April 17, 2003

Mr. Carroll Rogers
Chairman
LeFlore County Board of Commissioners
P.O. Box 607
Poteau, OK 74953

Re: Investigation of LeFlore County Jail, Poteau, Oklahoma

Dear Mr. Rogers:

We write to report the findings of our investigation of conditions of confinement at the LeFlore County Jail ("Jail") in Poteau, Oklahoma. On November 8, 2002, we notified you of our intent to investigate the Jail pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Our investigation focused on issues of security and protection from harm, medical and mental health care, fire safety, environmental health and safety, opportunities to exercise, and access to the courts.

We conducted tours of the Jail on December 10-12, 2002, and January 21-22, 2003, with our expert consultants in the fields of corrections, medical care, fire safety and environmental health and safety. During our on-site inspections, we interviewed the Sheriff, the Undersheriff, the Chief Investigator, the Jail Supervisor, detention officers, Sheriff's Department administrative staff, and inmates. Before, during, and after our visit we reviewed a number of documents, including policies and procedures, incident reports, shift logs, and investigative reports. We also interviewed the community-based health care provider and reviewed medical records maintained by that individual. At the end of each tour, our expert consultants conducted informal exit meetings with the Sheriff in which they conveyed their preliminary findings.

We commend the Sheriff, Undersheriff, Chief Investigator, Jail Supervisor, detention officers, and administrative staff of

the Sheriff's Department for their help throughout the course of the investigation. They have cooperated fully with our investigation and have provided us with substantial assistance.

Based on our investigation, and as described more fully below, we conclude that certain conditions at the Jail violate the constitutional rights of inmates. We find that persons confined at the Jail risk serious injury from deficiencies in the following areas: security and protection from harm, access to medical and mental health care, fire safety, environmental health and safety, opportunities to exercise, and access to the courts.

I. BACKGROUND

A. DESCRIPTIONS OF FACILITY

The Jail occupies the top floor of the four-story LeFlore County Courthouse in Poteau, Oklahoma. The Courthouse was built in 1926 and has been in continuous use ever since. The County added the Jail to the roof of the Courthouse in the 1930's. The County utilizes the basement for storage and floors one, two and three for offices and courtrooms.

The Jail includes the Jailer's Office, kitchen, pantry, women's cell, trustees' cell, protective custody cell, "drunk tank," and seven congregate cells for men, five of which are grouped around a central open area, called "the bullpen," with a shower at the end. The Jail specifically reserves only 6 beds for women.

On December 10, 2002, there were approximately 54 inmates housed at the Jail, including 43 male inmates and 11 female inmates. On January 21, 2003, the Jail housed 55 inmates, including 41 male inmates and 14 female inmates. Of those 55 inmates, all but one were pre-trial detainees. Although the Jail does not track the average length of stay, interviews with inmates and reviews of daily census forms indicated that the average length of stay is approximately one month.

B. LEGAL FRAMEWORK

Pursuant to CRIPA, the Department of Justice has authority to investigate and take appropriate action to enforce the constitutional rights of inmates in jails. 42 U.S.C. § 1997. With regard to sentenced inmates, the Eighth Amendment to the

U.S. Constitution requires humane conditions of confinement; prison officials must ensure "that inmates receive adequate food, clothing, shelter, and medical care and must 'take reasonable measures to guarantee the safety of the inmates.'" Farmer v. Brennan, 511 U.S. 825, 832-33 (1994) (quoting Hudson v. Palmer, 468 U.S. 517, 526 (1984)). The Eighth Amendment protects prisoners not only from present and continuing harm, but from the possibility of future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993).

The county must also ensure that all inmates in the Jail receive adequate medical care, including mental health care. Riddle v. Mandragon, 83 F.3d 1197, 1202 (10th Cir. 1996) (citing Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977)); Young v. City of Augusta ex rel Devaney, 59 F.3d 1160 (11th Cir. 1995).

The vast majority of inmates at the Jail are pre-trial detainees, who have not been convicted of the criminal offenses with which they have been charged. The rights of pretrial detainees are protected under the Fourteenth Amendment, which ensures that these inmates "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). In addition, the Fourteenth Amendment prohibits punishment of pretrial detainees or the imposition of conditions or practices not reasonably related to the legitimate governmental objectives of safety, order and security. Id. at 535-37.

II. FINDINGS

A. SECURITY AND PROTECTION FROM HARM

Inmates constitutionally are entitled to incarceration in an environment that offers reasonable protection from harm. Inmates at the Jail face crowded conditions, no opportunities for exercise, and few alternatives to idleness, all of which increase tensions among inmates. Numerous lapses in basic security and supervision at the Jail significantly increase the risk of harm faced by inmates in this environment.

1. Classification and Inmate-on-Inmate Violence

The Jail uses only two basic methods of classifying inmates. First, the Jail separately houses male and female inmates. Second, the Jail has a policy of housing separately inmates

classified as “maximum security” in a congregate cell called the “hard cell.” Aside from those basic classifications, detention officers base their housing assignment decisions primarily on available space rather than an “objective” classification system. An objective classification system uses a behavior-based scale to identify potentially predatory inmates as well as inmates likely to be victimized by others. This system minimizes violence in shared housing units. The failure to use an objective assignment system places inmates at significant and unnecessary risk of harm.

