U.S. Department of Justice

Civil Rights Division

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

April 10, 1998

The Honorable Buzz Norris
Judge-Executive
Daviess County Fiscal Court
212 St. Ann's Street, Room 202
Owensboro, KY 42303

Re: Daviess County Detention Center

Dear Judge-Executive Norris:

On March 24, 1997, we notified you that, pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997 et seq., we were investigating conditions at the Daviess County Detention Center ("Detention Center") in Owensboro, Kentucky. Subsequently, on June 19, 1997, we notified you that our CRIPA investigation of the Detention Center included conditions at the Harold N. Taylor Restricted Custody Facility ("RCF"), the E. Robert Goebel Secure Juvenile Detention Facility ("SJDF"), and the Louis Johnson Youth Alternative Center ("YAC"). In addition, we informed you that we were also investigating the SJDF and YAC pursuant to the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141.

We conducted our investigation by reviewing facility records and off-site inmate medical charts; interviewing administrators, staff, off-site medical and mental health providers, inmates, and juveniles; and conducting an on-site survey of the facilities in May and July 1997, with four expert consultants who specialize in adult and juvenile penology, environmental health, and correctional medicine. Consistent with CRIPA's statutory requirements, we are now writing to inform you of our findings. In addition, we thank the Detention Center staff for their cooperation.

The Detention Center consists of the following: a main jail, housing both male and female adult pre-trial and convicted state inmates whose length of stay may be as long as five years; RCF, an adult inmate work release center; SJDF, a secure juvenile detention center; and YAC, a non-secure juvenile detention center. The main jail, built in 1886 and renovated in 1986, has

146 beds.[1] The RCF is an 80-bed minimum security facility, opened in 1995. It currently houses inmates who are performing community service through County agencies or serving court-ordered work release sentences. The SJDF is a 58-bed secure facility, opened in 1995 for pre- and post-trial juveniles. The YAC is a 24-bed non-secure facility for juveniles. It opened in 1996.

Based on our investigation of the Detention Center, we have concluded that conditions and practices at these four facilities violate the constitutional rights of juveniles, convicts, and detainees. The areas of constitutional violation are wide ranging. To summarize: Detention Center staff systematically use excessive force against inmates, fail to supervise and protect inmates from harm by other inmates, and fail to respond appropriately in cases of medical emergencies. Medical care, mental health care, and suicide prevention are constitutionally inadequate. The main jail is dirty and unhealthy. Inmates are not provided adequate access to the courts. Punishment of inmates for alleged violations of disciplinary rules is summary and rendered without due process; there is no opportunity for inmates to hear and counter the charges, and no impartial review of the charges. Inmates at both the adult and juvenile secure facilities are granted insufficient opportunity to exercise. Finally, the juvenile facilities are failing to provide adequate education and an opportunity for activities during non-school hours.

The constitutional law governing conditions of confinement for inmates and juveniles has two sources. With respect to inmates who have been convicted of criminal offenses, the Eighth Amendment's ban on cruel and unusual punishment governs all aspects of conditions discussed here. The Eighth Amendment "imposes duties on [prison] officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care." Farmer v. Brennan, 114 S.Ct. 1970, 1976 (1994). It also forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1 (1992). In addition, the Constitution requires that inmates be afforded access to courts by a method adequate to allow them to attack their convictions and sentences directly or collaterally, and challenge unconstitutional conditions of confinement. Lewis v. Casey, 116 S.Ct. 2174, 2182 (1996). Pretrial detainees "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Id. at 545. With respect to pretrial detainees, the Fourteenth Amendment prohibits

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[1] Although the main jail has a rated capacity of 192 inmates according to the 1990 American Correctional Association National Jail and Adult Detention Directory, our expert consultant counted 146 actual beds during our tour.

conditions or practices not reasonably related to the legitimate governmental objectives of safety, order, and security. Bell v. Wolfish, 441 U.S. 520 (1979). Pretrial detainees have not been convicted of anything, and therefore they may not be punished. Further, detained children have constitutional rights to adequate shelter, medical care, mental health treatment, and protection from harm. See Youngberg v. Romeo, 457 U.S. 307, 315, 324 (1982).

I. EXCESSIVE FORCE

Detention Center staff regularly engage in excessive force to punish and "manage" adult and juvenile inmates, causing serious bodily harm. Based upon our investigation, we find that the use of excessive force by correctional staff is a problem which is endemic to all the Detention Center facilities. The Detention Center lacks important safeguards that might protect inmates from excessive uses of force by staff. For example, it lacks any use of force policies, procedures, or guidelines although it maintains and regularly uses non-lethal weapons such as pepper spray, stun guns, and side handle batons on inmates. In addition, the Detention Center lacks a mechanism for investigating and disciplining staff for illegitimate uses of force.

