April 17, 2003

Mr. Wendell Vencl
Chairman
Garfield County Board of Commissioners
114 West Broadway
Room 101
Garfield County Courthouse
Enid, OK 73701

Re: Investigation of Garfield County Jail and
Garfield County Work Center, Enid, Oklahoma

Dear Mr. Vencl:

We write to report the findings of our investigation of conditions of confinement at the Garfield County Jail ("Jail") and Garfield County Work Center ("Work Center") in Enid, Oklahoma. On June 6, 2002, we notified you of our intent to investigate the Jail and Work Center pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Our investigation focused on issues of fire safety, personal safety, medical and mental health care, environmental health and safety, opportunities to exercise, and access to the courts.

We conducted tours of the Jail and the Work Center on July 23-25, 2002, and September 19-21, 2002, 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 Jail Administrator, 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, use of force reports, shift logs, and investigative reports. We also interviewed the community-based health care providers and reviewed medical records maintained by those individuals. 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, Jail Administrator, and detention officers at the Jail and Work Center 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 and the Work Center violate the constitutional rights of inmates. We find that persons confined at the Jail risk serious injury from deficiencies in the following areas: fire safety; security and protection from harm; access to medical and mental health care; environmental health and safety; opportunities to exercise; and access to the courts. Further, we find that persons confined at the Work Center risk serious injury from deficiencies in access to medical and mental health care and access to the courts.

I. BACKGROUND

A. DESCRIPTIONS OF FACILITIES

The Jail occupies the top two floors of the five story Garfield County Courthouse in downtown Enid, Oklahoma. The Courthouse was built in 1933 and the Jail was refurbished in the 1960's. The County utilizes the basement and floors one, two and three for offices and courtrooms.

The first floor of the Jail includes a the Jailer's Office and dispatch center, the kitchen, a pantry, a visiting room, a four-man cell reserved for trustees, two ten-man congregate cells, and four two-man cells, reserved for the most violent or mentally ill inmates. The second floor includes a converted cell used for storage and medical examinations, two ten-man congregate cells, three four-man cells, and three four-woman cells. In total, the Jail has 76 beds, of which 12 are reserved for women.

During our July 2002 visit to the facility, there were approximately 66 inmates housed at the Jail, including 55 male inmates and 11 female inmates. During our September 2002 tour of the facility, there were approximately 70 inmates housed at the Jail, including 56 men and 14 women.

The Work Center occupies a two story building located on the Garfield County Fairgrounds. The Sheriff created the Work Center in 2001. The first floor includes a Jailer's Office/intake area, two bathrooms, kitchen, pantry, and a dormitory room with 18 beds. The second floor includes a television room, a library, a meeting room and a bathroom. There were 11 male inmates housed at the Work Center during our July 2002 visit and 12 male inmates housed there during our September 2002 visit.

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 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 and the Work Center 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 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. 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 Jail does not have a central unlocking mechanism. This factor makes fire suppression and detection a critical issue. 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 and does not have a standpipe system to which fire fighters could attach their hoses to draw water to fight a fire. Further, there are no smoke detection or fire alarm systems installed in the building. Rather, some, but not all, of the hallways outside the inmate sleeping quarters are equipped with battery operated smoke detectors. Because the alarms are not part of an integrated building-wide system, only an alarm in the immediate area of the smoke or fire would sound. Individual alarms are not loud enough to penetrate the steel doors that separate the cells from the main hallways. In the event of a fire, an alarm might go unheeded if detention officers are not in close proximity to it. Further, there is no system for inmates to communicate with detention officers. Rather, inmates routinely beat on their shower stalls to gain the attention of detention officers. Because the Jail is regularly short staffed, there is often a significant delay before a detention officer responds to an inmate's attention generating behavior. In the event of a fire, such a delay could prove fatal.

