



U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

June 1, 1995

Ms. Iris Jessie
Acting City Manager
P.O. Box 1340
Columbus, GA 31902-1340

Re: Notice of Findings from Investigation of
Muscogee County Jail

Dear Ms. Jessie:

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

Our investigation consisted of a tour of the facility with expert consultants, the examination of documents, and extensive interviews with prisoners and staff at the facility. We were accompanied on our tours by three consultants: a penologist, a medical expert, and a fire safety/environmental sanitarian, all with expertise in jail facilities. Throughout the course of this investigation, County officials and MCJ 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 MCJ confines both pre-trial detainees and post-conviction inmates. In general, inmates may not be subjected to conditions that are incompatible with evolving standards of decency or deprive them of their basic human needs while incarcerated. See Estelle v. Gamble, 429 U.S. 97 (1976). With respect to the pre-trial detainees, the Fourteenth Amendment prohibits punishment of these persons and restrictive conditions or practices that are not reasonably related to the legitimate governmental objectives of safety, order and security. Bell v. Wolfish, 441 U.S. 520 (1979). For those convicted of a crime, the standard to be applied is the Eighth Amendment's proscription against cruel and unusual

CRIPA Investigation



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punishment. Wilson v. Seiter, 501 U.S. 294 (1991). When convicted prisoners are not, as here, separated from pre-trial detainees, the Fourteenth Amendment standard applies to all inmates.

MCJ is located in Columbus, Georgia. MCJ is comprised of two facilities, the main jail and the stockade. The main jail was originally built in 1939 and expanded in 1984 with a high-rise tower. The stockade was constructed in 1895. The capacity of MCJ is 575 inmates. On the day of our tour it housed 944 inmates. Approximately 19,000 inmates were booked last year.

Based on our extensive investigation, we believe that conditions at the Jail deprive inmates confined there of their constitutional rights. We find the conditions at the Jail to be particularly egregious.

Set forth below are our findings and the minimal remedial actions necessary to remedy the unconstitutional conditions:

I. Deficient Correctional Practices.

A. Staffing and supervision are inadequate. Staffing at MCJ is seriously inadequate. There are times both observed and documented when no officer is on duty on an entire floor of the main, high-rise jail. During such times, if an inmate needs staff assistance, other inmates bang on the floor of the dayroom to alert the inmates on the floor below, who, in turn, notify the officer on that other floor. The absence of an officer is a virtual open invitation to a would-be perpetrator of violence. If an emergency situation, such as a fire, were to occur, there would be nobody to notice the problem and commence timely evacuation. According to one of the Jail's own documents: "the time inmates were left unsupervised ranged from an hour and a half to almost six hours of every eight hour shift." This chronic understaffing situation poses an immediate and serious threat to the safety of the inmates and the overall security of the Jail.

Sheriff Hodge has acknowledged the severe understaffing and has stated in his recent budget justification that "[t]here are some things we should be doing for security and/or to come in compliance with State and Federal standards for jails, but we're not because we don't have the manpower." The Sheriff's statement details at length the duties and functions not provided due to inadequate staffing. Sheriff Hodge concludes his budget justification by requesting 48 additional correctional officers to provide core supervision and security functions. Our corrections consultant found MCJ to be "one of the most dangerously understaffed urban jails that I have ever evaluated." This situation of totally inadequate security and supervision is unacceptable and must be addressed immediately.

B. Staff training is deficient. Jail staff reportedly receive no specific jail training. Training in jail operations is needed to provide staff with the requisite skills and knowledge necessary to effectively perform their duties and to hold staff accountable for their job performances. Without proper staff training in such matters as jail security, discipline of inmates, emergency response, medical screening, and use of CPR, inmates are at risk of unnecessary harm.

C. Policies and procedures are inadequate. MCJ does not have adequate written policies or procedures. Indeed, MCJ fails to even have an inmate handbook so as to inform prisoners of rules and regulations of the Jail. Written policies and procedures are important as a training tool for staff and for providing guidance to staff in the performance of their duties. A lack of specific procedures to be followed by staff to govern, e.g., inmate classification, emergencies and evacuations, escapes, inmate disturbances, and mentally ill or suicidal inmates, is dangerous.

