Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

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OCT 26 1993

Mr. Billy S. Davis
President
Lee County Board of Supervisors
200 Jefferson Street
Tupelo, Mississippi 38802

Re: Notice of Findings of Investigation,
Lee County Jail

Dear Mr. Davis:

On May 3, 1993, we notified you of our intent to investigate the Lee County Jail (hereinafter "LCJ") pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq. Consistent with statutory requirements, we now are writing to advise you of the findings of our investigation. Throughout our investigation, county officials, including the Sheriff, Sergeant, and jail staff, provided us with substantial assistance and their full cooperation. Our consultants expressed appreciation for this assistance, and we wish to join them in thanking you for your cooperation.

In general, inmates may not be subjected to conditions that are incompatible with evolving standards of decency or deprived of their basic human needs while incarcerated. See Estelle v. Gamble, 429 U.S. 97 (1976). In making our findings, we are aware that many of the individuals confined at LCJ are pretrial detainees or persons not convicted of any crime. The Fourteenth Amendment prohibits punishment of these persons or restrictive conditions or practices which are not reasonably related to a legitimate governmental objective such as ensuring the detainees' presence at trial or maintaining jail security. Bell v. Wolfish, 441 U.S. 520, 540 (1979). For those convicted of a crime, the standard to be applied is the Eighth Amendment's proscription against cruel and unusual punishment. Wilson v. Seiter, ____ U.S. ___, 111 S. Ct. 2321 (1991); Rhodes v. Chapman, 452 U.S. 337 (1981). When convicted prisoners are not, as here, separated from pretrial detainees, the Fourteenth Amendment standard applies to all inmates.

Department of Justice attorneys, accompanied by three consultants (a penologist, a medical doctor, and a health and safety expert), toured LCJ on July 27 and 28, 1993. During these tours, we interviewed jail staff and inmates, examined records maintained at LCJ, and evaluated other records provided by the Sheriff Department's personnel. Numerous conditions at LCJ violate the constitutional rights of inmates confined therein. These constitutionally violative conditions and the required minimum remedial measures that LCJ must implement are set forth below:

## I. THE JAIL DOES NOT HAVE ADEQUATE SECURITY AND SUPERVISION.

**A. Staffing and Supervision.** LCJ lacks sufficient staff to ensure the safety of inmates and the security of the jail. There is only one jailer per shift, with the exception of Friday and Saturday nights and visiting day when there is an additional person. This lone jailer cannot reasonably patrol the housing units and cannot promptly evacuate the inmates in case of a fire or other emergency. Furthermore, LCJ does not have a female staff person to supervise female inmates. As a result of this understaffing, there have been inordinately high occurrences of violence with fights and thefts occurring almost daily. Additionally, the understaffing has resulted in over-reliance on inmate trustees. For example, inmate trustees are in charge of food preparation and are not supervised in their performance of this task.

The jail has few written policies and procedures. LCJ's document entitled "Jailer Procedures" fails to cover numerous topics, including medication distribution procedures, procedures for dealing with and supervising mentally ill or suicidal inmates, and procedures for supervising trustees, the general inmate population, and high security inmates. Jail policies and procedures are needed to ensure the security of the jail, to hold the staff accountable for their actions, and to provide basic operating procedures.

While the jail has a general classification system with respect to housing of inmates, it fails to classify inmates during exercise periods in the exercise yard. This defeats the purpose of the facility's classification system because violent and non-violent inmates are mixed.

**B. Staff Training.** With the exception of the Sergeant/Chief Jailer, none of the corrections staff at LCJ has had any jail-specific training. Training is necessary for corrections staff to be able to adequately supervise inmates and to ensure the security of the facility.

C. **Weaponry.** Because LCJ does not have a gun locker, officers coming in from the road carry their service revolvers into areas of the facility where the inmates are present. The lack of a place to secure weapons could result in someone being injured or killed if an inmate were to overpower one of these officers and gain possession of his or her weapon.

