EXHIBIT 3

REDACTED

August 26, 2022

BY ELECTRONIC MAIL ONLY

Ms. Laura Mullally
Assistant Attorney General
Department of Public Safety and Correctional Services
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RE: *Duvall v. Hogan*, BCBIC
Report of Plaintiffs' Counsel from August 2-3, 2022 Visit

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION

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Dear Ms. Mullally,

We write to detail the many concerning problems that we identified during Plaintiffs' counsel's visit to BCBIC on August 2-3, 2022. We hope that we can discuss these problems with you, your clients, Corizon and Centurion leadership, and the Court's experts during their planned September 21-23, 2022 visit to the jail, and find a collaborative, non-adversarial resolution to these problems. However, we reserve the right to seek court intervention through further enforcement motions if needed.

We thank Commissioner Randolph, Captain Murray, the wardens of BCBIC and MTC, and the other custody and health care staff who facilitated our visit to ensure that it was efficient and comprehensive. We also thank you and the staff who provided us the relevant sections of class members' medical records we requested after the visit. We appreciate the attentive response by custody, medical, and mental health leadership when we brought individual patients' problems to their attention.

During our tour, in addition to hearing about class members' individual medical and mental health needs, we also observed and learned of noncompliance with the Settlement Agreement ("Agreement") at BCBIC, and more generally, problems with conditions in the jail.

These problems include (1) extremely harsh living conditions in the Inpatient Mental Health Unit ("IMHU") compounded by apparent delays in people being transferred to the state psychiatric facility in violation of state law, (2) profound problems with the infirmary's accessibility for people with disabilities, and the quality of medical care for patients, (3) shortages of health care staff; (4) dangerous and inappropriate insulin administration practices, (5) delays in outside specialty medical care, (6) the classification and treatment of detained women, (7) apparent delays in people being transferred to state prison and newly-detained men being forced to sleep in the intake area and the gymnasium due to a lack of space in general population, flying in the face of basic COVID-19 intake protocols, and (8) hygiene problems in living units. We discuss each problem in turn.

I. Inpatient Mental Health Unit Policies and Practices

The IMHU is designed to house the most seriously mentally ill jail detainees, including patients awaiting transfer to or returning from DMH hospitals, and people who have engaged in acts of self-harm or have exhibited bizarre behavior. Prior to our tour, we requested a roster listing everyone placed in the IMHU in the previous 90 days, including their date of placement. Upon receipt of the list, we were concerned to see the number of people who had been in the IMHU for months on end. There were at least nine people on the roster who were listed as being in the unit continuously since May 2022. For example, we interviewed [redacted], in the IMHU on August 2; according to Defendants' records, he had been held there continuously since May 19. We interviewed [redacted], in the IMHU on August 3; he had been held there continuously since June 4. We interviewed [redacted], in the IMHU on August 2; according to Defendants' records, he had been held there continuously since May 19.

People in the IMHU are held in the harshest and most deprived conditions we have ever encountered in any prison or jail in the United States, including in death row and "supermax" units. They have very limited out-of-cell time of only ***two to three hours per week***. They are effectively held incommunicado from their attorneys and families: by policy they are allowed out of their cells to use the phones twice a week for 15 to 20 minutes, but multiple people said that in practice they were often only able to get phone access once a week due to shortages of custody staff. IMHU patients do not appear to have any in-person visits from loved ones or attorneys; of the people we asked, none of them had had a single visitor while they were incarcerated in the IMHU. Many people lacked basic information about the status of their criminal cases due to the inability to connect by phone with their defense attorneys; they also reported that any phone contact with their families were sporadic.

We tried to give class members a one-page information sheet about the *Duvall* case, and self-addressed stamped envelopes so they could write the ACLU in the future, and

custody and mental health staff told us that our clients were not allowed to have any reading materials or writing materials while in the IMHU, including paper, envelopes, or pencils. This prevents class members from contacting or notifying the ACLU of their needs, and thus violates their right of access to the courts, and infringes on our attorney-client relationship, and our ability and ethical obligation to zealously represent them in our role as court-appointed class counsel.

People in the IMHU said that they are not allowed access to any reading materials or any sort of diversion, or indeed any property of any kind. Even religious texts, such as the Bible and Koran, are prohibited. The denial of religious literature violates class members' rights under the First Amendment and the Religious Land Use and Institutionalized Persons Act (RLUIPA). Multiple people reported feeling despondent due to the very harsh and deprived conditions, with their mental health spiraling downward.

Patients may not wear clothes even when they have stabilized and present no active risk of harm to themselves. For example, [redacted], is a trans woman who reported she was in the IMHU simply for safety reasons, after being threatened when housed with men in general population of the jail. (*See* pp. 33-34 for our discussion of this policy). She reported that she had asked repeatedly to be allowed to wear her clothes, and had been told that was not allowed. Another person housed in the IMHU, [redacted], reported that he had no psychological problems, but rather is recovering from a head injury. He too was not allowed to wear clothes. We personally observed that [redacted], had no clothes, and was given only a suicide smock to cover himself. Multiple detainees indicated that it was only a few days prior to our visit that they were first provided mattresses to sleep on, and previously only had their suicide smocks to sleep on.

Such harsh and deprived conditions might conceivably be justified for a period of hours for someone who is actively self-harming or suicidal. But these conditions in the IMHU persist for weeks and months, despite the fact that many patients are held there not because they are actively suicidal, but because they are awaiting transfer to a hospital or for other reasons.

A large and robust body of psychological research shows that holding people with mental illness in such harsh conditions serves no therapeutic purpose and can lead to exacerbation of their illness, self-harm, and suicide. It is also now a widely accepted fact that incarcerated persons who suffer from serious mental illnesses are at increased risk of harm from the painful experience of segregation or isolation. As Dr. Metzner has written:

> The adverse effects of solitary confinement are especially significant for persons with serious mental illness, commonly defined as a major mental

> disorder (e.g., schizophrenia, bipolar disorder, major depressive disorder) that is usually characterized by psychotic symptoms and/or significant functional impairments. The stress, lack of meaningful social contact, and unstructured days can exacerbate symptoms of illness or provoke recurrence. Suicides occur disproportionately more often in segregation units than elsewhere in prison. All too frequently, mentally ill prisoners decompensate in isolation, requiring crisis care or psychiatric hospitalization. Many simply will not get better as long as they are isolated.

Jeffrey L. Metzner, MD, and Jamie Fellner, Esq., *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, J. Am. Acad. Psychiatry Law, 38:104, 2010, at 104-05 (footnotes omitted).

For these reasons, mental health and correctional health care organizations unanimously condemn the solitary confinement of persons with mental illness. In 2012, the American Psychiatric Association issued the following statement:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space an adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for the individuals.

American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness*.[1] "In general, prolonged segregation means duration of greater than 3-4 weeks." *Id*.

Similarly, the National Commission on Correctional Health Care enacted policy in 2016 stating:

1. Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health.
2. Juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.

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[1] Available at http://nrcat.org/storage/documents/apa-statement-on-segregation-of-prisoners-with-mental-illness.pdf

National Commission on Correctional Health Care, *Position Statement on Solitary Confinement (Isolation)* (2016) (footnote omitted).[2]

In addition, the Fourth Circuit has repeatedly recognized the grave harm inflicted by solitary confinement. *Incumaa v. Stirling*, 791 F.3d 517, 534 (4th Cir. 2015) ("[p]rolonged solitary confinement exacts a heavy psychological toll that often continues to plague an inmate's mind even after he is resocialized"); *Porter v. Clarke*, 923 F.3d 348, 368 (4th Cir. 2019) (holding that solitary confinement of death-sentenced prisoners violates the Eighth Amendment, even without the aggravating factor of pre-existing mental illness). The U.S. Department of Justice has concluded that "prolonged use of mental health watch under restrictive housing conditions … subjects prisoners who are in mental health crisis to serious harm, or a substantial risk of serious harm, and shows deliberate indifference to their health and safety in violation of the Eighth Amendment." U.S. Dep't of Justice, Civil Rights Division, *Investigation of the Massachusetts Department of Corrections*, Nov. 17, 2020, at 17.[3] Conditions that violate the Eighth Amendment rights of convicted prisoners *a fortiori* violate the Fourteenth Amendment rights of the plaintiffs here, who are pretrial detainees not convicted of any crime.

Long-term isolation, the absence of meaningful social interaction and activity, and the other severe deprivations in the IMHU will only exacerbate the mental illnesses of those confined there. These conditions place people at significant risk of serious psychological harm. Moreover, the conditions in the IMHU are so harsh that people in general population who are in psychological distress may not report their symptoms due to the harsh conditions in the IMHU.