The lack of an appropriate classification system is particularly egregious. Classification policies and procedures are crucial in maintaining an appropriate level of security by identifying and properly housing inmates. Currently, there is no objective classification system in place. The need to find some space somewhere in the Jail for new inmates drives the whole housing process. This lack of a classification system results in the inappropriate placement of inmates into housing units, which, in turn, places inmates at undue risk of harm.

We should point out that the sole criterion for classifying where an inmate will be housed, other than space availability, is race. MCJ operates, as a matter of policy, its housing units on a racially segregated basis. There is no penological basis for such a deplorable practice. Segregation of inmates solely on the basis of race is an unsustainable policy and this practice must be stopped immediately.

Additionally, the Jail fails to provide a written grievance system. The failure to have a written grievance system leads to increased inmate tension which may translate to increased acts of violence.

D. Out-of-cell/exercise time is inadequate. By the Sheriff's own admission, MCJ inmates have not been provided any outdoor exercise since 1979 due to inadequate staffing, despite the fact that there are two outdoor exercise yards.

II. Medical and Mental Health Care and Suicide Prevention.

A. Policies and procedures are inadequate. While the Jail does have written policies and procedures regarding medical

services, our medical consultant found that, in practice, they are often not followed.

B. Sick call is deficient. The current sick call system at MCJ is woefully inadequate. Access is not provided in a timely manner. Inmates access medical care by submitting a sick call slip to a correctional officer. The slips are then triaged by a licensed practical nurse ("LPN"). MCJ provides no cell-side triage or medical rounds. The LPN triages the request slips solely by the complaint written. If the inmate is illiterate or does not adequately describe his complaint, the sick call request may be and is frequently ignored. Only urgent requests appear to be seen by the LPN.

Additionally, inmates are not notified of the disposition of their request and frequently fill out multiple requests for the same problem. It is only then that their condition may be reviewed. Significantly, our consultant found one inmate who had filled out 17 requests over a two month period for the same complaint and was still waiting to be seen at sick call. One prisoner who reported having a heart condition allegedly submitted a sick call request regarding chest pains three weeks prior to our inspection and had yet to receive any medical attention. This is grossly unacceptable.

The problem is exacerbated by the lack of physician oversight and responsibility. Physicians co-sign charts but rarely see patients. During our tour, the attending physician only saw three inmates out of the 68 requests approved for sick call. Moreover, one physician, when questioned, told our consultant that he had "never examined an inmate at the Jail," and only reviews charts during his visit.

C. Physician care is deficient. There is no medical director who assumes responsibility for ensuring medical attention is provided to inmates. Physician and psychiatric coverage for MCJ is in a state of flux. The physician, physician assistant, and psychiatrist resigned abruptly during July 1994. MCJ currently has a temporary agreement to provide medical services. The contract is for five hours of physician coverage per week and 20 hours of physician assistant coverage. Each day a different physician is on-duty at the jail. No psychiatrist, psychologist or mental health professional is on-site at the facility. MCJ has only an informal agreement with a local family practitioner who provides mental health services for the prisoners each Monday evening.

D. Examination room and equipment are inadequate. MCJ does not provide adequate clinic space to accommodate the needs of the prisoners. The lack of an appropriate physical structure prevents the delivery of adequate health care. For example,

despite an inmate population of almost 1,000 inmates, MCJ does not provide an on-site infirmary or specialty clinics.

E. Medication practices are deficient. Prescription medication is administered by Jail staff, none of whom have appropriate training. The correctional officers have not had any training in medication administration and are not familiar with side effects of the medications. One officer told our medical consultant that "I don't feel prepared to do this task." Medications, including psychotropic and controlled drugs, are stored in open boxes in the control room. All officers and trustees have access to these medications. There is no sign-out system. There is no system in place to check up on inmates who don't receive their medications and officers do not always sign the medication sheets to indicate that the drugs were given. Inmates complained that officers are careless about medications. This was verified by our medical consultant who reviewed incident reports that detailed incidents of medication being given to the wrong person and individuals being given their medication twice. Moreover, inmates complained that officers threatened to withhold medications as a form of punishment. Our medical consultant found the medication administration in this facility to be dangerous. MCJ fails to observe appropriate and safe practices in the administration, storage and charting of medication.

