Investigation of the Fulton County Jail

U.S. Department of Justice
Civil Rights Division

U.S. Attorney's Office
for the Northern District of Georgia

November 14, 2024

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In September 2022, Lashawn Thompson died alone in a filthy cell in the mental health unit of the Fulton County Jail. Mr. Thompson, who had a history of mental illness and was unhoused, was accused of spitting at a Georgia Tech police officer and arrested on a simple battery charge, then held on an old warrant. Three months after his arrest, Mr. Thompson was found in his cell, slumped over with his head on his toilet. A medical examiner reported that his malnourished body was infested with an "enormous presence of body lice," and concluded that he was "neglected to death."

There was widespread reporting and outrage about the conditions that led to Mr. Thompson's death. But there was another death on the mental health unit—several months before Mr. Thompson's—that never made the news. An unhoused man with serious mental illness was arrested and held in Fulton County Jail's mental health unit after breaking into a building to seek shelter and warmth. On the mental health unit he stopped taking his medications, and his health declined. He was found unresponsive following a likely seizure and was transported to an outside hospital for care, but never recovered. He died in hospice a month later.

Two more people died in the Jail's mental health unit in the weeks following Mr. Thompson's death. Both men had serious mental health needs; one had a developmental disability. Both were killed by their cellmates, and both were found with their feet bound. One of them was wrapped up in bedding "like a mummy." Altogether, these four Black men with serious mental health needs died in the Jail's mental health unit in under a year.

In July 2023, we opened a civil rights investigation into conditions in the Fulton County Jail under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, and the Violent Crime Control and Law Enforcement Act, 34 U.S.C. § 12601. Within weeks of opening our investigation, six more Black men had died in the Jail. One person was found unresponsive in his cell after his cellmate strangled him. And days later, tensions in the Jail erupted in violence: within 24 hours, five units in the Jail saw violent assaults, at least seven people were stabbed, and one person was killed.

After an extensive investigation, we find reasonable cause to believe that Fulton County and the Fulton County Sheriff's Office violate the constitutional and statutory rights of people incarcerated in the Fulton County Jail.

Fulton County Jail fails to adequately protect incarcerated people from the substantial risk of serious harm from violence, including homicides and

stabbings by other incarcerated people. Serious violence has harmed people with mental health needs and other vulnerable populations. Assaults are carried out with weapons fashioned from Jail fixtures and are made possible by physical deficiencies in the Jail environment, such as unlocked doors. The Jail has long had inadequate practices for reporting and responding appropriately to sexual violence. Poor supervision, poor classification practices, and inattention to the maintenance of the Jail are major contributors to the unacceptable violence.

Fulton County Jail deputies and detention officers use force against incarcerated people without adequate justification. This includes a practice of deploying Tasers against incarcerated people without reasonable cause. Understaffing in the facility contributes to the excessive use of force, as do poor policies, training, and the failure of supervisors to identify, correct, and discipline officers.

Fulton County Jail living conditions do not meet basic constitutional standards. The Jail has allowed housing areas to fall into a state of serious disrepair, with standing water collecting in living areas, exposed wires, pests poorly controlled, and deficient services for providing clean clothing and sheets. These conditions are dangerous and unsanitary. Meals are served to the incarcerated population in an unsanitary manner and do not meet nutritional standards. As a result, people in the Jail have suffered harms from pest infestation and malnourishment.

Medical and mental health care in the Fulton County Jail do not meet constitutional standards. The Jail impedes access to medical and mental health care through a lack of security staff. Medication administration gaps lead to medical and mental health complications and injuries. When medical emergencies occur, the Jail fails to provide appropriate medical care. And although people with mental health needs are overrepresented in the Jail population, the Jail environment exacerbates symptoms of mental illness. The Jail does not adequately protect people from a risk of suicide and does not adequately treat serious mental health needs.

Restrictive housing conditions in the Jail pose a substantial risk of harm, including acute mental illness and self-injury, and restrictive housing practices are discriminatory and unlawful. The Jail places people in isolation without adequate monitoring for decompensation. Restrictive housing placement processes discriminate against people with mental health disabilities in violation of the ADA. Jail officers punish people with long terms in restrictive housing without adequate due process protections.