D. **Inmate Access to Dangerous Items.** LCJ fails to control and monitor potentially dangerous kitchen tools and utensils. We found a variety of kitchen knives completely unsecured on a shelf under a food preparation counter. The inmate trustees have unfettered access to these dangerous implements and, through them, so do other inmates. LCJ does not account for the number of knives in its food service area.

We also found that inmate trustees have access to an unlocked room which contains the facility's electrical controls and inmates' personal property. Furthermore, we found two spring beds in the trustees' quarters, the springs of which can easily be removed and sharpened into weapons.

E. **Use of Mace.** The facility does not have a policy or procedure which governs the use of mace. Thus, the staff is left to determine appropriate responses to behavioral infractions, which permits the arbitrary use of mace. In some circumstances, LCJ's staff has used mace in inappropriate situations. Furthermore, LCJ stores its mace in an unlocked drawer in the control room to which inmate trustees have access.

F. **Overcrowding.** LCJ is routinely overcrowded. The stated capacity of the jail is 54, but there were 80 inmates on the first day of our investigative tour and the population has reached around 100 in the last year and a half. The size of the population has meant that all areas of the facility are consistently crowded and that some inmates have to sleep on bunks in the day rooms, on mattresses on the floor, and on top of day room tables. Overcrowding can exacerbate tensions between inmates and lead to violence. Furthermore, it impedes the jail staff's ability to adequately evacuate inmates in the event of a fire. Also, such overcrowding increases the potential for the occurrence and progression of infectious communicable diseases.

G. **The "Lunacy" Cell.** The cell nearest the control room has been designated as a place for holding suicidal persons and those who are temporarily held under the State's "Lunacy Law." The use of this cell for such purposes jeopardizes the safety of the inmates housed therein. There are numerous suicide hazards in

the cell including a vent grate with wide apertures, a broken lighting fixture which allows inmates access to a light bulb, and door hinges on the door to the adjoining bathroom. In the bathroom there was exposed electrical wiring, an exposed light bulb, and two protruding old faucets. Furthermore, the door separating the bathroom from the rest of the "lunacy" cell makes it impossible to properly supervise suicidal inmates. Finally, there is no bunk or palette in the cell, so inmates are forced to sit or lie on the floor. In its present state, the cell poses serious hazards to mentally ill and suicidal inmates who are housed in it.

**H. Drunk Tank.** The drunk tank in the facility doubles as the disciplinary segregation area. It contains a broken overhead glass light fixture which exposes the bulb underneath and does not contain a place off the floor to sit or lie on. Furthermore, the exhaust and supply vents in the cell were partially blocked.

## II. MEDICAL, MENTAL HEALTH, AND SUICIDE PREVENTION SERVICES ARE GROSSLY INADEQUATE.

**A. Medical Resources and Access to Medical Care.** The facility does not have any medical resources on site and does not provide inmates with adequate access to medical care. Reportedly, the jailer screens inmates for medical problems at intake; however, we found no documentation indicating that this screening takes place. There is no documentation of medical history and no indication that LCJ screens for mental problems, suicidal ideation, dental problems, communicable diseases, or substance abuse. There is no formal system for requesting sick-call. In the event that a corrections officer believes that an inmate needs medical or dental care, the inmate is taken to the emergency room of the local hospital. The corrections staff is not trained in evaluating the medical needs of inmates. Many inmates complained that they found it very difficult to get any medical care.

LCJ fails to ensure that inmates receive proper referral and follow-up for identified medical problems. LCJ has a stated policy that any follow-up medical care recommended by physicians at the hospital is only provided if the family of the inmate can pay for the recommended care. Inmates who cannot pay for follow-up care do not receive it. Furthermore, the jail does not provide adequate medical care for pregnant inmates. For example, the jail failed to ensure that a pregnant inmate at high risk for a life-threatening complication of pregnancy received the follow-up care recommended by the emergency room physician.

