March 6, 2003

Mr. Darrell Cockerham
Chairman
Patrick County Board of Supervisors
P.O. Box 137
Stuart, Virginia 24053

Mr. David Hubbard
Sheriff, Patrick County
103 West Blue Ridge Street
Stuart, VA 24171

Re: Investigation of Patrick County Jail
Stuart, Virginia

Dear Mr. Cockerham and Sheriff Hubbard:

On December 8, 2001, we notified you of our intent to investigate conditions of confinement at the Patrick County Jail ("Jail"), pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq. ("CRIPA"). Our investigation focused on issues of security and protection from harm, access to medical care, environmental health, access to the courts, opportunities for exercise, and release practices. We are writing to report the findings of our investigation, supporting facts, and recommended remedial measures, as required by CRIPA.

We toured the Jail on four separate occasions with expert consultants in the fields of corrections, environmental health and safety, medical care and fire safety. These tours were conducted on March 19-21, April 8, June 10-11 and June 25, 2002, respectively. While at the Jail, we interviewed the Sheriff and Chief Jailer, Jail staff and inmates; we reviewed documents including state and county inspection reports, the policies and procedures manual, the unusual incidents logbook, and individual inmate records. We interviewed the community-based providers of food services and medical and mental health care. At the end of

each tour, our expert consultants conducted informal exit meetings with the Sheriff in which they conveyed their preliminary findings.

We appreciate the assistance provided to us by the Patrick County Sheriff and staff at the Jail, who extended every courtesy to us during our visits, and provided all documents we requested.

Based on our investigation, and as described more fully below, we conclude that certain conditions at the Jail violate the constitutional rights of inmates. We find that persons confined at the Patrick County Jail risk serious injury from deficiencies in the following areas: security and protection from harm, access to medical and mental health care, environmental health and safety, access to exercise, and access to the courts.

I. BACKGROUND

A. FACILITY DESCRIPTION

The Jail is part of the County Courthouse building, built in 1822; the addition containing the Jail was built in the 1920s. The Jail contains a total of 19 bunks and has an average population of approximately 30 inmates; inmates without a bunk sleep on mattresses placed on the floor. The Jail houses primarily pre-trial detainees and sentenced misdemeanants, whose average length of stay is just short of six months.[1/]

The first floor of the Jail contains an office for the Sheriff's Office dispatcher, the Jail's control room, an open space used for processing intakes, and a single-bunked "drunk tank." The Jail's two cellblocks are located on the second and third floors. Female inmates are housed temporarily in the drunk tank until they are moved to other jails with facilities for

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[1] When queried by our consultant, Jail staff did not know the average length of stay at the Jail. From data provided by the Jail, our consultant calculated that inmates in custody on January 31, 2001 had an average length of stay of 166.33 days, equal to just under 24 weeks. The average population was also calculated by our consultant from monthly data reported by the Jail to the Virginia States Department of Corrections.

female inmates; the Jail otherwise houses only men. The first floor drunk tank also serves as the Jail's only isolation cell.

The cellblocks each contain four small cells in a linear configuration, which open onto a small day area measuring approximately 5 by 30 feet. There is a shared toilet and sink in each cell, and a shared shower and toilet in the day room. The dayroom also contains a large stationary table with two benches, where the inmates eat all of their meals. There is a narrow catwalk between the dayroom and the exterior walls that is used by staff and trusties for access to storage and to pipe chases at both ends of the catwalk. Light fixtures are located in the day room and the catwalk; there are no lights at all within the cells. There is also a small living space with a single bunk for an inmate trusty, located in the corner of the catwalk nearest the exit to the stairway.

The cells in the cellblocks each contain two bunks mounted approximately 24 to 28 inches from the floor, and mattresses on the floor below these bunks. These "upper" bunks are approximately knee level (for a man of average height.) Inmates on the mattresses below these bunks have so little headroom that they cannot sit upright on their mattresses. With an average population regularly exceeding the total of 19 available bunks, inmates routinely sleep on mattresses on the floor, below the fixed bunks. When the population swells above 35, inmates also sleep on mattresses in the day room of the cell blocks.[2/]

The Jail has no private area to conduct medical examinations, medical screening or intake interviews. Officers conduct intake interviews with the inmate standing in the public lobby just outside the control room. The Jail also has no area for exercise, apart from the small and crowded dayroom.