Written reports by deputies reveal the scope of this problem. For example, we discovered one incident report written by a deputy about an intoxicated inmate at the main jail who was assaulted by another deputy. The shift sergeant instructed the assaulting officer how to write his report "so it would show that the marks on [the inmate's] faces was caused by a fall and not being assaulted." Another incident report stated that an inmate at the main jail "struck his head on the door causing a gash on his head." The report stated that the inmate was found by a deputy lying in a "puddle of blood" with a "purple left ear" seven hours later. Several staples were required to close the head wound. The inmate, however, reported that he sustained his injury when a deputy threw him into a wall, kicked him in the head, and dragged him upstairs. His story appears to be far more consistent with the reported injuries.

Staff misuse and abuse weapons such as pepper spray, stun shields, and stun guns, resorting to them early and often, for both management and punishment. Except for an initial training session on the physical operation of these weapons, the Detention Center fails to provide its staff with any other guidance or training on their use. No policy about appropriate levels of force for different circumstances exists. The result is bodily harm to inmates. For example, Detention Center records reveal that an employee used a stun gun to awaken an inmate at the main jail who had "passed out." SJDF staff, inmates, and incident reports also indicate that staff regularly use stun guns and

pepper spray to control uncooperative youth and break up fights. But, after using these weapons on inmates, the Detention Center violates accepted professional practice by failing to provide them with any medical treatment. A number of juveniles indicated that they were not even allowed to shower or wash up after being subjected to pepper spray. Juveniles detained at SJDF also reported that youth are physically struck by deputies.

The Detention Center also does not provide a meaningful system for inmates to report physical abuse by staff. Nor does it investigate reports that are made. While the policy and procedure manual provides for an inmate grievance procedure, our investigation uncovered no evidence whatsoever that such a procedure is followed. The complete absence of a grievance system at all four facilities means that there is little way for an inmate to complain of an illegitimate use of force. In sum, the Detention Center's lack of a system for reporting and investigating abuse, a grievance system, policies and procedures on the use of force, the lack of adequate training, and the regular and frequent use of non-lethal weapons to manage detainees enable widespread, unchecked uses of excessive force by correctional staff.

II. FAILURE TO PROTECT INMATES FROM HARM

A. Dangerous restraint practices

Detention Center staff regularly use a restraint chair at the main jail for intoxicated inmates even though there are no written policies or procedures governing its use. Any intoxicated person placed in the restraint chair must be watched constantly to prevent death by positional asphyxiation. Although the chair is located in a cell across from the control room, visibility is very limited. In addition, the deputies assigned to the control room are generally too busy to maintain constant surveillance. The Detention Center's failure to provide staff with guidance regarding the appropriate use of a restraint chair and the limited visibility of the chair from the control room creates the potential of great bodily harm to inmates.

B. Failure to supervise

The Detention Center — especially the main jail and the SJDF — fail to supervise inmates sufficiently to provide even a minimal level of safety. The result is acute and even fatal harm to inmates when their emergency medical needs go unmet, and when there is inmate-on-inmate violence. The Detention Center relies on inmates to inform staff when there is a problem, but offers inmates no reliable and fast method for doing so.

The problem is most acute at the main jail, where the population of over 200 inmates are housed in 30 cells located on

three floors. The housing areas are extremely crowded, creating a volatile situation. Nonetheless, there is virtually no auditory or visual surveillance of the housing areas. Inmates reported that because officers do not conduct routine rounds, there are frequent extended periods of time when no deputy is present. In addition, there are no intercoms or panic buttons. Instead, inmates try to draw staff attention by banging on cell doors, or, in some areas of the main jail, using pay phones to call the control room and report a problem.

Especially in light of the physical layout, and the absence of visual or auditory surveillance, the staffing levels at the main jail are dangerously low — just thirteen deputies and three sergeants are assigned. On the second shift (8:00 a.m. to 4:00 p.m.), only three deputies supervise over 200 inmates. In addition to supervision, deputies are responsible for handling visitation, maintenance, feeding, pill distribution, recreation, and transportation. Three deputies simply cannot adequately supervise inmates while performing all these duties. The risk of harm posed by inadequate staffing and communication between staff and housing areas at the main jail is illustrated by an incident that occurred the day we began our tour in May. That morning, an inmate took a deputy hostage — but the jail staff did not even know about it until another inmate telephoned the control center for assistance.