LCJ's medication distribution system is inadequate. The jailer, who lacks training regarding delivery of medications and recognition of side-effects, distributes the medication to the inmates. He does not visually observe the taking of the drugs.

LCJ also does not record the over-the-counter medications given to inmates. In addition, an inmate's medication is confiscated upon booking and is kept in the dispatcher's office. There is no verification of the status of the prescription or that the medication in the vial is in fact that which was prescribed.

**B. Mental Health Care and Suicide Prevention.** The facility does not provide adequate mental health care services to its inmates, nor does it take any suicide prevention measures. LCJ has no arrangements with an appropriate medical professional to provide necessary mental health services to inmates who need such services. LCJ does not have any policies and procedures regarding how staff is to deal with mentally ill or suicidal inmates. LCJ does not screen inmates for mental illness or for suicidal ideation and none of its staff has any jail suicide prevention training. Furthermore, LCJ does not require its staff to be CPR trained and certified. Also, LCJ lacks emergency medical supplies. Because the staffing of the jail is deficient, there is inadequate supervision of suicidal and/or mentally ill inmates. As previously discussed, the facility does not have appropriate housing for suicidal, mentally ill, and intoxicated inmates.

## III. LCJ HAS SERIOUS ENVIRONMENTAL HEALTH AND SAFETY DEFICIENCIES.

**A. Physical Plant Maintenance.** Physical plant maintenance is completely lacking in the facility. We found defective plumbing, inadequate and inoperative ventilation, and exposed electrical wiring throughout the facility. The plumbing system in the pipe chases on both cell block areas of the jail was defective, resulting in leaking water pipes and partial flooding of the pipe chases and adjacent cells. Additionally, numerous toilets and sinks within the cell blocks were nonfunctional. The ventilation system was completely inoperative. LCJ's installation of individual domestic-type air conditioners did not provide minimum ventilation for the purposes of fresh air supply, air exchange, and overall cooling, as indicated by the 91 degrees fahrenheit temperatures and the 75% relative humidity in the cell housing areas. There were numerous domestic-type household fans located throughout all housing areas and day rooms. These fans facilitate airborne dissemination and spreading of diseases among inmates. In the female cell, there was no provision for ventilation, either exhaust or supply.

Throughout the cell housing areas there were exposed and nonconforming electrical wiring and electrical switches and outlets without proper covers. These deficiencies increase the potential for an electrical fire or electrocution of inmates and staff.

Lighting levels were grossly substandard throughout the entire cell housing areas. The lack of adequate artificial lighting increases eye strain, resulting in headaches and fatigue while reading or writing. Also, inadequate lighting increases the potential for accidental injuries, e.g., rapid evacuation during a fire or related natural disaster, falls, and tripping hazards.

B. **Environmental Sanitation.** There was a substantial buildup of soil residue and filth in showers, toilets, and sinks. There was also an active infestation of roaches throughout the living areas. The food service area was also unsanitary. Our inspection revealed soil buildup and residue on the floors and kitchen equipment, and an active infestation of roaches. Food contact surfaces were not properly cleaned and sanitized. For example, there was evidence of food spoilage in and around the meat slicer's cutting blades. Neither the refrigeration nor freezer unit were clean. The exterior fan coil units on both pieces of equipment were clogged with dirt and grease.

C. **Women's Housing Unit.** The female housing unit is not fit for human habitation. The women are housed in a converted storage room which has no ventilation, no natural light, no second exit, numerous exposed pipes (which facilitate suicide), unprotected overhead fluorescent bulbs, and numerous areas where combustible materials were used, e.g., the shower stall and privacy partition separating toilet and shower, and storage shelves above the washers and dryers. Also, the floor of the housing unit was covered partially with combustible carpet. The housing unit is of insufficient size to house eight inmates.

The fire extinguisher in the housing unit was on discharge, rendering it inoperative for immediate use. Also, the unit was not equipped with a smoke detector. The exit pathway was obstructed with double bunks, plastic bags filled with clothing, and extended partitions, thus increasing the potential for loss of life in the event of a fire. The room contained the facility's laundry machine and dryer. The clothes dryer was not properly ventilated, thus generating excessive heat within the living quarters. There were personal items in the housing unit, such as curling irons, which can serve as potential weapons.