B. LEGAL FRAMEWORK

CRIPA gives the Department of Justice authority to investigate and take appropriate action to enforce the constitutional rights of inmates in jails. With regard to

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[2] The Jail's population counts show that inmates frequently sleep on the dayroom floor. The Jail's inmate manual even notes that no bed clothing is allowed on the cellblock floors "EXCEPT: . . . For inmates assigned to sleep on the floor because of overcrowded conditions in the jail." See Inmate Manual, p. 2.

sentenced inmates, the Eighth Amendment requires "humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care and must 'take reasonable measures to guarantee the safety of the inmates.'" Farmer v. Brennan, 511 U.S. 825, 832-833 (1994) (quoting Hudson v. Palmer, 468 U.S. 517, 526 (1984)). Prison officials have a duty to protect prisoners "from violence at the hands of other prisoners." Farmer, 511 U.S. at 833. The Eighth Amendment protects inmates not only from present and continuing harm, but from future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993).

The county must also ensure that all inmates in the Jail receive adequate medical care, including mental health care. See Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977); Young v. City of Augusta ex rel Devaney, 59 F.3d 1160 (11th Cir. 1995).

The majority of inmates at the Jail are pre-trial detainees, who have not been convicted of the criminal offenses with which they have been charged. The rights of pretrial detainees are protected under the Fourteenth Amendment, which ensures that these inmates "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). In addition, the Fourteenth Amendment prohibits punishment of pretrial detainees or the imposition of conditions or practices not reasonably related to the legitimate governmental objectives of safety, order and security. Id. at 535-37.

II. FINDINGS

A. SECURITY AND PROTECTION FROM HARM

Inmates at the Jail face extremely crowded conditions, no opportunities for exercise, inadequate library resources and few alternatives to idleness, all of which increase tensions among inmates. Numerous lapses in basic security and supervision at the Jail significantly increase the risk of harm faced by inmates in this environment.

1. No Security Classification System

There is no classification system used at the Jail. Inmates are assigned to bunks based primarily on available space.[3/] The Jail reacts to reports of fighting and conflict by moving inmates between its two cellblocks, and ultimately, by transferring some inmates to other facilities. Although the Jail lacks a system of records to track incidents of violence or assaults among inmates, interviews with inmates, entries in the Jail's unusual incidents logbook, and the practice of transferring inmates to different floors to stop fighting each suggest that assaults among inmates at the Jail are not uncommon. An objective classification system is essential to minimizing assaults and violence among inmates in shared housing. The failure to use a classification system to assess each inmate's relative risk of violence, or, conversely, the inmate's risk of being victimized, places inmates at significant and unnecessary risk of harm. A classification system would also provide a rational basis for judging which inmates should be moved to other jails, instead of the current practice of transferring an inmate only after the inmate demonstrates, through his behavior at the Jail, that he poses too great a risk or a management problem.

2. Inadequate Capacity to Segregate Inmates

The Jail has no ability to provide special housing for inmates who may need it for purposes of disciplinary segregation, protective custody, or to accommodate medical or mental health needs. For example, inmates asserted that those charged with sexual offenses were generally housed in the same cellblock to avoid "trouble" from other inmates. The Jail dos not maintain separate high and low security classification housing in its two cellblocks. Only the single-bunked drunk tank is available to segregate inmates, and it is often unavailable because it is also used to house female inmates or to observe newly-admitted and intoxicated inmates.

Of particular concern is the apparent practice of holding female inmates for several days in the drunk tank, where they have no access to a shower. The physical deficiencies of the drunk tank, described infra, are such that it should house no

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[3] Staff members also rely upon their personal knowledge of the inmates, which is considerable because they are from a small community and because many inmates are repeat offenders.

more than one person at a time, and should be utilized as a temporary holding cell for no more than 24 hours at a time.

3. No Systematic Enforcement of Facility Rules

Jail records show that inmates are provided written notice and a disciplinary hearing for rule violations.[4/] However, because there are so few privileges available to inmates at the Jail, and almost no ability to segregate inmates, the Jail has few options for imposing a penalty on those found to have violated the rules. Instead, inmates are usually shuffled between the cellblocks to separate antagonists from each other and their victims.[5/]

Jail logbooks indicate that inmates have sustained injuries likely associated with fighting, but there are no records of investigations following such injuries.[6/] The failure to investigate injuries arising from potential assaults also contributes to assaultive and predatory behavior going unchecked.

There is also no documentation that staff perform sufficiently frequent and random searches of inmate living areas. Such searches are essential to control accumulation of contraband, which presents both a security and a fire hazard when unchecked. Inmates who are found with contraband should be disciplined.

4. Failure to Inform All Inmates of Jail Policies

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[4] We were provided copies of only three disciplinary reports for the period October 18, 2001 through February 20, 2002. If this represents all of the hearings held during that time, then the vast majority of violations were not the subject of a disciplinary hearing.

[5] The Chief Jailer stated that he seldom, if ever, takes away good time from sentenced prisoners for rules violations.

