEMENT:** This agreement is contractual and is binding upon the parties hereto and their successors, assigns, and representatives.

5.02 **NOTICE:** All notices, demands, or other writings may be delivered by either party hereto to the other by United States Mail or other reliable courier at the following address:

To Contractor:
Bowie County Auditor
PO Box 248
New Boston, TX 75570

To County:
Harris County
Attn: Ed Emmett, County Judge
1001 Preston, Suite 911
Houston, TX 77002

With a copy to:
Harris County Purchasing Agent
1001 Preston, Suite 670
Houston, TX 77002

The address to which any notice, demand, or other writing may be delivered to any party as above provided may be changed by written notice given by such party as above provided.

5.03 **AMENDMENTS:** This agreement shall not be modified or amended except by a written instrument executed by the duly authorized representatives of both parties and approved by commissioners courts of the respective parties hereto.

5.04 **PRIOR AGREEMENTS:** This agreement contains all of the agreements and undertakings, either oral or written, of the parties with respect to any matter mentioned herein. No prior agreement or understanding pertaining to any such matter shall be effective.

5.05 **CHOICE OF LAW AND VENUE:** The law which shall govern this agreement is the law of the State of Texas. All consideration to be paid and matters to be performed under this agreement

are payable and performable in Texarkana, Bowie County, Texas, and venue of any dispute or matter arising under this agreement shall lie in a district court of Harris County, Texas.

5.06 **APPROVALS:** This agreement must be approved by the Commissioners Court of Harris County and the Commissioners Court of the Contractor in accordance with the Interlocal Cooperation Act.

5.07 **FUNDING :** Prior to the execution of this agreement, Contractor has been advised by Harris County, and Contractor clearly understands and agrees, such understanding and agreement being of the absolute essence to this contract, that Harris County shall have available the total maximum sum of ***$4,106,250.00*** specifically allocated to fully discharge any and all liabilities which may be incurred by Harris County, including any and all costs for any and all things or purposes, ensuing under or out of this agreement, irrespective of the nature thereof, and notwithstanding any word, statement or thing contained in or inferred from the preceding provisions of this agreement which might in any light by any person be interpreted to the contrary. Harris County's liability for payment under the terms and provisions of this agreement is limited to such sum, plus additional amounts of funds from time to time certified available pursuant to Tex. Loc. Gov't Code Ann, §§111.031 - 111.093, as amended, for the purpose of satisfying Harris County's obligations under the terms and conditions of this agreement.

Signature and Execution:

HARRIS COUNTY, TEXAS

By: Ed Emmett
County Judge
and Approved by the Harris County Commissioners Court by Order Dated AUG 11 2009)

BOWIE COUNTY, TEXAS

By: James M Carlow
Bowie County Judge (As Authorized and Approved by the Bowie County Commissioners Court by Order Dated 6/13/09)

APPROVED AS TO FORM:
VINCE RYAN, County Attorney

Portia Poindexter
Portia Poindexter, Assistant County Attorney

Harris County Sheriff
Date Approved: 8/4/09

Bowie County Auditor

James W. Prince
Bowie County Sheriff
Date Approved: 7-27-09

ATTEST:

Velma Moore

Bowie County Clerk

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

The Commissioners Court of Harris County, Texas, convened at a meeting of said Court at the Harris County Administration Building in the City of Houston, Texas, on the ____ day of AUG 11 2009, 2009 with the following members present, to-wit:

Ed Emmett	County Judge
El Franco Lee	Commissioner, Precinct No. 1
Sylvia García	Commissioner, Precinct No. 2
Steve Radack	Commissioner, Precinct No. 3
~~Jerry Eversole~~	~~Commissioner, Precinct No. 4~~

and the following members absent, to-wit: Eversole, constituting a quorum, when among other business, the following was transacted:

ORDER AUTHORIZING EXECUTION OF AN INTERLOCAL COOPERATION AGREEMENT BETWEEN HARRIS COUNTY AND BOWIE COUNTY

Commissioner Lee introduced an order and made a motion that the same be adopted. Commissioner García seconded the motion for adoption of the order. The motion, carrying with it the adoption of the order, prevailed by the following vote:

Vote of the Court	Yes	No	Abstain
Judge Emmett	☑	☐	☐
Comm. Lee	☑	☐	☐
Comm. García	☑	☐	☐
Comm. Radack	☑	☐	☐
~~Comm. Eversole~~	~~☐~~	~~☐~~	~~☐~~

The County Judge thereupon announced that the motion had duly and lawfully carried and that the order had been duly and law-fully adopted. The order thus adopted follows:

Recitals

1. Harris County desires to contract with Bowie County for the detention, care, and transport of up to 500 adult inmates detained by the Harris County Sheriff.

2. Harris County and Bowie County desire to enter an agreement pursuant to Texas Gov't Code Ch. 791, ("the Interlocal Cooperation Act") authorizing local governments to purchase of services, provided that the services are authorized by the governing body of the counties, the services are payable from the current revenues of the purchasing party,

Presented to Commissioner's Court

AUG 11 2009

APPROVE_____

Recorded Vol_____ Page

and they are for an amount that fairly compensates the performing part for the services or functions performed.

3. Bowie County is capable of providing and willing to provide the services in the Interlocal Cooperation Agreement.

Now therefore be it Ordered by the Commissioner Court of Harris County:

1. That the recitals set forth in this Order are true and correct.

2. That Harris County Judge Ed Emmett be, and he is hereby, authorized to execute an Interlocal Cooperation Agreement between Harris County and Bowie County providing for the detention, care, and transport of up to 500 adult inmates detained by the Harris County Sheriff, from this date through February 28, 2010 with the option to renew the agreement for additional one (1) year terms thereafter, and at a cost not to exceed ***$4,106,250.00*** .

3. All Harris County officials and employees are authorized to do any and all things necessary or convenient to accomplish the purpose of this Order.

Exhibit 3

Kelly E. Johnson, C.P.M., C.P.C.M.
Harris County Purchasing Agent

August 4, 2009

Commissioners Court
Harris County, Texas

RE: Interlocal Agreement

Members of Commissioners Court:

Please approve the attached Order authorizing the County Judge to execute the attached Agreement for the following:

Description: Detention, Care and Transport of up to 400 Adult Inmates for the Harris County Sheriff's Office

Vendor: Dickens County, Texas

Term: August 11, 2009 through February 28, 2010 with annual renewal options

Amount: $3,285,000

Reviewed by: __X__ Sheriff's Office __X__ Harris County Purchasing

A purchase order will be issued upon Commissioners Court approval.

Vote of the Court:	Yes	No	Abstain
Judge Emmett			
Comm. Lee			
Comm. Garcia			
Comm. Radack			
~~Comm. Eversole~~			

Sincerely,

Kelly E. Johnson
Purchasing Agent

MB MAB/rml
Attachments
cc: Sheriff's Office
Vendor

Presented to Commissioner's Court
AUG 11 2009
APPROVE L/G
Recorded Vol____ Page____

FOR INCLUSION ON COMMISSIONERS COURT AGENDA AUGUST 11, 2009

1001 Preston, Suite 670, Houston, TX 77002 Tel 713-755-5036 Fax 713-755-6695

INTERLOCAL COOPERATION AGREEMENT

This Agreement is made by and entered into between Dickens County, Texas (hereinafter "Contractor") and Harris County, Texas (hereinafter "Harris County") on the date indicated below.

WHEREAS, Harris County is seeking to provide for the housing and care of certain inmates incarcerated or to be incarcerated in its jail, and

WHEREAS, Contractor currently has the jail capacity and the ability to provide housing and care for such inmates, and

WHEREAS, both parties are political subdivisions of the State of Texas authorized to enter into an Interlocal Cooperation Agreement for such detention services pursuant to Chapter 791 of the Government Code (Vernon's 1992) (formerly Article 4413(32c), Tex. Rev. Civ. Stat.), and

WHEREAS, Harris County and the Contractor desire to enter into an agreement pursuant to which the Contractor will provide housing and care for certain inmates incarcerated or to be incarcerated in the County's jail.

NOW, THEREFORE, in consideration of the promises, covenants and agreements contained herein, the parties hereto mutually agree as follows:

ARTICLE I

DETENTION SERVICES

1.01 **HOUSING AND CARE OF INMATES**: Contractor agrees to accept, and provide for the secure custody, care and safekeeping of inmates of the County in accordance with state and local law, including the minimum standards promulgated by the Texas Commission on Jail Standards. The Contractor shall provide housing, care, meals, and routine medical services for such inmates on the same basis as it provides for its own inmates confined in its own jail subject to the terms and conditions of this Agreement.

1.02 **MEDICAL SERVICES:** The per day rate under this agreement covers only routine medical services such as on-site sick call (when provided by on-site staff) and non-prescription, over-the-counter/non-legend and routine drugs and medical supplies. The per day rate does not cover medical/health care services provided outside of the Contractor's facility or by other than facility staff, prescription drugs and treatments, or surgical, optical and dental care, and does not include the costs associated with any hospitalization of an inmate. The County shall pay the Contractor an amount equal to the amount the Contractor is required to expend for medical services and shall pay the County approved drug formulary rates for prescription drugs other than those routine medical services provided for by the per day rate. When it becomes necessary for an inmate to be hospitalized, the Contractor shall contact the County, through its Sheriff or designated representative, as soon as possible to inform the County of the fact that the inmate has been, or is to be, hospitalized and of the nature of the illness or injury that has required the hospitalization.

The Contractor shall submit invoices for such medical services along with its regular monthly billings for detention services, and such invoices shall be paid on the same terms as the regular monthly billing.

The Contractor has the right to arrange for the hospital or health care provider to bill the County directly for the costs of the hospitalization and/or medical care, rather than the Contractor paying the costs and billing the same to the County. If the hospital or health care provider refuses to bill the County directly, the County shall reimburse the Contractor for such costs within forty-five (45) business days of

receipt of an invoice from the Contractor therefor, which invoice may be delivered personally, by facsimile, by mail or by other reliable courier.

1:03 **MEDICAL INFORMATION:** If the Contractor deems it necessary pursuant to the HIPAA regulations (codified at 45 CFR Parts 160 and 164), Harris County shall provide the Contractor with medical information for all inmates sought to be transferred to the Contractor's facility under this agreement, including information regarding any special medication, diet or exercise regiment applicable to each inmate.

1:04 **TRANSPORTATION AND OFF-SITE SECURITY:** The Contractor agrees to provide one (1) guarded round-trip inmate transport per week of up to forty (40) inmates per transport at its expense for Harris County. Additional weekly transports will be billed to Harris County at the rate of $28.57 per hour per officer.

Contractor will provide stationary guard services $28.57 per hour per guard as requested or required by the circumstances or by law for inmates admitted or committed to an off-site medical facility. Harris County shall compensate the Contractor for the actual cost of said guard services to the Contractor, which shall be billed by the Contractor along with the regular monthly billing for detention services.

The Contractor is responsible for the transport of its inmates from the Contractor's facility to the Texas Department of Criminal Justice, Institutional Division.

1.05 **SPECIAL PROGRAMS:** The per day rate set out in this agreement only covers basic custodial care and supervision and does not include any special educational, vocational or other programs. The parties may agree by a written amendment to this agreement, or by separate agreement, for the provision of special programs for the consideration and under the terms mutually agreed to by the parties.

1.06 **LOCATION AND OPERATION OF FACILITY:** The Contractor shall provide the detention services described herein at Dickens County Correction Center in Dickens, Texas, which is operated by Community Education Centers

ARTICLE II

FINANCIAL PROVISIONS

2.01 **PER DIEM RATE:** The per diem rate for detention services under this agreement is Forty-five dollars ($45.00) per man day. This rate covers one inmate per day up to a maximum, not to exceed number of 400 adult beds. Harris County shall only contract the detention services under this agreement as needed, and as qualified inmates are identified through the classification process. At no time shall Harris County commit to a minimum number of inmate man-days. Any portion of any day shall count as a man-day under this agreement, except that Harris County may not be billed for two days when an inmate is admitted one evening and removed the following morning. In that situation, the Contract will bill for the day of arrival, but not for the day of departure.

2.02 **BILLING PROCEDURE:** Contractor shall submit an itemized invoice for the services provided each month to Harris County, in arrears, invoices will be submitted to the officer of Harris County designated to receive the same on behalf of Harris County. Harris County shall make payment to the Contractor within thirty (30) days after receipt of the invoice. Payment shall be in the name of Dickens County, Texas and shall be remitted to:

Dickens County Auditor
PO Box 179
Dickens, TX 79229

Amounts which are not timely paid in accordance with the above procedure shall bear interest at the lesser of the annual percentage rate of 1%, or the maximum legal rate applicable thereto, which shall be a

contractual obligation of Harris County under this agreement. County further agrees that the Contractor shall be entitled to recover its reasonable and necessary attorney's fees and costs incurred in collection of amounts due under this agreement.

ARTICLE III

TERM OF AGREEMENT

3.01 **INITIAL TERM:** The Initial Term of this agreement is from the date of execution of this agreement by both parties through February 28, 2010.

3.02 **RENEWALS:** This agreement maybe renewed, after the Initial Term annually by mutual agreement of the parties. In the event that the parties seek to renew this agreement at the end of the primary term or any renewal period, the per diem rate for detention services shall be at the rate negotiated by the parties for such renewal period. The terms, conditions and rates with regard to any renewal period shall be as mutually agreed between the parties, and as approved by the commissioners courts of the respective parties.

3.03 **TERMINATION:** This agreement shall terminate at the end of the primary term or of any renewal term unless renewed pursuant to Section 3.02. In addition, this agreement may be terminated upon sixty (60) days written notice by either party delivered to the officer specified herein by the other party to receive notices. This agreement will likewise terminate upon the happening of an event that renders performance hereunder by the Contractor impracticable or impossible, such as severe damage to or destruction of the facility or actions by governmental or judicial entities which create a legal barrier to the acceptance of any of Harris County's inmates.

ARTICLE IV

ACCEPTANCE OF INMATES

4.01 **COMPLIANCE WITH LAW:** Nothing herein shall create any obligation upon the Contractor to house Harris County's inmates where the housing of said inmates will, in the opinion of the Contractor's Sheriff, raise the population of the facility above permissible numbers of inmates allowed by law, or will, in the Sheriff's opinion, create a condition of overcrowding or create conditions which endanger the life and/or welfare of personnel and inmates at the facility, or result in possible violation of the constitutional rights of the inmates housed at the facility. At any time that the Contractor's Sheriff determines that a condition exists at the Contractor's facility necessitating the removal of Harris County's prisoners, or any specified number thereof, Harris County shall, upon notice by the Contractor's Sheriff to the Sheriff of Harris County, immediately (within forty-eight (48) hours) remove said prisoner from the facility.

4.02 **ELIGIBILITY FOR INCARCERATION AT FACILITY:** The only inmates of Harris County eligible for incarceration are those inmates eligible for incarceration in the facility in accordance with the state standards under both the Jail Commission approved custody assessment system in place at Harris County's jail and pursuant to the custody assessment system in place at the Contractor's facility.

4.03 **RESERVATION WITH REGARD TO ACCEPTANCE OR CONTINUED INCARCERATION OF INDIVIDUAL INMATES:** Contractor reserves the right for its Sheriff or his designated representative to review the background of all inmates sought to be transferred to the Contractor's facility, and Harris County shall cooperate with and provide information requested regarding any inmate by the Contractor's Sheriff. The Contractor reserves the right to refuse acceptance of any prisoner of Harris County. Likewise, if any inmate's behavior, medical or psychological condition, or other circumstances of reasonable concern to the Contractor's Sheriff makes the inmate unacceptable for continued incarceration in Contractor's facility in the opinion of the Contractor's Sheriff, the county will be

requested to remove said inmate from the facility, and shall do so immediately (within eight (8) hours) upon the request of the Contractor's Sheriff. Inmates may also be required to be removed from the facility when their classification changes for any purpose, including long-term medical segregation.

4.04 **INMATE SENTENCES:** Contractor shall not be in charge or responsible for the computation or processing of inmates time of confinement, including, but not limited to, computation of good time awards/credits and discharge dates. All such computations and recordkeeping shall continue to be the responsibility of Harris County. It shall be the responsibility of Harris County to notify the Contractor of any discharge date for an inmate at least ten (10) days before such date. The Contractor will release inmates of Harris County only when such release is specifically requested in writing by the Sheriff of Harris County. However, it is agreed that the preferred and usual course of dealing between the parties shall be for the Contractor to return inmates to Harris County facility shortly before their discharge date, and for Harris County to discharge the inmate from its own facility. Harris County accepts all responsibility for the calculations and determinations set forth above and for giving Contractor notice of same, and to the extent allowed by law, shall indemnify and hold the Contractor harmless for all liability or expenses of any kind arising therefrom. Harris County is responsible for all paperwork, arrangements and facilitation of inmates to be transferred and the Contractor shall be responsible for the transportation and delivery of Harris County inmates to the Texas Department of Criminal Justice, Institutional Division.

ARTICLE V

MISCELLANEOUS

5.01 **BINDING NATURE OF AGREEMENT:** This agreement is contractual and is binding upon the parties hereto and their successors, assigns, and representatives.

5.02 **NOTICE:** All notices, demands, or other writings may be delivered by either party hereto to the other by United States Mail or other reliable courier at the following address:

To Contractor:
Dickens County Auditor
PO Box 179
Dickens, TX 79229

To County:
Harris County
Attn: Ed Emmett, County Judge
1001 Preston, Suite 911
Houston, TX 77002

With a copy to:
Harris County Purchasing Agent
1001 Preston, Suite 670
Houston, TX 77002

The address to which any notice, demand, or other writing may be delivered to any party as above provided may be changed by written notice given by such party as above provided.

5.03 **AMENDMENTS:** This agreement shall not be modified or amended except by a written instrument executed by the duly authorized representatives of both parties and approved by commissioners courts of the respective parties hereto.

5.04 **PRIOR AGREEMENTS:** This agreement contains all of the agreements and undertakings, either oral or written, of the parties with respect to any matter mentioned herein. No prior agreement or understanding pertaining to any such matter shall be effective.

5.05 **CHOICE OF LAW AND VENUE:** The law which shall govern this agreement is the law of the State of Texas. All consideration to be paid and matters to be performed under this agreement

are payable and performable in Dickens, Dickens County, Texas, and venue of any dispute or matter arising under this agreement shall lie in a district court of Harris County, Texas.

5.06 **APPROVALS:** This agreement must be approved by the Commissioners Court of Harris County and the Commissioners Court of the Contractor in accordance with the Interlocal Cooperation Act.

5.07 **FUNDING :** Prior to the execution of this agreement, Contractor has been advised by Harris County, and Contractor clearly understands and agrees, such understanding and agreement being of the absolute essence to this contract, that Harris County shall have available the total maximum sum of ***$3,285,000.00*** specifically allocated to fully discharge any and all liabilities which may be incurred by Harris County, including any and all costs for any and all things or purposes, ensuing under or out of this agreement, irrespective of the nature thereof, and notwithstanding any word, statement or thing contained in or inferred from the preceding provisions of this agreement which might in any light by any person be interpreted to the contrary. Harris County's liability for payment under the terms and provisions of this agreement is limited to such sum, plus additional amounts of funds from time to time certified available pursuant to Tex. Loc. Gov't Code Ann, §§111.031 - 111.093, as amended, for the purpose of satisfying Harris County's obligations under the terms and conditions of this agreement.

Signature and Execution:

HARRIS COUNTY, TEXAS

By: Ed Emmett
County Judge
and Approved by the Harris County Commissioners Court by Order Dated AUG 11 2009)

DICKENS COUNTY, TEXAS

By: Lisa Arnold
Dickens County Judge (As Authorized and Approved by the Dickens County Commissioners Court by Order Dated 6-18-2008)

APPROVED AS TO FORM:
VINCE RYAN, County Attorney

Portia Poindexter
Portia Poindexter, Assistant County Attorney

Harris County Sheriff
Date Approved: 8/1/09

Sandy Vickers
Dickens County ~~Auditor~~ Treasurer

Jimmie Land
Dickens County Sheriff
Date Approved: 7-28-09

ATTEST:

Dickens County Clerk

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

The Commissioners Court of Harris County, Texas, convened at a meeting of said Court at the Harris County Administration Building in the City of Houston, Texas, on the ____ day of AUG 11 2009, 2009 with the following members present, to-wit:

Ed Emmett	County Judge
El Franco Lee	Commissioner, Precinct No. 1
Sylvia García	Commissioner, Precinct No. 2
Steve Radack	Commissioner, Precinct No. 3
~~Jerry Eversole~~	~~Commissioner, Precinct No. 4~~

and the following members absent, to-wit: Eversole, constituting a quorum, when among other business, the following was transacted:

ORDER AUTHORIZING EXECUTION OF AN INTERLOCAL COOPERATION AGREEMENT BETWEEN HARRIS COUNTY AND DICKENS COUNTY

Commissioner Lee introduced an order and made a motion that the same be adopted. Commissioner Garcia seconded the motion for adoption of the order. The motion, carrying with it the adoption of the order, prevailed by the following vote:

Vote of the Court	Yes	No	Abstain
Judge Emmett	✓	☐	☐
Comm. Lee	✓	☐	☐
Comm. García	✓	☐	☐
Comm. Radack	✓	☐	☐
~~Comm. Eversole~~	~~☐~~	~~☐~~	~~☐~~

The County Judge thereupon announced that the motion had duly and lawfully carried and that the order had been duly and law-fully adopted. The order thus adopted follows:

Recitals

1. Harris County desires to contract with Dickens County for the detention, care, and transport of up to 400 adult inmates detained by the Harris County Sheriff.

2. Harris County and Dickens County desire to enter an agreement pursuant to Texas Gov't Code Ch. 791, ("the Interlocal Cooperation Act") authorizing local governments to purchase of services, provided that the services are authorized by the governing body of the counties, the services are payable from the current revenues of the purchasing party,

Presented to Commissioner's Court
AUG 11 2009
APPROVE_____

and they are for an amount that fairly compensates the performing part for the services or functions performed.

3. Dickens County is capable of providing and willing to provide the services in the Interlocal Cooperation Agreement.

Now therefore be it Ordered by the Commissioner Court of Harris County:

1. That the recitals set forth in this Order are true and correct.

2. That Harris County Judge Ed Emmett be, and he is hereby, authorized to execute an Interlocal Cooperation Agreement between Harris County and Dickens County providing for the detention, care, and transport of up to 400 adult inmates detained by the Harris County Sheriff, from this date through February 28, 2010 with the option to renew the agreement for additional one (1) year terms thereafter, and at a cost not to exceed ***$3,285,000.00***.

3. All Harris County officials and employees are authorized to do any and all things necessary or convenient to accomplish the purpose of this Order.

Exhibit 4

Kelly E. Johnson, C.P.M., C.P.C.M.
Harris County Purchasing Agent

August 4, 2009

Commissioners Court
Harris County, Texas

RE: Interlocal Agreement

Members of Commissioners Court:

Please approve the attached Order authorizing the County Judge to execute the attached Agreement for the following:

Description: Detention, Care and Transport of up to 376 Adult Inmates for the Harris County Sheriff's Office

Vendor: Jefferson County, Texas

Term: August 11, 2009 through February 28, 2010 with annual renewal options

Amount: $2,575,075

Reviewed by: X Sheriff's Office X Harris County Purchasing

A purchase order will be issued upon Commissioners Court approval.

Sincerely,

Kelly E. Johnson
Purchasing Agent

Vote of the Court:	Yes	No	Abstain
Judge Emmett			
Comm. Lee			
Comm. Garcia			
Comm. Radack			
~~Comm. Eversole~~			

MB

MAB/rml
Attachments
cc: Sheriff's Office
Vendor

Presented to Commissioner's Court
AUG 11 2009
APPROVE
Recorded Vol____ Page____

FOR INCLUSION ON COMMISSIONERS COURT AGENDA AUGUST 11, 2009

1001 Preston, Suite 670, Houston, TX 77002 Tel 713-755-5036 Fax 713-755-6695

INTERLOCAL COOPERATION AGREEMENT

This Agreement is made by and entered into between Jefferson County, Texas (hereinafter "Contractor") and Harris County, Texas (hereinafter "Harris County") on the date indicated below.

WHEREAS, Harris County is seeking to provide for the housing and care of certain inmates incarcerated or to be incarcerated in its jail, and

WHEREAS, Contractor currently has the jail capacity and the ability to provide housing and care for such inmates, and

WHEREAS, both parties are political subdivisions of the State of Texas authorized to enter into an Interlocal Cooperation Agreement for such detention services pursuant to Chapter 791 of the Government Code (Vernon's 1992) (formerly Article 4413(32c), Tex. Rev. Civ. Stat.), and

WHEREAS, Harris County and the Contractor desire to enter into an agreement pursuant to which the Contractor will provide housing and care for certain inmates incarcerated or to be incarcerated in the County's jail.

NOW, THEREFORE, in consideration of the promises, covenants and agreements contained herein, the parties hereto mutually agree as follows:

ARTICLE I

DETENTION SERVICES

1.01 **HOUSING AND CARE OF INMATES:** Contractor agrees to accept, and provide for the secure custody, care and safekeeping of inmates of the County in accordance with state and local law, including the minimum standards promulgated by the Texas Commission on Jail Standards. The Contractor shall provide housing, care, meals, and routine medical services for such inmates on the same basis as it provides for its own inmates confined in its own jail subject to the terms and conditions of this Agreement.

1.02 **MEDICAL SERVICES:** The per day rate under this agreement covers only routine medical services such as on-site sick call (when provided by on-site staff) and non-prescription, over-the-counter/non-legend and routine drugs and medical supplies. The per day rate does not cover medical/health care services provided outside of the Contractor's facility or by other than facility staff, prescription drugs and treatments, or surgical, optical and dental care, and does not include the costs associated with any hospitalization of an inmate. The County shall pay the Contractor an amount equal to the amount the Contractor is required to expend for medical services and shall pay the County approved drug formulary rates for prescription drugs other than those routine medical services provided for by the per day rate. When it becomes necessary for an inmate to be hospitalized, the Contractor shall contact the County, through its Sheriff or designated representative, as soon as possible to inform the County of the fact that the inmate has been, or is to be, hospitalized and of the nature of the illness or injury that has required the hospitalization.

The Contractor shall submit invoices for such medical services along with its regular monthly billings for detention services, and such invoices shall be paid on the same terms as the regular monthly billing.

The Contractor has the right to arrange for the hospital or health care provider to bill the County directly for the costs of the hospitalization and/or medical care, rather than the Contractor paying the costs and billing the same to the County. If the hospital or health care provider refuses to bill the County directly, the County shall reimburse the Contractor for such costs within forty-five (45) business days of

receipt of an invoice from the Contractor therefor, which invoice may be delivered personally, by facsimile, by mail or by other reliable courier.

1:03 **MEDICAL INFORMATION:** If the Contractor deems it necessary pursuant to the HIPAA regulations (codified at 45 CFR Parts 160 and 164), Harris County shall provide the Contractor with medical information for all inmates sought to be transferred to the Contractor's facility under this agreement, including information regarding any special medication, diet or exercise regiment applicable to each inmate.

1:04 **TRANSPORTATION AND OFF-SITE SECURITY:** The Contractor agrees to provide one (1) guarded round-trip inmate transports per week of up to forty (40) inmates per transport at its expense for Harris County. Additional weekly transports will be billed to Harris County at the rate of $28.57 per hour per officer.

Contractor will provide stationary guard services $28.57 per hour per guard as requested or required by the circumstances or by law for inmates admitted or committed to an off-site medical facility. Harris County shall compensate the Contractor for the actual cost of said guard services to the Contractor, which shall be billed by the Contractor along with the regular monthly billing for detention services.

The Contractor is responsible for the transport of its inmates from the Contractor's facility to the Texas Department of Criminal Justice, Institutional Division.

1.05 **SPECIAL PROGRAMS:** The per day rate set out in this agreement only covers basic custodial care and supervision and does not include any special educational, vocational or other programs. The parties may agree by a written amendment to this agreement, or by separate agreement, for the provision of special programs for the consideration and under the terms mutually agreed to by the parties.

1.06 **LOCATION AND OPERATION OF FACILITY:** The Contractor shall provide the detention services described herein at the Jefferson County Jail in Beaumont, Texas,

ARTICLE II

FINANCIAL PROVISIONS

2.01 **PER DIEM RATE:** The per diem rate for detention services under this agreement is Forty-two dollars and fifty cents ($42.50) per man day. This rate covers one inmate per day up to a maximum, not to exceed number of 376 adult beds. Harris County shall only contract the detention services under this agreement as needed, and as qualified inmates are identified through the classification process. At no time shall Harris County commit to a minimum number of inmate man-days. Any portion of any day shall count as a man-day under this agreement, except that Harris County may not be billed for two days when an inmate is admitted one evening and removed the following morning. In that situation, the Contract will bill for the day of arrival, but not for the day of departure.

2.02 **BILLING PROCEDURE:** Contractor shall submit an itemized invoice for the services provided each month to Harris County, in arrears, invoices will be submitted to the officer of Harris County designated to receive the same on behalf of Harris County. Harris County shall make payment to the Contractor within thirty (30) days after receipt of a County approved invoice. Payment shall be in the name of Jefferson County, Texas and shall be remitted to:

Jefferson County Auditor
1149 Pearl Street
Beaumont, Texas 77701

Amounts which are not timely paid in accordance with the above procedure shall bear interest at the lesser of the annual percentage rate of 1%, or the maximum legal rate applicable thereto, which shall be a

contractual obligation of Harris County under this agreement. County further agrees that the Contractor shall be entitled to recover its reasonable and necessary attorney's fees and costs incurred in collection of amounts due under this agreement.

ARTICLE III

TERM OF AGREEMENT

3.01 **INITIAL TERM:** The Initial Term of this agreement is from the date of execution of this agreement by both parties through February 28, 2010.

3.02 **RENEWALS:** This agreement maybe renewed, after the Initial Term annually by mutual agreement of the parties. In the event that the parties seek to renew this agreement at the end of the primary term or any renewal period, the per diem rate for detention services shall be at the rate negotiated by the parties for such renewal period. The terms, conditions and rates with regard to any renewal period shall be as mutually agreed between the parties, and as approved by the commissioners courts of the respective parties.

3.03 **TERMINATION:** This agreement shall terminate at the end of the primary term or of any renewal term unless renewed pursuant to Section 3.02. In addition, this agreement may be terminated upon sixty (60) days written notice by either party delivered to the officer specified herein by the other party to receive notices. This agreement will likewise terminate upon the happening of an event that renders performance hereunder by the Contractor impracticable or impossible, such as severe damage to or destruction of the facility or actions by governmental or judicial entities which create a legal barrier to the acceptance of any of Harris County's inmates.

ARTICLE IV

ACCEPTANCE OF INMATES

4.01 **COMPLIANCE WITH LAW:** Nothing herein shall create any obligation upon the Contractor to house Harris County's inmates where the housing of said inmates will, in the opinion of the Contractor's Sheriff, raise the population of the facility above permissible numbers of inmates allowed by law, or will, in the Sheriff's opinion, create a condition of overcrowding or create conditions which endanger the life and/or welfare of personnel and inmates at the facility, or result in possible violation of the constitutional rights of the inmates housed at the facility. At any time that the Contractor's Sheriff determines that a condition exists at the Contractor's facility necessitating the removal of Harris County's prisoners, or any specified number thereof, Harris County shall, upon notice by the Contractor's Sheriff to the Sheriff of Harris County, immediately (within forty-eight (48) hours) remove said prisoner from the facility.

4.02 **ELIGIBILITY FOR INCARCERATION AT FACILITY:** The only inmates of Harris County eligible for incarceration are those inmates eligible for incarceration in the facility in accordance with the state standards under both the Jail Commission approved custody assessment system in place at Harris County's jail and pursuant to the custody assessment system in place at the Contractor's facility.

4.03 **RESERVATION WITH REGARD TO ACCEPTANCE OR CONTINUED INCARCERATION OF INDIVIDUAL INMATES:** Contractor reserves the right for its Sheriff or his designated representative to review the background of all inmates sought to be transferred to the Contractor's facility, and Harris County shall cooperate with and provide information requested regarding any inmate by the Contractor's Sheriff. The Contractor reserves the right to refuse acceptance of any prisoner of Harris County. Likewise, if any inmate's behavior, medical or psychological condition, or other circumstances of reasonable concern to the Contractor's Sheriff makes the inmate unacceptable for continued incarceration in Contractor's facility in the opinion of the Contractor's Sheriff, the county will be

requested to remove said inmate from the facility, and shall do so immediately (within forty-eight (48) hours) upon the request of the Contractor's Sheriff. Inmates may also be required to be removed from the facility when their classification changes for any purpose, including long-term medical segregation.

4.04 **INMATE SENTENCES:** Contractor shall not be in charge or responsible for the computation or processing of inmates time of confinement, including, but not limited to, computation of good time awards/credits and discharge dates. All such computations and recordkeeping shall continue to be the responsibility of Harris County. It shall be the responsibility of Harris County to notify the Contractor of any discharge date for an inmate at least ten (10) days before such date. The Contractor will release inmates of Harris County only when such release is specifically requested in writing by the Sheriff of Harris County. However, it is agreed that the preferred and usual course of dealing between the parties shall be for the Contractor to return inmates to Harris County facility shortly before their discharge date, and for Harris County to discharge the inmate from its own facility. Harris County accepts all responsibility for the calculations and determinations set forth above and for giving Contractor notice of same, and to the extent allowed by law, shall indemnify and hold the Contractor harmless for all liability or expenses of any kind arising therefrom. Harris County is responsible for all paperwork, arrangements and facilitation of inmates to be transferred and the Contractor shall be responsible for the transportation and delivery of Harris County inmates to the Texas Department of Criminal Justice, Institutional Division.

ARTICLE V

MISCELLANEOUS

5.01 **BINDING NATURE OF AGREEMENT:** This agreement is contractual and is binding upon the parties hereto and their successors, assigns, and representatives.

5.02 **NOTICE:** All notices, demands, or other writings may be delivered by either party hereto to the other by United States Mail or other reliable courier at the following address:

To Contractor:
Jefferson County Auditor
1149 Pearl Street
Beaumont, Texas 77701

To County:
Harris County
Attn: Ed Emmett, County Judge
1001 Preston, Suite 911
Houston, TX 77002

With a copy to:
Harris County Purchasing Agent
1001 Preston, Suite 670
Houston, TX 77002

The address to which any notice, demand, or other writing may be delivered to any party as above provided may be changed by written notice given by such party as above provided.

5.03 **AMENDMENTS:** This agreement shall not be modified or amended except by a written instrument executed by the duly authorized representatives of both parties and approved by commissioners courts of the respective parties hereto.

5.04 **PRIOR AGREEMENTS:** This agreement contains all of the agreements and undertakings, either oral or written, of the parties with respect to any matter mentioned herein. No prior agreement or understanding pertaining to any such matter shall be effective.

5.05 **CHOICE OF LAW AND VENUE:** The law which shall govern this agreement is the law of the State of Texas. All consideration to be paid and matters to be performed under this agreement

are payable and performable in Beaumont, Jefferson County, Texas, and venue of any dispute or matter arising under this agreement shall lie in a district court of Harris County, Texas.

5.06 **APPROVALS:** This agreement must be approved by the Commissioners Court of Harris County and the Commissioners Court of the Contractor in accordance with the Interlocal Cooperation Act.

5.07 **FUNDING :** Prior to the execution of this agreement, Contractor has been advised by Harris County, and Contractor clearly understands and agrees, such understanding and agreement being of the absolute essence to this contract, that Harris County shall have available the total maximum sum of ***$2,575,075.00*** specifically allocated to fully discharge any and all liabilities which may be incurred by Harris County, including any and all costs for any and all things or purposes, ensuing under or out of this agreement, irrespective of the nature thereof, and notwithstanding any word, statement or thing contained in or inferred from the preceding provisions of this agreement which might in any light by any person be interpreted to the contrary. Harris County's liability for payment under the terms and provisions of this agreement is limited to such sum, plus additional amounts of funds from time to time certified available pursuant to Tex. Loc. Gov't Code Ann, §§111.031 - 111.093, as amended, for the purpose of satisfying Harris County's obligations under the terms and conditions of this agreement.

Signature and Execution:

HARRIS COUNTY, TEXAS

By: Ed Emmett Sr

Ed Emmett, Harris County Judge (As Authorized and Approved by the Harris County Commissioners Court Dated AUG 11 2009)

APPROVED AS TO FORM:
VINCE RYAN, County Attorney

Portia Poindexter

Portia Poindexter, Assistant County Attorney

Harris County Sheriff
Date Approved: 8/3/09

JEFFERSON COUNTY, TEXAS

By: Ronald Walker for RW

Ronald Walker, Jefferson County Judge (As Authorized and Approved by the Jefferson County Commissioners Court Dated 8/3/09)

Jefferson County Auditor

J. Mitch Woods

Jefferson County Sheriff
Date Approved: 8/3/09

ATTEST:

Carolyn L Guidry

Jefferson County Clerk

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

The Commissioners Court of Harris County, Texas, convened at a meeting of said Court at the Harris County Administration Building in the City of Houston, Texas, on the ____ day of AUG 11 2009, 2009 with the following members present, to-wit:

Ed Emmett	County Judge
El Franco Lee	Commissioner, Precinct No. 1
Sylvia García	Commissioner, Precinct No. 2
Steve Radack	Commissioner, Precinct No. 3
~~Jerry Eversole~~	~~Commissioner, Precinct No. 4~~

and the following members absent, to-wit: Eversole, constituting a quorum, when among other business, the following was transacted:

ORDER AUTHORIZING EXECUTION OF AN INTERLOCAL COOPERATION AGREEMENT BETWEEN HARRIS COUNTY AND JEFFERSON COUNTY

Commissioner Lee introduced an order and made a motion that the same be adopted. Commissioner García seconded the motion for adoption of the order. The motion, carrying with it the adoption of the order, prevailed by the following vote:

Vote of the Court	Yes	No	Abstain
Judge Emmett	☑	☐	☐
Comm. Lee	☑	☐	☐
Comm. García	☑	☐	☐
Comm. Radack	☑	☐	☐
~~Comm. Eversole~~	~~☐~~	~~☐~~	~~☐~~

The County Judge thereupon announced that the motion had duly and lawfully carried and that the order had been duly and law-fully adopted. The order thus adopted follows:

Recitals

1. Harris County desires to contract with Jefferson County for the detention, care, and transport of up to 376 adult inmates detained by the Harris County Sheriff.

2. Harris County and Jefferson County desire to enter an agreement pursuant to Texas Gov't Code Ch. 791, ("the Interlocal Cooperation Act") authorizing local governments to purchase of services, provided that the services are authorized by the governing body of the counties, the services are payable from the current revenues of the

Presented to Commissioner's Court

AUG 11 2009

APPROVE_____

Recorded Vol Page

purchasing party, and they are for an amount that fairly compensates the performing part for the services or functions performed.

