U.S. Department of Justice

Civil Rights Division

JMS:LC:CMS:SJD:BJ:dj
DJ 168-32-71

Special Litigation Section - PHB
950 Pennsylvania Ave, NW
Washington DC 20530

April 23, 2012

Via Electronic and First Class Mail

Marlin N. Gusman
Orleans Parish Sheriff
2800 Gravier Street
New Orleans, LA 70119

c/o T. Allen Usry, Esq.
Counsel for the Sheriff's Office
2800 Gravier Street
New Orleans, LA 70119

Re: Update to Letter of Findings
United States' Civil Rights Investigation of the Orleans Parish Prison System

Dear Sheriff Gusman:

Despite our findings and repeated attempts to encourage you to meaningfully address the numerous problems, the already troubling conditions in the Orleans Parish Prison (OPP or the Jail) are deteriorating. Since we issued our findings letter on September 11, 2009, which identified serious constitutional violations, you have failed to take basic steps to correct the systemic issues that we identified. As this letter demonstrates, urgent and substantial action is required.

We have attempted to work with your client to develop a comprehensive reform plan. Most recently, on November 8, 2011, we sent you a draft consent decree. Since that time, you have failed to seriously negotiate. In March, five months after our initial settlement offer, we finally received your first substantive response. In the interim, OPP prisoners have needlessly suffered and staff members' safety has been at risk, contrary to the best interests of the people of New Orleans.

Given the seriousness of the problems in OPP, we urge your client to:

1. Take immediate steps to address the concerns raised in this letter regarding the most basic measures to ensure prisoner safety, health, and well-being; and

2. Engage in an aggressive schedule of negotiations with the Special Litigation team to reach an agreed-upon remedy embodied in a federal consent decree with a monitor.

As you are well aware, our investigation is being conducted pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA authorizes the Attorney General to sue in the United States District Court to remedy patterns or practices of Constitutional or federal law violations in prisons and jails. It is largely uncontestable that the deficiencies in the operation of OPP violate the Constitution. Rather than spend time, money, and effort in contested litigation, we believe that everyone – most especially the men and women in OPP, the staff, and the people of New Orleans that rely on the jail for public safety – will be best served by a negotiated resolution. But if you fail to immediately negotiate in good faith, we will be forced to consider whether litigation is appropriate.

This letter outlines the most urgent issues facing OPP, your staff, and prisoners. It is not intended to be a comprehensive recital of all issues. The draft consent decree that we provided you in November includes many common sense, sustainable remedies to unconstitutional conditions that may not be included below.

I. Executive Summary

A team of attorneys from the Department of Justice ("DOJ"), Civil Rights Division, Special Litigation Section together with expert consultants in correctional operations and mental health care just re-inspected OPP on April 3 through 5, 2012.[1] We found alarming conditions and were distressed that the problems we described in our initial findings letter persist or have worsened.[2]

Inadequate Protection from Violence and Sexual Assault

OPP is a violent and dangerous institution. Our inspection uncovered shockingly high rates of serious prisoner-on-prisoner violence and officer misconduct. We received reports of widespread sexual assaults, including gang rapes. The violence, sexual assaults, and pervasive atmosphere of fear are the direct result of inadequate staffing, deficient classification, use of prisoners to provide security supervision through "Tier Reps," poor staff training, and failed systems of accountability.

[1] As part of our April 2012 site visit, we interviewed administrative staff, security staff, investigative staff, medical and mental health staff, prisoners, and former prisoners. We reviewed a large volume of documents before, during, and after our visit. The documents that we reviewed included policies (draft and official), procedures, incident reports, use of force reports, investigation reports, prisoner grievances, sick calls, classification documents, orientation materials, mental health records, and training materials.

[2] The Sheriff reports that he is making efforts to improve the facility. Less than one week after we conducted our April 2012 tour, Jail staff told us that OPP was closing the House of Detention, where some of the most atrocious physical plant deficiencies have existed. This closure marks a significant step forward but is a fraction of the comprehensive reform necessary to ensure that OPP provides protection, care, and treatment to prisoners in a manner that comports with the Constitution.

Inadequate Suicide Prevention

Suicide prevention measures at OPP are grossly inadequate, resulting in unnecessary suffering and very likely leading to at least five suicides since our findings letter in 2009. The Jail has inadequate mechanisms to identify suicidal prisoners, inadequate treatment and staffing, and poor training of officers. Prisoners identified as being at risk for self harm are subjected to inhumane treatment that discourages them from seeking help, including the placement of groups of prisoners in a cramped, filthy "suicide tank" with no bed or toilet.

Inadequate Mental Health Care and Access to Medical Care

OPP is deliberately indifferent to prisoners with serious medical and mental health needs. The Jail has inadequate mechanisms to identify prisoners with mental illness, and too few treatment staff members to address urgent and chronic conditions. Prisoners with physical illness, either emergent or chronic, experience unreasonable barriers in accessing care. As a result, prisoners suffer during their incarceration and are returned to the community, in far too many cases, sicker and less equipped to avoid future involvement with the criminal justice system than when they entered.

Concerns regarding Inadequate Services to Limited English Proficient Individuals

As a recipient of federal financial assistance, OPP has agreed to abide by terms of Title VI of the Civil Rights Act of 1964 that prohibit discrimination on the basis of race, color, or national origin (including limited English proficiency). Our site visit revealed significant issues with respect to the ability of limited English proficient ("LEP") prisoners to communicate their needs to facility staff. For example, we observed no mechanisms to identify LEP prisoners, track them during their incarceration, or ensure that they are protected and receive necessary services. OPP also has very few bilingual staff and none in Templeman V, where many Spanish-speaking LEP Department of Homeland Security ("DHS") detainees are housed. Monolingual Spanish-speaking prisoners also report being asked to sign documents in English without the benefit of a written translation or interpreter. OPP also lacks grievances forms in Spanish, hampering prisoners' ability to voice concerns and complaints.

II. Urgent Unconstitutional Conditions Requiring Emergency Action

The conditions in OPP fail to meet the most basic obligation of prison officials to provide humane conditions of confinement. *See Farmer v. Brennan*, 511 U.S. 825, 832 (1994). The conduct of officials at OPP evinces deliberate indifference to basic needs, including safety and necessary treatment for serious medical and mental health needs. *Id.* The conditions we found clearly meet both the subjective and objective components of the deliberate indifference test. OPP has long known of conditions – at a minimum, since our exit briefings following our 2008 site visits and our 2009 findings letter – and has disregarded the harm and risk of harm the conditions create. *Farmer*, 511 U.S. at 833.

A. Inadequate Protection from Violence and Sexual Assault

Prisoners confined to OPP are unreasonably vulnerable to assault, including rape, by other prisoners, and excessive force by staff.