[6] For example, in a logbook entry on November 16, 2001, a deputy notes that he "noticed several inmates sitting at the table looking toward the shower" and that, upon investigation, he found "everything was OK except [inmate D.B.] was standing in his cell and his right eye was red and had a small cut on it." The inmate stated he had fallen, and no further investigation was done.

Inmates uniformly reported to us that manuals explaining Jail policies were distributed just before our first visit. The Jail must make manuals available to inmates in a timely and consistent manner. In addition, we are concerned that the Inmate Manual is printed only in English, and that inmates who speak only Spanish must depend on other inmates to communicate with staff and understand the Jail's rules. Because the Jail's population routinely includes inmates who have a limited ability to read and/or understand English, the Jail must provide explanations of essential information in the inmate manual for these inmates. The County must convey this information in order to protect inmates' constitutional rights, including the right to due process before imposition of discipline for rules violations, the right to medical and mental health care for serious health conditions and the means to access this care while in the Jail, and the right to petition the courts and the means of doing so while incarcerated.

In addition, the inmate grievance system does not provide a sufficient means for inmates to challenge Jail administrators about conditions of their confinement. The Jail has no documentation to refute the claims of inmates that their grievances are frequently ignored, and that responses, when given, are often significantly delayed.[7/]

5. No Control of Caustic Chemicals and Weapons

There are no controls of caustic cleansers or equipment, and no antidotes, eye washes or chemical control kits within easy access. Caustic chemicals are readily available to inmate trusties, who are supervised only loosely.[8/] There are also insufficient controls on medical wastes and sharps. All of these items can be used as weapons to injure staff or other inmates, and must be controlled.

Jail staff gave us different definitions of the security perimeter of the Jail, which we define as that space within which

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[7] Staff told us that written complaints from inmates are addressed by the Chief Jailer or the Sheriff, but that the written complaints are not retained.

[8] The Jail has no clear criteria for selecting inmate trusties.

all weapons should be locked down and secured in order to preclude inmate access. We observed officers come into the Jail from outdoors without first securing their weapons, and move past the drunk tank (which was unlocked on at least one occasion when an inmate was inside) and through the open lobby on their way to the dispatcher's office or to the control room. Inmates were often present in the drunk tank or in the lobby through which the officers passed, creating a clear security risk. The security perimeter of the Jail must be clearly defined and all weapons must be secured within that space.

B. MEDICAL CARE

The provision of medical services to inmates at the Jail is seriously deficient and puts inmates at risk of harm. Most fundamentally, the Jail has no on-site medical care providers. In addition, no medical professionals are involved in screening inmates for medical concerns or in supervising or following up on outside medical visits. From these fundamental deficiencies, numerous unacceptable risks follow.

1. Intake Screening

The intake screening process is insufficient to ensure that inmates receive necessary medical care while incarcerated. The most significant deficiency is the lack of oversight by a responsible medical care provider. Although § 4.5 of the Jail's policy and procedures manual states that a copy of the Jail's medical screening form is made available for a physician's review,[9/] the deputies and the local physician concurred that this practice is not followed.

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[9] The local physician sees inmate patients on an as-needed basis at his office. Although the Jail describes him as its medical director, he does not have a contract with the Jail, and performs none of the functions of a medical director. He does not review Jail policies and procedures concerning medical care, does not review intake screening forms, and does not provide or supervise any care at the Jail; in fact, he stated to us that he has never been to the Jail.

The intake screening process does not elicit[10/10/] or document sufficient relevant health information for each inmate. This problem was first brought to our attention on our March 19th visit; we identified this as a significant deficiency that required immediate remediation. During our June 10 visit, eight of eight current inmate files reviewed by our physician consultant contained no medical screening information at all.[11/] Failure to perform an intake screening and/or to record this information presents a serious and unacceptable risk of harm to inmates. Inmates who are injured or suddenly taken ill while in the Jail may be denied timely and appropriate care in the absence of basic medical information that should have been collected at intake, including history of illness and mental illness and identification of current medications and allergies. The risk of such harm can be minimized, and often eliminated, by the simple act of asking and recording basic medical information at intake. That the Jail may at times collect intake information that cannot be retrieved by Jail staff is as dangerous a practice as failing to collect the information in the first place.

In addition, the physical location in which the screening by Jail staff is conducted requires inmates to respond to questions about confidential medical information in an open lobby space adjacent to both the control room and to the main stairway in and out of the Jail. The lack of confidentiality minimizes the likelihood that inmates will respond truthfully to questions about whether they have serious medical or mental illness.

