**U.S. Department of Justice**

Civil Rights Division

Office of the Assistant Attorney General

*Washington, D.C. 20035*

June 1, 1995

Mr. Wayne West
Chairman
Dooly County Commission
P.O. Box 322
Vienna, GA 31092

Re: Notice of Findings from Investigation of
<u>Dooly County Jail</u>

Dear Mr. West:

On October 3, 1994, we notified your office of our intent to investigate the Dooly County Jail ("DCJ" or "Jail") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 <u>et seq</u>. 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 DCJ 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 the Dooly County Jail. 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. <u>Estelle</u> v. <u>Gamble</u>, 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 persons, since they have not been convicted of any crime. <u>Bell</u> v. <u>Wolfish</u>, 441 U.S. 520, 540 (1979). Detainees may not be subjected to any restrictive acts or practices which are not reasonably related to legitimate

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governmental objectives, such as ensuring the detainees' presence at trial or maintaining jail security. Id.

DCJ has a "new" and "old" section, opened in 1985 and 1963, respectively. The Jail has a reported capacity of 36 male inmates. During our tour, the Jail housed 36 male inmates. No females are presently housed at the Jail; however, the former women's cell is located within sight and sound of the adjacent men's cells. We found many deficiencies at the Jail. The unconstitutional conditions we identified are as follows:

I. CORRECTIONAL POLICIES AND PRACTICES ARE DEFICIENT.

A. **Policies and procedures bear no relation to existing practice.** The policies and procedures manual provided by the Jail is detailed, but it was written for another county and has never been tailored to DCJ or properly implemented. For instance, the existing grievance procedure was only recently introduced and has not been effective. Also, the policies have significant omissions. For example, the Jail requires that inmates pay forty dollars in addition to any court-imposed fines before release, but we saw no policies or procedures regarding this "turnkey fee." Thus, there are no provisions for indigence or written justifications for this archaic practice.

B. **Inmates are not classified or separated based upon penological principles.** The Jail has no classification system for separating inmates based upon security, mental health and other considerations. No administrative or other segregation of inmates exists at the Jail.

C. **Officers do not receive adequate training and monitoring.** Most of the staff have not attended the state's jailer school and there is no systemic training program. While Jail procedures require 40 hours of in-service training, no such training was ever conducted until the day before we arrived for our inspection. Jail staff receive equipment such as pepper gas and tasers; yet there is little, if any, training or monitoring of their use. Verbal abuse of inmates appears fairly common and can escalate to serious incidents.

D. **Staffing is inadequate.** On the day of our tour, two officers were on duty. Normally, the Jail has four officers who each work alone during their twelve-hour shifts. These officers also handle booking. The staffing levels are too thin to ensure adequate security. Officers may not enter the housing areas without backup; yet backup is not generally available. Rounds are not conducted on a frequent, regular basis.

**E. Opportunities for exercise are insufficient.** Inmates are permitted an opportunity to exercise once a week for two hours. Exercise takes place in an outside yard and is concurrent with visitation.

II. MEDICAL CARE IS INADEQUATE.

**A. Medical policies and procedures are not implemented.** While existing medical policies cover a number of important areas, we found no evidence that those polices have been implemented. For example, the policies refer to a health appraisal process and a request procedure for medical care. Yet, we found that there are no health appraisals or medical request systems in place. The policies were apparently borrowed from another county. As such, they have no relevance in day-to-day Jail operations.

**B. Intake screening is inadequate.** The receiving screening form is nothing more than a few questions on the booking sheet. The questions do not probe for information about alcohol abuse, mental health problems or communicable diseases.

**C. Medical services are virtually nonexistent.** There is no medical examining room at the Jail; nor is there any regular, medical staffing. Every Monday, a jailer goes through the facility and signs up inmates for sick call. The doctor then sees inmates on Tuesday. The doctor is not, however, on call. Thus, there is no medical coverage at the Jail for most of the week. The doctor does not take medical histories or give physicals. His progress notes are very sparse. In the past year, he has billed for approximately 60 examinations. Twenty-six of those exams apparently took place the Monday before our inspection. Jail officials have overruled medical decisions in the past, refusing to provide medications or other items prescribed by the doctor.