2. Smoke Exposure

The Jail does not protect residents from dangerous exposure to smoke. A single staircase rises from the basement of the Courthouse to the first floor of the Jail (the fourth floor of the building). A separate, open staircase connects the first and second floors of the Jail. These stairwells are not fully

enclosed. In the event of fire, they would become avenues by which heat, smoke, toxic fumes and other products of combustion could spread unimpeded through the Courthouse and Jail, making the stairs impassable and unreliable means of escape.

The lack of a self contained breathing apparatus ("SCBA"), for staff 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 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. Inmates store their personal property either on their bunks or in paper bags underneath the bunks. Any inmate property not stored in cells is kept in a converted cell which is open to the corridor. Further, trash in cells is stored in plastic waste receptacles without covers. These waste receptacles could fuel any fire that occurred in a cell.

During a tour of the Jail on September 17, 2002, we observed the storage of three plastic jerricans of gasoline and a portable generator in the detached staircase that serves as the primary evacuation route from the Jail. The jerricans and generator partially blocked the staircase. The storage of the combustible material presented an extreme danger in the event of an emergency. At our insistence, the Sheriff removed the gasoline and the generator from the staircase and stored them outside of the Courthouse.

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

In the event of an evacuation, inmates and detention officers have two routes to exit the Jail. Inmates may evacuate

the Jail by either traversing the staircase that runs from the first floor of the Jail to the basement or by exiting the Jail through a door on to the roof of the third floor and then crossing a steel bridge that connects to a free standing stair (and then descending down to ground level).

Manual key-locks secure all cell doors and doors to the hallways and it requires seven 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. Further, a number of the cells have difficult or faulty locking devices. It took one detention officer over ten minutes to open one of the cells. Such a delay could prove to be fatal in a fire emergency.

Even if detention officers could identify all keys by touch, they neither carry nor have reasonable access to all keys necessary to unlock doors in the evacuation route. We asked a detention officer on duty in the Jail to gather all keys required to open the doors in the evacuation route. A considerable delay ensued before the detention officer completed this task. In the event of a fire emergency, a detention officer will not have a surfeit of time to gather the keys and unlock the cells.

The Jail has a good, written evacuation plan in its policy and procedure manual. However, some detention officers seemed unaware of evacuation procedures. Although the detention officers understood the routes to follow to evacuate the Jail, which are posted on the walls, 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. No detention officer with whom we spoke had ever participated in a fire drill, nor could any officer recall receiving instruction on what do in the event of a fire.

The Jail relies on the local fire department to respond to any emergency related to fire. The local fire and police departments reportedly have keys to the exterior doors of the Courthouse, but they do not have keys to unlock the door to the Jail. Detention officers would have to unlock the door on the first floor of the Jail in order for the emergency responders to enter the Jail.

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 building, 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.

B. SECURITY AND PROTECTION FROM HARM

Inmates are constitutionally 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

The Jail does some classification of inmates, principally segregating sentenced from unsentenced inmates. Aside from that basic classification system, 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 numerical scale to identify potentially predatory inmates as well as inmates likely to be victimized by others. This sytem minimizes violence in shared housing units.

The failure to use an objective assignment system places inmates at significant and unnecessary risk of harm. For example, detention officers placed an inmate accused of child molestation in a 10-man congregate cell. The inmates in the cell, aware of the charges against the man, severely beat him on at least two separate occasions in one day. The inmate required hospitalization, spending several days in a coma. This incident could have been avoided had detention officers considered the safety risks of placing the inmate in a 10-man cell.

2. Segregation

The Jail lacks the capacity 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 reacts to reports of fighting and conflict by moving inmates between cells, and, ultimately, by transferring some inmates to other facilities. Because contract jails will not accept inmates with violent tendencies, these inmates must be housed at the Jail.

As the Jail lacks segregation space, the Jail has adopted a practice of restraining particularly violent inmates by handcuffing the inmate's arms to the cell bars while the inmate lay on the floor of the cell. The practice is inhumane and dangerous and must cease.