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[10] Screening forms designed to elicit accurate information about communicable diseases and basic medical and mental health concerns are standard in the corrections industry, and available from numerous public sources. The Jail's screening form is deficient because it does not include these standard questions, and thus, does not reliably detect medical and mental health concerns.

[11] Jail staff explained that they had been experiencing problems with a new computer system in which the responses to intake screening questions were input directly into the computer. Staff asserted that they had performed initial screening for the inmates whose files we reviewed, but that they were unable to access that information on the computer, speculating that either the computer program had not saved the information, or that they were not familiar enough with the program to be able to access the data.

Insufficient screening puts the booked inmate and other inmates at risk both because inmates may not be provided with timely medical care and appropriate housing, and because inmates with communicable diseases, including easily-spread respiratory infections like tuberculosis, may infect the general population.

Because the Jail has no on-site medical care, no review of intake information by a medical practitioner, and no oversight by a responsible medical authority, the deputies effectively serve as the gatekeepers for medical care. Jail deputies determine when, or if, an inmate receives medical attention from an outsider provider, which is a significant departure from universally accepted standards of care.

2. Health Assessments

The accepted standard of care is to conduct a physical examination and take a medical history within 14 days of admission to a correctional facility.[12/] It is also standard procedure to perform a screening test for tuberculosis at this time. Although the Jail's Inmate Manual indicates that this assessment will be provided without charge (pursuant to the co-payment policy), in practice, no health assessments or tuberculosis screening tests are provided to inmates at the Jail. A health assessment serves the purpose of establishing a baseline health status for an inmate, and documents health problems for which a treatment plan should be initiated. Lacking this baseline, the medical care provided at the Jail is only reactive to emergent crises, placing inmates at increased risk of pain and injury.

3. Access to Acute and Emergency Care

The Jail is fortunate to have nearby a local hospital with full emergency services that can provide necessary and appropriate emergency care. Although the Jail appears to respond

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[12] This examination is commonly referred to as a "health assessment." In most states, a trained nurse or physician's assistant may perform the health assessment under the supervision of a physician; the assessment should not be performed by non-medical staff.

timely to most medical complaints noted in the unusual incidents logbook, we noted several exceptions, particularly in the area of mental health care. Moreover, it is of great concern that only those complaints deemed significant enough to be mentioned in the logbook are responded to at all. Complaints dismissed by correctional staff as insignificant are not even recorded in the logbook, much less brought to the attention of a medical provider. Correctional staff are not trained to diagnose medical conditions. These practices present an unacceptable risk of harm to inmates' health, and make it likely that inmates will endure unnecessary pain before a worsening condition is ultimately brought to the attention of a medical care provider.

The Jail's practice of providing first aid to persons who have been exposed to chemical agents such as pepper spray only upon request does not comply with accepted professional standards. First aid, including an opportunity to flush eyes and other exposed body areas with water, should be provided as soon practicable after an exposure to chemical agents. In addition, if non-medical staff provide the first aide, they should receive additional training in monitoring exposed persons for signs of significant adverse reactions, such as allergic responses or breathing difficulties. Any significant adverse reactions should be evaluated by medical professionals.

4. Access to Routine Care

The Jail has adopted a co-payment requirement for most medical services. The co-payment system as implemented in Patrick County is unconstitutional because it has the effect of deterring access to necessary medical care. The Patrick County system is flawed for several reasons: the policy is internally contradictory; the policy is not conveyed clearly to inmates; the policy creates a financial disincentive for inmates to seek treatment for chronic and pre-existing conditions, even those which are life-threatening or a threat to the health and safety of others; and there is no mechanism to waive the co-payment fee completely for indigent inmates.

It appears that no written information is provided to inmates to explain the co-payment policy,[13/] and the inmates we

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[13] The Inmate Manual describes only the ways in which an inmate may access health care services: he may fill out a sick

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interviewed had various understandings of it. Generally, inmates believed that they would be charged a co-payment for all medical care, unless it was ordered in an emergency.[14] The policy states that there is no charge for initial intake medical and dental screenings, an initial health appraisal, mental health screening initiated by staff, follow-up visits requested by the physician, and emergency care. In practice, however, emergency care is the only medical service routinely provided to inmates, and thus, as a practical matter, the inmates' understanding is correct. Inmates also understood that they could seek care from a private provider at their sole expense. This is problematic because access to necessary care while incarcerated may be deficient for those without financial resources.

The Jail's policy excepts care related to pre-existing conditions from the general co-payment policy, making individual inmates financially responsible for the full cost of care for all pre-existing conditions, "including the cost of medications, such as insulin, heart medications, etc."[15] This policy creates a dangerous barrier to care for chronic conditions. See, e.g., Unusual Incidents Logbook entry dated March 7, 2001 (inmate refused prescription medication, telling officer that if he had to pay for his heart medication (a pre-existing condition), then he could not get any personal hygiene items).

