April 4, 2002

Ms. Ruth Carter
City of Detroit
Corporation Counsel
660 Woodward Avenue
1650 First National Building
Detroit, Michigan 48226-3535

Re: Investigation of the Detroit Police Department

Dear Ms. Carter:

As you know, the Civil Rights Division and the United States Attorney's Office for the Eastern District of Michigan are jointly conducting an investigation of the Detroit Police Department (DPD), pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141. We greatly appreciate the cooperation of the City of Detroit and the DPD thus far in this investigation.

At the beginning of our investigation, your office requested that we inform the City as soon as possible if we identified any problems during the course of the investigation. Over the course of two trips, the first occurring March 19 to 23, 2001, and the second occurring July 16 to 20, 2001, we have visited all thirteen DPD precinct stations that have holding cells, the Special Crimes Unit holding facility, which is used primarily to detain juveniles, and the two holding cells at the Detroit Receiving Hospital (DRH). We have interviewed more than 70 DPD officers and over 50 detainees and we have reviewed numerous documents. On our second tour of DPD holding cells, we were accompanied by officials from the Detroit Fire Department and Detroit Department of Public Health.

The DPD has 239 holding cells that are currently in use. In 2000, over 110,000 detainees were held in DPD holding cells. These holding cells are intended for short-term, prearraignment detention. However, our investigation revealed that detainees were routinely held for 48 hours or more. The DPD detained some individuals for extended periods of time, some for as long as several months, such as parole violators awaiting transportation to a Michigan Department of Corrections facility and incarcerated individuals who were scheduled to appear as witnesses at a trial. (1)

On April 25, 2001, following our first tour, we sent the City a letter identifying concerns about fire safety, mental health screening, suicide hazards, and the use of restraints that, based on our observations during our first tour, we believed required immediate attention because they presented potentially serious and imminent risks to DPD detainees. We also had an informal discussion about our preliminary concerns regarding the conditions in DPD holding cells on July 20, 2001, after our second tour, when we and three of our consultants met with former Corporation Counsel Phyllis James and DPD command-level staff. While the DPD took some steps to remedy these problems, as discussed below, many of these steps do not address fully our concerns.

This letter provides a more comprehensive discussion of our concerns in the following areas: fire safety, medical care, detainee safety, observation cells, environmental health and safety, and food service. This letter does not address our significant concerns related to the First Precinct holding facility or its written policies and procedures because this facility closed on September 5, 2001, and your office represented that it will no longer be used to hold detainees. We note, however, that our review of the First Precinct holding facility raised concerns similar to those we discuss below. This letter also does not address our preliminary concerns with DPD use of force practices and procedures, which were discussed

in a letter we sent you on March 6, 2002. In addition, the concerns discussed below do not relate to our investigation of the arrest and witness detention policies and practices of the DPD.

Some of the concerns addressed in this letter relate to physical and environmental conditions in DPD holding cells, while others relate to detention policies and procedures, e.g., detainee intake. The City and the DPD could address many of the concerns regarding physical and environmental conditions by implementing our recommendations in the DPD holding cells, or by housing detainees in an alternate, centralized location. If the DPD chooses to house detainees in an alternate location, the DPD should take appropriate measures to ensure that the physical and environmental concerns identified in this letter are not present and do not later arise in the alternate location. With respect to other concerns raised in this letter, we suggest that the DPD revise its detention policies and procedures in order to implement our recommendations, regardless of whether the DPD decides to house detainees in an alternate location.

This letter is not an exhaustive discussion of our concerns about the conditions in DPD holding cells because important aspects of our investigation have yet to be completed, most notably reviewing the documents regarding incidents in the holding cells and precinct contingency plans that establish emergency procedures. Although the DPD has provided numerous documents, we continue to await the complete production of requested documents including, but not limited to, documentation of detainees who have died, attempted suicide or received medical treatment while in DPD custody. As our investigation progresses, we may identify additional areas of concern.

I. Fire Safety Issues

Detainees in DPD holding cells are entirely dependent on DPD staff for their safety in the event of a fire or other emergency that might require evacuation. All DPD holding cells must be individually unlocked, as the DPD does not have any locking systems that would allow staff to unlock the cells from a remote location. In addition, because the holding cells are used for short-term detention, detainees do not become familiar with the exit routes from the building, although emergency exit diagrams had recently been posted at the time of our second tour. This combination of factors makes fire suppression and detection a critical issue in DPD detention facilities. (2)

A. Fire Suppression and Detection

DPD holding cells have substantial deficiencies in fire suppression and detection. None of the precincts (other than the now-closed First Precinct) had sprinkler systems throughout the building. In the precincts with partial sprinkler systems, the systems were not being maintained and they were not fully operational at the time of our tours. For example, the sprinkler heads in the garage of the Eighth Precinct had been painted over, which would prevent them from working, even assuming that all other parts of the system were operational.

In addition to sprinkler systems, portable fire extinguishers, which need to be inspected annually, are necessary to prevent a small fire, such as a trash fire, from becoming a much larger fire that could have devastating effects. In our letter of April 25, 2001, we noted that many precincts' holding cell areas had no fire extinguishers or had fire extinguishers with expired inspections. On our second tour, while all precincts had fire extinguishers, there was not one precinct where all of the fire extinguishers had been inspected within the last year.

Smoke detectors are critical to detection and early suppression of fires because inhalation of smoke is the primary cause of serious injury and loss of life in fires. In addition, connection of the fire alarm and smoke detection systems to the sprinkler system is critical to early detection and suppression of fires. In

our letter of April 25, 2001, we noted that most of the precincts we toured did not have smoke detectors.