**D. Communicable disease control is nonexistent.** Despite the fact that just four or five months ago there was a serious tuberculosis incident at the Jail which required the local health department's intervention, there is still no regular tuberculosis testing at the facility. There is no venereal or other communicable disease testing either. Our medical consultant was especially concerned about the poor sanitary conditions at the Jail. Those conditions substantially increase risks to inmate health.

**E. Emergency medical care is inadequate.** Our medical consultant determined that there are substantial delays even for emergency medical care. An inmate with a medical emergency has no easy means of notifying officers about the problem. Inmates reported having to bang on the walls and shout for as long as 40 minutes before anyone responded. This is especially a problem at

night, when officers do not conduct regular rounds and the doors to the housing areas are shut tight.

**F. Suicide and mental health care are inadequate.** There have been several suicide attempts at the Jail, including one within a few weeks of our tour. During the most recent incident, it took almost a half hour for officers to respond to the emergency. While the Jail has obtained the services of a mental health counselor, that counselor has an irregular schedule. Theoretically, officers can request that the counselor come to the Jail when they suspect an inmate is suicidal. Since there is no suicide screening or training, this procedure is of questionable value.

**G. Medication administration practices are dangerous.** Staff have no training in medication administration. They hand out medications and sign logs without obtaining the inmates' co-signature. Inmates have no idea what medications they are receiving from the jailers and the jailers do not know either. Many inmates stockpile rather than take their medications. We found inmates with small containers, even bags, full of prescription medicines. Medications are not securely stored. Instead, they are kept in a tackle box and unlocked file cabinet. Our medical consultant found one log entry that showed that the jailer was giving an inmate medication two times a day, even though the prescription required that the inmate take the medication four times a day.

**H. Dental Care is poor.** Other than extractions, inmates receive no dental care. What care they do receive is sometimes delayed for weeks.

**I. Medical training is insufficient.** The Jail itself has no medical training program. Only two of the Jail officers have received first aid, CPR and other basic medical training from the state's jailer school.

III. ENVIRONMENTAL HEALTH AND SAFETY CONDITIONS ARE DEFICIENT.

**A. Overall jail conditions are deplorable.** Both the old and new Jail sections have many physical defects. Indeed, the building hazards are so severe that the Jail is unfit for human habitation. The deficiencies range from electrical hazards to rubbish throughout the facility. The roof is damaged. We found extensive evidence of ceiling leaks in the housing areas. In a few of the cells, inmates are sleeping on the floors.

**B. Policies, procedures and training on sanitation and safety are inadequate.** There are no policies, procedures or training regarding general housekeeping, food handling, fire safety, chemical use and other environmental health and safety concerns.

**C. Fire and electrical safety is inadequate.** This Jail has a history of failing fire inspections. Many of the defects identified in past fire marshal's reports persist. There is a large amount of combustible material in the Jail because of trash and debris buildup. The fire and smoke alarms do not work. Extinguishers need servicing. Jail staff do not conduct fire drills. We found exposed wires, wires wrapped around metal, wires near water, and other electrical hazards in the cells. We found an uncovered, highly flammable, foam mattress in one of the cells.

**D. Plumbing fixtures are in dilapidated condition.** Many toilets, pipes and other plumbing fixtures leak water. There is standing water throughout the Jail. Water pressure is low or non-existent in some cells. Many drains are clogged with debris. One cell does not even have a working lavatory and the inmates have to use facilities in neighboring cells. The Jail plumbing system is strangely configured. To run water, inmates have to turn on a spigot which is in a pipechase running behind their cells. One inmate cannot reach his spigot from his cell.

**E. Lighting is inadequate.** Light levels in both the old and new sections are less than ten foot-candles. Many lights are not working, are missing bulbs, or are unshielded. The lighting in the cells is so poor that it is difficult even to ascertain whether a cell is occupied.

**F. Ventilation is insufficient.** Many vents are clogged with debris. General ventilation is poor.

**G. Food sanitation is poor.** The Jail does not have a kitchen. Food is obtained from a nearby, private establishment. The lunch meal on the day of our tour, tuna fish, was served at approximately 65 degrees Fahrenheit. This is much warmer than food safety standards permit.

**H. Chemical handling practices are dangerous.** We found a container of phosphoric acid cleaner in one of the inmate cells. This type of cleaner can cause chemical burns and should never be stored in housing areas.

**I. Personal hygiene items are inadequate.** Inmates lack towels, washcloths and sheets. Those few towels and sheets available were dirty or tattered.