Each of the problems described above heightens the barrier to an inmate's seeking necessary medical care. This is

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[13](...continued)
call request form; he may inform Jail staff of an emergency; or he may request transport to a health care provider other than the "jail physician/dentist." It does not describe the co-payment policy.

[14] Before receiving non-emergency care, inmates must sign a form entitled "Patrick County Jail Medical Co-Payment Charge Sheet, Attachment IV," which states that the co-payment for office visits is $10, and the prescription fee is 25% of the total charge. These charges are half those listed in the Jail's Policies and Procedures Manual, and introduce unnecessary confusion to the inmate about the amount that will be charged to his account.

[15] Memorandum to all inmates from Sheriff David Hubbard, dated June 6, 1997, included in the Jail Policies and Procedures Manual.

particularly problematic in a facility like the Patrick County Jail because, as described below, inmates are confined in small, crowded cells with inadequate sanitation and poor ventilation. Illnesses easily spread in such an environment, leading to unnecessary sickness and suffering.

5. Chronic Care

As noted above, the screening for chronic medical conditions is superficial, consisting primarily of a checklist asking if the inmate has been treated for certain conditions. Jail policy also makes the expense of care for pre-existing chronic conditions an individual inmate's sole responsibility. This practice violates accepted standards of care, and poses an unacceptable risk of harm, both to inmates with untreated and/or undiagnosed chronic illnesses, and to other inmates and staff who may be at risk of infection if the illness is contagious. Finally, we saw no evidence that medically-necessary restricted diets, for example, for inmates with diabetes, hypertension or other chronic conditions, were reviewed by a registered dietician to ensure compliance with nutritional guidelines.

6. Licensure

The Jail currently does not verify the licensure of its outside medical providers. It is an accepted requirement that these licenses be verified at least annually; that medical care is provided off-site does not negate this requirement.

7. Mental Health

Mental health services at the Jail are provided through Piedmont Community Services ("Piedmont"), one of several state-mandated community service organizations that provide mental health, mental retardation and substance abuse services to the state's citizens. Piedmont provides its services without charge to the Jail pursuant to a letter agreement, essentially affording inmates access to care equivalent to what they would have outside the Jail. However, the Jail's mental health care suffers from the same fundamental deficiencies as its medical care, including: an insufficient screening process; no system to ensure continued

care for pre-existing mental illnesses; a disincentive created by the chargeable care policy to seeking care for chronic conditions before the inmate's condition escalates to an emergency; and, finally, that mental health care is primarily reactive.

a. Screening Is Insufficient

The screening form used by deputies at intake is not sufficient to screen for significant mental health concerns, and the present system relies heavily upon an inmate's self-reporting of a history of mental illness. The lack of privacy at intake compounds the deficiencies of the current screening. As with medical screening forms, questionnaires designed to elicit sensitive and important mental health information are standard in the corrections industry, and more complete and effective screening instruments are widely available. The County must prioritize upgrading its mental health screening, particularly given the lack of mental health providers on staff at the Jail.

b. Monitoring Is Insufficient

The Jail's policies grant too much discretion to correctional officers to assess an inmate's need for mental health services. In addition, the policies do not always reflect actual practice. For example, the policy manual states that the mental health counselor will be notified immediately of all threatened suicides, however, we noted several instances in the logbook where a counselor was not called immediately. See, Unusual Incidents Logbook entry dated March 15, 2001, 5:46 p.m. (inmate with known mental illness told officer he needed help before he "did something;" inmate placed in segregation and logbook noted that mental health would be called "in the a.m."). This practice shows that correctional staff may make their own assessment of the genuineness of a threat, in effect, making Jail staff the gatekeepers to mental health services. It places inmates with mental illnesses at an unreasonable risk of harm. In the March 15th incident, an hour after the initial logbook entry, the inmate was discovered to have a swollen and possibly broken hand from punching a wall, and was taken to the emergency room. Jail deputies must be trained to follow policy and consult on-call community mental health professionals for guidance immediately whenever an inmate, through his statements or behavior, indicates that he may harm himself.