Furthermore, both male trustees and male jail staff have unfettered access to the room. Men come into the housing area while women are going to the bathroom or taking or coming out of the shower. This situation exposes the women to potential sexual abuse and other abuses.

D. **Personal Hygiene and Bedding.** Inmates are not regularly provided with clean linen, e.g., pillows, pillow cases, blankets, and sheets. Moreover, LCJ fails to provide inmates with a supply of personal hygiene items such as soap, toothpaste, toothbrushes,

razors, washcloths and towels. These materials are essential in maintaining personal hygiene. We found numerous torn mattresses in the facility. Torn mattresses cannot be adequately cleaned and sanitized so as to prevent the transmission of disease from inmate-to-inmate.

E. Fire Safety. The hardwired smoke detection system was inoperative. The alarm annunciator panel located in the Sheriff's office was also defective. LCJ has placed battery-powered smoke detectors on the side walls in remote areas of both cell housing units as temporary means of smoke detection and alarm; however, when the steel doors to the cell blocks were shut, the alarm from these detectors was not readily identifiable as such in the Sheriff's office.

We found combustible materials (e.g., wooden storage racks, clothing, paper, and cardboard) in the storage room containing the hot water heater. In the northwest and northeast cell blocks the suspended gas-fired heaters were defective. The exposed and nonconforming electrical wiring on and to the heating units increase the potential for fire and electrocution of inmates. We also found combustible plywood bed boards throughout the facility. Plastic trash bags were being utilized in some housing units as shower curtains and as covers for defective toilets to inhibit odors of human waste. Plastic trash bags are combustible and emit toxic gases upon ignition.

## IV. LCJ DOES NOT PROVIDE ITS INMATES WITH AN ADEQUATE OPPORTUNITY FOR OUT-OF-CELL EXERCISE.

Although LCJ has a policy of letting inmates into its exercise yard five times a week, a check of the jail's records indicated that in the week prior to our visit the inmates were not let out for three days, and were not let out for one day two weeks prior to our visit, due to the unavailability of a road deputy to supervise the inmates in the yard.

## V. LCJ DOES NOT PROVIDE ITS INMATES WITH REASONABLE ACCESS TO LEGAL MATERIALS.

Although the facility does have some state case law, it does not have law dictionaries or law books containing federal cases. LCJ has no documentation that demonstrates that inmates have adequate access to essential legal materials.

## MINIMUM REMEDIAL MEASURES

To rectify these deficiencies at LCJ and to ensure that constitutional conditions of confinement are achieved, the following minimum remedial measures must be implemented:

I. Security and Supervision.

1. Hire sufficient jail staff to ensure that LCJ has a total staffing complement of 13 positions. When the jail houses female inmates, the jail should have a female staff person on duty to supervise these inmates.

2. Require all jailers to complete a basic training course for jailers. Jailers must be trained in recognizing the signs of mental illness and suicidal tendencies.

3. Implement written policies and procedures for the operation of LCJ, including but not limited to, responsibilities of staff, emergency response procedures, use of mace, procedures regarding distribution of medication, and procedures for dealing with mentally ill or suicidal inmates.

4. Inventory and secure the kitchen knives and tools, and maintain a log of their use. Remove personal items from cells that constitute potential security problems and issue them strictly on an as-needed but reasonable basis.

5. Ensure that LCJ houses only an appropriate number of inmates and that none of the inmates sleep on the floor.

6. Provide a secure area for officers to store weapons when they enter LCJ.

7. Replace spring beds in the trustees' quarters with appropriate bunks.

8. Secure the room containing the inmates' personal possessions and the electrical controls of the facility at all times when it is not being used by staff.