1. Prisoner-on-Prisoner Violence and Sexual Assault

OPP has failed to take reasonable measures to protect prisoners from violence at the hands of other prisoners. Prison conditions may be restrictive and even harsh, but gratuitously allowing a prisoner to be beaten or raped "serves no 'legitimate penological objective,' any more than it squares with 'evolving standards of decency.'" *Farmer*, 511 U.S. at 833-34 (citing *Rhodes v. Chapman*,452 U.S. 337 (1981)). Further, being violently assaulted in prison is simply not "part of the penalty that criminal offenders pay for their offenses against society." *Id*. OPP officials have a duty to protect prisoners from violence at the hands of other prisoners. *Farmer*, 511 U.S. at 832-833; *Longoria v. Texas*, 473 F.3d 586, 592 (5th Cir. 2006).

Consistent with our September 2009 letter, we found a high incidence of prisoner-on-prisoner violence at OPP, particularly in the HOD and Tents units, creating a climate of fear that is tolerated by staff at all levels of the institution. For example, during our inspection, we met with one prisoner who described his housing unit as a "little warzone." Another prisoner explained that deputies just "let fights happen." He told us that another prisoner stabbed him after staff knowingly placed him in a "tank" or cell with another prisoner who had a disagreement with him and a shank. When he complained to the Warden, he was told that they were "grown men" and should not be complaining. Many other prisoners we met provided similar stories, and staff confirmed that OPP operates with a climate of fear and violence.

Further, sexual violence is pervasive throughout the jail. A recent report by the DOJ Office of Justice Programs (OJP) confirms this conclusion reached from interviews and records review (OJP).[3] A survey of prisoners conducted by the Bureau of Justice Statistics ("BJS") revealed that 7.5% of OPP prisoners had experienced sexual assault while incarcerated.[4] OJP's Review Panel on Prison Rape singled out OPP and reported that it is "is deeply disturbed by the apparent culture of violence at OPP." OJP PREA Report at 82. The OJP Panel heard testimony from OPP officials and interested parties, including one former prisoner who testified that he was orally and anally gang raped "so many times [he] lost count," and his grievances reporting the rapes went unaddressed. OJP PREA Report at 76-78.

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[3] The Review Panel on Prison Rape of DOJ's Office of Justice Programs issued an April 2012 "Report on Sexual Victimization in Prisons and Jails" ("OJP PREA Report"). The OJP PREA Report is available at www.ojp.usdoj.gov/reviewpanel/pdfs/prea_finalreport_2012.pdf. In the OJP PREA Report, OJP explains that it selected OPP as a "high-incidence" facility in its effort to highlight female facilities and because the Bureau of Justice Statistics had also identified OPP as "having one of the highest rates of prisoner-on-prisoner sexual victimization."

[4] See OJP PREA Report at 4-5. See also Bureau of Justice Statistics Report, "Sexual Victimization in Prisons and Jails Reported by Prisoners, 2008-2009 (January 2010) (A. Beck et al.), available at http://bjs.ojp.usdoj.gov/content/pub/pdf/svpjri0809.pdf.

The high level of violence is confirmed by OPP's Special Operations Division ("SOD"). In 2011, SOD conducted approximately 411 criminal investigations. Of the 411, at least 66 were related to physical altercations between prisoners. The 66 cases are further broken down as follows: 28 cases involving second degree battery, 16 for aggravated battery, 14 for sexual assaults, six for simple battery, one for second degree battery, and one for aggravated assault. There were also 15 cases involving the carrying of a weapon (typically related to a prisoner carrying a shank). This level of prisoner-on-prisoner violence is alarming, and these statistics only represent those cases that rose to the level of a crime or a suspected crime.

This climate of fear and violence is caused by systemic deficiencies that are set out below:

a. Staff Members Fail to Respond to Serious Violence

Staff at OPP exacerbate dangerous situations and ignore prisoner pleas for help. During our visit we heard startlingly similar stories from a diverse set of prisoners. Prisoners we interviewed consistently allege that they were seriously injured or witnessed other prisoners get seriously injured after staff ignored fights or requests for help or even exacerbated the problem by placing prisoners in dangerous situations. The following examples illustrate the problem:

- A prisoner reported that in late September/early October 2011 he witnessed a fight between two prisoners during which one prisoner stabbed the other. Allegedly, the injured prisoner kept yelling out to a deputy by name, but the deputy did not respond**.**

- When prisoners seek protection, some staff respond in a manner that places the prisoners in danger. Two prisoners reported that when they made verbal complaints about other prisoners, a security staff member yelled, "Stop snitching!" or "Stop ratting!" A white prisoner stated that when he approached a staff member, the staff member responded loudly calling him "Aryan Brotherhood" in front of other prisoners.

- At least two prisoners stated that when a fight or incident occurs a deputy on watch will say that he or she will not call a senior officer or that he or she does not want to be bothered with the "paperwork" required to document an incident. Another prisoner explained that a security staff member in a bubble told the unit, "I'm going to sleep so don't knock on the window."

- A prisoner explained that when he called for help after being stabbed, the deputy failed to respond for an extended period. When the deputy finally responded, he did not call for help or medical assistance. The injured prisoner never received medical care, only some Vaseline from another prisoner to stop the bleeding. Fortunately, the wound was not serious. The injured prisoner claimed that based on this incident he filed a grievance but never received a response. The prisoner who had stabbed him was eventually moved to another unit.

These incidents reveal serious deficiencies in policy, staff training and accountability.

b. Inadequate Staffing and Prisoner Supervision

Staffing levels at OPP continue to be inadequate to protect prisoners from harm. Consistent with our on-site inspections in 2008, we found instances in which a single officer was required to supervise an entire pod of more than 80 prisoners for a 12-hour shift. Despite being fully aware of the most problematic buildings, OPP fails to adequately staff buildings plagued by a high frequency of injuries to prisoners by other prisoners. This poses a serious threat to both prisoners and staff.

Exacerbating staffing shortages, we found that OPP continues to operate without a staffing plan. A staffing analysis and resulting staffing plan are vital in determining supervision posts, the span of control for each post, and what posts are essential to adequately staff OPP. During our April 2012 site visit, we visited various units on one day and observed the following unreasoned and dangerous staffing patterns:

- The "Tents" are dormitory or "open-bay-style" housing with multiple double bunks. The Tents house between 60-88 prisoners per unit. On one day during our tour, there were 417 prisoners housed in the various Tents. Each Tent had one deputy assigned to it. The ratio of deputy to prisoners was approximately 1 to 60 to 88 prisoners.