A second example of actual practice departing from policy is the Jail's policy to house persons in need of mental health monitoring in the isolation cell, or drunk tank. In practice, we were told that the Chief Jailer sees a benefit in housing depressed inmates on the cellblocks, where fellow inmates may alert the staff to a suicide threat. The logbook shows incidents where inmates were placed in isolation, and other incidents where they remained on the cellblock. The policy manual should be revised to require that potentially suicidal inmates be monitored by staff, and that this monitoring (whether constant or 15-minute checks) be documented. In addition, the revised policy should specify how the Jail will implement constant observation, when it is required by an inmate's mental status, given that the location of the isolation cell precludes constant observation from any of staff's usual posts.

c. Provision of Continuous Care

Finally, the co-payment requirements and ineffective screening may result in harmful delays and interruption of care for those inmates with chronic mental illnesses. The community mental health providers we spoke with expressed frustration at the disruption in care caused when a client is incarcerated, and noted that interruption of services may lead to unnecessary deterioration in an inmate's condition before care is re-initiated at the Jail. We agree.

C. ENVIRONMENTAL HEALTH AND SAFETY

Jail records indicate that, during 2001, the average population was slightly more than 32 inmates per day, or 179% of its design capacity of 18. This significant level of crowding, combined with the Jail's small and outdated facility, leads to unacceptable deficiencies in space, lighting and sanitation.

1. Space and Sanitation

The Jail houses inmates in extremely tight quarters. The 7 ½ by 7 ½ foot cells open onto a 5 by 30 foot dayroom, which is surrounded on all side by a catwalk approximately 2 ½ feet wide. When four inmates are housed in each cell, two sleep on mattresses on the floor under the bunks; the inmates on the floor have so little space that they cannot even sit upright on their mattresses. Inmates reported that additional mattresses are sometimes placed on the floor in the dayroom to accommodate

additional inmates. Professional standards require that mattresses not be placed directly on the floor because they impede proper sanitation and may present fire and safety hazards.

The single toilet and lavatory unit in each cell, plus a single toilet and shower in the dayrooms provide insufficient access to hygiene when the facility is crowded. Several of the lavatory units in the cells were not functioning properly, impeding inmates' ability to wash their hands and otherwise maintain proper hygiene. The shower on the lower cellblock was clean and in good repair, however, the shower on the top-floor cellblock was in very poor repair. The steel walls of the unit and the concrete floor in front of it are damaged and retain moisture, which makes the unit impossible to clean and disinfect thoroughly.

Crowding may cause and exacerbate poor sanitary conditions, which can lead to disease and vermin infestation. Current conditions at the Jail demonstrate these sanitation hazards. First, several of the Jail's mattresses have cracked or torn covers resulting from overuse. Such mattresses cannot be effectively cleaned and sanitized between inmates. Given the high turnover at the facility, failure to replace these mattress could expose numerous people to disease and/or body lice. Second, because inmates are not provided with lockers or shelves to store personal items, the already limited floor and surface space in many cells is littered with inmates' personal articles, such as clothing, hygiene materials, and magazines. The trash and clutter attracts roaches and other vermin, and impedes thorough cleaning. It also increases the fireload dangerously and serves as a hiding place for contraband. Finally, inmates eat all three meals on their cellblocks, and often keep leftover food and food containers in their cells and the dayroom, again attracting vermin.

2. Universal Precautions

No precautions against blood borne pathogens were evident. Inmates and staff acknowledge that inmates had recently cleaned up blood from an inmate fight without using rubber gloves or disinfectants. Staff did not appear aware of universal precautions for handling bodily fluids. Universal precautions is a topic that must be included expressly in pre-service training and orientation for new hires (who may work in the Jail for up to one year before completing the state-mandated training). In

addition, staff should be required to demonstrate their competency in basic skills - i.e., demonstrate that they understood the training presented to them, and should be provided annual in-service refresher trainings on this issue.

3. Lighting

Lighting is inadequate. There are no lights in any of the cells. The only lights are flourescent fixtures affixed to the ceiling on the catwalk and dayroom. During our visit we measured less than five foot-candles of light in the interior of the cells near the lavatory. In comparison, the Virginia Administrative Code requires at least 20 foot-candles of light at desk level and in personal grooming areas. Poor lighting contributes to accidental injuries, inhibits personal hygiene and grooming, and causes eyestrain. Low light also impedes staff's ability to observe and supervise inmate activity in the cells.

D. FIRE SAFETY PRECAUTIONS

The Jail's design provides only one means of egress from the cellblocks, through a single stairwell. This is a significant departure from national and state standards, which require two exits.[16/] In the event of a fire, smoke could easily accumulate and travel through the single stairway, making the stairwell impassable. The Jail's sprinkler system offsets the danger of a single stairwell, however, other practices at the Jail exacerbate this risk.

First, the stairwell doors at each floor are generally kept open, and do not have automatic closing mechanisms activated by smoke detectors. In the event of a fire, smoke could travel unimpeded through the stairwell to both cellblocks.

