NYCLU

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October 7, 2010

Joanie Mahoney, County Executive
Ann Rooney, Deputy County Executive for Human Services
Gordon Cuffy, County Attorney
421 Montgomery Street
Syracuse, New York 13202

Members of the Onondaga County Legislature
401 Montgomery Street
Syracuse, New York 13202

Dear Ms. Mahoney, Ms. Rooney, Mr. Cuffy, and the Members of the Legislature,

On behalf of the New York Civil Liberties Union (NYCLU), the Syracuse/Onondaga County branch of the NAACP, Disabled in Action of Greater Syracuse (DIA), and the Syracuse Council of the League of United Latin American Citizens (LULAC), we write to express grave concerns about the adequacy of medical care at the Onondaga Justice Center, and to request that the County enact comprehensive and effective measures to protect the constitutional rights of the detainees in the Justice Center, as well as in Jamesville Penetentiary and Hillbrook Detention Center. As you know, we have been receiving complaints and monitoring conditions in the Justice Center, especially with regard to medical care. In the past year, however, with a series of deaths and a marked increase in both the quantity and severity of complaints, our concerns have grown substantially.

The proposal to privatize medical and mental health care services at the Justice Center, Jamesville Penetentiary, and Hillbrook Detention Center should not be seen as a substitute for more fundamental action to correct current deficiencies in the delivery and oversight of the medical and mental health care in these facilities. On the contrary, the present situation calls for strengthening involvement of the County Department of Health and other relevant County officials in ensuring compliance with minimum constitutional standards, as well as the institutionalization of an independent oversight function that allows for the participation of representatives of key community organizations and constituencies. Moreover, we are concerned that simply transferring responsibility for this care into new hands will not address the conditions, policies or practices that are the underlying cause of the problems we see today. Indeed, without a more thorough examination of what has actually caused these problems and a serious attempt to address them, we are concerned that the intended privatization of medical care services will only perpetuate current problems.

I. A WORRISOME PICTURE OF MEDICAL CARE WITHIN THE JUSTICE CENTER

The seriousness of the problems with medical care services at the Onondaga Justice Center is illustrated most starkly by three recent deaths at the facility. The deaths of Chuniece Patterson[1], L. Edmond[2]

[1] Chuniece Patterson passed away on November 12, 2009, due to apparent negligent medical care related to an ectopic pregnancy. See *Syracuse.com*, "Pregnant inmate died after hours of agony in Syracuse jail", May 16, 2010, http://www.syracuse.com/news/index.ssf/2010/05/pregnant_inmate_died_after_hou.html; See also, *CNYcentral.com*, "Pregnant woman dies in Syracuse jail cell", November 12, 2009, http://www.cnycentral.com/news/story.aspx?id=376257

and Raul Pinet[3], and the injury suffered by Maeparo Ramadhan, all indicate the **need for a strong assessment of the current medical care policies and practices at the facility before any transition is made to privatized care**. The conclusions drawn in the final report of the New York State Commission of Corrections on the death of Chuniece Patterson speak very strongly to the severity of the problems with the medical care at the jail. The Report states that "...Had Ms. Patterson received adequate and competent medical care, her death would have been prevented..."[4] Privatization should not be seen as a silver bullet that will automatically provide a solution to the problem. Even if future care is managed by an outside company, the County retains its fundamental legal obligation to ensure that detainees receive constitutionally required medical and mental health care.

It should be stressed that the undersigned organizations frequently receive serious complaints from detainees at the facility, related to, among other things: not receiving required medication; not getting timely and proper attention to serious medical conditions or complaints; failure to take appropriate measures to deal with the potential spread of infections; failure to meet the basic medical needs of people with disabilities; failure to provide appropriate emergency medical response; and disdainful and dismissive treatment of detainees who present medical-related complaints.

Many of these cases have never been profiled in the newspaper and so have not as readily stirred public opinion, yet they are no less deserving of attention. As described in a recent letter to the editor signed by ten community organizations and published in the Post-Standard, there have also been cases in the past few years of nurses refusing to dispense prescribed medications, of nurses and deputies who ignored or dismissed inmates repeated complaints of pain and illness, of medical staff refusing to provide a wheelchair to an inmate with a severe mobility impairment, and of a nurse instructing deputies to let a severely disabled inmate "suffer."

II. THE PROPOSAL TO PRIVATIZE MEDICAL CARE IN THE JAIL RAISES SERIOUS CONCERNS

As detailed below, based on what is known about the process to date and the Request for Proposals (RFP) issued by Onondaga County regarding the proposed privatization of medical services, we are concerned that there are not sufficient assurances that appropriate medical care services will indeed be provided at the facility and that adequate oversight will be thoroughly guaranteed. The particular problems we have identified, as well as suggestions for responses to these problems, are outlined in detail below.