Dr. Patterson opined in his tenth report (March 2021), that in the IMHU, "given the 22-24 hours per day detainees spend in cell, it operates basically as a segregation unit. The staffing and physical plant do not currently allow for more intensive programmatic activities." Doc. 755-3 at 10. This is not a new problem; Dr. Patterson states that he has reported the harsh conditions and lack of treatment and programs in the IMHU on prior site visits and past monitor's reports. *Id.* Dr. Patterson recommended that Defendants increase custody staffing in the IMHU so that the Jail can "provide five to six hours on average of structure activities ***per day*** for IMHU detainees…" Doc. 755-3 at 10 (emphasis added). Defendants apparently have ignored his recommendation. Dr. Metzner states in his December 2021 report that the IMHU "appears to function as a segregation level of confinement" and he "strongly recommended that the default property for all IMHU inmates include a tear resistant mattress, unless clinically contraindicated, and usual detainee clothing

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[2] Available at https://www.ncchc.org/solitary-confinement-isolation-2016/

[3] Available at https://www.justice.gov/opa/press-release/file/1338071/download

unless clinically not indicated (e.g., the detainee is on suicide precautions)." Doc. 755-2 at 23. Defendants did not provide mattresses until days before our visit, eight months after Dr. Metzner's recommendation; the clothing policy remains unchanged.

One reason for some patients' lengthy confinement in the IMHU appears to be delays by the state psychiatric facility in receiving them for court-ordered forensic evaluation or for placement due to incompetency to stand trial. Dr. Merles, the mental health director, said transfers should be accomplished within ten days; but it normally takes three to six weeks before the state psychiatric facility accepts the patients. This is in violation of 2018 legislation that mandated the ten-day timeframe.[4]

Plaintiffs' Counsel's Requests

- We request that Defendants (including, if needed, the Governor's designees) conduct a root cause analysis of the reasons for the delays in transfers to the state psychiatric facilities or state prisons, and implement the needed reforms to expedite these transfers out. We request that Centurion and custody staff conduct weekly reviews of the status of all persons who have been in the IMHU awaiting transfer out, and document the efforts made to coordinate with the Department of Health's Behavioral Health Administration and other relevant state agencies to expedite the transfers.
- We request that Defendants develop a plan to implement Dr. Patterson's recommendation that people in the IMHU receive five to six hours per day of structured therapeutic activity outside of their cells.
- We request that Defendants develop a plan to implement Dr. Metzner's recommendations that people in the IMHU be allowed to wear the usual detainee clothing unless they are actively engaged in self-injurious behavior. The decision as to whether people are kept naked with a suicide smock or allowed to wear detainee clothing should be made by mental health providers and not custody staff; and the decision to make a person be naked with a smock should be reviewed and revisited by

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[4] Michael Dresser, *Maryland legislature OKs deadline for state-run psychiatric hospitals to admit patients from jails*. Balt. Sun (Apr. 2, 2018 at 8:50 pm), at https://www.baltimoresun.com/politics/bs-md-mental-hospital-deadlines-20180402-story.html.

Circuit Court Judge Gale Rasin held Department of Health officials in contempt of court in 2017 for the failure to increase the number of psychiatric hospital beds for defendants with mental illness. *See* Ovetta Wiggins & Ellie Silverman, *State officials held in contempt in lawsuit over mentally ill inmates*. Wash. Post (Sept. 28, 2017), at https://www.washingtonpost.com/local/md-politics/md-state-officials-held-in-contempt-in-lawsuit-over-mentally-ill-inmates/2017/09/28/969ff71c-a46e-11e7-b14f-f41773cd5a14_story.html.

mental health staff at a minimum daily, and preferably every eight to 12 hours.

- We request that Defendants permit people in the IMHU to have reading materials, including but not limited to religious texts, and paper, envelopes, and writing implements unless they are actively engaged in self-injurious behavior. The decision as to whether people are denied reading and writing materials should be made by mental health providers and not custody staff; and the decision to deny such materials should be reviewed and revisited by mental health staff at a minimum daily, and preferably every eight to 12 hours.
- We request that all persons in the IMHU, regardless of their mental health status, be permitted to use the phone to call their defense attorneys within 24 hours of a request, rather than being limited to the narrow window of time when they are allowed out of their cells. We request that all persons in the IMHU be permitted to possess envelopes and business cards for *Duvall* class counsel, unless the person is actively using these envelopes and cards to engage in self-injurious behavior.

II. Abysmal Conditions and Medical Care in the Infirmary

The medical infirmary is physically located in the Metropolitan Transition Center (MTC) but is covered by the Agreement. *See* Doc. 541-2, ¶ 16(iv). We toured the infirmary the morning of August 3, 2022, and the conditions and care provided to class members were nothing short of shocking.[5] We brought numerous patients' urgent and untreated medical needs to the attention of Corizon management, and Captain Murray documented numerous physical plant defects and ADA violations with her photographs and in her notes.

Patients reported that they are allowed out of their rooms twice a day for 15 minutes, when they can either take a shower (if they are mobile enough to access a shower), or use the phone. We also found multiple patients with broken medical beds; no clean sheets, blankets, or clothing; inaccessible showers and toilets for people with disabilities; and ventilation systems that apparently were broken or barely working, making the shared rooms very hot and stuffy. For example, in Rooms 407, 408, and 409, at about 10:15 am on August 3, these rooms' thermometers were showing temperatures of almost 80 degrees. Room 409 did not even have a fan to move the air; Room 407's fan was hanging from a cord blowing air downward toward the floor, and 408 had a fan near the television ineffectually circulating air in these rooms holding multiple patients.

[5] The infirmary not only houses class members from BCBIC, but also houses people from other jails and prison facilities (including the federal facilities) for patients who need infirmary level or skilled-nursing care.

(Left: Photograph 112 –Room 407, 79.3 degrees and 58% humidity at 10:20 am)
(Right: Photograph 122 – Room 407's fan)

A. Accommodations for Patients With Disabilities in the Infirmary [6]

The Agreement requires that "[t]he Commissioner shall promulgate and implement policy and procedure to ensure that plaintiffs with disabilities that require special accommodations are housed in locations that provide those accommodations, including, as applicable, toilets that can be used without staff assistance, accessible showers, and areas providing appropriate privacy and sanitation for bowel disimpaction." Doc. 541-2 ¶ 21(a). Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-12134 and its implementing regulations for correctional and medical facilities (28 C.F.R. 35.151(k); 36 C.F.R. § 223 *et seq.*; 36 C.F.R. § 232 *et seq.*) require that detainees with mobility disabilities are housed appropriately.

Dr. Puisis' May 2022 report found Defendants in "Partial Compliance" with Provision 21, and with Paragraph 21(a). Doc. 766-2 at 37.[7] He noted that the process regarding

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[6] This discussion pertains to the accessibility in the infirmary, but on our tour of the intake area on August 2, we saw that the intake holding cell for people with disabilities (Booking Cell 6) had no grab bars in it. *See* Photographs 43-48. On Aug. 3, 2022, Warden Abello showed us photographs showing grab bars had been installed in this cell.

[7] The Agreement does not have a category of "Partial Compliance." Defendants are either compliant, or noncompliant. In addition, under Paragraph 39 of the Agreement, compliance is assessed by numbered paragraph, not by lettered subparagraph. Compliance with a numbered paragraph requires compliance with all of that paragraph's lettered subparagraphs.

"housing ADA patients [is] still defective." *Id*. at 38. His report does not discuss the physical plant of the infirmary, however, and it is unclear whether he visited the unit on his last visit.

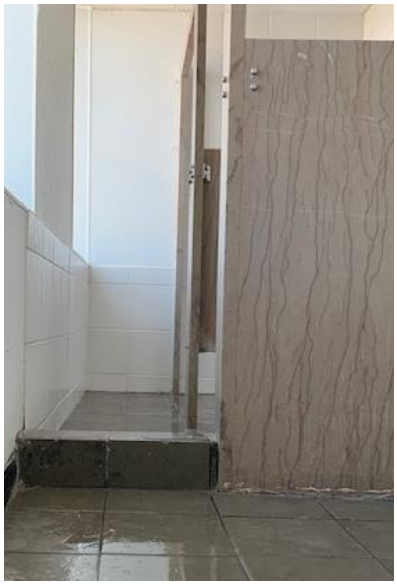
We observed that infirmary rooms did not have accessible toilets within them. Below are photos of the bathroom in Room 407; other rooms had identical designs.