9. Immediately cease using the female housing unit to house inmates and provide female inmates with clean, safe housing. The females should not be housed in the newly designated "lunacy" cell as they previously have been.

10. Cease using the "lunacy" cell to house mentally ill and/or suicidal people until all hazards therein have been removed. Install a bunk or raised palette in the cell.

11. Repair the light fixture in the drunk tank and install an appropriate palette or bunk to afford inmates a place to sit or lie down.

12. Provide separate exercise periods for the four male housing units so that proper classification is maintained.

II. Medical Care, Mental Health Care, and Suicide Prevention.

1. Develop and implement adequate written policies and procedures governing access to and delivery of medical and mental health care.

2. Provide adequate medical care to LCJ inmates. Such care should include timely evaluation of sick-call requests by a person qualified to evaluate such requests, treatment for communicable diseases, essential prenatal care, chronic illnesses, and follow-up care for serious medical problems. The jail should implement an appropriate sick-call system to assure appropriate action is taken. Inability of inmates to pay for services should not limit access to medical care.

3. Inmates must be screened for medical problems upon intake. Screening should include, but not be limited to, medical, dental, mental health, substance abuse problems, tuberculosis, and other communicable diseases. This screening must be documented and must be performed by a health care professional or an appropriately trained corrections officer.

4. Ensure that inmates have access to mental health care for serious mental health problems and to crisis intervention, as needed.

5. Contract with a pharmacist or other appropriate health professional to oversee medication procedures at LCJ. Medications must be stored safely and properly monitored. LCJ must also ensure that medications are distributed to the inmates who are to get them, and taken by those inmates at the time of distribution. Ensure that medication is distributed to inmates by a health professional or a corrections staff person who has received training in medication administration and recognition of side-effects of drugs commonly used at the jail.

6. Provide appropriate jail suicide prevention training to jail staff and ensure that inmates at risk of suicide are frequently observed and that such observations are recorded in writing.

7. Ensure that at least one corrections officer on each shift is certified in CPR.

8. Purchase rescue equipment which must include, but not be limited to, a first aid kit, a 911 Rescue Tool, disposable rubber gloves, and a CPR pocket mask.

III. Environmental Health and Safety.

1. Clean the jail and ensure that it remains clean.

2. Provide inmates with personal hygiene materials including, but not limited to, soap, toothpaste, shaving soap, razors. Also, provide towels, washcloths and bed linen to inmates, as needed. Torn mattresses must be replaced.

3. Repair deficiencies in the ventilation system, heating system, electrical wiring, lighting fixtures, and plumbing and ensure they are maintained in good working order. Provide adequate ventilation and lighting in all living areas.

4. Immediately clean the food service area and the food contact surfaces and equipment and clean them at regular intervals thereafter.

5. In order to provide adequate fire safety, LCJ must: repair its hardwired smoke detection system; repair its annunciator panel; provide inmates with emergency evacuation instructions; remove combustible plywood bed boards; cease using plastic trash bags for improper uses; remove combustible materials from the vicinity of the water heater; install flame retardant shower curtains; remove obstructions from exit ways; and ensure that fire suppression equipment is regularly inspected and maintained.

**IV. Opportunity for Out-of Cell Exercise.**

Afford inmates outdoor (weather permitting) supervised exercise a minimum of one hour, five times per week.

**V. Access to Legal Materials.**

Provide inmates with adequate access to legal materials.

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). That period expires on December 14, 1993. Therefore, we anticipate hearing from you before that date with any response you may have to our findings and a description of the specific steps you will take to implement each of the minimum remedies set forth above. If you do not respond within the stated time period, we will consider initiating an action against your jurisdiction to remedy the unconstitutional conditions.

Thank you for your cooperation. 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 Iris Goldschmidt, Trial Attorney, Special Litigation Section, at (202) 514-6264.

Sincerely,

James P. Turner
Acting Assistant Attorney General
Civil Rights Division

cc: Mr. Edward Crider
Sheriff
Lee County

William M. Beasley, Esq.
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