Georgia is one of only four states where the juvenile justice system's jurisdiction ends at 16. There are 17-year-old boys and girls at the Jail, many of whom spend over a year in custody. These children are subjected to violence and excessive force, experience sexual abuse, and are denied adequate mental health care. The Jail's use of restrictive housing uniquely harms these children because they are psychologically different from adults, making their time in isolation much more damaging, exacerbating the onset of mental illness, increasing the risk of suicide, and causing long-lasting trauma. **The Jail also fails to provide special education services to 17-year-old boys and girls who are entitled to them,** in violation of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. §§ 1400–1482.

None of these problems are new. And despite widespread awareness of these issues, the unconstitutional and illegal conditions have persisted. Vulnerable populations—including children, those who are gay or transgender, people with medical and mental health needs, and others—often bear the brunt of these conditions. Deaths and other harms have continued. In April 2024, an incarcerated person died in the Jail after being stabbed 20 times. Less than a week later, a man was found dead in his cell, likely hours after his death.

The report that follows explains the scope of our investigation and provides background information about the Jail. The report describes the constitutional and statutory violations that we found in the Jail, including the legal framework applied, the unacceptable conditions identified, and the deficient practices that led to the problems. We end by identifying changes that need to be implemented to fix the violations and prevent further harms.

BACKGROUND

1. Jail Population

Fulton County is the largest county in Georgia with more than one million people, just over 10% of Georgia's total population. It includes most of the city of Atlanta.

The Fulton County Jail is the secure detention facility for people awaiting resolution of criminal charges in Fulton County. The entities responsible for the Jail are the Fulton County Sheriff's Office, which operates the Jail, and Fulton County, which funds the Jail. The Fulton County Sheriff is Sheriff Patrick "Pat" Labat. Sheriff Labat took office in January 2021. The seven-member Fulton County Board of Commissioners is the governing body for Fulton County. Through the Board of Commissioners, Fulton County provides funding for the Jail and maintains the Jail facilities. The County sets funding levels for the Sheriff's Office, but the Sheriff is an independent, elected official whose authority is defined in the Georgia constitution.

The Fulton County Jail has four buildings: the Main Jail and three annex facilities (collectively, the "Fulton County Jail" or "Jail"). The Jail population is nearly all people with pending criminal charges. In July 2024, only 2% of the Jail population was serving a criminal sentence. Thus, nearly all of the people held in the Jail are not there as the result of being found guilty of a crime.

People spend long periods detained in the Jail. According to an analysis commissioned by the County, nearly one quarter of the population in the Jail on January 20, 2023 (873 people) had been held a year or more. We did our own analysis of the Jail's population as it existed on a random day in March 2024, and found the average length of stay was 279 days. We identified 245 people who had been in custody for two years or more, 14 people who had been in Jail for over five years, and one who had been there more than a decade. These lengthy periods of confinement are more consistent with time spent in prisons than in a jail meant for pretrial detention. Many people in the Jail's population have repeat stays in the Jail. In June 2023, 764 people booked into the Jail, or 41% of bookings that month, had one or more prior bookings.

Black people are overrepresented in the Jail as compared to the Fulton County population. According to Jail census data from March 2024, 91% of people incarcerated in the Jail are Black, compared to just 45% of the Fulton County population. Nine percent of people incarcerated in the Jail are white, and less than 1% are Hispanic, Latino or Asian/Asian American. In comparison, the population of Fulton County is 38% white, 8% Hispanic or Latino, and 8% Asian/Asian American.

A significant portion of the Jail's population has an identified mental illness. By September 2023, 380 people booked into the Jail in June 2023—20% of bookings that month—were placed on the Jail's mental health caseload. According to the Sheriff, 62% of people who enter the Jail have been identified as having mental health and/or substance use disorder needs. The Jail's mental health provider also identified 272 persons in custody at the Jail in September 2023 who had a serious mental illness.

Exacerbating challenges facing the population with mental illness, the demand for competency restoration services has outpaced the availability of such services in Georgia. When people charged with violent felonies are found incompetent to be tried and meet criteria for inpatient treatment, they are often held in the Jail for long periods awaiting placement in a state-run hospital.[1]

Because Georgia is one of only four states where the juvenile justice system's jurisdiction ends at 16, all 17-year-olds, regardless of offense, are charged as adults.[2] Along with 17-year-olds who have been charged as adults at 17, the Jail houses 17-year-olds who, because of the nature of their charge or a court order, were charged as adults at 16 or younger. These children are moved to the Jail when they turn 17. In March 2024, there were 37 17-year-old boys in the Jail, and one 17-year-old girl. The average stay for people who enter the Jail at 17 is 392 days.