(Photographs 114-115: Room 407 Bathroom – Not ADA Accessible)

Due to this toilet's inaccessibility, [redacted], a class member with paraplegia who is a full-time wheelchair user, must urinate into containers he then asks other detainees in his room to dump into the toilet, as nursing staff refuse to do so. On our visit, he had a container holding at least a liter of urine in it next to his bed, as well as another similarly-sized container about one-quarter full of urine. He estimated this was at least three to four days' production of urine. One would hope that in that amount of time, staff had gone into his room to check on him and the other patients and would have seen the bodily fluids that needed to be properly disposed for the safety and hygiene of everyone living in the room. Assuming medical staff *had* gone in his room in the previous three to four days, the fact that none took any efforts to dispose of the urine is shocking:

(Photograph 121: Full containers of urine on floor of hospital room)

The accessible shower on the fourth floor was in the room used to house COVID-positive patients, and thus wheelchair users could not use the ADA shower in it. They had not been able to take a shower for weeks or months. The only working shower on the fourth floor is inaccessible, with steps and narrow entrances:

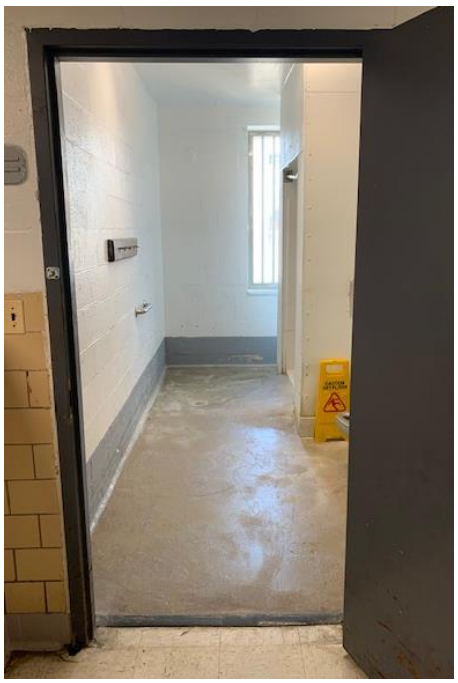


(Photographs 129-130, Infirmary 4th Floor Shower Behind Nurse's Station).

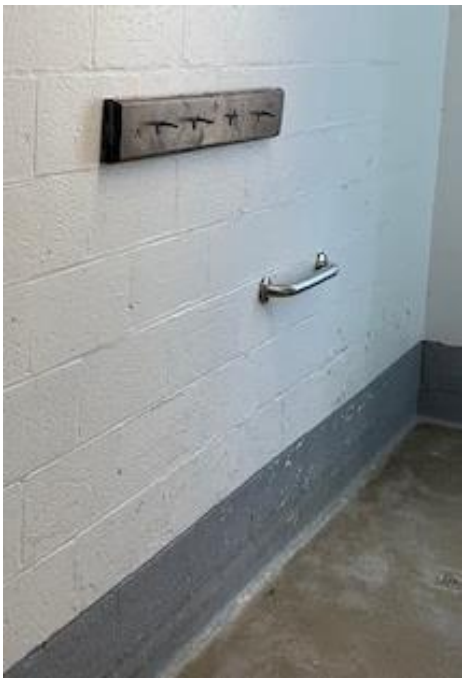
One floor down, the third floor's ADA accessible bathroom was broken and padlocked shut. Similar to those on the fourth floor, patients with mobility impairments incarcerated on the third floor of the infirmary—including, again, persons with severe disabilities such as paralysis and bowel and urinary incontinence—reported they had not been able to clean themselves properly for months, and compounding their misery, they were

not receiving clean linens or clothes with any regularity. After some questioning, custody and health care staff admitted that the third floor ADA bathroom had been "broken" since at least May, but nobody could say what was actually wrong with the bathroom. Nobody could explain why it inexplicably had not been repaired in over two months, or even prioritized for repair. Water flowed out of the shower both hot and cold, so it was unclear if it was truly "broken."

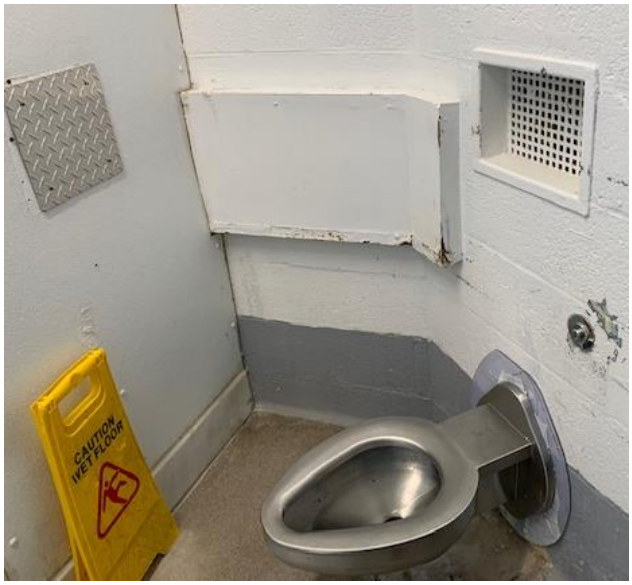
Regardless of its functionality, this "ADA shower" was not accessible or in any way compliant with the ADA Accessibility Guidelines ("ADAAGs"), as it only had one grab bar at a substantial distance from the actual shower. There was a step to get from the main part of the bathroom into the shower. The shower itself did not have a grab bar. The toilet next to the sink had no grab bars.



(Photograph 160: Out of Order 3rd floor ADA bathroom;
Photograph 161: grab bar on left below towel rack)




(Photographs 164, 168 – 3rd floor ADA shower: one grab bar; shower with no grab bar)

(Photographs 163, 171; 3rd floor ADA bathroom – no grab bars on toilet)

Another class member, [redacted], housed in Room 309, has two broken legs and was in splints and in traction at the time of his intake in early July from the hospital, reported that hospital doctors told him he could not put any weight on his legs and needed to stay in traction. He reported that nursing staff told him that he would have to wheel himself to the door to the toilet, stand up and walk on his broken legs, in order to use

the inaccessible toilet. Below are pictures of the bathroom in room 309:

(Photographs 155-157, Room 309 Toilet)

The plastic cushioning is on the edge of the door because it would not otherwise stay shut. The air vent in the bathroom was rusted, moldy, and broken, and the ceiling was plywood screwed over the original ceiling:

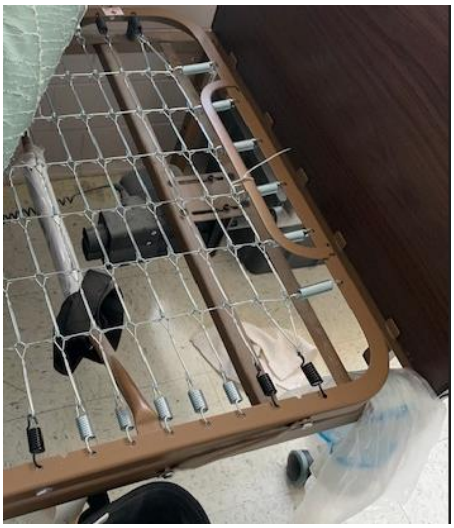
(Photograph 158, Room 309's bathroom ceiling)

In addition to the structural barriers impacting people with disabilities, they are not receiving needed accessible devices, or their auxiliary aids were broken or in poor repair. Under the ADA, the jail must provide accommodations, including assistive devices, to ensure that the detainee has equal access to prison services, programs, or activities. 28 C.F.R. § 35.130; 42 U.S.C. § 12132. The jail's contracted medical staff must consider, in addition to any definition of "medical necessity" used by Corizon, whether an appliance or aid is necessary to afford a detainee with a disability the greatest degree of independence possible. *See* 28 C.F.R. § 35.130(a)(1)(iii) ("A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing or other arrangements, on the basis of disability—[. . .] Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others. . .").

We spoke with [redacted], who as noted above has paraplegia. He has no transfer bars or trapeze bars with his bed, and reported that he has great difficulty transferring from his wheelchair to his bed. His bed does not adjust so that he can elevate his legs. He stated that he had waited for over a month to be given a special air mattress to reduce pressure sores, but while waiting, at least one of his sores worsened. (See pp. 21-22):

(Photograph 118: Unadjustable bed, lacks grab bars or trapeze bar. Room 407. H-4-3)

Other patients who said they had a medical need for an adjustable bed had broken beds. In Room 308, [redacted], reported that due to gunshot wounds in his leg, he was prescribed an elevated bed, but the bed that he was given could not adjust.



(Photograph 141: Broken bed H-36, room 308)

His assigned wheelchair was in poor condition: the right armrest was broken off, and the leg rest was broken. He also was using a folded-up sheet instead of an appropriate Roho or other type of wheelchair cushion that prevents the development of pressure sores:

(Photographs 143-144: Wheelchair)

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On another bed, occupied by [redacted], the wire that connected the controls to the bed had been cut:


(Photographs 146-147: broken remote and wire, bed H-33, room 308)

A non-class member assigned to bed H-31 in Room 308 had a bed where the control wire was similarly cut:

(Photograph 148: broken bed control wire, bed H-31, room 308)

[redacted], housed in room 309, is paralyzed below his chest. He has a massive stage 4 pressure sore on his buttocks, and needs an elevated bed, air mattress, and

a Roho cushion for his wheelchair. He said that he only has an eggcrate cushion on the mattress, which is inadequate. (See page 20 for a discussion of his untreated medical needs).

[redacted], housed in room 309, is 74 years old and has multiple serious medical problems. He, too, has an elevated bed that is not functional. He also needs a narrower wheelchair to allow him to have access to the shower.