During our second tour, we visited four precincts that had centralized smoke detection systems. However, only the system in the now-closed First Precinct was operational. The remaining nine precincts utilized individual battery-operated smoke detectors as the only means of smoke detection. These detectors rely on nine-volt batteries for power and only sound individually when smoke is present. Moreover, the individual smoke detectors in DPD holding facilities are not adequately maintained or tested. Several of the detectors we tested at random did not function, one because it had no battery installed.

The location of these detectors was also problematic. In all the precincts, the cell area is separated from the front desk and administrative areas by walls and doors, creating a sound barrier. The DPD staff's response could be significantly delayed if a fire started in the cell block of most precincts, as they do not have detention officers permanently stationed in the cell area. For example, in the Third Precinct, the alarm on the smoke detector in the cell block could not be heard at the front desk under ordinary operating conditions. In addition, in four different precincts the smoke detectors were placed randomly in locations that would not optimize the likelihood of successfully detecting smoke.

Finally, in the event of a fire or other emergency, it is critical to have a back-up power source in order to ensure that emergency lighting, exit signs, and fire detection and suppression systems continue to operate. Some precincts had lights and exit signs with battery back-up, but a number of these did not work when tested. In addition, while most of the precincts have an emergency generator on site, these generators are not connected to the buildings' electrical systems. Accordingly, if a power outage occurs, the DPD contacts the maintenance department, which then assigns someone to report to the precinct to connect the generator to the building. These delays in providing power make this an inadequate system for ensuring back-up power in an emergency.

The DPD should install automatic sprinkler systems in all holding cell areas and in any other areas of the buildings that are not physically separated from the cell areas by walls made of fire resistant materials. Proper maintenance and testing of the existing partial sprinkler systems should also be done. Portable fire extinguishers should be available and periodically inspected and tested. The DPD should replace the individual smoke detectors with listed smoke detection systems that are connected to fire alarm systems, so the actuation of one detector sounds an alarm throughout the building. A listed system is one that has been tested and accepted by a nationally-recognized testing laboratory. Further, we recommend that some type of notification system, either visual or audio, be installed so that detainees can report emergency conditions to DPD staff without a delay. Emergency lighting, exit signs, and fire alarm and smoke detection systems must have an emergency power source - either batteries or an emergency generator - in the event of an electrical power failure. Therefore, we also recommend that the DPD connect all of the emergency generators to the buildings' electrical systems so that the transfer of the power is automatic in the event of a loss of power.

B. Occupant Protection

During our inspection, we identified several areas that were not sufficiently separated from occupied areas to limit the spread of fire, specifically the stairwells, garages, and hazardous rooms such as janitors' closets. These areas need to be properly separated from the remainder of the building with construction materials to prevent fire, smoke, toxic fumes, and other combustion products from spreading to other areas.

If stairwells are not sealed tightly, products of combustion are able to pass into the stairwell shafts,

allowing the fire to spread between floors. This may also prevent a stairwell from being used as an exit route and may cause the occupants to be trapped on upper floors or in the basement. During our tours we observed many stairwell doors that were not constructed of fire-rated materials and were either propped open or not completely closed.

The garage areas in all of the precincts are not properly separated from the administrative offices and cell blocks by two-hour fire-rated doors and walls. All of the precincts use their garages for storage and parking of automobiles, motorcycles, lawn equipment, and containers of combustible and flammable liquids. We observed multiple fifty-five gallon barrels of combustible motor oil being stored in precinct garages. In addition, piping that penetrates the separating walls was not properly sealed with materials that help prevent fire and smoke from traveling from floor to floor.

We also observed that, in most precincts, rooms classified as hazardous rooms or spaces, such as a storage room, janitor's closet, mechanical room containing gas- fired equipment, or elevator machine room, were not properly separated with construction materials and doors designed to withstand fire conditions for one or more hours. Doors to these rooms were not equipped with self-closing and positive-latching devices to ensure the doors will close on their own and remain closed once shut. The Sixth, Eleventh, and Twelfth Precincts appeared to have hazardous rooms properly enclosed, however, the remainder of the precincts did not. Specifically, ventilating louvers, piping duct work, and electrical conduits were not properly sealed, which would permit the products of combustion to escape and travel to occupied areas of the buildings in the event of a fire.

In the First, Third, Fourth, and Thirteenth Precincts, as well as the Gang Squad, newer acoustical ceiling tiles have been suspended over what appeared to be the original ceiling tiles that were made from a highly-combustible material. Fire spreads rapidly over the surface of this type of material, which can contribute to "flashover" conditions where the amount of heat generated by the burning materials radiates throughout the room until the ignition point of other combustible materials is reached and they ignite simultaneously.

A critical component of fire safety is the distance occupants must travel to reach an alternate exit in case the primary exit is blocked by either fire or accumulated smoke. This distance is evaluated by looking at the length of the common path of travel and dead end paths. A common path of travel is the distance that must be traveled from any location within the building to a point where there is a choice of directions leading to separate exits, which should not exceed 50 feet. A dead-end path is a corridor or passageway that ends without any outlet or exit from the building, which should not exceed 20 feet. Many precincts had longer common paths of travel and dead-end paths. For example, in the Seventh Precinct the common path of travel was 120 feet, more than twice the maximum-recommended distance. The Third Precinct had a dead-end path of 80 feet, which is four times the maximum-recommended distance. Although the acceptable travel distance is increased in buildings with full sprinkler systems, no precinct currently housing detainees has a full sprinkler system.