3. Inadequate Staffing

Jail policy dictates that three detention officers should be on duty at all times. However, the Jail often has two detention officers on duty, as was the norm during our July 2002 inspection. Two detention officers are insufficient to staff the Jail, particularly during the day shift when the energies of one detention officer must be devoted exclusively to administrative tasks. The other detention officer must supervise and address the needs of the inmates on both floors of the Jail.

Because the Jail has so few officers on duty per shift, detention officers do not sufficiently supervise the inmates. Detention officers makes rounds of the cells approximately once an hour on a regular schedule. This is insufficient to maintain adequate supervision and control of inmates.

The shortage of detention officers has the potential to create problems when an emergency or violence occurs at the Jail. As there is no audio monitoring system, an inmate who is in danger or in need of emergency medical attention in the further reaches of the Jail must rely on his or her peers to make sufficient noise to garner a detention officer's attention. If detention officers respond, and there are only two officers on duty, it is Jail policy that they cannot extract an inmate from a cell until a law enforcement deputy or Enid Police Department officer arrives to assist.

The Jail does not always have a female jailer on duty. The Jail must have a female detention officer on duty when a female is in custody.

4. Training

Training of detention officers is inconsistent at best. Several of the detention officers at the Jail had not completed the state-mandated three day training course. Although Oklahoma State law requires annual in-service training, the Jail does not provide such training. In addition, few detention officers had current CPR certification. One detention officer on each shift should be CPR certified.

The Jail has an outmoded policy and procedure manual last revised in 1982. It should be revised to reflect current standards, especially "Firearms, Ammunition and Chemical Agents" (28.05 and 29.09); "Physical Force" (29.07); and "Security Checks" (29.05). A current policy and procedure manual would be particularly helpful at the Jail as some of the detention officers lack any formal correctional training.

5. Suicide Prevention

During our July 2002 tour, our expert consultant noted serious suicide hazards at the Jail. 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. During our September 2002 visit to the Jail, we noted that the Sheriff had removed the bars from the shower stall frames and had removed the metal shower curtain rods, replacing the rods with a shower curtain that relied on velcro strips.

6. Use of Force

Chemical agents are not stored or maintained in a proper manner at the Jail. Detention officers keep canisters of chemical spray in an unlocked cabinet in the Jailer's Office, accessible to anyone. Further, supervisors do not periodically weigh the canisters to determine if an undocumented use of chemical spray has occurred.

Jail policy requires that when a detention officer uses force, be it a chemical spray or physical force, the officer must prepare a post-incident "Use of Force" report. The Undersheriff reviews all "Use of Force" reports for completeness and to determine if the detention officer was justified in deploying force. Although the use of force reporting form is sound, all detention officers involved in or witness to an incident should

independently prepare a Use of Force report, and not just the officer that used force.

7. Failure to Inform all Inmates of Jail Policies

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. The Jail does not provide an orientation to new inmates. Instead, basic rules are posted on the walls outside the cells.

8. Inmate Discipline

Written rules and regulations govern inmate conduct at the Jail. Although the rules are posted throughout the Jail, the method for dealing with infractions appears to be inconsistent. 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 individual inmates.

C. MEDICAL CARE

The provision of medical services to inmates at the Jail and the Work Center is seriously deficient and places inmates at risk of harm. Most fundamentally, the Jail has no on-site medical care providers. In addition, no medical professionals screen inmates for medical concerns or supervise or follow-up on outside medical visits. 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 intended 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 provide timely treatment to those who need it, and fails to collect accurate information to guide future care.

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. Detention officers enter the inmate's responses into a database and the information provided becomes part of the inmate's correctional file.

Although detention officers record an inmate's responses to questions concerning medical or mental health problems, neither a medical professional nor jail administrators review 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. For example, an inmate booked into the Jail on June 3, 2002 informed a detention officer that he had a seizure disorder that required medication. The inmate did not receive that medication until July 10, 2002, after he had been examined by the Jail's community-based physician.