- HOD is a multi-story building that is several decades old and has approximately 10 floors. On the day of our visit, HOD had approximately 665 prisoners. Each floor has four separate cellblocks in a linear style arrangement. Each cell block has multi-occupancy cells. The typical staffing deployment consists of one deputy per floor. Each floor has four individual cellblocks with up to 30 prisoners per cellblock. With the exception of the 10^{th} and 8^{th} floors, the ratio of deputies to prisoners is approximately one deputy to 120 prisoners if all beds are filled.

- Old Parish Prison is a multi-story building that was built in 1927 and was the original facility. It has multi-occupancy cells and dormitories ranging from four to 48 beds and houses maximum security prisoners. This building has a maximum capacity of 831 and on the day of the visit, there were 701 prisoners housed there. There are 22 security staff (deputies and supervisors) during the 12-hour day shift and 18 security staff (deputies and supervisors) during the night shift. There is typically one deputy assigned to each cellblock consisting of 20 to 48 prisoners. The ratio of deputies to prisoners varies according to the style of the cellblock, ranging from one deputy to 20 to 48 prisoners. Contrary to expected practice, OPP continues to house maximum security prisoners in multi-occupancy cells in this facility.[5]

[5] American Correctional Standards ("ACA") guidelines are instructive regarding housing of various prisoner classifications. They specify that minimum security prisoners can be housed in dormitory styled housing, cubicles, or rooms. Medium security prisoners can be housed in rooms and/or multiple occupancy cells and/or dormitories. Finally, maximum security prisoners should be housed in single cells, very secure units with heavy duty hardware. Currently, OPP does not adhere to these prisoner classification and housing principles.

- The Temporary Detention Center ("TDC") was opened on February 29, 2012. This facility has a capacity of 500 beds. During our tour, 386 prisoners were housed there. According to the facility Warden, there are 23 deputies and six watch commanders assigned to the TDC. Each building at TDC has two dormitories with one raised housing control center that can oversee two 64-66 prisoner dorms. Some of the dorms have four secure cells within the dormitory. There are typically two deputies assigned to each housing unit. The approximate ratio of deputy to prisoners at TDC is one deputy to 65 prisoners.

As a consequence of the inadequate staffing, deputies only walk into the housing units approximately twice a day during a 12-hour shift. When a fight or disturbance occurs, all the deputy can do is call for assistance and wait. Such inadequate staffing results in a failure by OPP to keep its prisoners reasonably safe. Due perhaps to the lack of staffing, OPP relies on the dangerous practice of "Tier Reps," discussed further below, to control and watch prisoners.

c. Inappropriate Use of Tier Reps

A "Tier Rep" is a prisoner from a particular housing unit, tier, or floor who serves ostensibly as another pair of eyes and hands for OPP. This practice is dangerous and discouraged.[6] Prisoners should never be used to replace the role of a security staff member. Tier Reps are used at OPP to maintain order, de-escalate fights, designate clean-up duties, and in some instances hand out grievance forms and sick call forms. Tier Reps thus have an inappropriate amount of power and control over other prisoners. The following are examples of the breadth of power a Tier Rep can wield and its consequences to other prisoners:

- Tier Reps and their "crew" are tasked with dispensing food to the other prisoners because OPP does not provide individual prisoner trays. This gives Tier Reps an inappropriate amount of power over other prisoners.

- Because OPP's mechanisms to disburse and receive both sick call slips and grievance forms are inadequate (discussed further below), some Tier Reps hoard blank forms and disperse them to prisoners they favor but decline to provide the forms to others.

- When arguments or violence breaks out between prisoners, a Tier Rep sometimes intervenes to "keep the peace." If the Tier Rep is unable to resolve the situation, a Tier Rep can suggest which prisoner needs to be moved. Movement and housing of prisoners should be determined by OPP staff only.

[6] ACA 4-ALDF-2A-9. "No prisoner or group of prisoners is given control, or allowed to exert authority, over other prisoners." See ACA 4-ALDF-2A-09.

d. Failure to Detect Weapons

Prisoners and staff report that OPP is awash in weapons. So far this year, through early April, SOD has recovered at least 47 shanks, according to their planned shakedown log. During this same time period, SOD found other items that could be used as weapons such as metal pipes and electrical cords in addition to contraband that had no place in a prison cell such as cell phones and lighters. Statements from prisoners indicate that weapons recovered are likely only a fraction of the weapons circulating through the facility. The volume of weapons in the facility and the level of violence reflect failures in procedures to prevent weapons from coming into OPP and in basic procedures, including sufficient shakedowns, to detect them and remove them from circulation.

Separately, our corrections expert noted that OPP has a false sense of security based on its use of a "BOSS III" chair in the Intake and Processing Center. The Boss III chair is designed to detect whether an individual is carrying a metal object. However, when our expert sat in the chair, the device failed to detect our expert's cell phone and keys. Similarly, when a rank officer sat in the chair it did not detect his keys, cell phone, and other metal objects on his person. Consequently, OPP should consider replacing, repairing, or at the very least re-calibrating the chair and any other instruments it uses to detect metal.

e. Inappropriate Commingling of Violent and Non-Violent Prisoners

OPP fails to properly classify prisoners to reduce the risk of violence. Up until one month ago, OPP continued to use the same deficient classification system we found in 2009. Specifically, OPP relied on a charge-based classification scheme that used the amount of a prisoner's bond as the primary classification factor for general population prisoners (aside from separation of prisoners based on gender). The prior system did not consider the prisoner's prior convictions, prior assaultive behavior, or true potential for violence. As a result, prisoners with varying degrees of classification (low-level offenders and serious-violent offenders) were assigned to the same housing unit.

In March 2012, OPP revised its classification system to use two main questionnaires. First, the new OPP classification system uses a Prison Rape Elimination Act ("PREA") survey and second, an OPP-specific "security" question form. While the new classification system is objective and thus an improvement, we remain concerned about prisoner safety because there is no existing mechanism to re-assess and re-classify individuals already at OPP. Accordingly, there remains a high risk of serious injury from prisoner-on-prisoner violence based on inadequacies of the prior classification system.

2. Failure to Prevent, Detect, and Correct Excessive Use of Force and Officer Misconduct

In 2009, we found a pattern or practice of unnecessary and inappropriate uses of force by OPP correctional officers, in violation of the Constitution's requirement that any force used be proportionate to the threat posed by the prisoner. *Hudson v. McMillian*, 503 U.S. 1, 7 (1992). We found several examples where OPP officers openly engaged in abusive and retaliatory

conduct, which resulted in serious injuries to prisoners. Our corrections expert found that the officers' conduct was so flagrant it clearly constituted calculated abuse.