The Jail Supervisor and detention officers maintained that there was very little violence at the Jail. Conversations with current and former inmates revealed, however, numerous, credible allegations of a pattern of physical violence. Several alleged incidents, described below, indicate that there is a serious problem of physical violence at the Jail.

One former female inmate incarcerated at the Jail in 2000 and 2001 informed us that there were “lots of fights” in the women’s cell. She stated that two female inmates beat the other inmates in order to have those other inmates removed from the cell. The inmate reportedly witnessed attacks involving throwing bleach in another inmate’s eyes, using a toothbrush to stab another inmate, and beating another inmate’s head against the radiator in the cell. The former inmate stated that the victims of the alleged assaults did not receive medical treatment.

Another former female inmate stated that in March 2002 she was booked into the Jail and, within five minutes of entering the cell reserved for women, two other inmates attacked her, one allegedly using a portable fan to beat her in the face. The female inmate reported that she was removed from the women’s cell and placed in the protective custody cell with three other women, all of whom reportedly claimed that they also had been beaten by other inmates.

A former male inmate incarcerated in 2002 stated that physical violence was a matter of course at the Jail. He stated that he regularly saw male inmates physically attack other inmates. He stated that inmates that were admitted to the Jail allegedly under the influence of narcotics or alcohol frequently acted out once placed in a cell and, as a result, were “beaten down” by other inmates.

It was impossible to verify the level of inmate-on-inmate violence as the Jail keeps very little, if any, documentation of violent incidents. The failure to consistently document these incidents, or to investigate or to punish the perpetrators, ensures that violence will continue to occur.

2. Segregation

The Jail lacks any space to provide special housing for inmates who may need it for purposes of disciplinary segregation, protective custody, or to accommodate medical or mental health needs. The Jail does have a cell nominally reserved for "protective custody." However, Jail administrators and detention officers routinely utilize that cell to house women in order to relieve the overcrowding in the lone women's cell. The failure to segregate inmates can lead to disastrous consequences. The following two examples of inmates that were housed in general population yet needed to be placed in special housing, one of a man who needed to be protected and another of a woman who needed to be isolated to protect others, are illustrative.

During our December 2002 tour, detention officers had placed a man accused of child molestation in one of the congregate cells that front the open common area called "the bullpen." Inmates in the other cells fronting the bullpen were cognizant of the charges filed against the accused man. We observed a number of those inmates yelling graphic threats to the accused individual. According to the accused man, when detention officers released inmates into the bullpen area, either to use the shower or to stretch their legs, the officers did not stay in the area to supervise the inmates. The inmates allegedly reached through the bars to attack the accused man and threw cleaning fluids and bodily fluids at him. The individual also informed us that another inmate in the congregate cell had attacked him the day before, and that he had previously suffered two other physical attacks. We observed an open wound behind the man's ear and were shown a bloody towel that the man reportedly had used to tend to his injury. The man had not received any medical attention for his obvious injury.

During the same tour, we spoke with a female inmate housed in the four-bunk protective custody cell with three other women (there were seven women housed in the six-bed women's cell at the time). The inmate informed us that when detention officers attempted to place additional female inmates in the protective

custody cell, she would physically attack the new inmates so that detention officers would be forced to place the inmates in the already-crowded women's cell so that she could have the protective custody cell to herself. When we returned to the Jail in January 2003, there were 13 women in the women's cell. The inmate we spoke with in December was the sole occupant of the protective custody cell. The inmate informed us, and detention officers confirmed, that she physically attacked any inmate that detention officers attempted to place in the protective custody cell with her. Although the inmate effectively isolated herself, she did so at the cost of three beds and injuries to other female inmates.

3. Inadequate Supervision

The Jail routinely has inadequate staffing to provide generally accepted levels of inmate supervision. During the week, the Jail has three detention officers on duty from 6 a.m. to 2 p.m. and two detention officers on duty at all other times. On the weekends, the Jail has one detention officer on duty at all times and a reserve officer comes in for a few hours on Sunday to assist with visiting hours. Three detention officers, let alone the single officer during the weekends, are insufficient to staff the Jail.

The lack of supervision jeopardizes the safety of inmates. There have been several credible allegations of male detention officers engaging in sexual relations with female inmates. The Jail has failed to provide adequate staffing to ensure that inmates are safe and secure at all times.

Detention officers informed us that there are times during the week when all three officers are occupied with either booking inmates or escorting them to and from court. Further, at nights and on weekends, it is not unusual for there to be periods of time when the Jail is left untended. Leaving the Jail unsupervised creates the possibility for great violence to occur.

The staffing of one officer during the weekend poses other problems. If a fight or medical emergency occurs, that detention officer may not open the cell door to break up the fight or provide medical assistance. Rather, the detention officer must summon help and wait for that assistance to arrive. Such a delay could lead to serious injury, if not death.