Detention officers conduct the intake screenings in a setting which does not ensure confidentiality. The Jailer's Office is open and adjacent to the elevator lobby, where other inmates wait to be booked, as well as the main staircase of the Jail. 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 easily-spread respiratory infections like tuberculosis, may infect the general population.

Because neither the Jail nor the Work Center have on-site medical providers, have review of intake information by a medical practitioner, or have oversight by a responsible medical authority, detention officers effectively serve as the gatekeepers for medical care. This is a significant and unacceptable departure from universally accepted standards of care.

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 and the Work Center is only reactive to emergent crises.

3. Sick Call

Detention officers collect sick call requests and give them to 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. This system allows for confidentiality and reduces concern that detention officers might restrict access to medical services.

A local registered nurse conducts sick call at the Jail and at the Work Center each week or every other week and is available at all time by beeper. The nurse evaluates inmates and either provides treatment or refers the inmate to a doctor. It can take up to four weeks to see a physician. 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 and supervision from a physician. The nurse is practicing beyond her clinical scope.

The nurse does not generally conduct physical exams or take vital signs when evaluating inmates. This practice is not in conformance with medical community standards. In addition, the nurse documents little of the care provided. Detention officers or the nurse enter any information captured in the exam into the inmate's correctional file, which is accessible to all detention officers. The Jail should document all treatment in a confidential file separate from an inmate's correctional file.

The area used for medical examinations is wholly inadequate. The nurse evaluates inmates in a cluttered, dirty, converted cell on the second floor of the Jail that primarily serves as a storage room. The room is outfitted with a desk and refrigerator for the storage of medicines and vaccines. The medicine refrigerator lacks a thermometer to check that proper temperatures are maintained. Further, the vaccines stored in the

medicine refrigerator were expired, some by as much as four years. The examination room lacks any medical equipment, including an examination table or a sink. Because it is an open cell, without sufficient sight and sound separation from the rest of the Jail, there is no opportunity to maintain appropriate privacy. The setting for medical evaluations is inadequate for medical services as it is virtually impossible to properly evaluate inmates.

4. Medication Storage and Distribution

At the Jail, detention officers store all medications, including controlled substances, in a locked box in the Jailer's Office. However, the lock on the box was broken and reportedly has been for some time. Controlled substances have the potential for abuse and misuse and should be stored in a secure environment to which access is limited.

Detention officers dispense medications without adequate training or supervision. The inconsistent documentation of medical treatment and medication distribution increases the likelihood that inmates will suffer harm.

5. 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.

6. Acute Care

The Jail and Work Center lack 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. For example, according to the log kept by detention officers, an inmate was involved in a fight with another inmate on August 9, 2002. Although the inmate complained of dizziness and a detention officer noted the inmate suffered a "cut," the inmate did not receive medical attention at that time. Two days later,

detention officers transported the inmate to the local hospital where he was treated with medical staples for a laceration to his scalp. Hospital medical staff allegedly instructed the inmate to return in one week to have the staples removed. The inmate informed us that, one week later, detention officers refused to transport him to the hospital. Instead, another inmate allegedly removed the staples from the inmate's scalp with a pair of toe-nail clippers.

7. 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 need for chronic care is not hypothetical. At the time of our visit, two inmates had been incarcerated at the Jail in excess of two years. Further, as there is no oversight of the medical screening conducted at the Jail and Work Center, it is likely that there are a number of inmates in need of chronic care.

D. MENTAL HEALTH CARE

The Jail and Work Center fail to deliver adequate mental health care to its residents who need such services. Specifically, the Jail and Work Center do not provide sufficient access to care or adequate suicide prevention.

The Jail and Work Center have not contracted with a psychiatrist to provide care for the inmates. The Jail and Work Center do utilize the services of a local mental health center for crisis intervention. However, the assistance the mental health center provides is limited to determining whether an inmate already in crisis is suicidal. The mental health center does not provide any follow-up or aftercare.