OPP does not appear to have implemented any new systems to prevent, detect, or correct patterns of excessive use of force. This failure permits the officer misconduct that contributes to the persistent dangerous conditions in OPP. For example:

- In September 2011, a deputy forced a prisoner to perform oral sex. The prisoner alleged that the deputy falsely claimed the prisoner had a sick call visit, placed him in handcuffs, removed him from the cell, and escorted him into a closet outside the tier, where he forced the prisoner to perform oral sex. The prisoner further stated that earlier that day, the same deputy had asked two prisoners to have sex with each other so that the deputy could watch.

- In July 2011, officers beat a prisoner in the Tents. According to OPP reports, the prisoner and OPP officers had a verbal altercation that escalated into a physical confrontation. The officers involved in the battery indicated that the prisoner had attacked them, but a video revealed that the officers beat the prisoner with closed fists. SOD reviewed this incident and found that the officers used excessive force. The officers involved in the battery and following cover-up were suspended then later fired for beating the prisoner. However, OPP later rehired the officer fired for filing a false report.

- In August 2010, a prisoner committed suicide one day after an officer beat him. The prisoner was in his locked cell when an officer ordered him to move away from the gate. When he refused, the officers sprayed chemical agents into his cell. The officer then opened the prisoner's cell door. Once the cell door was opened, the prisoner came out of his cell. Once out of his cell, the prisoner was again sprayed with foam spray and physically assaulted by several officers. The prisoner was then taken to HOD-10 for medical attention. One day later, the prisoner killed himself. SOD confirmed the officer's assault on the prisoner.

a. Gaps in Investigations

Investigations of OPP staff are handled by two different offices, SOD, which investigates criminal misconduct, and the Internal Affairs Division ("IAD"), which is tasked with investigating administrative violations of OPP policies and procedures. This system as it currently works, however, results in OPP failing to adequately identify and investigate misconduct. SOD has the authority to initiate an investigation on its own based on documents it receives – medical referral forms, use of force reports, and incident reports – as well as after receiving a direct referral from the Warden. IAD, on the other hand, does not receive these documents, does not receive referrals from SOD, and does not have access to the same Jail Management System ("JMS") as SOD.[7] Consequently, IAD and SOD do not communicate at a level necessary to ensure that both administrative and criminal misconduct by staff is

[7] Further, while Incident Reports ("IRs") are on JMS, the newly created Use of Force ("UOF") reports are not. Both IRs and UOF reports should be on JMS and available to SOD and IAD.

investigated and all responsible staff are held accountable. The current practice dictates that IAD does not receive any referrals from SOD that pertain to: (1) prisoner-on-prisoner violence, (2) sexual assaults, (3) suicides, or (4) use of force incidents. When SOD determines that an incident in one of these four areas does not rise to the level of a criminal investigation, IAD is not consulted and OPP misses a key opportunity to identify staff who may have violated OPP policies and should be subject to administrative review and discipline.

SOD also investigates prisoner-on-prisoner incidents, mainly violence, to determine if criminal charges against a prisoner would be appropriate, but it excludes many serious incidents.[8] When investigating prisoner-on-prisoner violence, the threshold for conducting a criminal investigation is whether a "significant injury" has occurred. We were informed by OPP that this "significant injury" standard is interpreted to mean whether the injured prisoner received stitches. This standard is not documented or memorialized in any policy that we reviewed and is too narrow to capture all serious acts of violence. SOD also inappropriately closes cases in which the victim prisoner refuses to cooperate, regardless of the level of injury. It is not surprising that prisoners would refuse to cooperate because any kind of cooperation could put them in further physical risk. OPP needs to do more to ensure that all acts of violence are fully investigated and the perpetrators are not in a position to re-offend. OPP also fails to forward matters where the victim prisoner fails to cooperate to IAD. By failing to communicate and forward such information to IAD, SOD, and OPP as a whole fail to protect prisoners from further violence.

b. Failure to Track Staff Misconduct in an Efficient and Effective Manner

OPP's investigatory deficiencies are compounded by its lack of a functional officer early warning system to identify patterns of conduct (example: high level of violence) or individuals (example: deputy who is involved in various incidents in a short period of time) and respond proactively. SOD tracks its criminal investigations on its "VANTOS" system. The system is a critical tool for SOD to quickly find information which relates to a particular deputy. However, VANTOS does not allow for filtering of information to easily identify how many times a particular deputy was the focus of an investigation. Nor does VANTOS have an automatic setting to alert SOD when a deputy has reached a predetermined number of complaints against him or her, has been investigated a certain number of times, has used forced against prisoners, or has been a witness to potential misconduct. In short, OPP fails to have any form of useable early warning system to identify any specific individuals or trends in shifts, housing units, or types of violence.

3. Failure to Provide a Functional Grievance System

As we found in 2009 and as highlighted in the OJP PREA Report, OPP continues to lack a functional prisoner grievance system. A prisoner grievance system is a fundamental mechanism for allowing prisoners to raise conditions of confinement related concerns and issues to administrative staff. If viewed as credible by prisoners, a grievance system can serve as a

[8] SOD also investigates charges against prisoners that do not involve violence but a violation of OPP rules. For example, SOD would investigate if a prisoner was found to possess contraband (cell phone, weapon, or narcotics).

source of intelligence to security staff regarding potential security breaches as well as staff excessive force or other misconduct. The grievance system should be readily accessible to all prisoners and not dependent on staff to provide blank forms or pass the grievance along to the grievance coordinator. Prisoners should be able to file their grievances in a secure and confidential manner, without the threat of reprisals. Staff responsible for answering prisoner grievances should do it in a responsive and prompt manner.

The grievance process at OPP does not meet any of these criteria because: (1) there is no accountability or tracking of all grievances that are submitted; (2) grievances and requests for services are submitted on the same form; (3) grievance forms are not readily available to prisoners without going through either a staff member, the mail delivery person, or a Tier Rep; and (4) responses to grievances are not handled in a private manner. Consequently, the grievance system fails to provide prisoners with a safe avenue to voice their concerns or complaints. Similarly, OPP staff are unable to use the grievance system as a source of intelligence about possible staff misconduct, violence, or other issues at OPP.

B. Grossly Inadequate Suicide Prevention Practices

As we found in 2009, OPP is deliberately indifferent to the risk of prisoner suicide. The Constitution requires OPP to protect prisoners from suicide and self-harm. *See Partridge v. Two Unknown Police Officers of the City of Houston*, 791 F2d. 1182, 1187 (5th Cir. 1986) (holding that a failure to take action to save suicidal prisoners from self-harm may constitute a constitutional violation). In determining the adequacy of a mental health care program, the Fifth Circuit holistically assesses the prisoner's conditions of confinement. *Gates v. Cook*, 376 F.3d 323, 343 (5th Cir. 2004) (acknowledging that "the isolation and idleness of Death Row combined with the squalor, poor hygiene, temperature, and noise of extremely psychotic prisoners create an environment 'toxic' to the prisoners' mental health."). The suicide prevention practices at OPP are grossly inadequate and pose a grave risk of deadly harm to suicidal prisoners.