The infirmary is where many of the sickest and most disabled plaintiffs are housed, yet the clear failure by health care or custody staff to provide the most basic of housing accommodations to them was alarming. Pursuant to ADA regulations and Paragraph 21(b) of the Agreement, the Jail must have an ADA coordinator, whose role includes ensuring that the detention facility accommodates people with disabilities.

Common sense indicates, and baseline correctional practice requires, that the person in this role ***must*** know at all times where all of the people with disabilities are housed in a carceral facility, and their living conditions. We were unable to confer with the ADA coordinator after observing and documenting these appalling conditions. Corizon's Semi-Annual Self-Audit for July 1, 2021-Dec. 31, 2021 asserts in its discussion of compliance with Paragraph 21(b), that medical and custody ADA staff conduct on a weekly basis,

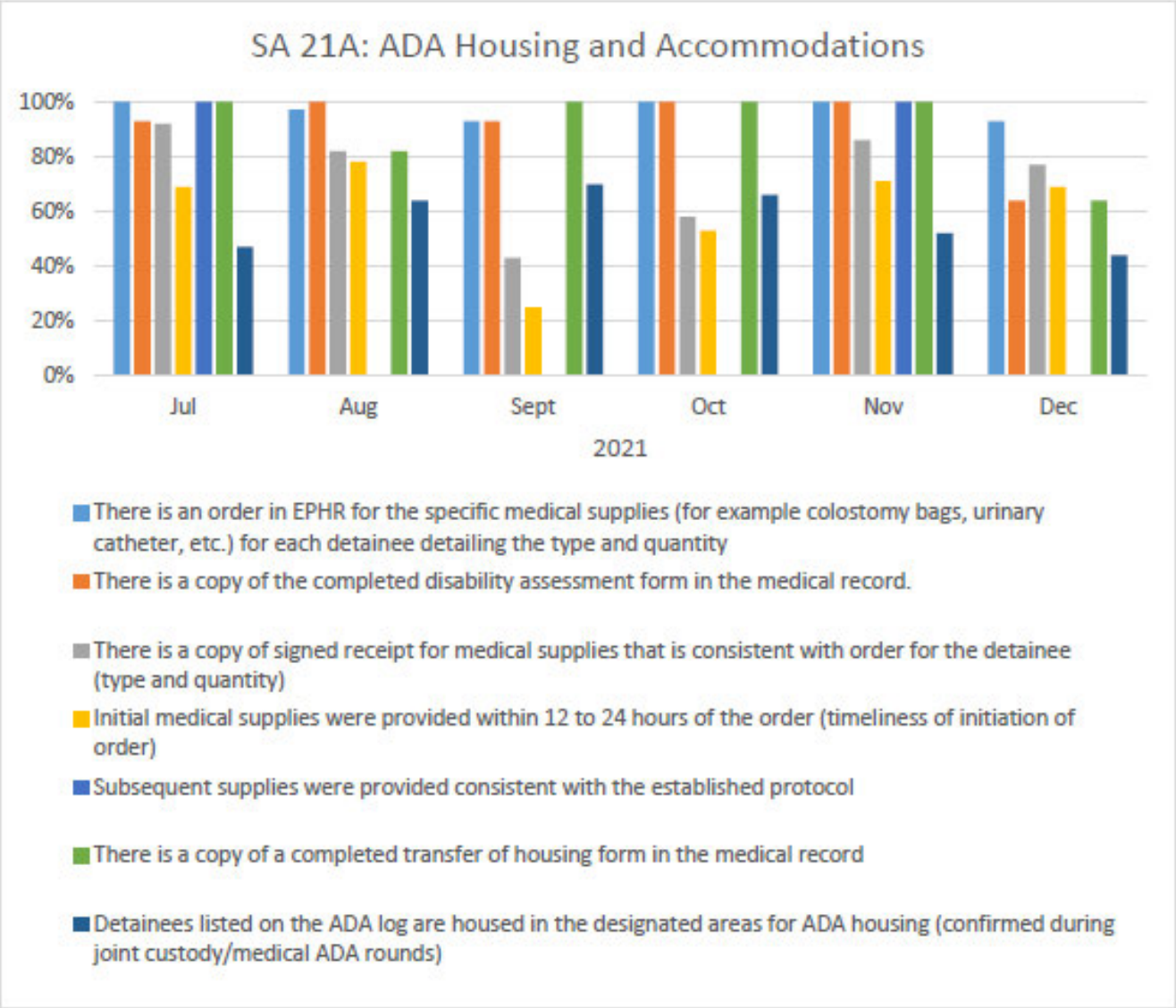
> physical rounds on each designated ADA housing unit, as well as each housing unit throughout the facility to ensure that there are no additional ADA accommodation requests, regardless of the housing unit.
>
> *During the reporting period, Covid-19 affected custody staffing and led to a few weekly medical/Custody ADA rounds being missed.

Semi-Annual Report at 35.

If in fact such weekly rounds are occurring, there is simply no excuse for the appalling conditions in which so many of our clients in the infirmary are confined.

In his most recent report, Dr. Puisis found Defendants compliant with Paragraph 21(b) because the ADA coordinator position has been filled; however, given Defendants' abject failure to address the needs of plaintiffs with disabilities in any sort of meaningful way, this finding cannot be sustained. It is not sufficient that a person simply be designated as ADA coordinator; compliance with Paragraph 21(b) requires that that person actually "address concerns of plaintiffs with disabilities regarding accommodations for their disabilities."

As noted, Dr. Puisis' May 2022 report found Defendants in "partial compliance" with Provision 21, and with Paragraph 21(a), a finding that Plaintiffs object to because there is no such category as "partial compliance," and that compliance is assessed by numbered paragraph, not by lettered subparagraph. Doc. 766-2 at 37. Corizon's Semi-Annual Report for July 1-Dec. 31, 2021 showed a widespread failure to provide accessible devices or housing on a timely basis, in violation of Paragraph 21(a). Semi-Annual Report at 33-35. Corizon pointed to staffing shortages, and the use of paper records, as contributing to their admitted noncompliance with Paragraph 21(a). Their own data showed the following compliance levels for the second half of 2021:



Plaintiffs' Counsel's Requests:

- We request that the Commissioner or her designee conduct a top-to-bottom audit of all physical spaces where people with mobility impairments are incarcerated at BCBIC and the infirmary, to ensure that class members with disabilities are accommodated and housed in conditions that comply with the Agreement, ADA regulations, and ADAAGs for correctional facilities. This may require consultation with structural experts so that any repairs or alterations are done in a way that comply with ADAAGs and do not inadvertently place people at further risk of physical injury.
- Plaintiffs request documentation of all of the "few" weekly medical/custody ADA rounds that Corizon admits were cancelled in the second half of 2021. *See* Semi-Annual Report at 35. Please provide documentation of whether these weekly rounds have been conducted in 2022.
- Please confirm whether the "weekly medical/custody rounds" that Corizon asserted were made of all ADA housing units and patients included physical rounds of the infirmary.
- The ADA coordinator should be notified by medical staff at intake of all persons with mobility impairments who are being booked into the jail, so that she or her designee can provide the detainee with information about their rights and assess the detainee's accessibility needs. Dr. Puisis' May 2022 expert report recommended that a root cause analysis be made of the failures in the intake assessment process in not identifying ADA needs. Doc. 766-2 at 38.
- The ADA coordinator (or the Commissioner's designee) should work with health care staff to ensure that there is an up-to-date daily roster listing all detainees with mobility (or sensory) impairments, and then the coordinator and/or designee should visit and speak to these detainees on a regular basis to ensure that they have received necessary medical supplies and are accommodated.

In sum, Plaintiffs' counsel will continue to closely monitor compliance with Provision 21, and we recommend that Dr. Puisis find Defendants noncompliant rather than "partially compliant" with Paragraph 21(a) in his next report. We further recommend that Dr. Puisis find Defendants noncompliant with Paragraph 21(b) for allowing these appalling conditions to persist.

B. Inadequate Medical Care in the Infirmary

We also met with numerous class members housed in the infirmary with very serious medical conditions who reported receiving inadequate medical care. We have attempted to confirm their allegations by reviewing their medical records, but in some cases the problems were visible, which we tried to document through photographs.

[redacted].[8]

Mr. [redacted] is paralyzed from his chest down, is a fulltime wheelchair user and uses a colostomy bag. He reported that he was arrested in mid-July on a warrant. He stated that he was housed in BCBIC for about four days, including spending several nights in 4 North and in the clinic, and was moved to the infirmary on July 26.

Mr. [redacted] had a very large, Stage 4 pressure sore on his buttocks that was infected and so deep that it was infected into his tailbone. (He agreed that pictures be taken to document the sore). He reported that he was seeing a wound specialist regularly in the community, and that the pressure sore needs to have its dressing changed twice a day, but he's lucky to have nursing staff change the dressing once a day. Capt. Murray brought his case to the attention of Corizon's regional medical director, and as shown in the photo below she personally inspected the sore and the dressing. As noted above on pp. 16-17, he does not have assistive devices for his bed and wheelchair that can reduce the pressure and pain. He stated that he had developed a fever since coming into custody, and that a culture was made of the wound in the previous week. He reported that he was told by the infirmary provider that he had osteomyelitis and needed intravenous antibiotics, but had not received IV antibiotics by the time that we spoke with him.


