U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20035

SEP 9 1993

REGISTERED MAIL
RETURN RECEIPT REQUESTED

The Honorable Fred L. Gaddis
Mayor
Forest City
120 South Davis St.
Forest, Mississippi 39074

Re: Notice of Findings of Investigation,
Forest City Jail

Dear Mayor Gaddis:

On May 3, 1993, we notified you of our intent to investigate the Forest City Jail (hereinafter "Jail") pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. Section 1997 et seq. Consistent with statutory requirements, we are now writing to advise you of the findings of this investigation. Throughout the course of this investigation, City officials, including the Chief of Police, City Attorney, and jail personnel, 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 making our findings, we recognize that the Forest City Jail essentially only confines inmates who are pretrial detainees. 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). With respect to pretrial detainees, the Fourteenth Amendment prohibits punishment of these persons or any restrictive condition or practice which is not reasonably related to a legitimate governmental objective such as safety, order or security. Bell v. Wolfish, 441 U.S. 520 (1979). For any inmates confined at this facility who are 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.

U.S. v. Forest City

JC-MS-009-002

Based on our investigation, we believe that conditions at the jail violate the constitutional rights of the prisoners confined therein. These conditions are:

I. Security and Supervision

1. Staffing and supervision. The lack of adequate staffing and inmate supervision at the Jail present a danger to the safety of the inmates. The Jail staff consists of four dispatchers/jailers who are usually seated in the dispatch room. These dispatchers/jailers, who can see what is going on in the dayroom of the main housing unit but little more, never enter the main housing area. Instead, if any problem occurs and there is a need to enter the area, the dispatcher must summon a police officer off the street to respond. This danger is exacerbated by non-functional locks on some of the cells in the main unit preventing the secure confinement of certain inmates, and the prolonged confinement of felons, for which the Jail was not intended.

2. Staff training. Forest City Jail does not provide any staff training directly related to jail operations. The only training provided involves operation of the police radio. Training is necessary to ensure that Jail staff has sufficient knowledge of their responsibilities and the requisite skills to fulfill them so that the facility can be operated safely. Lack of training can result in inappropriate staff responses, leading to unnecessary injuries or violence.

3. Policies and Procedures. The facility has no written policies and procedures for operation of the Jail. Such policies are necessary to ensure safe and orderly operation of the Jail. The Jail also lacks written policies regarding the use of mace and restraint devices by staff on inmates.

4. Housing of juveniles. The facility sometimes houses juveniles. Although the Jail apparently houses juveniles in cells separate from adult inmates, the housing of juveniles, particularly those in the juvenile justice system, with adults subjects these youths to undue risk of harm.

II. Medical and Mental Health Care and Suicide Prevention

1. Medical Care. The facility is not providing adequate medical care. The Jail fails to properly screen inmates upon intake or to document an inmate's medical history and possible medical problems. Sick call procedures by which inmates gain access to medical treatment are deficient. Inmates simply express their medical complaints verbally to either Jail officers or the housekeeper. No individual at the Jail responsible for determining whether an inmate needs to be sent to be examined by a physician has a medical background or health training. Also,

the medication distribution system is inadequate. Medication is distributed by individuals who lack appropriate training. As well, proper procedures for keeping track of medications and their distribution are virtually non existent.

Additionally, the facility lacks adequate written policies and procedures with respect to medical care. Particularly dangerous is the absence of written policies for handling inmates admitted while intoxicated, and female inmates who are pregnant. Lastly, the existing policy for disease control is inadequate. In general, the Jail fails to screen inmates for communicable diseases. TB screening is conducted only on inmates bound for the State Department of Corrections. The failure to test all other detainees for TB leaves other inmates at risk for TB as well as employees in the facility and the community at large upon inmates' release.

2. Mental Health Care. There are no written policies and procedures regarding provisions of mental health services to inmates. Additionally, there currently is no mental health professional available to examine inmates or for consultation to assist in inmate assessments and treatment.

3. Inadequate suicide prevention practices. The facility fails to provide adequate procedures for suicide prevention. Significantly, there is no written suicide prevention policy, and staff receive no training in the subject. Further, inmates considered at risk for suicide are currently placed in an inappropriate cell, i.e., one that does not allow for adequate observation and possesses physical features that would facilitate suicide. There are also features in other cells that present suicide risks, e.g., overhanging metal rods in shower stalls.

III. Environmental Health and Safety

1. General Sanitation and Personal Hygiene. The facility is unsanitary. Numerous mattresses are torn, cracked and dirty. Shower stalls and walls are caked with mold and scum. Further, the Jail fails to consistently provide inmates with materials to maintain personal hygiene, such as toothbrushes, toothpaste, razors, towels, clean sheets, sufficient feminine hygiene products, clean clothes when needed, and materials with which to clean their cells. All that is provided to inmates with any consistency is toilet paper and soap.

2. Food Services. The Jail serves only two meals a day - breakfast between 7:30-8:00 a.m. and dinner between 4:30-5:00 p.m. The Jail has not determined that this number of meals and the food served are nutritionally adequate.

3. Lighting. In virtually all inmate housing areas lighting levels are grossly inadequate. Lighting was

insufficient to enable inmates to see well enough to maintain adequate personal hygiene. As well, the low levels of light would result in significant eye strain if inmates tried to read.

4. Ventilation. Air flow measurements were taken in all of the housing areas and found to be inadequate. It was determined that there are no fresh air intake vents bringing in outside air. Further, registers in the housing units are clogged. Inadequate ventilation can facilitate the spread of communicable respiratory diseases.

5. Plumbing. A majority of the cells did not have functional faucets in the sinks located next to the cell toilets. Also, some toilets leaked. These plumbing deficiencies could cause the spread of disease.