Detention officers either do not sufficiently supervise the inmates or do not document their supervision. Jail policy requires detention officer to make rounds of the cells each hour. A review of the Jail's log indicated that it was not uncommon for hours to pass without a detention officer making a documented round.

Our observations confirmed that detention officers do not sufficiently supervise inmates. We observed that detention officers often stayed in the Jailer's Office and did not frequently venture into the Jail. Detention officers entered the Jail only to transport prisoners or when trustees alerted detention officers to a situation that required their attention. Instead, detention officers relied on trustees to operate the Jail. Trustees prepared and served all meals without any supervision. In addition, trustees brought inmate's verbal requests for medication or medical attention to the detention officers. In turn, the trustees then delivered over-the-counter medication to the inmates. Permitting trustees to perform these duties inappropriately gave them the power to reward and punish other inmates. For instance, inmates reported that trustees sometimes would tell a particular inmate that the inmate's food had been adulterated.

Finally, the Jail does not consistently have a female jailer on duty. The Jail must have a female detention officer on duty when a female is in custody.

4. Training of Detention Officers

Formal training of detention officers is virtually non-existent. Only one of the detention officers at the Jail had completed the state-mandated three-day training course. The Jail Supervisor had no formal correctional training. Although Oklahoma State law requires annual in-service training, the Jail does not provide such training. In addition, only three detention officers had received CPR certification. One detention officer on each shift should be CPR certified.

The Jail has a policy and procedure manual that is issued by the Oklahoma Sheriff's Association. The manual is not specific to the Jail and, from our observation, it does not appear that detention officers follow many of the policies.

5. Suicide Prevention

During our December 2002 tour, our expert consultant noted serious suicide hazards at the Jail and informed the Sheriff of these hazards. For example, each shower stall had a non-structural bar at the top of its frame as well as a metal shower curtain rod. An inmate could use either the bar or the rod to hang herself or himself. When we returned to the Jail in January 2003, no measures had been taken to correct the hazards.

6. Failure to Inform All Inmates of Jail Policies

The Jail does not provide an orientation to new inmates. A correctional facility must provide all new inmates with an orientation that covers the following areas: rules and regulations; the process for obtaining medical or mental health care; emergency procedures; commissary items and ordering; visiting hours and regulations; and rules for sending and receiving mail.

7. Inmate Discipline

Written rules and regulations govern inmate conduct at the Jail. However, there is no system for formal disciplinary reports and hearings for alleged major violations of rules. Rather, individual detention officers act as investigator, jury and sentencing judge, doling out punishment on the spot, often engaging in group discipline rather than penalizing only the culpable inmates. Such group punishment creates a manifest risk of retaliatory inmate-on-inmate violence.

B. MEDICAL CARE

The provision of medical services to inmates at the Jail is seriously deficient and places inmates at risk of harm. Most fundamentally, the Jail has no on-site medical care provider. In addition, no medical professionals screen inmates for medical concerns or supervise or follow-up on outside medical visits. Further, the Jail fails to maintain any records on the sporadic health care provided to the inmates in its custody. From these fundamental deficiencies, numerous unacceptable risks follow.

1. Intake Screening

The intake screening process is insufficient to ensure that inmates receive necessary medical care while incarcerated. The

screening process is necessary to ensure that inmates who suffer from chronic conditions or otherwise need prompt medical attention are referred to a medical professional for needed follow-up care. The system at the Jail fails to collect accurate information to guide future care and fails to provide timely treatment to those who need it.

Detention officers conduct intake screening as part of the booking process in the Jailer’s Office. Detention officers ask inmates a series of questions concerning different topics, including medical and mental health care, and enter the inmate’s responses into a database. The information provided becomes part of the inmate’s correctional file.

The screening process is severely deficient. The screening questionnaire has not been approved by a physician, which is evident as the form does not include any questions concerning possible exposure to tuberculosis. Although detention officers record an inmate’s responses to questions concerning medical or mental health problems, neither a medical professional nor a jail administrator reviews that information. Even when detention officers identify an inmate with serious medical needs during the intake process, the Jail does not immediately refer those inmates to a medical professional. Detention officers, who themselves have no medical training, determine when, or if, an inmate receives medical attention. This is a significant and unacceptable departure from universally accepted standards of care.

Even though detention officers conduct intake screenings, there are no policies clearly delineating situations in which the Jail will not accept prisoners who exhibit serious medical problems. For example, the Jail Supervisor and detention officers stated that they would accept an intoxicated individual that had lost consciousness. Given that the Jail has no on-site medical care provider and very few detention officers to monitor inmates, unconscious individuals should not be accepted.

Detention officers conduct the intake screenings in a setting which does not ensure confidentiality. The Jailer’s Office is open to the Jail hallway where inmates, particularly trustees who are permitted to roam freely in the Jail, can hear an inmate’s responses to medical questions. The lack of confidentiality minimizes the likelihood that inmates will respond truthfully to questions about whether they have serious

medical or mental illness. Insufficient screening puts people at risk both because inmates may not be provided with timely medical care and because inmates with communicable diseases, including respiratory infections like tuberculosis that spread easily, may infect the general population.