Severe overcrowding at the main jail is also creating a dangerous situation for inmates. There are approximately 146 beds at the main jail. However, the inmate count on May 5th was 228 — almost 160% of bed capacity. A review of inmate counts from January 1996 to May 1997 revealed that the main jail's population is consistently 200 or more inmates. Overcrowding, which is also discussed below as it relates to unsanitary conditions at the main jail, also contributes significantly to problems of inmate violence. Inmates are so crowded together that conflict is inevitable and, given the lack of supervision discussed above, extremely dangerous. Fights, assaults, threats, and extortion are frequent. Inmates fight or purchase the right to use a mattress or a bed from other inmates, in order to avoid sleeping on the floor or sleeping on a mattress soiled from nearby toilets.

At SJDF, low staffing levels and the physical layout are similarly leading to very dangerous situations for the juveniles there. The SJDF is designed to hold a maximum of 58 juveniles. Just one or two deputies, alone, supervise these youths. For example, we observed one officer attempting to supervise 43 youths during lunch time on the day of our visit. Youths reported that it is not unusual for one deputy to supervise all the living units on the weekend and the second shift during the week at times. While the census at SJDF was between 43 and 45 during our July visit, staff reported that more than 70 juveniles

have been housed at the facility in the past. Staffing ratios at SJDF fall well below professionally accepted practices. Moreover, some of the rooms at SJDF are tucked deep into corners and cannot be seen from the control station. Our consultant found that it is not possible for one deputy to observe all juveniles in their cells in each living unit by standing on the elevated platform of the control station. Given the size of the population, the low staffing pattern, and the lack of direct line of sight supervision for some rooms at SJDF, we find that supervision is inadequate to provide youth safety.

C. Classification/Housing Assignment

The Detention Center facilities are rendered even more dangerous for adults and juveniles because of the County's failure to classify inmates using all appropriate criteria. While the County separates adult males from adult females, adults from juveniles, and adult sex offenders from the general adult population, it fails to use other criteria to determine safe and appropriate housing for inmates. There is no classification instrument to guide the housing decisions, and no collection and maintenance of information about inmates to aid in making housing decisions during their stay at the Detention Center. For example, the Detention Center fails to identify and appropriately separate inmates with special needs, e.g., physical or mental impairment, from other inmates likely to abuse or take advantage of them. This total breakdown in accepted jail practice causes serious harm to inmates.

In a particularly egregious example of improper classification at the main jail, a slightly built inmate who was charged with first degree sodomy was moved from a designated "protective custody/sex offender" dorm to a general population cell with three other inmates. Within hours of the move, the inmate was assaulted by his cellmate and sustained multiple injuries to his head and shoulder. A few days later, he was returned to the "protective custody/sex offender" cell where he was again involved in an assault with another inmate. The next month, the inmate was moved again when a cellmate complained of his behavior. This inmate suffered repeated assaults that were predictable and probably preventable, yet jail authorities simply moved him from one inappropriate housing situation to another.

Another example of the consequences of improper classification can be found in housing assignments of an inmate with hearing and speech impairments. A month after admission to the main jail in April 1996, he was transferred to a dorm where one of his cellmates assaulted him; his head wound required 13 stitches. A few months later, staff moved him to another dorm because his cellmates were calling him names. In October, staff noted that the inmate was being ridiculed by his cellmates, but did not attempt to intervene or move him. He was subsequently

observed with two black eyes and a busted nose. Again, the inmate was not moved and less than a month later staff again noted that he was having difficulty getting along with the other inmates.

An equally dangerous practice, separate from (though related to) the Detention Center's failure to classify inmates based on predictable needs for protection and separation, is the Detention Center's failure to respond to reports of impending violence. Our consultant, on May 7th, interviewed an inmate who had recently sustained two black eyes in a fight with another inmate. Before the altercation, the inmate had requested to be moved because of the problems he was experiencing with his attacker. The Detention Center ignored his request.

In sum, we find that the Detention Center does not properly classify and house inmates in order to provide for their safety.

D. Fire Safety

The Detention Center fails to afford inmates adequate fire safety. During our visit to the main jail, posted fire evacuation plans were so faded that they could not be read. In addition, we found no documentation or other evidence of fire drills. In light of the severe overcrowding and the abundance of clothing and other flammable material in many of the cells, regular fire drills and legible evacuation plan are necessary to ensure the safety of inmates at the main jail.