- **A LACK OF TRANSPARENCY**

In July of this year, the County began to seek private vendors to provide medical and mental health care services in all three correctional facilities. After learning about this, we became concerned about how this privatization would affect the above mentioned problems. In an attempt to add transparency to the process, the NYCLU made a Freedom of Information Law (FOIL) request for the bids received by the County in response to its Request for Proposals (RFP). The County denied the NYCLU's request, claiming that making the bids public would result in an unfair competitive advantage. Since then, the county has moved rapidly forward to consider these bids and move towards selecting a vendor, and is now engaging in

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[2] L. Edmond died on June 18, 2010, apparently due to MRSA infection. See, *Syracuse.com*, "Onondaga County jail inmate dies in hospital", June 18, 2010, http://www.syracuse.com/news/index.ssf/2010/06/onondaga_county_jail_inmate_di.html

[3] Raul Pinet died on August 6, 2010. See, *Syracuse.com*, " Syracuse man dies after losing consciousness at Justice Center booking section", August 7, 2010, http://www.syracuse.com/news/index.ssf/2010/08/syracuse_man_dies_after_losing.html Also see, *CNYcentral.com*, "Father speaks out about death of son", August 7, 2010, http://www.cnycentral.com/news/story.aspx?id=493715

[4] New York State Commission of Corrections, Final Report in the matter of the death of Chuniece Patterson, an inmate of Onondaga Justice Center, June 18th 2010, Findings, 1).

negotiations with that vendor behind closed doors, even as County officials presented next year's budget proposals to the legislature with no specific information about how future care would be delivered. We are concerned about this lack of transparency, and **urge the County to subject the process to greater openness and public input**. Considering the public interest at stake, if the privatization is indeed to occur, it is essential for the County to not only to allow but also to promote public monitoring of and input into the provisions of the contract to be signed. The obligations assumed under such a contract need to be transparently debated and construed.

Moreover, once the County has selected a vendor, there is no longer an issue with competitive advantage. Given the lack of clarity in the obligations of the vendor described in the RFP (as described in more detail below) and the flexibility offered to vendors who wish to propose alternative methods of meeting particular obligations, **it is crucial that the process of reaching a contractual agreement provide the highest level of public confidence in the contractual obligations required by the county. This cannot occur behind closed doors. The County should make its initial draft contract for this vendor public, and solicit input from legislators and the public about its provisions. County Legislators and the public should then be provided with an additional opportunity for input before the contract is finalized.** Without this dimension of transparency and opportunity for legislator and public input, it may seem as if the county is simply passing on its obligation to ensure the adequacy and quality of services at the three correctional facilities where Onondaga residents and other are held by its justice apparatus.

- **THE LACK OF A CLEAR DIAGNOSIS OF THE CURRENT SITUATION**

In addition, the reasons included in the RFP[5] to justify seeking a private contractor to provide the correctional medical and mental health services that the County Department of Health currently ensures, when contrasted with the gravity of the recent incidents that reached public attention, seem to indicate the lack of a complete and accurate understanding of the present problems. The RFP states only that "the County has had chronic difficulty in *maintaining pace* due to staff turnover in nursing and other positions." (italics added). There is no mention of the recent deaths or the serious problems we detail above. Accordingly, we **urge the County to immediately commence a broader analysis to thoroughly document and assess current issues with the delivery of medical and mental health care in the Justice Center, in order to guarantee detainees, their families and the community as a whole that proper measures will be adopted so that tragic incidents will not recur.**

The legitimacy of such an evaluation would only be secured if the assessment mechanism to be set up looks not only at quantitative measures but properly attends to the concerns of current inmates and their families by giving them opportunity to participate in the process. For that purpose, **the Onondaga County Commission of Human Rights, the undersigned organizations, and other local human and civil rights organizations with an interest in the matter should have a formal role to play in the design and implementation of the evaluation plan.**

The results of such analysis will provide the County Executive and Legislators with a thorough and updated report of the situation that will represent a suitable baseline for comparison with the services that may be provided in future either by the private sector - if the privatization process indeed moves forward - or if the County chooses to continue to provide nursing care using County employees as it does now. Otherwise, the County will be unable to assess whether the quality and adequacy of medical and mental health services has improved, declined, or remained at similar levels.

[5] See RFP, point 7.1, "Scope of Service. Overview of the organization". There the RFP states "...the County currently provides healthcare and mental health services at these facilities. *Unfortunately, the County has had chronic difficulty in maintaining pace due to staff turnover in nursing and other positions. As such,* the County is now looking to the private sector to provide its correctional health and mental health services" (Emphasis added)

On one matter in particular, however, the proper course of action is already clear: in order to assure that the circumstances that caused the death of Ms. Chuniece Patterson will not be repeated, it is essential for the County to immediately develop and implement the policies recommended in the New York State Commission of Corrections' final report on the case. Thus, **the obligation to implement these recommendations should be clearly stated within the stated contractual obligations of the vendor, and adequate monitoring policies should be devised.**