It is essential that each cell block have a means of exhausting smoke from a fire. None of the precincts had manual or automatic smoke exhaust systems. Moreover, many windows could not be opened to obtain some level of ventilation.

Improper cigarette disposal is a significant fire hazard. We were informed that smoking is not permitted in any of the precinct buildings. However, during our tours we saw cigarette butts in various locations throughout the buildings, particularly in basements, garages, and cell blocks. In addition, throughout the cell areas in many precincts there were words, letters, and symbols etched into the ceilings and walls in what appeared to be a black stain. When we asked about these markings, detention officers told us they were made with cigarette lighters brought into the cells by detainees.

We recommend that the DPD renovate all stairwells, garages, and hazardous rooms to provide smoke-resistant and fire-resistant enclosures. This should include the areas around pipes, which should be fitted with a fire-tested material such as putty to prevent fire and smoke from moving floor to floor. Further, once improved doors are installed they must be kept closed for proper fire suppression. The DPD should remove all large quantities of flammable liquids from the attached garages and place them in a separate building or in a fire-rated storage room within the existing structure. Only small containers of flammable liquids may be stored in attached garages, and then only in cans that the fire department and/or fire marshal's office deems acceptable for storing flammable liquids.

The DPD should immediately remove the highly-combustible ceiling tiles in the precincts listed above. We further recommend that the DPD build additional exit routes from cell blocks where the common path of travel is beyond 50 feet, or the dead-end paths of travel exceed 20 feet.

If automatic sprinklers are not installed throughout the buildings where the holding cells are located, the DPD must establish a means of exhausting smoke from these areas. This can be accomplished by manual or automatic means.

If smoking in the precinct buildings is to be permitted, then appropriate ashtrays should be provided and safeguards implemented. If it is not permitted, then the no-smoking policy should be more strictly enforced. The DPD should carefully monitor prisoners to ensure that cigarette lighters and matches are not brought into the holding cells.

C. Emergency Procedures

We were provided with emergency or contingency plans for most precincts as part of the documents produced by the DPD. Although these plans are dated as far back as 1998, a number of officers, when questioned, did not know their responsibilities in the event of an emergency evacuation. We also received conflicting responses from officers within the same precinct. Moreover, none of the officers with whom we spoke had ever participated in a fire drill. A number of officers indicated that the drills were planned in the near future.

It is absolutely essential that staff be able to identify, both by sight and touch, the appropriate keys to unlock all doors necessary to evacuate completely detainees from the building. During our tours, at least one holding cell staff member at each precinct was asked to identify the key or keys necessary to open all cell doors. Only in the Second Precinct was an officer able to identify the correct keys to open the cell doors by touch. This officer had improvised a make-shift method of identifying the appropriate keys. In most precincts, it took several minutes for detention officers to identify the correct keys by sight. For example, in the Twelfth Precinct, one of the doors to the sally port was locked, as it should have been. However, it took several minutes of searching through drawers and cabinets for the staff to locate the key. Moreover, some officers had to test the keys in the lock to determine if they had identified the correct key.

We recommend that the DPD develop and implement revised emergency procedures in consultation with the fire department. This policy should address emergency evacuation procedures (including storage and marking of keys), fire drills, use of fire extinguishers and other fire suppression equipment to suppress small fires, and notification of the fire department in case of emergency. The training and equipment inspection required in operating twelve holding facilities is extensive, especially given the numerous deficiencies noted above. We therefore suggest that the DPD appoint an adequately-trained person who would work on fire-safety issues, including training the DPD staff in, and monitoring compliance with, emergency and fire-safety procedures.

II. Medical/Mental Health Issues

A. Detainee Intake/Screening

Effective intake and screening procedures are crucial to the early identification of medical and mental health issues and thereby the prevention of injury, illness, and death among detainees. On December 5, 2000, the DPD implemented the Special Order and Detainee Intake Form, D.P.D. 651 (jointly referred to as the "DIF"). On October 25, 2001, we received a Draft Special Order ("Draft Order") and Draft Detainee Intake Form, D.P.D. 651 ("Draft Form"), and a Draft Medical Envelope ("Draft Envelope"). The Draft Order, Draft Form, and Draft Envelope are not currently being used by the DPD. While these proposed revisions of the intake procedures are positive steps, they remain deficient in a number of areas. Specifically, both the current and proposed DPD policies and procedures fail to provide detention officers, who are not medical professionals, sufficient guidance on what medical information to collect, what actions they should take in response to such information, and how to ensure the information is transmitted to others responsible for the detainee.

Current DPD policy requires that any prisoner or detainee who complains of illness or requires periodic medication be sent to Detroit Receiving Hospital (DRH). Our interviews with detention officers and Officers-in-Charge (OICs) revealed that the policy is often not applied as written. In practice, some detention officers decide which medical complaints they consider significant enough to bring to the attention of the OIC. For example, the severity of alcohol withdrawal symptoms required before a detention officer would request a conveyance to DRH varied among officers. The OIC in turn decides what action, if any, to take regarding a detainee's condition. The Draft Order changes the current policy by requiring the conveyance of any detainee who "requires" prescription medication for a "life threatening condition" or has "obvious injuries or illnesses." The intake procedure should not require DPD officers to make these medical judgements. Instead, it should provide sufficient information so that detention officers can appropriately determine when to involve medical professionals who are qualified to make such judgements. The Draft Order also defines the conditions that require conveyance too narrowly, which means that many individuals with conditions that warrant immediate medical treatment may not be conveyed to DRH. For example, an asthmatic detainee who requests prescription medication may not be conveyed to DRH if the detention officer does not believe the medication is "required" and does not consider asthma to be a "life threatening" condition.