Second, the Jail does not have battery-operated emergency lights in the stairwell or elsewhere. An existing back-up generator provides emergency power, but the loss of light while the generator starts up could critically delay evacuation in a fire. In addition, we note that generators are not completely reliable, and that the Jail's own logbook on March 29, 2001 notes an instance where the emergency generator did not function for

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[16] A minimum of two exits is required by the National Fire Protection Life Safety Code and the Virginia Statewide Building Code.

38 minutes during a power-outage.

Third, the keys needed to evacuate the cellblocks in an emergency are not identifiable by touch. In the event smoke or loss of light makes visual identification impossible, keys marked with tactile identification can speed evacuation.

Fourth, the Jail has no smoke detectors in sleeping quarters. Finally, we saw insufficient documentation of sufficiently frequent fire drills, including the movement of inmates out of the cellblocks, to ensure that staff are prepared for emergency evacuations.

E. EXERCISE AND OUT-OF-CELL TIME

Inmates receive insufficient opportunities for exercise, and no outdoor exercise at all. Regular large-muscle group exercise is essential to maintaining strength and health, and its near-total absence at the Jail is unacceptable. In addition, the crowded conditions, small dayroom space and the dearth of programming may heighten anxiety and depression in all inmates, particularly those with mental illnesses.

F. ACCESS TO THE COURTS

The County has a responsibility to provide inmates with reasonable access to the courts in order to challenge their sentences, directly or collaterally, and the conditions of their confinement. The County provides no assistance at all to enable inmates to exercise this right. The Jail has no law library and no staff trained to offer legal assistance to inmates. In addition, inmates have extremely limited space, and their work papers may be confiscated if they are not sufficiently contained. Inmates depend upon deputy jailers to copy any materials needed for legal proceedings. We did not identify any inmate whose ability to pursue a claim was impaired because of these deficiencies in access to legal services. Nonetheless, with no systems in place to provide inmates with access to the courts, we are concerned that such an injury is likely to occur.

G. CALCULATION OF RELEASE DATES

The Jail lacks any semblance of a management information system, which leads to poor management decisions that may deprive inmates of their constitutional rights. One clear example is in the calculation of release dates. The Chief Jailer hand-calculates the release date for all inmates and informs the inmate in writing.[17/] Inmates and their families had relayed to us concerns that inmates were occasionally released after the specified date. The Jail has no data system capable of checking this allegation by retrieving names, sentencing orders, calculations of good time credit and the actual date of release. We reviewed, instead, population reports which the Jail submits to the State Department of Corrections for purposes of computing reimbursements to the Jail. During the first two months of 2001, three inmates appear to have been held past their expected release date (we defined the expected release date as the sentenced term minus good time). These discrepancies tend to support the inmates' and family members' accusations. To investigate release practices further would require comparing the sentencing order, the Chief Deputy's good time calculation (which does not appear to be retained in any file) and the actual release dates. Although not conclusive, the variances noted from data on the state reimbursement reports were disturbing, and point to a need for Jail managers to collect and retain this type of information for management purposes.

III. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and to protect the constitutional rights of Jail inmates, the County and the Sheriff should implement the minimum remedial measures set forth below.

A. Security and Protection From Harm

1. The current inmate population far exceeds the capacity of the existing Jail to provide reasonably safe and sanitary housing. We look forward to meeting with County officials to discuss the various options for addressing this problem.

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[17] If the inmate is being held in a neighboring jurisdiction, the Chief Jailer informs that jail, which typically returns the inmate to Patrick County for release.

2. The County must implement an objective classification system and house inmates accordingly.
3. The County must collect and analyze basic data to aid in population management, including lengths of stay, utilization of medical and mental health resources, and cumulative statistics on indicators of violence and injury.

4. Female arrestees should be held at the Jail no longer than necessary to arrange transport to another jail, and in no event for more than 24 hours.

5. The County must create more space in which to segregate inmates for disciplinary, security, medical or mental health reasons.

6. The County must investigate suspicious inmate injuries for evidence of potential assault, and must document the result of these investigations.

7. The County must take steps to limit contraband in the cells.

8. The County must implement controls on caustic chemicals; must provide easily-accessible eye wash and chemical control kits for the event of accidental spills; and must implement procedures to control medical wastes and sharps.

9. The County must define the security perimeter of the Jail and control weapons within this perimeter.

10. The County must revise its policy on use of pepper spray to include a requirement that the person who is sprayed receive first aid and an evaluation by medical personnel as soon as possible, regardless of whether the inmate makes a request for medical attention.

11. The County must inform Spanish-speaking inmates of Jail rules in Spanish, either by translating and disseminating the manual or by having an employee provide the information orally. If oral translation is the chosen method, the County must notify inmates that bilingual assistance is available.