(Photographs 149, 151; See also Photographs 150, 152)

[8] As of the date of this letter, we had not received his medical records to confirm all of his statements regarding his medical needs.

Please ensure that Mr. [redacted] receives twice-a-day wound changes, all necessary intravenous antibiotics to treat or prevent infection, and prompt referral to a wound care specialist for evaluation. We also request that he be provided the assistive devices described above at pages 16-17.

[redacted][9]

Mr. [redacted] has paraplegia and is a full-time wheelchair user. He reported that he was shot in the back in 2020 and paralyzed; and after being treated in a rehab center, he was incarcerated in the infirmary in 2020. He said that he was not moved frequently enough in 2020 while in the infirmary, and developed pressure sores in his ankle and on his buttocks that became infected with MRSA. He said that due to the open sore on his buttocks, in 2020 he had to have a colostomy installed because he could not expose the sore to feces if he were using continence briefs.

He was released in 2020, when he began seeing a wound care specialist regularly to treat the pressure sores, including by using a wound vac. After more than a year of specialist treatment in the community, the sores had shrunk to the point that they could be surgically closed. Closing the sore on his buttocks would also allow him to have his colostomy reversed. He stated that he was scheduled for surgery to close the wound on his buttocks when his probation was revoked in May 2022 and he was jailed.

Mr. [redacted] reported that he asked someone he named as Dr. Tedla (spelling unclear) at the infirmary about whether he could still go have the scheduled surgery, and that Dr. Tedla said that since it was "cosmetic surgery," Corizon would not approve or pay for the surgery. Mr. [redacted] reported that the sore on his right ankle has worsened since being jailed in the infirmary, and the wound on his buttocks had grown to the size of a golf ball and was at Stage 3.

Additionally, Mr. [redacted] stated that when he was in the community, he was receiving regular occupational and physical therapy to strengthen his upper body and to keep some strength in his legs, but that no OT or PT has been provided in the infirmary to him or other patients who could benefit from it.

Captain Murray asked Corizon's regional medical director to personally inspect the pressure sore:

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[9] As of the date of this letter, we had not received his medical records to confirm all of his statements regarding his medical needs.

(Photograph 124, see also Photograph 123)

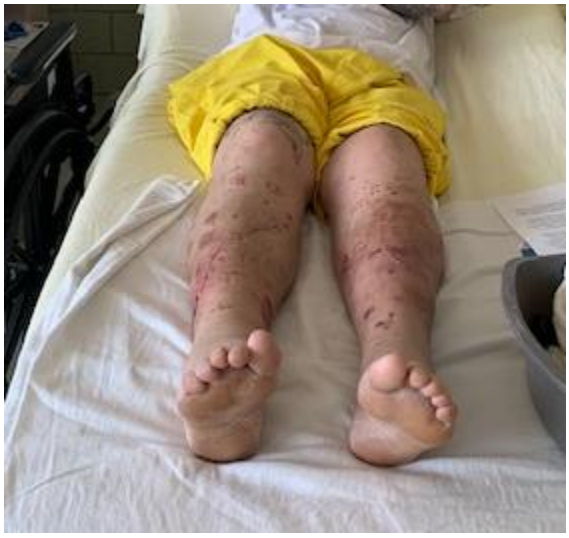
Please ensure that Mr. [redacted] is promptly seen by a wound care specialist for follow-up, and if he is going to continue to be incarcerated in the jail, that surgical repair of his pressure sore be promptly scheduled. We request that he be provided ongoing PT/OT. We ask that all specialist recommendations be promptly implemented and provided. We also request that he be provided a functional hospital bed with transfer or trapeze bars, as described above at page 14.

[redacted]

Mr. [redacted] has two broken legs due to a motor vehicle accident prior to his arrest. He stated that he had been in the hospital with both legs in traction, and was discharged to the infirmary on July 6, 2022, with both legs in splints and instructions that he be in traction or otherwise able to elevate his legs at all time. A July 21, 2022 follow up consultation report from Dr. Mark Gage at the University of Maryland Medical Center states that he needed to have his legs elevated "as much as possible," As detailed on pp. 12-13 he has to stand and walk on his broken legs to use the toilet in his room. At his first follow-up appointment with the orthopedic specialist, Dr. Gage recommended that he receive rehabilitative treatment and physical therapy so that he can strengthen his legs and regain the ability to walk, but that Mr. [redacted] reported that was not provided at the infirmary, and there was no evidence in his medical chart that he is receiving PT/OT.

His legs were extremely swollen, and covered with open sores and incisions, which he was concerned were going to become infected due to the unhygienic conditions in the room. He said he was diagnosed with cellulitis, which his medical record confirmed. He stated that he needed to have a second follow up with the orthopedic specialist but at the time we

interviewed him (Aug. 3), he hadn't gone out. A note by the infirmary provider Dr. Ali dated August 12, 2022, stated that consult for second post-op follow up was submitted to Corizon Utilization Management ("UM") on August 5, and that a request for onsite PT had been submitted to UM on July 23, but it does not appear that these consult requests have been approved or scheduled.



(Photograph 159 – swollen broken legs).

Please ensure that Mr. [redacted] is promptly seen by an orthopedic specialist for follow-up to his reconstructive surgeries. We request that he be provided ongoing PT/OT on-site without further delay.

[redacted]

Mr. [redacted] had his femur fractured on July 20, 2022. He is in significant pain, and is not receiving physical therapy or needed orthopedic follow-up. An August 15, 2022 note in his medical record reads "He is scheduled to see Orthopedist at UMMS/STC scheduled for 8/12/2022 but didn't go due to transportation issue. F/u with Schedulers re new appointment." **Please ensure that Mr. [redacted] is seen promptly by an orthopedic specialist for the appointment that was cancelled due to transportation issues. We request that he be provided ongoing PT/OT on-site without further delay.**

[redacted][10]

Mr. [redacted] was housed in the infirmary. He stated that several weeks earlier while he was at BCBIC, he had severe pain in a surgical incision from a past hernia repair surgery. He

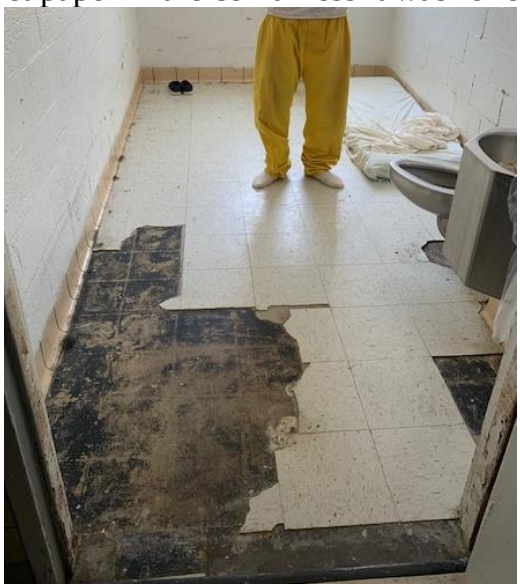
[10] As of the date of this letter, we had not received his medical records to confirm all of his statements regarding his medical needs.

reported that he was not seen by medical staff for five days despite multiple sick call requests. He was finally taken to the hospital after an abscess in the surgical incision and the hernia mesh became so infected that it ruptured. He reported that he needs to see surgeon for follow up and evaluation of repair of the hernia mesh. **Please ensure that Mr. [redacted] has his follow-up consultation and evaluation with the surgeon for repair of the incision and hernia mesh without further delay.**

[redacted]

Mr. [redacted] appeared to be on some kind of watch in cell 418 in the infirmary. According to staff, he had been in the infirmary since December 20, 2021; it was unclear whether he had been on watch for the entire 7½ months since that time. Documents in his medical record shows that his intake may have been earlier, on July 28, 2021. Mr. [redacted] was talking to himself, and obviously extremely impaired. Review of his medical record reveals multiple references to an unspecified "mental disorder," without elaboration; despite his obvious impairment and placement on 1:1 watch, he has apparently never been assigned a mental health diagnosis. His most recent behavioral health encounter in his medical record, dated July 10, 2022, does not indicate his diagnosis and states that he was going to be released to an unknown location.