The Draft Order is an improvement over the current DIF because it provides some instruction to the detention officer regarding the identification and referral of detainees in need of medical treatment by listing specific symptoms associated with certain conditions. For example, the current DIF requires the detention officer to determine whether the detainee is in drug or alcohol withdrawal with only a check box for "yes" or "no." The Draft Order improves on this by listing symptoms commonly exhibited by individuals suffering from alcohol or drug withdrawal, including "sweating, severe shaking, nausea/vomiting, and pin point pupils," thereby allowing the detention officer to identify relevant medical information. However, this and other lists of symptoms are on the Draft Order, not the Draft Form that officers will be completing during intake. Because it is this list of symptoms that enables the detention officer to identify relevant medical information, the list should be on the Draft Form itself and not solely on the separate Draft Order.

Although the Draft Order improves the current DIF by identifying symptoms of certain conditions, neither attempt to identify detainees with high blood pressure, heart disease, asthma or other chronic conditions. Furthermore, apart from tuberculosis (TB), both the current DIF and the Draft Form require the detention officer to ask only a single question about exposure to a "contagious disease," specifically, "Have you recently been exposed to a contagious disease?" This is an inadequate method of screening for communicable diseases, such as hepatitis, HIV/AIDS, and other sexually transmitted diseases.

The Draft Order also specifies the procedures to be followed by a detention officer if the officer identifies certain symptoms associated with some conditions, such as mental illness, drug or alcohol withdrawal, or being potentially suicidal. However, there are no procedures established for other conditions, such as TB, heart conditions or diabetes. For example, although there are numerous questions related to TB on the Draft Form, there are no procedures identified for the conveyance of detainees who are identified as TB active, other than a general statement in the Draft Order to identify "detainees who may have tuberculosis and need medical treatment." Furthermore, some of the procedures that are specified on the Draft Form are not defined. For example, although the Draft Order defines "monitor" and "constant supervision," there is no definition for "monitor closely."

There are also problems in how both the current DIF and the Draft Form collect information. The Draft Form is an improvement over the current DIF because it calls for collecting relevant medical information from additional sources that the DIF ignored. The Draft Form includes a section for the arresting officer to record information regarding the detainee's medical condition based on the officer's personal observations as well as information conveyed to the officer by third parties. However, DPD policy does not require any other officer with relevant medical information to convey that information to the detention officer. In addition, it is unclear how information is to be collected from detainees. Both the current DIF and the Draft Form require that the detention officer conduct an "actual verbal exchange" with the detainee; however, other instructions in the Draft Order seem to require that the detainee complete a portion of the form. The instructions should be rewritten to remove this ambiguity and require detention officers to complete the form based on a verbal exchange with the detainee.

The Draft Order also improves the current DIF by establishing procedures to ensure review and some level of accountability. The Draft Order requires the OIC and the detention officer to review the detainee intake form at the beginning and end of each shift. The OIC is further required to document all 15-minute checks and to record the rationale for the OIC's decision about whether to take action regarding a detainee's medical condition at intake. DPD policy should unambiguously require that any subsequent decisions about whether to take action regarding a detainee's medical condition be similarly documented by the OIC.

Both the current DPD policy and the Draft Order require diabetic detainees to administer their own injections of insulin under the supervision of the detention officer at the precinct of arrest. Neither the current policy nor the Draft Order include protocols to ensure that the medications are administered as prescribed or in a safe and hygienic manner, for example, by providing for glucose-level testing prior to the insulin injection.

There are also a number of deficiencies in the tracking of the detainee's medical and mental health information. For example, currently completed DIFs are stored at the precinct where the arrest and detention was initiated, but are generally not kept in the holding cell area. They do not travel with a detainee if he or she is conveyed to the hospital, to court, or to another precinct. The Draft Order recommends that information regarding a detainee's medication and its administration be recorded on the back of the intake form, but also requires that this information be kept on the Draft Medical Envelope, which is kept with the Draft Form. Information regarding the delivery of medication to a detainee should be recorded on a single, identifiable form and in a uniform manner, as discussed below in the section on medication.

We recommend that the DIF be revised in consultation with medical and mental health professionals to provide a detailed list of specific symptoms detention officers should look for during intake. This revision should include lists of symptoms for conditions similar to those contained in the Draft Order and include additional symptoms which address communicable diseases, ambulatory impairments, and mental health conditions. Specific inquiry should also be made as to whether the detainee has chronic

conditions, such as asthma, diabetes, epilepsy, heart trouble or high blood pressure.

The DPD should develop, also in consultation with medical and mental health professionals, protocols unambiguously establishing what actions detention officers should take relating to the comprehensive medical information gathered. These protocols should address emergency care, hospitalization, prescription medication, drug and alcohol withdrawal and chronic conditions. The protocols should specify what conditions require EMS notification and transport. The DPD should develop a policy which ensures that injected medications are administered as prescribed and in a safe and hygienic manner. We also recommend the DPD develop a protocol for tracking and transferring information regarding detainees that ensures relevant information is continually updated and available.

After the intake form is revised, the DPD personnel responsible for intake must be trained on how to conduct an intake interview and collect the information necessary to complete the new form. This training should also address the protocols establishing how detention officers and OICs should follow-up on the information they obtain. Medical and mental health professionals should be involved in developing and presenting this training.