F. Special diets are nonexistent. Special diets are not available as medically needed. It is also unclear whether the meals being given are nutritionally adequate.

G. Dental care is deficient. MCJ provides dental services on Wednesday evenings. However, the dentist averages 26-30 patients per visit, so the treatment modality consists only of extractions. Our consultant verified inmate complaints that the dentist broke teeth during extractions. The dentist left the broken teeth in the inmates' gums which later resulted in infections.

H. Mental health care and suicide prevention are inadequate. As stated, the only mental health care provided in this facility is afforded by a family care practitioner six hours per week. Inmates are forced to wait 3-4 weeks before seeing the physician despite the severity of their individual problems. There are no routine crisis intervention or counseling services nor is a routine mental health assessment performed when prisoners are processed into the Jail. Requests by inmates for mental health care are often ignored. For inmates receiving psychotropic medications, blood tests are not routinely obtained. Moreover, inmates often are not receiving prescribed medications in a timely manner. One female inmate did not receive her prescribed psychotropic medication, Dilantin, for five days after being transferred to the facility from the state hospital. She finally had a seizure. Another inmate, with a prescription for

Mellaril, likewise, did not receive his medication for several days after transfer. A third inmate, on Lithium, received no medication while on lock down.

The suicide policy is unclear and inconsistent. While individuals are reportedly identified on intake as at risk for suicide, little to no mental health counseling is provided. Those identified as suicide risks are merely isolated in strip cells. There were 47 inmates on suicide watch at the time of our investigative tour. Additionally, staff lack adequate training in suicide prevention.

III. Environmental health and safety deficiencies.

A. General sanitation is inadequate. The general sanitation of the Jail is grossly inadequate. The severe overcrowding throughout places a great demand on both the physical plant and the facility staff. A general lack of cleanliness existed throughout the facility, especially in the inmate housing areas. A lack of maintenance has made numerous toilets and showers unusable. Our expert environmental consultant found sanitation practices to be totally unsatisfactory. The reasons for inadequate sanitation include a lack of staff to oversee the cleaning procedures, improper selection of cleansing agents, poor repair of floor and wall surfaces, a lack of written procedures relating to cleaning of these areas, and an inability of the inmates to obtain needed cleaning supplies.

Our consultant determined that MCJ is a facility that has outgrown its ability to adequately house the number of inmates placed there. The environmental and safety issues exist largely as a result of too many inmates and not enough staff. Maintenance appears to receive little priority, even when repeated requests are formally submitted by the inmates and correctional officers. Inmates frequently cannot use a shower because a floor-drain is clogged or control knobs are broken. They are housed in cells without a source of water to drink or to wash their hands because the fixtures are broken. Broken toilets, showers and lavatories, missing window panes, broken and dangerous light fixtures, and filthy toilet and shower areas, are prevalent throughout the facility.

B. Fire safety is deficient. Electrical hazards in this facility are a serious problem. There are ample opportunities for inmates to electrocute themselves or other inmates either accidentally or on purpose. Exposed wiring, open junction boxes, and broken light fixtures are common. MCJ fails to conduct routine fire drills. Additionally, laundry room dryers have an excessive lint accumulation creating a potential fire hazard.

C. Plumbing is deficient. As with the electrical system, plumbing problems exist throughout the Jail. Because of the overcrowding, the number of plumbing fixtures would be inadequate for the number of inmates using them even if they were all functional. However, in some cell blocks, only one shower is functional to serve over 60 inmates. In several locations, shower knobs or nozzles are missing, making the fixtures either unadjustable for water temperature or totally unusable. Throughout the facility, toilets and lavatories are in poor repair or totally inoperable.

D. Ventilation is inadequate. There are no fresh air intake vents in the Jail. Further, the registers in the cells are clogged. Inadequate ventilation increases the potential for the spread of infectious communicable diseases throughout the Jail. The housing area is provided with an insufficient amount of fresh air and our consultant found no circulation of air.