- COUNTY RESPONSIBILITIES AND MECHANISMS FOR OVERSIGHT NEED FURTHER PRECISION

The RFP contains several references to the process by which the County will monitor the provision of medical care services that demand further clarification and precision, especially considering the fundamental rights of the inmates at stake. Provisions like those contained in paragraphs 7.2.1.6 (on "Periodical Health Appraisals"), 7.2.5.6 (on "quality assurances"), 7.2.7.5/6 (on "statistical data collection"), 7.2.7.10 (on the review by the contractor of "administrative and operational policies and procedures"), 7.2.7.1.2/.1 (on "risk management and mortality review"),7.2.7.1.4 (on "Safety and sanitation" inspections), 7.2.7.1.5 (on the formulation by contractor of a "Cost Containment Program") and 7.2.7.1.9 (on the review of the medical director) do not state the precise monitoring and reporting duties that the contractor will be expected to perform or the policies they will be expected to formulate in order to facilitate this. **These obligations should be reformulated in a much clearer manner in order to ensure that the County is meeting its legal obligations to ensure the provision of adequate medical care in the jail.**

In particular, the RFP establishes that "the county shall employ a contract monitor to monitor the health care contract (...) The contract monitor shall determine in the county's behalf whether or not the county is and has been receiving the staffing and services indicated in the contract and the offeror's response to the RFP. The contract monitor has the right to (...) call other individuals or organizations to assist him or her in the evaluation of the medical and mental health services..."[6] But the RFP states neither the qualifications that a person should demonstrate in order to be appointed as "Contract monitor", nor any procedure that will be conducted for his or her selection. **The tragic events above mentioned demand that this position should be selected with the utmost care and professionalism.**

Moreover, considering that the contract will cover the provision of medical services of three facilities – which according to the RFP detain a daily average of more than 1,000 inmates - it seems utterly impossible for one individual to efficiently monitor the adequacy and quality of both medical and mental health care services. **It is essential to devise well-equipped and transparent monitoring mechanisms that will allow a ongoing and comprehensive review of the medical and mental health care provided to inmates. This cannot be accomplished in three facilities by one person alone.**

In this context it is important to note that in a recent newspaper interview, the County Health Commissioner affirmed that since the Justice Department Investigation of the Justice Center in the mid- 1990s, the jail has had in place a *"quality assurance committee that regularly monitors and reviews medical treatment."*[7] However, the actual work of such a body is unclear, as we have not even heard of the existence of such Committee or been aware of how we could observe or provide input into its official deliberations, or examine its official reports. Recent attempts to contact county officials to inquire as to the composition and location of such a committee were fruitless, and indeed revealed that some county officials were not even aware of its existence. This highlights the need for clearly established lines of responsibility for monitoring medical care in the jail.

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[6] RFP, 7.2.7.1.7.

[7] See Syracuse Post-Standard, "Refugee who fled war in Africa finds injury in a Syracuse jail", June 7th, 2010, http://www.syracuse.com/news/index.ssf/2010/06/refugee_who_fled_war_in_africa.html

- **<u>THE NECESSITY AND BENEFITS OF AN INDEPENDENT OVERSIGHT MECHANISM</u>**

The fact that the RFP expressly establishes that the Contract Monitor will have the right to work with "other individuals or organizations" sets the framework for institutionalizing independent oversight over these facilities.

Notwithstanding the strong necessity for the Contract Monitor's mechanism to consist of a multidisciplinary team of skilled and experience professionals hired for that job by the County (and not a sole individual), it is clear that given the magnitude of the work involved to review the provision of health care services of a population of over a 1000 detainees will entail, the **input of an independent oversight body composed of organizational and community representatives could be invaluable.** It is already clear that inmates and their families often come to organizations such as the signatories to this letter with complaints about medical and mental health care in the Justice Center. In several recent cases, this has been the only mechanism through which the current Director of Nursing has learned of issues relating to medication, acute medical needs, unaddressed or unclear mental health situations, and failures of medical staff to respond appropriately to inmate conditions and complaints. Institutionalizing a similar feedback mechanism could only assist the Contract Monitor in an already difficult job. Our proposal is to institutionalize this kind of communication in order to make it more effective.

In the context of a larger concern about the County's ability to ensure transparency and accountability for the management of custody staff and operations in the Justice Center and the concurrent liability of the County for the decisions of an elected Sheriff in charge of all three facilities, an independent body with a role in oversight of these correctional facilities overall would be a good step. Until and unless the County can exert an effective influence over the management decisions of the Sheriff in regards to the operations of the Custody Division, the County will be unable to ensure that its liability for misconduct and neglect are reduced. If the County could impose an obligation on the Custody Division to work with an independent oversight body, perhaps there would eventually be increased accountability for and more public confidence in the management of the Jail.

For any such independent oversight body to have meaningful input on the situation however, provisions should be made to institutionalize the work of this body and to grant the designated members of this independent body proper access to the facilities. Otherwise, no independent oversight could be considered as actually taking place.

We respectfully request a meeting to discuss the proposals outlined herein. Please contact us at your earliest convenience. If we do not hear from you, we will follow up shortly.

Sincerely,

Barrie Gewanter
Director, CNY Chapter NYCLU

On Behalf of:

The New York Civil Liberties Union – NY State Affiliate of the ACLU
Preston Fagan, President – Syracuse/Onondaga County Branch of the NAACP
Luz Encarnacion, President – League of United Latin American Citizens (LULAC-Syracuse)
Sally Johnston, President – Disabled in Action (DIA) of Greater Syracuse