Once an inmate is deemed suicidal, whether by detention officers, jail administrators, or the local mental health center, the Jail has no mechanism to monitor that inmate. Instead, detention officers, at the direction of the Sheriff and Jail Administrator, place the suicidal inmate on the floor of the cell and handcuff the inmate's hands to the bars. This treatment is cruel and inhumane. It provides no psychiatric intervention and

demonstrates a gross indifference to the medical needs of inmates.

The practice of handcuffing inmates to the bars of a cell, which is also employed to restrain inmates that pose a physical threat to others, creates a situation that places an inmate in danger. The handcuffed inmate is left to the mercy of the other inmates who are free to abuse or otherwise victimize the prostrate inmate. Given the limited number of detention officers on duty at any one time, the Jail cannot properly supervise the restrained inmate and the other inmates in the cell. For example, the Jail logbook notes that on June 12, 2002 an inmate on suicide watch was cuffed to the bars of his cell. The inmate informed the supervisor on duty that another inmate had threatened him with physical violence. Neither the supervisor nor any detention officer removed the handcuffed inmate from the cell. The practice also raises issues concerning bathroom use, access to drinking water and eating. One inmate stated that he was dependent while handcuffed to the bars on other inmates to feed him each meal, spooning the food into his mouth. Although the other inmates ministered to the handcuffed inmate's needs, they could have taken his food and consumed it themselves.

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 menu used by the Jail at the time of our July 2002 visit was inadequate and did not provide adequate nutrition. In addition, the Jail did not have written instructions on preparing medical or religious diets. A registered dietitian or medical professional should provide written protocols for the preparation of such diets.

Trustees prepare all food served 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 assigning them 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 improperly stored 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.

Major pieces of food storage and service equipment were either damaged or broken. The pieces of food storage and service equipment that were serviceable, as well as the utensils, trays, preparation equipment and pots, tended to be dirty and covered with dried food. In addition, these items were not consistently sanitized as required. We observed inmates washing dishes by hand in a manner that would not ensure the cleanliness of the dishes.

The floors in the kitchen are not properly sealed, which exposes food to insects and rodents. Broken window panes in the kitchen also permit the entry of insects. We noticed flying insects in and on a potato masher in the kitchen. We also observed roach and rodent droppings near the freezers in the basement.

2. Physical Plant

In general, the cells in the Jail are extremely dirty, odoriferous and poorly maintained.

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 a detention officer to observe what is going on in the cells, and leaves both the inmates and the officer at risk. Only one cell had light levels that met or exceeded minimally acceptable levels. At least two cells had levels of lighting that measured less than one foot candle of light.

The Jail provides adequate ventilation to circulate fresh air and prevent the transmission of communicable diseases.

However, in at least five cells, either inmates blocked the air supply vents or the vents were clogged with dust and mold. These vents must be opened and, if occluded by dust and mold, properly cleaned.

The Jail has a number of plumbing problems. In the kitchen, there exists the potential for back siphonage which could result in contamination of the potable water supply. In the cells, the showers were dirty and mildewed and several of them were leaking. In addition, the temperature of the water supplied to the cells was inadequate. Two cells lacked hot water altogether and a third cell produced water at a temperature too low to be conducive to good hygiene. Five other cells had water that flowed at temperatures high enough to cause skin burns.

The risk of insect and pest infiltration 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.

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 from a personal hygiene perspective. At present, prisoners exchange their clothing once a week. At least two exchanges of outer clothing and three exchanges of undergarments should be permitted per week. While inmates can send their wash to be laundered by trustees, inmates reported that trustees return 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 regularly holds more prisoners than it has bunk space. Inmates without a bunk sleep on mattresses placed on the floor. This practice impedes 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. As of July 23, 2002, two inmates had been incarcerated at the Jail for over two years. Not once had those inmates had the opportunity for fresh air or to exercise out of doors. 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 or the Work Center with access to legal materials.