6. Fire Safety. The Jail fails to protect inmates from harm due to fires. The facility is not inspected by the local fire department or the State Fire Marshal's office. No fire drills are conducted. All smoke detectors are not functional and are not connected to an enunciator panel. Also, the Jail's fire extinguishers are not routinely inspected and serviced. One extinguisher we observed had not been serviced since May 1982. There are combustible materials in the main housing area. Finally, torn mattresses present a fire hazard because the material inside is flammable.

7. Emergency Preparedness. Numerous deficiencies exist with respect to emergency preparedness. There are no emergency evacuation plans posted in the housing units, and inmates are not instructed what to do in case of an emergency. Further, there is no fenced or secure discharge area for inmates, and at night there is only one jailer/dispatcher on duty. The result is that, in the event of an emergency, the Jail cannot be evacuated until outside help arrives via street officers from the Sheriff's Department or the City Police Department.

IV. Exercise/Out-of-Cell Time

The facility fails to provide inmates adequate exercise or out-of-cell time. Except for limited opportunities to make phone calls, the inmates are essentially confined to their housing areas 24 hours a day. Where, as here, inmates are being confined at the Jail for sustained periods, e.g., four months or longer, the facility must provide the opportunity for exercise outside the housing unit. Exercise is necessary to maintain health and to reduce the potential for violence within the Jail.

V. Access to Counsel

The Jail does not provide suitable arrangements for attorney visitation. Currently, inmates in the main housing unit must

visit with their attorneys through the bars of the open dayroom. This arrangement does not allow for sufficient privacy and places an unreasonable limitation upon the attorney-client relationship.

MINIMUM REMEDIAL MEASURES

To rectify these deficiencies at the Jail and to ensure that constitutional standards are achieved, we recommend that the following minimum remedial measures be implemented:

I. Security and Supervision

1. Staffing and supervision. The Jail must provide additional staff and/or monitoring of inmates to ensure their safety and security. The number of staff or intensity of monitoring required will depend, in part, on whether the Jail continues to house inmates charged with felonies for prolonged periods of time.

2. Staff training. All dispatchers/jailers must receive adequate training in small jail operations to ensure the safe and secure operation of the Jail.

3. Policies and Procedures. A policies and procedures manual for operation of the Jail must be developed and implemented to encompass, inter alia, the various functions of the Jail, responsibilities of staff, use of force and restraint devices by staff, and adequate emergency response procedures.

4. Juveniles. Juveniles should not be housed at the Jail. They should be placed in facilities for, and dedicated to the housing of juveniles.

II. Medical and Mental Health Care and Suicide Prevention

1. Medical Care. To ensure provision of adequate medical care to inmates, the facility must: ensure appropriate management of intoxicated inmates; establish a sick call procedure that ensures requests for treatment are reviewed in a timely manner by a person trained to evaluate such requests and that the granting or denial of treatment is documented in writing; ensure that medical care is provided in a timely manner by a qualified medical professional; provide appropriate training to dispatchers on administering of medications and their potential side-effects; and provide TB screening for all inmates incarcerated seven days or more, and provide screening for other communicable diseases. Finally, the Jail must develop and implement adequate, written policies and procedures governing access to and delivery of medical care.

2. Mental Health Care. The Jail must ensure provision of basic mental health screening, evaluation, and treatment, including development and implementation of appropriate written policies and procedures.

3. Suicide Prevention. Staff must be trained in identification and monitoring of inmates at risk of suicide. Successful suicide or serious suicide attempts must be investigated to determine how and why they occurred. Finally, appropriate written policies and procedures regarding these matters must be developed and implemented. Additionally, the facility must provide an adequate "observation cell," and eliminate risks posed by physical features conducive to suicide, such as shower stalls and metal bunks (mattress supports) with holes.

III. Environmental Health and Safety

1. General Sanitation. The Jail must be cleaned and maintained in a sanitary manner. Inmates must be provided appropriate items to maintain personal hygiene and materials with which to clean their units.

2. Food Service. The Jail must have a qualified professional evaluate the food and ensure that it is nutritionally adequate and modify the diet as appropriate by, e.g., serving three meals a day.

3. Lighting. The Jail must provide adequate lighting in inmate living areas.

4. Ventilation. The Jail must provide adequate ventilation in inmate areas.

5. Plumbing. Inmates must have running water in sinks, toilet leaks must be timely repaired, and plumbing sufficient to meet the needs of the Jail population must be provided.

6. Fire Safety. To provide adequate fire safety, the Jail needs to: post evacuation plans in the housing units and ensure staff and inmates are educated regarding egress procedures in case of fire emergency; provide a secure evacuation area for inmates; ensure smoke detectors are functional; regularly conduct fire drills ; ensure emergency lighting is functional; conduct documented internal fire safety inspections; and provide mattresses to inmates that are fire safe.

IV. Exercise/Out-of-Cell Time

Inmates must be afforded at least one hour of exercise outside the housing unit a minimum of three times per week.

V. Access to Counsel

A secure room or office suitable for attorney/inmate visits must be provided.

Finally, we note that, although our investigation is being conducted pursuant to CRIPA, which authorizes the Department to identify only constitutional rights violations with respect to correctional facilities, the failure to separate juvenile offenders from adults also violates the Juvenile Justice and Delinquency Prevention Act, 42 U.S.C. § 5601 et seq. The County should take remedial action with respect to separating juveniles from adults on that basis as well.

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 October 28, 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.

We look forward to working with you and other City officials to resolve this matter in a reasonable and expeditious manner. If you or any of your staff have any questions, please feel free to call Timothy R. Payne, Senior Trial Attorney, Special Litigation Section, at (202) 514-6441.

Sincerely,

James P. Turner
Acting Assistant Attorney General
Civil Rights Division

cc: Thomas D. Lee, Esquire
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