3. Jefferson County is capable of providing and willing to provide the services in the Interlocal Cooperation Agreement.

Now therefore be it Ordered by the Commissioner Court of Harris County:

1. That the recitals set forth in this Order are true and correct.

2. That Harris County Judge Ed Emmett be, and he is hereby, authorized to execute an Interlocal Cooperation Agreement between Harris County and Jefferson County providing for the detention, care, and transport of up to 376 adult inmates detained by the Harris County Sheriff, from this date through February 28, 2010 with the option to renew the agreement for additional one (1) year terms thereafter, and at a cost not to exceed ***$2,575,075.00***.

3. All Harris County officials and employees are authorized to do any and all things necessary or convenient to accomplish the purpose of this Order.

Exhibit 5

THE JUSTICE MANAGEMENT INSTITUTE

1888 Sherman Street, Suite 410 • Denver, CO 80203 • Phone: (303) 831-7564 • Fax: (303) 831-4564

Barry Mahoney, President
Elaine Nugent-Borakove, Vice President
Debra Whitcomb, Senior Associate

June 17, 2009

County Judge Emmett and
Commissioners Lee, Garcia,
Radack, and Eversole
Harris County Commissioners Court
1001 Preston
Houston, Texas 77002

Re: Harris County Criminal Justice System Improvement Project – Preliminary Report

Dear Judge Emmett and Commissioners:

During 2009, pursuant to authorization from Commissioners Court, The Justice Management Institute (JMI) has been conducting a study of the criminal justice system in Harris County. The JMI team has reviewed existing practices, has identified areas in which we believe that improvements can be made, and has developed a set of recommendations for ways to improve criminal justice system operations.

The first product of this effort—a report entitled *Harris County Criminal Justice System Improvement Project – Preliminary Report*—is enclosed with this letter. In the course of our review of system operations we have paid particular attention to issues related to the rapidly growing population of the Harris County Jail, but have sought to address a wide range of issues. We have reviewed a great many documents and statistical reports and have also had the opportunity to speak with over 90 individuals involved in criminal justice and related fields. Throughout our work on the project, we have received wonderful cooperation from everyone with whom we have had contact.

The enclosed report is *preliminary* and we plan to submit a more detailed report subsequently. We greatly appreciate the confidence that the County has placed in JMI in conducting the study and hope that the enclosed report is useful to members of Commissioners Court in decision-making concerning criminal justice operations in the County.

Sincerely,

Barry Mahoney

Barry Mahoney

c: Dr. Dick Raycraft

Denver, CO • Washington, D.C.

Board of Directors

Harvey Solomon | *Victoria S. Cashman* | *Maureen E. Conner* | *Barry Mahoney* | *Fritz Ohlrich* | *William H. Etheridge* | *Thomas A. Zlaket*

HARRIS COUNTY CRIMINAL JUSTICE SYSTEM IMPROVEMENT PROJECT

PRELIMINARY REPORT

By

Barry Mahoney and Elaine Nugent-Borakove

June 2009

The Justice Management Institute
1888 Sherman Street
Denver, Colorado 80203
Tel: 303-831-7564
www.jmijustice.org

INTRODUCTION

This document outlines preliminary findings and recommendations from a study of the criminal justice system in Harris County conducted by The Justice Management Institute (JMI). The first phase of the study has had three main objectives:

1. Develop baseline information about the current situation and recent trends with respect to criminal justice system operations;
2. Identify system strengths and key issues that warrant further investigation and possible development of alternative processes; and
3. Formulate plans for further research and consideration of alternative processes that can (a) improve justice system operations; and (b) reduce or contain the costs of system operation.

The report provides an overview of the current situation and relevant trends in criminal justice system operations, summarizes the key issues identified by the JMI team, and provides a set of recommendations for systemic change. The recommendations also include court and agency specific strategies that can be implemented to address the key issues identified by JMI.

OVERVIEW: MAIN THEMES FROM THE STUDY

From the outset of this project, a primary focus has been on the population of the Harris County jail, which stood at 11,546 as the JMI team began on-site work in February 2009. As part of the study, JMI has explored possible ways to reduce the jail population to a level that would bring the jail population to an acceptable level without the need for construction of new jail facilities or for continued "outsourcing" of jail inmates to privately run facilities outside the County. The jail population increase has been driven to a significant extent by an upsurge in arrests—especially for possession of trace amounts of illegal drugs—over the past several years. However, there are a multitude of other factors contributing to the rise in jail population. Reducing the jail population should be a high priority goal, and the report has a number of recommendations for accomplishing this.

While the jail population is a major concern, there are also a number of other issues that have drawn the attention of the JMI team. Some are related to the jail population problems, but others are largely independent of those problems. The report has recommendations for addressing these issues. Before turning to specific issues and recommendations, however, we think it useful to note several overarching themes that stand out as warranting attention from policymakers. The prevalence of these themes points to a need for shaping a fresh vision for criminal justice in Harris and for making careful investments in new resources:

- ***Too much reliance on jail as the primary (and often sole) resource for handling persons whose law-breaking is basically a result of substance abuse and mental illness.*** There is a strong need to develop facilities and services to address these problems and reduce the recycling of these persons through the criminal justice system.
- ***Too much reliance on costly and inefficient paper-based records and outdated computer systems.*** The County needs to rapidly modernize the information and communications technology infrastructure needed for criminal justice operations. Doing so will greatly reduce duplicative data entry, facilitate timely access to records, enable much more rapid flow of information within and across agencies and institutions, and provide a foundation for analysis of system issues and performance.
- ***Lack of capacity for analysis of system operations and performance.*** At present, there is a "silo" approach to justice system planning and resource utilization, with a primary focus on the budgets and needs of individual institutions and agencies. There is a need for county-level oversight and coordination of the interrelated operations of the courts and agencies involved in and affected by criminal justice processes.

THE CURRENT SITUATION: KEY FACTS AND RELEVANT TRENDS

The principal criminal justice system issue currently facing Harris County is the population of the jail. However, while the jail population problem has become increasingly serious in recent years, it is by no means the only issue facing policymakers concerned about criminal justice system operations. There are many other issues—some integrally related to jail crowding—that warrant attention. Some key facts and relevant trends:

- In a little over five years, the average daily population of the jail has increased by more than 50 percent—from 7,648 in January 2004 to 11,546 in February 2009. The percentage growth in the jail population far exceeds the percentage growth in the County's population over the same period.
- There has been no increase in the jail facilities in Harris County since 2002. The design capacity of the existing jail facilities in Harris County is 9,434. The Texas Jail Commission has granted Harris County permission to exceed the design capacity temporarily and install 1,612 temporary bunks in existing cell blocks to enable housing of additional inmates.
- Because of the high population in the jail, staff in the Sheriff's Detention Command are working extensive overtime hours at an estimated cost of over 1 million every two weeks.
- Even with the temporary exception to established standards granted by the Texas Jail Commission, it is necessary to house some inmates in facilities outside the County. Approximately 1,000 Harris County jail inmates are now housed in privately-operated facilities in Louisiana.
- Over 80% of the jail inmates—and an even higher percentage of the inmates charged with or convicted of low-level drug offenses—are persons who have previously been in the jail.
- Approximately 25% of the inmates in the jail (over 2,500) have some type of mental health problem, as indicated by the fact that they are prescribed psychotropic medications. The Harris County Jail is now the largest facility providing mental health services in the state of Texas.
- About 90% of the inmates with mental health problems have previously been in the jail—a reflection of the frequent "re-cycling" of many of these persons through the criminal justice system.
- In recent years, the jail has markedly improved its capacity to house and provide services for mentally ill inmates. However, there is broad agreement among jail officials, other criminal justice practitioners, and the local mental health treatment community that more must be done to improve treatment for mentally impaired persons. There is strong consensus on the desirability of developing effective alternatives to jail for mentally impaired persons who are arrested (sometimes repeatedly) for low-level offenses.

- The jail population increase over the past six years has been driven mainly by an upsurge in arrests, especially arrests for offenses involving small amounts of illegal drugs. Any drug possession or delivery arrest is routinely charged as a felony by law enforcement agencies.
- Although more than half of the persons admitted into the jail are released within three days (usually because they bond out or because their case is resolved at first appearance with a non-incarcerative sentence), a significant number of inmates remain in pretrial detention because they are unable to post bond.
- About 50% of the persons arrested in Harris County obtain release on bond prior to the disposition of the charges against them. The great majority of these releases (more than 80%) are on surety bond, with the remainder divided between cash bond and personal bond.
- Release on personal bond is granted almost exclusively in cases involving only misdemeanor charges. Thus, in 2008, over 4,000 misdemeanor defendants were released on personal bond, but fewer than 400 felony defendants were released in that fashion.
- Since the early 1990s, Pretrial Services has been asked by judges, in both the District Courts and the County Courts, to provide supervision for some defendants released on surety bail with special conditions that must be monitored. The frequency with which this "courtesy supervision" has been provided by Pretrial Services has increased very sharply during this period, rising from a total of 243 cases in 1994 to 6,596 in 2008. During the same period, the number of defendants on personal bond who are supervised by the agency has dropped from 8,754 to 4,556—a 48% decrease.
- Pretrial Services' supervisory resources are limited. Supervising defendants on surety bond has the effect of limiting the resources the agency can use for supervision of persons who could be safely released on personal bond with appropriate conditions of supervision.
- Caseloads have increased sharply in the District Courts over the past ten years. From a total of 27,628 cases filed by indictment or information in 1999, the total has risen to 45,163 in 2008—an increase of over 63 percent. Filings that charge possession of illegal drugs have increased much more sharply: from a total of 7,609 cases filed in 1999, the total more than doubled by 2008, when 15,926 drug possession cases were filed. The increase is most dramatic in the past five years.
- The increase in misdemeanor cases filed in the County Criminal Courts at Law has been much less steep—from 56,031 cases in 1999 to 76,680 in 2006 (37%), then dropping off to 69,913 cases in 2008 (an increase of 25 percent over 1999 filings). During the past decade, however, misdemeanor drug cases in the County Courts (mainly possession of marijuana or drug paraphernalia) have more than doubled, from 6,599 in 1999 to 13,328 in 2008.
- Trends in court resources—principally the number of judges in the District Courts and County Criminal Courts at Law—have been basically flat. In the Criminal District Courts

the number of judges has remained unchanged at 22 since 1984, when the 351st District Court was established. In the County Criminal Courts at Law, judgeship resources have been level since 1995, when the fifteenth court was added—the only new court since 1986.

- The combination of increased case volume and a static level of resources is having adverse impacts on the courts. With new court case filings outstripping case dispositions, both the District Courts and the County Criminal Courts at law are experiencing much larger pending caseloads and growing backlogs of old cases.
- Just as the caseloads of courts and judges have been increasing, so too have the caseloads of prosecutors and defense attorneys. The high rates of new case filings, coupled with lack of standards for the caseloads that can be carried for attorneys, inevitably leads to scheduling conflicts and resultant re-sets of court events.
- Although limits are set on the number of new indigent defense cases that a lawyer can accept in a day of week, there are no limits on the number that can be accepted over the course of a year or that a lawyer can have pending at any one time. There is no overall coordination of indigent defense services.
- Substance abuse and mental illness are widely recognized as major contributors to the illegal behaviors that lead to arrest and jailing of many of the individuals caught in the criminal justice system. However, facilities and services for addressing these problems fall far short of meeting the needs.
- Waiting times for admission to treatment programs are often very lengthy. For example, as of May 2009 there was a waiting list of over three months for entry into the jail-based "New Choices" program and a wait of over 5 months for entry into CSCD's "Young Men About Change" (YMAC) residential treatment program.
- The County currently has little capacity for system oversight or for systemic planning, policy development, and resource allocation. Budget and resource allocation needs tend to be made on an agency-specific or court-specific basis. At present, it is difficult for County government officials to obtain and integrate information about the ways in which actions (or inactions) of a single agency or institution affects the ability of other entities to function effectively. There is growing awareness of the ways in which criminal justice system operations affect and are affected by policies in other sectors of society, including medical and mental health, housing, transportation, and education. However, at present there are no established mechanisms for easily exchanging relevant information or coordinating policies across sectors.

STRENGTHS OF THE SYSTEM

Harris County has a strong foundation upon which to build as it seeks to address the jail crowding problems and make overall system improvements. The strengths of the system provide a solid base for considering possible changes that can enable the system to function with greater effectiveness and efficiency, reduce jail crowding and accompanying costs, increase fairness in the process, and make it a model for other large urban jurisdictions. They include the following:

- **Strong justice system institutions.** The courts, the District Clerk's office, the District Attorney's office, the defense bar, the Sheriff's office, and the County Attorney's office are all well-established county-level institutions. The principal law enforcement agency that brings new arrestees into the system—the Houston Police Department—is also highly regarded. In many of these institutions, the top-level leaders are new, and they have brought fresh perspectives and new energy to consideration of criminal justice problems and issues.
- **Highly efficient front-end case processing.** Basic information about each criminal case involving an arrest is transmitted rapidly by law enforcement officers to the District Attorney's office. The DA's intake staff, working on an around-the-clock basis, reviews police reports, contacts the arresting officer if necessary to obtain clarification, obtains information on the arrested person's prior criminal record, drafts charges, and files complaints with the Clerk's office. The initial stages of the pretrial process move very quickly, with the case record in electronic form. With a judicial officer (magistrate) on duty throughout the day and night, a probable cause determination is typically made within 12 hours after the arrest. The same magistrate sets bond for detained defendants at the time of the probable cause hearing. We know of no other urban criminal justice system that handles the early stages of cases more efficiently.
- **Excellent procedures for gathering information about newly arrested persons.** Harris County Pretrial Services does an excellent job of acquiring information about arrested defendants. The information is directly relevant to the initial setting of bond by the magistrate and to the trial judge's review of the bond and consideration of possible pretrial release when the case is on the court calendar the next court day. It should also be helpful to defense attorneys and prosecutors, too, in gaining a rapid sense of the defendant's background and developing approaches to resolution of the case. Additionally, it can be a foundation for building a defendant-specific information base relevant to subsequent risk assessment and supervision by the Community Supervision and Corrections Department. Unfortunately, the information is not easily accessible and at present is not used nearly as widely as is desirable.
- **Excellent forensic testing at the Harris County Medical Examiner's Office.** The Harris County Medical Examiner's office has been awarded numerous top certifications for the quality of its crime lab work and is nationally recognized for its outstanding performance. With a highly experienced staff of scientists and other personnel, the office has an excellent foundation for top-quality work in DNA testing and other types of forensic testing.

- **Progress toward improvements in indigent defense services.** In September 2009 Commissioners Court approved plans for initial development of a Public Defender Office for Harris County including staffing and cost projections for operation of the office as a county department. Progress has been made in formulating plans for having a public defender office staff several of the Criminal District Courts (with use of assigned counsel when necessary) and for having a specialized unit of qualified defense lawyers handle cases in the County Criminal Courts that involve defendants with indicated mental illness or mental retardation.
- **Good basic management information about cases, defendants, and caseloads.** The case-specific information available to judges and other system practitioners is extensive, timely, and generally regarded as reliable. The JIMS system regularly produces a number of standard reports that are very useful for purposes of monitoring caseload status and identifying possible problems. However, the JIMS system is difficult to program, can be difficult to access, and does not readily produce ad hoc reports needed for real-time management. There is a clear need for migration to web-based systems that enable rapid retrieval and exchange of information and that enable analysis of systemic issues. The information in the JIMS system can be a valuable base for next stage planning and automated system development.
- **Significantly improved capacity in the courts for analysis of available information.** In recent years, the administrative offices of the County Criminal Courts at Law and the District Courts have made major strides in developing a web-based system for obtaining and analyzing information on defendants, cases, and overall caseloads. The system builds on the data in JIMS and is able to provide rapid analysis of key aspects of court and systems operations. Work on linking the courts' "Business Intelligence System" with the information systems of individual agencies is in progress, and can potentially provide a model for very rapid and effective multi-entity information sharing. In recent months, the District Clerk's office has made significant strides in introducing new technology into the operations of that office.
- **Improvements in the capacity of the Community Supervision and Corrections Department to supervise offenders using evidence-based practices.** In the six years since JMI conducted an assessment of CSCD's operations and needs, significant progress has been made in upgrading operations and training capabilities. The introduction of risk assessment methodology and the use of evidence-based practices that emphasize public safety through client behavioral change in many of CSCD's specialized units are especially noteworthy. CSCD's leadership has expressed enthusiasm for organizational change that would expand the improvements in the specialized units to units responsible for general supervision of offenders.
- **System leaders' openness to improvements in the operation of the system.** The justice system leaders and senior-level staff with whom JMI team members have spoken during the course of the project have evinced interest in the project and have been candid in describing what they perceive to be problem areas. Many of them have had very constructive suggestions for improvement, and all have indicated that they would support changes that would enable overall system improvement.

- **County government support for innovation and improvement.** This study was authorized by the Harris County Commissioners Court, and the JMI team has received indications that Commissioners Court members will carefully consider the study's recommendations. Senior officials in the Department of Management Services and the County Attorney's office have made it clear to JMI team members that they are extremely interested in developing feasible ways to reduce the jail population and introduce greater efficiency, cost-effectiveness, and fairness into the criminal justice system in Harris County. They recognize that this may involve investments in new approaches and new resources in some areas such as mental health and substance abuse treatment and related services.

KEY ISSUES

1. **The population of the jail.** With over 11,200 inmates currently in the custody of the Sheriff, the number of jail inmates is approximately 1,800 over the design capacity of the County's jail facilities and about 2,400 over the target figure for safe operation of the jail. Swiftly and safely reducing this population should be a top priority goal.
2. **County government's limited current capacity for system oversight and coordination.** At present, it is difficult to look across the agency and court "silos." The County needs a greatly strengthened capacity for analysis of justice system operations, planning, policy development, and resource allocation.
3. **Arrest and charging policies.** The number of arrests and filings—especially in drug possession cases—has risen sharply, with major impacts on the jail population. These policies and practices, and their impacts, should be examined closely.
4. **Indigent defense organization and practices.** Possible development of a public defender system or indigent defense coordinator is a major system improvement issue.
5. **Bail and pretrial release supervision practices.** These practices need to be modernized. Potential changes include revision of bail schedules, greater use of personal bonds, bond reviews of defendants detained because of inability to post bond, and strengthened supervision of released defendants.
6. **Caseload management and delays in case resolution.** There is a clear need to address problems of backlog and delay that contribute to jail crowding through lengthy periods of pretrial detention.
7. **Forensic testing.** The County should have a top-quality unified crime lab that is independent of any law enforcement agency. High priority should be given to ensuring capacity for timely and accurate testing of DNA evidence and suspected illegal drugs.
8. **Practices in probation supervision and handling of probation violations.** Top priorities for CSCD include full implementation of evidence-based practices, more effective handling of violations of conditions, upgrading of automated information systems needed for case management, and strengthened internal research capabilities.
9. **The need to strengthen treatment and related services for the mentally ill and for substance abusers.** There is a critical shortage of both residential facilities and non-residential resources for addressing the needs of system-involved persons with mental illness, substance abuse issues, or both.
10. **Information technology and utilization of information.** Too many components of the justice system and related service agencies are burdened by outdated computer software and paper-based records systems that make exchange of information difficult, slow the processing of cases, complicate delivery of needed services, and make it exceedingly difficult to conduct research on program operations and impacts.
11. **Education and training.** As changes are introduced in long-established policies and practices, practitioners at all levels will need to know the reasons for new approaches, understand what is expected, and develop the skills needed to meet new expectations.

PRINCIPAL RECOMMENDATIONS

Recommendations for Rapidly Reducing the Jail Population

1. As a top priority, initiate a multi-faceted Jail Population Reduction Program involving key justice system and county government leaders, with top-quality staff support.

(a) Establish a Jail Population Reduction Working Group or Task Force with knowledgeable staff provided by Commissioners Court and the participating agencies.

(b) Set targets for gradual reduction of the jail population to an acceptable level. Seek to bring the jail population into compliance with Texas Jail Commission standards within two years.

(c) Develop action plans for achieving the desired jail population reductions, focusing on reducing admissions to the jail and reducing the duration of confinement

(d) Provide for oversight and monitoring of the program and the action plans by central county government.

2. Develop and implement strategies for reducing the intake of persons to the jail, using at least the following approaches:

(a) Law enforcement agencies: Re-examine and consider revising arrest policies and practices regarding persons who have committed relatively minor non-violent offenses, to make greater use of pre-arrest diversion.

(b) District Attorney's Office: Review policies and practices regarding intake and charging in cases involving minor non-violent offenses. Provide for pre-charging diversion to community-based programs, with treatment when needed, if possible.

(c) CSCD and the courts: Revise procedures for handling "technical" violations of conditions of probation, to provide for the submission and filing of motions to revoke probation only when CSCD internal sanctions and intensified supervision have proven ineffective in achieving compliance with key conditions. Reduce the frequency and duration of "jail therapy" as a response to non-compliance with probation conditions.

(d) Law enforcement agencies, Sheriff's office, MHRA, and Commissioners Court: Develop and use a broader range of options for dealing with situations involving minor offenders who are intoxicated or mentally ill.

(1) Continue and expand Crisis Intervention Team (CIT) training for law enforcement officers, to enable them to handle these situations more effectively and make greater use of pre-arrest diversion of mentally ill persons.

(2) As an early priority, develop community-based case management services, of varying levels of intensity, that will enable effective support and supervision of mentally ill minor offenders whose incarceration in jail does not serve a public safety purpose.

(3) Develop and use a low security facility (which could be adjacent to the jail) that can provide detox and mental health crisis intervention, to supplement the NeuroPsychiatric Center (NPC) facility now in operation.

(4) Develop facilities and related policies to provide limited term housing for "nuisance" offenders who are not in "crisis' (and thus do not need NPC-like facilities) and do not need to be confined in high security jail facilities, but who may require short-term intervention/treatment.

(e) Sheriff's Office and District Courts: For sanctions imposed on District Family Court and Civil District Court detainees ordered to spend time in jail (a total of 37 in April and 42 in May 2009, mainly jailed for failure to pay child support), develop and use alternatives to confinement in secure jail facilities, including (a) a minimum security facility; and/or (b) work program, perhaps combined with electronic home confinement.

3. Develop strategies for reducing the duration of confinement of persons who are in pretrial detention. Review the feasibility of the following approaches and implement changes where feasible:

(a) Revise bail schedules and bond-setting policies to minimize the possibility that low-risk persons remain in detention solely because of inability to post bond.

(b) Use Pretrial Services' risk assessment tools to determine level and types of monitoring/supervision likely to be needed to protect public safety and assure defendant's return to court of released.

(c) Make increased use of personal bond, with special conditions (to be supervised by Pretrial Services) when appropriate.

(d) Develop and use a broader range of supervised release options for persons released on personal bond, including (1) use of electronic reporting and notification systems centered in kiosks distributed around the county; (2) day reporting centers for moderate risk defendants released on personal bond; and (3) use of electronic home confinement linked, if regarded as necessary for public safety, to GPS monitoring.

(e) Conduct periodic reviews of the bond amounts of persons whose risk assessment scores (as computed by Pretrial Services) are low or moderate and who remain in custody because of inability to post bond. The reviews should be conducted by Pretrial Services staff. The initial review should be conducted within 7-14 days after initial appearance and subsequent reviews conducted thereafter at monthly or more frequent intervals. The review process should include production of a report that reviews and updates the original risk assessment and, where appropriate, suggests appropriate conditions of release to mitigate risk of non-appearance or pretrial crime.

(f) Revise District Attorney case intake screening and charging criteria to encourage greater use of pretrial diversion (deferred prosecution or deferred adjudication) in (1) cases involving trace amounts of illegal drugs that have in the past been charged as state jail felonies, especially as first or second offenses; and (2) cases involving

defendants with indicated mental illness or mental retardation problems who are accused of committing minor offenses.

(g) Develop and implement plans for rapid judicial consideration and resolution of motions to revoke probation that involve persons in jail. Seek to resolve the motions within [1-14] days after the probationer has been admitted to the jail.

(h) Establish a Case Coordination Unit in the Sheriff's Detention Command (or, alternatively, in Pretrial Services or via staff of the Jail Population Reduction Working Group [see Recommendation # 1]). Provide for the staff of this unit to identify pretrial defendants in cases pending more than specific periods of time (which may vary by seriousness of charge – see next recommendation) and to notify the assigned judge, court coordinator, and District Attorney's office of the time that these cases have been pending.

(i) Adopt and use case processing time standards or guidelines for the periods of time within which cases involving pretrial defendants in jail should be resolved and for the time from initial appearance to indictment or information in felony cases. The time periods may vary in accordance with the seriousness/complexity of the case, and should be used to guide case scheduling. The extent to which the standards or guidelines are met should be monitored, and reports provided to the judges and the District Attorney. Consider the following suggested time standards:

- District Courts: Cases involving defendants in custody who are charged with state jail felonies and third degree felonies should be targeted for resolution within 45 - 60 days after initial appearance; less if possible. More serious felony charges are likely to require longer periods, but ordinarily not more than 120 days except in capital cases and other extraordinarily serious/complex cases.
- District Attorney's Office: The time from initial appearance to the filing of an indictment (or to waiver of an indictment and filing of an information) should be targeted for a maximum of 30 days in state jail felony cases and third degree felony cases; a maximum of 45 days in other felony cases.
- County Criminal Courts at Law: Cases involving defendants in custody should be targeted for resolution within a maximum of 30 - 45 days after initial appearance; less if possible.

(j) Seek to enable rapid turnaround of lab tests of suspected drugs, so that the test results are available within 14 days or less, to enable much more rapid resolution of cases involving possession or sale of illegal drugs.

(k) For cases in which a defendant is held in custody on both felony and misdemeanor charges: Develop policies and procedures to ensure that the misdemeanor charges are resolved immediately (on the same day) following the resolution of the felony charge.

4. Develop strategies for reducing the length of time that persons convicted of felony or misdemeanor charges are confined in the Harris County Jail after conviction. Review the following approaches and implement changes where feasible:

(a) Award additional credit toward time served (above the additional day of "good time" credit for good behavior) for participation in work programs and/or educational programs. If necessary, revise existing classification policies and other policies that may make it difficult for inmates to earn such credit.

(b) Expand the use of electronic home confinement (using GPS if necessary for public safety), with allowance for good time credit for time in home confinement.

(c) Use housing options other than Harris County Jail, including work farms and work release with partial confinement in low security facilities.

(d) Develop procedures to allow accelerated release of some categories of inmates sentenced to County time who are nearing the end of their sentence (probably subject to court approval).

(e) Review and revise the classification procedures at the Jail, so that persons who pose minimal risk are not automatically classified as medium risk, thus making it difficult for them to work and obtain additional jail time credit.

Recommendations for Strengthening the County's Capacity for Justice System Oversight, Planning, Policy Development, and Resource Allocation

5. Establish a Criminal Justice Coordinating Council (CJCC) or similar entity that includes (a) leaders of the institutions and agencies involved in or significantly affected by criminal justice system operations in the County; and (b) representatives of the public and of Commissioners Court.

- The CJCC should be charged with responsibility for policy development and oversight of system improvement initiatives that involve multiple entities and affect the overall operation of the justice system in the County.
- The CJCC, with support from staff, should develop a fresh vision for criminal justice in Harris County, should establish goals for the effective performance of the criminal justice system as a whole, and should develop a system of performance indicators that can be used to gauge the effectiveness of system operations.

6. Establish a central staff unit, headed by a Criminal Justice Coordinator to be appointed by Commissioners Court, that will:

(a) provide staff support for the CJCC or Advisory Council; and

(b) provide direct assistance to Commissioners Court in developing and analyzing information about overall criminal justice system operations that are relevant to decisions about planning, budgeting, resource allocation, and policy development.

7. Undertake planning for resources currently needed or likely to be needed in the near future as the population of Harris County continues to increase, including:

- At least one new crisis intervention facility, with related stabilization/temporary housing capacity
- Residential facilities for persons who have committed minor offenses related to mental illness or intoxication and who, though not in crisis, are in need of some type of temporary housing and related services.
- Facilities for treating substance abusing offenders and persons diverted from criminal case processing on a residential and intensive outpatient basis.
- "Step-down" re-entry facilities for persons released from or nearing the end of terms of confinement in the Harris County Jail, with transitional services (especially for mentally ill inmates).
- Low-security facilities (halfway-house type) for detention of persons committed to the jail by the District Family Courts and Civil District Courts.
- A new Inmate Processing Center (IPC) and initial assessment center, possibly with housing for newly arrested persons who are likely to be released within 72 hours.
- Ultimately—after implementation of all of the recommendations designed to reduce admissions and shorten the length of confinement—additional jail facilities at all levels of security, to provide needed jail bed space

Recommendations Concerning Specific Aspects of System Operations

Arrest Policies and Practices

8. Examine practices and trends in arrests for criminal offenses in light of the effect of the arrest policies on jail population and court caseloads.

- Consider ways in which arrest policies might be altered to alleviate population pressures on the jail without compromising public safety. In particular, study the impacts (including impacts on the jail population and on crime prevention and suppression) of policies and practices involving arrests for possession of trace amounts of illegal drugs.
- Consider possible alternative approach to enable reduction in the volume of felony arrests for these offenses while achieving desired crime prevention and suppression objectives.

Prosecutorial Policies and Practices

9. Consider revision of intake, charging, and plea negotiation policies and practices in cases involving persons accused of relatively low-level offenses whose conduct does not pose a danger to others or to property. In particular:

- Seek to utilize pre-trial intervention / diversion in a significantly higher proportion of cases involving (1) mentally ill persons accused of committing relatively minor offenses; and (2) persons charged with possession of small amounts of illegal drugs as a first offense.
- Revise plea and sentence recommendation practices to encourage greater emphasis on drug abusing offenders receiving substance abuse treatment. Seek to avoid building felony conviction records in cases involving persons charged with possession of small amounts of illegal drugs, particularly as a first or second offense.

Indigent Defense Services

10. Continue the planning for improved of indigent defense services that is currently underway. Initiate changes in policies and practices regarding delivery of indigent defense services that will ensure effective delivery of defense services in a fair and cost-effective fashion.

- Provide for indigent defense to be independent of direct judicial control, with accountability and transparency in the delivery utilization of these services
- Establish a nonpartisan governing board to oversee development of public defense services and to provide general oversight and supervision regarding delivery of and payment for indigent defense services.
- Provide for a chief public defender (or chief executive officer under a different title) who has overall responsibility for organization and delivery of public defense services in the County—whether through utilization of staff, contracts with firms and individual attorneys, or a combination of approaches—and is accountable to the governing board.

- Through the governing board, establish:

  (a) standards regarding attorneys' caseload sizes, taking account of the varying seriousness and complexity of cases and of the experience and demonstrated ability of individual attorneys;

  (b) standards/requirements for education and training for lawyers providing indigent defense services;

  (c) standards regarding access to and compensation of experts and investigators;

  (d) a system for reviewing the quality of attorney service delivery, recognizing outstanding performance, and addressing problems that emerge.

  (e) requirements for reporting on workloads and utilization of resources.

- Place priority on development of a special unit or cohort of attorneys qualified to represent mentally ill defendants, as currently planned by the County Criminal Courts.

- Development and implement plans for conducting research and evaluation studies designed to help shape a system for delivery of indigent defense services that assures effective representation of counsel in all criminal proceedings and that is cost-effective.

11. Consider the feasibility of providing for representation of newly arrested persons at the probable cause hearing before a magistrate, and in any event prior to first appearance in the assigned court. To test the feasibility of this approach consider using a pilot project approach with careful evaluation.

- Representation at the outset of the case would be consistent with national standards calling for prompt assignment of counsel.

- Early representation would enable effective defense representation, including consultation with the defendant and advocacy concerning bail setting and conditions of release prior to the time judicial officers make these critical decisions.

- Early representation should facilitate prompt resolution of cases, thus reducing delays and helping to reduce pending caseloads.

Bond Amounts and Utilization of Pretrial Services

12. Revise bond policies and procedures to provide for a range of bail amounts and supervision options to be set by judicial officers.

- Provide for judicial officers to take into consideration the risk levels identified through the risk assessment instrument used by pretrial services plus input from prosecution and defense attorneys.

- Consider (a) lowering the presumptive amounts applicable to persons charged with misdemeanors and low-level felonies; and (b) making increased use of personal bond, with conditions of supervision that are appropriate to the nature and level of risk posed by the person's release.

13. Strengthen the ability of Pretrial Services to (a) provide useful information on newly arrested persons to judicial officers, prosecutors, and defense attorneys; and (b) provide effective supervision of low-to-moderate risk persons who are unable to post bail. In particular:

- Fully implement the recently revised risk assessment instrument and Defendant Report form and cover sheet.
- Ensure that reports and risk assessments on interviewed defendants are delivered to every courtroom in advance of first appearance and are made easily available to defense attorneys as well as to prosecutors.
- Develop procedures for periodic reviews of persons charged with relatively low-level offenses (e.g., misdemeanors, state jail felonies, third degree felonies) who have been unable to make bond within 6 days after initial appearance. Provide updated information (including information on possible mental illness/mental retardation issues) and recommendations to the judge, prosecutors, and defense attorneys.
- Develop a significantly enhanced supervised release program capable of providing effective supervision to persons released on personal bond with conditions of supervision.
- Establish priorities for the types of cases in which Pretrial Services will be asked to supervise released defendants and for the types of conditions to be imposed on defendants and monitored by agency staff.
    - Place top priority on supervising defendants released on personal bond.
    - Review and consider phasing out the practice of having Pretrial Services staff supervise persons released on surety bond ("courtesy supervision").
    - Consider having Pretrial Services, CSCD, and MHMRA form contractual relationships to provide "team" supervision of released defendants who are mentally ill, to strengthen supervision capabilities and enable continuity of services through the course of the case (including any period on probation) and to facilitate transition to post-supervision living arrangements.

Forensic Testing

14. Develop and implement plans for upgrading and expanding unified forensic testing capabilities in Harris County to ensure timely turnaround of lab test results with particular attention to timely and accurate testing of DNA evidence.

Caseflow Management in the Courts

15. Establish and implement case processing time standards to guide case scheduling and set expectations for timely resolution of cases. The standards should take account of:

- The seriousness and complexity of different categories of cases, with standards reflecting an expectation that relatively simple cases will be resolved speedily and that more time may be needed for cases that are more serious and/or more complex.
- The custody status of cases, with standards calling for speedier resolution for cases involving defendants in custody.
- The medical and mental health status of defendant and the desirability of providing for prompt attention to delivery of needed treatment and related services.
- The need for adequate time for preparation and court events in all cases.

16. Implement principles and techniques of differentiated case management, in order to enable swift resolution of relatively simple cases, provide adequate time for preparation and negotiation in all cases, and enable timely resolution of every case consistent with the standards that are adopted.

17. Develop and implement a targeted old case backlog reduction program in the District Courts, in order to reduce pending caseloads to a more manageable level and help assure more timely resolution of all cases.

- Provide for additional temporary resources—visiting judges, additional prosecutors and defense attorneys, and court staff—to handle the higher volume of cases and court proceedings needed to significantly reduce pending caseloads, especially in the District Courts.

18. Consider major expansion of specialty dockets, in light of the high proportion of persons charged with misdemeanor offenses and lower-level felony offenses who have substance abuse, mental illness, or co-occurring disorders. Incorporate "best practices" identified through research on the operations of specialty courts and dockets in other jurisdictions.

- Significantly expand the STAR Drug Court program.
- Consider the use of pre-adjudication diversion to a drug court program for persons charged with drug possession as a first or second offense.
- Explore expansion of the Mental Health Court dockets now in operation.
- Because of the unique problems posed by substance abusing and mentally ill veterans of U.S. wars who become involved in illegal activities, explore the possibilities of establishing special dockets that focus explicitly on the issues involved in responding to alleged criminal behavior by these individuals.

Probation Policies and Practices

19. Undertake an organizational development initiative within the Community Supervision and Corrections Department, centered on integration of the principles and techniques of evidence-based practice (EBP) into the full range of CSCD operations.

- Clarify and strengthen the relationship between CSCD and the Courts, to establish courts' support for the Department's implementation of EBP.
- Institutionalize an integrated continuum of services for probationers from the point of assessment to the point of departure from court-ordered supervision, including both specialized and general supervision.
- Develop and implement a grid for use of progressive sanctions by CSCD officers, in the event of a probationer's failure to comply with conditions of probation, to strengthen the effectiveness of CSCD supervision and reduce the frequency with which motions to revoke probation are submitted to the courts.
- Simplify the formal process for case management by officers, including upgrading information system capabilities so that officers can easily access and transmit data needed for case management.
- Streamline the revocation process, to make it less paperwork-intensive and reduce the frequency with which motions to revoke probation are filed.
- Expand comprehensive training for staff, with particular attention to: (1) training (or re-training) CSCD officers in the principles and techniques of effective case management and core practices for dealing with clients; and (2) training for front-line supervisors in the principles and practices of EBP and effective supervision practices in the context of an organization implementing EBP.
- Develop a substantially strengthened capability for conducting research on the effectiveness of specific CSCD programs and the overall effectiveness of the Department in reducing criminogenic behavior.
- Work collaboratively with the Texas Criminal Justice Assistance Division in planning and implementing the overall organizational development initiative.

20. Strengthen relationships with external organizations that provide needed services to mentally ill and substance-abusing probationers.

- Strengthen existing ties and develop new partnerships that will enable effective delivery of services through a full range of treatment modalities, including varying levels of outpatient treatment as well as residential treatment and care.
- Seek to ensure effective transitions from probation supervision to community-based supporting services as persons are discharged from probation.

Recommendations Concerning Provision of Treatment and Related Services Needed to Address Problems of Substance Abuse and Mental Illness

21. Strengthen the County's capabilities for multi-agency planning, problem-solving, and allocation of additional resources to address the problems posed by substance abusing and mentally ill persons.

- Establish a special task force or other vehicle to develop plans for new approaches to these pervasive problems. Engage citizen leaders, as well as criminal justice and treatment professionals, in development and implementation of strategies.
- Develop a data base, accessible by justice system agencies, that provides basic information on the availability of different types of treatment modalities relevant to the treatment of substance abuse, mental illness, and co-occurring disorders for persons charged with criminal offenses.
- Develop and use an assessment tool which will enable practitioners to determine which treatment modalities are most appropriate for placement of individuals into treatment programs and delivery of needed services.
- Develop an action plan for experimentation with new approaches, including rapid diversion coupled with justice system monitoring and supervision, housing, treatment, and case management services.
- Develop the capability of conducting program evaluations/performance monitoring to improve utilization of available resources and achieve reductions in recidivist behavior and drug usage.

