U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General | *Washington, D.C. 20035*

June 1, 1995

Mr. John L. Leach, III
Chairman
Lee County Commission
P.O. Box 966
Leesburg, GA 31763

Re: Notice of Findings from Investigation of Lee County Jail

Dear Mr. Leach:

On October 3, 1994, we notified your office of our intent to investigate the Lee County Jail ("LCJ" or "Jail") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq. Consistent with the requirements of CRIPA, the purpose of this letter is to advise you of our findings from this investigation, the supporting facts, and to recommend necessary remedial measures.

Our investigation consisted of a tour of the facility with expert consultants, the examination of documents, and extensive interviews with prisoners and staff at the facility. We were accompanied on our tours by three consultants: a penologist, a medical expert, and a fire safety/environmental sanitarian, all with expertise in jail facilities. Throughout the course of this investigation, County officials and LCJ staff extended to us and our consultants their cooperation, for which we wish to convey to you our thanks.

In making our findings, we recognize that both pre-trial detainees and sentenced inmates are confined at LCJ. In general, inmates may not be subjected to conditions that are incompatible with evolving standards of decency or which deprive them of their basic human needs. Estelle v. Gamble, 429 U.S. 97 (1976). For inmates convicted of a crime, the Eighth Amendment's proscription against cruel and unusual punishment provides the relevant constitutional standard. With respect to pre-trial detainees, the Fourteenth Amendment generally prohibits punishment of these

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persons, since they have not been convicted of any crime. Bell v. Wolfish, 441 U.S. 520, 540 (1979). Detainees may not be subjected to any restrictive acts or practices which are not reasonably related to legitimate governmental objectives, such as ensuring the detainees' presence at trial or maintaining jail security. Id.

LCJ was opened in 1953, and has a capacity of 23 inmates. During our tour, the Jail housed 27 inmates, including 15 state prisoners. We found many deficiencies at the Jail. The unconstitutional conditions identified are as follows:

I. CORRECTIONAL PRACTICES ARE DEFICIENT.

A. Policies and procedures are inadequate. The policies and procedures manual is only a few pages long and contains almost nothing of relevance to Jail operations.

B. Intake and classification are inadequate. There is no screening procedure for determining suicide risk, security status or other issues at intake. No classification system exists to separate dangerous from non-dangerous inmates. There are no administrative or punitive segregation cells. The failure to properly separate inmates based upon security or other special needs puts them at risk of harm.

C. Inmate supervision is insufficient. There are no regular patrols of the inmate housing areas by staff. Documents and logs suggesting otherwise are inaccurate. Inmates consistently report that they must rely on trustees to relay messages to officers. Staffing levels are inadequate, with only one dispatcher and one jailer on each shift. The County plans to move all the dispatchers to another building. Once that occurs, the jailer will have no backup in the event of an emergency. Even if a jailer were to enter the housing area, he or she would have a hard time observing inmates through the narrow slats of each dimly lit cell.

D. Suicide prevention is inadequate. There have been at least eight suicide attempts at the Jail since 1989. None of the cells are suicide-resistant. Without any suicide policies, screening or other preventive measures, suicidal inmates are at serious risk of harm, including death.

E. Exercise and visitation are inadequate. Inmates receive only two hours of exercise per week, and this exercise is concurrent with visitation hours. During bad weather, both visitation and exercise are canceled. Thus, during most of the week, inmates are locked inside dimly lit, crowded cells, without adequate light or ventilation.

F. Nutritional needs are not met. Inmates receive only two meals a day, and crackers and soda for "lunch." They do not receive juice or milk. The menu is not reviewed to ensure adequate nutritional content.

G. Training for staff is insufficient. None of the Jail staff have attended the state's two-week jailer school.

H. The cell used for female inmates is inappropriate. The female cell is located next to a two-man cell, and is within earshot of the other male dormitories. Unlike the male housing units which have phones within reach of the bars, women locked in their cells cannot reach their phone to make needed calls.

II. MEDICAL CARE DOES NOT MEET CONSTITUTIONAL STANDARDS.

A. Medical and mental health policies are inadequate. There are no medical, suicide or mental health policies and procedures.

B. Receiving screening and routine examinations are nonexistent. There is no receiving screening for inmates to identify potential medical or mental health problems. No medical histories are taken. No physicals, specialty care or communicable disease screenings take place.

C. Sick call is unsatisfactory. The Jail relies upon a registered nurse/paramedic to handle almost all medical complaints. The R.N. is on call 24 hours a day and is supposed to visit the Jail once every three days to conduct sick call. Theoretically, sick call consists of an inmate telling a jailer that he or she needs to see the R.N., and the jailer then promptly places the inmate's name on a list of patients. Our medical consultant found, in practice, that there are substantial delays before inmates can see the R.N. Inmates consistently reported that they had to transmit their sick call requests through a trustee to the jailer and that their complaints sometimes went unheeded for weeks at a time. Inmates housed in the back of the Jail especially have problems attracting the attention of a trustee or jailer when they have a medical emergency. The R.N. refuses to go through the housing unit and may not visit as frequently as claimed. There are no medical appointment logs; the medical transport log is kept with a confusing Jail operations and dispatch log; the informal sick call list is nothing more than a sheet of scrap paper which is thrown out after the R.N. visits the Jail. Thus, very little documentation confirming the quality and frequency of medical care exists.

