



U.S. Department of Justice

Civil Rights Division

of the Assistant Attorney General

Washington, D.C. 20035

JUL 6 1993

FEDERAL EXPRESS MAIL

Mr. Lynn Cartlidge  
President  
Forrest County Board of Supervisors  
Paul B. Johnson Chancery Building  
641 Main Street  
Hattiesburg, Mississippi 39401

Re: Notice of Findings of Investigation,  
Forrest County Jail

Dear Mr. Cartlidge:

On May 3, 1993, we notified you of our intent to investigate the Forrest County Jail pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 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, County officials, including the Sheriff, County Attorney, and jail personnel, provided us with substantial assistance and 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 are aware that most individuals confined at the Forrest County Jail are pretrial detainees or persons not convicted of any crime. The Fourteenth Amendment prohibits punishment of these persons or any act or practice which is not reasonably related to a legitimate governmental objective. Bell v. Wolfish, 441 U.S. 520 (1979). For those convicted of a crime, the applicable standard is the Eighth Amendment's proscription against cruel and unusual punishment. Wilson v. Seiter, \_\_\_ U.S. \_\_\_, 111 S.Ct. 2321 (1991); Chapman v. Rhodes, 452 U.S. 337 (1979). When convicted prisoners are not, as here, separated from pretrial detainees, the Fourteenth Amendment standard applies to all inmates.

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

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JC-MS-010-002

1. Access to medical services to meet the serious medical needs of inmates is inadequate; mental health services for prisoners are inadequate and holding cells for mentally ill and drug and/or alcohol intoxicated inmates pose a direct threat to their health and well-being;

2. Security staff is inadequate to ensure the safety of inmates; inappropriate use of trustees or "floor workers" must cease immediately; staff training is grossly inadequate;

3. Crowding prevents the appropriate classification of prisoners and exposes inmates to unreasonable risks of harm; juveniles are improperly housed in the facility;

4. Measures for the personal hygiene of inmates are inadequate; deficiencies in various aspects of food service jeopardize the health of inmates;

5. Opportunities for exercise are inadequate; and

6. No functional law library is maintained and appropriate access to legal materials is not provided.

A full description of the facts supporting these findings is set forth in the Attachment to this letter.

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

1. Adequate medical care must be provided to all inmates to meet their serious medical needs; the policy of denying visitation to prisoners who request medical care must cease immediately; appropriate mental health services, including proper care and surveillance in the jail or elsewhere, must be provided, as needed; holding cells for mentally ill and alcohol and/or drug intoxicated inmates must be made safe immediately by removing physical hazards from the cells and ensuring proper surveillance of individuals placed in them;

2. Security staffing must be enhanced; trustees or "inmate floor workers" must not be placed in areas of the jail or given responsibilities which may compromise the security of the facility or jeopardize the safety of prisoners; appropriate staff training must be provided;

3. Unlawful crowding must be eliminated and measures implemented to ameliorate the effects of emergency, temporary crowding; and appropriate classification system must be implemented; juveniles under the authority of juvenile courts must not be housed in the jail;

4. Appropriate personal hygiene items must be provided to inmates who need them; hot water must be provided in the women's unit; all inmates must be provided with a bed and suitable bed linens; deficiencies in food service must be eliminated;

5. Appropriate opportunities for out-of-door exercise must be consistently provided to prisoners; and

6. An appropriate law library or access to legal materials must be provided.

We look forward to working with you and other County officials to resolve this matter in a reasonable and expeditious manner.

Sincerely,



James P. Turner  
Acting Assistant Attorney General  
Civil Rights Division

Enclosure

cc: Francis T. Zachary, Jr., Esquire  
Forrest County Attorney

Jeffrey Hollimon, Esquire  
Forrest County Board Attorney

Mr. Billy McGee  
Sheriff

George L. Phillips, Esquire  
United States Attorney

## ATTACHMENT

Our investigation of the Forrest County Jail consisted of tours of the facility by consultants in the areas of penology, medicine, and sanitation, accompanied by our attorneys, on May 19 and 20, 1993. During the course of these tours, we interviewed staff, inmates, and reviewed records maintained at the jail. We have also evaluated other records provided to us by jail personnel following our tours.

In summary, our consultants found access to medical care to be inadequate, mental health services to be non-existent, and holding cells for mentally ill and drug and/or alcohol intoxicated inmates to be so hazardous as to present a direct threat to the health and well-being of inmates placed in them. Security staff is inadequate to maintain proper security and surveillance of inmates. To supplement inadequate staff, the Sheriff relies on the use of trustees or "floor workers" to serve various functions, some of which compromise the security of the facility. Substantial overcrowding precludes proper classification of prisoners. Juveniles under the authority of juvenile courts are improperly held in the jail in grossly inadequate conditions. Opportunities for exercise are inadequate as are measures to maintain the personal hygiene of prisoners. Access to a law library or legal materials is legally deficient.