E. Overcrowding, bedding and personal hygiene. The Jail is seriously overcrowded. When we toured, the facility held 944 inmates. A review of records revealed that the inmate population had been over 1,000 during the past year -- two times the Jail's capacity. The Jail fails to provide an adequate amount of unencumbered space per prisoner to ensure adequate hygiene and protection against contagious diseases. Inmates are forced to sleep on dilapidated mats on concrete floors. Pillows are not provided. Linens are ripped and torn and are often used as toilet paper due to the absence of toilet tissue.

Additionally, numerous inmates complained of the unavailability of personal hygiene items, such as deodorant and shampoo. The Jail fails to provide such items, even to indigent inmates.

F. Food services are deficient. The food service operation needs a major overhaul. Problems exist in almost every phase of the operation, creating serious risks of food-borne disease. Unless the inmate population is reduced significantly, the kitchen area needs to be renovated and enlarged. Our consultant found the food handling practices to be abysmal. Food items and dangerous cleaning compounds were observed side by side on a food preparation table. Floors were dirty throughout the kitchen. Chicken bones and other food remnants were observed under and behind shelving in the storeroom, contributing heavily to an ongoing roach problem. In the kitchen lavatory used by food handlers, the toilet was literally falling off the wall; there was no hot water in the sink and no hand towels were available. In addition, the refuse dumpsters outside the building are in extremely poor repair. The bottoms are rusted out so badly that food remnants placed in these dumpsters are falling out.

G. Lighting is inadequate. The Jail does not provide adequate lighting for inmates. Lighting at this level is insufficient to protect against possible eye strain and inhibits adequate cleaning and maintenance of cells and maintenance of personal hygiene.

H. Pest control is inadequate. Despite an outside contract with a pest control company, a serious roach infestation was observed in the kitchen area. Roaches were observed in the kitchen itself during meal preparation, in the kitchen restroom, and particularly in the storeroom. In fact, a roach was observed crawling up the leg of one of our attorneys. Poor sanitation conditions and structural problems with floors, walls and ceilings all contribute to this serious problem.

IV. Recommendations Regarding Correctional Practices.

A. Staffing and supervision. Improve Jail staffing to ensure adequate surveillance and supervision of inmates. Hire, at a minimum, the 48 correctional officers identified in the Jail's 1995 fiscal budget request. In addition, conduct a staffing study to determine with greater specificity the staffing complement with which the Jail should operate. Conduct and properly document routine visual inspections of the housing areas. Incidents involving violence must be properly documented, both in the individual offender's records and in a master log for the Jail. Master logs regarding violent incidents must be evaluated at appropriate intervals to enable jail administrators to properly deploy security personnel.

B. Staff training. Ensure all jailers have attended the state's jailer training school and receive periodic, additional training.

C. Policies and procedures. Create and implement comprehensive MCJ policies and procedures which must include, but not be limited to, a classification system, incident reports, disciplinary procedures, and suicide prevention. Ensure staff understanding and compliance with policies and procedures. Draft and distribute to every inmate a comprehensive inmate handbook which includes, but is not limited to, explanation of the Jail rules and regulations, and grievance and disciplinary procedures.

Immediately stop the policy and practice of segregation of inmates solely on the housing of race. In accordance with the implementation of a comprehensive classification system, integrate the Jail.

Create and implement a written grievance system.

D. Out-of-cell/exercise time. Inmates must be provided with exercise, outdoors when weather permits, one hour per day,

five days per week. Reasonable exercise equipment and activities should be provided for both indoor and outdoor exercise.

E. Access to reading materials. Provide adequate access to law books, writing materials and other reading materials for inmates.

V. **Recommendations Regarding Medical and Mental Health Care.**

A. Medical services. Create and implement comprehensive policies and procedures regarding the provision of health care. Such policies must cover, but not be limited to, initial medical screenings, non-urgent sick call requests, communicable disease testing, physical examinations and staff training.