2. Health Assessments

Physical examinations, including a medical history, should be conducted within 14 days of admission to a correctional facility. Further, inmates should receive a screening test for tuberculosis at this time. A health assessment serves the purpose of establishing a baseline health status for an inmate, and documents health problems for which a treatment plan should be initiated. Inmates currently receive health assessments only if they request to be seen by the doctor or nurse. The medical care provided at the Jail is only reactive to emergent crises.

3. Sick Call

Detention officers collect "Medical Request" forms and, if the officers consider the reported malady to be of sufficient severity, they or the Jail Supervisor contact the nurse. The expectation in a jail setting would be for inmates to place their requests in a locked box to which detention officers would not have access, but which would be reviewed regularly by the medical care provider. This system allows for confidentiality and reduces concern that detention officers might restrict access to medical services.

A local registered nurse conducts sick call. Although she is available at all times by beeper, she has no regular, fixed schedule for conducting sick call. Further, there are no arrangements to replace the nurse's services when she is on vacation, ill or otherwise unavailable. A physician rarely, if ever, conducts sick call. In a time period extending from October 1, 2002 to January 12, 2003, a doctor conducted sick call one time at the Jail. The sick call system is inadequate to provide timely and appropriate care.

The nurse follows no treatment protocols, policies or procedures when providing care to the inmates. The nurse does not have the training to evaluate patients without guidance from treatment protocols. The nurse is practicing beyond her clinical scope.

When the nurse conducts sick call, she often utilizes trustees to assist her in providing services, such as helping her bandage an inmate's wound. The use of trustees, who lack any medical training, is a violation of the inmate's privacy. Further, a trustee's possession of confidential medical information gives that trustee undue power and influence over another inmate.

The area used for sick call is wholly inadequate. The nurse evaluates inmates either in the Jailer's Office or in the Jail kitchen. There is no medical equipment in either room.

4. Medication Storage and Distribution

At the Jail, all prescription medications, including controlled substances, are stored in a file box in the Dispatch Office. At the time of our January 2003 tour, the file box was unlocked at all times and the key was left in the lock. Controlled substances have the potential for abuse and misuse and should be stored in a secure environment to which access is limited.

Trustees regularly dispense over-the-counter medications and, on occasion, distribute prescribed medications to inmates. Permitting trustees to distribute both prescription and non-prescription medication is unacceptable. It can create the potential situation where trustees could either steal the medication, sell it to another inmate, or exert undue pressure and power over the intended recipient.

Jail officers also distribute medications at the Jail. They do so without training or supervision. Finally, a physician never follows-up with inmates receiving medication to judge the effectiveness of the medication, to continue the medication or to determine whether alternative therapy would be appropriate.

5. Chronic Care

In order to properly treat inmates with chronic illnesses, a medical professional must see inmates on a regular schedule appropriate to the disease, so that their illnesses may be monitored, the symptoms controlled and documented, and medications delivered and adjusted in a timely manner. The Jail does not have a chronic care program. Since the Jail fails to provide medical oversight of screening, and inmates often are

housed at the Jail for a month, it is likely that they do have inmates requiring chronic care.

6. Acute Care

The Jail lacks any policies concerning the management of medical emergencies. Instead, detention officers and Jail administrators must decide whether to contact the nurse to have her ascertain if the inmate should receive immediate medical attention. This practice presents an unacceptable risk of harm to inmates' health, and makes it likely that inmates will endure unnecessary pain before a worsening condition is ultimately brought to the attention of a medical care provider.

7. Infection Control Program

All correctional facilities are at risk of housing inmates with communicable diseases. Jails should have policies addressing universal precautions to protect inmates and staff from possible exposure to blood and bodily fluids. Jails also should have policies and procedures to detect, isolate and treat inmates with communicable and infectious diseases. The Jail has no such policies or procedures. Two examples show the need for such policies and procedures.

First, during our December 2002 visit, our expert consultant in environmental health and safety noted that syringes were stored in an unlocked desk drawer in the Jailer's Office, that there were no alcohol wipes available, and that detention officers or trustees were re-capping syringes after use and then placing them in the hazardous waste receptacle. Recapping a syringe possibly exposes an individual to blood-borne pathogens including HIV and Hepatitis B.

Second, during our January 2003 visit, the women's cell housed 14 female inmates in a cell measuring approximately 210 square feet. One of the inmates had a compromised immune system and another was pregnant. A recently released inmate, who had been housed in the same cell, stated at intake that she had tuberculosis. There had been no provision for isolating the women with tuberculosis. Tuberculosis could have threatened the life of the pregnant woman and had adverse consequences for her pregnancy. In addition, medication prescribed to the woman with a suppressed immune system had run out and no one had taken measures to ensure that the prescription was renewed. The lack

of medication and proximity to a tubercular individual jeopardized the health and life of the inmate with the suppressed immune system.

8. Licensure

The Jail currently does not verify the licensure of its outside medical providers. The Jail should verify these licenses at least annually; that medical care is provided off-site does not negate this requirement.

9. Dental Care

The Jail does not contract with a designated dentist to provide care to inmates. Further, specific policies and procedures governing the provision of emergency or non-emergency dental care for inmates do not exist.