The conditions in his cell were appalling, as indicated in the photos below, with the toilet full of feces. He slept on the floor on a thin mattress and had no reading materials or anything else in his cell. There was a sign on the door to his cell indicating that he could not have toilet paper in the cell unless it was rolled off as necessary:




(Photographs 125-126 – Cell 418)

(Photograph 127)

Plaintiffs' Counsel's Requests:

- We request that Dr. Puisis review the medical charts of every patient listed above, and that Dr. Metzner review the chart of [redacted]. We ask that if these patients are still incarcerated at the time of the expert visit, the experts examine and speak with them to assess their current situation and determine if the problems that were apparent on August 3 have since been resolved.
- We request that Defendants, pursuant to their oversight role with Corizon's $680 million, five-year contract with the Department,[11] require Corizon to provide on-site occupational therapy and physical therapy through its own employees or a subcontractor.
- We request that Defendants describe what financial penalties, if any, have been assessed against Corizon by DPSCS or its Office of Procurement Services for noncompliance with this contract since 2018.
- We request that Defendants describe what remedial efforts they will demand from Corizon for their failure to provide minimally adequate medical or mental health care to infirmary patients.

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[11] See Hannah Gaskill, *Board of Public Works Rejects Multimillion-Dollar Prison Medical Contract.* Maryland Matters (June 18, 2020), at https://www.marylandmatters.org/2020/06/18/board-of-public-works-rejects-multimillion-dollar-prison-medical-contract/.

III. Shortages of Health Care Staff

Multiple class members—both in the infirmary and in the general population—reported that shortages of medical and nursing staff were adversely affecting the timeliness of responses to requests for care, and especially affecting the timely delivery of psychotropic and chronic care medications. Moreover, Corizon's Semi-Annual Report for July 1-December 31, 2021, admitted that

> In 2021, BCBIC custody and medical staffing were affected with large numbers of staff out with COVID, sometimes leaving the facility to run at 50% staffing[,] limiting clinics and only being able to carry out critical of care delivery areas such as intake screening, sick-call, med pass, and withdrawal treatments. The Great Resignation that hit the country also affected staffing with approximately 30% nursing and staff loss due to higher-paying wages in other healthcare specialty jobs. To allow the jail to continue functioning, staffing agencies provided most of the nurses at BCBIC. To stop the bleed of nurses leaving our patients in Baltimore, Corizon took an unconventional approach of increasing frontline staff wages by as high as 30% to compete with hospital pay and improve recruitment and retention.

Duvall Semi-Annual Report: July 1, 2021-December 31, 2021, at 5.

After the tour we requested health care staff schedules to show which positions had been actually worked since June 1, 2022. The documents we received on August 23 provided staffing information through August 31, so it appears that at least some of these documents reflect what is scheduled, versus what was actually worked. We note that the records showed frequent shortages of staff, and an ongoing reliance upon registry / non-permanent staff. On August 24, we clarified that we also would want to review Centurion's documentation regarding mental health staffing levels and actual positions worked, but had not received those documents as of the date of this letter.

Infirmary Staffing

MTC Third Floor Infirmary Staffing: June-August 2022: This shows multiple staff vacancies, including RN, LPN, and PCT. In June, all health care staff positions on the night shift were vacant (0.4 RN, 1.4 LPH, and 1.4 PCT) with the exception of 1.0 RN. Although the charge nurse position is not listed as vacant, it appears this person worked no hours in June, July, or August.

MTC Fourth Floor Infirmary Staffing: June-August 2022: This shows multiple staff vacancies, including RN, LPN, and PCT. In June, the only RN position on the day shift was

vacant, and *all* health care staff positions on the night shift were vacant. Although the charge nurse position is not listed as vacant, it appears this person worked no hours in June, July, or August.

MTC Infirmary Provider Staffing: June-August 2022: During our tour we were told that Dr. Luka is normally on site 11 am – 7 pm weekdays; and that a physician's assistant is on duty from 3 am to 11 am weekdays. There is no date or timeframe associated with the document we were provided. It shows that the "Disp day Mid-level SC" position (unclear what this means) is vacant. It also shows that 3rd floor infirmary rounds are done during the day, and 4th floor infirmary rounds during the evening, Monday-Friday, apparently by physicians. For Saturday and Sunday, the provider for rounds is listed as "PRN."

Advanced Practice Provider (APP) Staffing
June 2022 APP Staffing: These documents showed:

- **Female sally port**: uncovered 9 days on night shift (8 pm to 8:30 a.m.); also uncovered one day on day shift. Even when ostensibly covered, it is often uncovered for a portion of the night shift (e.g., person worked 12:30-9 a.m.).
- **Intake physicals/sick call**: Some days there is only one person assigned; there is sometimes no one assigned on weekends. Sometimes the single person assigned appears to have other duties (e.g. on June 12, 18, 23, 24, and 26, the single person listed under "intake physicals/sick call" is also listed under "IHMU Rounds/Intake").
- **Addiction medicine** – no staff on many days.
- **4 Center** – no staff on many days, including for three consecutive days (June 17-19).
- **IMHU rounds-** No staff listed for June 5 and 17.

July 2022 APP Staffing: These documents showed:

- **Female sally port**: uncovered 13 days on night shift (8 pm to 8:30 a.m.). Even when ostensibly covered, it is often uncovered for a portion of the night shift (e.g., person worked 12:30-9 a.m.).
- **Intake physicals/sick call**: Some days there is only one person assigned; there is sometimes no one assigned on weekends. Sometimes the single person assigned appears to have other duties (e.g. on July 2 and 22, the single person listed under "intake physicals/sick call" is also listed under "IHMU Rounds/Intake").
- **Addiction medicine** – no staff many days, including two periods of three consecutive days (July 8-10 and 29-31).
- **4 Center** – no staff many days, including for four consecutive days (July 1-4).

It appears that some staff listed on this schedule are simultaneously working at other facilities – *e.g.*, there are several entries for "Alemu MTC," and "Elizabeth YDC."

August 2022 APP Staffing: These documents showed:

- **Female sally port**: uncovered the majority of days on night shift (8 pm to 8:30 a.m.). Even when ostensibly covered, it is in fact uncovered for a portion of the night shift (person worked 12:30-9 a.m.).
- **Intake physicals/sick call**: Many days there is only one person assigned; there is sometimes no one assigned on weekends. Sometimes the single person assigned appears to have other duties (e.g. on August 1, 3, and 5, the single person listed under "intake physicals/sick call" is also listed under "IHMU Rounds/Intake").
- **Addiction medicine** – no staff many days, including for five consecutive days (August 19-23).
- **4 Center** – no staff many days, including for nine consecutive days (August 13-21).

Nursing Staffing

June 2022 Nursing Staffing: These documents indicate that Corizon fell short – often far short – of their nurse staffing targets on many days. For example, the target is 11 RNs on day shift; on June 5 and 19, the actual number of RNs working was 4, and on June 13 and 27, the actual number was 5. The target is 5 LPNs on night shift; on June 4, 11, 18, and 25, the actual number working was 2.

July and August 2022 Nursing Staffing: These documents claim to meet the staffing requirements every single day in July and August, but it appears that Corizon is using a significant number of registry nurses.

Plaintiffs' Counsel's Requests:

- Plaintiffs request that Defendants, with their health care vendors and the input of the court monitors, develop a plan for immediately ensuring that all health care positions are covered.
- Plaintiffs request that Defendants, with their health care vendors and the input of the court monitors, develop a plan for filling all health care staff vacancies within six months.

IV. Insulin Administration

Prior to our visit, we requested a list of all insulin-dependent diabetics housed in the Jail. The experiences of people with diabetes in receiving their medication in a timely manner and regular blood sugar checks implicate multiple provisions of the Settlement Agreement. See, e.g., Doc. 541-2 at ¶¶ 17(d), 18(a), 18(b), 19(c), 19(g). Dr. Puisis reviewed the medical care provided to insulin-dependent diabetics in his most recent report. See Doc. 766-2 at 16-20.

Corizon's Semi-Annual Report for July 1-Dec. 31, 2021, showed that blood sugar tests were completed and documented in the medical records as ordered less than 30 percent of the time in July, zero (0) percent of the time in August, and 13 percent of the time in September 2021. Semi-Annual Report at 51. This constitutes profound noncompliance with Paragraph 19(c):

SA 19C: Vital Sign and Blood Sugar Monitoring

Audit Indicator	Jul	Aug	Sept	Average Score
Vital signs completed and documented as ordered in EPHR	35%	48%	41%	41%
Blood sugar tests completed and documented in EPHR as ordered	29%	0%	13%	14%
Vital signs results documented as reviewed by the clinician during a patient encounter	60%	54%	40%	51%
Blood sugar tests documented as reviewed by the clinician during a patient encounter	67%	100%	100%	89%
Score Summary for SA 19C:	48%	51%	49%	49%

Compliance levels for Paragraph 19(g) were equally abysmal (*id*. at 53):

SA 19G: Vital Sign and Blood Sugar Monitoring

Audit Indicator	Jul	Aug	Sept	Oct	Average Score
There is an order for blood sugar or vital signs monitoring in EPHR by the provider with parameters in the audit period	58%	74%	47%	29%	52%
There is documentation in the EPHR that the vital signs and /or blood sugars were taken according to the provider orders during the audit period	4%	22%	27%	6%	15%
Abnormal results for vital signs and /or blood sugar have documentation in EPHR with nursing referral to the clinician during the audit period	50%	67%	21%	50%	47%
There is documentation of the review and disposition by the clinician in EPHR for abnormal readings of vital signs or accucheck as a result of that nursing referral during the audit period	100%	85%	67%	58%	78%
Blood sugar tests reported in the lab contractor blood sugar report documented as reviewed in EPHR by the clinician during patient encounter during the audit period	100%	43%	33%	100%	69%
There is an abnormal A1C >9 result for the audit period during the audit period	100%	100%	100%	100%	100%
Score Summary for SA 19G:	69%	65%	49%	57%	60%

We met with at least ten insulin-dependent diabetics housed across the jail who uniformly reported that they were not getting insulin with meals or every 12 hours, resulting in dangerous spikes and variances in their blood sugar levels. Multiple plaintiffs with diabetes reported that there was only one "insulin nurse" for the entire jail, who recently quit. Across multiple housing units, they reported that they would get their morning insulin very early in the morning, approximately 4 or 5 am, but were not given a snack, and would not get breakfast until 7 or 8 am. They also reported that the time for the administration of PM insulin could range from 4 pm to 10 pm, and it was not accompanied by a meal or snacks.