Treatment staff that we interviewed reported that there have been five completed suicides in the past two years. In two of these suicides, deficient monitoring contributed to the prisoners' suicides. In one of these two, a prisoner was supposedly monitored by correctional officers using closed-caption camera, and in the other, the prisoner was supposedly under direct visual monitoring. Aside from OPP's grossly inadequate monitoring practices, we also found that inhumane conditions for suicidal prisoners deter identification and exacerbate mental illness.

1. Inhumane Suicide Watch Conditions that Deter Identification and Exacerbate Mental Illness

OPP engages in a routine, punitive practice of placing suicidal prisoners in a "turtle suit"[9] in a crowded, filthy confinement cell called a "suicide tank" with no toilet, beds, blanket, sink, or telephone – simply three long benches along the walls of the cell. We observed prisoners sleeping on the floors with no mattresses or covering, and we also learned that prisoners often

[9] Every prisoner in the suicide tank was required to wear a "turtle suit," although not required by OPP policy. A turtle suit is a tear-resistant single piece of garment that is used to reduce the likelihood of suicide.

urinated and defecated in cups because they did not have appropriate access to the toilet. Beyond this, we further noted that the living conditions inside the suicide tank were deplorable – dirty floors, trash under benches, handcuffs attached to the legs of benches, dirty windows, and a pungent smell throughout the suicide tank. When asked about the deplorable conditions and the utility for using the suicide tank, OPP staff members argued that prisoners were required to keep the suicide tank clean and that housing suicidal prisoners in such a manner created an environment for "support and encouragement." OPP reportedly began housing prisoners in the "suicide tank" following an incident in which a suicidal prisoner attacked a correctional officer.

Neither medical nor mental health staff are consulted before a prisoner is placed in the suicide tank. Prisoners are not evaluated for level of suicide risk, level of supervision, or whether they need to be transferred to an outpatient mental health facility (which is apparently unavailable regardless of the need). Thus, prisoners housed in these horrific conditions are both over- and under-identified as compared to the population of prisoners requiring treatment and suicide watch.

Prisoners are placed in the suicide tank until mental health staff are able to conduct an evaluation, which typically occurs many hours later. This delay is especially prevalent when prisoners are sent to the suicide tank after the psychiatrist leaves for the day. On these occasions, prisoners typically wait prolonged periods before they assessment to determine if placement is necessary. OPP's practice is anti-therapeutic and only enhances isolation, depriving prisoners of meaningful social interactions and increasing the risk of suicide. OPP's practice of isolating prisoners can also contribute to the difficulty in obtaining critical information to determine the source of suicidal ideation, and creates an environment where prisoners are reluctant to communicate with medical staff. When interviewed, prisoners on the psychiatric floors of OPP reported that they were reluctant to report suicidal ideation because they did not want to be placed in the suicide tank. Prisoners view the suicide tank as a punishment rather than an acceptable option for mental health treatment.

Further troubling, we noted that once prisoners were placed on suicide watch, the mental health evaluations were cursory and rarely addressed suicide risk issues. Prisoners languish in the suicide tank while the psychiatrist focuses on determining whether they are malingering. We found examples of prisoners who remained on suicide precautions for more than five weeks. During these extended periods of isolation, we found that prisoners did not receive meaningful treatment, aside from being medicated and monitored. OPP also neither carefully evaluates prisoners before removing them from suicide watch, nor has any stepdown program. Instead, OPP inappropriately relies on "contracts for safety" in which prisoners agree not to harm themselves if they leave the suicide tank. This is clearly contrary to generally accepted correctional mental health care standards.

2. Failure to adequately monitor prisoners on suicide watch

In addition to deterring suicidal prisoners from seeking help due to the inhumane conditions provided for suicidal prisoners, we found that OPP fails to adequately monitor its prisoners on suicide watch. At a minimum, OPP should have "a basic program for the identification, treatment, and supervision of prisoners with suicidal tendencies." *See Ruiz v.*

Estelle, 503 F. Supp. 1265, 1339 (S.D. Tex. 1990) *aff'd in part and rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982).

Although OPP's policy requires correctional officers to directly observe and document prisoner activity every 15 minutes, we observed and found clear violations of this policy. While on site, we observed that only one officer was assigned to monitor everyone on suicide watch without anyone to relieve him. We further observed at least one instance when he left his assigned monitoring post in order to escort another prisoner, who was not on suicide watch. Once the correctional officer left, the prisoners on suicide watch were left unmonitored. This example is emblematic of the deep-rooted monitoring problems that we found at the jail. The following example best illustrates how lapses in monitoring have led to deadly harm:

- In August 2011, a 48-year-old man committed suicide by asphyxiation after swallowing toilet paper. He was evaluated and placed in general population before being placed on suicide watch. While on suicide watch, he was placed in a two-person cell with another prisoner, and a correctional officer was assigned to constantly observe his behavior to ensure that he did not attempt to cause self-harm. The correctional officer left him unmonitored for five hours, and it appears that no other officer or supervisor monitored or even conducted a check of his cell. During these five hours, he swallowed enough toilet paper to kill himself. This incident is an egregious example of OPP's inadequate monitoring and supervision practices that contributed to his death.

These monitoring lapses magnify the need for OPP to ensure that correctional officers, responsible for constantly monitoring prisoners on suicide precautions, receive adequate training and understand the importance of monitoring suicidal prisoners. Moreover, these examples highlight the unacceptably low staffing levels at the facility that have contributed to the harm and risk of harm that we found throughout the facility.

C. Constitutionally Inadequate Mental Health Care and Access to Medical Care

OPP continues to lack the appropriate staff and structure to provide constitutionally adequate mental health care. OPP's mental health services continue to be deficient in the following areas: (1) evaluation and screening; (2) staffing; (3) assessment and treatment; (4) treatment planning; and (5) quality assurance review. These deficient OPP practices cause prisoners serious harm and create an unreasonable risk of harm.

Prisoners have a constitutional right to adequate medical and mental health care, including psychological and psychiatric services. *Farmer*, 511 U.S. at 832; *Gates*, 376 F.3d at 332 (holding that "mental health needs are no less serious than physical needs"). Jail officials violate the constitutional rights of prisoners if they are deliberately indifferent to their serious medical needs, including prisoners' psychological needs. *Estelle v. Gamble*, 429 U.S. 97, 107 (1976); *See Hare v. City of Corinth*, 74 F.3d 633, 650 (5th Cir. 1996) (en banc).