III. MEDICAL CARE

A. Access

Inmate access to medical care at the Detention Center is inadequate in several ways. Correctional staff, who have no medical training, evaluate and treat illness. All decisions on access to medical professionals are made by correctional staff. Our review of two months of sick call requests illustrated the harm to inmates that results from this practice. For example, one inmate complained that the cream he had been given "for the spots" was not working. He had reported "spots on my up[per] body" two weeks before. Both times he was simply given over-the-counter anti-itch medication. Neither time was his rash, which may well have been contagious, evaluated or treated. Another request stated that an inmate had an "open boil . . . (may be infected)." The inmate was not examined, but simply given "boil ease." And another time, an inmate who complained about swelling in his eye, which he thought might be infected, was given over-the-counter eye medication without being evaluated by a qualified medical professional.

Correctional staff also handle on their own much more serious problems. For example, one inmate with diabetes was reported to correctional staff to be passed out in his cell. An incident report notes that the inmate was "unable to respond to deputies," and that his "skin was cool and clammy." Deputies tested his blood sugar level, and then gave him a "tube of insta-glucose." They did not call for medical assistance, but rather waited, and retested. Finding the inmate's blood sugar level still dangerously low, they repeated the procedure, and then again a third time, and then, after one more test, gave him a soda to drink. After that, "he seemed to start to come around." Three hours later, the inmate's blood sugar level was dangerously high, and he was given an insulin injection. During this episode, no qualified medical professional was ever called to evaluate this inmate's condition or treat him.

These circumstances pose acute risks both for the inmate and for correctional staff, who are neither trained nor equipped to provide medical treatment. Indeed, review of inmate medical records revealed that around the time of the incident involving the diabetic inmate, one correctional officer was in fact pricked by one of the diabetic inmate's needles, raising a risk of transmission of a blood borne pathogen such as hepatitis or HIV.

In addition, deputies, and on occasion inmate trusties, hand out all medication, both over-the-counter and prescription. When we visited SJDF in July, several juveniles received psychotropic medication from the deputies on a daily basis. Correctional staff who lack health care training are unable to recognize dangerous side effects associated with medication, particularly psychotropic drugs. It is contrary to professional practice to permit correctional staff who are not health-trained to administer medication.

Moreover, Detention Center policy requires each inmate to pay ten dollars for each doctor's visit, and five dollars for each prescription. We found no evidence that the fee waiver policy for indigent inmates is followed. In practice, Detention Center staff are more likely to transport inmates to the doctor if the inmates had money to pay the ten dollars, and will sometimes allow inmates to have medication only if they are able to pay for it. Moreover, the Detention Center's failure to provide adequate hygiene supplies for indigent inmates means that inmates with limited funds must choose between paying for medical care or hygiene. Thus the co-payment system functions as a major barrier to access to care.

B. Inadequate response to medical emergencies

As discussed in more detail with reference to security issues, the main jail lacks an adequate system for maintaining contact between inmate areas and correctional staff. While

inmates use pay phones to contact the control center, that "system" is inadequate, because several of the largest housing areas have no phone, and the women's housing areas each have the phone only part of the week. Thus, there are a number of housing areas from which there is essentially no way for inmates to notify correctional staff of an emergency. This poses very acute risks to inmate health and safety. The risks for inmates with asthma are exacerbated by Detention Center policy that inmates may not have asthma inhalers in their housing areas.

In addition, staff response to emergencies appears medically inappropriate, posing another great risk to inmates suffering from acute medical problems. In September 1996, an inmate had a heart attack at the main jail in one of the men's housing areas with no phone, and therefore no way for his cellmates to notify Detention Center staff. Instead, the inmates yelled until some women inmates heard them and phoned the Control Room. It took another fifteen minutes for staff to arrive at the cell. An officer called 911 for an ambulance and decided that the inmate needed CPR. Instead of performing CPR themselves, corrections staff directed two inmates to do it. The heart attack victim died. Our expert concluded that the lack of an adequate system for maintaining contact between staff and inmates and the apparent inability or unwillingness of staff to take appropriate action in the event of medical emergencies creates a potentially dangerous and life-threatening situation.

Another example of inappropriate response to medical emergencies occurred last spring when a juvenile hanged himself at SJDF. The deputy who found the youth untied him, rather than the preferred and faster practice of cutting him down. The officer then started CPR (though the Detention Center's records of deputies certified to perform CPR do not include the responding officer). But rather than calling for emergency medical response, and doing CPR until arrival of a team qualified to determine whether the youth was dead, the officer simply decided, at some unspecified point, to stop. The deputies made five different contacts while the crisis was unfolding — they called a supervising deputy, the Jailer, a Lieutenant, a Sergeant, and the coroner. But SJDF records do not include any information indicating that Detention Center staff at any time called an ambulance or any medical personnel.