1. Access to medical care, including mental health services is inadequate.

Provisions for access to medical care necessary to meet the serious needs of inmates are inadequate. Although prisoners are "screened" for medical problems upon admission to the facility, the screening is done by untrained, non-medical personnel ill-equipped to evaluate the medical or mental health condition of an incoming inmate. Indeed, the jail lacks any procedure or protocol for action when the screening actually indicates a potential medical problem.

In addition, there is no medical triaging of sick call requests. Except in cases of great emergency, in order to obtain medical assistance, an inmate must request a sick call form from a security guard who, in turn, puts each form in a binder in the control room. A nurse who is on duty at the jail during the week places the name of each inmate who has submitted a form on the doctor's list. A physician visits the jail each Monday evening at 7:00 p.m. to see such individuals. Although the nurse sees inmates who have requested to see a doctor, she makes no judgment as to whether the nature of their medical complaint requires immediate attention or evaluation more rapid than the time of the next regularly scheduled doctor's visit will permit. Moreover, she takes no additional medical history. She simply gives over the counter medications, as needed. In the absence of any triaging, or evaluation of the potential seriousness of a medical complaint, inmates with significant medical problems may not

receive timely medical care. Medical personnel as well as current practices are inadequate to ensure the provision of adequate care.

Medical services for inmates with chronic conditions are likewise inadequate. No program or protocol exists for providing consistent care to inmates with asthma or seizures. Screening and testing for tuberculosis is likewise deficient. To the extent any organized program exists for the detection and treatment of tuberculosis, it is limited to convicted prisoners awaiting transfer to the state prison. No CPR training is afforded to staff.

Medical care is also deliberately limited and restricted by a policy which denies visitation rights to any prisoner requesting medical assistance. Specifically, if a prisoner requests to see a doctor, he or she forfeits upcoming visitation. Such a practice amounts to punishment for requesting medical care, however legitimate the request, and serves to deny needed care. Our physician consultant found a number of inmates at the jail with medical problems, including lesions and other physical problems, who claimed that they were foregoing needed medical treatment in order not to jeopardize a forthcoming visit. The policy of forcing inmates to choose between receiving medical care or visiting with family members is arbitrary, tantamount to a denial of medical care, and a form of punishment without penological justification.

Both our medical and penology consultants found suicide prevention measures and mental health services to be wholly inadequate. There are no mental health services available at the jail and the holding cells into which disturbed or mentally ill and alcohol and/or drug intoxicated prisoners are placed pose a direct threat to their health and safety.

Although the jail has not had a recent suicide, a review of records maintained at the facility indicate at least one suicide attempt. Due to staffing shortages, the security guards rely on prisoners to observe individuals who might be at risk of suicide. Disturbed individuals are placed into "observation" or holding cells on the first floor of the jail. These cells are, however, dangerous and present a direct threat to the health and well-being of the individuals placed in them. There is a wire mesh underceiling which can be reached by standing on a bed or the toilet in the cell. A person can hang him or herself from the mesh. In addition, persons placed in these cells are not monitored adequately. Moreover, jail personnel have received no training in recognizing mental illness or suicide prevention.

During the course of our tour of the jail, our consultants observed a severely mentally ill inmate, clad only in an undershirt, housed in the general population. Our consultants

were advised that he had been waiting for several weeks for an evaluation at a local mental health clinic. Since no mental health services are provided at the jail and no mental health professionals ever visit the jail, he had received no treatment. He was housed as the third person in a cell designed for two persons on an extra mattress on the floor. He had allegedly eaten some glass and was prone to defecate on the floor of the cell. During an interview, he babbled incoherently. After we immediately consulted with the county attorney regarding the dangerousness of this disturbed person remaining in the jail, the county took steps resulting in his removal from the jail. In brief, mentally ill prisoners should not be housed in the general population of the jail which is wholly ill-equipped to house and care for such individuals. Such individuals require an appropriate environment in the jail or elsewhere that provides appropriate monitoring, supervision, and safety. Such an environment currently does not exist at the Forrest County Jail.

In sum, access to medical care, including mental health services is inadequate. Placement of disturbed individuals in the observation or holding cells on the first floor of the jail is especially dangerous and must cease immediately.

## 2. Inadequate Security and Supervision

The Forrest County Jail lacks adequately trained and sufficient numbers of security guards to ensure the reasonable safety of inmates. Most inmates are housed on the first, third, and fourth floors of the jail. While one guard is posted on the third and fourth floors, other duties take these guards away from these posts leaving inmates housed there without any surveillance or supervision. Moreover, a review of incident reports indicates that there have been occasions where only one guard was available to supervise these floors. Further, our penologist consultant indicated that the one shift supervisor available on each shift has too many other assigned duties, including supervision of the jail's control center, to actually function as a supervisor and assist security guard staff.

Due to inadequate surveillance and supervision, incident reports reflect assaults occurring when no guard was present in the areas of the jail where the assault reportedly occurred. In addition, assaults have reportedly occurred from incidents involving loan sharking, gambling, and other illicit activities in the jail. Further, two assaults occurred during our tour of the facility. A 14 year old juvenile was assaulted by an older, adult prisoner. Another, involving two adult prisoners, resulted from a loan sharking operation uncovered by our consultant who found large amounts of canteen goods in one of the prisoner's cells. The fact that this kind of activity could be uncovered by our consultant during the relatively brief period of time he

spent in the jail suggests the general inadequacy of surveillance and supervision of prisoners in the jail.