22. Expand the crisis intervention/stabilization capabilities that law enforcement and medical/mental health agencies in the County need for responding effectively to misbehavior by intoxicated and/or mentally ill persons.

23. Develop supportive housing for mentally ill chronic minor offenders.

24. Substantially expand the capacity of the County to provide treatment and aftercare for substance abuse, mental illness, and co-occurring disorders in residential and outpatient centers.

- Ensure that there is a broad range of options and that they include gender-responsive treatment options for women that address the complex needs and multiple challenges that have brought them into the criminal justice system.
- Expand programs that can provide case management of varying levels of intensity to persons who frequently become involved in the criminal justice system. Seek to ensure that effective outreach and service delivery systems are used to provide services needed by the "chronic system users."
- Utilize modern risk assessment tools to enable appropriate placements and delivery of services, taking account of risks and needs.

25. Develop plans for delivery of comprehensive services aimed at reintegrating offenders into communities in Harris County when they are released from incarceration, including attention to housing, subsistence, transportation, medical care, and employment assistance.

- Develop programs for mentally ill chronic minor offenders as a top priority.

Recommendations Concerning Development of Information Systems, Research Capabilities, and Education and Training

26. Continue to strengthen the capacity of County agencies and the courts to obtain, store, exchange, analyze, and use information on individuals involved in criminal justice processes.

- Build on the existing JIMS system and on the web-based information system recently developed by the administrative offices of the County Criminal Courts at Law and the Criminal District Courts and by the District Clerk's office.
- As an early priority, develop a web-based system that will integrate (1) the Pretrial Services Agency's Defendant Report and risk assessment tool; (2) information in the Jail's management information system concerning defendants' background and classification status; (3) information about cases and defendants in the records of the District Clerk; (4) CSCD's probation management system; and (5) to the extent feasible, information on offender mental health histories available from MHMRA.
- Seek to enable a continuous flow of accessible information concerning individuals charged with criminal offenses as they move through the system, thus eliminating duplicative data entry, enabling updating as needed, and providing justice system decision makers with timely and accurate information relevant to custody status, treatment needs, case resolution, and supervision if an individual is placed under the supervision of Pretrial Services or CSCD.

27. Strengthen the ability of the agencies and institutions involved in criminal justice to engage in and learn from research on the impacts and effectiveness of alternative approaches to criminal justice issues and practices.

- Through budgetary appropriations, encourage development of agency-specific research capabilities.
- Establish an independent *"Criminal Justice Research and Policy Institute"* that will (1) be a clearinghouse and resource for information about findings from research done in Harris County and elsewhere; and (2) have the capacity to conduct its own research on key system operations issues.

28. Provide for education and training programs to familiarize practitioners in the courts and justice system agencies and other "partner" agencies with the goals and policies that are developed, to enable them to function effectively in implementing plans for system improvement.

- Consider developing a *"Criminal Justice Training Institute"* that would be responsible for providing training on (a) system operations that involve multiple entities; and (b) by arrangement with courts and agencies, providing training that is specific to those entities.
- Ensure that education and training are provided on an on-going basis, including (a) orientation for new hires; and (b) continuing education and training for staff at all levels.

Exhibit 6

RSS

On this the 23rd day of June, 2009, the Commissioners Court of Harris County, Texas, sitting as the governing body of Harris County, at a regular meeting of the Court, upon motion of Commissioner Lee, seconded by Commissioner Eversole, duly put and unanimously carried,

IT IS ORDERED that a report prepared by The Justice Management Institute concerning the Harris County criminal justice system be accepted; and

IT IS FURTHER ORDERED that Management Services be directed to prepare a suggested order for consideration at the July 14th court meeting that would enable the county to begin moving forward on recommendations outlined by The Justice Management Institute.

The vote of the court on the above motion was as follows:

AYES:	Five (Judge Emmett, Commissioners Lee, Garcia, Eversole, and Radack)
NOES:	None
ABSTENTIONS:	None

Presented to Commissioner's Court

JUN 23 2009

APPROVE _____

Recorded Vol. _____ Page _____

Exhibit 7

WHEREAS, on June 23, 2009, the court accepted a report from The Justice Management Institute (JMI) with recommendations for reductions in jail population involving improvement initiatives for the criminal justice system; and

WHEREAS the court directed Management Services to prepare a suggested order for consideration at the July 14, 2009 meeting that would enable the county to begin moving forward on the recommendations outlined by JMI; now, therefore, be it resolved that on this, the 14th day of July, 2009, the Commissioners Court of Harris County, Texas, sitting as the governing body of Harris County, upon motion of Commissioner Lee, seconded by Commissioner Garcia, duly put and unanimously carried,

IT IS ORDERED that the Harris County Criminal Justice Coordinating Council, composed of the District Attorney, District Clerk, Sheriff, County Attorney, Administrative Judge of the District Courts, Administrative Judge of the Criminal Trial Division of the District Courts, Presiding Judge of the County Criminal Courts, Presiding Judge of the 16 Justices of the Peace Courts, a Constable to represent the eight constables, and two members of Commissioners Court, be created.

IT IS FURTHER ORDERED that the Office of Criminal Justice Coordination (CJC) be created with two full-time positions, a Director and a Deputy Director, to be filled by existing county employees, Ann Caprice Cosper as Director and Clarissa Stephens as Deputy Director, who will be transferred to the new positions with a July 18, 2009 effective date. These staff positions will be assisted at this time for administrative and related needs by Management Services staff.

IT IS FURTHER ORDERED that, until the Council decides otherwise, Judge Cosper serve as the acting chair, in a non-voting capacity, in order to convene and conduct initial meetings of the Council, and that the first Council meeting be held as soon as possible with Barry Mahoney, current President of the Justice Management Institute, to be invited to review the JMI report and recommendations with Council members.

The Council will decide on its organization, officers, priorities, and committees. Along with selected board members, committees will include non-board persons with knowledge and expertise in specific subject matters. CJC staff will coordinate with the committees and officials and their staffs for preparation of reports and agenda items requested by Council members. The Council will decide on other participants to be invited to attend meetings. The Criminal Justice Coordinating Council will be the focal point for efforts to improve the criminal justice system and seek reductions in the jail population.

The vote of the Court on the above Motion was as follows:

AYES:	5 (Judge Emmett, Commissioners Lee, Garcia, Eversole, and Radack)
NOES:	0
ABSTENTIONS:	0

Presented to Commissioner's Court

JUL 14 2009

APPROVE_____

Recorded Vol_____ Page_____

Exhibit 8

WHEREAS, on July 14, 2009, Commissioners Court approved an order establishing the members of the Harris County Criminal Justice Coordinating Council, comprised of 11 elected officials including two members of Commissioners Court and one Constable; and

WHEREAS, in addition to the two members of Commissioners Court and one Constable, the other eight Council members are elected officials of other departments that have involvement with the criminal justice system, including the District Attorney, District Clerk, Sheriff, County Attorney, Administrative Judge of the District Courts, Administrative Judge of the Criminal Trial Division of the District Courts, Presiding Judge of the County Criminal Courts, and Presiding Judge of the 16 Justices of the Peace; now, therefore, be it resolved that, on this, the 28th day of July, 2009, the Commissioners Court of Harris County, Texas, sitting as the governing body of Harris County, at a regular meeting of the court, upon motion of Commissioner Garcia, seconded by Commissioner Lee, duly put and unanimously carried,

IT IS ORDERED that the recommendation of Management Services that the Commissioners of Precincts One and Two and the Constable of Precinct One be designated for service on the Council at this time be approved.

The vote of the Court on the above motion was:

AYES:	Five (Judge Emmett, Commissioners Lee, Garcia, Radack and Eversole)
NOES:	0
ABSTENTIONS:	0

Presented to Commissioner's Court

JUL 28 2009

APPROVE _____

Recorded Vol_____ Page_____

Exhibit 9

AGENDA

Harris County Criminal Justice Coordinating Council
Harris County Civil Courthouse
17th floor conference room
Thursday, August 20, 2009
1:00 P.M.

I. **JMI Study:** Presentation by Barry Mahoney, President of Justice Management Institute.

II. **Council Meetings:** Recommendation that the regular meeting schedule of the HCCJCC for the next six months be held on the afternoon of the first Commissioners Court meeting of each month at 2:00 P.M. in the 17th floor conference room of the Civil Courthouse, namely, September 15, 2009, October 13, 2009, November 10, 2009, December 8, 2009, January TBD, 2010, and February TBD, 2010.

III. **By-Laws:** Recommendation for immediate creation of a By-Laws Committee to formulate proposed by-laws, mission and vision statements and that Judge Tad Halbach serve as Chair of said committee.

IV. **Committees:** Recommendations to consider creation of the following five committees:
   1. Jail Population Committee
   2. Criminal Justice Systems Operations
   3. Special Needs Offenders
   4. Information Systems
   5. Planning and Resource Allocation

V. **Jail Population Committee:** Recommendation for immediate creation of the Jail Population Committee and appointment of committee members from the office of each Council member.

HARRIS COUNTY CRIMINAL JUSTICE SYSTEM IMPROVEMENT PROJECT

JMI PRELIMINARY REPORT SUMMARY

OFFICE OF CRIMINAL JUSTICE COORDINATION UPDATE

AUGUST 20, 2009

Project Objectives

1. Develop baseline information
   a. Current situation
   b. Recent trends
2. Identify system strengths
3. Identify key issues for investigation & possible development of alternative processes
4. Develop plans for further research & consideration of alternative processes to:
   a. Improve justice system operations
   b. Reduce/contain costs of system operation

Main Themes

- Too much reliance on jail as the primary (and often only) resource for handling persons whose law-breaking is a result of mental illness or substance abuse.
- Too much reliance on costly and inefficient paper-based records and outdated computer systems.
- Lack of capacity for analyzing *system* operations.

Key Facts & Trends

- Jail population has increased sharply
  - Up by over 50% in 5 years
  - Current population (11,244) greatly exceeds design capacity
  - Over 25% of inmates are on psychotropic meds
- Drug arrests are way up
- Use of personal bonds has decreased
- Criminal caseloads have increased substantially
  - District Courts: 63% increase in 10 years
  - County Courts: 25% increase in 10 years
  - Volume of drug case filings has more than doubled

Key Facts & Trends (*continued*)

- Trends in court resources have been flat
  - Criminal District Court: No additional judges since 1984
  - County Criminal Court: Only 1 new judge since 1986
- Pending caseloads are increasing
  - Frequent scheduling conflicts; more re-sets
  - Longer case processing times
- Limited facilities/services for substance abuse & mental illness
- Costs are high

Harris County Criminal Justice System

- Approximately 40% of total General Funds Annual Budget of $1.48 billion is Administration of Justice – Adult Criminal
  - Does ***not*** include Judges or CSCD state funded costs
  - ***Does*** include Sheriff and Constables Law Enforcement
- Estimated Cost per Jail Bed per Day

Detention Housing Costs Excluding One-Time & Overhead Costs	Approximate Daily Cost Per Inmate
General Population With No Health Issues	$40-$45
General Population Receiving Medical Drugs	$45-$50
General Population Receiving Mental Health Drugs	$55-$60
General Population Receiving Medical & Mental Health Drugs	$65-$70
Infirmary Patient	$230-$250
Specialized Mental Health Housing (Inside the Jail)	$265-$285
Contracted Mental Health Housing (24 Beds located at HCPC)	$465-$485
Overall Average Detention Cost Including One-Time and Overhead Costs	$70-$75

Harris County Jail Population

- July 2009 Average Daily Jail Population – 11,125
  - 54% Pre-Trial Detainees
  - 27% Serving Sentences in the County Jail
  - 8% Awaiting Treatment or Probation
  - 11% Awaiting Transfer to another jurisdiction – primarily State Jail or TDCJ
- 8/19/09 Population – 11, 228

Age	Total	M	F	B	W	O
<25	30%	90%	10%	50%	49%	1%
25-34	31%	86%	14%	49%	51%	0%
35-44	21%	83%	17%	47%	52%	1%
45+	19%	86%	14%	57%	42%	1%
Total	100%	87%	13%	50%	49%	1%

Harris County Jail Population

- 80% of population has a SPN older than their length of stay
- 25% potentially have a Mental Health issue based on medication prescribed
- Nationally 60-80% are estimated to have a Substance Abuse issue
- 12% have recently received homeless services based on a match of JIMS to HMIS data

Strengths of the System

- Strong justice system institutions
- Highly efficient front-end case processing
- Excellent procedures for gathering information about newly arrested persons
- Excellent forensic testing at the Harris County Medical Examiner's office
- Progress toward improvements in indigent defense services

Strengths of the System (*continued*)

- Good basic management information about cases, defendants, & caseloads (BUT: can be difficult to access and to produce essential ad hoc reports)
- Significantly improved capacity in the courts for analysis of available information
- Improvements in the capacity of CSCD to supervise offenders using evidence-based practices
- System leaders' openness to improvements in system operations
- County government support for innovation & improvement

Key Issues Identified

1. Jail population
2. Limited capacity for system oversight/ coordination
3. Arrest & charging trends
4. Indigent defense organization & practices
5. Bail & pretrial release
6. Caseload management & delays in case resolution
7. Forensic testing
8. Practices in probation supervision & handling of violations
9. Need to strengthen treatment/ services for the mentally ill & substance abusers
10. Information technology & use of information
11. Education & training

Recommendations - 5 Main Areas

1. Reduce the jail population, without endangering public safety
2. Strengthen capacity for system oversight, planning, policy development, & resource allocation
3. Examine/improve aspects of system operation
4. Provide substance abuse & mental illness treatment/related services
5. Develop information systems, research capabilities, education & training

Office of Criminal Justice Coordination – Staff Work

- Working with Council Members to collect information on current initiatives
- Gathering information from agencies and departments regarding data available
- Working with Council Members to identify system performance measures

Representative Recent Initiatives

- Juvenile Deferred Prosecution Program
  - Since March, 1,116 juvenile offenders have been accepted; only 43 have violated the terms and conditions
  - DIVERT Program - Direct Intervention using Voluntary Education Restitution and Treatment Program to divert first time DWI offenders to treatment and education
  - District Clerk implemented an online case information system
  - Specialty and Problem Solving Courts in both County and District Courts
  - Courts Data Warehouse and Caseload Explorer
  - Implementing Evidence Based Practices in CSCD
  - Pre-Trial implementation of new validated risk assessment instrument
  - Sheriff's Office implementation of Health Services quality improvements
  - Expansion of inmate education programs
  - All agencies addressing Mental Health Issues

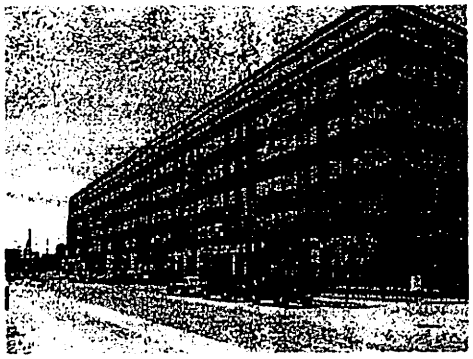
Mid Year Presentations

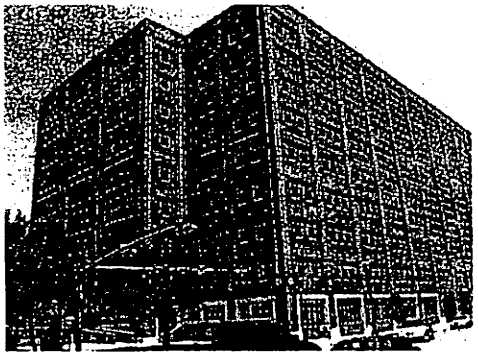
- Assessment of Needs for the expanded DNA program is near completion for presentation at Mid Year Review
- Presentation of Public Defender's Office analysis and recommendations will be presented at Mid Year Review

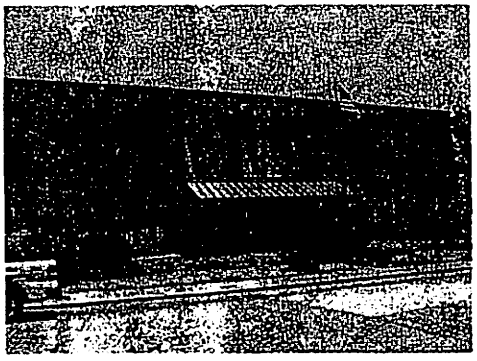
Exhibit 10

US Department of Justice
National Institute of Corrections

JAIL SYSTEM ASSESSMENT







Bill Crout and
James Coleman
Technical Resource Providers
June 22 to June 25, 2009

US Department of Justice

National Institute of Corrections

Disclaimer

RE: NIC Technical Assistance No. 09J1058

This technical assistance activity was funded by the Jails Division of the National Institute of Corrections. The Institute is a Federal agency established to provide assistance to strengthen state and local correctional agencies by creating more effective, humane, safe and just correctional services.

The resource persons who provided the on site technical assistance did so through a cooperative agreement, at the request of the Harris County Sheriff's Department, and through the coordination of the National Institute of Corrections. The direct onsite assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

The contents of this document reflect the views of Mr. Bill Crout and Mr. James Coleman Technical Resource Providers. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

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INTRODUCTION

The Harris County Sheriff's Office operates one of the largest jail systems in the United States. With an average daily population of over 11,000 inmates and approximately 130,000 bookings per year it is the third largest jail system following only Los Angeles (with over 18,000 inmates) and New York City (with over 13,000 inmates). These inmates at housed in one of three detention facilities located near the downtown of Houston. The newest of these three facilities (1200 Baker) also contains the administrative offices of the Sheriff. The three other facilities (701 Jail and 1307 Jail) are located within a block of each other. Finally, a fourth facility, the Intake Processing Center (IPC), is also located in close proximity to the first three. These four facilities make up the Harris County Jail System.

Sheriff Adrian Garcia was elected late last year and took command of the Sheriff's Office in January 2009. Since that date he has worked diligently to improve the operations of the entire department. As part of his efforts to improve the quality of services being provided to the citizens of Harris County, he invited the National Institute of Corrections (NIC) into his jail system with the intention of identifying areas of operations that can be improved.

This report reflects the observations, conclusions and recommendations of Mr. Bill Crout and Mr. James Coleman who served as contract "Technical Resource Providers" (TRPs) during its recent *Jail Systems Assessment*. Together, both of these independent contractors have over 75 years of experience in law enforcement and jail operations. This report reflects several days of review of materials prior to arrival and four days of on-site activities. Although this is a relatively short period of time to complete a jail assessment, both TRPs are confident that major issues affecting this complex jail system have been identified.

The TRPs wish to recognize the hard work performed by Captain Greg Summerlin and Sergeant Paul Davidson in making this assessment possible. They gathered a myriad of data and records for the TRPs to review, organized staff for interviews as requested and served as the direct contact between the TRPS and the Sheriff's Office during the four very full days spent on-site.

BACKGROUND - CIRCUMSTANCES THAT LED TO REQUEST

Mr. John Dyess, Chief Administrative Officer of the Harris County Sheriff's Office contacted NIC in early April 2009 on behalf of Sheriff Garcia. Mr. Dyess asked NIC for a technical assistance to examine the overall operations of the jail system. After being approved by the administration at the Jails Division, NIC, Mr. Jim Barbee (NIC Staff Person) contacted the TRPs on April 15, 2009. He gave the TRPs tentative notice to proceed with the Jail Assessment pending a scope of work statement and final approval by the NIC. Mr. Bill Crout completed the following scope of work and submitted it to Mr. Barbee:

Proposal:

At the request of Harris County Sheriff's Office, the National Institute of Corrections (NIC) proposes to conduct a Jail Systems Assessment (JSA). The JSA will assess the policies and procedures and practices of the jails within the Harris County jail system with the intent to ensure that the jail system is operating safely, securely and efficiently. The JSA will use the American Correctional Association (ACA) standards as well as good correctional practices (the community standards) as a benchmark for this project.
The JSA is not intended to conflict with any other assessment, audit or inspection being currently conducted on the jail system by other agencies. It is also not intended to investigate individual incidents that may have occurred at the jail system. Rather, it will use a "systems approach" to assess what is right with the system and what areas may need improvement. It may best be described as a "tune-up" for the jail system. At the conclusion of the assessment, the NIC will provide the Sheriff with a report containing details of its activities together with the assessment and recommendations.

Methodology:

The NIC has contracted with two technical resource providers (TRPs) to conduct the assessment. These TRPs will conduct the assessment in three phases: These phases are:

> ***Phase I***
> *Phase I is preparation and a document review prior to the on-site assessment. The TRPs will request a number of documents from the Harris County Sheriff's Office to begin becoming familiarized with the*

operations of the jail system. These documents include, but are not limited to, :

- *Policy and Procedures Manual(s) for the system's jails.*
- *The jail system's Organization Chart.*
- *Post Orders for the jails.*
- *Inspection Reports from the Texas jail inspecting authority for the previous four years.*
- *Staffing schedule utilized at each jail.*
- *Classification documents utilized during classification process.*
- *Details of the "jail information system" being used (if any).*
- *Inmate grievance forms used at each jail.*
- *Inmate handbooks (if any) used at each jail.*
- *Inmate discipline reports (forms) used at each jail.*
- *Sick call or request for medical/mental health services request forms.*
- *Critical Incident Report forms used.*
- *A synopsis of any suicides or attempted suicides that have occurred in the jails during the last two years.*

Phase II

Phase II will be the on-site work that will be completed by the TRPs. We anticipate being on-site at a time agreeable to all of us for at least three full days. This on-site time will be spent meeting with the Sheriff and his command team, meeting with specific staff, touring the three jails and reviewing completed documentation for jail activities. At the conclusion of our on-site activities, we will provide a debriefing to the Sheriff and any other individuals that he feels appropriate. At this debriefing, will provide a list of preliminary recommendations for improvements to the jail system as well as a preliminary assessment. It is our intention that this entire process be as transparent as possible and that the ultimate report that will be provided to the Sheriff will not contain any surprises. Specifically, Phase I will contain the following activities:

- *Initial meeting with the Sheriff and his command staff.*
- *Initial meeting with the Jail Administrator (responsible for all jails).*
- *Meeting with Jail Commander from the "1200 Jail".*
- *Tour of the 1200 Jail including informal discussions with supervisory and line staff members.*
- *Review of sample completed documentation, including:*

- *Cell Check logs*
- *Inmate Grievances and the department's responses*
- *Inmate Discipline forms*
- *Incident reports*
- *Individual Inmate classification sheets*
- *Operational updates -*
- *Inmate Exercise/Recreation logs*
- *Clothing Exchange logs*
- *Pod/Unit activity logs*
- *Medical screening forms (initial screening - not medical files)*
- *Any other form of documentation relevant to this assessment.*

- *Interview "specialized staff" including:*
  - *Classification supervisor*
  - *Programs supervisor*
  - *Medical supervisor*
  - *Mental health supervisor*
  - *Scheduling supervisor*
- *Debrief 1200 Jail Commander*
- *Meeting with 1307 Jail Commander*
- *Same activities as itemized for the 1200 Jail*
- *Meeting with the 701 Jail Commander*
- *Same activities as itemized for the 1200 Jail*
- *Debrief for the Sheriff and other appropriate individuals.*

Phase III

Phase III is the report writing phase. The TRPs will return to their homes and will complete a draft document containing the jail assessment, including recommendations. The lead TRP will provide this draft in electronic form to the Sheriff. The TRPs request that the Sheriff and his staff review the document to ensure that there are no factual mistakes. After the review is completed, the final report will be completed and distributed to the Sheriff in hard and electronic form. A copy of this report will also be provided to the NIC.

Final Remarks

We cannot emphasize enough that this jail assessment is intended to provide the most positive recommendations possible. We will not enter the Harris County

Jail system with the intent to find problems and offer no solutions. Rather, it is our intent to provide a critical, balanced and non-biased assessment and make recommendations to make incremental improvements to the system. We understand the difficult job that it is to operate a jail system and only wish to be part of positive change rather than a negative influence.

Upon acceptance of the above scope of work, the TRPs were referred to Captain Greg Summerlin. The week of June 22 to June 25 was decided on as the on-site phase (Phase II) of the jail assessment. During May and June numerous documents were sent to the TRPs and reviewed. The following list includes both those documents sent in advance of the on-site phase and those received during the assessment.

1) *HCSO Organization Charts*
2) *Schematic Drawings*
   a) *1200 Jail*
   b) *1307 Jail*
   c) *701 Jail*
   d) *Intake Processing Center*
3) *Shift (Employee) Schedules*
   a) *1200 Jail*
   b) *1307 Jail*
   c) *701 Jail*
   d) *Support*
4) *Inspection Reports - Texas Commission on Jail Standards*
   a) *2006*
   b) *2007*
   c) *2008*
   d) *2009*
5) *Report - Forecast of the Harris County Jail Population, Charles M Friel PhD*
6) *Report - NIC Mental Health Programming in the Harris County Jail System, April 29, 2006, Margaret E. Severson (TRP)*
7) *Report - US Department of Justice - June 4, 2009*
8) *Inmate Classification Instruments (forms)*
9) *Letter will attachments, Texas Commission on Jail Standards, Approval to Modify Classification Instruments*
10) *Basic HCSO Intake Flowchart*
11) *Inmate Complaint Forms*
12) *Inmate Offense Report*
13) *Inmate Discipline Appeals (examples)*

14) *List of Jail Suicides from January 2000 to present.*
15) *Inmate Handbook*
16) *Employee Pay Scales*
17) *Preliminary Criminal Justice Study, Justice Management Institute, June 18, 2009*
18) *Report - Correctional Education Programs at the Harris County Sheriff's Office, Houston Community College, May 19, 2009*
19) *Harris County Jail Population (jail classification divisions)- 6/22/2009*
20) *Inmate Bunk Status Report, 23 June 2009*
21) *Intake Health Screening Form*
22) *Contractual Facilities (Louisiana Private Jails) Totals (Population)*
23) *Harris County Sheriff's Office Commissary Price List*
24) *Cellblock Descriptor, Classification Section, HCSO*
25) *Disciplinary/Grievance Monthly Statistical Review, April 2009*
26) *Binder of Materials - Behavioral Health at the Harris County Jail, Michael Seale, MD Executive Director for Health Services, HCSO*
    a) *PowerPoint Presentation on MH Services*
    b) *Flow Charts of Process (Mental Health)*
    c) *MHMRA Mental Health Forms Utilized*
    d) *HCSO, Health Services Bureau, Forms utilized by both Mental Health and Medical*
    e) *HCSO Forms*
    f) *MHMRA Patient Handouts*
27) *Use of Force Documents*
    a) *Planned Use of Force Flow Chart*
    b) *Unplanned Use of Force Flow Chart*
    c) *Cover letter (example) - OIG Use of Force Review*
    d) *Memo - Use of Force Review Process - Criteria and Protocol 11-12-08*
    e) *HCSO Use of Force Report*
    f) *HCSO Use of Force Medical Report*
    g) *HCSO Policy - Use of Force Policy #501*
    h) *HCSO Policy - Less Lethal Impact and Restraining Devices - Policy #502*
    i) *701 Detention Command SOP, HCSO, Use of Force Policy and Procedures DOC.07.001.00*
    j) *1200 Detention Command SOP, HCSO, Use of Force Policy and Procedures DOC.07.001.00*
28) *Death In Custody Documents*
    a) *HCSO - Deaths in Custody (Synopsis) - 2001 to 2008*
    b) *HCSO Policy - Significant Incident Notifications Policy # 402*
    c) *HCSO Policy - Significant Incident Notifications Policy # 402.1*

d) *HCSO Form - Death In Custody Notifications*
e) *HCSO Form - Death in Custody - Bullet Points (example)*
f) *HCSO Policy - Hospital Security Division - Inmate Death in Custody Policy # 5.0-05*
g) *Form - Office of the Texas Attorney General - Custodial Death Report (blank)*
h) *HCSO 701 Detention Command SOP - In-Custody Death Investigations #DOC 07.002.00*
i) *HCSO 1200 Detention Command SOP- In-Custody Death Investigations #DOC 07.002.00*
j) *HCSO 701 Detention Command SOP - Inmate Health / Medical Emergency #DOC N/A*
k) *HCSO 1200 Detention Command SOP - Inmate Health / Medical Emergency #DOC N/A*

INITIAL ASSESSMENT

The TRPs, in consultation with Captain Summerlin, developed the following schedule to guide their activities and to ensure that specific Sheriff's Office Personnel and others, were available while on-site.

This document was intended to provide a framework for the NIC Jail Assessment to be completed during the week of June 22, 2009. Every effort will be made to adhere to this schedule, however adjustments may need to be made. It is the intent of the consultants to be respectful to all interviewee's time and to cause the least amount of disruption as possible.

Date/Time	Activity	Participants	Location
Monday 06-22-09			
0900	Initial Meeting	Sheriff and his staff TRPs	Sheriff's Conference Room
1000	Jail Administrator (System) Meeting	Jail Administrator and staff TRPs	
1030	1200 Jail Manager Meeting	1200 Jail Manager TRPs	
1100	Interview	Classification Supervisor TRPs	
1130	Interview	Programs Supervisor Consultants	

Date/Time	Activity	Participants	Location
1200	Lunch		
1300	Interview	Inmate Medical Services Supervisor TRPs	
1400	Interview	Inmate Mental Health Supervisor TRPs	
1500	Interview	Scheduling Supervisor TRPs	
1600	Tour	TRPs	Primary Booking Area (IPC)
Tuesday 6-23-09			
0830	Tour and informal interviews of staff	TRPs	1200 Jail
1200	Lunch		
1300	Meeting	1307 Jail Commander	
1330	Tour and informal interviews of staff	TRPs	1307 Jail
Wednesday 6-24-09			
0830	Meeting	701 Jail Commander	
0900	Tour and informal interviews of staff	TRPs	701 Jail
1200	Lunch		
1300	Additional Interviews To be determined	TRPs	
Thursday 6-25-09			
0830	OPEN TIME (Consultants prepare for Sheriff debrief, may interview any individuals not previously identified,		
1300	Debrief	Sheriff and his staff Consultants	Sheriff's Conference Room
1700	Conclude visit		

On June 22, 2009 the TRPs (Mr. Bill Crout and Mr. James Coleman) met with Sheriff Adrian Garcia and his executive staff . Sheriff Garcia welcomed us and then shared that his three major concerns that he wished us to focus on were; (1) the recently failed state inspection by the Texas Commission on Jail Standards, (2) the recent Department of Justice Report, and (3) the need for "New Technology". Sheriff Garcia stated that he wished for the process to be transparent and was particularly interested in finding cost-savings measures that could be taken without jeopardizing the safety and security of the public, staff, and inmates.

The TRPs presented an overview of their professional backgrounds and their understanding of the assessment's goals. Sheriff Garcia committed that the TRPs would have an unfettered access to all areas of the jail and to all relevant documentation. The Sheriff also stated that he also wished for the TRPs to review the front line management for accountability, and the completeness of the reporting process for in-custody deaths

After a briefing on the inmate population, the Sheriff identified other major issues facing the Sheriff's Office as:

- An organizational culture change with detention officers (white shirts) taking the place of certified deputies (dark shirts) in the jail;
- The recent implementation of detention officer sergeants in the jail;
- The training of detention officers;
- Civilianization of previous certified positions; and
- Concerns raised during the recent pandemic (swine flu).

We concluded the initial meeting with Sheriff Garcia and his executive staff with the agreement that we would all meet on Thursday, June 25 at 1:00 p.m. to discuss the findings and recommendations by the TRPs.

JAIL SYSTEM ASSESSMENT

The jail assessment began with the interview of groups of individuals responsible for the various functions of the jail system. These interviews initially took place in the 701 Jail Administration Conference Room. Over the next four days we continued to use the conference room as well as visiting various locations throughout the jail system. The list below contains the names of all individuals who were interviewed either at the conference room or at their place of assignment. In addition to this list, the TRPs informally interviewed numerous jail staff, programs staff and inmates while touring the various locations in the jail system.

Individuals interviewed were:

1. *Sheriff Adrian Garcia, HCSO*
2. *Mr. John Dyess, Chief Admin. Officer, HCSO*
3. *Mr. Jose Jimenez, Director, HCSO*
4. *Mr. Randall Smidt, Sr. County Attorney*
5. *Major Mike Smith, Detentions Bureau, HCSO*
6. *Mr. Alan Bernstein, Public Affairs Director, HCSO*
7. *Captain Greg Summerlin, Strategic Planning and Research HCSO*
8. *Sergeant Paul Davidson, Strategic Planning and Research HCSO*
9. *Captain Kevin Radabaugh, HCSO*
10. *Ms. Bregette Yarbrough, Programs - Asst Director of Inmate Education, Houston Community College*
11. *Mr. Robert Simms, Programs - Director of Inmate Education, Houston Community College*
12. *Dr. Mike Seale, Medical Director, HCSO*
13. *Mr. Bobby Davis RN, Medical Administrator, HCSO*
14. *Dr. Thomas Brandon, Mental Health Unit, HCSO*
15. *Ms. MonaLisa Jiles, LPC, MHMRA, HCSO*
16. *Sgt. Larry King, Admin Sergeant, 1200 Baker Street Jail, HCSO*
17. *Captain Michael Richmond, 701 Jail Commander, HCSO*
18. *Sgt. Andrew J. White, Admin. Sergeant, 1307 Jail, HCSO*
19. *Captain John T. Hart, Admin. Captain, Administrative Services HCSO*
20. *Sgt. David Hasten, 701 Jail, HCSO*
21. *Sgt. Michael L. Graves, Inmate Processing Center (IPC), HCSO*
22. *Lt. James Strickland, Inmate Processing Center (IPC), HCSO*
23. *D.O. Sergeant Brent S. Buntyn, Disciplinary Court, HCSO [*
24. *Ms. Shirley Thibodeaux Instructor, Fashion Design - Inmate Education*

25. *Sgt. Glenn Shaft, Training Sergeant, HCSO*
26. *Marlene A. Orta, L.V.N. - 1200 Clinic, HCSO*
27. *Lt. Curtis Ruggles, Jail Commander, 1307 Jail, HCSO*
28. *Sgt. Kimberly Smith, Office of Inspector General, Use of Force Review HCSO*
29. *Lt. Alvin. Hollinger, 701 Jail Administrative Lieutenant, HCSO*
30. *D.O. Sergeant Orshen R. Clark -Administrative Services, HCSO*
31. *Lt. David Guarino – Classification Lieutenant, Administrative Services, HCSO*
32. *Ms. Lisa Hulsey, Senior County Attorney*
33. *Detention Officer W. R. Laws III, ADA Compliance Officer, HCSO*
34. *Lt. Robert Henry, 1200 Jail Administrative Lieutenant, HCSO*

PHYSICAL PLANT ASSESSMENTS

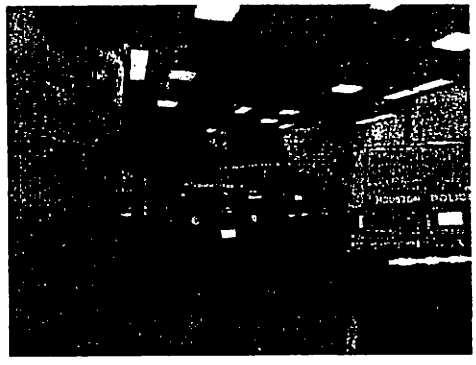
The following physical plant assessments are intended to provide an overview of the buildings that make up the jail system. An in-depth analysis of these facilities would take much more time than that which was afforded with this NIC technical assistance project. The following will attempt to highlight various functional use areas in these facilities and include their strengths and weaknesses.

Inmate Processing Center:

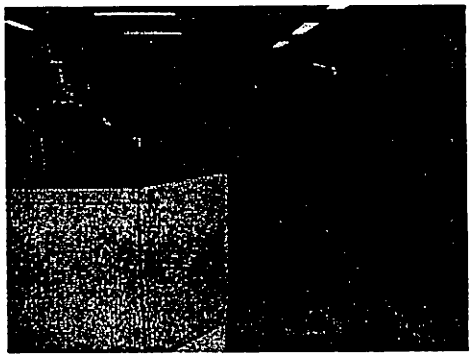
The Intake Processing Center (IPC) is a three story structure located at 1201 Commerce, Houston, Texas. It is in close proximity to the three "jails" that constitute the Harris County Jail System. It is also connected by tunnel to two of these facilities - the 701 and the 1200 Jails. This facility was originally opened in 1991 to serve as the entry point, and exit for all inmates processed into and out of the Harris County Jail System. It is important to note that the total inmate population at this time was approximately 6,000 inmates - a little over one half of today's population. Over 130,000 individuals are processed into and out of the jail system through this building annually.

VEHICLE SALLYPORT

The vehicle sallyport is a secure zone where vehicles can deliver inmates to the jail system. Also, inmates who need to be transported to other locations may use this secure enclosure. Based upon our experience, we immediately observed that the size of the sallyport is not adequate to handle the volume of traffic. This was confirmed by staff who relate that often, there are vehicles containing inmates lined up outside of the facility waiting for an open slot.

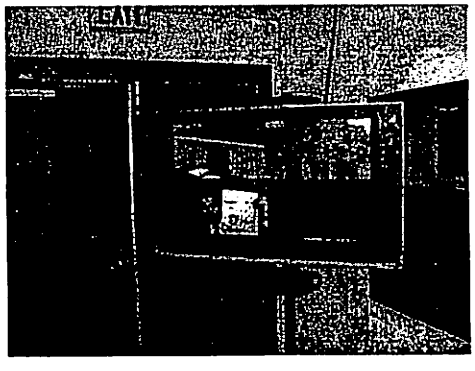


INTAKE PROCESSING



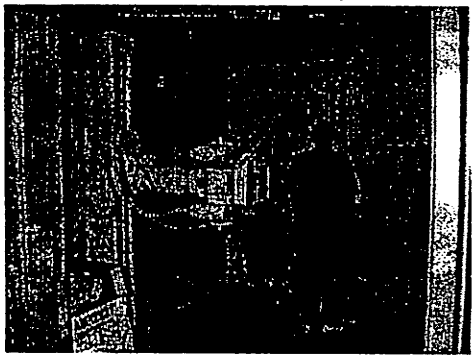
The intake processing area includes several rooms where inmates are digitally photographed, fingerprinted, temporarily detained (holding cell) and processed into the system through an interview process. because of the limitations of space in this area, there is often a bottleneck which limits the flow of inmates though the system

Located nearby, is a probable cause video courtroom where the court examines the charges and circumstances leading to the arrest of the inmate and determines if there is probable cause for further detention.



MEDICAL/MENTAL HEALTH

Staff report that significant medical and mental health resources are expended at the "front end" (processing) of the inmates incarceration in an attempt to identify inmates in immediate need of medical/mental health attention. In addition to being individually interviewed by licensed medical staff, inmates receive a chest x-ray to determine the possibility of Tuberculosis. The digital x-rays are immediately screened for significant issues then read by a radiologist in more detail within 24 hours. Inmates with immediate medical/mental health concerns are either immediately examined, or if appropriate, transferred to the 1200 Jail where the medical and mental health clinics are located.