C. Inadequate screening and treatment for infectious and contagious diseases

The Detention Center does no tuberculosis (TB) screening of any kind, despite the fact that Daviess County has a documented incidence of TB infection. (County health officials told our consultant that other law enforcement officers in the Owensboro/Daviess County area have recently screened positive for TB exposure.) The Detention Center population, then, likely

includes infected inmates. But the Detention Center is doing nothing whatsoever to ensure that those who are infected are treated, and do not infect others. Less seriously, but still problematic, numerous inmates at the main jail and RCF report persistent skin rashes — likely to include cases of transmissible infections. The Detention Center's preferred treatment for skin problems — hydrocortisone cream — reduces itching, but neither treats the underlying problem for the complaining inmate nor reduces chance of transmission.

D. Inadequate medical care

Intake. The Detention Center does not perform any intake physical exams, and even when an inmate tells deputies of medical issues during intake, no referral is made to medical providers. Moreover, the screening that is done at the main jail is conducted in an open area, often with several inmates present. If an inmate is withdrawing from alcohol and has a risk of developing delirium tremens, the officers give him two vitamins from a bottle labeled "one for DT's," but offer no other medical intervention or observation.

At SJDF and YAC, youth who enter and leave these facilities before the nurse's weekly visit to the facility are never seen by any medical professional. Some of these youths may have highly communicable diseases, placing the entire population at risk. For those who do see the nurse, the medical exams are cursory at best. A medical history and vital signs are taken but no testing for infections diseases such as tuberculosis is performed.

Quality of Care. There is no sick call at the main jail and RCF. No on-site services of any kind are provided, except "pill pass." The Detention Center's primary physician states that he does not attempt to provide chronic care, but merely to deal with acute issues as they arise. He stated that he does not do follow up monitoring of medication needs. Thus, even when he sees inmates with chronic care needs, their underlying medical problems often go unaddressed. Moreover, the care provided to inmates is simply inadequate; inmates are misdiagnosed and mistreated. The risks posed are very serious, and the health and safety of inmates have certainly suffered. Indeed, our review of recent treatment decisions made for inmates revealed inappropriate, incomplete, and even harmful treatments.

Continuity of Care. Because all medical treatment of inmates is done by health care providers outside the Detention Center, the records charting patient care are scattered at numerous sites, with numerous providers. As a result, there is no continuity of care from one provider to the next.

IV. MENTAL HEALTH CARE

A. Access

During our tour, we observed several acutely mentally ill individuals at the main jail, obviously in need of psychiatric evaluation and treatment, being left for days at a time in "observation" — i.e., in a cell by themselves. One inmate was observed singing for hours on end, and eating his own feces. Detention Center staff were looking into the possibility of a permanent transfer of this inmate, but there was no plan to get him the emergency care he so obviously needed.

Detention Center medical request slips show the difficulty experienced by inmates seeking mental health care. For example an inmate at the main jail with a psychiatric history submitted a request that stated "I need to see a psychiatrist. I need medication, my nerves are real bad again." He was given "2 Ibuprofen 3 times a day." Similarly, a request from another inmate stating that he had migraine headaches, but also asking to talk to a psychiatrist or counselor, resulted only in the inmate getting ibuprofen.

In addition, there is no ongoing mental health or counseling program. The Lieutenant in charge of the juvenile facilities told us that when a juvenile states that he is thinking about suicide, SJDF staff or a chaplain speak with the youth. No referral is made to a mental health professional. As with medical care, a correctional staff person, here the Lieutenant, decides when a juveniles sees a psychologist or psychiatrist.

B. Suicide prevention

Because inmates (particularly juveniles) present a very high risk of suicide, prevention is an important health issue. The Detention Center fails to take even minimally acceptable steps in suicide prevention. The screening instrument used is inadequate because it does not sufficiently assess the common indicators of suicide risk. Moreover, staff do not use the more limited information the intake questionnaire does contain in order to minimize the risk of suicide. Staff are inadequately trained in emergency medical response, such as CPR, and in other aspects of suicide prevention. The Detention Center also fails to provide appropriate mental health care to inmates who are at risk.

At SJDF, the physical plant aggravates the problem. For example, over the toilet and near the far end of the top bunk in each cell are metal grates with half-inch openings in the ceiling from which a sheet or other item may be easily affixed. In at least some of the cells — including the isolation cells — there are clothes hooks approximately five feet off the floor.

Both of these features provide an easy opportunity for suicide by hanging.