The Jail has struggled to address a ballooning population and overcrowding. At a Board of Commissioners meeting in May 2022, the Sheriff reported that due to overcrowding, there were 366 people sleeping in temporary beds on the floor of the Jail. In a July 2022 Board of Commissioners meeting, the Sheriff advised that the total population in the Jail was about to reach 3,400, an increase of 600 from the year before, and a Fulton County Commissioner described the overcrowding in the Jail as "inhumane." The increased Jail population and strain on Jail facilities are, in part, a result of court delays following the COVID pandemic.

In an attempt to address the overcrowding, the County sought to speed up cases in the criminal courts, including by adding new judges and expanding remote access to the

---

[1] *See* Andy Miller & Rebecca Grapevine*, Long Wait for Justice: People in Jail Face Delays for Mental Health Care Before They Can Stand Trial*, The Current (June 11, 2022), https://thecurrentga.org/2022/06/11/long-wait-for-justice-people-in-jail-face-delays-for-mental-health-care-before-they-can-stand-trial/ [https://perma.cc/R7J7-EPTJ].

[2] Members of the Georgia General Assembly have introduced measures to raise the age of juvenile-justice jurisdiction to include 17-year-olds; although a recent bill to do so passed the Georgia House of Representatives, it was not enacted. *See* Raise the Age Act, H.B. 462, 157th Gen. Assemb., Reg. Sess. (Ga. 2023), https://www.legis.ga.gov/legislation/64535 [https://perma.cc/WPR7-DT7S].

courts. The Sheriff's Office also created its own program, called the "Inmate Advocacy Unit," to identify people in the Jail who need their criminal cases expedited or who could be appropriately released. According to the Sheriff, as of September 2023, the Inmate Advocacy Unit had secured the release of 78 people.

Fulton County and the Sheriff's Office have also transferred many Fulton County detainees to other counties and jail facilities, at significant cost. As of March 2024, Fulton County and the Sheriff's Office were housing 267 people in other counties and 388 people at the Atlanta City Detention Center (ACDC) pursuant to a lease with the City of Atlanta.

Over the past year, the Jail's population has declined. In mid-August 2024, the total Jail population was 1,822, and the Main Jail population was 1,580, both a decline of about 1,000 people from the year before. The Main Jail's population declined in part because housing units were uninhabitable. In August 2024, a presentation to the Board of Commissioners showed that 630 beds at the Main Jail were off-line: six zones (216 beds) had sewage backups, six zones (216 beds) were undergoing repairs, and six zones (198 beds) were unavailable due to fire restoration or were awaiting parts for repair of a critical safety feature. The population will likely increase when these units re-open.

2. "The [J]ail is a crisis"

In the wake of Mr. Thompson's death in September 2022 and the outcry surrounding it, the County and Sheriff's Office made public efforts to remedy conditions inside the Jail, particularly those that contributed to Mr. Thompson's death. At a Board of Commissioners meeting in April 2023, one Commissioner stated, "[T]he jail is a crisis, it's in a crisis situation. . . . [Mr.] Thompson died, in part, because of the overall crisis that the jail is in." During that meeting, the Board of Commissioners approved $5.3 million in emergency funding for the Jail to clean medical and psychiatric observation areas, improve security, and consult an emergency management firm. The funding included the Sheriff's request for $2.1 million to a private company to put digital wristbands on people incarcerated in the Jail and monitor their biometric data. But the County rescinded funding for this contract five months later, after learning that only 15 wristbands were in use at the Main Jail.

The Sheriff accepted resignations from three high-ranking members of the Sheriff's Office, suggesting that they were responsible for the circumstances that led to Mr. Thompson's death. He also indicated that he might seek a new healthcare provider for the Jail. But the Jail's private healthcare provider, NaphCare, announced that it planned to terminate the contract because of violence and unsafe working conditions in

the Jail. Ultimately, the dispute was resolved, and NaphCare remains the current healthcare provider.