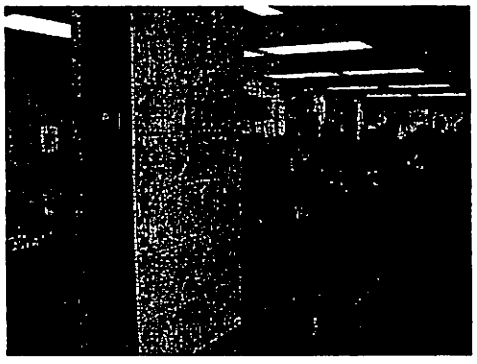
CLASSIFICATION

Inmates are interviewed, using a standardized objective classification instrument, to determine their safety/security risks. Inmates are classified as maximum, medium and minimum security. In addition inmates will be sub-categorized by gender, protective custody, and administrative segregation due to high publicity, high violence potential or a history of assaults on staff. Classification staff (with input from medical staff) then determine where to house the inmate in the system.

FEMALE BOOKING

Booking of female inmates occurs on the second floor in an area separate from the male section. The female booking process is the same as for the males inmates. All females being process into and out of the jail; system must share common areas such as medical/mental health evaluation, classification, probable cause hearings.

RELEASE PROCESSING



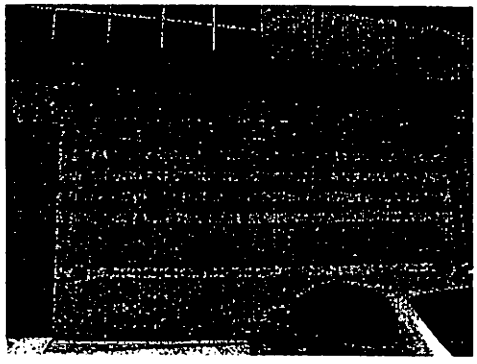
The release processing area is also located on the second floor of this building. With over 130,000 releases per year, this area becomes extremely busy at times. Unfortunately, inmates are neither received or released in even intervals - they tend to come into the area in waves. Consequently these areas can become overwhelmed.

PROPERTY STORAGE

The third floor of the IPC is taken up, in large measure, by property storage. All of the inmates clothing and personal property in inventoried at booking and stored in this area until they are released. Inmates property (except for "bulk property" which is stored in another area) is placed into blue bags and hung on a conveyer belt similar to those used by dry cleaners. It is difficult to imagine how more property could be stored in this space - it is already being used to store property for twice as many inmates as it was designed for. Of a positive note, there was no odor that is associated with other jail's inmate property rooms. Staff report that all inmate property is sprayed to eliminate this odor.

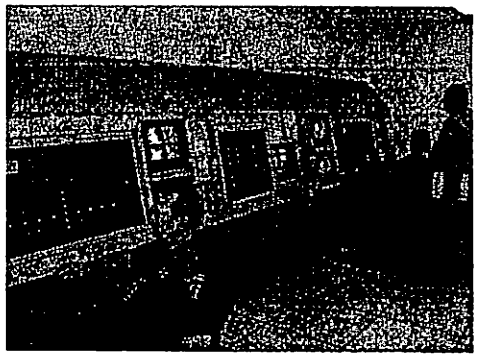
Overall, the cleanliness of the facility was very good in spite of its use. While the flow of the facility appears to be fair, the number of inmates frequently overwhelms functional use area. The fact that this facility is working as well as it does, is a testament the dedication of management and line staff who operate it.

1200 Baker Street Jail:



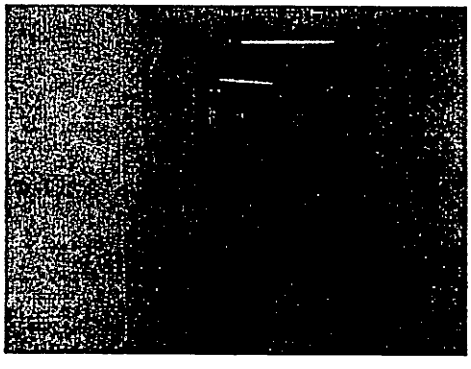
The six story 1200 Baker Street Jail is located as its name suggests. It is the newest of the three jails in the Harris County Jail System having been constructed in 2003. It contains 4,156 beds arrayed in single, multiple and dormitory cells. This facility contains medical and mental health beds as well as the primary medical infirmary for the jail system. It contains both male and female inmates. Finally, the main headquarters for the Sheriff's Office is located here.

CONTROL ROOM



The control room for this state of the art facility ensures the safe and secure movement of staff and inmates within the system. Generally, staff assigned to these post positions, monitor movement on common areas (corridors) and operate doors that allow ingress and egress to the secure envelope of the building. Staff working inside the building do not have the ability to open doors through the security envelope which eliminates the possibility of staff being overpowered to effect an escape.

SECURITY CORRIDORS/TUNNELS



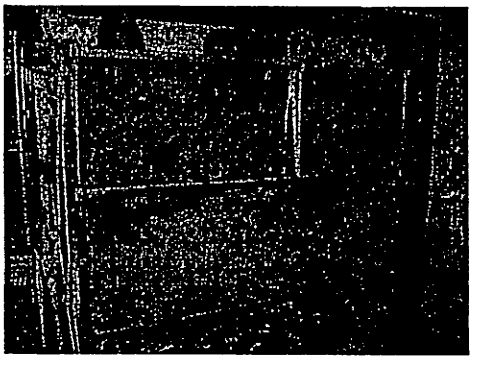
Another safety and security feature of the jail system is the tunnel system that links the IPC, 1200 jail and the 701 jail. This enhances the safety and security of inmates and staff because inmates never leave the secure portion of the jail system to be transported between facilities. This is also very cost-effective because it eliminates the need for buses and

additional transportation deputies. Over a very short period of time, these inmate transportation tunnels will pay for themselves and continue providing dividends to the County.

LAUNDRY

A critical function that occurs in every jail is the laundry. This is because it is a link in maintaining sanitary conditions in a jail, which in turn results in fewer contagious diseases being transmitted between inmates, and in some case we have seen in other jails - staff. We observed that all of the washing and drying machines were working. Staff report providing general inmate clothing exchanges at least twice a week and every day for inmates who work on crews (kitchen, outside maintenance, cleaning etc.) which meets the "community standards."

A key indicator on whether the facility is being maintained in a sanitary condition, is the occurrences of MRSA - a staph infection known to affect hospitals, jails and prisons. We were informed by medical staff on several occasions, that the incidents of MRSA in the Harris County Jail System is very low. We know that the incidents of MRSA in other large jail systems is very high. This, together with our observations of the laundry areas as well as the entire facility, leads the TRPs to the conclusion that the facility is extremely clean.

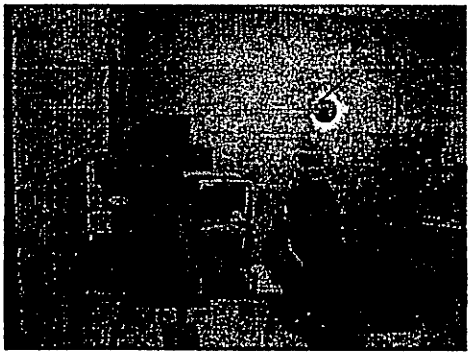


CLINICS

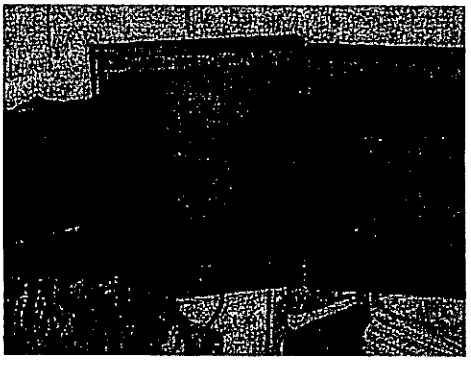
One of the area of the jail that most impressed the TRPs was with the clinics. While the TRPs are not medical experts, they do have expertise in jail operations. Jail operations all contain the element of medical services provided to the inmates. Of course, the litmus test that must be given to medical services is that it must provide what services are available in the community.

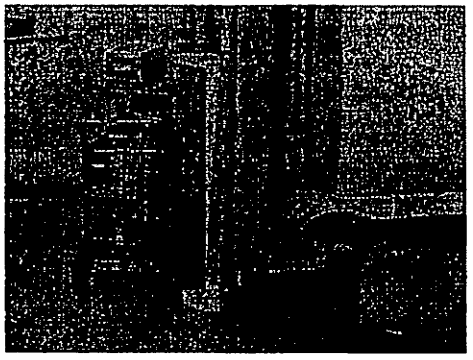
Providing dental care to inmates is a basic service that jails must provide. Medium and smaller jails will provide this service by sending inmates into the community (escorted by custody staff). This is not only dangerous but very expensive to the counties for staff time, transportation vehicles and dentists' fees. The HCSO has a complete dental clinic where inmates receive these services within the secure perimeter of the facility. The TRPs have rarely seen such a comprehensive array of dental services provided inside the jail. The taxpayers of Harris County also reap the reward because this is a very cost-effective way to provide these services.

Another medical function that is most often provided by transporting inmates to the community is ophthalmology. Inmates needing prescription eyeglasses can be evaluated within the secure portion of the jail. The TRPs have never seen an ophthalmology office within the jail, but are of the opinion that, like the dental services, provides a very cost-effective and safe way to provide these services.



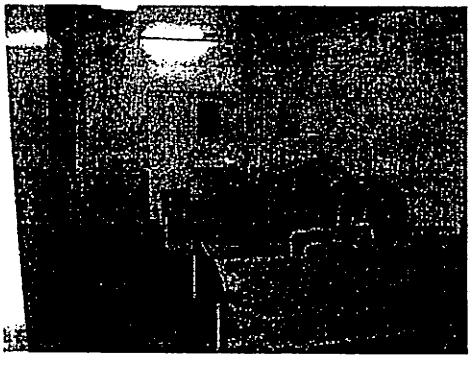
X-Ray imagery is another basic service that doctors much have access to in order to do their job. This facility contains state of the art digital x-ray equipment where images and be digitally transferred from one office/terminal to another. This provides doctors a much more efficient method for accessing this tool versus the traditional film (which is difficult to store and access). This provides another example of the quantity of medical services being provided to the inmates.

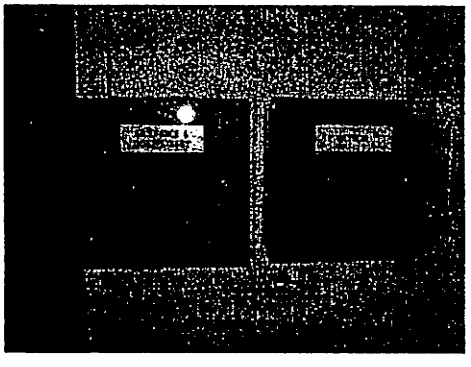




Looking more like a hospital emergency room than a jail clinic, the jail infirmary appears to contain all of the necessary equipment to provide both immediate care to inmates needing medical services.

The infirmary also contains medical beds for those inmates needing this type of housing and care. While this facility will never replace the need for hospital access, care is provided on par with that which is contained in a nursing home environment.





Scattered throughout all of the facilities that the TRPs visited were locked metal boxes where inmates may insert their request for medical services as well as grievance forms. These boxes are frequently accessed by designated staff and the contents reviewed for the most appropriate action.

Mental Health Services

The TRPs visited the mental health section of the jail where the most serious cases of inmates with mental illnesses are cared for and housed. Without getting into a paper on the mentally ill in jails - of which volumes are written, the TRPs observed teams of caring staff working with the most mentally ill in the system.

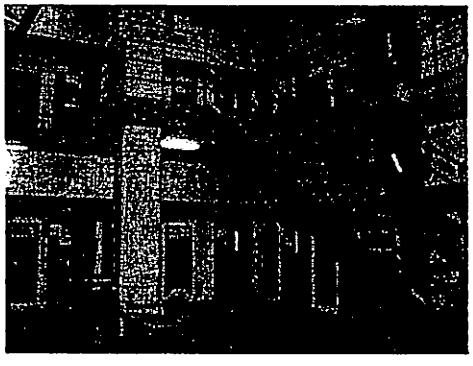
The most impressive feature of the mental health unit, from the TRPs' perspective, was the Crisis Intervention Teams or CITs. There are approximately 45 correctional staff (both blue and white shirts) who have volunteered to work as members of these teams. These staff are provided an additional 112 hours of specialized training in working with mentally ill inmates. Mental health staff describe the CIT personnel as our "eyes and ears" in the units. The TRPs observed a CIT member being used in conjunction with regular mental health staff to "deescalate" the behavior on a mentally ill inmate.

These teams regularly work with mentally ill inmate - they know and understand them as individuals. They learn what "sets them off" and are trained in how to address the problem. They do not replace mental health professionals, but they do replace the custodial staff working with these individuals. What the County receives is a much more efficient and humane way in dealing with the mentally ill in the jail.

The mental health staff report that there is a need for additional space for "group counseling." They also described that while there are now 280 dedicated mental health beds, they have a need for 376 beds. They have a specific need for additional single cell housing for females.

INMATE HOUSING

The TRPs visited several housing units contained within this facility. Without exception, they were extremely clean and well maintained. In addition, the noise level and tension level was relatively low. According to documentation, staff conducted frequent "safety checks" of the inmates to ensure safety and security needs.



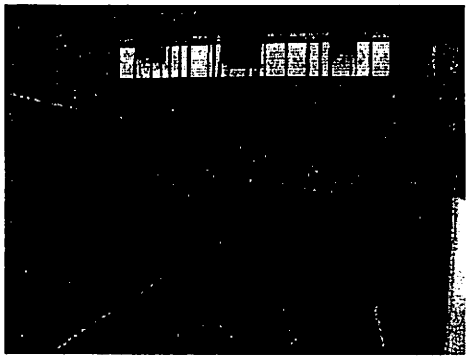
LAW LIBRARY

The law library and associated services (the availability of para-legal staff) was very impressive. All necessary law books updates were being undertaken while we were visiting. Most jails are now using disks provided by legal reference services to comply with the need to provide these services to inmates rather than the books.

PROGRAMS

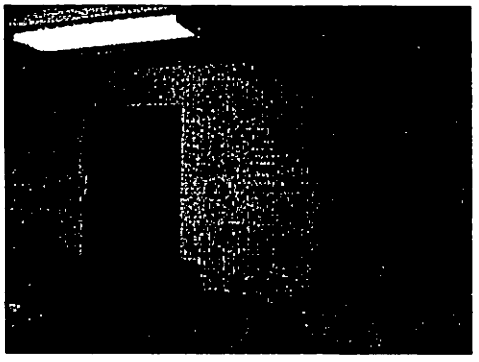
The 1200 Jail provides several areas where educational and vocational training is provided to the inmates. These areas supplement the wide variety of programs offered to inmates at the Crites Street Facility that is operated by Houston Community College.

RECREATION/EXERCISE



The opportunity for large muscle exercise and recreation is mandated for all jails. Within a high-rise jail such as the 1200 facility, it is difficult to attain. However, this facility contains exercise yards on each housing floor. Access to fresh air is also provided. On hot days, large evaporative air conditioners are used to cool the air.

INMATE GRIEVANCES AND DISCIPLINE



One method used by jail experts to determine the relative quality of jail management is what process are in place to ensure that inmates can communicate with the supervision and management of the facility. This inmate grievance process is an excellent way for managers to assess the health of the jail. Inmates who grieve a particular process or individual within the jail may provide the manager with warning that these process or individuals need to be reviewed.

Similarly, the issue of inmate discipline reveals the degree of due process afforded. Where inmates believe that the process is fair and impartial, they are more likely to more easily supervised.

The TRPs have seen few jail systems that have as good of an inmate disciplinary system as Harris County Sheriff's Office. Inmates who have administrative action imposed upon them for violating the jail's rules are afforded significant "due process" before the sanctions are applied. This system utilizes a room, not unlike a court room, to hear the defense of the inmates, together with any witnesses that the inmate may produce. A lieutenant serves as the hearing officer and their decision may be appealed up to the Detention Bureau Commander whose decision is final. Significantly, the lessons learned from this process are also used in the training of custody staff.

1307 Baker Street Jail:

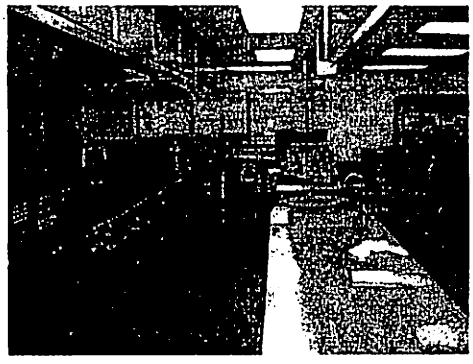
The 1307 Jail is located diagonally across the street from the 1200 Jail. This facility is also know to staff as "Little Baker". This facility has 1072 beds in dormitory cells and is used to house minimum security male inmates with no apparent health problems. It houses both male and female inmates.

Without a doubt, this facility ranks as one of the top five cleanest jails we have ever seen. This does not happen overnight, or ever with concentrated scrubbing over a month - it occurs as an ongoing and continuous process. It is important to the management of the jail for several reasons. First, it maintains a high level of sanitary conditions. Secondly, it send a strong message to the inmates of the high expectations that staff have for them - it really sets the tone for how professionally the facility is operated.

DIALYSIS UNIT

What truly makes this facility remarkable is the dialysis unit that is located within the secure perimeter of the facility. The TRPs have never seen a dialysis unit such as this one located within the walls of the jail. The existence of this unit not only speaks to the constellation of medical services being provided to the inmates, but it addresses many of the cost effective and safety issues previously discussed in connection with the 1200 dental unit.

KITCHEN

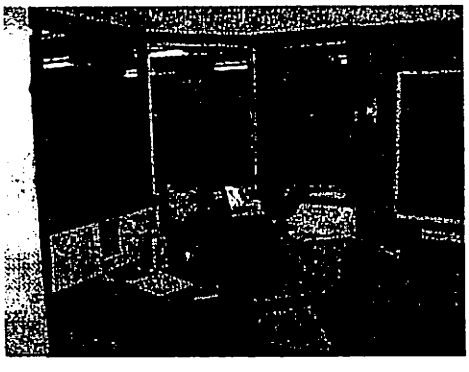


While all of the three jail facilities contained kitchens, it is noteworthy that the 1307 jail kitchen also provides meals for outside groups including "meals on wheels" and senior center meal programs. Inmate labor is used, with supervision provided by kitchen staff and custodial personnel. A registered dietician whose office is in the 1200 Jail kitchen area, prepares menus that assure proper nutrition to the inmates. During the four days, the TRPs asked several inmates for their opinion on the quality and quantity of the food. All of the inmates questioned stated that the food was either good or okay and all stated that it was sufficient.

PROGRAMS

As with observations in the other three facilities, the 1307 Jail contains program space for education and vocational education.

HOUSING

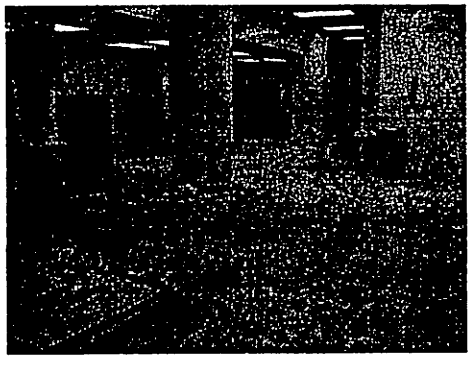


Housing in 1307 consists of dormitory style cells located on the second floor while large dayrooms occupied the first. The Texas mandated staffing ration of 1:48 is maintained in all facilities, hence the 48 bed dorms. Staff occupy an adjacent control room and periodically walk through the units.

701 San Jacinto Street Jail:

The 701 San Jacinto Jail is located at the cross street of Baker and San Jacinto Street. This facility which was originally constructed as a cold storage facility was retrofitted into a jail and opened in 1991. It contains 3,965 beds located on seven floors. It is one of the first of the "New generational" jails that were constructed in the later 1980s through today that utilize a podular design for the housing units. This design provides better sight lines of the inmates while they are in their dayroom and of the cell door fronts of single occupancy cells. It also allows significant visibility into multiple occupancy and dormitory cells.

CLINIC



This facility was flooded in the basement level during Hurricane Ike. This required that the clinic be temporarily moved to a higher floor while the original clinic is repaired. This has presented custody and medical staff with a challenge to provide medical care in this facility.

Significantly, it was in this "temporary clinic" that the TRPs found a number of medical staff including three doctors working to deliver medical care to inmates of this facility. The TRPs have rarely seen three doctors together in a jail setting. It illustrated to us that inmate access to medical care is being provided at an apparent high level - certainly comparable to the community standard.

PROGRAMS

Similar to the other facilities we visited, there are a number of vocational education opportunities available in this facility. The print shop is but one example of the types of training offered. Other opportunities in this building include GED classes.

LAUNDRY

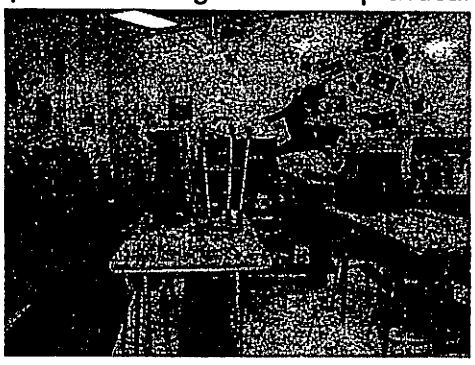
Similar to the other facilities that the TRPs visited, the laundry was well stocked, functional and extremely clean.

HOUSING

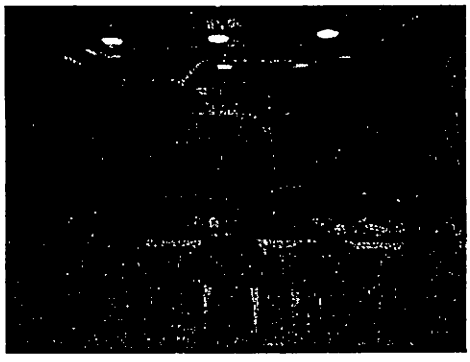
The TRPs visited several housing units representing the different types of inmate housing. We found that without exception, these housing areas were clean and well supervised. Inmates did not display tense of aggravated behavior. The noise level, in spite of the hard walls, was relatively low.

Cites Street Center:

While not a jail, the Crites Street center provides a high level of practical vocational training for inmates that supplements the training received in the jails. In our opinion, the Sheriff should highlight this facility wherever possible as an example where inmates are improved, and not warehoused.



Indeed, we could spend a week on-site at this facility and still not do it justice in any report. This facility reflects "best practices" in any jail environment. It should also be mentioned that the success of this program is in due to a large part by the long standing collaboration between Houston Community College and the Sheriff's Office. Additionally, the caring and long tenured staff at this facility ensure its success.



Classes that are provided to inmates include:

- Culinary arts
- Carpet design and wall and floor covering
- Consumer electronics (computer and television repair)
- Air conditioning and refrigeration
- Woodworking and cabinet repair
- metal shop
- automotive repair, and
- auto body repair.

These classes prepare the inmates for useful lives and in many cases have broken the cycle of recidivism. Harris County should continue to support and, if possible, expand on these very worthwhile and cost-effective programs.

RECOMMENDATIONS

The Harris County Jail System does an excellent job in performing its mandate to hold inmates in custody pending trial, during trial and if applicable, upon sentencing. The TRPs have noted a number of examples where the HCSO does an exceptional job in providing various services. Other jail systems could look to this jail system to provide example of "best practices" in many areas. Without a doubt, staff at all levels appeared to be dedicate, knowledgeable and committed to their profession. This is a good jail system that desires to be even better.

This being said, there are a number of areas that the Sheriff can examine where incremental improvement is necessary. Some of these options are within his control and others need to be acted upon by the County Commissioners and/or the public.

STAFFING

At any hour of any given day, approximately 25 to 30 percent of the staff working in the jail are on overtime. Almost $2,000,000 per month is spent on overtime for the jail. Staffing levels is predicated on needed post positions and Texas state mandates (1 officer per 48 inmates). There is no formal *Staffing Plan* that addresses the post positions that must be filled and the "actual "relief factor" (productive hours) that each class of employee has.

> *We recommend that the Sheriff's Office complete a validated Staffing Analysis. This analysis must be completed by personnel or contractors who have a strong knowledge of jails and their complexities. The product of this Staffing Analysis will provide decision makers with validated information so that an appropriate number of staff are identified necessary to safely operate the jails.*

INTAKE PROCESSING CENTER

As described in the Facility Assessment portion of this report, we observed that the size and functionality of the IPC is extremely undersized. This is creating inefficiencies through bottle necks the booking process being delayed. As stated earlier, this facility was intended to only support half of the current inmate population. While the HCSO may ease its jail population pressures through sending some inmates to private jails in other states, the pressure on the IPC will continue to build.

We recommend that the IPC facility be replaced with a larger well-designed facility. The County should adopt a systems approach (take the entire jail system into consideration while under design) to the design of this facility. This new facility should support a population higher that that which is predicted at its opening. It is critical to begin this process immediately. New construction such as this required four to five years from the time the approval is made to the opening. As such, Harris County is behind the curve. Further delays will result in processing in and out times taking longer and longer which may invite litigation.

DETENTION OFFICERS

The two classes of employees working in the jails are certified deputies and detention officers. The certified deputies (including sergeants, lieutenants and captains) could potentially be transferred from the jail to patrol. Indeed, with this system in other jurisdictions, certified deputies may only see the jail as something that they must do prior to being assigned to patrol. The detention officers most often see the jail as either a step to becoming a certified deputy or a career.

There has been considerable debate within sheriff's departments that operate jails as which is the best option - certified deputies or detention officers. HCSO has made the decision, at least in part, to employ a mix of detention officers and certified deputies. It has also made the decision to begin the career series process by promoting a number of Detention Officers to DO Sergeant positions. This creates a cultural stress, especially where deputies are making more money than detention officers working the same assignment, or where they must take direction from "non-certified" supervisors.

We recommend that the HCSO develop a Transition Plan that addresses the many issues that occur with the change of an employee culture. This plan will be central in the development of a recommended career series of correctional supervisors and managers who will eventually replace the certified staff in operating the jails. It is important to address the pay differential (our experience is that there is usually a 5% difference between certified and non-certified staff). This plan should also address those occasions where certified deputies may want to remain in the jail. Finally, it should address the inclusion of detention officers so that they feel part of the team.

TECHNOLOGY

Technology in jails has been responsible for considerable staff efficiencies as well as safer environments. HCSO has employed a number of technologies that are doing just this. For example, digital imaging of all inmates and fingerprints has saved considerable time and made the jail much more efficient. While these are two examples of "old-new technology" their case illustrates our point. Other examples include the inmate management system and the digital x-ray imaging system.

We recognized three areas where technology need to be employed - there may be others, but these should be the top priority.

Justice Systems Management System.

During our tours of the various areas of the jail, we saw the inmate record system where files on all 11,000 plus inmates were stacked on a very long table. The paper system being used by the justice system (jail, courts, DA) appear to be 1950s technology, including the use of carbon paper on the inmate property inventory form!

> *We recommend the Harris County Justice System continue its efforts to develop a Justice Systems Management System. This system would maintain electronic records that could be appropriately started at arrest, and updated throughout the detention and/or court (trial) process. This would be an extremely complex and political process, but it has worked in other jurisdictions.*

Medical Records

Inmate medical records represents another area where we saw 1950s technology at work. One room was so full of paper medical records that it was difficult to imagine how more records could be added. We understand that there are already efforts taking place to ensure the development of a computerized medical records system.

> *We recommend that the Sheriff's Office continues its efforts to ensure computerization of medical records. We understand that an RFP is being developed by Dr. Seale.*

Inmate Tracking

In any jail it is very important to know where all inmates are at all times. Other large jail systems have even experienced inmate-on-inmate homicides in their jails as a result of not being able to properly track inmates. We want to be clear that we did not observe the same conditions in the Harris County Jail System, but it would be prudent to address this issue before the system becomes even larger than it is now.

> *We recommend that the HCSO investigate and develop a computerized system for inmate tracking. Two technologies that are currently available are tracking through the use of "bar codes" on inmates' ID bracelets and RFID - small computer chips embedded in the same wrist band. Each technology has its benefits and drawbacks. Ultimately, the HCSO must make a decision on one product that is the best fit for its jails.*

Jail Beds

While no county can build itself out of the need for jail beds, it is apparent that Harris County needs to plan the construction of additional beds. While we agree that the jails are "crowded" - they often hold up to their rated capacity - we disagree that they are overcrowded - a point where more people are housed than the facility is rated for. If the one thousand or so inmates that are being housed out of state, were suddenly returned to Harris County, then the facilities would definitely be overcrowded. Nevertheless, as stated earlier, it takes around five years to plan, construct and open a new jail.

> *We recommend that Harris County develop a Strategic Master Plan for inmate housing (jails).*

GENERAL COMMENTS AND OBSERVATIONS

This section of the report addresses the areas of the jail that were assessed by the TRPs and that have not been previously discussed.

SUICIDES

During the initial request for information from the HCSO, the TRPs asked for data on the number of suicides that have occurred since 2001 in the jail system - the 1200, 701, 1307 jails and the IPC. We were extremely surprised to see that there had only been three completed suicides in the downtown housing jails mentioned during this time frame. We thought that there must be some type of mistake made in gathering the data.

During our on-site visit, one of the first issues addressed with Sheriff's staff was to verify the total numbers, which they did. Even though even three suicides are tragic, we were astonished that with a system as large as HCSO, that there had only been three completed suicides during this long period of time. Our experience has shown that even in the best operated jail systems, and even in much smaller jails, it is almost unheard of to only have three completed suicides during a eight and a half period of time. At this point we felt that the jail staff are either doing something extraordinary to prevent the numbers of suicides, or were extremely lucky.

During our on-site visits of the jail facilities, we discovered that there are four primary reasons that HCSO has so few suicides.

- First, medical and mental health care are "front loaded" into the system. This means that high level medical and mental health assessments occur as a part of the booking process. Experience has shown that a majority of suicides occur during this initial 48 hour period of time. At-risk inmates are identified, and appropriate measures taken to prevent self-abuse.
- Secondly, the mental health staff are aggressive in identifying at-risk inmates and providing appropriate preventative measures.
- Thirdly, the Crisis Intervention Team - specially trained custody staff - act as a personnel multiplier in performing the two functions as custody staff and mental health para-professionals. This increases the number of trained staff available to identify at-risk inmates. And

- Fourthly, all custody staff perform frequent "safety checks" (aka cell checks) on all inmates. Inmates exhibiting at risk behavior are quickly identified and referred to mental health.

As correctional professionals, we know that the number of suicides directly relates to how well a jail system is performing the function of ensuring that the inmates in its care and custody leave the jail in at least as good shape - and often much better - than they were when they entered the system.

CLASSIFICATION

The classification of inmates in a jail system is a critical piece to maintaining good order in the jail. Quite simply, inmates are identified as needing various security levels. Some inmates need to be housed in single occupancy cells because they are assaultive, predatory, or may need protective custody. Other inmates with a lower security level can be housed in group cells or dormitories because they generally get along with other inmates and pose a much reduced risk of aggressive behavior. Finally, there is a group of inmates in any jail system that require much less secure housing and, with supervision, can perform many of the work tasks needed in the jail.

The inmate population for the HCSO jail system have been identified as being 60% maximum, 23% medium and 17% minimum security. This caused us to examine the classification process because we initially were of the opinion that the HCSO was "over-classifying" their inmates. Most jail systems that we have seen have a much different distribution of security levels for their inmates. We generally see systems that approximate 30% maximum, 40 % medium and another 30% minimum security levels. This is important because if your over-classify, you place too many individuals into a category of inmates that must receive intensive supervision, This dilutes the supervision - resulting in a more difficult job in supervising the inmates. It may also put a strain on the physical plant by placing inmates into valuable single occupancy cells when they could be housed in group cells.

We discovered that the reason for this "over-classifying" is that the HCSO must use a Texas state mandated classification instrument. We reviewed this instrument and agree that it provides an objective system for identifying inmates of various risk levels. However, the devil is in the details - or in this case the definitions. To its credit, HCSO has recognized this fact and has recently successfully requested some modifications to this format that should result in a

more balanced inmate population. Staff should maintain focus on this issue and request further adjustments where possible.

USE OF FORCE

As we stated in our scope of work, the TRPs were not on-site to examine any individual cases of misconduct or, for example, deaths in custody. Rather, we focused on systems issues - what are the policies and procedures in place to address various functional areas of the jail. As such, we examined policies, procedures and formats intended to ensure that these policies and procedures are followed. The area of use of force is one such are that we examined.

We found that the policies and procedures regarding the use of force to be well written and meets that "community standard" for such an area in the jail. They are written so that they are easily understandable and the use of various terms are, when necessary, explained in such a way that they are clear to the reader.

We also found that the reporting process for use of force incidents is extremely comprehensive, yet not overly complex. It ensures that each incidence of use of force is examined and tracked at various levels of management to determine whether the incident was within policy and otherwise appropriate, or where it required additional investigation and, if necessary, disciplinary action. We were satisfied that the process currently in place provides the necessary safeguards to ensure that use of force incidents are appropriate.

Use of force incidents in the jail are an unfortunate necessity. We are satisfied that whether to apply the use of force and the appropriate application of force is use, is well documented. However, we caution management to ensure that a balance is maintained so that staff do not perceive that any "proper application" of force will subject them to a disciplinary process. Where this happens, whether in the jail, or on patrol in the community, incidents that could have been easily de-escalated through a minimal use of force often spin out of control requiring a much larger use of force. We also caution that misconduct by individual custody staff where employee discipline is needed, not be used to revamp the entire system unless this misconduct proves to be a "systems issue." Likewise we would hope that the public and the media be able to differentiate between individual isolated incidents of misconduct - that are appropriately addressed by management, and a broken system.

DEATHS IN CUSTODY

It is well documented throughout in jails throughout the United States that the inmates jails are receiving today are much sicker, mentally ill, and accused of more serious crimes than the inmate of only a couple of decades ago. Consequently, we are seeing a significant number of "deaths in custody" - where inmates die in jails due to "natural causes."

The TRPs do not have the expertise and background to investigate individual incidents of deaths in custody. What we do have is the knowledge of how these deaths should be documented and investigated by custody staff for the purposes of examining the potential role that custody staff had, if any, in the death.

After review of applicable policies and procedures for deaths in custody, we are satisfied that they are thorough, comprehensive, and clear. They meet, in our opinion, the "community standard" for responding to, reporting and investigating all deaths in custody. That said, we recommend two modifications:

- First, that a section be added to the "Significant Incident Notifications" policy and procedures (Policy #402) that specifies that the Sheriff is notified of all in-custody deaths or serious injuries of inmates as soon as practical by the Detentions Bureau Commander.
- Secondly, we recommend that the HCSO institute a policy, similar to the medical "quality improvement meetings", that are intended to examine all actions taken, or not taken, by custody staff that could have influenced the death. Information from this meeting will then be used to make any corrections in custody policies, procedures or practices that are necessary. County legal staff must be involved in the design and implementation of such a process.

SHERIFF'S WEB SITE

The HCSO should be congratulated on its well designed and comprehensive web site. The TRPs were able to obtain a large amount of information on the agency from this site. It is easy to navigate and provides transparency to the public on details of the operations of this large and complex organization.

TEXAS COMMISSION ON JAIL STANDARDS (TCJS) REPORTS

One of the factors that precipitated this assessment was the most recent inspection by the TCJS. In this inspection, the agency was "out-of-compliance" with a number of standards. One of the TRPs was the chief jail inspector for eight years in California in the past and has a in-depth perspective on these inspections.

All jail inspections should be taken seriously and any non-compliance issues resolved as quickly as possible. All agencies - not just jails - can benefit by outside unbiased experts reviewing their operations. This review should be viewed by the agency, and the public, as a positive action to ensure excellence in that particular agency. Where agencies take immediate and strong action to remedy these non-compliance areas, the agency should be praised. There should be concern, however, if after being notified of non-compliance issues, the agency does nothing to resolve them.

We observed that the HCSO takes these inspections very seriously and has taken pains to address each of the non-compliance issues. We directly observed examples of this during our on-site visit. The only area that the Sheriff is having difficulty with is the number of inmates in custody - the population of the jail. To be fair, he has very little power to remedy this problem. He must receive into custody individuals placed into the jail by law enforcement and the courts. He does not have an unlimited budget to build new detention facilities when the jails he does operate become crowded or overcrowded. Only the county has these resources. Consequently, if the TCJS cites the Sheriff for non-compliance of jail population limits, it is the county that needs to address this deficiency.

We also need to note that during the previous years (2007 and 2008) The jail was in full compliance with standards.

Department of Justice Report

At the end of the second day on-site, we were provided with a copy of the U.S. Department of Justice report on the jail dated June 4, 2009. Although it raised a number of issues that we were also reviewing, we did not allow this report to drive our assessment. Rather, as we outlined in our scope of work, we continued our assessment independently from other reports and investigations. This NIC report should stand on its own merits.

Final Note

We conclude our report be acknowledging the efforts of Harris County Sheriff Adrian Garcia and all of his staff for the unfettered access to materials, facilities and personnel. We were efficiently provided access to all copies of documents, personnel and physical plants that we asked for. This is an example of an agency that practices what it states - it is a transparent organization.

Exhibit 11

WILLIAM JAMES CROUT

P. O. Box 312 **Templeton, California 93465** **(805) 434-9882**

Education:

California Polytechnic State University - San Luis Obispo, California
School of Liberal Arts
Bachelor of Science – Social Sciences - June 1987
Federal Bureau of Investigation National Academy – Quantico, Virginia
161st Session – Graduated
University of Virginia Extension
Nine Units of Graduate Work – Management – June 1990

Experience:

Crout & Sida Criminal Justice Consultants, Inc. – Templeton, California
Corrections Consultant and Managing Partner – (January 2006 to Present)

- Provide expert witness services on correctional related matters
- Provide corrections consultation for local jails including:
  - Staffing Analysis;
  - Facility Assessments;
  - Facility Needs Assessments; and
  - Security Audits.

National Institute of Corrections (U.S. Department of Justice)
Contract Consultant – (2001 – Present)

- Conduct "Jail and Justice System Assessments" for counties nationwide (approximately eight per year).
- Co-Instructor of "Jail Inspectors Course."

American Jail Association (AJA)
Contract Instructor – (2006 to 2007)

- Teach classes on correctional topics nationwide.