D. Physician care is inadequate. There is no regular doctor for the Jail. As a result, the R.N. has no physician backup. Although the R.N. informed us that he regularly refers

inmates who need more extensive medical care to a nearby clinic, transport logs and inmate interviews indicate that this is not the case. There appears to be a large discrepancy between the R.N.'s reported number of transports and the actual, documented number. Furthermore, our medical consultant was surprised that many inmates who complained about significant medical problems, such as hypertension, had never been referred to a clinic doctor by the Jail's R.N. The continuity of care is extremely questionable, since even when an inmate is sent to the clinic, the Jail does not provide to, or receive from, the clinic any records, physician notes or other documents. We also received disturbing reports from the local clinic alluding to an informal jail practice of delaying medical care until an inmate becomes a state prisoner. This practice may save the County money for medical costs, but it puts the health of inmates at serious risk. The County also appears to deny needed medical care to inmates who are about to be released.

E. Facilities and equipment are unavailable. There is no examination room or medical equipment. The R.N. does not have emergency supplies, reference books or even the most basic examining instruments.

F. Medication policies and practices are inadequate. The R.N. prepares medication doses and stores them in envelopes for later distribution by the jailers. These envelopes are prepared up to three days in advance of actual distribution. Untrained jailers administer the medications to the inmates. Inmates do not sign the medication log, so there is inadequate proof that inmates receive their medication in a timely fashion. On the afternoon of our tour, we found one medication envelope which had not been given to the inmate, even though it clearly stated that the inmate was to receive the medication during breakfast. Medications and syringes are stored in an unlocked cabinet with the dispatcher.

G. Special diets are nonexistent. No special diets are provided for inmates, such as diabetics, who may have special dietary needs.

H. Dental care is inadequate. It takes three to four months for inmates to receive dental care.

I. Mental health care is inadequate. No inmate in the Jail had spoken with a mental health counselor and some did not know one was available. The R.N. did not know that there have been a number of suicide attempts at the Jail, including one not long before we arrived.

III. PHYSICAL PLANT CONDITIONS ARE UNSANITARY AND DANGEROUS.

A. General conditions are unsanitary and unsafe. Our consultants concluded that LCJ is one of the dirtiest, most run-down and grossly inadequate jails they have ever seen. Presently, it is unfit for human habitation. We understand the County has passed a sales tax to fund construction of a new facility. Yet, almost a year later, no architectural plans have been drafted and the entire building process has reportedly stalled. In any case, the existing facility is clearly inadequate.

Besides the poor physical plant, there are many other deficiencies involving environmental health and safety. There are no environmental health and safety policies or procedures. The existing facility is overcrowded, with many inmates sleeping on the floors of cramped, archaic, slatted cells. Some of the inmates not sleeping on the floors received their temporary cots just a few hours before we arrived for our inspection. There are insufficient sanitary facilities for the number of inmates. For example, 11 inmates in one cell had to share a single, dilapidated toilet and shower. Many plumbing fixtures were clogged, filthy, rusted and leaking. Pest control appears completely inadequate. There were roaches on shower floors and walls throughout the dingy Jail.

B. Fire safety is inadequate. The Jail is a fire hazard. It is cluttered with boxes, hanging sheets, clothes, cartons and other combustibles. Cell roofs are covered with bags, hats, used filters and other clutter. The electrical system is a shambles. There is exposed wiring throughout the Jail. There is wiring wrapped around metal fixtures and vents. During a test of the fire alarm system, our environmental health and safety consultant found that the smoke detectors do not work and are not properly maintained. The fire alarm itself works erratically. Fire extinguishers were missing or needed recharging. Mattresses have no labels indicating fire resistance. The dirty pillows are not easily cleanable or fire resistant. Exhaust from the clothes dryer is vented indoors through a water container in an attempt to control lint. At one time, it was vented to the nearby hot water heater room, which is presently filled with rags, lint and other flammables.

C. Clothing, linens, and personal hygiene items are insufficient. Inmates are not provided with adequate clothing, blankets, towels and personal hygiene items.

D. Food sanitation is inadequate. Food service is provided by "Mama Jean's Kitchen" in Albany. During dinner, we observed that the trustees do not observe basic sanitary practices when serving meals. The meals are individually packaged in polystyrene containers, and are not otherwise insulated or kept

heated during transport. Thus, food temperatures are below recommended levels on arrival. The Jail has a refrigerator for storing some food items, but this refrigerator has not been cleaned in some time. Mold and a black material have built up on the walls.