In November 2023, reports surfaced about misuse of the Jail's Inmate Welfare Fund. The Fund comes from money incarcerated people and their families spend on phone calls and commissary items (such as food, clothing, and hygiene items), and, by County law, was to be used for the welfare of the incarcerated population. Instead, money intended to benefit the incarcerated population went to staff benefits (e.g., Honey Baked Ham gift cards and a bounce house rental), community events, vehicles, and Tasers. In response, the Board of Commissioners abolished the Inmate Welfare Fund and the Sheriff's Office lost direct access to millions of dollars that had been reserved for the incarcerated population's benefit.

Deaths and serious injuries remain prevalent at the Jail. Thus far in 2024, three men at the Main Jail have died: one of a suspected drug overdose, one by stabbing, and one by suicide.

3. Our Investigation

Opened in July 2023, our investigation initially focused on six issue areas—living conditions, protection from harm, use of force, medical and mental health care, and discrimination against people with psychiatric disabilities—under CRIPA and the ADA.[3] In April 2024, we expanded our investigation under CRIPA and 42 U.S.C. § 12601 to encompass three additional areas: restrictive housing, disciplinary practices for incarcerated people, and special education services for young people.

We gathered information from multiple site inspections, interviews with current and former jail and medical and mental health staff, interviews with incarcerated and recently incarcerated people and family members, and extensive document review, including jail and medical records. We observed Fulton County Board of Commissioner Meetings at which measures relating to the Jail were discussed. And we met with organizations that advocate for the incarcerated population.

Expert consultants accompanied us during site inspections and interviews. They have expertise in jail operations, use of force analysis, jail sanitation, nutrition, and the provision of medical and mental health care in jail settings. They have decades of experience working inside jail settings as corrections professionals, as well as experience evaluating jail systems and identifying problems. We also consulted an

[3] We received complaints that the Fulton County Jail was discriminating against people with disabilities, and we accepted and investigated these complaints under Title II of the ADA, 42 U.S.C. §§ 12101 *et seq*.

expert in implementation of the IDEA in correctional facilities, and a team of data experts who helped us analyze Jail data on violence, use of force, and contraband.

We thank both Fulton County and the Fulton County Sheriff's Office for their cooperation with this investigation.

4. The Jail Facilities

The Fulton County Jail consists of the Main Jail at 901 Rice Street in Atlanta, and the annexes: the South Fulton Jail (South Annex) in Union City; the Alpharetta Jail (North Annex) in Alpharetta; and the Marietta Annex, a short distance from the Main Jail in Atlanta (collectively, "Fulton County Jail" or "Jail").[4]

4.1 Main Jail

The Main Jail was built in 1989. Originally designed to house up to 1,125 people in single-person cells, the facility began double-celling people almost immediately after its opening, and now has 2,254 beds. The most recent staffing analysis, conducted in 2015, found that the most the Main Jail could accommodate based on its operations (staffing, programming, and services) was 1,868 people. In July 2023, there were 2,669 people in the facility, but in mid-August 2024, with multiple housing areas off-line pending repair, the population was 1,580 people.

The Main Jail is the central booking area for the County. It has an Intake Unit and a Medical Unit with medical and psychiatric observation housing for men and women. Seventeen-year-old girls in the Sheriff's custody reside in the women's medical unit.

The Main Jail consists of a three-story low-rise structure joined to an elevator tower, providing access to two housing towers. The North Tower has seven floors for housing, and the South Tower has six. Each housing unit has eight zones arranged in a horseshoe around an elevated control tower. The housing zones have between 16 and 18 cells, split over two tiers. The cells open into a dayroom with tables bolted to the floor, phones, a kiosk (for ordering commissary and submitting grievances, among other things), and a shower on each tier.

[4] Fulton County holds people in other detention facilities due to capacity constraints, including through agreements with Cobb, Forsyth, and Oconee counties. The County currently has a lease agreement with the City of Atlanta to house people, including nearly all of its female population, at ACDC. Unlike the arrangements with other counties, the Fulton County Sheriff's Office is responsible for staffing ACDC and providing daily care for the detainees housed there. ACDC was not a focus of this investigation, and we did not inspect that facility.