California Board of Corrections – Sacramento, California
Executive Director (Acting) – (July 2004 – December 2004)
Deputy Director - (June 1997 – February 2005)

- Managed Facilities Standards and Operations Division, responsible for:
  - Developing and biennially reviewing/revising Titles 15 and 24 California Code of Regulations, standards for local adult jails, juvenile halls and camps;
  - Biennially inspecting all local adult jails, juvenile halls and camps in California;
  - Gathering, analyzing, and distributing data on local corrections via the *Jail and Juvenile Detention Profile Surveys*;
  - Conducting Plan Reviews on all new and remodeled local juvenile halls, camps and adult jails;
  - Administering the *Mentally Ill Offender Crime Reduction Grant* consisting of $84 million distributed to 30 projects in 26 counties; and

- Conducting special studies and analyses for local juvenile and adult detention agencies.

- Maintain strong collaborative relationships with Sheriff's and Probation Departments through executive training, on-site technical assistance and participation at professional association meetings
- Responsible for preparing and maintaining division's $2.4 million administrative budget.
- Supervise approximately 20 professional staff.
- Present complex Board of Corrections Agenda Items to the Board at its bi-monthly meetings on behalf of counties and the division.
- Directed, and participated in, the comprehensive *Institutions Operational Quality Assurance Project for the California Youth Authority* on behalf of the Youth and Adult Correctional Agency resulting in a multi-year operational blueprint for the Youth Authority.

California Board of Corrections – Sacramento, California
Field Representative - (April 1995 – June 1997)

- Inspected jails juvenile halls, and camps for compliance with *minimum standards* found in Titles 15 and 24, California Code of Regulations.
- Conducted complex staffing analyses and staff work.
- Facilitated numerous Executive Steering Committees and workgroups responsible for developing the *Jail Profile Survey,* the system for conducting biennial compliance inspections, Adult and Juvenile Titles 15 and 24 regulations, and internal management reviews.
- Designated as *lead trainer* for Board of Corrections' role in dozens of Jail Management Courses statewide.

Sacramento Area Council of Governments – Sacramento, California
Criminal Justice Consultant – (October 1992 – April 1995)

- Assigned to the Board of Corrections.
- Performed same tasks as Board of Corrections Field Representative.

San Luis Obispo Sheriff's Department – San Luis Obispo, California
Captain – (December 1990 – October 1992)

- Patrol Division Commander reporting to Chief Deputy and Sheriff
- Managed and supervised approximately 150 line, supervisory and management personnel – sworn and civilian – staffing three sub-stations and headquarters.
- Developed and maintained division's annual budget.
- Managed joint Probation and Sheriff's *Gang Task Force* through Office of Criminal Justice Planning grant.
- Collaborated with county agencies, community based organizations and other law enforcement agencies to develop the *Central Coast Conference on Youth* – an ongoing interagency strategy for working with at-risk youth.

San Luis Obispo Sheriff's Department – San Luis Obispo, California
Lieutenant – (February 1987 – December 1990)

- Jail Commander and Construction Transition Team Leader - reporting to Chief Deputy and Sheriff.
- Local Criminal Justice Consultant on loan to Board of Corrections (October 1987 to March 1989) – worked on team responsible for administering approximately $1.5 billion in jail construction bonds to counties.
- Managed 300-inmate jail system including approximately 100 staff.
- Sheriff's representative on jail transition team responsible for collaborating with other county staff, architects, construction management and contractors on the programming, design and construction of two new and remodeled jails.

San Luis Obispo Sheriff's Department – San Luis Obispo, California
Sergeant – (March 1983 – February 1987)

- Assistant Jail Commander and Patrol Watch Commander.
- Supervised jail staff and served as acting jail commander during the jail commander's absences.
- Supervised countywide patrol operations.

San Luis Obispo Sheriff's Department – San Luis Obispo, California
Deputy – Sr. Deputy – (December 1978 – March 1983)

- Patrol Deputy.
- Department Training Officer and Background Investigator.
- Special Enforcement Team (SWAT) member.

Los Angeles Police Department – Los Angeles, California
Police Officer I, II and III – (July 1971 – December 1978)

- Patrol Officer.
- Field Training Officer.
- Community Relations Officer – Schools Program.

Exhibit 12

9146 Bellehurst Cove
Cordova, TN 38016

Phone 901- 266-0123
E-mail jimliztesh@msn.com

James E. Coleman

Objective

With the help of GOD to provide a living for my family. To change the image of "201", while helping the Shelby County Corrections community to be recognized as a leader in our field.

Functional summary

Born and educated in Nashville, TN. Began correctional career with Davidson County Sheriff's Office in Nashville and have held various positions within the field. Most notably, Director of Training with the TN Corrections Institute, and the TN Board of Pardon and Parole, Corrections Specialist with the National Institute of Corrections, Director of Union County, New Jersey's Division of Corrections and Correctional Management Consultant.

Employment (Last ten years)

[November 1, 2001 -] Assistant Chief 01 - 04 / 04 – Present Chief Jailer

Shelby County Sheriff's Office Memphis, TN

- Provide safe keeping of persons awaiting their day in court. Average daily population over 2700.
- Staff compliment 1100. 850 uniform 250 civilian

[April, 1998 – October 2001] Director

Union County Division of Corrections Elizabeth, New Jersey

- Provide safe and secure keeping of persons awaiting trail and also for those persons serving court ordered sentences. Average daily inmate population 1200
- 400 uniform staff and 150 civilian

Education

1978 TN State University Nashville, TN

Bachelor of Science in Criminal Justice

Professional memberships

Current Chairman of Local Detention Facilities committee for American Corrections Association, Former American Jail Association's Board Member, Co- Founder West Tennessee Corrections Associations Shelby County Corrections Consortium,

References

Provided upon request

Exhibit 13

Edit Back

U. S. Department of Justice United States Marshals Service	

DETENTION FACILITY INVESTIGATIVE REPORT

A. *Detention Facility Information*

Facility Name: HARRIS CO JAIL		
Address: 701 N. San Jacinto Street Houston, TX 77002	USMS District No. 79 District Name: Southern District of Texas Sub-Office: Houston Facility Telephone: 713-755-8400 County: Harris	
Facility Administrator: John Hart	Title: Captain	Telephone: 713-755-8415
Detention Facility Contact: Curtis Ruggles	Title: Lieutenant	Telephone: 713-755-8425
USMS District Point of Contact: Mario Campos	Title: DUSM	Telephone: 713-718-4800
Distance from USMS Offices Using Facility: Miles: 2		
Driving Time From USMS Offices Using Facility:	Hours: 0 Minutes: 5	

B. *Average Daily Detainee Population & Staffing Information*

Detainee Population Information:

	Adult Male	Adult Female	Juv. Male	Juv. Female	Total
Facility Capacity	9000	1000	0	0	10000
Facility Average Daily Population	8302	1275	27	2	9606
USMS	10	0	0	0	10

LOCAL	0	0	0	0	0
BOP	0	0	0	0	0
Other	0	0	0	0	0

Facility Staffing Information:

Security Staffing:				Medical Staffing:			
	# Auth	# Filled			#Auth	# Filled	Contract
Captain	3	3		Physician	8	8	
Lieutenant	15	15		Physician's Assistant	0	0	
Sergeant	82	82		Registered Nurse	26	26	
Security Officer	1300	1214		Licensed Practical Nurse	53	53	
Other				Nurse Practitioner	2	2	
				Emergency Medical Tech			

C. *Information IGA/Contract & Inspections*

IGA/Contract # (If Applicable): J-D79_M_043 Facility Code: 6DC/6DD
Inspection Date: 07/01/2009 Type of Inspection: Annual
Accredited By: NCCHC (List Other): CALEA
Time Limits: Term of Court
Does Facility Receive Federal Excess Property: No

D. *Facility Construction Information*

Date Facility was: Constructed: 1991 Remodeled:
Construction Added: Construction Planned:

Will any Planned Remodeling or Construction Affect Facility Capacity (If Yes, Please Comment)?

E. *Serious Incidents in Facility During Previous Calendar Year*

Number of: Suicide Attempts: 13 Suicides: 0
Escape Attempts: 0 Escapes: 0

Number of: Serious Assaults on Prisoners: 750
Serious Assaults on Staff: 236
Other Serious Incidents: 21

F. *Problems/Complaints Affecting Facility During Previous Calendar Year*

Court Orders Affecting Facility (Attach Copy if Available):
No court orders currently affecting facility.
Pending Major Litigation:
No pending major litigation.

Number of Written or Verbal Complaints Resolved Involving:

Detainees:	Attorneys:	Family Members:	Medical:	Abuse:
1002			293	39

G. *Visual Review of Facility:*

Living Area Comments:
Problems with the intercoms that were brought to the attention of Harris County from the last State of Texas inspection are currently being resolved.

Day Room Comments:
Problems with the toilets that were brought to the attention of Harris County from the last State of Texas inspection are currently being resolved.

Kitchen Comments:
Clean.
All meals prepared by inmates.
Three days of food on hand.
Three meals a day, Two hot.
Health standards regulated by Houston Health Department.
Water comes from City of Houston

Medical Area Comments:
Excellent- Fully staffed triage. Specialty Doctors rotate from medical contract with UTMB. Fully operational dental facility. Dedicated Mental Health/Mental Retardation Section. 30 negative pressure cells and numerous fully padded cells.

Recreation Area Comments:
Good. Basketball no longer allowed due to large number of injuries.

Visiting Room Comments:
Good.

Special Housing Comments:
Large Special Housing Unit for problem inmates.

Other:
Legal matters handled by Attorney Jim Faulkner (713) 755-6044

H. *Review of Confinement Conditions*

Background information and instructions regarding the review of conditions of confinement can be

found on Attachment 1 to this form. A comment must be made regarding any confinement condition that is found to be either Non-Compliant or Deficient at the end of Section H.

SECTION A: ADMINISTRATION/MANAGEMENT

A.1 Policy Development and Monitoring
The Facility Director ensures staff has the necessary information to operate and maintain the facility in accordance with local, state, and federal laws.
Compliant

A.2 Internal Inspections and Reviews
The Facility Director ensures internal operational inspections and reviews are coordinated regularly, and include systematic follow-up as needed.
Compliant

A.3 Detainee Records
The Facility Director adequately maintains all detainee records (including medical and mental health), ensuring their security and confidentiality.
Compliant

A.4 Admission and Orientation
The Facility Director provides an adequate admission and orientation.
Compliant

A.5 Personal Property and Monies
The Facility Director ensures personal property and monies are properly recorded, stored, and returned to detainees upon their release.
Compliant

A.6 Detainee Release
The Facility Director ensures detainees are released only with proper orders, identity verification, and notification.
Compliant

A.7 Accommodations for the Disabled
The Facility Director ensures that adequate accommodations are made for disabled detainees if the particular facility accepts disabled detainees.
Compliant

SECTION B. HEALTH CARE

B.1 Intake Health Screening
The Facility Director ensures that adequate medical, dental, and mental health screenings are performed and appropriate dispositions are made.
Compliant

B.2 Medical, Dental, and Mental Health Appraisals
The Facility Director ensures that full medical, dental, and mental health appraisals are completed for each detainee within 14 days of arrival.
Compliant

B.3 Access to Routine, Chronic, and Emergency Health Services

The Facility Director ensures that detainees have timely access to and receive adequate routine, chronic, and emergency health services (i.e., medical, dental, and mental healthcare).
Compliant

B.4 Experimental Research
The Facility Director ensures that detainees are not subjects of biomedical, behavioral, pharmaceutical, or cosmetic research.
Compliant

B.5 Response to Medical, Mental, and Dental Health needs
The Facility Director ensures that all staff are trained in processes and resources are in place to adequately respond to the medical, and dental health needs of detainees.
Compliant

B.6 Suicide Prevention
The Facility Director ensures that an adequate suicide prevention program is in place.
Compliant

B.7 Detainee Hunger Strikes
The Facility Director is prepared to respond appropriately to a detainee hunger strike, including providing appropriate medical and mental healthcare.
Compliant

B.8 Detainee Death
The Facility Director is prepared to adequately respond to a detainee death.
Compliant

B.9 Informed Consent/Involuntary Treatment
The Facility Director ensures that informed consent is obtained, when appropriate, prior to delivery of care.
Compliant

B.10 Infectious Disease
The Facility Director ensures that there is an infection control program that promotes a safe and healthy environment for staff, detainees, and visitors.
Compliant

SECTION C: SECURITY AND CONTROL

C.1 Post Orders
The Facility Director ensures staff members have a clear understanding of the duties, responsibilities, and expectations associated with their posts.
Compliant

C.2 Permanent Logs
The Facility Director ensures that permanent logs are maintained for recording daily information, including routine occurrences, emergencies, or any unusual incidents.
Compliant

C.3 Security Features
The Facility Director ensures that inspections of all security features are conducted regularly in order to

identify needed maintenance or other discrepancies.
Compliant

C.4 Security Inspections
The Facility Director ensures security patrols/inspections of all areas of the facility are conducted regularly.
Compliant

C.5 Control of Contraband
The Facility Director ensures the adequate control and disposition of contraband.
Compliant

C.6 Detainee Searches
The Facility Director ensures an adequate detainee search program exists that preserves constitutional rights.
Compliant

C.7 Detainee Accountability and Supervision
The Facility Director ensures the physical accountability and adequate supervision of detainees to ensure the safety of both staff and detainees.
Compliant

C.8 Use of Force
The Facility Director ensures that force is used only when necessary and only as long as necessary. The Facility Director also ensures that when force is used, it is not excessive and is properly documented and reported.
Compliant

C.9 Non-routine Use of Restraints
The Facility Director ensures that restraints are used only when necessary. The Facility Director also ensures that when restraints are used, they are used appropriately and only for non-punitive purposes.
Compliant

C.10 Tool & Equipment Control
The Facility Director ensures adequate control of keys, tools, culinary equipment, medical equipment, supplies, and vehicles.
Compliant

C.11 Weapons Control
The Facility Director ensures adequate control of weapons.
Compliant

C.12 Detainee Discipline
The Facility Director ensures a fair detainee disciplinary system is in place that preserves due process.
Compliant

C.13 Supervision for Special Housing
The Facility Director ensures adequate supervision of detainees in administrative segregation, protective custody, and disciplinary detention.
Compliant

C.14 Contingency/Emergency Plans
The Facility Director ensures that an effective and adequate written contingency/emergency plan is in place.
Compliant

SECTION D: FOOD SERVICE

D.1 Sanitation Requirements
The Facility Director ensures that the facility meets all applicable food service standards regarding sanitation procedures for purchasing, serving and transporting, cooking, eating utensils and cooking equipment, as well as temperature requirements for food preparation and storage. The Facility Director also ensures that only appropriate staff and detainees are employed in food service jobs.
Compliant

D.2 Adequate and Varied Meals
The Facility Director ensures that nutritionally adequate and varied meals are provided.
Compliant

D. 3 Special Diets
The Facility Director provides for special diets when prescribed by appropriate medical or dental personal. The Facility Director also ensures detainees are given reasonable opportunities to observe their religious dietary practices.
Compliant

SECTION E: STAFF/DETAINEE COMMUNICATION

E.1 Staff-Detainee Communication
The Facility Director adequately promotes and encourages detainee opportunities to communicate to staff, both written and verbal. When necessary, communications aids are provided (translations, translators, hearing impaired aids, etc.).
Compliant

E.2 Diversity Training
The Facility Director provides staff with appropriate diversity and sensitivity training.
Compliant

E.3 Detainee Grievances
The Facility Director ensures that detainee grievances are addressed in a timely manner through a formal process.
Compliant

SECTION F: SAFETY AND SANITATION

F.1 Fire Safety
The Facility Director ensures an adequate fire safety program, which conforms to local, state, and federal law, where applicable, is in place.
Compliant

F.2 Non-Hazardous Furnishings
The Facility Director ensures that furnishings (e.g., mattresses, cushions, ect.) are fire-resistant, non-toxic, and not a fire safety hazard.

Compliant

F.3 Control of Dangerous Materials
The Facility Director controls the storage, exposure, use and disposal of all flammable, caustic, toxic, and hazardous materials and other waste.
Compliant

F.4 Environmental Control
The facility Director provides detainees with clean, sanitary, and adequately ventilated facilities.
Compliant

F.5 Clothing and Bedding
The Facility Director provides all detainees with clothing and bedding that are clean, well maintained, and suitable for the climatic conditions of the area.
Compliant

F.6 Personal Hygiene/Well-being
The Facility Director promotes and facilitates detainees' personal hygiene and well-being.
Compliant

F.7 Physical Facility and Equipment
The Facility Director ensures that the physical facility and equipment do not present a hazard to detainees, employees, and visitors.
Compliant

SECTION G. SERVICES AND PROGRAMS

G.1 Classification, Review, and Housing
The Facility Director objectively classifies detainees, conducts adequate re-classification reviews, and houses detainees based on the level of custody required.
Compliant

G.2 Religious Practices
The Facility Director ensures that detainees of all faiths have reasonable and equitable opportunities to participate in the practices of their faith.
Compliant

G.3 Volunteer Work Assignments
The Facility Director ensures that unsentenced detainees are not required to work unless they volunteer to do so.
Compliant

G.4 Work Assignments and Security
The Facility Director ensures that work assignments do not compromise the security of the facility or community, or the delivery of health care. The Facility Director also ensures that detainees do not supervise other detainees.
Compliant

G.5 Juvenile Needs
The Facility Director ensures the special diet, exercise, and education needs of juvenile detainees under the age of 16 are met. The Facility Director also ensures the special education requirements of

applicable detained under 21 are met.
Compliant

G.6 Exercise and Out-of-Cell Opportunities
The Facility Director ensures detainees have a reasonable opportunity for exercise and out-of cell time.
Compliant

G.7 Legal Materials
The Facility Director affords detainees reasonable and equitable access to legal materials and reasonable opportunities to prepare and copy legal documents.
Compliant

G.8 Legal Representation
The Facility Director ensures detainees have reasonable access to legal representation and the courts.
Compliant

G.9 Telephone Access
The Facility Director ensures detainees have reasonable and equitable access to telephones.
Compliant

G.10 Visitation Privileges
The Facility Director ensures detainees are allowed reasonable visitation with family and friends.
Compliant

G.11 Detainee Mail and Correspondence
The Facility Director ensures detainees can send and receive mail and maintain the confidentiality of privileged correspondence.
Compliant

SECTION H: WORKFORCE INTEGRITY

H.1 Staff Background and Reference Checks
The Facility Director ensures all staff have initial background and reference checks before they are hired and that periodic criminal history checks are conducted once staff are employed.
Compliant

H.2 Staff Training, Licensing, and Credentialing
The Facility Director ensures all staff are adequately trained, licensed, and credentialed, and that expected standards of conduct are included in the training program.
Compliant

H.3 Staff Misconduct
The Facility Director ensures that an adequate system is in place to report allegations of staff misconduct and that such reports are thoroughly investigated and addressed, including forms of misconduct covered by other specific standards.
Compliant

SECTION I: DETAINEE DISCRIMINATION

I.1 Discrimination Prevention
The Facility Director ensures that detainees are not discriminated against based on gender, race, religion,

national origin, or disability (including discrimination in work and education programs).
Compliant

Please list comments by section and confinement condition beginning with Section A. (i.e. Section A, A-1: Facility does not:....)
A.3-Inmate records are kept secured and at facility.
B.1&B.2-Inmates must complete a full medical and mental health screening upon arrival.
C.6-Many floors have a mandatory search policy for all inmates entering the floor.
E.3-Grievances heard by Grievance Review Board within fourty-eight hours.
F.5-Bedding exchanged every three days and clothing every two days.
F.6-Indigent packages available for those inmates with no money.
G.1-Inmates classified upon initial arrival and once every ninety days.
G.2-Religious services provided daily.
G.3-Facility staff fully aware that Federal Inmates are not allowed to work.
G.7-Inmates have full access to legal library with legal aids availble to answer questions.
H.1-All staff must pass a full background investigation before entry on duty.
H.2-Regular continuing education courses required of all staff.

J. Monitoring Report Certification:

Type in the SMTP Email Address of the Reviewed In-District Supervisor:
STiller@usms.doj.gov **(JDoe@usms.doj.gov). SMTP address from Outlook.**

Performed By (Please Print Name): Mario Campos		Electronic Signature: Mario Campos
Title: DUSM		Date: 07/27/2009
Reviewed In-District By (Please Print Name): Steven Tiller		Electronic Signature: Steven Tiller
Title: Acting Chief Deputy		Date: 07/27/2009

NOTE: Please obtain a copy of all inspection certificates, menus, prisoner handbooks or any other relevant documentation that supports a Detention Facility Investigative Report. All supporting documentation should be filed with the corresponding Detention Facility Investigative Report. Please do not forward supporting documentation to the Prisoner Services Division.

Edit History	
Mario Campos	07/01/2009 04:35:55 PM
Mario Campos	07/27/2009 02:36:08 PM
Mario Campos	07/27/2009 02:41:22 PM
Mario Campos	07/27/2009 02:44:46 PM
Mario Campos	07/27/2009 02:45:19 PM

ATTACHMENT 1

Purpose of the Conditions of Confinement Detention Standards and Monitoring Report
The core mission of the Conditions of Confinement program is to monitor non-federal facilities that hold USMS detainees to help ensure that these facilities:

- are safe,
- are humane,
- protect detainee statutory rights, and
- protect detainee constitutional rights.

Core Detention Standards
The Core Detention Standards were developed to ensure the safe and humane confinement of federal detainees and to uphold the protection of their statutory and constitutional rights. The 59 standards are divided into 9 sections by relevance. Each standard contains a title and defining statement. The 9 sections are:

A. Administration/Management
B. Health Care
C. Security and Control
D. Food and Service
E. Staff/Detainee Communication
F. Safety and Sanitation
G. Services and Programs
H. Workforce Integrity
I. Detainee Discrimination

The reviewer should ask the appropriate questions and verify appropriate documentation while seeking out pertinent information for making assessments. For example, if a standard requires that the Facility Director provide adequate medical, dental, and mental health screenings as part of the intake process, the reviewer should detail what is generally included in a screening, and verify the 4 items listed below in determining if the standard is being met. Reviewer should verify that:

- Does a policy exist?
- Is the policy adequate?
- Is the policy being implemented successfully?
- Is the desired outcome being achieved?

Each Policy will be assessed for compliance using the following definitions:

- **Fully Compliant** - Adequate policies, procedures, and processes are in place to achieve a standard.
- **Partially Compliant** - Improvements are necessary, such as additional resources, policy clarifications, process or procedural changes, to fully achieve the standard.
- **Non Compliant** - Adequate policies, procedures, and processes are either not in place or not working.
- **Not Applicable** - Standard is not relevant for the facility.

General Guidance for Reviewers: Policy Communication and Review

1. Interview high-level staff to ask how policies and procedures are communicated to staff and detainees.

2. Verify that adequate information is actually available via some means of communication (e.g., policy manuals, orientation, procedures, or legal guidelines.

3. Check pre-service and in-service training curricula to determine the extent to which staff training addresses the relevant policies and procedures.

4. Interview random correctional staff and detainees to determine the extent of their familiarity with the relevant policies and procedures.

5. Review policies and procedures to determine whether there are any indications of regular (at least annual) review and revision.

6. Is the facility operating in accordance with local/state/federal standards, regulations, and laws.

7. Is the facility operating in accordance with standards and policies established by nationally recognized organizations such as ACA, AJA, NCCHC, OSHA, or NFPA.

Summary of Core Detention Standards

A: ADMINISTRATION MANAGEMENT

A.1 Policy Development and Monitoring
A.2 Internal Inspections and Reviews
A.3 Detainee Records
A.4 Admission and Orientation
A.5 Personal Properties and Monies
A.6 Detainee Release
A.7 Accommodations for the Disabled

B: HEALTH CARE

B.1 Intake Health Screening
B.2 Medical, Dental, and Mental Health Appraisals
B.3 Access to Routine, Chronic, and Emergency Health Services
B.4 Experimental Research
B.5 Response to Medical, Mental & Dental Health Needs
B.6 Suicide Prevention
B.7 Detainee Hunger Strikes
B.8 Detainee Death
B.9 Informed Consent/Involuntary Treatment
B.10 Infectious Disease

C: SECURITY AND CONTROL

C.1 Post Orders
C.2 Permanent Logs

E: STAFF/DETAINEE COMMUNICATION

E.1 Staff-Detainee Communication
E.2 Diversity Training
E.3 Detainee Grievances

F: SAFETY AND SANITATION

F.1 Fire Safety
F.2 Non-Hazardous Furnishings
F.3 Control of Dangerous Materials
F.4 Environmental Control
F.5 Clothing and Bedding
F.6 Personal Hygiene/Well-being
F.7 Physical Facility and Equipment

G: SERVICES AND PROGRAMS

G.1 Classification, Review, and Housing
G.2 Religious Practices
G.3 Volunteer Work Assignments
G.4 Work Assignments and Security
G.5 Juvenile Needs
G.6 Exercise and Out-of-Cell Opportunities
G.7 Legal Materials
G.8 Legal Representation
G.9 Telephone Access
G.10 Visitation Privileges
G.11 Detainee Mail and Correspondence

C.3 Security Features
C.4 Security Inspections
C.5 Control of Contraband
C.6 Detainee Searches
C.7 Detainee Accountability and Supervision
C.8 Use of Force
C.9 Non-Routine use of Restraints
C.10 Tool & Equipment Control
C.11 Weapons Control
C.12 Detainee Discipline
C.13 Supervision for Special Housing
C.14 Contingency/Emergency Plans

D: FOOD SERVICE

D.1 Sanitation Requirements
D.2 Adequate and Varied Meals
D.3 Special Diets

2009

H: WORKFORCE INTEGRITY

H.1 Staff Background and Reference Checks
H.2 Staff Training, Licensing, and Credentialing
H.3 Staff Misconduct

I: DETAINEE DISCRIMINATION

I.1 Discrimination Prevention

Exhibit 14

EmployStats

Economic & Statistical Research
Employment | Wage & Hour | Damages | Police Conduct

Dwight Steward, Ph.D.
Economist and Statistician

Dr. Dwight Steward is an expert in statistical and economic analysis of labor and employment related issues. He has experience in consulting and litigation involving employment discrimination and wage and hour matters —on behalf of both defendants and plaintiffs.

Dr. Steward has also developed and implemented innovative methodologies to assist attorneys in the assessment of economic damages in cases involving death or catastrophic injury. As an expert witness, he has authored hundreds of expert reports, been deposed in over 130 cases and testified in over 40 trials. He has also testified in hearings, arbitrations, city council meetings, and before the Texas state legislature.

Dr. Steward writes regularly on employment related issues and frequently speaks to economic and legal professional groups. Dr. Steward's research on the statistical analysis of police racial profiling has received national attention.

In addition, Dr. Steward previously taught in the Department of Economics and the Red McCombs School of Business as the University of Texas at Austin and at Sam Houston State University. He taught numerous courses in economics, statistics, and corporate finance and was voted the teacher of the year by UT's largest business and professional organization.

EDUCATION

Ph.D., Economics, University of Iowa

B.A., Economics, University of Texas at Austin; earned U.S. Army Officer Commission – Field Artillery

SELECTED WRITINGS AND PRESENTATIONS

Employment Discrimination and Wage and Hour Analysis Sessions Chairperson, Western Economic Association International Meetings, Seattle, Washington, 2007

Labor and Employment Law CLE Conference, Speaker, University of Texas Law School, Austin, Texas, 2008

Labor and Employment CLE, Speaker, Defense Research Institute (DRI), Chicago, Illinois, 2005

"Evaluating the Statistical and Economic Significance of Statistical Evidence in Employment Discrimination Cases, Expert Evidence Report, BNA, Inc. Vol. 5, No. 5; p. 117-119; 2005

"Back Pay and Front Pay Calculations in Employment Termination Cases: Accounting for Re-Employment and Mitigation Efforts" (Joint with Stephanie Botello), 2008, Available at Social Science Research Network: http://ssrn.com/abstract=1218642

"Lies, Damn Lies, and Statistics: A View from a Statistical Expert", Texas State Bar Advanced Employment Law CLE Chapter 13.1, 2003

Expert witness testimony list, full listing of speaking engagements, and writings available on request

Phone: 512.476.3711 | Fax: 512.476.9712 | www.employstats.com
River Place Corporate Center 6500 River Place Blvd Building V Suite 202 Austin, Texas 78730

PUBLIC TECHNICAL REPORTS, PUBLICATIONS AND WORKING PAPERS

"Back Pay and Front Pay Calculations in Employment Termination Cases: Accounting for Re-Employment and Mitigation Efforts" (Joint with Stephanie Botello), 2008, Available at Social Science Research Network: http://ssrn.com/abstract=1218642

Economic Damages Primer for Attorneys: The building blocks for valuing economic damages in personal injury, wrongful death, medical malpractice, and products liability cases, (Joint with Charles Mahla, Ph.D., Michael Sadler, Ph.D., Chad Shirley, Ph.D., Doug Berg, Ph.D., et al.), Econ One Research, Inc., September 2007

"How Long do Mexican Migrants Work in the U.S.?" (Joint with Amy Raub and Jeannie Elliott), Journal of Forensic Economics, Volume XIX No. 2

"Evaluating the Statistical and Economic Significance of Statistical Evidence in Employment Discrimination Cases, Expert Evidence Report, The Bureau of National Affairs, Inc. Vol. 5, No. 5; p. 117-119; March 7, 2005 and March 23, 2005

"Racial Differences in Interest Rates", Midwestern Business and Economic Review, p. 9 – 24, Number 34 Fall 2004

"Lies, Damn Lies, and Statistics: A View from a Statistical Expert", Texas State Bar Advanced Employment Law CLE Chapter 13.1, 2003

"Evaluating Statistical Evidence in Employment Discrimination Cases, Expert Evidence Report, Bureau of National Affairs, p. 117-119.

"An Examination of Consent Searches and Contraband Hit Rates at Texas Traffic Stops", (Co-Authored) Technical Report Prepared for NAACP, LULAC, and Texas Criminal Justice Reform Coalition 2005

"Racial Profiling: Texas Traffic Stops and Searches; A first look at the nation's most comprehensive racial profiling dataset", (Co-Authored) Technical Report Prepared for NAACP, LULAC, and Texas Criminal Justice Reform Coalition, 2004

"Re-Zoning Austin's West Campus: A Unique Opportunity for Smart Growth", Technical Report Prepared for the University Area Partners, 2004

"Drug Treatment Programs and Cost Savings in the Texas State Criminal Justice System", Technical Report Prepared for Justice Policy Institute and NAACP Voter Fund, 2003

"A Statistical Methodology to Help Courts Select Racially Balanced Texas Juries", Technical Report Prepared for the NAACP, 2003

"A re-examination of police racial profiling using the Becker model of discrimination", co-authors Doug Berg and John Maroney , Working paper, 2002

"A Fixed-Effects Discrete Choice Model of Racial Profiling in Police Vehicle Searches", Working Paper, 2002

"A Preliminary Examination of Racial Profiling in Texas: A look at Police Search Rates in Texas", (Co-Authored), Technical Report Prepared for the NAACP, 2000

"A Note: Bootstrap Standard Errors and Confidence Intervals for Weak Axiom of Cost Minimization (WACM) Based Managerial Efficiency Estimates", Published Applied Economics Letters V.2., 1998

"Bank Mergers and Cost Efficiency", PHD Dissertation, University of Iowa, 1995

"Racial differences in interest rates: a cluster analysis approach", co-authors Doug Berg and Donald Bumpass (SHSU) (2002), Paper accepted for presentation at Economics and Finance Association February 2003 meeting in Savannah, Georgia.

INVITED PRESENTATIONS AND PUBLIC SPEAKING ENGAGEMENTS

UTCLE The 15th Annual Labor and Employment Law Conference, Austin, Texas, May 29-30, 2008

NAACP 71st Texas Annual meeting, "Police Use of Force and Racial Profiling Panel Discussion" McAllen, Texas, October 12, 2007

Western Economic Association International, Chairperson of Employment Discrimination and Wage and Hour Analysis Sessions, Seattle, Washington, June 29 – July 1, 2007

UT School of Law 14th Annual Employment Law CLE, Presented with Stephanie Botello, "Calculating, proving, and mitigating damages involving re-employment", Austin, Texas, May 17, 2007

Iowa Economic Alumni Workshop, Tippie College of Business, "How Long do Mexican Migrants Work in the U.S.?", Iowa City, Iowa, April 21, 1007

Trialsmith CLE webinar series, "Calculating economic damages in injury and death cases", February 8, 2007

American Economic Association Annual *Meeting*, Session Chairperson, "Economic issues in estimating damages in commercial and personal injury cases", Chicago, Illinois, January 6, 2007

MADD National Diversity Forum II, speaker for "Profiling to Behavior" a moderated panel discussion, Dallas, Texas, May 16 – 18, 2006

Academy of Economics and Finance meeting, presented "Valuing employee stock options grants in litigation", Houston Texas, February 10, 2006

American Economic Association annual meeting, presented "Estimating the work life expectancy of undocumented Mexican migrant workers", Boston, Massachusetts, January 2006

DRI 2005 annual meeting, speaker for employment law "Lies, Damn Lies, and Employment Statistics, Chicago, Illinois, October 21, 2005

Labor and Employment Roundtable, sponsored by Texas Lawyer, August 31, 2005

Austin Business District Roundtable, 'Economic Roundtable on the Future of the Austin and Texas Economy, July, 2005

Iowa Alumni Workshop, Department of Economics, Tippie College of Business: "Economics and economists in the U.S. legal system: A view from the trenches", University of Iowa, April, 2005

Police Executive Research Forum: "Data Analysis Guidelines for Poststop Analyses", Las Vegas and Kansas City; 2004

Texas State Capitol Media Press Conference –Study Release, Topic: "An Examination of Consent Searches and Contraband Hit Rates at Texas Traffic Stops", Austin, Texas, 2005

Police Executive Research Forum, Racial Profiling Meeting: Denominator Conference, *"Use of census data to measure racial disparities in traffic stops"*, Las Vegas, Nevada, 2004

Austin City Council Meeting, West University Area Rezoning, "Rezoning Austin's West Campus, A Unique Opportunity for Smart Growth, Austin, Texas, 2004

African-American Economic Legislative Forum, Host by Rep. Senfronia Thompson, Roundtable Speaker, Texas State Capital, Austin, Texas, 2004

North Texas Police Racial Profiling Conference, The University of Texas at Arlington, Center for Mexican American Studies, "The 2002 Racial Profiling Data Revisited: A Look to the Future", Arlington, Texas 2004

NAACP and LULAC Police-Community Town Hall Meeting, "A Look at Police Racial Profiling Statistics in Fort Worth, Fort Worth, Texas, 2004

NAACP and LULAC Police-Community Town Hall Meeting, "A Look at Police Racial Profiling Statistics in Beaumont, Beaumont, Texas, 2004

NAACP and LULAC Police-Community Town Hall Meeting, "A Look at Police Racial Profiling Statistics in Houston, Houston, Texas, 2004

Texas State Capitol, Sen. Royce West Legislative Roundtable of Police Racial Profiling Data Collection and SB 1074, Roundtable Speaker, Austin, Texas, 2004

Police-Community Relation Forum, "A Preliminary Look at Racial Profiling in Texas and the Huntsville Area", Huntsville, Texas, 2003

Economic Issues in the African-American Forum, "The Roots of African-American Economic Progress", Radio Program, KAZI, Austin, Texas 2003

Texas State Bar Advanced Employment Law CLE Seminar Topic: "Lies, Damn Lies, and Statistics", Houston, Texas, 2003

Haynes and Boones, LLP, Presentation, Topic: "Use and [Misuse] of economics in economic damage calculations", Austin, Texas, 2002

Texas Police Chief Forum on Racial Profiling, "Using Search Data and Stop Data to Measure Racial Profiling", University of Texas at Austin, Austin, Texas, 2002

Texas State Capitol Press Conference –Study Release, Topic: "Selecting racially balanced Texas Juries", Austin, Texas, 2003

Texas State Capitol, Press Conference-Study Release, Topic: "Cost savings and efficiency in the Texas State Criminal Justice System", Austin, Texas, 2003

PowerCenter, Presentation, Topic: "Drug treatment programs and cost savings in Texas", Houston, Texas, 2003

Texas State Senate Chambers, Presentation, Topic: *"Statistical analysis of police racial profiling data"*, Austin, Texas 2001

This Week with Senator West, Television show, Roundtable Discussion, Topic: *"Detecting racial profiling"*, Austin, Texas 2001

Texas State Capitol, Media Press conference, Topic: *"Release of NAACP police racial profiling study"*, Austin, Texas, 2000

College of Business Administration, Sam Houston State University; Huntsville, Texas, Presentation, Topic: *"Lending discrimination"*, Huntsville, Texas 1998

Federal Reserve Bank of Chicago; Moderator, Topic: "*Detecting Lending Discrimination in Credit Markets"*, Chicago, Illinois, 1997

Federal Reserve Board., Presentation, Topic: *"Bank mergers and managerial"*, Washington D.C, 1995

Exhibit 15

Central Office – Legal Services Unit
7800 Shoal Creek Blvd., Suite 171-E
Austin, Texas 78757
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Toll Free 1.800.252.9108
Fax 512.454.3999
www.advocacyinc.org

July 22, 2009

Via CMRRR 7004 1350 0002 7500 2734

Loretta King
Acting Asst. Attorney General
U.S. Dept. of Justice
Civil Rights Division
950 Pennsylvania Avenue
Washington, DC 20530

Re: Investigation of the Harris County Jail

Ms. King:

Advocacy Incorporated, the nonprofit protection and advocacy agency in Texas, is aware that the DOJ's CRIPA division recently sent a letter detailing its findings of its investigation into the conditions at the Harris County Jail ("HCJ") and its request for the HCJ to implement remedial measures. Advocacy is writing this letter to provide the DOJ with information that it hopes will be helpful in determining what, if any, remedial action it requests of the HCJ.

Advocacy, Inc. has spent many hours monitoring Texas jails. In late 2006 and early 2007 Advocacy began to focus its attention on the HCJ. Its initial relationship with the HCJ was very adversarial, but it quickly developed into a mutually supportive working relationship that has resulted in significant improvements for individuals with mental illness housed in the HCJ. HCJ has been willing to listen to our concerns and our advice regarding working with and treating persons with mental illness and the HCJ has far exceeded our expectations in implementing recommendations made by our national expert after touring and inspecting the Jail, (the tour and inspection was limited to the mental health care).