C. MENTAL HEALTH CARE

The Jail fails to deliver adequate mental health care to its residents who need such services. The Jail does not provide inmates with an adequate mental health screen or a mental health assessment 14 days after admission. In addition, the Jail has not contracted with a psychiatrist to provide care for the inmates.

The experience of one mentally ill inmate illustrates the lack of mental health services at the Jail. At the time of our December 2002 visit, we encountered an evidently mentally ill inmate housed in the "drunk tank" who was yelling and shouting uncontrollably, frequently calling the female detention officer on duty "Mama." The man had not received any mental health care at the Jail since his incarceration in October 2002. When we returned to the Jail in January 2003, the same inmate was housed at the Jail in a congregate cell and still had not received any mental health care. Our expert medical consultant conducted a mini-mental health exam that revealed that the inmate was not oriented to time, date or place. In our interview with the nurse, we discovered that the nurse had seen the inmate, but only after one of the inmate's prescription medications had lapsed and, suffering withdrawal, the inmate stood in his cell for three straight days. Detention officers called the nurse to tend to the swelling in the inmate's legs, and not for his evident mental health problems.

D. FIRE SAFETY

Inmates at the Jail depend entirely on detention officers for their safety in the event of a fire or other emergency that might require evacuation. Detention officers must unlock each individual cell, as the cells are secured by individual padlocks. This factor makes fire suppression and detection a critical issue, particularly on the weekend when only one detention officer is on duty. Inadequate fire safety measures at the Jail compromise severely the safety of inmates and detention officers. These deficiencies include the lack of fire alarm and sprinkler systems, insufficient smoke detection units, inadequate protection from smoke exposure, excessive combustible materials, and substandard evacuation preparation.

1. Detection, Alarm and Sprinkler Systems

The Jail has substantial deficiencies in fire detection and suppression. The Courthouse lacks a sprinkler system. The standpipe system extends to the third floor, but not to the Jail. There are no smoke detection or fire alarm systems installed in the building. Rather, some of the areas of the Courthouse and the Jail are equipped with battery operated smoke detectors. Because the smoke detectors are not part of an integrated building-wide system, only an alarm in the immediate area of the smoke or fire would sound. In the event of a fire, an alarm might go unheeded if detention officers are not in close proximity to the smoke detectors.

2. Smoke Exposure

The Jail does not protect residents from dangerous exposure to smoke. A single staircase rises from the first floor to the third floor of the Courthouse. A separate staircase connects the third floor and the Jail. These stairwells are not fully enclosed with fire-rated enclosures. In addition, an antiquated elevator shaft runs from the first floor to the Jail floor. In the event of fire, the stairs and elevator shaft would become avenues by which heat, smoke, toxic fumes and other products of combustion could spread unimpeded through the Courthouse and Jail. The stairs would be impassable and an unreliable means of escape.

The lack of a self contained breathing apparatus ("SCBA"), for detention officers to use in the evacuation of prisoners,

compounds the inadequate smoke exposure protections. Given the amount of combustible material in the Jail, the lack of smoke containment, and the laborious process to open all the cell doors, a SCBA is essential to ensure that detention officers will be able to safely evacuate all prisoners and staff.

3. Combustibles

Many of the cells and other locations in the Jail contain excessive amounts of combustible materials, including clothing, books, paper, bedding material, linens, and other personal property. Although smoking is forbidden at the Jail, inmates were observed smoking in their cells and cigarettes butts were observed in the kitchen. The floors below the Jail contain a dangerous abundance of combustible materials. Many areas are lined with wood paneling and contain typical office supplies and furniture. In addition, there are several record storage areas. A fire in these lower floors exposes the Jail to significant smoke exposure.

4. Fire and Evacuation Preparedness

Inmates and detention officers have two routes to evacuate the Jail. Inmates may traverse the internal staircases or they may exit the Jail through doors on to the roof of the Courthouse and descend a standing stair attached to the building.

Padlocks secure all cell doors and it requires five separate keys to release all inmates from their cells and evacuate them. Throughout the Jail, detention officers could not identify the keys that open cells or exit doors without first looking at the keys. Conditions may arise during a fire which make visual identification impossible, and, therefore, the inability to identify keys by touch may prevent resident evacuation. In addition, an “emergency” set of keys is kept in the Dispatch Office on the first floor and not in the Jail where they would be needed.

Detention officers seemed unaware of evacuation procedures. Although the detention officers understood the routes to follow to evacuate the Jail, they did not know the procedures necessary to evacuate inmates safely and securely. This appears to be the result of the failure to conduct frequent fire drills.

The Jail relies on the local volunteer fire department to respond to any emergency related to fire. Jail officials have not conducted any emergency planning with the fire department to ensure effective emergency response. Given the number of prisoners housed at the Jail, the amount of combustible material within the Courthouse, and the cramped design of the facility, it is imperative that local fire officials acquaint themselves with the evacuation procedures and physical layout of the Jail.

E. ENVIRONMENTAL HEALTH AND SAFETY

The Jail does not provide adequate diet, clothing, or environmentally adequate shelter.