4.2 South Annex

The South Annex in Union City, Georgia, is located about 20 miles south of the Main Jail. It has 285 beds, and as of mid-August 2024, it housed 146 people. It held Fulton County's female population until December 2022, when Fulton County and the Sheriff's Office temporarily shuttered the facility and relocated the women to ACDC.

The South Annex re-opened in July 2023. The Sheriff's Office initially said its use of the South Annex as temporary housing for persons from the Main Jail would allow repairs on housing units and relieve population pressure there. But when we visited the facility in October 2023, staff told us that the facility was for the more violent and harder-to-manage population and people being disciplined for violating jail rules. It also has a unit specifically for 17-year-old boys.

The housing area in the South Annex is a single floor divided into east and west units. Each unit has a central control booth with four pods arranged in a horseshoe. The pods have between 5 and 10 cells, distributed across a bottom and top tier. Some cells are two-person cells, and others house up to eight people. The cells open onto a dayroom for each pod, with fixed tables, a shower, phones, and a kiosk.

4.3 North Annex

The North Annex is located 25 miles north of the Main Jail in Alpharetta. It has 50 beds and as of mid-August 2024, held 27 people.

The North Annex has an intake and reception center, and separate housing areas for men and women. Fulton County and the Fulton County Sheriff's Office house detainees there, particularly people who need separation from the jail population because of the nature of their charges or conflicts in the Jail.

4.4 Marietta Annex

The Marietta Annex is located a short distance from the Main Jail on Marietta Boulevard. It has 80 beds and as of mid-August 2024, 69 people. The facility houses "trustees," incarcerated people who work in the Jail providing cleaning and meal preparation services for about a dollar a day. There is also a small population of people who participate in rehabilitative programming.

The Marietta Annex has one control booth at the center of four large rooms. Two of these rooms are dormitory-style housing units with bunk beds. The other two rooms are used for officer training and some programming for the incarcerated population.

CIVIL RIGHTS VIOLATIONS IDENTIFIED

We find reasonable cause to believe that Fulton County and the Fulton County Sheriff's Office violate constitutional and federal statutory rights of people incarcerated in the Fulton County Jail.

Protection from Harm

The Fulton County Jail does not adequately protect incarcerated people from a substantial risk of serious harm from violence by other incarcerated people inside its facilities. Violent acts by incarcerated people against other incarcerated people in the Jail include homicides, stabbings, and sexual abuse. People with serious mental illness, people identified as gay or transgender, and young people are particularly vulnerable to violence in the Jail. Poor supervision, classification, Jail maintenance, contraband control, and investigations contribute to the unacceptable violence.

Correctional officials "have a duty . . . to protect prisoners from violence at the hands of other prisoners."[5] Jail officials violate the Eighth and Fourteenth Amendment rights of those in their custody when they are deliberately indifferent to an excessive risk of violence.[6] "[O]ccasional, isolated attacks by one prisoner on another may not constitute cruel and unusual punishment, [but] confinement in a prison where violence and terror reign is actionable."[7] Deliberate indifference may be established where "serious inmate-on-inmate violence [is] the norm or something close to it."[8]

Failure to classify or separate violent from non-violent people can amount to deliberate indifference and create an excessive risk of violence to the incarcerated population. The failure to adequately supervise and monitor incarcerated people, provide sufficient

[5] *Farmer v. Brennan*, 511 U.S. 825, 833 (1994) (citation omitted); *see also Wilson v. Seiter*, 501 U.S. 294, 303 (1991) (describing "the protection [an incarcerated individual] is afforded against other inmates" as a "condition of confinement" under the Eighth Amendment).

[6] The rights of the Jail's pretrial detainees, who have not been convicted of a crime, come from the Fourteenth Amendment's Due Process Clause. Those protections are at least as great as the Eighth Amendment protections available to convicted prisoners in the Jail. *See Bell v. Wolfish*, 441 U.S. 520, 545 (1979); *Marsh v. Butler Cnty.*, 268 F.3d 1014, 1024 n.5 (11th Cir. 2001) (en banc), *abrogated in part on other grounds by Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007).

[7] *Purcell ex rel. Est. of Morgan v. Toombs Cnty.*, 400 F.3d 1313, 1320 (11th Cir. 2005) (citation omitted).