Interestingly, upon review of the DOJ Report, it is Advocacy's opinion that many of the areas that DOJ found to be insufficient are the very areas in which HCJ has already made huge strides and where HCJ probably far exceeds the standards of most jails nationally. A few examples of the major improvements that HCJ has made on a completely voluntary basis, without the threat of a lawsuit are:

1. Increasing the following positions:

POSITIONS	2007	2009
Psychiatrists	4 (only one was full-time)	11
Psychologist	2	3
Case managers	8	7
LPHA	10	13
Psych tech	25	34

2. Hiring and training 64 Detention Officers ("DO"), all of whom have received an additional 48 hours of specialty training in Mental Health-Crisis Intervention Management. These DO's wear plain clothes instead of the law enforcement uniforms to minimize the intimidation effect sometimes perceived by inmates. The additional training has already led to a reduction in restraints and altercations.

3. Increasing the range and number of housing options for persons with mental illness. HCJ added 24 beds at an offsite psychiatric facility (HCPC) for those inmates whose mental health has significantly deteriorated and can't be treated in a jail setting, making it probably the only jail in the country that utilizes an offsite psychiatric facility to provide care to those inmates who are most in need. HCJ increased its acute psychiatric bed capacity from 51 to 108 at the jail. HCJ added a 12 bed cognitive behavioral therapy unit managed by psychologists and increased the number of beds in their mental health step down units to 148, bringing a total number of beds dedicated solely to mental health care to 280.

4. Improved Initial Identification, Evaluation, and Medication. This is one of the main areas that in the past Advocacy would receive numerous complaints from inmates. Now, Advocacy rarely if ever receives complaints about inmates not receiving medications or seeing a psychiatrist upon booking and, when it does, HCJ quickly resolves the issue.

HCJ accomplished this by significantly reorganizing the process through which inmates with mental illnesses are screened, identified and evaluated upon booking. Now, when an inmate is being booked into the HCJ and determined through the initial screening process to have a possible mental health need, they are diverted to the clinic for a higher level of evaluation prior to housing to better determine the appropriate housing location, medication, and evaluation needs of the individual inmate.

This new process has reduced the average time it takes an inmate to see a psychiatrist after intake screening from months to being seen the same day as being booked and it has enabled inmates to receive psychiatric medications after booking in approximately 2 days, compared to what used to be months.

5. Restraint/Seclusion. The Medical Director revised the restraint and seclusion policies and procedures for the mental health units. He requested Advocacy's input when revising these

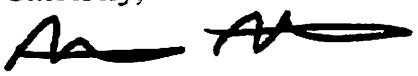
policies and ultimately agreed to implement the restraint and seclusion polices used in Texas' state hospitals which exceed CMS's Conditions of Participation (CoPs) standards regarding the use of restraint and seclusion. Again, something I am sure no other jail has been willing to adopt.

6. Adding a Utilization Review Manager who provides quality assurance data to Advocacy on a regular basis and has been willing to add fields to the data collection when necessary to address potential areas of concern.

Advocacy has been in many Texas jails. None of the jails that Advocacy has monitored has taken the initiative, without litigation, to make such sweeping and substantive changes to the care and treatment of the individuals with mental illness. This is not to say that HCJ is perfect, there are still areas that need improvement, but HCJ has been one of the few jails that Advocacy has worked with that is committed to truly making changes that in many cases exceed national standards. Considering all of the institutions that are not willing to make changes on their own, why make a facility that is trying to do the right thing, and in fact has done just that in many areas, feel as if it were all for naught? Advocacy's fear is that this will stifle HCJ strive for perfection and instead leave them at mediocrity since they may now just comply with the conditions of the settlement instead of looking to excel.

Thank you for taking the time to review Advocacy's comments and concerns. If you have any questions, please do not hesitate to contact me at 512-454-4816.

Sincerely,



Beth Mitchell
Senior Managing Attorney

BLM/kp

cc: Adrian Garcia, Harris County Sheriff

Exhibit 16

RESPONSE

to the

U.S. DEPARTMENT OF JUSTICE

INVESTIGATION of the HARRIS COUNTY JAIL

REPORT

by

John G. Peters, Jr., Ph.D., CLS

August 14, 2009

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PRE-ON-SITE VISIT ISSUES 7

Professional Opinion: Harris County and/or Sheriff Tommy Thomas reasonably trained their deputies and/or jailers according to State of Texas and other generally accepted law enforcement standards prior to the on-site visit by the DOJ. 7

Professional Opinion: **Harris County and/or its Sheriff, Tommy Thomas met and/or exceeded policy requirements for developing use-of-force policy for deputies and/or jailers prior to the on-site visit by the DOJ.** 7

DOJ Pledge: The DOJ pledged transparency in its investigation of the HCJ. 9

Methodology: What was the DOJ investigation-research methodology? 9

Table 1 Six Ways of Knowing 10

Table 2 Scientific Research Steps 11

Validity and Reliability: DOJ attorneys and consultants failed to identify how they checked the validity and reliability of information obtained from inmate interviews. 13

Fallacy: The failure to validate unsupported claims is an example of an Ex Post Facto Fallacy. 13

POST-VISIT ISSUES 14

Causation: The DOJ report has confused temporality, association, and correlation with causation. 14

Slanter: The DOJ has engaged in slanter throughout the report. 15

More Fallacies: The DOJ report engaged in the Ex Post Facto Fallacy, Fallacy of Division, Fallacy of Selected Instances, and Fallacy of Dicto Simpliciter when it arrived at defective conclusions. 17

Constitutional Force Standards: The DOJ failed to demonstrate that any HCJ officers inflicted cruel and unusual punishment on any HCJ inmates. 19

Table 3 HCJ 2008 and 2009 Frequency of Select Force Categories 20

Discipline and Control: The use of force deployed by HCJ staff in the incidents identified in the DOJ report was consistent with maintaining discipline and control of inmates housed within the HCJ. 21

Restraint and Force: The DOJ has failed to identify that HCJ officers used hazardous restraint and force techniques on inmates without appropriate guidance or sanction. 22

Professional Opinion: There is no constitutional or other legal requirement that correctional officers write their own use-of-force reports. 23

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VNR: Vascular neck restraints are safe when applied properly, and should not be prohibited, per se, by HCJ policy. 23

Professional Opinion: Hogtying has not been an authorized restraint method per HCJ policy. 24

DOJ Recommendation: Cell extractions should be videotaped for evidentiary purposes when reasonable and safe. 24

Professional Opinion: Appropriate force is not the constitutional standard as noted by the DOJ. 25

Professional Opinion: HCJ does meet and/or exceed generally accepted correctional standards. 25

Professional Opinion: DOJ investigators and consultants knew or should have known that the HCJ had created the Office of the Inspector General and had begun to review use-of-force reports and/or incidents. 26

Professional Opinion: There exists a disconnect between the comments made by DOJ attorneys and consultants during their ―Brief Out" on August 8, 2008 and the June 4, 2009 DOJ report. 26

Professional Opinion: HCJ administrators investigated use-of-force incidents, and when appropriate, disciplined those officers who were involved. 27

DOJ Accuracy: The consultants reports are needed to assess the validity and accuracy of the DOJ attorney‘s interpretation of the consultants‘ findings and opinions. 28

SUMMARY 29

REFERENCES 30

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FOCUS OF ANALYSIS

Through counsel for Harris County, Texas, I was asked to review the United States Department of Justice (DOJ) report dated June 4, 2009, and then analyze the report‘s findings and recommendations, correctional standards, use-of-force standards, in addition to related issues and then offer opinions about same. The analyses and opinions developed are contained within this report.

I am not a party to this DOJ investigation, and over the age of twenty one. A copy of my *Curriculum Vitae* is attached to this report, which identifies my education, professional experience, over 160 publications, and other training and experience. There are areas of my education, training, and experience, which are very relevant to issues identified and opinions developed in this matter.

One area is law enforcement training. I have been providing instructor-level, or Train-the- Trainer, training throughout North American and England since 1979. Topics have included, but are not limited to: use of force; expandable baton; straight baton; side-handle baton; tactical handcuffing; tactical flashlight; electronic restraint devices; handgun retention and disarming; unarmed defensive tactics; handling of emotionally disturbed persons; restraint devices; identification and prevention of in-custody (or arrest-related) death; etc. Lesson plans and training documents were also prepared for each topic, and in many cases, an informational video was also produced. I have trained thousands of law enforcement officers as instructors in these topics. I am also a certified TASER M26, X26, X3, ECD Instructor who has taken a five-second TASER ECD exposure, and a certified TASER armorer.

As a former law enforcement patrol officer, deputy sheriff, and law enforcement administrator I am also familiar with the need for written policy, rules, and procedures, and the need to properly train officers about them. I was also President of a Pennsylvania Civil Service Commission, where I oversaw testing requirements for law enforcement officers and also was involved with disciplinary actions involving law enforcement officers. Supervisory training is also a key ingredient to organizational effectiveness, as is having contemporary policies and procedures. I have written about these issues, conducted organizational diagnoses about management, training, policies and procedures, etc. in law enforcement organizations, and hold graduate degrees in management.

In addition to my law enforcement experience, I have also taught in graduate (doctoral and master levels) and undergraduate programs. My primary courses were research methods and statistics, in addition to leadership, management, learning theory, instructional design, communications, and business-related courses.

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I am also a faculty member of the Americans for Effective Law Enforcement (AELE), a not-for-profit organization that conducts training on several topics, including jail legal issues. I have taught and continue to teach in several AELE programs, including the ―AELE Jail and Prisoner Legal Issues" program. I have also earned the designation of *Specialist* from the AELE in three areas: police liability; corrections liability; and public employment liability.
I have taught for and consulted with the Harris County Sheriff's Department. Most recently, I was contracted by Harris County to monitor investigators and/or consultants from the United States Department of Justice Civil Rights Division who were there to inspect the numerous correctional facilities of Harris County. I have toured the Harris County jail and holding facilities in Harris County, Texas.

Additionally, I was a presenter at the American Jail Association National Training Conference held in Sacramento, CA in 2008, and in Louisville, Kentucky in 2009. I have presented for the American Correctional Association, Laurel, MD, and have consulted with Sheriff's Departments across the United States during the past 29 years, offering training services, sample policies, use-of-force training, etc.

BACKGROUND of DOJ Investigation

The United States Department of Justice (DOJ) Civil Rights Division notified the Harris County Judge's Office regarding its intention to investigation the conditions at the Harris County Jail (HCJ) on March 7, 2008 (King, June 4, 2009, p. 1). DOJ cited statutory authority pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 United States Code §1997 (p. 1). The HCJ meets the definition of an ―institution" under CRIPA, ―which is owned, operated, or managed by, or provides services on behalf of any State (i.e., Texas) or political subdivision of a State (i.e., Harris County), and is a jail . . ―(CRIPA, 42 U.S.C. §1997 (1)(A)(iii). In a follow-up letter to the Harris County Attorney the DOJ announced that it would conduct a tour of the HCJ on July 8-12, 2008 and again on August 5-9, 2008 (Cheng, April 30, 2008, p. 1). The DOJ investigators would be assisted by Mr. Manuel Romero (Mr. Romero), Dr. Joseph Fowlkes (Dr. Fowlkes), Mr. Leonard Rice (Mr. Rice), and Dr. Amanda Ruiz (Dr. Ruiz) (p. 1). The April 30, 2008 DOJ letter also requested ―general corrections information" that was provided by the HCJ (p. 1). Sheriff Tommy Thomas was the Sheriff of Harris County when notification was received from the DOJ regarding its intention to investigate the HCJ. The HCJ is under the leadership and direction of the Harris County Sheriff's Office. Sheriff Thomas was not re-elected in 2008 (Personal communication, Lieutenant Henry, November 2008), and was replaced with Sheriff Adrian Garcia.

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HARRIS COUNTY JAIL

The Harris County Jail is located in Houston, Texas, and was ranked the third largest jail in the United States (at midyear 2008) following Los Angeles County, CA, and New York City, NY jails, respectively (Minton & Sabol, 2009, p.7). According to the Bureau of Justice Statistics (BJS), a subdivision within the DOJ, the HCJ averaged 15.857 inmate deaths per year from 2000-2006 (www.ojp.usdoj.gov/bjs). On average, this figure is an extremely low percentage per year—0.0132%-- of the total number of inmates received per year (mean = 120063 inmates/year) at the HCJ during this range of time.

ON-SITE VISIT of HCJ: #1

From July 8-12, 2008 the DOJ investigators and consultants conducted their first on-site inspection of the HCJ and its satellite facilities. I was unable to participate in the first on-site visit.

ON-SITE VISIT of HCJ: #2

DOJ attorneys and consultants conducted a second on-site inspection of the HCJ and its satellite facilities from August 5-9, 2008. I was present during this on-site inspection, and accompanied Mr. Romero, DOJ attorney Mr. Christopher Cheng (Mr. Cheng), Mr. Leonard Rice (Mr. Rice) and others throughout various HCJ venues.

DOJ REPORT and FINDINGS: June 4, 2009

The DOJ Civil Rights Division issued a report on June 4, 2009 regarding its investigation and findings of the HCJ (King, June 4, 2009). The 24-page report described the HCJ in a brief overview, identified the legal framework under which the DOJ has the statutory authority to conduct such investigations, alleged constitutional deficiencies, and recommended remedial procedures (pp. 2-20).

This report is in response and rebuttal to the DOJ report, and will primarily focus upon ―protection from harm" issues and allegations. This report contains three sections: Pre-Visit Issues; On-Site Issues; and Post-Visit Issues. Prior to responding to the DOJ report on a claim-by-claim basis, a review of research methodology, statistical analyses, and causation are presented so that the reader will better understand this report‘s response and rebuttal of the DOJ report.

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PRE-ON-SITE VISIT ISSUES

Professional Opinion: Harris County and/or Sheriff Tommy Thomas reasonably trained their deputies and/or jailers according to State of Texas and other generally accepted law enforcement standards prior to the on-site visit by the DOJ.

Discussion: According to the **Standards for Law Enforcement Agencies** (November 2001), training is noted as one of the most important responsibilities and duties of a law enforcement agency. According to the Commission on Accreditation for Law Enforcement Agencies (CALEA), ―well trained officers are generally better prepared to act decisively and correctly in a broad spectrum of situations" (p. 33-1).

It is well publicized in the criminal justice community and generally accepted that the employer and the employee's administrator must reasonably train **employees in their core tasks** (see *Understanding & Managing Law Enforcement Liability: Critical Areas of Concern*, 1993; City of Canton, Ohio v. Harris, et al, 489 U.S. 378, 109. S.Ct. 1197 [1989].) Contemporary and reasonable law enforcement administrators and other municipal administrators know when they fail to conduct core training, they can be held to be deliberately indifferent under what one court has defined as ―just not giving a damn"(Bordanaro v. McLeod, 871 F2d 1151, 1164 [1st Cir. 1989]. These and similar court holdings are discussed in contemporary training courses, which contemporary and reasonable county and agency administrators attend.

Having taught law enforcement officers throughout the State of Texas during the past three decades, I am familiar with the requirements to be a law enforcement officer, and in my professional opinion to a reasonable degree of professional certainty, coupled with my education, training, and experience, the deputies and jailers who were involved in this incident were reasonably trained according to the standards established by the Texas Commission on Law Enforcement Officer Standards (TCLEOSE), and the American Jail Association (AJA), and the American Correctional Association (ACA).

Professional Opinion: **Harris County and/or its Sheriff, Tommy Thomas met and/or exceeded policy requirements for developing use-of-force policy for deputies and/or jailers prior to the on-site visit by the DOJ.**

Discussion: CALEA standard 1.3 *Use of Force* directs law enforcement administrators to develop ―A written directive [that] states personnel will use only the force necessary to accomplish lawful objectives" (Commission on Accreditation of Law Enforcement Agencies, Inc., November 2001, p. 1-4). A related CALEA standard, 1.3.4 states: ―A written directive governs the use of authorized less-than-lethal weapons by agency personnel" (p. 1-4).

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Additionally, CALEA standard 1.3.6 states: ―A written report is submitted whenever an employee: ―. . . b. takes an action that results in, or is alleged to have resulted in, injury or death of another person; c. applies force through the use of lethal or less-than-lethal weapons; or d. applies weaponless physical force at a level as defined by the agency" (p. 1-5). In my professional opinion to a reasonable degree of professional certainty, coupled with my education, training, and experience, Harris County and/or Sheriff Thomas met and/or exceeded the CALEA standards regarding a written policy on use-of-force and reporting force events.

The Honorable Emory A. Plitt, Jr. defined a policy as ―a general statement of philosophy, principles and objectives in a given area. Policies tell what the department wants to accomplish and why. Policy provides the framework within more specific guidance that can be provided in the form of procedures and rules" (Plitt, 2006, p. 42-3).

Continuing, the former Maryland State Police legal counsel focuses on and defines rules. ―Rules are much more specific. They leave less room for the exercise of discretion and decision-making by the rank and file officer. Rules spell out what must be done or not done in specific situations. Rules are intended to mandate specific behaviors. Rules help to make the department's response as uniform as possible to specific situations" (Plitt, 2006, p. 42-3).

Procedures are the last to be defined. ―Procedures spell out a routine to be followed in handling a particular matter. They are typically more detailed than rules and are usually concerned with setting out an orderly manner in which to proceed. They set out the exact actions to be taken" (Plitt, 2006, p. 42-3).

Sheriff Thomas issued a *General Order* on the topic of **Use of Force**, which included policies, procedures, and rules that HCSO deputies were directed to follow (Harris County Sheriff's Department, **Use of Force**, Bates Stamp, Brown-HCSO--0041). In the HCSO policy, subject resistance levels are identified and defined (Bates Stamp, Brown-HCSO—0043 through 00445), along with key definitions that are located throughout the 6-page policy.

Law enforcement administrators are keenly aware of the positive role training and/or written policies can have on civil lawsuits and on administrative investigations. Documented prior training (instruction) is often enough to defeat a claim of deliberate indifference (City of Canton v. Harris, 489 U.S. 378, 109 S. Ct. 1197 (1989)). Plitt (2006) defined deliberate indifference as: (1) a choice made from among various alternatives; (2) a knowing choice, usually made with some state of mind; (3) a choice made with some knowledge or appreciation of what the consequences of the choice will/might be; (4) a choice made with knowledge of a particular problem or situation; and, (5) a choice made after some time to consider the choices available (p. 42-5; see also Plitt, 2008). Anticipating problems that will confront officers and training to minimize their discretion at the operational level are two roles of training that follow the need for

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training in specific areas. Written policies, too, can also demonstrate reasonable guidance to control employee behavior.

System-wide written policies, rules, and procedures not only assist administrators in their planning, organizing, directing, and controlling of their agencies and/or units, but also they ―minimize the likelihood of unintentional infringements on constitutional rights" (Plitt, 2006, p. 42-2).

In my professional opinion, coupled with my education, training, and experience, Harris County and/or Sheriff Thomas met and/or exceeded national policy recommendations and/or requirements regarding policies, procedures, and rules governing their employees' use-of-force prior to the on-site visit by the DOJ.

DOJ Pledge: The DOJ pledged transparency in its investigation of the HCJ.

Professional Opinion: The DOJ has not been transparent as pledged in its written and verbal statements.

Discussion: On July 3, 2008 DOJ attorney Christopher N. Cheng (Mr. Cheng) pledged investigation transparency in his letter, ―In keeping with our pledge of transparency. . ." (p. 2), which was re-pledged in the June 4, 2009 DOJ report authored by Acting Assistant Attorney General Ms. Loretta King (Ms. King), when she wrote, ―consistent with our commitment to provide technical assistance and **conduct a transparent investigation** . . ." [emphasis added] (p. 1). However, this transparency oath has not been honored by the DOJ, which will be explained under the **Post-Visit Issues**.

Methodology: What was the DOJ investigation-research methodology?

Professional Opinion: The DOJ investigators and attorneys have not revealed their investigation-research methodology regarding the analysis and formulation of their opinions thereby making it essentially impossible to sufficiently respond to the DOJ report.

Discussion: Without exacting knowledge of how the DOJ attorneys and consultants gathered and then analyzed the data they collected and/or were provided it is essentially impossible to respond to the DOJ findings. For example, in his July 3, 2008 letter, Mr. Cheng wrote that ―It is our customary practice to conduct inmate interviews privately . . ." (p. 2). Mr. Cheng does not elucidate how the data obtained from private inmate interviews will be evaluated for reliability and/or validity. If DOJ attorneys and/or consultants relied to any degree on information that lacked veracity the HCJ staff and consultants need to be informed how these data were evaluated by the DOJ for accuracy and veracity. Obtaining information from privately interviewing

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inmates is one way of learning information, but is not considered a reliable research methodology.

It is important for HCJ officials to learn how the DOJ attorneys‘ and consultants‘ obtained information, what weight they attached to the information, how they assessed the validity and reliability of the information, how they used the information obtained, and also how and to what standards they compared the information to develop their findings. Since there are various pathways to ―knowing”, it is important that HCJ officials learn how the DOJ attorneys and/or consultants gathered their knowledge and then distilled knowledge from the information obtained.

A review of scientific literature identified six ―ways of knowing”. Table 1 lists and defines each of these pathways.

Table 1 Six Ways of Knowing

Pathway of Knowing	Definition
Tenacity	A willingness to accept ideas as valid because they have been accepted for so long or repeated so often that they seem true
Intuition	Accepting ideas as valid because they ―feel‘ intuitively true
Authority	Accepting ideas as valid because some respected authority asserts that the ideas are true
Rationalism	Developing valid ideas using existing ideas and principles of logic
Empiricism	Gaining knowledge through observation
Science	A process that combines the principles of rationalism with the process of empiricism, using rationalism to develop theories and empiricism to test the theories

Sources: Peters, 2009, p. 413; Graziano & Raulin, 2000, p. 9

Scientific research, according to Kerlinger (1964) ―is systematic, controlled, empirical, and critical investigation of hypothetical propositions about the presumed relations among natural phenomena” (p. 11). As a former professor of research methods and statistics there are specific steps to the scientific research model. Table 2 identifies each step.

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Table 2 Scientific Research Steps

Step
Initial idea
Problem definition
Procedures design
Observation
Data analysis
Interpretation
Communication

These seven steps outline the phases of a research or investigative project. ―The essence of the scientific method is the insistence that all propositions be subjected to an empirical test. Only after this has been done does the scientist decide to accept or reject a proposition" (Cozby, 1981, p. 5). These phases generally apply to both quantitative and qualitative research designs, although Cresswell (1994) notes that ―the format is much less standardized in **qualitative** designs than quantitative designs" (p. 13).

―The quantitative design permits the investigator to view reality as being objective, and something that can be objectively measured" (Regent University, Week 2, p. 1). A **quantitative** study ―. .is an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analyzed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true" (Cresswell, 1984, p. 2). How objective were the DOJ attorneys and investigators when they gathered and reviewed information about the HCJ. Although Mr. Cheng noted in his July 3, 2008 letter ―. . conducting private inmate interviews does not mean that we have pre-conceptions about what we will learn during such interviews" (p. 2), Mr. Cheng again fails to explain how he or the other DOJ attorneys and/or consultants will validate the veracity and reliability of the information obtained, or how they will permit HCJ staff to respond to the information and claims gathered in these informal, private, inmate interviews. It appears from Mr. Cheng's letter that DOJ attorneys and consultants are entering this investigation with bias, and are not remaining distant from the study, or honoring the pledge of ―conducting a fair and impartial investigation" (p. 2).

In contrast, a **qualitative** study ―is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting. Unlike the quantitative approach where the investigator remains distant from the study and eliminates his or her values, the investigator in the qualitative approach interacts with those studied, and admits his or her values and biases" (Regent University, 2002, Week 2, pp. 1-2). Investigator bias may surface during a discussion of the theoretical basis or bases for the investigation, but this, too, is not clear from the pre-on-site visit correspondence from the DOJ.

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Regardless of the type of investigation, **theories** play an important role. Graziano and Raulin (2000) define theory as ―a formalized set of concepts that organizes observations and inferences and predicts and explains phenomena" (p. 37). ―In a theory, concepts are knitted together into a coherent system to describe or explain some aspect of the world" (Polit & Beck, 2004, p. 29). It appears from the limitations of the DOJ *a priori* regarding HCJ staff and attorneys not being permitted to sit in on inmate interviews coupled with the DOJ's lack of transparency, the DOJ theory prior to conducting on-site visits and/or reviewing documents was that the HCJ had committed constitutional violations. **Variables** are also used in quantitative studies.

Independent variables are those variables that are ―actively manipulated by the researcher (e.g. training) to see what [their] impact will be on other variables (e.g., performance)" (Graziano & Raulin, 2000, p. 59). *Dependent variables* are those variables that the investigator hypothesizes ―will be affected by the independent-variable manipulation" (p. 59). A *constant* is ―any variable that is prevented from varying (i.e., held constant)" (p. 59). Polit and Beck (2004) provide the following example of a constant: ―If it rained continuously and the temperature was always 70° F, weather would not be a variable, it would be a **constant**" (p. 29).

―The investigator's concepts first appear as variables, and ultimately as hypotheses" (Regent University, 2002, Week 2 pp. 1-2). ―A **hypothesis** is a statement of the researcher's expectations about relationships between the variables under investigation: Polit & Beck, 2004, p. 49). An example of an hypothesis is: HCJ detention officers (independent variable) failed to meet State of Texas statutory training requirements (dependent variable). Most quantitative research studies would then be conducted to confirm or disprove this hypothesis using statistical analysis and procedures.

The DOJ attorneys and consultants failed to identify and/or use any a scientific methodology during their investigation, however they verbally said they reviewed archival data, conducted very limited random and unstructured interviews of HCJ inmates during their on-site inspections of the HCJ. No one mentioned how the information obtained from inmates was validated or determined to be accurate. If the DOJ would provide the consultants reports and also explain the methodology, validation, and reliability processes, HCJ staff and others who could then exhaustively respond to the DOJ report.

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ON-SITE VISIT ISSUES

Validity and Reliability: DOJ attorneys and consultants failed to identify how they checked the validity and reliability of information obtained from inmate interviews.

Professional Opinion: The failure of DOJ attorneys and consultants to determine the validity and reliability of information obtained from inmate interviews may lead to errors in conclusions and produce unsupportable claims.

Discussion: During the August on-site visit, Mr. Romero and Mr. Cheng asked a small number (not statistically reliable) of HCJ inmates about specific topics, and then appeared to note their responses. In one setting on August 5, 2008 while visiting a pod within the medium adult population (6A 2A/6A2B) one or more inmates complained to Mr. Romero and Mr. Cheng, during an informal and unstructured question and answer session, that they had problems getting haircuts, yet many of the inmates appeared to have fresh haircuts (Personal communication, August 5, 2008). Mr. Romero and Mr. Cheng prevented HCJ staff and attorneys to sit in on these interviews. This has made it impossible for HCJ staff and attorneys to dispute and/or investigate inmate allegations obtained during these interviews because they were not made available. This *a priori* mandate by the DOJ regarding inmate interviews smacks of bias on the part of the DOJ and also of pre-determined litigation.

I did not see or hear Mr. Romero and Mr. Cheng ask HCJ personnel to confirm or to deny the inmates‘ information. In short, Mr. Romero and Mr. Cheng assumed the information obtained was accurate without taking the time to confirm validity and reliability. If the information gathered from HCJ inmates were used to substantiate any conclusions and/or recommendations of the DOJ, these data and information must be released so their validity and reliability can be analyzed. HCJ inmates may have embellished and/or presented misleading information to ―federal” investigators who were standing in front of them. Arguably, such information may be examples of ―tenacity” and ―intuition”, both of which may not be valid or reliable. This is another example of how the DOJ failed to use a scientific process in its investigation.

Fallacy: The failure to validate unsupported claims is an example of an Ex Post Facto Fallacy.

Professional Opinion: The DOJ attorneys and consultants must validate information obtained from any source prior to issuing claims.

Discussion: Fallacies are, in short, errors in reasoning. More than a mistake, ―a fallacy is an ―argument‘ in which the premises for the conclusion do not provide the needed degree of support (www.nizkor.org). The failure of DOJ attorneys and/or consultants to validate the information

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and/or claims of HCJ inmates is an example of ―after the fact" or ex post facto reasoning, which is a fallacy. ―The **ex post facto fallacy** is a common and serious error. It can mislead investigators into severe misinterpretations of the data" (Graziano & Raulin, 2000, p. 136).

In my professional opinion, the DOJ attorneys and consultants' with whom I associated failed to validate or determine the reliability of the inmates' information, in short, taking the information at face value. Lacking a scientific approach to data collection and interpretation, and without the reports of the DOJ consultants, HCJ administrators, and Harris County leaders have been placed at a significant disadvantage, as the validity and reliability of the information gathered by the consultants' are unknown. HCJ administrators and Harris County leaders have further been placed into a position of having to defend a negative; that is, being forced to defend a claim that has no factual support.

POST-VISIT ISSUES

Causation: The DOJ report has confused temporality, association, and correlation with causation.

Professional Opinion: The DOJ report consistently confuses causation with other concepts that do not support causation.

Discussion: In several paragraphs of the DOJ report one can see the attempt to link one variable to another one and then strongly suggest that one *caused* the other (King, June 4, 2009, p. 11). Cause (independent variable) is what produces an effect on a condition (dependent variable) (Peters, 2009, p. 421). For example, ―Given the nature of HH's mental health condition, the Jail's delays in providing mental health treatment and evaluation **likely contributed** to HH's continuing mental decline and behavioral disturbances" [emphasis added] (see King, June 4, 2009, p. 11). Clearly *temporality* has been confused with *causation*.

―*Temporality* focuses upon time and is often improperly applied in causation analysis" (Peters, 2009, p. 421). In short, an event, ―A" (e.g., delay in providing mental health treatment)occurred before a latter event, ―B" (e.g., mental decline) is an example of temporality. Temporality is often confused with causation, but ―t[]he fact that ―A" precedes ―B" does not mean that ―A" caused ―B" (p. 422). In my professional opinion, the DOJ example of HCJ inmate HH ignored other preceding events, and non-scientifically confuses ―temporality" with ―causation".

The DOJ report also confused *association* with causation. ―Association is different than correlation, as it focuses upon how the independent variable provides information about the dependent variable" (Peters, 2009, p. 423). In short, association does not equal causation. In the ―Excessive Use of Force" section of the DOJ report it is noted, ―Officers ―grab[bed] the front of [TT's] shirt and place[d] him on the wall to gain control of the incident'" (King, June 4, 2009, p.

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16). The report then made a leap to ―these and other similar incidents suggest that staff use hazardous restraint and force techniques without appropriate guidance or sanction. In some cases, medical records confirm that detainees may have suffered notable injuries, such as lacerations to the scalp or eye" (p. 16). These examples clearly demonstrate the DOJ has confused causation with association.

For example, after a person struggles with correctional officers and is captured and controlled, (s)he is generally handcuffed prior to being searched (Peters, 1988). If the person died after being handcuffed for safety concerns, then the handcuffs were associated with the death, but, in the foregoing hypothetical event, they were not the cause of the person's death.

Correlation is the next statistical concept where the DOJ again demonstrates its fallacious attempt to substantiate and create causation. The DOJ report cited four (4) examples of what was implied is ―excessive force by HCJ staff", and then wrote: ―These and other similar incidents suggest that staff use hazardous restraint and force techniques without appropriate guidance or sanction" (King, June 4, 2009, p. 16). This fallow attempt at correlation (hazardous restraint and force technique causes excessive force) does not stretch to causation. ―Correlation is a statistical technique used to measure the strength of two or more variables and does not equal causation" (Peters, 2009, p. 423). It is therefore important to differentiate between correlation and causation, especially in use-of-force events, as temporality (―A" happened before ―B") or a strong correlation does not equate to causation (p. 423).

The DOJ also failed to identify the percentage of alleged use-of-force incidents that were found in that data analysis of the use-of-force population and/or sample provided by the HCJ.

Slanter: The DOJ has engaged in slanter throughout the report.
Professional Opinion: The DOJ report contains words that suggest the DOJ has proof of several of its alleged claims, but upon closer examination the report only uses words that suggest there is proof to support these claims.

Discussion: When a literary device attempts to convince an audience by using words that conceal a dubious claim, this is known as a *slanter* (Epstein, 2002, p. 195). Epstein (2002) argues ―slanters are bad because they try to get us to assume a dubious claim is true without reflecting on it" (p. 195). Examples include, but are not limited to, claims about excessive force by HCJ correctional officers. Often the recitation that follows is comprised of witness interviews and other non-scientific information that is used for what is known as *proof substitute*.

According to Epstein (2002), ―a *proof substitute* is a word or phrase that suggests the speaker has a proof, but no proof is actually offered" (p. 199).When *slanters* or *proof substitutes* are used, it shifts the burden of proof to the other party. The other party, say, the first person to claim that the world is round, is now faced with the monumental task of ―disproving" the opposition's claim. It

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takes more evidence to disprove a claim, than to prove it. As Epstein noted, ―It's easier to ask for a disproof of your claims than to prove them yourself" (p. 219).

Throughout the DOJ report there are examples of ―slanters" and ―proof substitutes". For example, ―Our review of the Jail's records suggests that such improper force technique is being used with troubling frequency", yet the DOJ has failed to provide the quantitative frequency counts, trend analysis, etc. to support and prove her claim (King, June 4, 2009, p. 15). ―In some cases, medical records confirm that detainees **may** have suffered notable injuries, such as lacerations to the scalp or eye" (p. 16), is another example of proof substitutes [emphasis added]. For undetermined reasons, the DOJ report failed to include the entire story of the incident, and again has taken a finding (e.g., laceration) out of context.

When correctional officers are required to use reasonable force, there is always the possibility of someone being injured, including the correctional officer. However, injury alone does not provide support for a claim of excessive force. Mesloh, Henych, and Wolf (2008) found in their study on force used by law enforcement officers that ―the injuries of both officers and suspects rose correspondingly with the length of the confrontations" (p. 89). They also found that an officer's use of ―decisive force early on in the active suspect-officer confrontations appears to be the solution in ending conflict quickly. . ." (p. 89), otherwise there may exist a force deficit where the officer uses ―. . .less force than may be justifiable or necessary to subdue the suspect and end the confrontation" (p. 89).

As the DOJ attorneys and/or consultants should know, to prove excessive force in a correctional setting, the correctional officer's state of mind must be known (i.e., malicious or sadistic) if the analysis is performed under the Fourteenth Amendment, and if the inmate upon which the force was used was a pre-trial detainee (Hill, 2009, p. 50-1). This *state of mind* ―must be a knowing one—with appreciation of the consequences—evaluation of the alternatives (p. 50-1). Similarly, if the inmate upon which the force was used was a convicted person, then the Eighth Amendment is used to determine if the correctional officer's use of force was ―the infliction of cruel and unusual punishment" (p. 50-1).

In my professional opinion, the DOJ has again confused causation with temporality, association, correlation, and proof substitutes throughout the report. Further, the DOJ has failed to provide the requisite data necessary to substantiate its claims of excessive force, which have placed Harris County and the HCJ in a defensive position to disprove the DOJ's non-supported claims. The DOJ must provide the necessary information to help remedy these issues, and to remove the opaque barriers that it has created.

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More Fallacies: The DOJ report engaged in the Ex Post Facto Fallacy, Fallacy of Division, Fallacy of Selected Instances, and Fallacy of Dicto Simpliciter when it arrived at defective conclusions.

Professional Opinion: The DOJ report contains several examples and types of fallacies, which are errors in logic to support its claims.

Discussion: As previously mentioned, the DOJ report noted ―Officers _grab[bed] the front of [TT's] shirt and place[d] him on the wall to gain control of the incident'" (King, June 4, 2009, p. 16), and then using defective logic made a leap to ―these and other similar incidents suggest that staff use hazardous restraint and force techniques without appropriate guidance or sanction. This is an example of an **ex post facto fallacy**.

Each use of force incident can be labeled as a separate case, similar to when a patient visits a psychologist. A psychologist listens to the patient discuss subjective experiences. After one or more visits the psychologist may attempt to link or associate certain past experiences with the patient's current issue(s). While this approach may be helpful in *suggesting* hypothetical relationships, it fails to rule out other potential causes. ―For this reason, we cannot have confidence in any causal inference we might be tempted to draw" (Graziano & Raulin, 2000, p. 136).

In my professional opinion, the DOJ engaged in an **ex post facto fallacy** (after the fact) when it used defective logic to link four separate incidents (e.g., the grabbing of TT's shirt) to excessive force by HCJ officers who were involved in these incidents.

The DOJ attorneys also engaged in the **Fallacy of Selected Instances**, which ―results from enumerating instances without obtaining a representative number to establish an inductive generalization" (Aldisert, 1997, p. 195). ―Our review of the Jail's records **suggests** that such improper force technique is being used with **troubling frequency** [emphasis added] (King, June 4, 2009, p. 15). The word ―suggests" demonstrates that the DOJ is unsure if HCJ employees are using improper force techniques. DOJ attorneys also failed to define the term ―troubling frequency", and apparently relied upon the four incidents identified in her report, which demonstrated the **Fallacy of Selected Instances**.

Four incidents, or cases, are inadequate to reasonably generalize that HCJ employees were using improper force with troubling frequency. The reliability of the DOJ attorneys and/or consultants measurement is impossible to determine without the consultants' reports.

When the DOJ applied a general rule (e.g., excessive force) to the grabbing of ―TT"s shirt (a specific incident), and thus engaged in the **Fallacy of Dicto Simpliciter.** ―The application of the general rule is inappropriate because of the situation's . . . exceptional facts" (Aldisert, 1997, p. 193). The DOJ's summary of the TT incident failed to mention several key variables that, in my

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professional opinion, do not make this incident into an excessive force example, and therefore is very misleading to the reader.

The DOJ failed to mention that TT had quickly and aggressively pulled a towel away from a HCJ officer and then took an aggressive stance, causing the officer to perceive a threat to his personal safety. The officer admitted to grabbing TT by the shirt and placing him against the wall for control, while he removed the towel from TT‘s grasp. The DOJ also failed to mention that TT did not sustain any injury, and that he verbally apologized for his aggressive behavior. This incident was investigated by HCJ personnel. The force used on TT by the HCJ officer was found to be reasonable and in compliance with HCJ regulations and guidelines.

In yet another example, the DOJ fallaciously attempted to show excessive force by HCJ officers when they attempted to break up a fight between two inmates. Writing that ―An officer used both a headlock and multiple strikes to SS‘s rib cage” (King, June 4, 2009, p. 16) was used by the DOJ to *suggest* HCJ officers use hazardous restraint and force techniques. However, a review of the *Use of Force Report* indicated that SS first swung at a HCJ officer with a closed first, missed, and then became more combative as he approached the officer. Reacting to the imminent threat of harm the officer punched SS and when SS tried to again punch the officer with a closed fist, the officer placed SS into a headlock to subdue him. SS was sent for medical attention, but showed no signs of injuries. The incident was investigated by HCJ personnel. The force used on SS by the HCJ officer was found to be reasonable and in compliance with HCJ regulations and guidelines.