To compensate for inadequate staffing, the Sheriff relies on "floor workers" or trustees, i.e., inmates, to perform a variety of functions in the jail. Although it is entirely appropriate for such inmates to assist in cleaning and other routine maintenance functions, it is inappropriate for these inmates to have access to areas where they can exercise authority over or otherwise adversely affect other inmates. For example, during our tour our penologist consultant observed trustees sitting idly in security stations, a place where an inmate can learn information which may compromise security. It also appeared to our penologist consultant that trustees have access to areas of the jail where they are not assigned when they are not performing assigned tasks. Such access represents a major breach of security.

Finally, no formal staff training is afforded security guards. As such, they lack training across a broad array of topics relevant to the professional operation of a correctional facility.

### 3. Unlawful Crowding and Lack of Classification

The jail is consistently overcrowded. Although the facility is designed to house 172 inmates, a review of records for the past six months indicates that it consistently houses a significantly larger number of prisoners and has housed up to 242 individuals on a single day. On the day of our tour of the facility, the jail housed 203 inmates. The jail is so crowded that some inmates have slept on mattresses on the floor for the past year.

The crowding has a substantial, adverse impact on the jail's ability to implement its classification policies. Due to crowding, the appropriate separation of prisoners, e.g., violent inmates from prisoners prone to victimization, convicted from detainee, juvenile from adult, has proved to be impossible. Lack of appropriate classification has led to violent incidents at the jail of the kind described above. Although appropriate classification can reduce the incidence of assault, crowding at the jail precludes such necessary classification.

The facility also houses juveniles, both youths under the authority of a juvenile court and individuals certified to be tried as adults. In no case should juveniles be incarcerated in the same cell or cell area as adult prisoners. Moreover, juveniles under the authority of a juvenile court should not be housed in the jail at all. Conditions of confinement of juveniles are especially harmful. They are housed primarily in cells on the first floor of the jail without any natural light

although, due to crowded conditions, they have been housed elsewhere with adults. Lighting in juvenile cells is deficient. Insufficient lighting impedes the ability of guards to maintain proper surveillance of these cells. Moreover, they are not afforded adequate opportunities for exercise. No reading materials are afforded. We were also informed that these juveniles are not permitted either telephonic contact or a visit with their parents for one week following incarceration. Absent a legitimate governmental objection, this restriction is unjustified.

#### 4. Personal Hygiene Deficiencies and other Hazards

Inmates at the jail do not receive adequate linen, clean clothing, supplies of soap and other personal hygiene items. Inmates receive no sheets, pillows, or pillow cases. No clothing is issued to inmates, who must rely on relatives and friends to bring them fresh clothes. Those without access to relatives or friends must wear the clothes they were wearing when they entered the jail or use an "informal network" to barter for or otherwise obtain clothing from other inmates. Our consultant discovered that inmates often request departing inmates to leave their underwear behind for their use. Soap and other toilet articles are not provided.

Serious plumbing deficiencies exist at the jail. Hot water in the women's area is so inadequate as to be insufficiently hot to kill bacteria. Toilets in the jail have significant water back-flow problems. This means that if you flush the toilet in one unit, the toilet on the opposite or adjacent wall overflows, spreading contaminated water and other debris onto the floor. There are inadequate toilet facilities in the women's area of the jail. Shower facilities are inadequate throughout the jail.

Our consultants also noted the absence of safe, tamper proof light fixtures on the third and fourth floors of the jail. Presently, inmates may break the lightbulbs and use the pieces as weapons or electrocute themselves from exposed sockets.

There are severe deficiencies in food service. Freezer temperatures are inadequate to keep food frozen and prevent the growth of bacteria. Food preparation equipment has not been cleaned and is very dirty. Moreover, dishes and other related items are not adequately cleaned and pose significant health risks.

Finally, the facility does not have a maintenance program to ensure fire safety equipment is in good working order. Our consultant found a number of potentially serious deficiencies ranging from malfunctions in the fire detection system to defective fire extinguishers. In addition, staff had not been

adequately trained in evacuation and other fire safety procedures.

5. Opportunities for Exercise are Inadequate

Inmates are afforded, at best, only sporadic opportunities for out of door exercise. Jail logs reveal that insufficient out of door exercise has been permitted. In view of the crowded conditions at the jail, opportunities for meaningful exercise are critical to relieve tension and the frustration that invariably flow from incarceration and which can lead to violence. Opportunities for exercise, one of life's vital necessities, must be enhanced.

6. Access to Legal Materials is Inadequate

The Sheriff relies on the county law library to permit inmates access to legal materials. Procedures to allow such access are inadequate and result in the effective denial of access by inmates to law books and other legal materials. Procedures need to be revised to either permit inmates to go to the library, have library materials brought to the inmates on a reasonable basis, or a law library should be established at the jail.