Thoroughly screen and assess the medical history of every inmate within 24 hours of an inmate's entry into the Jail. Ensure that medical conditions are referred to a health care professional. Ensure inmates are informed of the necessary procedures to access medical services. Complete physical exams must be performed by qualified medical staff within 14 days of an inmate's entry into the Jail. Inmates housed in the Jail for more than seven days must be tested for tuberculosis and other communicable diseases, as appropriate.

B. Sick call. Ensure that sick call slips are dated and signed by the submitting inmate, receiving staff member and attending health care professional. Ensure that inmates receive prompt medical and mental health care.

C. Physician care. Retain the services of a "responsible health authority" ("RHA"). Retain the services, full-time, of appropriate medical personnel.

D. Examination room and equipment. Provide an adequate clinic area for sick call triaging. This area must afford proper privacy and ensure professional and thorough examinations. Provide appropriate on-site infirmary and specialty clinics.

E. Medication. Ensure administration of all prescription medication by qualified personnel. Medication must be maintained in a secure, locked area.

F. Special diets. Provide special diets. Provide printed menus detailing meals served. Ensure that all meals are nutritionally adequate.

G. Dental care. Provide inmates with prompt dental care. Dental services may not be limited to extractions.

H. Mental health care and suicide prevention. Create and implement comprehensive policies and procedures for the provision

of mental health care. Create and implement suicide precautions. Ensure all staff are trained in recognizing and promptly referring to a qualified professional, common symptoms of mental illness, mental retardation or suicidal behavior.

VI. Recommendations Regarding Environmental Health and Safety.

A. General sanitation. Thoroughly clean the entire Jail. Review and implement, with appropriate documentation of compliance, a Jail housekeeping plan. Ensure routine cleaning of all housing areas.

B. Fire Safety. Create fire exit plans and post them conspicuously throughout the Jail. Develop, based upon consultation with an appropriate professional, written plans for an emergency disaster, e.g., flood or fire. Maintain an emergency generator. Conduct and document routine fire drills. Ensure proper storage of gasoline and gasoline powered equipment. Eliminate all electrical and fire hazards.

C. Plumbing. Ensure that all plumbing fixtures are operational and maintained in working order.

D. Ventilation. Ensure that inmates are provided adequate ventilation.

E. Overcrowding, bedding and personal hygiene. Substantially reduce the inmate population. Provide each inmate with an adequate amount of unencumbered living space. Ensure that no inmate has to sleep on the floor. Provide an adequate number of sanitary facilities for the number of inmates in each cell block. Provide each inmate with adequate bedding to include, but not be limited to, sheets, blankets along with a pillow, pillowcase and fire-resistant mattress. Provide inmates, including female prisoners, with necessary personal hygiene items.

F. Food services. Ensure that inmates receive nutritionally adequate meals. No more than 14 hours may expire between meals. Ensure that food reaches inmates at proper temperatures to protect against food-borne illnesses.

G. Lighting. Provide lighting adequate for reading and sanitation in the housing area.

H. Pest Control. Implement an effective pest control system throughout the Jail.

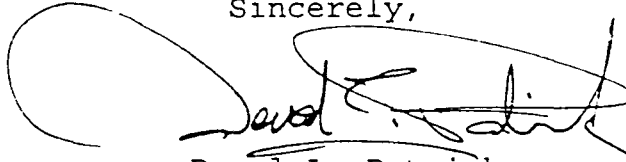
Finally, we note that the severity and magnitude of the unconstitutional conditions at the Jail may preclude full remediation of all of the deficiencies identified in this letter.

In these circumstances, the City should consider building a new jail as a long-term remedy.

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). We expect to hear from you as soon as possible, but no later than 49 days after receipt of this letter, with any response you may have to our findings and a description of the specific steps you have taken, or intend to 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 unlawful 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 the attorneys in the Special Litigation Section assigned to this matter, David Deutsch, (202) 514-6270, Shanetta Y. Brown, (202) 514-0195, and Christopher Cheng, (202) 514-8892.

Sincerely,



Deval L. Patrick
Assistant Attorney General
Civil Rights Division

cc: Hardey Polley, Esquire
County Attorney

Mr. Gene Hodge
Sheriff
Muscogee County Jail

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