[8] *Marbury v. Warden*, 936 F.3d 1227, 1234 (11th Cir. 2019) (quoting *Purcell*, 400 F.3d at 1322).

staffing, confiscate dangerous contraband, and investigate misconduct may also constitute deliberate indifference and expose incarcerated people to a substantial risk of serious harm.

1. The Jail exposes incarcerated people to extreme violence and the risk of serious harm.

Leadership at the County and Sheriff's Office are aware of the violence in the Jail and have publicly decried it. Yet they have failed to take adequate action to address the crisis, and homicides, stabbings, and other violent acts continue at dangerous levels.

1.1 Killings, stabbings, and assaults are common in the Jail.

In less than 24 hours in August 2023, at least seven people were stabbed and one was killed at the Jail. The violence spanned five units and three floors. It started at 11:30 p.m., when officers discovered that people from one housing zone had opened their zone door and entered another zone to assault people. The next day at 2:21 p.m., an officer heard screaming coming from a restrictive housing unit on the 7th Floor. He found one incarcerated person with blood on his shoulder, and a second incarcerated person on the floor in a pool of blood; that person died from multiple stab wounds. The locking mechanism for the doors in that unit had been broken, and while officers tried to secure the scene, incarcerated people kept trying to assault each other. One incarcerated person had to be treated for exhaustion. Almost simultaneously, at 2:26 p.m., a sergeant found another incarcerated man with blood on his face and chest in another unit. The victim required emergency medical transport for multiple puncture wounds to his face and back following an attack. At 9:15 p.m., an officer tased someone to break up a fight; medical attention for the Taser deployment was delayed because the Jail was "overwhelmed with stretcher calls."

From 2022 to the present, six incarcerated people have died in violent attacks at the Jail:

- In April 2024, a 37-year-old man died after being assaulted by another incarcerated person. Medical staff found the victim lying at the entrance of the housing unit with multiple wounds and covered in blood. The victim was stabbed 20 times with a nine-inch weapon and sustained stab wounds to the head, neck, torso, arms, and legs.

- In August 2023, a 23-year-old man died when he was stabbed multiple times by one or more other incarcerated people, as described above. The victim was found lying face down on the floor of the dayroom in a pool of blood with deep lacerations to his upper back. He had stab wounds to his head, neck, abdomen, back, and arms.

- In August 2023, a 34-year-old man died from strangulation. The victim was found unresponsive in his cell.
- In November 2022, a 32-year-old man died in the mental health unit after his cellmate allegedly assaulted him. The victim's feet were bound, and he had a bloody nose and "raccoon eyes," a sign of head trauma. Medical responders reported that his body was cold to the touch.
- In October 2022, a 20-year-old man died in the mental health unit after being strangled by his cellmate. The victim was found wrapped in a county-issued blanket with straps tied around his ankles, knees, waist, chest, and neck.
- In September 2022, a 33-year-old man died after being stabbed by another incarcerated person. The victim had a stab wound between his shoulder and neck and a deep gaping wound above his eyebrow.

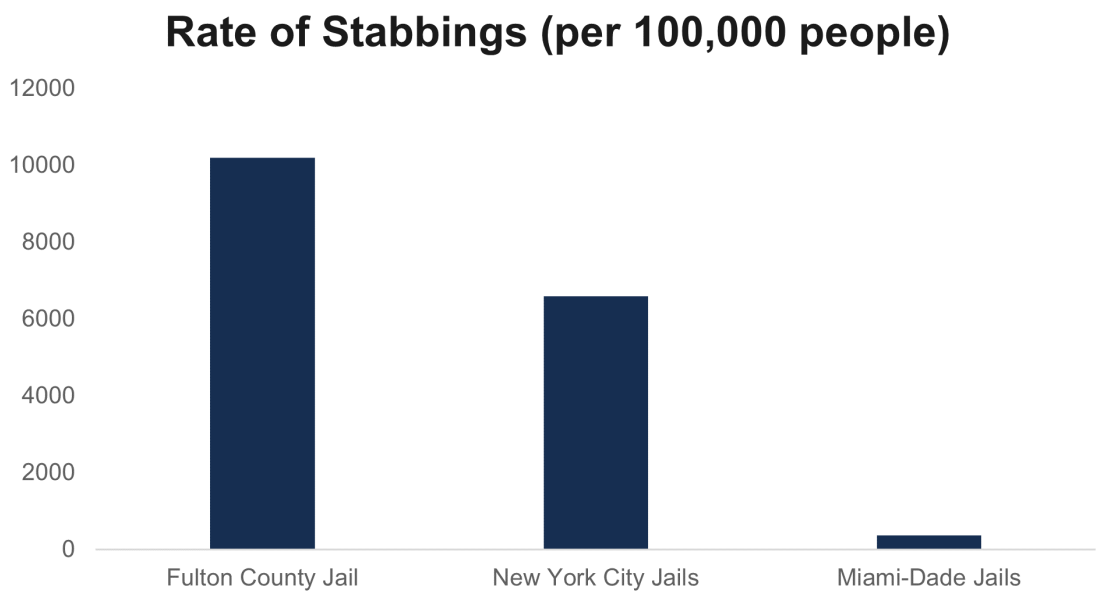
A significant percentage of the homicide victims had one or more serious mental illnesses. All had been incarcerated for months or years: Their average length of stay in the Jail was 253 days; the longest stay was 654 days. All six victims were Black men. Half of the homicides at the Jail involved sharpened weapons.