B. Medication

Proper and timely administration of prescription medication is essential to prevent exacerbation or relapse of a detainee's illness. Our investigation showed that currently, the DPD does not have an adequate system in place to ensure that medication is properly and timely administered, or that its administration is consistently documented. Additionally, there is no consistent practice regarding the storage and disposal of prescribed medications. While most of these deficiencies would be addressed by the implementation of the Draft Medical Envelope discussed above, this new policy needs clarification regarding what information is recorded, how to record such information, and the dissemination of instructions or warnings regarding medication.

Currently, DPD policy states that detainees may take only medication that is prescribed or authorized by the DRH. General Procedures, Volume III, Chapter 2, Section 6.1. Once medication has been prescribed or authorized, it is stored in the detainee's property envelope and the detainee "may request medication at the prescribed intervals." This reliance on the detainee to determine when the next dose is required is problematic, particularly as most detainees do not have access to a watch or clock. The policy also does not require a log tracking the administration of medication, which makes review and auditing by supervisors very difficult. Although we were told that the DPD has a practice of providing the prescription medications it purchases to detainees upon their release, we learned that this is not done consistently. In the Eighth Precinct, for example, we located approximately 30-40 bags of old medications dating back to July 2000, in a cardboard box in the file room, as well as old medications mixed in with current ones in a drawer at the front desk.

The Draft Medical Envelope improves substantially on this policy, although it has several deficiencies. It improves current policy by requiring documentation of the name and cell number of the detainee who is to receive medication, the name of the medication, and the dose and frequency of administration. The Draft Medical Envelope also improves current policy by requiring the detention officer to record the time the medication is administered and have the detainee initial the form indicating the medication was received.

There are, however, several problems with the Draft Medical Envelope. Although detainees' medication will be stored in the Draft Medical Envelope, which is to be stapled to the completed Draft Form, the policy does not address where the detention officer is to store the packet. Medication should

be stored in a designated secure area that is easily accessible by detention officers. Furthermore, the Draft Medical Envelope does not establish a procedure for detention officers if a detainee who is taking medication is transferred. In addition, the Draft Medical Envelope is unclear regarding disposal of medication because it has both a space for detainees to sign when they are provided with prescription medication upon discharge and a space for the officer to indicate how he or she disposed of prescription medication "e.g., transferred to the Wayne County Sheriff's Pharmacy." The Draft Order states that information regarding medication may also be recorded on the Draft Form. To ensure completeness and accuracy and to facilitate review and auditing, information regarding medication should be recorded on only one form. Also the Draft Medical Envelope only has columns to record the administration of three doses for each medication. Finally, safe administration of prescription medication requires that the detention officer and detainee be advised of any special instructions for administration and of possible adverse reactions. Although the Draft Medical Envelope requires detention officers to document any special instructions regarding the administration or storage of medication, it does not address warnings or side-effects of medication or require that the detainee be advised of any instructions or warnings prior to administration of medication.

We recommend that the DPD revise its policy regarding prescription medication, in consultation with medical professionals. Medications should be stored in a secure location at the precinct, travel with detainees who are transferred, and remaining medication should be provided to detainees who are released. In addition, the DPD should designate a single place for officers to record information regarding medication for detainees and allow sufficient space to document the administration of medication. To facilitate the proper administration of medication, we recommend the DPD require detention officers to specify the schedule when the medication should be given (e.g., 6:00 a.m., 10:00 a.m., 2:00 p.m.), in addition to recording the actual time medication is administered. Finally, officers, OICs, and detainees should be advised of any special instructions or warnings regarding any medication.

C. Infectious Disease Control

The DPD does not have a sufficient policy for handling detainees with known or suspected infectious diseases or for handling biohazard materials, such as used needles or items exposed to blood. As discussed above, the Draft Special Order and Draft Detainee Intake Form do not sufficiently address issues related to infectious disease. The DPD also has a written protocol regarding exposure of individuals to blood or bodily fluids of individuals with HIV, Hepatitis B, or Hepatitis C, that only addresses a very limited set of issues. Early identification of individuals with infectious diseases is critical to providing adequate healthcare and preventing the spread of disease. It is also important that appropriate public health officials are informed. However, we were informed that the DPD does not routinely notify the Detroit Department of Public Health about individuals with certain sexually transmitted diseases, despite the fact that such reports are required by Michigan law. Michigan Critical Health Problems Act, MCL § 325.71.

Our review indicates that, absent a policy, DPD officers are creating ad hoc procedures. We learned from our interviews that detainees with known or suspected communicable diseases are handled inconsistently, depending on the individual precinct or detention officer, and that officers were not clear on what constitutes an infectious disease. At the Third Precinct, for example, a detention officer said that he housed HIV-positive detainees with him in the processing area if they were being held on a misdemeanor charge. If an HIV-positive detainee was charged with a felony, the officer housed him or her in a separate cell "far away" from other detainees or in an observation cell. He indicated that he did not use any special measures with detainees with tuberculosis (TB), but did with detainees with hepatitis C. By contrast, in another precinct, a detention officer indicated that she did not use any special measures with detainees with hepatitis C, only for those with TB. She stated that four cells at the end of the corridor, which are not separated from the other cells in the cell block, were used for detainees with

contagious diseases. Housing detainees with contagious diseases at a distance from others is not an effective means of preventing the spread of disease. The DPD does not have any negative-pressure rooms that would effectively prevent the spread of such diseases.