E. Lighting and ventilation are inadequate. Even during a a bright afternoon, inside light levels were below eight foot-candles. Many windows are bricked up or otherwise sealed. Exposed light bulbs are located in a number of cells. Ventilation is very poor and air circulation is maintained by one unshielded household fan.

MINIMUM REMEDIAL MEASURES

IV. SECURITY AND SUPERVISION.

A. Policies, procedures, training. Create and implement comprehensive jail policies and procedures. Model procedures are available from both state and federal agencies. They cover classification systems, incident reports, disciplinary procedures, suicide prevention and other important policies. Increase staff training to ensure understanding and compliance with those procedures. All jailers should attend the state's jailer training school, and receive periodic, additional training.

B. Supervision and new jail construction. Proceed with construction of a new jail and cease using the existing facility. Technical assistance is available from a number of government agencies and private organizations. In the interim, conduct and adequately document patrols of all housing areas by officers, attempt to separate inmates based upon classification status, and reduce overcrowding. Staff the Jail with an adequate number of officers. Intensive supervision of the inmates, especially those showing suicidal tendencies, is essential given the poor design of the Jail.

C. Exercise. Provide inmates with daily exercise, outdoors when weather permits.

D. Nutrition. Provide inmates with adequate nutrition.

V. MEDICAL CARE, MENTAL HEALTH CARE AND SUICIDE PREVENTION.

A. Medical and mental health care policies and procedures. Create and implement comprehensive medical, mental health and suicide prevention policies and procedures. Such policies should cover initial medical screenings, non-urgent sick call requests, communicable disease testing, physical examinations and staff training.

B. Timely care and documentation. Provide inmates with prompt medical, dental and mental health care. Maintain adequate medical logs and records.

C. Responsible health authority. Retain the services of a "responsible health authority" ("RHA"). The RHA may be a part-time registered nurse but he or she must be under a doctor's supervision. The R.N. must have regular hours and should conduct daily triage and "walkthroughs" of the facility. The R.N. should have adequate medical supplies and equipment. Keep a stocked first aid kit at the Jail.

D. Medication practices. Train officers on medication administration. Store all medications in a secure location.

E. Mental health care. Contract with a qualified mental health care provider who should conduct a "walkthrough" once per week at the Jail. The provider should be on call and have the authority to make any necessary referrals.

F. Communicable disease control. Conduct communicable disease screening for all inmates entering the existing Jail.

G. Special diets. Provide special diets.

VI. ENVIRONMENTAL HEALTH AND SAFETY.

A. Construction and fire safety. Close the existing Jail as soon as possible. In the interim, conduct a complete fire and safety inspection and repair deficiencies. Some of the deficiencies which need to be addressed include the inoperative fire detection system, missing or poorly charged fire extinguishers, excessive buildup of flammable materials, and exposed wiring.

B. Environmental health and safety policies and procedures. Create and implement comprehensive environmental health and safety policies. Provide training on safe food handling practices, sanitation, use of chemicals and other environmental health issues. Food should be transported promptly in clean, well-insulated containers.

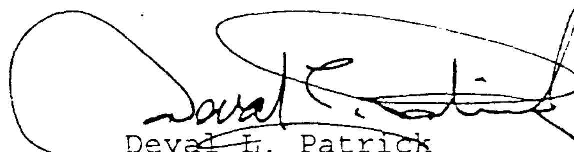
C. Housekeeping and maintenance. Clean the existing Jail, and maintain the physical plant, plumbing, lights and other fixtures in good repair. Clean the refrigerator.

D. Clothing, blankets, sheets and personal hygiene. Ensure that inmates, including indigent prisoners, have adequate personal hygiene items, as well as clean clothing, sheets, towels and washcloths. Ensure that all mattresses and pillows are clean, made of fire resistant materials, and designed for institutional use.

E. Provide adequate ventilation and lighting.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution 49 days after appropriate local officials are notified of them. 42 U.S.C. § 1997b(a)(1). Therefore, we anticipate hearing from you as soon as possible and before that date with any response you may have to our findings and a description of the specific steps you will take or have already taken to implement each of the minimum remedies set forth above and in our consultant reports. If you do not respond within the stated time period, we will consider initiating an action against your jurisdiction to remedy the unconstitutional conditions. We look forward to working with you and other County officials to resolve this matter in a reasonable and expeditious manner. If you or any member of your staff have any questions, please feel free to contact attorneys Christopher Cheng at (202) 514-8892, David Deutsch at (202) 514-6270, or Shanetta Brown at (202) 514-0195.

Sincerely,



Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: James W. Sizemore Jr., Esquire
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Mr. Harold Breeden
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Lee County Jail

James L. Wiggins, Esquire
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