We also spoke to [redacted], a new intake detainee housed temporarily in the gym, who stated that he needed to take insulin three times a day, and was not receiving it with the required frequency. Warden Abello shared his information with medical staff. His medical records indicate that he was not given insulin at all on August 6 (**after we brought his case to the attention of custody and medical staff**) and he only received it once on August 1. Mr. [redacted] has a number of dangerously high glucose levels recorded: 353 on August 4; 341 on August 4; and 341 on August 5.

Plaintiffs' Counsel's Request

- We request that Defendants immediately implement all recommendations made previously by Dr. Puisis about the care of insulin-dependent diabetics, as well as any future recommendations.
- We request that Dr. Puisis conduct another "diabetes audit" similar to the one discussed in his previous report, to assess the delivery of care to this population.

V. Delays in Specialty Care

Prior to our tour, we requested a list of all specialty consultation requests submitted to Corizon's Utilization Management in the previous 90 days, as multiple components of Provision 18 are implicated, especially Paragraph 18(d). Dr. Puisis' May 2022 report noted that the diabetes audit showed that only nine of 20 (45%) of patients were referred for a diabetic eye exam, and only two of 20 (10%) were referred for a dental examination. "These are standard of care referrals and should occur for all persons with diabetes. One person who was referred to a nephrologist had that referral denied." Doc. 766-2 at 21. He also noted that Defendants failed to keep an accurate specialty care log, as required by Provision 22 of the Settlement.

We spoke with [redacted], an insulin-dependent diabetic.[12] He reported that he has suffered from multiple retinal detachments and delays in specialty care since September 2021, and currently needs to see a retinal surgeon because he does not think his last surgery worked, and is having vision problems. He reported submitting multiple sick call slips asking for the specialist appointment. **Please ensure that Mr. [redacted] is promptly seen by a retinal specialist without further delay, and that all specialist recommendations are implemented without further delay.**

Other plaintiffs who described or had documented delays in specialty care included:

- [redacted], is pregnant and her outside OB/GYN consult was listed as pending Utilization Management review.
- [redacted], requests cardiology and oncology consults listed as pending. We have separately contacted you regarding Mr. [redacted]'s care. *See* Aug. 22, 2022 letter from David Fathi.
- [redacted],[13] reported that he had aggressive colon cancer in 2017 in the community, and underwent surgery, chemotherapy, and radiation. He reported that he was scheduled for a regular checkup with his oncologist and with a GI specialist for a colonoscopy in early August 2022, but he was incarcerated in June 2022. He reported that he has submitted sick call slips asking if he could be sent out for the appointments scheduled when he was in the community, and received no response.
- [redacted], stated that his jaw was fractured in February 2022. He has not received appropriate follow-up care; a May 2, 2022 note in his chart reads "defer orthodontic eval until release as this is not medically necessary." He is in significant pain; in an April 19 encounter, he complained of pain that was "8/10 in severity and not controlled with extra strength Tylenol."
- [redacted], has an amputated leg.[14] His prosthesis no longer fits properly and needs adjustment. Rather than have an orthotics specialist adjust the prosthesis, medical staff are making him use a wheelchair to get around. The ADA requires that when providing services, public entities must provide accommodation that maximizes the ability of a person with disabilities to achieve independence. 28 C.F.R. § 35.130 (a)(1)(iii). A person who would have greater mobility with a prosthetic leg, therefore, cannot be required to use a wheelchair for his mobility simply because Corizon chooses not to make necessary adjustments to his prosthesis.

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12 As of the date of this letter, we had not received his medical records to confirm all of his statements regarding his medical needs.

13 As of the date of this letter, we had not received his medical records to confirm all of his statements regarding his medical needs.

14 As of the date of this letter, we had not received his medical records to confirm all of his statements regarding his disability accommodations and medical needs.

VI. Classification and Treatment of Detained Women

Dr. Puisis has repeatedly documented his recommendation that BCBIC expand clinical space for female patients, as the floors on which they were housed had no clinic, and administrative space next to the elevator were made into clinical space. Doc. 766-2 at 6. Dr. Patterson has noted his concerns with the fact that detained women who need higher levels of mental health care have to be transferred to the MCIW Inpatient Mental Health Unit, versus having specialized space on site. Doc. 755-3 at 11. He also noted that Defendants' and Centurion's self-monitoring and reporting of metrics related to self-harm does not include the women moved from BCBIC to MCIW. *Id*. at 9.

We visited the housing units for women and spoke to multiple class members reporting unequal treatment and harsh conditions. Male detainees who are at higher levels of classification are allowed out of cell three hours twice a day, but all women are only allowed out of their cells for one hour twice a day. This is the only time that they are allowed to take showers, clean their clothes, or make phone calls. The women we spoke with universally reported that they had been locked in their cells continuously since the Saturday before our visit (we were there on a Tuesday) and they had only been allowed out of their cells an hour before our visit. There are no dormitory housing options for women. The women are not allowed to have television or radios in their cells – just a loud TV blaring in the day room area while they're locked in their cells for all but two hours a day. The women are never allowed to use the outdoor rec area on the roof adjacent to the gymnasium, because new intake men are sleeping in the gym. They also stated that the only reading materials they are provided are the Bible, religious tracts, and coloring books, but they are often not even given pencils or crayons to color with. These conditions are akin to the extended isolation described above at pp. 2-7. When we asked why they were subjected to such conditions, women reported that usually they were told that it was due to a shortage of custody staff to supervise them out-of-cell in the day room, or sometimes because male detainees had misbehaved elsewhere in the jail, and so all detainees were going to be punished. As one woman put it, "Staff tell us that if the men upstairs do something, we're going to pay, too."

Women we spoke with also universally complained about inadequate nutrition, including small portions and sack lunches. At least one woman reported that custody staff told her that the reason that they were getting small portions was "it's not like you're getting out of your cell and exercising or burning calories." [redacted], was 17 weeks pregnant when we spoke with her, and reported that she was not provided any additional food, such as milk or extra portions, and was receiving an unbalanced diet lacking fruit and vegetables. Her medical record shows that on July 1, she submitted a sick call request stating that she was experiencing hunger pains, and "I'm pregnant I would like to

receive insure and snack packs." The response by the provider stated that she would be prescribed a pregnancy diet but a hold on Ensure at the time.

Several women reported serious mental health concerns and said that mental health staff do not do regular rounds to check on people, and do not respond when sick call slips are submitted or custody staff ask for mental health staff to speak to someone. They also reported that when mental health staff do come to their units, all encounters are conducted cell-front, without any privacy. This is hardly a therapeutic encounter.

Finally, we spoke to two transgender women who reported that even though they had been taking female hormones for years, and identified and lived as women in the community, they were made to live in general population of men's units because they had not yet completed genital surgery. One reported being assaulted by her cellmate last year, including suffering injuries, and the other was housed in the IMHU for her own safety after being verbally threatened by male detainees in general population.

Plaintiffs' counsel's requests:

- Defendants should not treat women detainees more harshly than male detainees simply because there is less space or fewer women in the facility. Unless their behavior indicates otherwise, women should be given out-of-cell time equivalent to well-behaving male detainees.
- Locking people in their cells for long periods of time does not justify feeding them less food. Defendants must provide all detainees, particularly those who are pregnant, a nutritionally balanced and adequate diet.
- Transgender detainees should be given the option to house with the gender with which they identify, and their placement should not be dictated solely by gender at birth or genitalia.[15]

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[15] *See Williams v. Kincaid*, ___ F.4th ___, 2022 WL 3364824 (4th Cir. Aug. 16, 2022) (incarcerated transgender woman's challenge to her confinement in a male housing unit states a claim under the Americans with Disabilities Act).