The DPD's apparent attempts to address the issues raised by housing detainees with infectious diseases are inadequate and, in some cases, appear to pose a potential risk of harm to detainees. For example, several precincts had "Hepa-Aire Model CAP600UVP air purifiers" in the holding cell blocks hanging down from the ceilings. While these devices may have some usefulness in moving air around for ventilation purposes, they should not be considered effective as air purifiers in these installations. Indeed, this particular device is not designed to be placed directly in an occupied living space because it emits ozone and UV radiation that can be harmful to humans, especially those with asthma. According to company literature, these units are designed to be installed in the return air ducts of HVAC systems only. Such placement maximizes their use as purifiers and minimizes dangerous ozone emissions.

We recommend that the DPD develop and implement a policy on infectious disease control. This policy should be developed in connection with medical professionals and public health officials and should address the identification of infectious diseases, housing of detainees with infectious diseases, preventing the spread of infectious diseases, circumstances under which medical or public health officials should be notified, and the disposal of biohazardous material. Even in a facility designed for short-term stays, individuals identified as potentially TB-active during intake screening should be properly contained and managed in order to avoid exposing other detainees and staff to the disease.

III. Detainee Safety

We observed a number of deficiencies in DPD policies and practices regarding safety and security screening and detainee monitoring. The security screening necessary in a holding facility is not as extensive as the classification systems required at a prison or jail. However, a system of screening and housing detainees based on objective, behavior-based criteria is an important component of providing a reasonably safe environment. The DPD does not have an adequate system for identifying security risks during intake, such as determining whether detainees are suspected crime partners, combative or assaultive, or may be likely victims of inmate-on-inmate violence while in the precinct holding cells. In addition, the DPD does not have a systematic method of ensuring that such security information is passed between officers, for example when there is a shift change. This leads to a situation where detainees and staff may be injured.

We also identified problems with the monitoring of detainees by the DPD. Currently, detention officers are required to check the detainee general population at least once every thirty minutes and the OIC makes entries in the desk blotter to document the completion of this duty. Checks of the general population every half-hour are sufficient. However, the DPD does not ensure that such checks are actually performed and our review raised concerns that such checks were not conducted in accordance with DPD policy. The logs appeared too uniform - the detention officer or OIC generally indicated the check was performed precisely on the half-hour. This raises concerns that the logs do not accurately reflect the frequency and timing of monitoring. In addition, the entries generally did not record any information about the condition of the detainees at the time of the check.

The DPD fails to require precincts to maintain holding cell logs. A number of precinct cell blocks used grease boards or chalk boards to record the detainees' names, dates of arrival, cell assignments, and, in at least one instance, the need for prescription medication. Even if the DPD did regularly record information about monitoring, medication, and safety concerns on these boards, grease boards would not be an adequate method of tracking this information. The DPD would have no clear or permanent record of this essential information, which would prevent review by supervisors or auditing.

We recommend that the DPD collect information during intake that will allow an assessment of the security risk posed by or to a detainee and develop a protocol for housing detainees based on the security risks identified during intake. The DPD should also design and implement a holding cell log that is maintained separately from the precinct blotter. This holding cell log should document the actual time of each check by the detention officer. Checks should be done at sufficient intervals as necessary, a minimum of twice each hour for the general population. As with the medication log described above, to facilitate accuracy and access to the information, we suggest the holding cell log be kept in the cell block and that the detention officer who conducts the check complete the form. In addition, the OIC should be required to review and initial the log at least twice each shift to confirm that the detainees are being properly monitored.

Detainees who are placed in observation cells or the holding cells at DRH require more frequent monitoring. The DPD does not conduct or log regular monitoring of individuals in the DRH holding cells. DPD policy is to conduct checks on individuals in observation cells in the precincts every 15 minutes. General Procedures, Volume III, Chapter 2, Section 61.4. This policy, and the Draft Special Order and Draft Detainee Intake Form, D.P.D. 651, discussed above, require documentation of these checks in the desk blotter. This practice makes review or auditing extremely difficult. A log, similar to the general holding cell log, should be posted by the observation and DRH holding cells to record that those detainees are being checked every fifteen minutes. This log should provide a place for the detention officer to briefly note a detainee's actions at the time of each check.

IV. Observation Cells

Detainees who are determined by the DPD to be at risk for suicide or have other serious medical or psychological problems are placed in observation cells so that they can be monitored more closely. Nearly all of these cells are in poor repair and are not suitable for use as observation cells. Many are not within line of sight of the detention officer's desk or office space. Only the observation cells at the Eleventh Precinct could be seen easily by detention officers at all times. In addition to the problems with location, some of the observation cells are exceptionally difficult to see into because they are dark and the partitions that separate them are difficult to see through. At least five precincts had no lights in the observation cells, and others had insufficient lighting.

Some detention officers' efforts to address these issues are also problematic. For example, in the Third and Eighth Precincts officers told us that they kept potentially suicidal detainees handcuffed to a bench in the processing area for the duration of the officer's shift so they could be more easily observed. Temporarily handcuffing a potentially suicidal detainee to a bench in the processing area while securing an immediate transfer to a psychiatric assessment facility may be necessary due to the inadequate condition and location of the observation cells. Nevertheless, suicidal detainees should not be left handcuffed to a bench for prolonged periods of time for the convenience of detention officers, as appears to be the practice at some precincts.

As stated in the emergent conditions letter we sent in April 2001, we also identified several safety hazards in DPD observation cells. We identified exposed piping, cross bars, and other means by which a detainee could commit suicide in the Third and Fifth Precincts. On our second tour, a number of the cells we observed had similar problems with suicide hazards. For example, in the Special Crimes Unit facility, used for housing juveniles, we observed several suicide hazards in the male bullpen. This cell has elevated radiators, with exposed pipes running to them, exposed electrical conduit, and bars on the openings in the cell doors. In addition to the risks posed by these hazards, this cell is the farthest away from the detention officer's station, limiting observation. In the Fourth Precinct we saw broken glass in both of the observation cells, creating a severe safety hazard. Other observation cells we inspected had inoperable or missing toilets and sinks, floors in disrepair, and clogged floor drains.