1. Inadequate mental health screenings and referrals

OPP fails to adequately identify prisoners who require mental health services. The Constitution protects prisoners from not only ongoing harms, but also from the risk of future harm. *Helling v. McKinney*, 509 U.S. 25, 33 (1993). The shockingly low number of prisoners receiving mental health care at OPP reflects a system-wide breakdown in identifying prisoners in need of treatment. During our review, we noted that just over 200 prisoners were on the mental health case load, approximately 6% of OPP's prisoner population. In contrast, the national average for city jails with OPP's population is 18-30%. Even though OPP's mental health caseload is one-third the national average, we found that over half of the 200 prisoners under the psychiatrist's care were prescribed solely antipsychotics. The absence of anti-depressant, anti-anxiety, and more commonly prescribed psychotropic medications – combined with the lack of any non-medication behavioral therapy - suggests that prisoners with serious depression, anxiety, and other serious mental illness simply are not being treated.

OPP gives untrained Licensed Practical Nurses ("LPNs") the primary responsibility of completing initial medical screenings. During our tour, we found that LPNs were allowed to complete these screenings even though they did not have sufficient mental health training to adequately assess prisoners' mental health needs. As a result, we found examples where prisoners who should have been identified during the screening process were not referred to the psychiatrist and later committed suicide:

- In August 2011, a prisoner was sent to general population even after he reported during his initial screening that he had a history of mental illness, had suicidal thoughts, and was currently taking anti-anxiety medications. Instead of referring him to the psychiatrist, he was placed in general population. Less than six hours after being placed in general population, he had to be placed on suicide watch. Less than one week later, he committed suicide.

- In April 2010, a prisoner committed suicide in the Intake Processing Center. Although he reported a history of drug use, including swallowing cocaine before he was arrested, OPP staff failed to refer him to a psychiatrist. Instead, he remained in the intake area and continued to behave erratically (running around intake and trying to walk out of the jail). He was later placed in an isolation/holding cell where he was supposed to be closely monitored by closed-caption camera. Less than 45 minutes after being placed in the isolation/holding cell, he hanged himself by tying his shirt around his neck. OPP's failure to properly screen and monitor likely contributed to his death.

- In July 2010, less than 24 hours after being admitted, a prisoner committed suicide by tying a towel around his neck. Although he showed risk factors for suicide, he was placed in general population before being assessed by the psychiatrist. Before committing suicide, he reportedly screamed throughout the night and banged on his cell bars constantly, yet staff failed to respond. Even after multiple prisoners repeatedly pressed the intercom button, banged on the tier door, and jumped in front of the supervision camera, staff still did not respond to his cell. He reportedly attempted to harm himself multiple

times, before he was finally able to tie a towel around his neck and commit suicide. He had been dead for 10 minutes before staff finally came to his cell.

2. Inadequate Mental Health Treatment

A major reason for OPP's failure to deliver adequate mental health and suicide prevention is that there are simply too few staff to provide care. A correctional mental health program must include "the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individual manner those treatable prisoners suffering from serious mental disorders." *See Ruiz*, 503 F. Supp. at 1339. At the time of our tour, OPP employed one full-time psychiatrist, one social worker, and four LPNs, who were supervised by one registered nurse. OPP's mental health staff is grossly inadequate to handle OPP's daily population of about 2,900 prisoners. According to OPP's data, the psychiatrist reportedly works between 40-50 hour a week and has around 600 instance of care per month, excluding face-to-face visits. It is unsurprising that the psychiatrist simply does not have enough time to treat prisoners with serious mental illness.

In fact, we found that the psychiatrist is primarily writing prescriptions and monitoring prisoners on suicide watch. Even when prescriptions were ordered, we found that the psychiatrist had not evaluated prisoners before ordering or changing prescriptions. He instead reviewed previous incarceration records and prescribed similar medications consistent with past practices. This practice ultimately led to prisoners being prescribed medications with little regard to current mental health complaints. We also found examples where the psychiatrist had completely changed medication prescriptions and regimens without conducting a mental health evaluation.

Understaffing currently limits OPP to a reactive, overburdened mental health crisis program that fails to provide constitutionally required treatment. Through our discussions with prisoners, staff members, and record review, we found that staffing shortages have resulted in unreasonable delays in the delivery of care. OPP's mental health program does not extend beyond administering medications. Nor does anyone monitor the approximately 80 prisoners receiving second-generation antipsychotics for metabolic syndrome, contrary to generally accepted standards of care. We further found examples where the psychiatrist could not complete mental health evaluations because of time restraints. This problem is further exacerbated by OPP's lack of other mental health professionals to assist with evaluations, resulting in hundreds of prisoners not receiving the care they need.

Perhaps because of extreme short staffing, OPP also authorizes LPNs to perform duties far outside the scope of their training, expertise, or capacity for judgment. For example, LPNs are being authorized to administer involuntary intra-muscular medications pursuant to standing orders on an "as needed" basis. Absent a formal declaration of an emergency, intra-muscular medications should not be administered against a prisoner's will. And even then, medications should only be administered under the direct supervision of a physician. OPP's practice is dangerous and contrary to accepted standards.

Although OPP has a full-time social worker, the social worker is only able to devote half of his time working with prisoners suffering from mental illness. We found that OPP failed to

provide any mental health programs or counseling sessions designed to address substance or physical abuse, mental illness, or medication education. Furthermore, we noted that OPP did not offer group therapies or multi-disciplinary treatment planning. As a result, we found many instances where prisoners were unaware of specific medications prescribed, prisoners did not have any formal outlets to discuss problems, and prisoners did not have any programs that discussed successful return to the community. OPP was limited in offering such programs because there is insufficient staff to provide these services. Deadly harm has resulted:

- In October 2009, a prisoner reported a history of severe mental illness. Despite his history, it appears that his conditions steadily declined at the facility. As he lost weight, refused to eat, and refused medications, OPP staff took no action to address his deteriorating condition. Although alternative treatment options were available, staff simply watched as he continued to lose weight and become depressed. Still, OPP staff did not take any proactive steps to address his needs. Less than four months after admission, he died from physical complications of dehydration and inactivity, likely caused by OPP's failure to take steps to manage his condition.

Although treatment planning is necessary for providing care to prisoners with mental illness and the National Commission on Correctional Health Care requires treatment plans for prisoners with mental illness, OPP has yet to implement this crucial treatment mechanism. During our review of medical records, we noted that none of the charts that we reviewed contained treatment plans. As a result, we found that OPP was unable to provide appropriate care to prisoners who required close supervision or multidisciplinary care. Treatment plans should be developed once a condition is identified and then updated as warranted. Treatment plans should also be individualized and created by a multidisciplinary team to ensure that prisoners' needs are addressed. Most importantly, treatment plans should serve as the road map for determining what treatment and course of therapy is necessary to ensure that prisoners receive appropriate care. OPP does none of these things and fails to give prisoners access to a minimally acceptable range of mental health services.