VII. Delays in Transfers or Releases Resulting in Overcrowding at Intake and Failure to Observe COVID-19 Intake Protocols

We heard from multiple detainees across the jail that upon intake they spend one to three nights sleeping on the floor in the intake cells near the sally port. Once space opens up in the gym, male detainees go there to spend anywhere between two nights to a week sleeping there in plastic "boats" on the floor that are less than six feet apart, as seen above and below. We spoke with [redacted], in 3-North, still on COVID quarantine. He is paralyzed on his left side, with metal in his arms and legs, and reported that he had a hard time getting in and out of the sleeping boats on the floor in the gym.

It is only after their time in the gym together, that male detainees are moved to a COVID-19 quarantine unit at 4-North-A. This practice makes no sense: people are held in close quarters together for days in the intake cells and the gymnasium, and only after that are moved into separate cells for quarantine.[16]

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[16] Another aspect of the jail's COVID-19 precautions requires comment. After plaintiffs' counsel interviewed [redacted], on August 3, we received an email from defense counsel the following day, stating that Mr. [redacted] had tested positive for COVID-19. We appreciate the prompt notification. However, because Mr. [redacted] had been continuously housed

(Photograph 57: Plastic "boats" for sleeping in the gym)

When we visited the gym on August 2, there were 27 men living there. They shared one toilet in the gym, and one toilet and shower across the hall. The toilets and shower were unsanitary. There were also multiple men in the gym who reported having serious mental health or chronic physical conditions who were not getting medication, or needed urgent treatment, in violation of the Settlement Agreement's provisions related to intake care. We brought these patients to the attention of medical and custody staff accompanying us:

- [redacted]. As noted above on page 30, Mr. [redacted] reported that he is diabetic and needs insulin three times a day, but was not receiving it.
- [redacted], reported that at the time of his arrest he was undergoing treatment for lung cancer, but had not seen a provider since his intake the previous week. His medical record shows that he told intake staff that he had lung cancer during his intake on July 29. He was seen by a nurse practitioner on August 4, and released on August 5, three days after we spoke with him.
- [redacted]. He reported that he had not received his hypertension medications for multiple days since his intake, and Defendants' records confirm that he had recently been rejected from intake at BCBIC and was emergently hospitalized at Johns Hopkins for his high blood pressure for nine days. According to Johns

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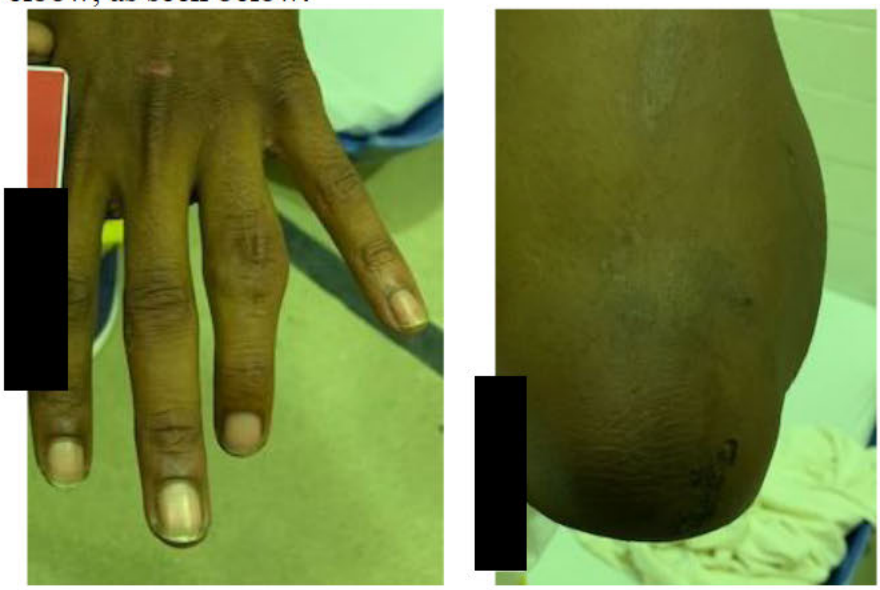
in the IMHU since June 4, it is obvious that he contracted COVID-19 while in the jail, from another detainee or from a staff member. This indicates a defect in the jail's COVID-19 prevention program that should be addressed.

Hopkins' discharge instructions, Mr. [redacted] was prescribed seven new medications and was directed to follow up with a cardiologist as soon as possible. His medical records indicate that he has cardiomyopathy, congestive heart failure, and sleep apnea. A family member reported that Mr. [redacted] father died from cardiomyopathy at the age of 54. Defendants' records show several high blood pressure readings since Mr. [redacted] has been at BCBIC: 162/94 on July 29; 171/109 on July 30; 158/103 on July 30; 170/80 on July 31; 156/81 on August 1; and 152/96 on August 4. Mr. [redacted] is CPAP-dependent and has been without his CPAP machine since his discharge from the hospital on July 29. Mr. [redacted] submitted a Sick Call Request Form on August 11 explaining that he "ha[d]n't…consistently received [his] proper dosage of meds."

- [redacted], had a visibly injured ring finger on his left hand, and injured elbow, as seen below.



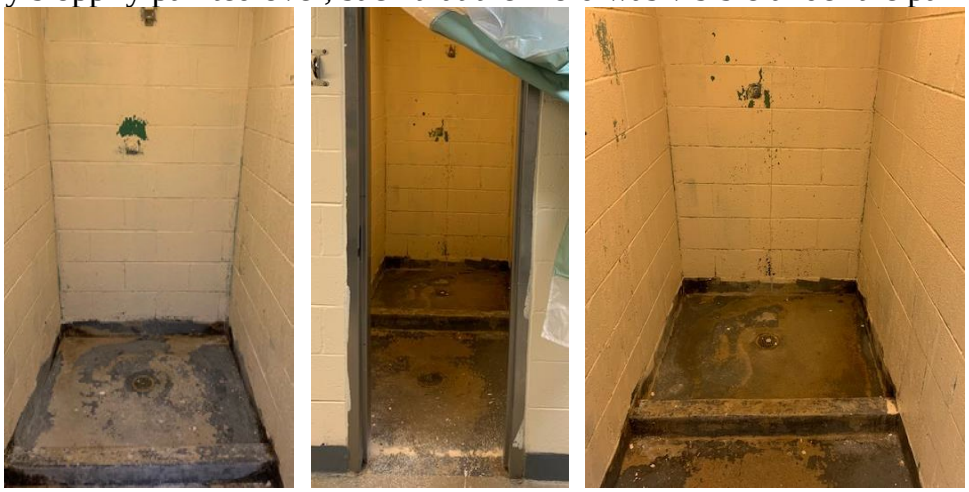
(Photographs 53, 54: Broken ring finger and injured elbow)

Warden Abello explained that part of the reason for the need to use the gym for housing was because there are multiple backlogs and delays in the state prison system in accepting people whose cases were completed and were sentenced to state prison. We spoke to detainees across the jail who were in that situation, and were eager to leave the harsh conditions of BCBIC to get to state prison where they would have more access to programs, services, out-of-cell time, and commissary and other personal property. For example, [redacted], reported that she is bipolar, and had been waiting for 45 days at BCBIC to go to the women's prison to serve an 18-month sentence, but due to a lack of appropriate beds in the women's prison for people with serious mental illness, she was waiting at BCBIC

in harsh conditions. [redacted], similarly stated that he had been sentenced but inexplicably remained at BCBIC.[17]

VIII. Hygiene Problems in Living Units

There were multiple living units where there were unhygienic conditions, especially in the shower and bathroom areas, and detainees reported poorly functioning toilets and sinks in their cells. Multiple shower areas had widespread visible black mold, some of which had been recently sloppily painted over, such that the mold was visible under the paint:



(Photos 5, 7, 8 – Showers in 4-N-B, recently painted with visible mold

(Photo 35, Moldy and dusty air vent; Photo 39, water-damaged light fixture)

[17] Relatedly, [redacted], reported having been on medication-assisted therapy (MAT) for opioid use disorder, prior to incarceration and while in BCBIC. However, the MAT treatment was discontinued due to an impending transfer to state prison, where MAT is not provided for opioid use disorder. Given the same state department runs the prisons and BCBIC, it is unclear why the MAT treatment is not continued at state prison.

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In large part due to the COVID-19 pandemic, this is the first time in several years that Plaintiffs' counsel has been able to visit the jail to observe conditions and the Defendants' compliance with the Settlement Agreement. What we found in our August 2022 tour was profoundly disturbing, and calls into question much of the self-reported compliance by Defendants and their health care contractors. It also calls into question Defendants' ability to come into full compliance with all provisions of the Settlement Agreement by June 30, 2024, as ordered by the Court. See ECF 764.

We look forward to discussing these issues in depth with you and the experts during their visit on September 21-23, 2022.

Sincerely yours,

ACLU NATIONAL PRISON PROJECT

Corene Kendrick, Deputy Director

David Fathi, Director

cc: Dr. Michael Puisis
Dr. Jeffrey Metzner
All counsel