The law library in the Courthouse offers little effective assistance to most inmates. Although the materials in the law library appear to be up to date, inmates are neither permitted access to the materials nor are detention officers trained or available to assist the inmates in legal research.

Attorneys may meet with their clients in a small visiting room on the first floor of the Jail. This visiting room presents a safety risk to the attorney as the door must be locked once the attorney enters the room with the inmate. Detention officers do

not visually monitor the meetings. Rather, an attorney must use a two-way radio to alert detention officers to unlock the door. Several local attorneys expressed hesitation about meeting with clients in the visiting room, citing safety concerns. We met with an inmate in the visiting room during one of our tours. The two-way radio provided by a detention officer did not work. It took over 15 minutes for detention officers to respond to repeated, periodic banging on the door of the interview room. In addition to the safety hazards, attorneys may meet with clients only when there are a sufficient number of detention officers on duty to permit such a meeting.

Our review of inmates' access to legal services at the Jail 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. FIRE SAFETY

1. 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 stored in the Jail.

6. Institute the use of non-combustible waste receptacles.

7. Use door keys that can be identified without the benefit of sight; train staff in their use; ensure that all keys to doors on exit routes are readily available; and maintain an extra set of "emergency keys" in the Jailer's Office to expedite evacuation of inmates in the event of an emergency.

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

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

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

11. 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 instituted 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 jail.

B. 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. Investigate 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 ensure that

there is at least one female detention officer on duty for each shift.

5. Provide detention officers with sufficient training, particularly in-service training, regarding jail operations and use of force.

6. Develop and implement policies, procedures and practices requiring each detention officer involved in a use of force incident to independently prepare a Use of Force report.

7. Develop and implement policies, procedures and practices regarding the use of physical restraints, including banning the practice of handcuffing inmates to bars as a form of suicide intervention or punishment.

8. Ensure frequent, irregularly timed and documented rounds by detention officers.

9. Install an audio communication system so that inmates can report emergency conditions to detention officers without delay.

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

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

C. 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 site-specific written policies and procedures governing the provision of health care, including medication distribution.

4. Provide for an appropriately confidential environment to conduct intake screening.

5. Ensure that inmates who need medically appropriate nutrition receive an appropriate diet as ordered by a physician.

6. Establish policy, procedures and practices for handling inmate sick call requests.

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

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

9. 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.

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

11. 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.

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

13. Develop and implement policy, procedures and practice for proper documentation and accurate, thorough and legible medical record keeping.

14. Properly store and dispose of medical supplies; dispose of expired medical supplies.

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

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

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

18. Provide a clean and private environment, equipped with the appropriate and necessary equipment, for the nurse or other medical professional to conduct medical assessments and examinations.

19. Develop and implement policies, procedures and practices for 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.

D. 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. Retain 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. 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 staff respond to sick call mental health requests in a timely manner.

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

E. ENVIRONMENTAL HEALTH AND SAFETY

1. Develop and implement policies, procedures and practices to properly store food, 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 provide for safe food handling and storage, including proper handwashing.

4. Ensure that inmates and staff who work in food service are in proper health to do so.

5. Ensure that all food service menus are reviewed at least annually by a registered dietician.

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

7. Maintain all mattresses and pillows in sanitary condition.

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

9. Provide sufficient lighting.

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

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

12. Ensure that airflow is not impeded.

13. 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.

14. 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; the training must be documented.

3. Review all policies annually; the review must be documented.

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, the Undersheriff, the Jail Administrator and the detention officers at the Jail. We understand that officials recognize 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 under separate cover. 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. Steve Hobson
Vice Chairman
Garfield County Board of Commissioners

Mr. Scott Savage
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Sheriff
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The Honorable Robert G. McCampbell
United States Attorney for the
Western District of Oklahoma