1. Nutrition and Food Service

The food service operation at the Jail does not meet nutrition or sanitation requirements and puts residents at risk of developing food borne illness.

The Jail lacks a menu. The trustee that served as head cook informed us that he orders and cooks food "off the top of his head." Inmates that are diabetic or require a medically prescribed diet are not provided with such foods. Although the nurse reportedly advises the cook as to a specific inmate's dietary needs, the cook stated that he had never received such instruction. Instead, trustees serve inmates with specific dietary needs the same food as other inmates and instruct them to try to adjust the foods they eat according to their medical needs.

Trustees prepare and serve every meal at the Jail without supervision from detention officers. This practice brings into question the quality of the food served. In addition, neither a medical professional nor a detention officer medically screen trustees before they are assigned to food preparation. The failure to medically screen and periodically monitor the health of inmates associated with food preparation possibly exposes the inmate population to a number of communicable diseases.

Food is stored improperly in the kitchen and pantry as well as in refrigeration and freezing units. We found powdered and dried foods left in open containers permitting contamination by dirt, moisture and insects. We found numerous examples where

refrigerated and frozen foods were not kept at temperatures low enough to inhibit growth of food borne bacteria.

The food storage and service equipment, as well as the utensils, trays, preparation equipment and pots, tended to be dirty and covered with dried food. Inmates were not provided with cups for drinking. Instead, they utilized soda bottles cut in half, which are never sanitized and are filthy. One female inmate stated that she shared a soda bottle with another female inmate as there were not enough makeshift drinking receptacles for each inmate.

The floors in the kitchen are not properly sealed, which exposes food to insects and rodents. Broken windows panes in the kitchen also permit the entry of insects. In particular, we noticed flying insects in and on food-encrusted utensils in the kitchen.

2. Physical Plant

In general, the cells in the Jail are extremely dirty, odoriferous and poorly maintained. The Jail provides no ventilation to circulate fresh air and prevent the transmission of communicable diseases.

The facility has serious problems with lighting. Lighting must be a least 20 foot candles to provide for reading, sanitation and personal hygiene. In addition, poor lighting makes it very difficult for detention officers to observe what is going on in the cells, and leaves both the inmates and the officers at risk. Not a single cell had light levels that met minimally acceptable levels. One cell had levels of lighting that measured less than one foot candle of light.

The current state of plumbing at the Jail causes great concern. The pipes in the plumbing chase behind the cells showed signs of severe corrosion. Uninsulated overhead pipes in the women’s cell dripped condensate water on the bunks. The showers were dirty and mildewed and several were leaking. In addition, the temperature of the water supplied to the cells was inadequate. One cell produced water at a temperature too low to be conducive to good hygiene and three others supplied water at temperatures high enough to cause skin burns.

The risk of insect and pest infestation in the cells is high. Inmates consume all their meals in their cells. The possibility of food spillage and hoarding presents a pest and rodent problem. Further, the Jail permits inmates to purchase and store in their cells unlimited quantities of snack foods and soft drinks from the Jail's commissary list. This creates a trash problem as well as a rodent and pest problem.

3. Mattresses

Our inspection revealed torn and cracked mattresses throughout the facility. Such mattresses cannot be cleaned or sanitized properly. Furthermore, they present an increased fire risk, as torn and cracked mattresses lose their fire-resistive qualities.

4. Inmate Clothing and Bedding

There are deficiencies in the Jail's issuance and maintenance of clothing and bedding that result in unsanitary conditions, facilitating the spread of disease. The schedule for the laundering of personal clothing is inadequate. Further, while inmates can send their wash to be laundered by trustees, inmates reported that trustees returned the laundry in a more soiled state than when it was sent. Many inmates forgo having the trustees launder their clothes and linens and, instead, wash them in the toilets in their cells.

The Jail requires inmates, or their families, to provide their own undergarments. If an inmate does not have family members to provide clothing, then that inmate never receives another pair of undergarments. Instead, inmates released into the community often "donate" their undergarments to other inmates. This practice is unsanitary and must cease. Instead, the Jail should place undergarments on its commissary list for sale to inmates, or, if an inmate is indigent, should provide new, clean undergarments to such inmates.

The Jail lacks sufficient clothing for the number of inmates it houses. Female inmates stated that they were not given replacement clothing when they sent their clothes to be laundered. Instead, the inmates reported that they were required to sit in their cells in their undergarments until a trustee returned the laundered clothing.

The Jail regularly holds more prisoners than for which it has beds. Inmates without a bunk sleep on mattresses placed on the floor. At the time of our January 2003 visit, the women's cell housed 13 inmates, six on bunks and seven on mattresses on the floor. Mattresses must not be placed directly on the floor because they impede proper sanitation and may present health, fire and safety hazards.

F. EXERCISE AND OUT-OF-CELL TIME

Inmates receive no opportunity for exercise and out-of-cell time. All prisoners are confined in small cells twenty-four hours per day. The lack of out-of-cell time and opportunity for exercise can exacerbate the conditions of residents with mental illnesses, lead to violence among inmates, and can put inmates at risk of developing anxiety and symptoms of depression.