The validity and reliability of the DOJ‘s attempt to *suggest* that HCJ officers were using hazardous restraint and force techniques is again highlighted in the selected incident of ―UU”. ―Officers used force on UU that resulted in a laceration requiring eleven staples to the scalp. Yet, the use of force incident was not reported by either of the officers who applied the force. Instead, another officer initiated the ―inmate offense report’” (King, June 4, 2009, p. 16). It is unclear whether DOJ attorneys and/or consultants reasoned that the failure of one officer to write a report is excessive force, or the injury to UU‘s head was excessive force. Not only is this example ambiguous, but also it is another ineffective example of attempting to link this incident to HCJ officers‘ use of a hazardous restraint and/or force technique fails.

A review of UU‘s incident report revealed that UU attempted to headbutt a HCJ officer, and was redirected away from the officer. After being redirected, UU collided with the pod door, and then was taken for medical treatment. Further review of UU‘s comments when being treated by HCJ medical staff revealed that UU suffered a laceration of the scalp, and that UU told medical personnel that he hit his head on the wall/door. This incident was investigated with the force level justified under both HCJ policy and law.

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Finally, the DOJ provided another example where ―An officer reported that he ‗grabbed inmate RR by the front of his jumpsuit top and the back of his neck and forcibly placed inmate RR on the ground. Once on the ground, I continued to apply pressure to inmate RR‘s neck and placed my right knee in the small of his back‘" (King, June 4, 2009, pp. 15-16). Again, it is unclear where the restraint and/or force technique was unreasonable.

A review of RR‘s incident report showed that RR faced the HCJ officer after being told to face the wall, clenched his fist, raised his voice, and aggressively asked the officer about the subject they were discussing. Refusing to place both hands behind his back when told to do so by the officer, RR was grabbed by the front of his jumpsuit top and back of his neck and forcefully placed upon the ground. The report infers that the officer used a hand to hold RR‘s neck stable while the officer placed a knee on the small of RR‘s back. RR was then handcuffed, taken to the medical clinic, where RR refused treatment. RR wrote a short summary of what happened where he admitted that he refused to place his hands behind his back. This incident was investigated and found the force level was justified under HCJ rules and regulations.

In my professional opinion, the DOJ report is very misleading and contains fallacious attempts to demonstrate through four select incidents that HCJ officers used hazardous restraint and/or force techniques failed on several points. First, the officers used defensive force techniques that were and are currently taught across the United States. Second, when the inmate was handcuffed, compliance was obtained and the force used by HCJ officers de-escalated. Third, the standard for judging excessive force does not consist of a sole criterion such as ―force was used" or ―the inmate was suffered an injury". Inmates were also offered medical evaluations, and each incident was investigated.

Constitutional Force Standards: The DOJ failed to demonstrate that any HCJ officers inflicted cruel and unusual punishment on any HCJ inmates.

Professional Opinion: The DOJ attorneys fail to identify the constitutional standards and criteria that were allegedly violated by HCJ officers that lead to constitutional violations of force.

Discussion: The Eighth Amendment of the United States Constitution, which applies to all 50 states through the Due Process Clause of the Fourteenth Amendment prohibits the infliction of ―cruel and unusual punishment" on those convicted of crimes (Hill, 2009, p. 49-3). Prisoners are different from the general public: ―prisoner‘s freedom has been taken away; facility has been given the responsibility for keeping the prisoner; place of incarceration is under exclusive control of the government" (Plitt, 2009, p. 33-2).

As a defensive tactics instructor who has trained thousands of law enforcement officers across the United States, Canada, and England during the last 30 years, a reasonable officer knows that

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any amount of force used can possibly cause an injury. Struggling and/or fighting with an inmate (or any person for that matter) is not pleasant, and there is no nice way to strike someone, yet sometimes officers must apply defensive force to protect themselves and/or others from harm. The DOJ's report suggested that any force used, which may have been associated with an injury to that person is excessive force. That is not the legal standard.

A statistical analysis of assaults on inmates, assaults on HCJ staff, fighting, and use-of-force incidents fails to support the DOJ's implication that HCJ officers use hazardous force techniques, and engage in excessive force. Table 3, below, shows that 2008 and 2009 (January through May) number of events in each of the aforementioned categories, with their respected percentages.

Table 3 HCJ 2008 and 2009 Frequency of Select Force Categories

CATEGORY	2008 Totals	Percentage of Inmates Received	2009 Totals (Jan. – May)	Percentage of Inmates Received
Inmates Received	133980	100%	57956	100%
Inmates Booked	131204	100%	58019	100%
Average Daily Inmate Population	11,139		56384	
Use of Force Incidents	393[1]	0.2933%	108	0.1864%
Assault on Inmate (inmate assault on inmate)	1317	0.983%	548	0.946%
Assault on Staff (inmate assaulting HCJ staff)	236	0.176%	98	0.169%
Fighting (≥2 or more inmates fighting between or amongst themselves)	4207	3.14%	1555	2.683%

Sources: HCJ Detention Bureau Monthly Statistical Reports 2008 & 2009; Personal communication, Ronny Taylor, July 14, 2009.

The extremely low percentages associated with "Use of Force Incidents," "Assault on Inmate (inmate assault on another inmate)," "Assault on Staff (inmate assaulting HCJ staff),", and "Fighting" (2 or more inmates fighting between or amongst themselves)", in my professional

[1] This figure includes 51 additional use-of-force incidents from courts, transportation/hospital, ERT, and inmate processing, which were not included in the Detention Bureau frequency count.

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opinion, show great restraint by HCJ officers, and do not support the implication that HCJ officers use hazardous force techniques and/or engage in excessive force.

Although the percentages of use-of-force incidents compared to inmates received is extremely low, ―Fighting" between or amongst inmates spikes in comparison to the other force incident categories. While ―Use of Force Incidents" were less than 1% (when compared to inmates received), ―Fighting" was greater than 2%, or 14 times higher than ―Use of Force Incidents". These frequency and percentage data of ―Fighting" , in my professional opinion, fail to support the claims made by the DOJ regarding HCJ officers using hazardous techniques and excessive use of force.

Discipline and Control: The use of force deployed by HCJ staff in the incidents identified in the DOJ report was consistent with maintaining discipline and control of inmates housed within the HCJ.

Professional Opinion: HCJ staff used force consistent with constitutional standards to maintain and/or restore security and/or discipline within the HCJ.

Discussion: Within the United States and many other civilized countries jails, it is well accepted that a legitimate governmental interest is the need to maintain both discipline and security of inmates who are incarcerated. These form the bases for inmate discipline handbooks, discipline procedures, and training correctional officers in the reasonable use of force. The failure of a governmental entity and/or its correctional staff to maintain discipline and keep secure those under its care, custody, and control has led to health and safety hazards, incidences of violence between and among inmates, and at the extreme of the continuum murder of inmates and/or staff by other inmates and/or rioting. The Santa Fe (NM) Penitentiary rioting of the last century is one example of where a loss of control lead to many inmates‘ deaths and injuries.

Hill (2009) noted that there can be many reasons correctional staff may use defensive force. These reasons include, but are not limited to: self-defense, enforce rules, restore order, prevent criminal acts, protect others, and prevent escape (p. 50-4).

It is also widely known and accepted that the category of prisoner can impact both discipline and security. For example, pre-trial detainees often create more demand for services, present greater security risks, and are often more tense and uncertain (Plitt, 2009, p. 21-4).

The HCJ staff is keenly aware of the two types of inmates it houses: pre-trial and convicted. Regardless of the inmate category, the HCJ staff must maintain discipline and security. Examples of how HCJ staff help to maintain reasonable discipline and security is through the training of jail staff, and through the use of written policies and procedures.

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HCJ officers are taught there are generally two categories of force: deadly and non-deadly. Deadly force is that degree of force that an actor uses with the purpose of causing, or which he knows to create a substantial risk of causing death or *serious bodily harm*. According to Black‘s Law Dictionary and police training materials on the use of force, serious bodily harm is bodily injury that (1) creates a substantial risk of death; (2) causes serious, or (3) permanent disfigurement; or (4) results in long-term loss or impairment of the functioning of any bodily member of organ (Commission on Accreditation of Law Enforcement Agencies Standards, Chapter 1, Glossary, pp. 1-4, March 1991, revision; Black‘s Law Dictionary, 5th ed., p. 631).

In each of the four use-of-force examples highlighted in the DOJ report, in my professional opinion, the HCJ staffs‘ use of force was not only reasonable, but also designed to maintain and/or restore discipline and security.

Restraint and Force: The DOJ has failed to identify that HCJ officers used hazardous restraint and force techniques on inmates without appropriate guidance or sanction.

Professional Opinion: The DOJ report failed to identify those incidents and/or defensive techniques that formed the basis(es) of its claim that HCJ officers used hazardous restraint and force techniques.

Discussion: The incipience of the DOJ‘s attempt to link four (4) examples to evidence alleged excessive force within the HCJ fails to support the hypothesis that HCJ officers used hazardous restraint and force techniques on inmates without appropriate guidance or sanction. ―Our review of the Jail‘s records suggest that such improper force technique is being used with troubling frequency” (King, June 4, 2009, p. 15). The DOJ failed to cite the frequency, and also limited the ―troubling frequency” to one force technique, which the report failed to identify. ―We found a significant number of incidents where staff used inappropriate force techniques . . .” (p. 15) is another example of failing to identify the frequency and also to define what the ―inappropriate force technique” was, while simultaneously defining the term. The DOJ investigators and consultants asked for and received thousands of pages of documents, and hundreds of use-of-force reports that covered several years.

The four so-called examples of excessive use of force highlighted by the DOJ failed to support its claim about hazardous restraint and force techniques on inmates without appropriate guidance or sanction, and also failed to establish a pattern of excessive force. Inmate injuries could have come from other inmates. ―Fighting” between and/or among inmates revealed the highest percentage of force incidents reviewed and calculated. Hence, inmate injuries may have occurred from other inmates, and not from HCJ officers.

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Professional Opinion: There is no constitutional or other legal requirement that correctional officers write their own use-of-force reports.

Discussion: ―Jail policy does not clearly require the individual using force to file a use of force [sic] report;". In my professional opinion, there is not a constitutional or other legal requirement that a correctional officer write his and/or her own use-of-force report. Report writing requirements often define who may write the report, when the report should be written, etc. Many agencies authorize use-of-force investigators to write the report concerning a specific use-of-force incident, while others may require individual officers to write the reports. When an officer is injured and hospitalized following a use-of-force incident with an inmate, the officer may not be in a position to write a report for several days or weeks, so having a rigid report writing requirement that officers must write their own reports would only serve as a lightning rod for controversy when injuries or illness precluded the officer from writing such a report.

Finally, although the DOJ raised this issue in the body of its report, the DOJ did not list this issue under ―Recommended Remedial Measures".

VNR: Vascular neck restraints are safe when applied properly, and should not be prohibited, per se, by HCJ policy.

Discussion: Vascular neck restraints (VNR) are safe when applied by trained officers to inmates to stop resistance. Dr. Christine Hall, M.D. (Dr. Hall) and her Canadian colleagues conducted one of the largest medical studies on the safety of vascular neck restraints. Noting ―there is a distinct and definable difference in application technique, physiology of effect and anticipated outcome between a vascular neck restraint and other types of holds involving the neck" (Hall & Butler, 2007, p. 6).

―A vascular neck restraint is a technique that applies lateral compression to the vascular structure of the subject's neck resulting in partial or complete occlusion of the carotid arteries as well as occlusion of the jugular veins. A properly applied VNR will not compress or harm the structures located in the anterior portion of the throat nor is it likely to cause harm to the cervical vertebrae; the subject's ability to breathe is not adversely affected during VNR compression" (Hill & Butler, 2007, p. 24). The vascular neck restraint is different than a respiratory chokehold, where a forearm is generally placed across an opponent's throat.

―The VNR results in compression of the carotid arteries, compression of jugular veins and compression of the carotid bulb, which stimulates the vagus nerve. The totality of these

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effects results in a decrease in blood supply to the brain, which in turn leads directly to altered levels of consciousness. Some subjects become compliant with less than maximal application of the VNR. When VNR is maximally applied, the atypically results in unconsciousness in 7-15 seconds, and consistently within 10 seconds. It must be understood that different subjects are affected by the technique in different ways and some subjects may not be rendered unconscious at all (no technique is 100% effective)" (Hall & Butler, 2007, p. 27; see also Koiwai, 1987; Lindell, 2006).

According to Hall (2007) the VNR ―hold is not a choke hold during which the intended mechanism of action is disruption of air flow/ventilation due to obstruction of the trachea or other upper respiratory structures or anterior neck structures. The vascular neck restraint is not an arm bar hold or a mechanical neck hold during which a similar obstruction of the trachea is anticipated to occur. Application of a vascular neck restraint does not include the application of a mechanical restraint such as bars, rods, bar-like devices, batons or flashlights" (p. 28).

Dr. Hall's report finds that, ―while no restraint methodology is completely risk free, there is no medical reason to routinely expect grievous bodily harm or death following the correct application of the vascular neck restraint in the general population by professional police officers with standardized training and technique" (Hall & Butler, 2007, p. 6).

In my professional opinion, VNR techniques should not be completely eliminated from the tool kit of HCJ correctional officers. The HCJ may eventually restrict the application of VNR techniques on susceptible populations (see Hall & Butler, 2007), the VNR may be the only technique that will work on some individuals who are in a state of combative delirium or under the influence of drugs and/or alcohol. Current HCJ policy prohibits the use of VNR, but does authorize its usage in deadly force situations. The DOJ has presented no medical evidence to show VNR techniques are unconstitutional and/or excessive force.

Professional Opinion: Hogtying has not been an authorized restraint method per HCJ policy.

Discussion: ―The jail should prohibit the use of . . .hogtying" (King, Jun3 4, 2009, p. 22). The DOJ has failed to document if hogtying was used in any of the alleged excessive force incident and/or is currently being used at the HCJ. Hogtying was prohibited by written HCJ policy, which should have been known to DOJ attorneys and/or consultants.

DOJ Recommendation: Cell extractions should be videotaped for evidentiary purposes when reasonable and safe.

Professional Opinion: This is a reasonable suggestion, when circumstances permit it.

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Discussion: ―Jail policies do not provide for routine videotaping of use of force" (King, June 4, 2009, p. 15). It is virtually impossible to videotape every use of force that occurs within the HCJ, or any jail for that matter. What is reasonable, in my professional opinion, is the development of a policy that requires cell extractions to be videotaped, when it was safe and reasonable to do such taping. In some instances, it may take too long for a videographer to arrive on a level or in a pod, but other than such exigent circumstances, it is a reasonable policy to have cell extractions and group inmate violence captured on tape. Videotape, unless it is altered, serves as an excellent record of what happened at the scene, and possibly more important, what did not happen during an extraction team's application of force.

Therefore, in my professional opinion, a policy that requires the video taping of cell extractions and other large scale use-of-force incidents is reasonable, provided that exigent circumstances do not prohibit the policy from being followed. The policy should also designate where the video tape should be stored, and how it should follow an ―evidence chain" to preserve its integrity and retraction for review.

Professional Opinion: Appropriate force is not the constitutional standard as noted by the DOJ.

Discussion: HCJ correctional officers may need to use force for many reasons, including but not limited to: self-defense; enforce rules; restore order; prevent criminal acts; protect others; and/or prevent escape (Hill, 2009, p. 50-4). Elements that officers may consider when using force include, but are not limited to: the need for using force; the degree of force that was used; the extent of injury that was inflicted, if any; whether the force was used in a malicious or sadistic manner; whether the force was conscience shocking; the totality of the circumstances; whether there were attempts to lessen the force used; whether there were any warnings, if practical; whether the situation that initially required force was resolved; whether there were several attempts to restrain the person; and whether there were other staff available for intervention (pp. 50-4, 50-5).

Although DOJ attorneys are critical of the force used by some HCJ correctional officers in the performance of their duties, they again fail to identify the point-by-point analysis used by investigators and/or consultants to develop alleged excessive force conclusions. Further, the blanket opinion that HCJ correctional officers should use ―appropriate force" is outside the constitutional force analysis, is vague and is misleading.

Professional Opinion: HCJ does meet and/or exceed generally accepted correctional standards.

Discussion: HCJ meets the correctional standards established by the State of Texas, and also standards established by the American Jail Association, the National Institute of Corrections, and

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the American Correctional Association. Therefore it is confusing when the DOJ wrote that the recommended remedial measures should be implemented by HCJ, ―at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice" (King, June 4, 2009, p. 20). The DOJ has failed to identify the standards to which it refers, and should know that the organizational ―standards" are really ―guidelines" and ―recommendations". The only ―standards" are set by the United States Supreme Court and/or Federal Appellate Courts or local courts.

When asked what standards the DOJ were using, Mr. Cheng said that the DOJ used it own set of ―standards" and that state standards were not considered (Personal communication, August 2008). If the DOJ sets its own standards and then fails to publish those standards, how can an agency such as HCJ meet unpublished standards?

In my professional opinion, the HCJ met and/or exceeded the State of Texas correctional standards, and also met and/or exceeded many other applicable ―standards" by other respected correctional associations. However, the DOJ's referenced ―generally accepted professional standards of correctional practice" is not only vague, but also appears to refer to only the DOJ's unpublished standards.

Professional Opinion: DOJ investigators and consultants knew or should have known that the HCJ had created the Office of the Inspector General and had begun to review use-of-force reports and/or incidents.

Discussion: The creation of the Office of Inspector General (OIG) was known to the DOJ investigators and consultants as they visited the OIG and spoke with its administrator and other OIG members. ―The Jail was already making some effort to improve use of force reviews" (King, June 4, 2009, p. 16) grossly understates the OIG creation and implementation. In my professional opinion, the creation and implementation of the OIG was a huge undertaking and one that should be highlighted as exceptional, rather than minimizing the OIG by referring to it as ―making some effort". The OIG has many goals and objectives, which include the review of all use-of-force incidents, and since it was in place and operational during the second on-site visit, this recommendation was unnecessary.

Professional Opinion: There exists a disconnect between the comments made by DOJ attorneys and consultants during their ―Brief Out" on August 8, 2008 and the June 4, 2009 DOJ report.

Discussion: DOJ consultant Mr. Romero told HCJ staff and DOJ consultants and attorneys during a Brief Out on August 8, 2008 that ―Of all the facilities that I've seen, I think generally from my prospective, [HCJ] had a very high level of efficiencies. . . . The areas that I've

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examined in the operations were related more to security, to protection from harm issues, and more specific areas . . . In each of these particular areas I won't go into a lot of detail, because I felt that they were operating very well. . . .The short term basis I think you're doing excellent with it now. . . . the use of force policies generally is a good policy." While Mr. Romero did discuss a few areas for improvement, overall his commentary was very positive of the HCJ staff and its operations. These comments formulate the basis for the noticeable disconnect when compared and contrasted to the DOJ report.

The disconnect appeared most prominent when the DOJ report discussed alleged and/or potential constitutional violations. For example, "The Jail should eliminate fixtures that can be used to facilitate suicide (e.g., exposed bars or bath fixtures) . . ." opined the DOJ under the remedial measures section of the DOJ report (King, June 4, 2009, p. 22). While the DOJ implied that having bars on a jail door is, per se, unconstitutional, in my professional opinion, this is not a constitutional issue.

The four use-of-force examples highlighted in the DOJ report fail to rise to the level of constitutional violations upon closer examination. They are more in line with Mr. Romero's positive view of the HCJ staff and its operations.

In another remedial measure recommendation the DOJ wrote, "The Jail should increase video surveillance in critical housing areas . . ." (King, June 4, 2009, p. 22). While the recommendation may be a good one, I am unaware of any constitutional requirement that video cameras be installed in the Jail.

Professional Opinion: HCJ administrators investigated use-of-force incidents, and when appropriate, disciplined those officers who were involved.

Discussion: Reiter (2006) writes "agency initiated complaints come in different forms. Most commonly found complaints are those initiated by a supervisor for some breach of rules and regulations. Other times it might be knowledge that comes to the agency without an actual complaint from the aggrieved party. . ." (p. 1.9). Reiter also notes that the "complaint process must be as foolproof as possible" (Chapter 2, p. 2.1). The widely-adopted text (now in its third edition) by Reiter who is former Assistant Chief of Police for the Los Angeles (CA) Police Department, outlines and discuses in very detailed form how the investigation should be conducted, who should be assigned to conduct it, what information should be identified and sought, and how the investigation can be used for disciplinary purposes.

There have been several documents reviewed that demonstrate that Harris County and former Sheriff Thomas reasonably investigated use-of-force incidents. The Clarence Freeman incident serves as an appropriate example. This incident was thoroughly investigated by HCJ administrators and resulted in a conviction [on plea] of a detention officer. It has been my experience with the HCJ administration that it

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investigates complaints about excessive force, and will apply corrective discipline up to and including termination and prosecution when justified.

Regarding complaint processing, the CALEA standard manual notes ―a written directive requires the agency to investigate all complaints against the agency or employees of the agency" (CALEA, Standard 52.2.1, p. 52-2). The CALEA standards manual notes ―the integrity of the agency depends on the personal integrity of the agency and discipline of each employee" (p. 52-1). In my professional opinion, the initiation of an internal investigation into the Freeman matter created an organizational culture that sent a strong message to employees that unreasonable behavior will not be tolerated.

DOJ Accuracy: The consultants reports are needed to assess the validity and accuracy of the DOJ attorney's interpretation of the consultants' findings and opinions.

Professional Opinion: To reasonably assess the validity and reliability of the DOJ attorney's interpretation of its consultants' reports, the reports must be provided to the HCJ.

Discussion: Acting Assistant United States Attorney General, Loretta King, wrote:

> ―Assuming there is continued cooperation from the County and the Jail, we would be willing to send our consultants' reports under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration of the issues discussed in this letter and offer practical *technical* assistance in addressing them" (King, June 4, 2009, p. 24).

The consultants' reports were generated with United States taxpayers' monies, therefore, the reports should be public records and also be available to the HCJ and to Harris County leaders. Failure to provide the consultants' ―observations, analysis, and recommendations. . ." (King, June 4, 2009, p. 24), handicaps the HCJ, Harris County leaders, and Harris County consultants from gaining insight into the consultants' analyses. Without the consultants' reports, an accurate assessment of consultants' observations, analyses, and standards used for the foundation of their opinions is prohibited. In my professional opinion, the DOJ viewpoint is unreasonable. If one or more consultants made errors in their analyses, observations, etc., like mathematical errors, these errors will carry through and be an integral part of the calculus of the DOJ lawyers' conclusions and recommendations. It is impossible to know at this point in time if the DOJ lawyers' statements are accurately represent what the consultants found during their evaluation of HCJ documents and on-site visits.

Although the DOJ report maintains, ―consistent with our commitment to provide technical assistance and **conduct a transparent investigation** . . ." [emphasis added] it contradicts

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existing DOJ practice of not providing the consultants reports with the DOJ report. Rather than being transparent, the DOJ created opacity by withholding these allegedly insightful reports.

SUMMARY

While the DOJ report contained operational recommendations, the overall report did not mirror the current operations of the HCJ. The report failed to support many of its claims, and without documentation, it is impossible to know or to understand the bases for the claims and/or remedial measures. To honor the DOJ‘s alleged commitment to transparency, the consultants‘ reports must be provided to HCJ officials so they can review the consultants‘ findings and opinions. Currently, the consultants‘ reports can only be obtained through DOJ coercion, specifically, ―Assuming there is continued cooperation from the County and the Jail, we would be willing to send our consultants‘ reports under separate cover . . . 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 . . . ” (King, June 4, 2009, p. 24). If this type of ―bullying” were done in a school, on a playground, etc., it might give rise to a statutory violation.

I am reminded of the words of Ms. Shanetta Cutlar, Chief of the Civil Rights Division‘s Special Litigation Section when she answered an attendee‘s question at an AELE workshop: ―No, our office could never comply with what I told you we want you to do in your jails.”

Respectfully submitted,

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Master of Business Administration (Marketing/Management), *With Distinction*, Graduate School of Management, Babson College, Wellesley, MA, 1978. (Accredited by New England Association of Colleges, and AACSB)

Master of Science (Public Relations), School of Public Communication, Boston University, Boston, MA, 1976. (Accredited by New England Assoc. of Colleges)

Bachelor of Science (Criminal Justice), *Summa Cum Laude*, University of Baltimore, Baltimore, MD, 1975. (Accredited by Middle States Assoc. of Colleges)

Associate in Applied Science (Police Science), *Cum Laude*; **Certificate in Corrections**, *Cum Laude*, Northern Virginia Community College, Annandale, VA, 1972. (Accredited by Southern States Assoc. of Colleges)

PROFESSIONAL EXPERIENCE:

2005 – Present. **Institute for the Prevention of In-Custody Deaths, Inc.** Henderson, NV. President, Chief Learning Officer. Administrative, teaching, plus curricula design, operational guidance, and implementation of in-custody death identification, prevention, and investigative programs (including jail suicide) for criminal justice, emergency responders, correctional, and medical agencies across the globe. Developer of informational video, text, instructor and basic training materials, etc. for training classes, in addition to identifying and synthesizing the literature on sudden and in-custody deaths (e.g., metabolic acidosis, agitated delirium, –excited

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delirium", asphyxia issues, etc.). Assisted a Texas Sheriff's Department in the monitoring of a United States Department of Justice Civil Rights Division investigation of its large correctional facility. Developed and sponsored the first and subsequent international sudden death, excited delirium conferences in November 2006, November 2007, and October 2008. Developed and sponsored first Forensic Analyst Program on Delirium and Sudden, In-Custody Death (2009).

1982 - Present: **Defensive Tactics Institute, Inc.** Henderson, NV. Founder, Vice Chairman, Chief Operating Officer, and senior instructor. President, 1982 - 1995. Administrative, marketing, public relations, financial, curricula design, teaching, plus the design, implementation and evaluation of less-than-lethal and non-lethal instructor and basic training programs for criminal justice agencies across the globe. Develop policies, procedures, rules and regulations for agencies on use-of-force training and equipment. Programs include, but are not limited to: prisoner restraint and transport; in-custody death; cultural diversity; sexual harassment; tactical handcuffing; TACTICAL OC®, defensive tactics, expandable & straight baton, firearm disarming and retention, tactical flashlight™, instructor development, Kubotan®, Kubotai®, edged weapons, and others.

1982 - Present: **John G. Peters, Jr. & Associates**, Las Vegas, NV. International Consultant and project manager. Consulting areas include police, correctional, security, and municipal practices; criminal justice products; civilian use-of-force; management studies; organizational diagnosis of criminal justice agencies; and, sexual harassment surveys and studies. Sexual harassment database is the largest identified that focuses upon criminal justice agencies. Statistical data analysis of TASER® voluntary self-exposures and field uses. Consulted in over 250 criminal and civil cases as a consulting and/or an expert witness.

1982: **United States Secret Service Defensive Tactics Advisory Panel**, Washington, D.C. Member. One of four defensive tactics instructors in the United States appointed to this pioneering panel. The Panel's purpose was to design and update existing self-defense tactics for the U.S. Secret Service (including the Presidential Protection Detail, and the Uniformed Division).

1982 - 1995: **Reliapon Police Products, Inc.**, Albuquerque, NM. Founder. President. Former Chairman of the Board, and Vice President of Marketing and Communications (1983 - 1994). Responsibilities included the overseeing of administrative, marketing, public relations, financial, and senior management matters of this specialized mail order, wholesale, video production, and publishing firm. Recruited and managed nationwide sales representatives. Products sold in the United States and abroad. Sold the company in 1994. Supervised six people.

1992 - 1994: **Institute for Liability Management**, Gallagher-Bassett Services, Inc., Itasca, IL. Senior Associate. Responsible for the conducting of police department Liability Assessment

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Profile Surveys (LAPS), the review of LAPS, plus the consultation/ implementation of LAPS; the development and review of high-risk policies; the teaching of courses including: Use-of-Force Instructor, Supervisory Responsibility and Liability Management, Pursuit Liability and Management, etc.; and, criminal justice practices consultation.

1989 - 1991: **Impact Productions, Inc. and Impact Duplications**. Albuquerque, NM. Co-founder. Writer-Producer for video productions and scripts. Wrote and produced two criminal justice informational videos: ASP Tactical Baton and Defensive Tactics With Electronic Restraints.

1982 - 1985: **Tri-Sector Professional Development Institute, Inc.** Albuquerque, NM. Founder. Administrative, marketing, public relations, and other duties, including curricula design and teaching, consulting, plus the design, implementation, and evaluation of management and related training programs for governmental, corporate, and non-profit agencies. Programs included: public budgeting, criminal investigation management, management by objectives, first-line supervision, discipline, civil liability, and the writing of policies, procedures, and rules and regulations.

1979 - 1982: **PR-24 International Institute, Inc.**, Braintree, MA. President and founder. Administrative duties, training, plus the design, implementation, and evaluation of the PR-24 baton, Kubotan®, and other defensive tactics programs for criminal justice agencies. Instructed the *Los Angles Police Department, the California Highway Patrol, the North Carolina Highway Patrol, the Las Vegas Metro Police, plus others*. Edited and published an international newsletter for instructors. Hosted the first PR-24 International instructor seminar.

1978 - 1979: **Public Systems Evaluation, Inc.**, Cambridge, MA. Senior Research Associate. Responsibilities included the conducting of literature reviews, attitudinal surveys, and topic area leadership in a project designed to assess and extend research findings in the area of police field services. Became one of the nation‘s leading authorities in the *management of criminal investigations*. Visited major California police departments in 1979 to obtain research and management reports on criminal investigation management.

1977 - 1978: **Braintree Police Department**, Braintree, MA. Staff Executive. In this *new* position, reported to, and assisted the Police Chief. Director of both the Administrative Bureau (7 divisions), the Planning and Research Unit, and liaison to the Auxiliary Police. Functionally reorganized the police department within the first three months. Responsible for the department budget (excess of $1 million). Tasks included writing, editing, and implementing policies, procedures, rules and regulations, Special Orders, General Orders, special investigations, interviewing applicants, discipline, etc.

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6/77 - 12/77: **Waltham Police Academy**, Waltham, MA. Consultant. In this new position, assisted the Academy Director with planning, organizing, coordinating, scheduling, and teaching.

1973 - 1977: **York County Sheriff's Department**, York, PA. Deputy Sheriff. Assignments included all areas of the criminal justice system: courts, corrections, and police. Assigned to the District Attorney's Fugitive Squad in 1974. Extensive experience in investigations and security techniques and applications.

1972 - 1973: **Northern York County Regional Police Department**, Dover, PA. Police officer (self-defense specialist). Pennsylvania's *first* regional police department. Conviction rate: criminal arrests--100%; traffic arrests--95%. Designed and instructed self-defense programs, including the PR-24 baton.

3/72 - 7/71; 6/69 - 6/70: **Federal Bureau of Investigation**, Washington, D.C. Clerk. Assigned to the Files and Communications Division. Received extensive training in public speaking. Instructed FBIRA Judo Club. Received a *Letter of Commendation* from then FBI Director, J. Edgar Hoover.

ACADEMIC EXPERIENCE:

2005-2006: **Neumann College**, Aston, PA. Adjunct faculty. Responsible for teaching in the Master of Leadership degree program. Designed and taught online facilitator course for undergraduate and graduate faculty.

8/00- 12/04: **Millersville University**, Millersville, PA. Adjunct faculty. Taught public speaking. Nominated for *Faculty of the Year, 2001* by Student Senate.

5/03 – 8/04: **Walden University**, Minneapolis, MN. Adjunct Faculty, School of Management/Public Administration. Supervised doctoral students in public administration areas, including but not limited to criminal justice, public safety, etc.

6/02 – 8/03: **Regent University**, Alexandria, VA. Assistant Professor. Responsible for the teaching of management, leadership, research, statistics, human resource management, independent study, and other business management courses; also, On-line course development. Serve on Admissions Committee and Curriculum Committee, in addition to advising students. Integral part of the SACS review for program accreditation.

3/00 – 9/01: **Walden Institute**, Bonita Springs, FL. Faculty. Responsible for teaching the Institute's on-line *Certified Online Instructor Course*.

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9/00 – 6/02: **Regent University**, Alexandria, VA. Adjunct faculty, Degree Completion Program. Responsible for teaching orientation, management, and statistics courses in Regent's *new* Degree Completion Program (DCP). Lead instructor for Groups #1A, 5A and 9A. On-line course developer for the Regent DCP.

1/01 – 3/02: **Capella University**, Minneapolis, MN. Core Faculty. First, full-time core faculty in industrial-organizational psychology. Responsible for teaching doctoral- and master-level courses in *organizational psychology, statistics, research methods, personnel, and psychology of leadership* in the School of Psychology. Served on doctoral- and master-level dissertation/thesis and comprehensive examination committees. Coauthored, rewrote, and updated *organizational psychology* on-line course. Primary designer of *Police Psychology* certificate program, including *police organizational culture* course.

1/01 – 5/01: **Elizabethtown College**, Elizabethtown, PA. Adjunct faculty. Responsible for teaching *Organizational Training & Design*, and *Advanced Public Relations*.

2000 – 1/01: **Capella University**, Minneapolis, MN. Adjunct Faculty. Responsible for teaching doctoral- and master-level courses in *organizational psychology, statistics, research methods, personnel, and psychology of leadership* in the School of Psychology. Serve on doctoral and comprehensive committees.

1998 –1/01: **Eastern College**, St. Davids, PA. Affiliate faculty. Responsible for teaching MBA courses (*statistics foundations, business research methods, issues in management, strategic thinking I & II*) and undergraduate courses (*research methodology & statistics; leadership; human resources, ethics, marketing; etc*.) in the School of Professional Studies. Designed, *Information and Business Process Systems*, as an on- ground and on-line course in the Management of Information Systems program and the Adult Intensive Track. Primary instructor for DCP Group # 208.

8/99-5/00: **Millersville University**, Millersville, PA. One-year, full-time, temporary faculty appointment. Responsible for teaching three undergraduate courses: *introduction to public relations, public relations writing (writing lab)*, and *public speaking*.

1996 - 1998: **University of Alabama--Tuscaloosa**. Adjunct faculty. Responsible for teaching criminal justice courses in the Advanced Police Academy.

1978 - 1980: **Northern Essex Community College**, Haverhill, MA. Lecturer. Responsible for teaching four courses: *Senior Seminar* (Police/Security Management); *Security Administration; Principles of Loss Prevention;* and *Introduction to Security*. Subject areas included the analysis,

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the design, the management, and the implementation of police-security programs via a systems approach. Received the highest faculty evaluation of both full-time and part-time faculty.

PROFESSIONAL COMMUNITY EXPERIENCE:

2000 - 2005: **Civil Service Commission**, Millersville, PA. Appointed January 2000 to serve a six-year term by the Millersville Borough Council. Elected President in April 2000.

1989 - 1994: **Academy Estates Residents' Association, Inc.**, Albuquerque, NM. Elected President in 1989, 1990, 1991, and 1994 and Vice President, 1992 by members of the Association.

1988 - 1991: **Sunport Optimist Club**, Albuquerque, NM. Chairperson, Finance Committee, 1988 - 1989. Within six months, guided the Club from a negative to a positive cash flow. Also served as co-editor of the Club's weekly newsletter.

1979 - 1982: **Town of Braintree (MA) Finance Committee**. Member, General Government Sub-Committee. Responsible for the review and analysis of general town government budgets. Voted on all town budgets, including schools, police, fire, and highways. Served during pre- and post-Proposition 2 ½ (similar to California's Proposition 13).

1979 - 1982: **Town Meeting Member**, Braintree, MA. Elected position. Voted on all financial, administrative, and other matters that affected the Town of Braintree. Town Meeting members approved all budgets, etc.

OTHER PROFESSIONAL:

Training Advisor: AMTRAK® Police Department (1996 - present). Instruct and consult on various police management and training issues (e.g., sexual harassment and instructor development).

El Paso County (CO) Sheriff's Department (former).

Routt County (CO) Sheriff's Department (1991 - 1994). Draft, review, and recommend policies, rules, regulations, plus conduct training (former).

Fairbanks (AK) Police Department (former).

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Pulaski County (AR) Sheriff's Department (former).

Member: International Association of Chiefs of Police; Justice Research & Statistics Association; *Certified Litigation* Specialist Academic Committee, Americans for Effective Law Enforcement; Faculty, Americans for Effective Law Enforcement; Academy of Criminal Justice Sciences; Malignant Hyperthermia Association of the United States; American Correctional Association (professional member); International Police Association (professional member); Who's Who in the East; Beta Gamma; Wilson Honor Society; Phi Theta Kappa; Lambda Alpha Epsilon; United States Combat Judo Association; United States Judo Association; and, United States Judo Federation.

Consultant: Various federal, state, city, county, local, and international criminal justice agencies including, but not limited to: Harris County (TX) Sheriff's Department; Chattanooga (TN) Police Department; Department of Energy Central Training Academy, Winnebago County Sheriff's Police (IL), Seattle Police Department, Oregon State Police, Tuscaloosa Police Department, Public Agency Training Council, plus corrections, security, and military agencies. Consulted with agencies in Canada, United Kingdom, and Australia. Former Advisory Board member to the Northern Essex Community College Criminal Justice Program.

Academic Awards: Dissertation nominated for academic award (1999).

M.B.A., *With Distinction*, Babson College. Second highest grade point average certificate, College of Liberal Arts, University of Baltimore; B. S. awarded, *Summa Cum Laude*; A. A. S. and Certificate in Corrections awarded, *Cum Laude*, Northern Virginia Community College.

Elected into Beta Gamma, Wilson, and Phi Theta Kappa National Honor Societies.

Professional Awards: Certified Litigation Specialist: police liability, correction liability; public employment liability; Certificates of Appreciation: U. S. Secret Service; Fairbanks (AK)Police Department; University of

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Alabama; U. S. Coast Guard; Escambia County (FL) Sheriff's Department; MSG, U. S. Marine Corps; plus more.

Letters of Commendation: Albuquerque (NM) Police Department; Bureau of Indian Affairs; Federal Bureau of Investigation; Washington State Criminal Justice Training Commission; California Highway Patrol; University of Alabama--Tuscaloosa; plus many more.

Honorary Citizen: Louisville, KY; Fairbanks, AK
Captain, Belle of Louisville; Kentucky Colonel

Professional Skills: Certified On-Line Instructor; Software programs: Word, WordPerfect, Excel, PowerPoint, SPSS, BlackBoard, WebCT; Hypnotist (clinical and investigative); WordPerfect; typing; Jiu-Jitsu (holder of a third degree black belt); Judo (holder of a first degree black belt); International Instructor-Trainer in several less-than-lethal and non-lethal impact tools, defensive tactics, and tactics.

Presentations:

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Fairfield, CA (June 22, 2009). Operationalizing Theory Into Practice: Sudden and In- Custody Deaths.