Based upon our investigation, we recommend that observation cells be fitted with adequate lighting and be fully repaired. Furthermore, they should be located within the line of sight of the detention officer or booking area with doors that allow the detainee to be easily seen. Pipes, radiators, overhead bars, and other similar suicide hazards should be removed or made inaccessible.

V. Environmental Health and Safety

A. Cleaning, Trash Removal, and Maintenance

In general, the DPD holding cells are extremely dirty and poorly maintained. During our inspection, we identified problems with DPD policies and practices regarding routine housekeeping, trash removal, and physical plant maintenance and repair. Accumulations of dirt, trash, and debris, especially in the amounts we observed, can have a serious and wide-ranging impact. Trash, particularly food and paper, attracts insects and rodents, which can spread disease. Accumulations of garbage add tremendously to the fire load of the facility. It also increases the potential for injury to inmates and staff, causes odor problems, and provides a convenient place for detainees to hide contraband, thereby compromising security.

In most precincts, cells do not appear to be cleaned on any regular basis. With limited exceptions, the holding cells were filthy, with excessive amounts of dirt, dust, and grime. Food debris and other trash was frequently observed in and around the detention cells. Trash, including bread, bologna, cigarette butts, paper cups, and used sanitary napkins were found on top of cells in Precincts Three, Seven, Eight, and Thirteen. The accumulation of trash of this nature on top of the male bullpen in the Eighth Precinct was several inches deep and covered the top of two cells. In the Thirteenth Precinct, we found what appeared to be feces on the wall of an occupied cell in the male felony area. We also saw bread, bologna, cigarette butts, used sanitary napkins, Styrofoam, and other trash in the pipe chase areas of this precinct. Similar kinds of trash were found in the floor drains, ventilation grates, and in window areas in many of the precincts.

There were no written policies addressing procedures and responsibilities for housekeeping or janitorial duties for the holding cells, apart from the now-closed First Precinct. In the absence of written policies, each precinct establishes its own practice, which has resulted in the significant sanitary problems described above. There was frequently no clear delineation of responsibilities and little or no oversight. For example, in the Thirteenth Precinct, a detention officer told us that cleaning responsibilities are not clearly assigned to building maintenance staff or jail staff. As discussed above, we observed numerous sanitation problems in the Thirteenth Precinct's holding cells. In the Twelfth Precinct, we were told that the sworn officers do not do any major cleaning because there is a civilian custodian from the central building maintenance department who is responsible for cleaning. The Fifth Precinct uses work release inmates from the Michigan Department of Corrections, and the Seventh Precinct contracts with a private janitorial service. At the Third Precinct, we were told that a maintenance person cleans once a week.

During our investigation we also learned that the DPD does not have a functioning maintenance program for the detention cell areas. There is a central building maintenance department, but there is no written, comprehensive maintenance plan. Several of the precinct officers we spoke to were unsure where the maintenance department was located, or what its responsibilities were. They also reported that requests for maintenance are frequently not acted on by the maintenance department.

With the exception of some fresh paint, we saw no signs of any ongoing routine maintenance. There were many cells without toilets or with broken sinks and toilets, broken light fixtures, and walls and

ceilings in poor repair. In the Thirteenth Precinct, for example, we smelled a foul sewer odor in the female bullpen. In an adjacent pipe chase area, we discovered a section of vent pipe that had been cut out and abandoned, allowing gases and odors to escape directly into this area.

The failure to clearly delineate cleaning and maintenance responsibilities extends to the holding cells at DRH, where we received conflicting accounts of who has these responsibilities. As a result, it appeared to us that the DRH holding cells do not get cleaned in any regular manner and we observed blood and other bodily substances on the concrete slabs, walls, and ceilings.

We also viewed janitors' closets, storage rooms, property rooms, mechanical rooms, and other similar areas in proximity to the holding cells. In these areas, we found a significant accumulation of dust, trash, and clutter. We saw improper storage of hazardous materials, including gasoline, biohazard bags, and unlabeled containers of caustic materials. At the Eleventh Precinct, for example, a mop sink room in the male felony cell area is used as a storage room. In this room, we found paint, a wheelchair, and miscellaneous boxes, all of which made the mop sink inaccessible. The property storage room in the Ninth Precinct had numerous gasoline containers lying around.

We recommend that the DPD design and implement a policy regarding the cleaning and maintenance of all precinct holding cells. This should include written guidelines and procedures that delineate responsibility for cleaning and maintenance. It should also set forth tasks that must be performed in accordance with a specific schedule. We recommend that the DPD include within these policies a requirement that, at a minimum, sweeping, mopping, and toilet and sink cleaning be done on a daily basis, and cells be cleaned and disinfected after each detainee is released. Pipe shafts, miscellaneous closets, and other areas should be cleaned on a regularly scheduled plan. Food, toilet paper, and other debris should be immediately removed from the tops of cells, and routinely removed on no less than a weekly basis. The policy should also require written documentation of the performance of cleaning and maintenance and inspection by the OIC.