12. The County must define the criteria for selecting inmate trusties.

13. The County must implement an inmate grievance procedure and document all grievances and the County's responses.

14. The County must provide all staff with orientation training and annual refresher training in universal precautions for handling items contaminated with bodily fluids.

15. The County must require supervisors to review daily logbook entries, and document that review.

B. MEDICAL CARE

16. The County must immediately retain the services of a medical doctor,[18] whose responsibilities will include: supervising all medical care rendered to inmates; reviewing revised medical intake screening forms and processes; monitoring care of serious and/or chronic conditions; ensuring that all inmates receive a health assessment within 14 days of intake; and annually reviewing all policies and procedures concerning medical or mental health screening and/or the provision care.

17. The County must immediately implement a system to ensure that medical intake information sheets and sick call requests are reviewed in a timely manner by trained medical care providers.

18. The County must immediately remedy problems with its intake screening software that prevent staff from accessing intake information on the Jail's computer.

19. The County must revise its co-payment policy to remove the disincentives to an inmate's seeking and receiving necessary medical care for chronic, pre-existing and/or life-threatening conditions.

20. The County must enhance its screening for infectious diseases, including tuberculosis.

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[18] In a facility the size of the Patrick County Jail, we anticipate that this could be a part-time position.

21. The County must verify the licensure of all medical care providers at least annually, without regard to whether the care is provided on or off-site.

22. The County must revise its mental health screening process to achieve a more thorough assessment of an inmates's history and any current symptoms or concerns, and to facilitate continued care for inmates with chronic mental illnesses.

23. The County must revise its policy on supervision of inmates identified at heightened risk of suicide consistent with currently accepted professional practice, and implement the policy consistently. The County must also ensure that correctional staff follow existing policy in consulting mental health professionals for guidance when an inmate exhibits signs of a possible mental health crisis.

C. ENVIRONMENTAL CONDITIONS

24. Inmates must not sleep on the floor.

25. All mattresses and pillows must be maintained in sanitary condition.

26. Inmates must be provided sufficient lighting for personal hygiene and for reading.

27. Each inmate should be provided with a locker or other fire-retardant container for storage of his personal belongings.

28. The County must repair all broken plumbing and fixtures and maintain them in good working order.

29. The County must ensure that all food service menus are reviewed at least annually by a registered dietician.

30. Trash collection schedules should be augmented to prevent the stockpiling of combustible materials.

D. FIRE SAFETY

31. The County must install smoke detectors in all housing areas, consistent with state code requirements.

32. To mitigate the threat to life safety posed by a single exit stairwell, the County must ensure that stairwell doors remain closed (or, replace doors with automatically-closing models activated by smoke) and must install battery-operated emergency lighting on each floor and in the stairwell.

33. The County must mark all emergency keys so that they are identifiable by touch as well as by sight.

34. The County must conduct regular fire drills, including inmate movement.

E. EXERCISE AND OUT-OF-CELL TIME

35. The County must provide inmates with regular opportunities for exercise, including outdoor exercise.

F. ACCESS TO THE COURTS

36. The County must provide access to a law library or legal assistance sufficient to enable inmates to prepare their defense and to challenge their conditions of confinement.

G. TIMELY RELEASE OF INMATES

37. The County must devise a procedure to ensure that inmates are not held past their release dates.

H. GENERAL PROVISIONS

38. All revised forms, practices and policies concerning each area of Jail operations discussed herein should be codified in a revised Jail policy and procedures manual. All policies should be reviewed annually by Jail management; the review should be documented.

39. The County must ensure that all deputies, and particularly those who have not yet attended the state-mandated training course, receive sufficient orientation training to enable them to fulfill their duties safely. In addition, all staff must receive training on revised policies and procedures. All staff training must be documented.

* * * * *

We appreciate the cooperative approach taken by the Sheriff and staff at the Jail. We understand that officials are aware of and acknowledge many of the problems discussed in this letter. In anticipation of our continued cooperation toward a shared goal of achieving compliance with constitutional requirements, we will forward our expert consultants' reports under separate cover. Although their reports are their work and do not necessarily represent the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of relevant concerns, and offer practical assistance in addressing them.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that 49 days after your receipt of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct the noted deficiencies. 42 U.S.C. § 1997b (a)(1). Accordingly, we will soon contact County officials to discuss in more detail the measures that the County and Sheriff must take to address the deficiencies identified herein.

Sincerely,

/s/ Ralph F. Boyd

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: Alan Black, Esquire
Patrick County Attorney

Mr. David R. Hoback
Patrick County Administrator

The Honorable John L. Brownlee
United States Attorney
Western District of Virginia