Canadian Centre for the Prevention of In-Custody Deaths, Inc.—Niagara Falls, Canada (May 26, 2009). Putting it All Together.

American Jail Association's 28th Annual Training Conference & Jail Expo—Louisville, KY (April 26, 2009). Excited Delirium—Preventing In-Custody Deaths.

IPICD Forensic Analyst Program—Las Vegas, NV. (April 17, 2009). Reconstruction of the sudden, in-custody death; Investigation checklist; Report writing for sudden, in-custody death events.

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IPICD Forensic Analyst Program—Las Vegas, NV. (April 16, 2009). Causation v. Fallacies; Reviewing and interpreting scientific studies.

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Washington Criminal Justice Training Commission, Burien, WA. (April 2, 2009). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths.

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Westminster Police Department, Westminster, CO. (March 30, 2009). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths.

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Los Angeles County Sheriff's Training Center, Whittier, CA. (March 16, 2009). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths.

AELE Legal, Psychological and Biomechanical Aspects of Officer-Involved Lethal and Less Lethal Force Workshop—Las Vegas, NV (March 9-10, 2009). Sudden and In-Custody Deaths.

CSAC-Excess Insurance Authority—Rancho Cordova, CA. (January 21, 2009). Webinar: Recognition, Prevention, and Management of Excited Delirium and Sudden, In-Custody Death.

Court Security Seminar, California Sheriff's Association —Marina del Rey, CA. (November 20, 2008). Excited Delirium User-Level Program.

IPICD 3rd Annual Conference: Excited Delirium & Sudden Death—Las Vegas, NV. (October 31, 2008). Scientific Method, Causation, and Fallacies.

Correctional Facilities Administrative Seminar, California Sheriff's Association—Sacramento, CA. (October 22, 2008). Excited Delirium.

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AELE Lethal and Less Lethal Force Workshop—Las Vegas, NV (October 21, 2008). Sudden and In-Custody Deaths.

CSAC-Excess Insurance Authority—Rancho Cordova, CA. (September 10, 2008). Webinar: Recognition, Prevention, and Management of Excited Delirium and Sudden, In-Custody Death.

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Salt Lake City, UT. (July 21, 2008). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths.

PRIMA 29th Annual Conference—Anaheim, CA (June 2, 2008). Excited Delirium and Sudden Death: Legal, Management, and Risk Management Issues.

American Jail Association's 27th Annual Training Conference & Jail Expo—Sacramento, CA (May 5, 2008). Jail Deaths: Excited Delirium—Prevention In-Custody Deaths: Part I.

California Sheriff's Association Seconds in Command Workshop—Mt. Shasta, CA (May 1, 2008). Excited Delirium.

AELE Lethal and Less Lethal Force Workshop—San Francisco, CA (March 25, 2008). Sudden and In-Custody Deaths.

Arizona Homicide Investigator Conference—Tempe, AZ (March 17, 2008). Excited delirium, sudden in-custody death, behavioral cues, and forensic investigation guidelines.

CA P.O.S.T. CIT Seminar/Curriculum Update—San Jose, CA. (February 28, 2008). Excited delirium history and behavioral cues.

American Jail Association—Ft. Walton Beach, FL. (January 21, 2008). Excited Delirium/Sudden In-Custody Deaths in the Correctional Setting.

AELE Jail and Prisoner Legal Issues—Las Vegas, NV. (January 15, 2008). Excited Delirium and Sudden, In-Custody Deaths.

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11th Annual Homicide Investigator Conference—Mesquite, NV (December 13, 2007). Excited Delirium, Sudden, In-Custody Death, Use of Force, and Forensic Investigation.

2nd Annual Sudden Death, Excited Delirium & In-Custody Death Conference—Las Vegas, NV (November 28, 2007). Scientific Method, Causation, Fallacies, and the FRCP 702 Gatekeeper Function.

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Honolulu, HI. (November 19, 2007). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths.

AELE Lethal and Less Lethal Force Workshop—Las Vegas, NV (November 12, 2007). Sudden and In-Custody Deaths.

California Sheriff's Association—San Jose, CA (October 24, 2007. Excited Delirium and Sudden In-custody Deaths.

WCRP Excited Delirium Workshop—Federal Way, WA (October 11, 2007).

WCRP Excited Delirium Workshop—Spokane, WA (October 10, 2007).

CVMIC Excited Delirium Conference—New Berlin, WI. (October 2, 2007). Excited Delirium Overview, Forensic Investigations, and Scientific Causation.

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Vancouver, B.C. (September 2007). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths

TASER®/FBINAA Use of Force, Risk Management, and Legal Strategies Conference—San Diego, CA (July 2007). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths

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Montana Chiefs of Police Association Missoula, MT. (July 2007). Excited Delirium, Sudden, In-Custody Deaths, Suicide-by- Cop.

Cincinnati (OH) Police Department (May 2007): Keynote speaker: Sudden/In-Custody Deaths.

Contra Costa County Sheriff's Department Correctional Services (April 2007): Sudden Death, Excited Delirium Deaths.

Illinois State Police Internal Investigator Symposium Springfield, IL (April 2007): Investigating Sudden Death, Excited Delirium Deaths

Utah Chiefs' of Police Association St. George, UT (March 2007): Sudden Death, Excited Delirium, Jail Suicide, and Suicide- by-Cop

AELE Lethal and Less Lethal Force—Las Vegas, NV (March 2007): History of Sudden Death: An Overview.

Las Vegas Metropolitan Police Department –Use-of-Force Media Day, Las Vegas, NV (February 2007): Sudden Death, Excited Delirium, and TASER ECDs

Boulder City Kiwanis Club, Boulder City, NV (February 2007): Sudden Deaths and TASER ECDs

Southern California Jail Manager's Conference, Santa Paula, CA (January 2007): Excited Delirium

Montana Association of Cities and Counties, Billings, MT (January 2007): Exited Delirium; Jail Suicide; Suicide by Cop

AELE Jail and Prisoner Legal Issues—Las Vegas, NV (January 2007): Psychological Considerations: Excited Delirium and Jail Suicide

P.A.T.C., Western Training Conference, Las Vegas (November 2006): Excited Delirium, In-Custody Death; Investigations

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Oakland, CA (November 2006).

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Operationalizing Theory Into Practice: Sudden and In-Custody Deaths

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Colorado Springs, CO (August 2006). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Portland, OR (July 2006). Operationalizing Theory Into Practice: Sudden and In- Custody Deaths

PRIMA Conference—Las Vegas (June 2006): Sexual Harassment and Research Findings

FBI National Academy Graduates—Utah (May 2006): Excited Delirium, In-Custody Death; Jail Suicide; Suicide by Cop

TASER® Annual Conference—Las Vegas, NV (May 2006): Excited Delirium, Sudden Death

TASER® Master Instructor Program—Las Vegas, NV (May 2006). Excited Delirium, Sudden Death

Harrah's Entertainment, Inc.—Las Vegas, NV (April 2006): Ethics

AELE Lethal and Less-Lethal Force—Las Vegas, NV (February 2006): Excited Delirium and In-Custody Deaths

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Scottsdale, AZ (January, 2006). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths

TASER® Use of Force, Risk Management, and Legal Strategies Conference—Scottsdale, AZ (December, 2005). Operationalizing Theory Into Practice: Sudden and In-Custody Deaths

Michigan Sheriff's Conference (October, 2005): Excited Delirium

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Intercourse (PA) Merchants Association (February, 2004): Village History

PRIMA Conference—Reno (May 2003): Sexual Harassment and Employment Issues

Academy of Criminal Justice Sciences, Boston, MA (Feb., 2003)

Civil Air Patrol, Leola (PA) Elementary School (November, 2002)

PRIMA Conference—San Antonio (May 2002): Sexual Harassment

Wisconsin Sheriff's Conference (January 2001): Sudden Death

Walden University (December 1998): Use of Force

Pennsylvania Sheriff's Conference (July 1998)

Walden University (March 1997)

Walden University (July 1997): Sexual Harassment

Milwaukee (WI) County Chief's Association (1995): Pepper Spray

Texas Narcotics Officers Association Conference (1988, 1989): Safe Prisoner Searching Methods

Waltham (MA) Police Academy (March 1982)

Boston University (October 1979)

Waltham Police Department (October 1979)

PR-24 International Instructor Conferences (1979, 1980, 1981)

Boston University (February 1979)

Westwood (MA) Police Department (February 1979): Defensive Tactics

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Panelist: ―Excited Delirium." CVMIC Excited Delirium Conference, New Berlin, WI, October 2, 2007.

―Sexual Harassment Research Findings in Local Government." PRIMA's 26th Annual Conference, Las Vegas, NV, June 12, 2006.

―Legal, Psychological and Biomechanical Aspects of Officer-Involved Lethal and Less Lethal Force." Americans for Effective Law Enforcement, Las Vegas, NV, February 2006.

―Interactive Mock Trial" (municipal government employment practices). PRIMA's 24th Annual Conference, Reno, NV, May 22, 2003.

―Officer-Assisted Suicide: Liability, Training, and Municipal Concerns." Milwaukee, WI: Lorman Educational Services, December 5, 2002.

―Interactive Mock Trial" (employment practices). PRIMA's 23rd Annual Conference, San Antonio, TX, May 16, 2002.

―Sexual Harassment: Research Findings In The Law Enforcement Workplace", Milwaukee, WI. Lorman Educational Services, December 4, 2001.

―Police Liability in Wisconsin", Milwaukee, WI. Lorman Educational Services, December 14, 2000.

―To Protect and Serve." KNME Channel 5, Albuquerque, NM: July 10, 1991. Invited panelist: police ―use-of-force"program.

PUBLICATIONS:

Texts:

1. **Official Kubotan® Techniques** (with Takayuki Kubota). (1981). Ventura, CA: Reliapon Police Products, Inc.

2. **Realistic Defensive Tactics**. (1981). Ventura, CA: Reliapon Police Products, Inc.

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3. **Official Kubotan Techniques--Civilian** (with Takayuki Kubota). (1982). Braintree, MA: Defensive Tactics Institute, Inc.

4. **Defensive Tactics With Flashlights**. (1983). Ventura, CA: Reliapon Police Products, Inc.

5. **Afraid of the Dark? Lite Your Way To Safety** (with Laurie A. Peters). (1984). Ventura, CA: Reliapon Police Products, Inc.

6. Tactical Handcuffing for Chain- and Hinged-Style Handcuffs. (1989). Ventura, CA: Reliapon Police Products, Inc.

7. **Prevention and Management of In-Custody Deaths** (with A. David Berman). (1997).Millersville, PA: Defensive Tactics Institute, Inc.

8. **Tactical OC®**. Ventura, CA: Reliapon Police Products, Inc. (forthcoming 2009).

9. **Recognition, Prevention, Management, and Investigation of Sudden and In -Custody Deaths**. Las Vegas, NV: 702 Visual Communications, Inc. (forthcoming 2009).

ARTICLES, NEWSLETTER, and HANDBOOKS

1. *BLURB*. Lancaster: Lancaster (PA) Judo Club, January 1976.

2. "Search: the Elevated Lying Position." *The Sentinel*, Spring 1976, pp. 44-45.

3. "Massachusetts Prison Furlough System. A Failure?" (with George Sacco) *The Advocate*, Spring 1976, pp. 2-9.

4. *BLURB*. Lancaster: Lancaster (PA) Judo Club, February-March, 1976.

5. "Massachusetts Prison Furlough System. A Failure?" (with George Sacco) *The Sentinel*, Summer 1976, pp. 61-64.

6. Warren Hall Handbook. Boston: Boston University Press, 1976.

7. *BLURB*. Lancaster: Lancaster (PA) Judo Club, April-May, 1976.

8. "Massachusetts Police Association's Position On Firearms." (with George Sacco) *The Sentinel*, Fall 1976, pp. 41-44.

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9. "Management vs Media." *The Sentinel*, Fall 1976, pp. 63-64.

10. "Escape From A Full Nelson." *The Sentinel*, Fall 1976, pp. 63-64.

11. *BLURB*. Lancaster: Lancaster (PA) Judo Club, September-October, 1976.

12. *Massachusetts Police Association's 1976 Convention Report* (with Bill Brooks, et al.) Peabody: Massachusetts Police Association, 1976.

13. "Dealing With Recidivism." *The Sentinel*, Winter 1976, pp. 57-62.

14. "This Way Please." *The Sentinel*, Winter 1976, pp. 49-50.

15. "Breaking A Front Choke Hold." *The Sentinel*, Winter 1976, pp. 48-49.

16. *BLURB*. Lancaster: Lancaster (PA) Judo Club, November-December, 1976.

17. "Pinned On Your Back: Now What?" *The Sentinel*, Spring 1977, pp. 55-56.

18. "Bartley-Fox: Is It Working?" (Part I with W. Brooks) ***The Sentinel***, Spring 1977, pp. 51-54.

19. *A Descriptive Study To Determine The Salutation Preference of Massachusetts' Drivers.* Wellesley: Babson College Press, 1977.

20. "Self-Defense Tips For Women." *The Sentinel*, Summer 1977, pp. 51-53.

21. "Bartley-Fox: Is It Working?" (Part II with W. Brooks) *The Sentinel*, Summer, 1977, pp. 47-50.

22. "First Names: Should They Be Used During Traffic Stops?" (with R. Goulet) *The Sentinel*, Summer 1977, pp. 15-20.

23. "You Want Me Out, Take Me Out." *The Sentinel*, Fall 1977, pp. 33-34.

24. *Northern Essex Hospital*. Haverhill: Northern Essex Community College, 1977.

25. "Escape From A Crushing Bearhug." *The Sentinel*, Winter 1977, p. 27.
26. "Shoplifting: Its Impact On You." (with D. Slifka). *The Sentinel*, Winter

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1977, pp. 31-32.

27. "The PR-24: An Answer To The Grey Area." *The Sentinel*, Spring 1978, pp. 19-21.

28. *Hypnosis: An Evaluation of its Impact on Learning In A Police Recruit Class.* Boston: Massachusetts Criminal Justice Training Council, 1978.

29. *The Connection.* Braintree: PR-24 International Institute, Inc., August-September 1979.

30. "Defensive and Offensive Blocking: How A New Type of Baton Can Work For You." Law Enforcement Communications, August 1979, pp. 47-51.

31. "Police Field Studies: A Review of Evaluation Research." (with Michael Cahn, and Edward Kaplan). *How Well Does It Work? Review of Criminal Justice Evaluation, 1978.* Washington National Institute of Law Enforcement and Criminal Justice, 1979, pp. 205-236.

32. *The Connection*. Braintree: PR-24 International Institute, Inc., October-November, 1979.

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―Excited Delirium." CSAC-EIA. Webinar. Rancho Cordova, CA. (January 2009).

―Sudden, In-Custody Deaths." Americans for Effective Law Enforcement Jail and Legal Issues Workshop: Las Vegas, NV (January, 2009).

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–Scientific Method, Causation, and Fallacies." IPICD 3rd Annual Conference: Las Vegas, NV (October 2008).

–Excited Delirium." Correctional Facilities Administrative Seminar, California Sheriff's Association: Sacramento, CA (October 2008).

–Sudden, In-Custody Deaths." Americans for Effective Law Enforcement, Lethal & Less Lethal Force Workshop: Las Vegas, NV (October 2008).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Salt Lake City, UT. (July 2008).

–Excited Delirium and Sudden Death: Legal, Management and Risk Management Issues." PRIMA 29th Annual Conference: Anaheim, CA. (June 2008).

"Sudden, In-Custody Deaths." Americans for Effective Law Enforcement, Lethal & Less Lethal Force Workshop: San Francisco, CA. (March 2008).

–Excited Delirium and Crisis Intervention Training." California P.O.S.T. workshop: San Jose, CA (February 2008).

–Recognition, Prevention, Management of Excited Delirium and Sudden and In-Custody Deaths: Version 3.0." (2008, February). Henderson, NV: Institute for the Prevention of In-Custody Deaths.

"Sudden, In-Custody Deaths." Americans for Effective Law Enforcement, Lethal & Less Lethal Force Workshop: Las Vegas, NV. (March 2007).

"Excited Delirium." Southern California Jail Manager's Association: Santa Paula, CA. (January 2007).

–Excited Delirium, Sudden Death, Jail Suicide, and Suicide by Cop." Montana Association of Cities and Counties Conference: Billings, MT. (January 2007).

–Psychological Considerations." AELE Jail and Prisoner Legal Issues Workshop: Las Vegas, NV. (January 2007).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Toronto, Canada (December 2006).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Montgomery, AL. (December 2006).

–Investigating Excited Delirium, Sudden Death, and Jail Suicide." P.A.T.C. Western Training Conference: Las Vegas, NV. (November 2006).

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–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Oakland, CA (November 2006).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Chicago, IL (October 2006).

–In-Custody Death and Injuries." AELE Police Liability Workshop: Las Vegas, NV. (October 2006).

–Management Issues in Law Enforcement Litigation." AELE Police Liability Workshop: Las Vegas, NV. (October 2006).

–The Aftermath of an Incident." AELE Police Liability Workshop: Las Vegas, NV. (October 2006).

–IPICD Specialist Program." Institute for the Prevention of In-Custody Deaths, Inc. Specialist Program: Henderson, NV. (September 2006).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Colorado Spring, CO. (August 2006).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Cleveland, OH (June 2006).

–Sexual Harassment: Findings in the Local Government Workplace." AGRIP Pooling Session 1132, PRIMA Conference: Las Vegas, NV. (June 2006).

–Excited Delirium, Sudden Death, and Jail Suicide." FBI National Academy GraduateS—Utah Conference: St. George, UT. (May 2006).

–Suicide by Cop." FBI National Academy Graduates—Utah Conference: St. George, UT. (May 2006).

–Cause and Effect." TASER® International Conference: Las Vegas, NV. (May 2006).

–Excited Delirium and Sudden Death." TASER® Master Instructor Conference: Las Vegas, NV. (May 2006).

–Identification, Prevention, and Management of In-Custody Deaths." ILEETA Conference: Chicago, IL. (April 2006).

–Ethics." Harrah's Entertainment, Inc.: Las Vegas, NV. (April 2006).

–Operationalizing Theory Into Practice: Sudden & In-Custody Deaths." TASER® Use of Force, Risk Management and Legal Strategies Seminar: Santa Ana, CA. (March 2006).

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–Identification, Prevention, Management, and Investigation of Sudden In-Custody Deaths, V.2." Institute for the Prevention of In-Custody Deaths, Inc. (October 2005).

–Identification, Prevention, Management, and Investigation of Sudden In-Custody Deaths, V.1." Institute for the Prevention of In-Custody Deaths, Inc. (July 2005).

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Exhibit 17

Response in Regards to the

U.S Department of Justice Investigation

of the Harris County Jail Report

:

by

Jonathan Roberts
&
Ronnie Aldridge

July 24, 2009

Summary

Through an agreement with the Harris County Jail (HCJ), we were asked to review the United States Department of Justice (DOJ) report dated June 4, 2009 and analyze the report's findings and recommendations on fire safety and sanitation and hygiene. Our response is contained within this report.

Copies of our resumes are attached to this report, which identifies our education, professional experience and relevant training in the areas of fire safety, sanitation and hygiene, industrial safety, industrial hygiene, and environmental issues.

Mr. Aldridge has over 10 years experience in developing written programs in the areas of lockout/tagout, confined space, and bloodborne pathogens, just to name a few. He also has many years experience in the correctional area as a Safety Coordinator for the Oklahoma Department of Corrections. As a Safety Coordinator, Mr. Aldridge performs health, fire safety, and sanitation and hygiene audits on approximately 90 facilities every six (6) months and participates in all department Pre American Correctional Association (ACA) audits along with providing training to all departmental employees on a wide array of health and safety topics.

Mr. Roberts has over 10 years experience in providing consultation and program coordination for environmental, health and safety programs. Much like Mr. Aldridge, Mr. Roberts has many years experience in the correctional area as a manager of the Oklahoma Department of Corrections Safety Administration. As a manger, Mr. Roberts performs health, fire safety and sanitation and hygiene audits on approximately 90 facilities every six (6) months, participates in all department Pre ACA audits and also reviews and writes departmental policies and procedures. Both Mr. Roberts and Mr. Aldridge have over 20 years of combined experience in the environmental, health and safety area.

The DOJ conducted two on-site tours of the HCJ complex. The first visit was conducted on July 8-12, 2008 and the second on August 5-9, 2008. Both Mr. Aldridge and Mr. Roberts were present on both tours and accompanied Mr. Leonard Rice (DOJ Consultant) throughout both of the on-site inspections.

We have carefully reviewed the DOJ's report on their findings at the HCJ, and our response to these findings is contained within this report. In this rebuttal, we will respond to the DOJ's allegations on sanitation and hygiene issues along with allegations on the jails fire safety programs. We will specifically address concerns in the jail's laundry facilities regarding the allegation that the jail does not meet minimum sanitary standards relating to proper washing and sanitizing of the clothing and linen and the allegation that the jail does not maintain enough accessible clothing or linen on-hand for the current population of detainees. According to the DOJ report, allegations were made concerning the jail's plumbing systems, citing that improved maintenance was needed to ensure hygienic conditions in certain housing units. Finally, the DOJ report made

allegations that the jail's fire safety programs are inadequate to protect life in case of an emergency.

Laundry Facilities

During the time of the DOJ tour, the jail did have several washing machines that were inoperative which since have been replaced with new ones. At no time while the washing machines were down did the jail fail to meet minimum sanitation standards in accordance with the Texas Administrative Code (TAC) 37-9-259.226.

The jail's laundry facility utilizes Ecolab for the delivery of all chemical products in order to maintain sanitary clothing and linen. All commercial grade washing machines have been programmed to deliver the proper amount of detergent to properly sanitize the detainee clothing and linen. The laundry facilities currently use Tristar L2000 xp detergent and Tristar Destainer (bleach) for cleaning and sanitizing the clothing and linen. The laundry facility also has a "Routine Preventive Maintenance Program" for the washing machines and dryers provided by Ecolab. The routine preventive maintenance consists of Ecolab inspecting the jail's laundry facility every month which consist of inspecting the clothing and linen for the following:

- Appearance
- Feel
- Odor
- Staining
- Wettability
- Wrinkling

The laundry machines, both washers and dryers are also checked monthly to ensure that they are in proper working condition and dispensing the appropriate amount of chemicals to meet above the minimum sanitary standards. The DOJ consultant also made a comment that the water temperature was not hot enough to properly sanitize the clothing and linen. The laundry uses a special detergent specifically formulated to be used with low water temperature washing and during the bleach cycle the water temperature is maintained at a lower temperature as not to degrade the bleach which in turn would lower the disinfection power of the bleach.

The DOJ report also made allegations that the jail did not maintain enough accessible clothing and linen for the number of detainees housed at the facility. This statement is inaccurate; at no time did the DOJ consultant see any detainee without proper clothing or linen. The laundry maintains extra clothing and linen in six (6) storerooms. The laundry exchange teams take large racks filled with clean clothing and linen for exchange and all detainees are offered clean clothing and linen at least weekly in accordance with TAC 37:9-277.2 and TAC 37:9-277.8. There are also several empty bins to collect the dirty laundry and when the bins are full with dirty laundry they are covered with disposable plastic covers and transported to the appropriate laundry facility for cleaning. The DOJ

consultant actually witnessed this exchange process on one (1) of the housing units and he had no negative comments on the exchange process.

The jail's plumbing and mechanical systems

During the first site visit the DOJ consultant made allegations regarding the jail's plumbing system, specifically the floor drains in the shower areas that these drains were not well maintained. The jail staff took immediate action in correcting this issue. The jail manually began to clean every drain in the facility and started to use an enzyme based cleaner for the drains. On the second visit, the DOJ consultant praised the jail's staff on how clean the drains were. During the second visit the DOJ consultant did not find a single floor drain that was dirty or unsanitary. In the DOJ report, the jails use of archaic flushable floor drains used in the detoxification cells was attacked citing, "Using such grossly inadequate facilities for long periods of time is itself problematic because they are unhygienic." The key words in this sentence is "long periods", the jail does not keep any detoxing detainee in this type of cell any longer than it takes for that detainee to go through the detoxification process. The jail is in full compliance with the use of this type of plumbing to provide a safe cell for detainee's who are going through the detoxification process. According to TAC 37:9.259.236 (2), "Plumbing. Cells shall be provided with one or more vandal resistive flushing floor drains with outside controls, or detention type toilet and lavatory and vandal resistive floor drains. The floor shall be properly pitched to drains. The DOJ report also stated that some of the flushable drains were clogged and back-flushed into the cells when flushed. At no time did we the consultants witness any flushable floor drain back-flush into the cell when used.

Fire Safety

The jail has adequate fire safety programs outlined in their policies and procedures to ensure the protection of life, these policies and procedures address all components required in the Code of Federal Regulations (CFR), International Fire Code (IFC), and the National Fire Protection Association (NFPA) specifically 29 CFR 1910.38, IFC 404.3.2. and NFPA 101.23.7. Before being assigned a location, all staff are fully trained on the facilities emergency procedures. On August 7, 2008 the DOJ consultant requested that a fire drill be conducted on one of the housing units and he observed the drill. After the drill was complete, he stated that the drill started off a little slow, but he was extremely impressed with the overall response and commended the entire fleet of staff that participated in the drill. When the group walked out of the housing unit there were approximately 20 fully trained correctional officers (C/O) in full Self Contained Breathing Apparatus (SCBA) ready to conduct a full evacuation of the housing unit if needed. This drill was unplanned and the number C/O's that are required to respond in an emergency situation far exceeds any requirement of state or federal regulations. To have that many staff to be able to put all the necessary equipment on and respond to an emergency situation and to do so in just a few minutes speaks volume about the jail's Fire Safety Programs. The HCJ's Fire Safety Program is one of the best that we have ever seen and the Fire Safety Officers do an impeccable job ensuring that all staff are trained on all types of emergency situations.

The inconsistencies in safety documentation noted by the DOJ consultant were not due to lack of training, but rather errors that were made in the pass on books. This issue was immediately addressed and corrected by the jail. These inconsistencies in documentation at no time were a threat to life safety in the event of an emergency situation. Finally, the DOJ consultant had concerns about appropriate staff did not have adequate access to emergency keys in the event of a failure in the Jail's electronic door control system. The jail's Fire Safety Officer showed the DOJ auditor how the jail would open the doors in case of an electric failure. The DOJ consultant had no negative comments on how the doors would be opened or how the master keys would be accessed for opening the doors in case of an emergency situation.

Conclusion

While the DOJ report contained recommendations on sanitation and life safety, the overall report did not reflect the current level of operation of the HCJ and without the DOJ consultants' reports it is not possible to fully understand the allegations or the recommendations of the claims noted in the report. During both brief-outs the DOJ consultant praised the staff and commented on how well the jail was operated. The issues that he had were minor and in no way violated any local, state, or federal regulations. The DOJ consultant also commented on how improved the facilities drains looked in the final brief-out of the second visit and once again commended all the staff for taking a proactive approach to this issue. The HCJ is also inspected by several state agencies at least yearly to ensure that the jail is following all local, state and federal regulations in the areas of sanitation and hygiene and fire safety. The allegations that are made in the DOJ report are in no way reflective of the local, state and federal regulations that the Harris County Jail adheres to. The HCJ has always taken a proactive approach to uncovering and remediating any issue that would adversely affect any offender or staff in a prompt manner. We have inspected many correctional facilities and the HCJ is one of the best operated and maintained jails in relation to fire safety, sanitation and hygiene for the population of detainees that the jail occupies.

Exhibit 18

RONNIE ALDRIDGE
3909 Tori Place
Yukon, Oklahoma 73099
(405) 354-5836 (Phone)
(405) 205-3264 (Cell)

PROFESSIONAL EXPERIENCE

Safety Coordinator
Oklahoma Department of Corrections
Compliance and Safety Administration
3400 N. MLK Avenue
Oklahoma City, Oklahoma 73111
October, 2005 to Present

- Conduct and maintain occupational health and safety programs for the prevention of industrial, motor vehicle and/or workplace accidents within the Oklahoma Department of Corrections. Inspect facilities to determine whether safety hazards exist and to ensure that the Department meets the regulatory requirements of local, state and federal authorities. Make onsite corrections of any safety violations and potentially hazardous conditions and prepare reports of findings and corrective action taken.

- Provides advice and guidance to facility personnel regarding inspection procedures and regulations; reviews policy and procedure and makes recommendations for updates related to safety operations.

- Operates safely related equipment and measuring devices such as ground fault circuit interrupter, air velocity, light meter and voltage detectors.

Safety Director
Stillwater Milling Company
P.O. Box 2407
Stillwater, Oklahoma 74076
March, 2001-July, 2006

- Direct supervision of all safety activities at the four locations of Stillwater Milling Company in the State of Oklahoma. Authored and implemented the following programs: Hazard Communication; Emergency Action Plan; Confined Space; Bloodborne Pathogens; Hearing Conservation; Respiratory Protection; Lockout Tagout; Safety Awareness; and OSHA Inspection Packet. Conducted training on each of these programs, as well as forklift training. Responsible for holding monthly safety meetings for all staff, and authored monthly safety bulletins. Conducted safety inspections at all four locations. Worked with the United States Department of Labor to achieve SHARP at two locations and worked toward that goal at the remaining two locations. Maintained

OSHA Form 300, air emissions, and tier 11 reports. Instrumental in litigation involving OSHA fines and an industrial accident which occurred prior to my employment.

Internship
International Environmental Corporation
January 1998-May 2005

EDUCATION AND TRAINING

Bachelor of Science in Industrial Safety, University of Central Oklahoma, 100 North University Drive, Edmond, Oklahoma 73034, December, 1999

Certified Instructor, CPR and First Aid
Accident Investigation and Instructor Training, Oklahoma Safety Council, 2001/2002
Hazwoper, 2008, 40 hour training
OSHA General Safety and Health, 10 hours
OSHA General Construction, 10 hours
OSHA SOI Standards for General Industry Outreach Trainer

Licensed Asbestos Inspector

Exhibit 19

JONATHAN ROBERTS
5008 NW 61st St.
Oklahoma City, OK 73122
Phone: (405) 722-1024 * Cell: (405) 615-8312

PROFESSIONAL EXPERIENCE

OKLAHOMA DEPARTMENT OF CORRECTIONS/COMPLIANCE AND SAFETY ADMINISTRATION
3400 N. MLK Ave.
Oklahoma City, OK 73111
(405) 425-7144
October 2005- Present

ENVIRONMENTAL PROGRAMS MANAGER
Responsible for providing senior-level consultative and program coordination for environmental programs, such as water and wastewater treatment facilities, water resources management, solid waste disposal, or other environmental concerns. Advise professional and technical personnel to ensure the department meets the regulatory requirements of local state, and federal laws and regulations applicable to the protection of the environment and public health in correctional facilities.

- *Act as liaison with other regulatory agencies*
- *Plan and coordinate programs, inspections and investigation of industrial and solid waste storage, collection, transportation and disposal of water supplies of sewer or industrial wastewater treatment facilities, and/or quality control facilities*
- *Assist in the development and ongoing coordination and compliance of environmental program policies and regulations and recommend and implement procedures to increase program effectiveness*
- *Direct environmental health and safety audits to determine compliance with state and federal requirements of correctional facilities*
- *Provide consultation and technical assistance to correctional facilities in planning and implementing environmental and health programs*
- *Serve as a technical resource for DOC facilities*
- *Develop and implement training programs for department staff regarding environmental programs and safety and health issues*
- *Investigate worker compensation claims*
- *Investigation accidents and near misses through the department*
- *Conduct incident investigations on employee injuries and near misses*
- *Conduct noise and airflow measurements*
- *Conduct indoor air quality investigations when needed*

ENVIRONMENTAL TESTING, INC.
4619 N. Santa Fe
Oklahoma City, OK 73188
(405) 488-2400
June 2001-October 2005

ANALYTICAL CHEMIST
Comprehensive responsibilities for laboratory analysis of soils, waters, and other materials using sensitive scientific instrumentation for disposal and remediation purposes. Review existing data and procedures to ensure compliance with all state and federal regulations. Educate and train new employees on laboratory safety, use of equipment and equipment maintenance.

- *Analyzed samples for volatile and semi-volatile compounds and total recoverable petroleum hydrocarbons using GC and Mass-Spec instruments*
- *Skilled in wet chemistry and extraction applications*
- *Comprehensive understanding of EPA methods and regulations*
- *Detailed review of data generated by all analysis*
- *Multi-faceted in the use of computer applications, such as Excel, PPT, and Chemstation*
- *Writing SOP's for laboratory use*
- *Excellent communication skills*

MICRO-TECH LABORATORY
500 N. Main St.
South Hutchinson, KS 67505
(602) 662-0033

LABORATORY MANAGER
Detailed and comprehensive responsibility for food analysis, including nutritional labeling, product development and vitamin content. Conduct research into causes of food poisoning, compile forensic data and suggest safety standards. Oversee staff recruitment, training and scheduling, place orders and maintain supply inventory. Review and analyze existing policy and procedures with a view toward enhancing efficiency and accurate analysis reporting.

- *Supervise staff development, training and skill reinforcement. Provide clear leadership in ensuring that all U.S. Public Health requirements and standards are observed. Stay current with AOAC, USDA, and FDA methods and regulations*
- *Set up and established laboratory to achieve USDA and FDA certifications*
- *Utilize and expand expertise with DNA synthesizer, GC, HPLC, Flourometer, Colorimeter and Spectrophotometer. Maintain all equipment.*
- *Perform all duties of chemist, microbiologist, and environmental specialist; assist with research and development.*

- *Responsible for all waste disposals.*

SEMINOLE NATION OF OKLAHOMA ENVIRONMENT
Seminole, OK 74868
(405) 382-5112
May 1998-February 1999

ENVIRONMENTAL TECHNICIAN
Detailed responsibility for maintaining smooth operation of all office and laboratory areas. Assisting in the drafting of vital documents for presentations of EPA officials. Key role in developing and implementing important programs for the company and community. Conducted all laboratory analysis and reports.

- *Assisted in drafting a Quality Management Plan*
- *Developed and implemented a recycling program for the environment office and surrounding community*
- *Performed site assessments on areas contaminated by petroleum spills*
- *Involved in extensive communication with governmental agencies and general public concerning environmental problems in the area.*

EDUCATION AND TRAINING

Bachelor of Science in Environmental
Health Science, East Central University, Ada, Oklahoma, 1998

Master of Science in Industrial
Hygiene and Environmental Management, Oklahoma University, Spring 2008

40-hour HAZWOPER, 2006
Class "D" Water and Wastewater Operator, 2006
40-OSHA General Industry Safety and Health Certification 2007
40-OSHA General Construction Safety and Health Certification, 2008

Exhibit 20

Michael M. Seale, M.D.

work 713-755-9202

1200 Baker Street
Houston, Texas 77002

Michael.Seale@Sheriff.hctx.net

Experienced family physician with fourteen years of correctional medicine leadership experience. Strong background in delivery of primary clinical care and in process improvement programs. Experienced in development and implementation of policies and procedures. Conversant with medical-legal risk prevention strategies and experienced in litigation response and preparation. Interest in public health policy issues, particularly as they pertain to the correctional environment. Frequently interacts with local, state and national authorities. Designed, implemented and manages a comprehensive behavioral health program in a large, urban jail setting. Participates in regulation of state-level jail guidelines through service as Commissioner for the Texas Commission on Jail Standards.

Employment History and Work Experience

Executive Director — 2006-present
Health Services Bureau
Harris County Sheriff's Office
Houston, Texas
Key Achievements:

- Development and implementation of comprehensive behavioral health program
  - Restructuring of personnel, renovation of physical plant
  - Development of contracts to codify arrangements with mental health provider
  - Development and refinement of policies and procedures
  - Development and implementation of off-site mental health hospital unit
- Responsible for over 350 employees and a $40,000,000 annual budget
- Responsible for overall provision of medical and mental health care to detainees in custody
- Accountable to maintain National Commission on Correctional Health Care accreditation

Assistant Dean for Correctional Medicine — 1997-2006
UT-Houston Health Science Center
Houston, Texas
Key Achievements:

- Responsible for management of correctional medicine program at the Harris County Sheriff's Office
- Coordinated academic and research programs in the jail environment
- Monitored and administrated negotiated budget
- Developed and implemented on-site specialty clinics (OB/Gyn, Infectious Diseases)

Medical Director — 1994-2006
Harris County Sheriff's Office
Houston, Texas
Key Achievements:

- Direct oversight and responsibility for the provision of clinical medical care to the detainees of the Sheriff's Office
- Development and implementation of clinical policies and procedures
- Provision of expert testimony and litigation support
- Responsible for ensuring continuous primary care physician coverage and adequate specialty care coverage for detainee medical care

Private Practice — 1990-1994
Houston, Texas
Key Achievements:

- Solo practice
- Served as Medical Director for Space Center Houston
- Served on Board of Directors for St. John Hospital physician-hospital organization

Director of Undergraduate Education — 1988-1989
University of Texas Medical Branch
Department of Family Medicine
Galveston, Texas
Key Achievements:

- Served as co-director for the Problem-Based Learning initiative at the Medical Branch

Assistant Professor — 1988-1989
University of Texas Medical Branch
Department of Family Medicine
Galveston, Texas

Michael Seale, MD

Appointments

Commissioner — 2002-present
Texas Commission on Jail Standards

Education History/Awards

Post-Graduate Education:

- **Certificate of Business Administration** — 2000-2001
  University of Houston-Clear Lake
  Executive Healthcare Training Institute
  Houston, Texas
- **Academic Fellowship** — 1989-1990
  Faculty Development Center
  Waco, Texas
- **Chief Resident** — 1987-1988
  University of Texas Medical Branch
  Department of Family Medicine
  Galveston, Texas
- **Residency** — 1985-1988
  University of Texas Medical Branch
  Department of Family Medicine
  Galveston, Texas

Graduate Education:

- **M.D.** — 1981-1985
  University of Texas Medical Branch
  Galveston, Texas

Undergraduate Education:

- **Phi Beta Kappa** — 1981
- **B.S. Biology–Summa Cum Laude** — 1977-1981
  Baylor University
  Waco, Texas

Licensure

Professional Qualifications:

- **Recertification, American Board of Family Practice** — 2003
- **Recertification, American Board of Family Practice** — 1996
- **Certification, American Board of Family Practice** — 1989
- **Texas Board of Medical Examiners** — 1988

2008 Presentations

Testimony, Sunset Advisory Commission regarding the Texas Commission on Jail Standards, December 15, 2008

"Harris County Jails–Medical and Mental Health Treatment in the Jail Setting," Representing Mentally Impaired Clients Seminar, Texas Criminal Defense Lawyers Association, October 29, 2008

"Behavioral Health at the Harris County Jail," Annual Bench Bar Conference, Houston Bar Association, April 25, 2008

References

References are available on request.