3. Inadequate Access to Medical Care from Deficient Sick Call Process

OPP's broken sick call process prevents prisoners from having timely and adequate access to health care. Delays of health care can constitute an Eighth Amendment violation "if there has been deliberate indifference that results in substantial harm." *Easter v. Powell*, 467 F.3d 459, 463 (5th Cir. 2006). OPP's sick call process fails to adequately collect, process, and track sick call requests. Indeed, there is no standardized process for accessing sick call requests. We instead found that prisoners received sick call request forms from deputies, Tier Reps, nursing staff, and even the mail lady. This antiquated request model inhibits prisoners from having access to health care. Unsurprisingly, we consistently heard complaints that requests still were not answered and appointments were never scheduled.

We also found that OPP did not review sick call requests on a daily basis. We noted that prisoners waited several days in many instances before their requests were reviewed. When questioned, nursing staff admitted that they were unable to review sick call requests at every housing unit because of staffing shortages. And we found that even when nursing staff went to different housing units to review sick call requests, nursing staff triaged the sick call request and

only responded to some requests. This is unacceptable and creates a culture where nursing staff select, without adequate training or professional judgment, which prisoners receive care. Because OPP does not have a system to track and log prisoner requests for health care, these problems with access to care will continue to persist.

We also learned that limited English proficiency prisoners experienced additional delays in access to care because OPP does not have staff to address their needs. Although OPP provides sick call requests forms in Spanish, we found that OPP did not have any nursing staff or a qualified interpreter who could discuss medical complaints or issues with this population at the Jail. We noted a practice at OPP where other prisoners assisted in answering questions and conveying medical complaints to OPP staff. This practice violates prisoner confidentiality, is unreliable, and needs to be discontinued to ensure that these prisoners receive appropriate access to health care.

4. Inadequate Quality Assurance Review

OPP continues not to have a consistent and effective process for quality improvement. Correctional facilities should have a structured process in place to identify areas that need improvement and to ensure accountability for errors that lead to grievous harm. *See generally Helling*, 509 U.S. at 33 (finding that prison authorities may not ignore a condition that is likely to cause future harm). OPP does not have a system that monitors high-risk, high-volume, or problem-prone aspects of mental health care at the Facility.

Although OPP has a Quality Improvement Committee, we were unable to find any evidence that it monitored the quality of mental health care or developed plans for improvement based on trends at the Jail. In fact, we noted that OPP failed to follow, measure, or document the quality or timeliness of critical mental health processes such as assessments, suicide prevention evaluations, suicide management, medication management, and treatment services. Because OPP is not tracking and analyzing critical data related to the provision of mental health care at the facility, we note that the reduction of future suicides or other crisis-related outcomes will be highly unlikely. These reviews are necessary to ensure the effectiveness of the mental health care and to implement corrective action so that the quality is improved.

III. Concerns Regarding Inadequate Services to Limited English Proficient Individuals

As noted, since the initiation of the instant investigation and the release of our letter of findings in 2009, additional concerns relating to OPP's compliance with Title VI of the Civil Rights Act of 1964 have come to our attention. Through this letter, we hope to advise OPP of its Title VI obligations and related corrective measures. Title VI of the Civil Rights Act of 1964 ("Title VI") authorizes the United States to initiate civil litigation in federal court for injunctive relief against a recipient of federal assistance whose program or activity violates Title VI or its implementing regulations. 42 U.S.C. § 2000d-1; 28 C.F.R. § 42.108. A recipient violates Title VI by discriminating on the basis of race, color, or national origin. Language access procedures are deemed to violate Title VI if they are intentionally discriminatory on the basis of their national origin or if the procedures have a discriminatory effect. 28 C.F.R. § 42.104(b)(2); *N.Y. Urban League, Inc. v. New York*, 71 F.3d 1031, 1036 (2d Cir. 1995); *Lau v. Nichols*, 414

U.S. 563, 569 (1974); *Sandoval v. Hagan*, 197 F.3d 484, 510-11 (11th Cir. 1999), rev'd on other grounds, 532 U.S. 275 (2001); *Almendares v. Palmer*, 284 F. Supp. 2d 799, 808 (N.D. Ohio 2003) (; *National Multi Housing Council v. Jackson*, 539 F. Supp. 2d 425, 430 (D.D.C. 2008).

OPP, as a recipient of federal assistance from DOJ, is subject to the requirements of Title VI. Further, OPP has been on notice of its legal obligation to treat limited English proficiency ("LEP") prisoners in a non-discriminatory manner. Pursuant to Executive Order 13166, each federal agency, in this case DOJ, that extends financial assistance is required to issue guidance explaining the obligations of their recipients to ensure meaningful access by LEP persons to their federally assisted programs and activities. See 65 Fed. Reg. 50,121 (August 16, 2000). In 2002, DOJ issued such guidance by providing non-discrimination/ LEP language access standards. These standards are applicable to correctional functions of law enforcement agencies receiving federal financial assistance, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 67 Fed. Reg. 41,455 (June 18, 2002) ("DOJ LEP Guidance"). When accepting grants from DOJ, recipients such as OPP sign contractual assurances promising to abide by Title VI nondiscrimination provisions, including those relating to meaningful access for limited English proficient individuals.

Our observations and the allegations we have received regarding the lack of meaningful access for Latino and other national origin minority LEP prisoners to the intake, processing, housing, and medical services at each of the OPP facilities raise serious concerns about the extent to which OPP's practices are consistent with its Title VI obligations.

According to U.S. Census Bureau, in 2010 the City of New Orleans had a total population of 325,543 individuals who are five years old and older.[10] Approximately 10.2% of these residents (33,205 individuals) spoke a language other than English at home.[11] When the 33,205 individuals were asked to rate how well they spoke English, approximately 11,987 (36.1%) answered that they spoke English "less than very well." These individuals would be considered LEP.[12]

In 2010, there were 16,206 individuals in New Orleans, over the age of five, who spoke "Spanish or Spanish Creole" and 12,636 of these individuals were between the ages of 18 and 64. Forty-five percent of this subgroup stated that they speak English "less than very well." Accordingly, they would also be considered LEP.[13] Because OPP estimates that 80% of their

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[10] See http://factfinder2.census.gov (Last Visited April 12, 2012)

[11] The 10.2% was further subcategorized into the following language groups: "Spanish or Spanish Creole" (5.0%), "Other Indo-European languages" (2.5%), "Asian and Pacific Island languages" (2.4%) and "Other languages" (.3%).

[12] See U.S. Census Bureau website: www.http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xthml?pid=table (last visited April 12, 2012).