G. INSUFFICIENT ACCESS TO THE COURTS

The County has the responsibility to provide inmates with reasonable access to the courts in order to challenge their sentences, directly or collaterally, and the conditions of their confinement. The County is not providing inmates at the Jail with access to legal materials.

Although the Courthouse has a law library, inmates are neither permitted access to the materials nor are detention officers trained or available to assist the inmates in legal research.

Our review of inmates' access to legal services was limited, and we did not identify any inmate whose ability to pursue a claim was impaired because of the deficiencies of service. Nonetheless, we are concerned that such an injury is likely to occur.

III. REMEDIAL MEASURES

In order to rectify the identified deficiencies and to protect the constitutional rights of the facility's inmates and detainees, the Jail should implement, at a minimum, the following measures:

A. SECURITY AND PROTECTION FROM HARM

1. Develop and implement an objective classification system and house inmates accordingly.

2. Provide adequate housing in which to segregate inmates for disciplinary, security, medical or mental health reasons.

3. Develop and implement policies, procedures and practices for the investigation of suspicious inmate injuries for evidence of potential assault, and document the result of these investigations.

4. Hire a sufficient number of detention officers to supervise inmates, ensure the safety and security of inmates and detention officers, and provide at least one female detention officer on duty for each shift.

5. Provide detention officers with sufficient training, particularly in-service training.

6. Develop and implement policies, procedures and practices to ensure frequent, irregularly timed and documented rounds.

7. Provide an adequate orientation to all inmates entering the Jail.

8. Develop and implement policies, procedures and practices for an inmate discipline system.

9. Develop and implement policies, procedures and practices to ensure the supervision of trustees.

10. Address and remedy the suicide hazards in the cells.

B. MEDICAL CARE

1. Retain the services of a medical doctor, whose responsibilities will include: supervising all medical care rendered to inmates; providing physician's sick call; reviewing revised medical intake screening forms and processes; monitoring care of serious and/or chronic conditions;

ensuring that all inmates receive a health assessment within 14 days of intake; and annually reviewing policies and procedures concerning medical or mental health screening and/or the provision care.

2. Provide inmates with a health assessment, comprehensive medical history and physical examination, performed by appropriately trained, licensed and, if appropriate, supervised personnel, within 14 days of their arrival at the facility.

3. Develop and implement policies, procedures and practices, that are site-specific, governing the provision of health care, including medication distribution.

4. Provide for a more confidential environment to conduct intake screening.

5. Provide an appropriately clean and confidential environment, equipped with the appropriate and necessary equipment, for the nurse or other medical professional to conduct medical assessments and examinations.

6. Develop and implement policies, procedures and practices to ensure that diabetics and other inmates who need medically appropriate nutrition receive an appropriate diet as ordered by a physician.

7. Develop and implement policies, procedures and practices for handling inmate sick call requests.

8. Verify the licensure of all medical care providers at least annually, without regard to whether the care is provided on or off-site.

9. Ensure that nurses provide medical care within the scope of their training and licensure.

10. Develop and implement policies, procedures and practices to ensure that medical information

received at booking, as well as treatment information and documentation, becomes part of an inmate’s medical record separate from the inmate’s correctional file.

11. Train booking officers to look for signs of mental and physical illness in inmates.

12. Develop and implement policies, procedures and practices to ensure that inmates reporting or exhibiting possible signs of significant medical or mental health problems at booking are seen promptly by a medical professional and receive appropriate follow-up care.

13. Validate and continue, if appropriate, current prescriptions for medications of incoming inmates within 12 hours of arrival at the facility, or sooner if appropriate.

14. Develop and implement policies, procedures and practices for proper documentation and accurate, thorough and legible medical record keeping.

15. Develop and implement policies, procedures and practices for the proper storage and disposal of medical supplies.

16. Train detention officers regarding their role in securing access to acute and emergent care for inmates, and provide adequate staff to accomplish these tasks.

17. Ensure that all correctional officers are certified annually in CPR and equip the Jail with pocket masks and rubber gloves.

18. Staff the Jail with a sufficient number of detention officers so that inmates requesting acute and emergent care may be treated timely and appropriately.

19. Establish a chronic care system which includes gathering information and establishing medication upon intake into the facility, establishing a

system of care of inmates with chronic diseases at established intervals, standardizing the information gathered at treatment visits, and devoting sufficient attention to inmates whose uncontrolled conditions must be stabilized.

20. Develop and implement policies, procedures and practices for distribution of prescription and over-the-counter medication; train detention officers in the proper mode of medication distribution; and cease permitting trustees to distribute any medication.

21. Develop and implement policies, procedures and practices to detect, monitor and isolate inmates with infectious diseases, where appropriate.

22. Train detention officers on universal precautions to protect inmates and staff from possible exposure to blood and bodily fluids.

23. Develop and implement policies, procedures and practices governing the provision of emergency or non-emergency dental care and contract with a designated dentist to provide care to inmates.

24. Provide regularly scheduled sick call to be conducted by a nurse or physician's assistant.

25. Provide regularly scheduled sick call to be conducted by a physician.

C. MENTAL HEALTH CARE

1. Provide every inmate with an initial mental health screening upon arrival at the facility and a mental status assessment within fourteen days of arrival.