**RECOMMENDATIONS:**

IV. <u>CORRECTIONAL POLICIES AND PRACTICES.</u>

**A. Policies, procedures, and classification.** Customize the current model procedures and implement them. Technical assistance is available from the Justice Department's National

Institute of Corrections. The County should also seek any available state assistance. Such policies need to adequately provide for a classification system, grievance and disciplinary procedures, inmate access to the courts, and other important matters. Additional or modified housing is required to ensure proper separation of inmates based upon sound classification principles, as well as to provide administrative and punitive segregation units.

B. **"Turnkey" fees.** Eliminate arbitrary fines and penalties.

C. **Training.** Establish a training program to ensure that officers attend the state jailer school and receive regular on-the-job and follow-up training.

D. **Staffing and supervision.** Ensure that there are at least two officers on each shift, in addition to any employees with dispatch functions. Conduct and document frequent rounds.

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

V. MEDICAL AND MENTAL HEALTH CARE.

A. **Policies and procedures.** Customize and implement the existing medical policies and procedures. The County should take advantage of any technical assistance available from federal and state agencies.

B. **Screening.** Devise and implement a separate medical screening form as part of a comprehensive screening process. Screening should cover alcohol abuse, mental health, infectious diseases, in addition to more general health issues.

C. **Staffing and equipment.** Put a "responsible health authority" ("RHA") in overall charge of medical care at the Jail. While a registered nurse can serve as the RHA, that nurse should have regular, daily hours. Implement a formal, written sick call request system. Conduct regular physical examinations, health appraisals and communicable disease testing. Provide the RHA with an adequate examination room, medical equipment and supplies. Jail officials should not overrule decisions by medical providers.

D. **Training.** Ensure that officers receive basic medical training from qualified professionals. This should include training in CPR, first aid and administration of medications.

E. **Mental health care.** Establish a formal, contractual arrangement with a qualified mental health counselor. The counselor should make regular visits and provide regular mental

health care. The counselor should be able to make referrals to psychiatrists and other mental health professionals.

**F. Medications.** Securely store all medications. Periodically sweep the Jail for hoarded medications and other contraband.

**G. Medical records.** Maintain adequate medical records regarding medical care. For example, medication logs should be co-signed by inmates. A set of records must be kept at the Jail itself.

**H. Dental care.** Provide timely, routine dental care.

VI. ENVIRONMENTAL HEALTH AND SAFETY.

**A. Renovate or close the Jail.** The facility is so decrepit and unsanitary that it poses a health and safety risk to everyone inside. A recent grand jury report recommends closing the Jail. We agree that, without significant renovations, this Jail should be closed. Renovations would require that the County retain the services of professional contractors, including an electrician, plumber and other qualified workers, to inspect and revamp the roofing, electrical, plumbing, ventilation and lighting systems. Even if a new Jail is built, the existing Jail needs similar, although perhaps less extensive, renovations to make it temporarily habitable for the current inmate population. After renovation or construction, the County must clean and regularly maintain the facility in good condition.

**B. Policies and procedures regarding sanitation and safety.** Create and implement policies and procedures covering general housekeeping, food handling, fire safety, disaster preparedness, chemical handling, personal hygiene and other environmental health and safety concerns. Train and drill staff so that they are familiar with these policies.

**C. Fire safety.** Immediately repair the fire/smoke alarm and detection system. Ensure that the system is operational and that all fire extinguishers are properly charged.

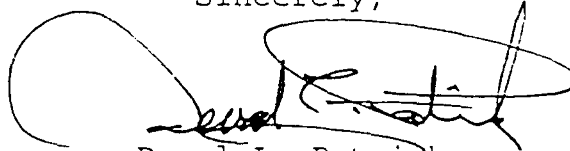
**D. Food sanitation.** Transport food in properly insulated, cooled or heated containers to ensure that they are served at proper temperatures.

**E. Chemical handling and storage.** Remove all hazardous chemicals from housing areas. Safely store, use and mix chemicals.

**F. Personal hygiene items.** Ensure that inmates have adequate towels, washcloths and sheets. Replace all damaged, unsafe mattresses with fire-resistant, clean and covered institutional mattresses.

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
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cc: John Davis, Esquire
County Attorney

Mr. Van Peavy
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