The harm caused by Detention Center practices and the facility's physical plant are illustrated by the SJDF suicide discussed above. The juvenile who killed himself was fifteen. His intake form notes that he reported to staff that he was receiving Paxil, an antidepressant, and had received treatment at a mental health facility just the day before. His medical appraisal form states that he reported that he had previously "huffed" paint. A prior admission to a mental health facility, taking antidepressant medication, and a history of substance abuse were all indicators that there was an increased risk of suicide for this youth. Despite these warning signs, this youth was not placed under any kind of observation, even temporarily, during the initial, highest risk, period of incarceration. Rather, he was housed in a cell from which he could not be seen easily by Detention Center staff. No special watch was done. A day later, he hanged himself using a sheet tied to a ceiling grate immediately above the toilet in his cell. Following the death of this juvenile, there were at least two additional serious suicide attempts at SJDF. In both cases, the attempts were initially uncovered by other juveniles, not staff.

Another Detention Center practice which places juveniles at risk is the amount of time staff keep youth locked in their cells. Our investigation found that youth at SJDF spend 16 to 20 hours a day locked in their cells. This is far too much time. The overuse of isolation for a teenage population increases the risk for suicide. Our consultant found that another successful suicide at the juvenile facilities is highly likely given the lack of adequate direct supervision, insufficient mental health screening at intake, the lack of classification, insufficient medical services, inadequate educational and non-school activities, and the overuse of isolation.

V. SANITATION

A. Cell sanitation

The conditions at the main jail during our site visit were extremely unsanitary — even though, as we were told by many inmates, the facility had made a major effort to clean up the jail in preparation for our tour. Nonetheless, without exception, the housing areas were stifling, smoky, and dark. Each housing area was saturated with cigarette smoke. In many of the cells, grease and debris blocked the air vents. The tobacco smoke, in combination with the lack of air movement in and through the cells, keeps the cells from being adequately ventilated. In addition, the lighting in housing areas falls below appropriate levels for sanitation and safety. There

were no lights at all in cells 307 through 311 the week we visited in May.

The unsanitary conditions at the main jail are exacerbated by the extreme overcrowding. The most seriously overcrowded cells are the holding tanks, Cells 103 and 104. These two windowless tanks have 8 beds each. It is not unusual for the population in Cell 103 to exceed 30 inmates with counts running as high as 50. In May, we found Cell 103 housing 23 inmates with mattresses occupying much of the floor space. In addition, when we visited Cells 206 and 207, there were just four beds but 10 and 12 female inmates respectively. The floor in these cells was so crowded with mattresses that it was nearly impossible to walk around without stepping on an inmate. One of the inmates sleeping on the floor was late in her term of pregnancy.

With so many inmates on the floor, keeping the cells clean is extremely difficult. Some of the mattresses on the floor were being soaked with overflowing shower and toilet water from obstructed drains. In addition, many of the toilets and showers were dirty and in need of repair.

Inmates at the main jail, particularly those housed in cells 103 and 104, lack adequate bedding. Inmates reported that at times the facility fails to provide them mattresses and they must sleep on the floor with no bedding. Bed space is at such a premium that inmates reported that it is not unusual for beds and mattresses to be sold and bartered. Many of the mattresses provided to inmates are cracked, worn and dirty. Also, all the sheets were a dingy gray color. Clean mattresses, sheets, and blankets are necessary to prevent the spread of communicable skin infections such as scabies.

Inmates also reported that the Detention Center fails to provide them with adequate hygiene supplies. According to the inmates we interviewed at the main jail, many went without hygiene kits for several days when they entered the facility. The Chief Deputy confirmed that hygiene kits are not routinely provided unless an inmate asks for one during admission. In addition, we were told of a consistent shortage of soap and other hygiene products, and inmates frequently pointed out an empty soap container as the only source of soap for a cell.

B. Food service

The Detention Center's food handling practices are lax and pose a serious risk to inmate health. The trustee food handlers are not trained and do not appear to understand the protective measures they must take to ensure food safety. Protective clothing (aprons, hair restraints, clean clothing) and gloves are not worn consistently by all the trustees who handle food. These practices allow contaminants to enter the food. In addition,

food is distributed to inmates in uncovered trays carried on unheated carts, which introduces the risk of contamination and food poisoning.