B. Plumbing

Generally accepted professional correctional standards require that detainees have access to drinking water and toilets 24 hours a day. Many cells in DPD holding facilities do not have running water and a number of cells do not have toilets or have broken toilets. For example, of the 21 cells in the Thirteenth Precinct, only five had working toilets. Two of these cells were held open to be used by the detainees without toilets in their cells. In order to use the toilets in these two cells the detainees must make a request to a detention officer, who is often unavailable. In addition, most detainees being held at the Thirteenth Precinct have no access to drinking water unless the detention officer escorts them to a sink outside the detention cell area.

We recommend that the DPD inspect all holding cells and repair the malfunctioning toilets and sinks, in conjunction with implementing a maintenance plan, as discussed above. Detainees should have regular access to a toilet and potable water.

C. Lighting

Lighting in the cell blocks was a consistent problem. Poor lighting makes it very difficult for the detention officer to see what is going on in the cells, and leaves both the detainee and the officer at risk. In addition to safety problems, poor lighting makes cleaning and repair work very difficult.

Generally accepted professional correctional standards require that illumination at desk level and in

personal grooming areas of jail cells be at least 20 foot-candles. Most of the cells we observed had less than 20 foot-candles of illumination. Several precincts do not have any lights in some cells, for example, the Second Precinct felony observation cells. Similarly, in the Thirteenth Precinct, the felony cells had no lights and solid ceilings. The lighting in these cells was so dim that it was difficult to see well enough in the cell block to determine whether a particular cell was occupied or not. Indeed, the detention officers carry flashlights with them so they can see into the cells.

We recommend that the DPD replace all missing light bulbs and fix broken fixtures in the holding cells. It should also place lighting in all cell block areas sufficient to reach 20 foot-candles of illumination at desk level and in personal grooming areas.

D. Accessibility

The DPD currently lacks proper facilities for physically disabled detainees. Individual cells and bathroom facilities in the holding cells are not wheel-chair accessible. Facilities and equipment necessary for self-catheterization, a procedure that enables paraplegics to urinate, are generally not available. The inability to accommodate detainees with disabilities often results in their basic needs not being met.

We recommend that the DPD develop and implement a policy on detention of individuals with physical disabilities. This should include designating a particular location where disabled detainees can be accommodated properly. This policy should also establish a protocol for the arresting precinct to assess a detainee's status and convey the individual to the designated facility where appropriate.

VI. Food Service

Our investigation revealed that, with the exception of the now-closed First Precinct, the Special Crimes Unit, and DRH, DPD detainees are fed bologna sandwiches consisting of two slices of white bread and one slice of bologna. Detainees are fed if they are in custody for more than six hours and receive one sandwich for each eight-hour shift that they are in custody. This policy appears to be fairly consistently followed, although we observed some deviations. For example, when we inspected the Prisoner Meal Book entries for July 18 and July 19, 2001, at the Thirteenth Precinct, it showed that inmates had been fed only twice in 33 hours because the precinct had run out of bologna. In addition, the DPD provides an alternative to bologna, peanut-butter and jelly sandwiches, in only two precincts. Therefore, most detainees who are unable to eat bologna for religious or medical reasons are left with only bread and water for the duration of their detention.

Moreover, some of the holding facilities for special populations lack any policy or consistent practice for providing detainees with adequate food. For example, the DRH holding cells have no standard operating procedure for providing food for detainees, despite the fact that detainees may stay in custody at the hospital for up to 24 hours while waiting to be returned to a precinct. We also learned that the Special Crimes Unit does not have a food program because it is intended to detain juveniles for a short period of time. However, many juveniles are housed for more than six hours, the time period the DPD uses for when adult detainees should be provided food.

We also observed a number of problems with food preparation and service procedures in the detention cell areas. We observed sandwiches being prepared in areas that were not sanitized, such as in the detention officers' break rooms, on a table used for fingerprinting juveniles, and on the counter in the detainee processing area. A number of the officers neither washed their hands before, nor wore food-grade plastic gloves while, preparing food for detainees. In most precincts, there are no readily

accessible hand-wash sinks for the officers to use before food preparation. Finally, sandwiches are frequently delivered in dirty cardboard boxes or trays.

The DPD should design and implement a policy on food preparation that addresses the sanitary concerns identified above, including designating appropriate food preparation areas and conducting ongoing sanitizing of those areas, training detention officers in proper food handling techniques, providing detention officers with adequate access to hand-washing facilities or food-grade gloves, and providing and sanitizing food-grade trays for food delivery. The DPD should also develop and implement a policy that ensures detainees in all precincts are provided an alternative to bologna, if they unable to eat it for religious or dietary reasons. As we noted above, housing individuals for longer periods of time raises more significant nutritional issues that are beyond the scope of this letter. Finally, food service should be arranged for detainees being held at DRH and for juveniles at the Special Crimes Unit who are held for more than six hours.

In conclusion, we appreciate the cooperation we have received from the City and the DPD, and look forward to further discussion regarding this letter and other issues related to our investigation.

Sincerely,

Steven H. Rosenbaum
Chief
Special Litigation Section
Civil Rights Division

Jeffrey G. Collins
United States Attorney
Eastern District of Michigan

cc: The Honorable Kwame M. Kilpatrick
Chief Jerry A. Oliver, Sr.

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1. Detaining individuals for extended periods of time raises additional issues regarding conditions of reasonable care and safety, including, but not limited to, providing toiletries, showers, bedding, exercise, visitation, and access to phones, which are beyond the scope of this letter.

2. Although DPD holding cells are subject to local fire codes, the Fire Marshal who accompanied us on our July 2001 tour indicated that his office had not conducted regular inspections and that he recorded numerous fire-code violations during our tour.