2. Contract with a psychiatrist to meet the serious mental health needs of the Jail's population.

3. Develop comprehensive site-specific mental health care policies and procedures, including medication distribution.

4. Develop and implement policies, procedures and practices to ensure that mental health care records are complete and accurate to maintain continuity of care, particularly regarding the administration of medications.

5. Develop and implement policies, procedures and practices to ensure that detention officers respond to sick call mental health requests in a timely manner.

6. Develop and implement policies, procedures and practices to ensure that inmates receive all necessary mental health medications in a timely manner.

D. FIRE SAFETY

1. Develop and implement policies, procedures and practices to ensure that detention officers conduct adequate fire drills for all shifts, covering all institutional areas.

2. Add sprinkler capability to the Jail.

3. Install sufficiently loud, listed fire and smoke detection systems.

4. Properly enclose stairwells, piping, chases and smoke barriers.

5. Provide metal containers in which to store all combustible personal property in the Jail.

6. Use door keys that can be identified without the benefit of sight, ensure that all keys to doors on exit routes are readily available, and train staff in their use.

7. Maintain emergency exit routes so that they are free of obstacles, safe and available for use.

8. Obtain self-contained breathing equipment and train detention officers in use.

9. Work with the local fire department to develop plans for evacuation and fighting fires at the Jail.

10. Connect an emergency generator to the Courthouse electrical system to ensure the automatic transfer of power in the event of an outage.

We recognize that the County has attempted to establish a sales tax to fund the construction and continuing operation of a new correctional facility to replace the existing Jail. Should it appear that construction of a new jail will occur, we will work with the County to develop interim measures to ensure fire safety before occupancy of the new facility.

E. ENVIRONMENTAL HEALTH AND SAFETY

1. Develop and implement policies, procedures and practices to provide for safe food handling and storage, including maintaining food temperatures that avoid the growth of harmful bacteria.

2. Develop and implement policies, procedures and practices to ensure that food storage, preparation and service systems are washed and maintained in a sanitary manner.

3. Develop and implement policies, procedures and practices to ensure that inmates and staff who work in food service are in proper health to do so.

4. Develop and implement policies, procedures and practices to provide medical diets as prescribed by a physician and ensure that all food service menus are reviewed at least annually by a registered dietician.

5. Provide sufficient bunks or portable sleeping surfaces so that inmates are not required to sleep on the floor.

6. Provide a sufficient number of mattresses and maintain them in sanitary and fire safety condition.

7. Develop and implement policies, procedures and practices to ensure that the facility follows nationally accepted standards for infection control and hygiene.

8. Provide sufficient lighting.

9. Clean the Jail and implement a system of regular pest control.

10. Provide and maintain water at an appropriate temperature for good hygiene for all cells.

11. Provide sufficient airflow within the Jail.

12. Develop and implement policies, procedures and practices to ensure that toilets, sinks, showers and drains are maintained in sufficient quantity, clean and in proper working order.

13. Provide adequate exchanges of sanitized bedding, clothing and undergarments.

F. EXERCISE AND OUT OF CELL TIME

1. Develop and implement policies, procedures and practices to provide inmates with regular opportunities for exercise.

G. INSUFFICIENT ACCESS TO THE COURTS

1. Develop and implement policies, procedures and practices to provide access to the law library or legal assistance sufficient to enable inmates to prepare their defense and to challenge the conditions of their confinement.

H. GENERAL PROVISIONS

1. Incorporate all revised forms, practices and policies concerning each area of Jail operations

discussed herein in a revised policy and procedures manual.

2. Train all staff on revised policies and procedures; document the training.

3. Review all policies annually; document the review.

4. Develop and implement a quality improvement system that monitors and improves deficiencies identified in this findings letter.

# # #

We appreciate the cooperative approach taken by the Sheriff and the detention officers at the Jail. We understand that officials are aware of and acknowledge many of the problems discussed in this letter. In anticipation of continuing cooperation toward a shared goal of achieving compliance with constitutional requirements, we will forward our consultants' reports. Although the reports are their work and do not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

In the unexpected event that the parties are unable to reach a resolution regarding our concerns, we are obligated to advise you that 49 days after receipt of this letter, the Attorney General may institute a lawsuit pursuant to CRIPA to correct the noted deficiencies. 42 U.S.C. Section 1997b(a)(1). Accordingly, we will soon contact County officials to discuss in more detail the measures that the County and Sheriff must take to address the deficiencies identified herein.

Sincerely,

/s/ Ralph F. Boyd, Jr.

Ralph F. Boyd, Jr.
Assistant Attorney General

cc: Mr. Freddie Cox
County Commissioner
LeFlore County Board of Commissioners

Mr. Lance Smith
County Commissioner
LeFlore County Board of Commissioners

Rob Wallace, Esquire
District Attorney
State of Oklahoma - District 16

Mr. Roy D. Gentry
Sheriff
LeFlore County

The Honorable Sheldon J. Sperling
United States Attorney
Eastern District of Oklahoma