VI. DUE PROCESS

The Detention Center fails to afford adults and juveniles any procedural safeguards prior to imposing disciplinary sanctions. We found that inmates at the adult and juvenile facilities are subject to arbitrary and summary sanctions, including extended periods of isolation, for alleged offenses of disciplinary policy. While the policy and procedure manual contains a section on inmate disciplinary offenses and hearing procedures, the staff fails to comply. Although the policy manual states that a written statement of inmate rights shall be provided to inmates on admission, none of the inmates we interviewed at the main jail and RCF had received such a statement. These inmates have no way of knowing the rules they are expected to follow, or their rights to contest allegations of infractions. And indeed, they are not given any such rights. They do not get notice of charges against them, or a chance to contest those charges, or any disciplinary hearing.

The absence of procedural safeguards poses a particularly serious problem at RCF. RCF houses two groups of inmates — those serving court-ordered work release sentences in which they attend their regular jobs during the day and return to custody at night and those performing community service during the day. Inmates reported that deputies at RCF frequently discipline them by sending them to the main jail. Thus, inmates who are serving work release sentences are placed at risk of losing their regular jobs. The Detention Center fails to provide inmates any opportunity to seek review of such decisions other than convincing the deputy or the lieutenant in charge of RCF to allow them to return to RCF.

Discipline at SJDF and YAC is similarly arbitrary. Juveniles can be placed in isolation for a variety of rule infractions from 24 hours to four weeks without an opportunity for a hearing. Youths are not released from isolation until the Lieutenant in charge says so. There is no process at all. Even staff admitted to our consultant that "frequently the rules change."

VII. ACCESS TO COURTS

The Detention Center has chosen to fulfill its obligation to provide inmates access to the courts by maintaining a collection of law books for inmates who request to use them. But the collection and the rules governing its use are constitutionally inadequate. First, access to the library is very limited. Second, the library itself lacks written material that could make

it useful to untrained inmates. Nor is assistance provided by staff or trained inmates. The facility also makes no special provision for illiterate inmates. Numerous inmates we spoke to told us that they wished to file lawsuits over conditions of confinement at the jail facilities, but were unable to find out the simplest information to enable them to file the lawsuit, including the address of the federal courthouse, the appropriate form of filings, the relevant statutory basis for a lawsuit, and any kind of case law. Moreover, two inmates told us that they had attempted to file lawsuits, but had been unable to do so, because jail authorities would not timely forward to the court a prison account statement, as required for inmate in forma pauperis filing.

VIII. OPPORTUNITY TO EXERCISE

Inmates at the main jail are not provided adequate opportunity to exercise. Inmates consistently reported to us that they had not been outside their cells in many weeks. Moreover, inmates confined to Cells 103 and 104 received no out-of-cell or outdoor exercise at all. (Both inmates and records indicate that inmates may be confined in these cells for 30 days or longer.) Similarly, youth at SJDF complained that their access to physical exercise was limited and often withheld completely by second shift and/or weekend staff.

IX. EDUCATION AND ACTIVITIES FOR JUVENILES

Although the staff claim that juveniles at SJDF and YAC attend three hours of school daily, all the SJDF youth interviewed for our investigation vigorously denied this assertion. They reported that they may attend school for one or two hours a day. Based on our conversations with staff and observations, it is clear the hours juveniles spend receiving instruction falls below that which is required by state law. Also, juveniles reported that they may be kicked out of school and placed in disciplinary isolation for rule infractions for extended periods of time. Youth in disciplinary isolation receive no access to educational or counseling staff.

The Detention Center also fails to provide adequate youth development programs, including adequate behavior management programs, life skills training, and adequate structured daily activities, including recreational opportunities. During non-school hours, staff keep juveniles at SJDF locked in their cells when they are not involved in the limited recreational activities provided. As a result, youth spend most of their waking hours in their cells with nothing to do.

MINIMUM REMEDIAL MEASURES

In order to remedy the deficiencies we have identified and to protect the constitutional rights of its adult and juvenile inmates, the Detention Center should implement promptly, at a minimum, the following measures:

1. *Excessive force.* The Detention Center should develop and implement comprehensive policies and procedures governing the application of force by staff, including non-lethal weapons. All staff should be adequately trained in these areas, and provision should be made for thorough review and retraining and/or discipline for inappropriate use of force or abuse. It also should institute an inmate grievance procedure covering complaints about uses of excessive force, and conduct serious evaluation and investigation when such complaints are made.

2. *Protection from harm.* The Detention Center should implement measures to provide reasonable safety for inmates. It should develop and implement policies and procedures governing use of restraints, including constant watch when restraints are used and there exists a danger of positional asphyxiation. The Detention Center should install intercoms or panic buttons for inmates to call staff in case of emergency, employ a sufficient number of deputies to provide adequate supervision and safety to each inmate, and develop an adequate risk assessment tool to guide staff in making appropriate classification and housing decisions, and collect and use information about inmates in making continuing decisions about appropriate housing placement. It also should reduce crowding at the main jail and implement adequate fire safety practices.