[13] Id.

prisoners are local residents, there is a strong likelihood that OPP regularly encounters LEP individuals in their daily intake, processing, and housing of prisoners.

A. Lack of Competent Bilingual Staff and Interpreters

We did not observe LEP prisoners at OPP receiving meaningful access to programs and services. OPP has one bilingual classification staff member, very few, if any, bilingual security staff, and no bilingual medical or mental health staff. It does not appear that the language skills or competency of these self-identified staff members has been formally assessed or tested to ensure that they are competent in English and the target non-English language. Interpreter competency requires "more than self-identification as bilingual." DOJ LEP Guidance at 41461. A competent interpreter must demonstrate "proficiency in and ability to communicate information accurately in both English and in the other language and identify and employ the appropriate mode of interpreting," and have "knowledge in both languages of any specialized terms or concepts peculiar to the entity's program or activity." *Id.*

In many circumstances "other inmates or other detainees are not competent to provide quality and accurate interpretations..." DOJ LEP Guidance at 41462. Informal prisoner interpreters "should only be an option in unforeseeable emergency circumstances; when the LEP inmate signs a waiver that is in his/her language and in a form designed for him/her to understand; or where the topic of communication is not sensitive, confidential, important, or technical in nature and the prisoner is competent in the skill of interpreting." *Id.* The special circumstances of confinement "may raise additional serious concerns regarding the voluntary nature, conflicts of interest, and privacy issues surrounding the use of inmates and detainees as interpreters, particularly where an important right, benefit, service, disciplinary concern, or access to personal or law enforcement information is at stake." DOJ Guidance at 41462, n. 11.

Although the Templeman V building houses DHS ICE detainees who are nearly 100% LEP,[14] OPP has made no provision for language services to ensure communication with this population. None of the OPP staff working there – medical or security – are bilingual. The Warden at Templeman V admitted that sometimes they rely upon other prisoners to serve as interpreters. Security staff there admitted that they rely on other prisoners, use hand motions, or have to guess at what the prisoner is trying to communicate. Prisoners at Templeman V confirmed inadequate and inappropriate communication. Two LEP prisoners indicated that they are routinely either ridiculed or ignored when they seek help or attention from staff and speak in Spanish. One prisoner stated that OPP staff members call Latino prisoners "monkeys." Other former prisoners also confirmed that when they sought help, OPP staff completely ignored them.

The ability to communicate medical emergencies and needs is particularly essential. When we interviewed the nurse at Templeman V, she admitted that she does not speak Spanish and must rely on telephoning a doctor who is bilingual to interview prisoners. Based on our conversations with the nurse, however, it was unclear how regularly she contacts a bilingual doctor. We also observed that DHS ICE prisoners do not have ready access to sick call slips.

[14] The DHS ICE detainee unit can house a maximum of 30 detainees. When we visited in April 2012, there were at first a total of 19 ICE detainees, 18 of whom were LEP. Later that same day, there were three ICE detainees, all of whom were LEP.

Instead they must ask deputies, who admit they cannot understand when LEP prisoners speak to them.

Consequently, LEP individuals at OPP cannot communicate with security or medical staff and may have been denied meaningful access to medical and other services available to other prisoners. Our investigation also revealed instances in which OPP may not have provided LEP prisoners with medical services, on account of their inability to communicate with the medical staff. At a minimum, OPP needs to provide immediate access to staff or qualified interpreters who are competent and can communicate with prisoners regarding medical and other important needs.

B. Intake System in English Only

The intake system at OPP is almost exclusively in English and does not provide all vital materials in any language other than English. OPP provides two videos to prisoners arriving at OPP, neither of which is available in a language other than English. The first video, which runs 14 minutes, explains the intake and classification process. The second video, which runs 12 minutes, explains the general rules at the Jail for prisoners. Each video is shown in different parts of the Intake and Processing Unit. While OPP has a Jail "Information Sheet" in English and Spanish, it needs to give sufficient information to LEP prisoners regarding classification and intake and other basic information about Jail rules and how to access medical, grievance, and other services.

C. Forty-Eight Hour Holds

OPP's practices for processing 48-hour prisoner holds for U.S. Department of Homeland Security, Immigration and Citizenship Enforcement ("DHS ICE") are not tracked to ensure that holds do not exceed the maximum 48 hours. Instead, the OPP staff members responsible for managing these holds appear to rely upon memory or handwritten notes on files. While OPP may not receive many 48-hour hold requests in one day, the current OPP process is vulnerable to individuals "falling through the cracks." Additionally, OPP's current policy and procedure regarding processing the 48-hour holds time has not been memorialized into a written policy.

We spoke with former LEP prisoners who had been held by OPP beyond the maximum 48-hour hold period. They explained that when they attempted to ask staff about their 48-hour holds, they could not communicate because the staff could not understand what they were asking. Similarly, there was no available OPP staff person to interpret for them and explain what was occurring. OPP needs to implement a tracking mechanism and method for prisoners to report issues with 48-hour holds. Failure to adequately track these holds and provide staff who can communicate with LEP prisoners is inconsistent with OPP's Title VI obligations.

D. Documents in English Only

In addition to language barriers in verbally communicating with monolingual staff, OPP fails to translate important documents into Spanish for LEP prisoners. LEP prisoners throughout OPP reported that they were regularly asked to sign important forms written in English without

the aid of appropriate language assistance. Documents that have potential important consequences on a prisoner's rights or access to benefits or services are considered vital and need to be translated into frequently encountered LEP languages. See DOJ LEP Guidance at 41463-4. Sight translations of these documents can only be provided by competent staff or interpreters.

At Templeman V, we observed that DHS ICE detainees do not have ready access to sick call slips. Instead they must ask deputies, who admit they cannot understand when LEP prisoners speak to them. Grievance forms did not appear to be available at all at Templeman V, and OPP does not have grievance forms in Spanish in any of the facilities. As explained in the DOJ LEP Guidance, sick call and grievance forms would be considered vital documents and should be translated and available to LEP prisoners to ensure they are provided meaningful access to programs and services. See DOJ LEP Guidance at 41463-4.

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This letter is a public document. Accordingly, it will be posted on the Civil Rights Division's website. Please contact Special Counsel Laura Coon at 202-514-1089 or Trial Attorney Corey Sanders at 202-305-3229 to discuss the path forward. We remain committed to working with you to address these serious issues that affect the health, life, and safety of prisoners and staff and the public safety of the people of New Orleans.

Sincerely,

Jonathan M. Smith
Chief, Special Litigation Section
Civil Rights Division

cc: The Honorable Mitch Landrieu
Mayor
The City of New Orleans

Richard Cortizas, Esq.
Acting City Attorney
The City of New Orleans

The Honorable Jim Letten
United States Attorney
Eastern District of Louisiana