3. *Medical care.* The Detention Center should provide adequate medical care, end the involvement of correctional staff in health care except emergency medical response, and employ or contract with a qualified physician specializing in internal or family medicine and with registered nurses to provide adequate treatment to inmates. In addition, it should implement comprehensive medical intake assessments, including screening for communicable diseases, alcohol and drug use, and mental illness, to be conducted for each inmate upon admission to the facility by a qualified health professional, and have a physician conduct full health assessment within two weeks of admission. It should also train all staff in emergency medical response and CPR.

The Detention Center should develop a sick call policy and procedure that includes, at a minimum, the following: a) written sick call request slips; b) a collection method where the request slips go directly to a qualified health professional; c) logging procedures to record each request for sick call services; d) review of inmate requests by a registered nurse or physician on a daily basis to determine urgency of the need to be examined; e) a

sick call clinic conducted by a qualified health professional; f) a policy requiring medical staff to record the results of sick call in an inmate's record; g) a policy requiring all requests from inmates to be received, screened and responded to by qualified health professional; and h) confidentiality of medical records. In addition, it should implement a policy that prevents personnel responsible for determining whether an inmate receives medical care from knowing an inmate's financial status, to ensure that an inmate's indigence does not compromise his or her access to medical care.

Where specialized care continues to be provided off-site, the Detention Center should ensure that records are obtained after each provider visit, and kept in a confidential, on-site, inmate medical file.

4. *Mental health care.* The Detention Center should provide inmates with adequate mental health care, including emergency evaluation and treatment, develop adequate suicide prevention measures, and train all Detention Center staff in suicide prevention, and recognizing signs of mental illness.

5. *Sanitation.* The Detention Center should provide inmates at the main jail with sanitary conditions. It should ensure that cells are adequately ventilated, provide adequate lighting in all housing and food preparation areas, repair all broken showers, sink, and toilet fixtures, and develop and maintain a regular cleaning schedule. The Detention Center should ensure that each inmate has a place to sleep an adequate distance from sinks, showers, and toilets, and should provide each inmate who spends the night in the Detention Center with a clean sheet, pillow, blanket, and fire retardant mattress. It also should institute a regular mattress and blanket sanitation program and develop adequate food handling practices.

In addition, the Detention Center should provide each adult and juvenile inmate with a personal hygiene kit upon admission. It should provide an adequate supply of hygiene items to all inmates during their stay.

6. *Due Process.* The Detention Center should afford all inmates due process prior to imposition of any disciplinary sanction. Due process should include, at a minimum, written rules of conduct, notice of and opportunity to contest any allegations of misconduct, and impartial review. The Detention Center also should develop and implement policy and procedure governing inmate disciplinary procedures and inmate grievances.

7. *Access to courts.* The Detention Center should provide all inmates with access to courts. If the method of access is a law library rather than provision of lawyers or legal assistance, the Detention Center should develop an adequate collection of law

books, expand inmate access to law books, and provide assistance to illiterate inmates who wish to file a lawsuit.

8. *Opportunity for exercise.* The Detention Center should provide all inmates with adequate opportunity to exercise out of their cells and outdoors.

9. *Education and activities.* The Detention Center should provide all juveniles with adequate education and appropriate activities during non-school hours and days. It should provide juveniles with adequate and appropriate opportunities for exercise, recreation, and reading materials. All youth in disciplinary isolation should receive access to educational and counseling staff. The Detention Center should hire sufficient staff to supervise and provide appropriate activities during non-school hours to its juvenile detainees. It also should develop a separate policy and procedure manual governing operations, staffing, disciplinary procedures, education, and other services at SJDF and YAC.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at the Detention Center 49 days after you have been informed of the findings of our investigation. 42 U.S.C. §1997b(a)(1). We hope to be able to resolve this matter amicably and cooperatively. We will contact the County Attorney to arrange a meeting to discuss in greater detail the issues raised in this matter. We look forward to working with you to resolve this matter in a reasonable and practical manner.

Sincerely,

Bill Lann Lee
Acting Assistant Attorney General
Civil Rights Division

cc: Robert M. Kirtley, Esquire
Daviess County Attorney

Mr. David Warren
Mr. Gary Boswell
Mr. Fred Marksberry
Daviess County Commissioners

Mr. Harold Taylor
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Daviess County Detention Center

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