Assaults and stabbings with man-made "shanks" are a feature of life at the Jail. In May 2024, four incarcerated people entered another man's cell and stabbed him eight times in his sleep. Days before the April 2024 stabbing death, another incarcerated man was stabbed in the head and did not seek medical treatment for ten hours because of ongoing threats on his life. One of the 2023 homicide victims was injured in three previous stabbings at the Jail.

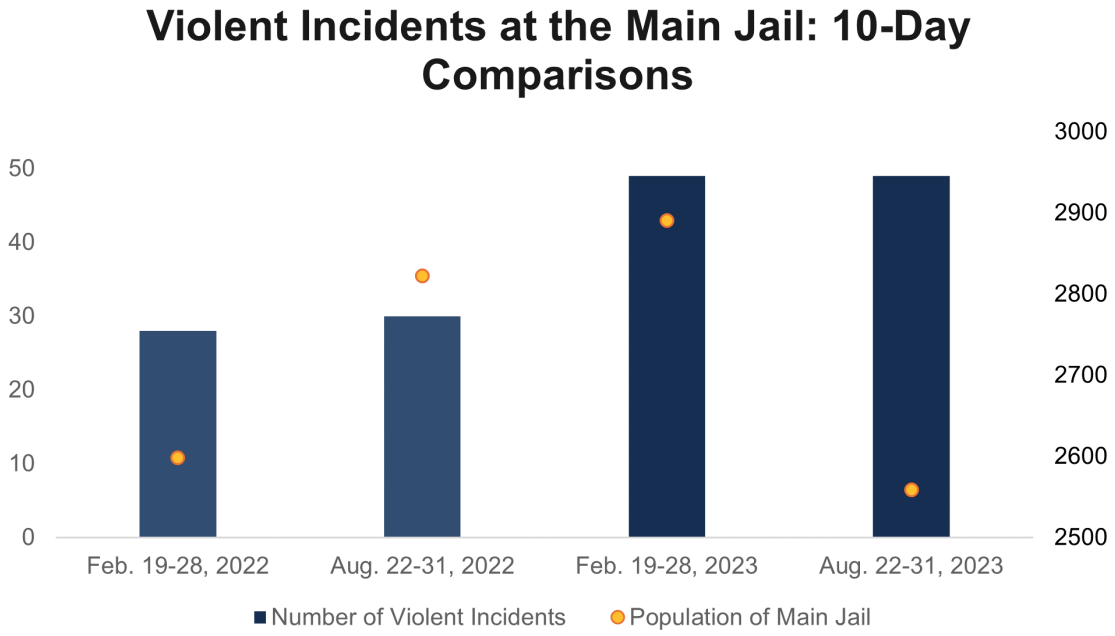
"I had knives put to my throat, and I had to call my mom telling them, please wire somebody some money or I'm going to be killed. Nobody should be subject to that at a jail where you're supposed [to] be waiting to get your day in court."

- **Fulton County Jail detainee at September 2023 meeting of Board of Commissioners**

According to Sheriff's Office reports, in 2023 there were 1,054 assaults on incarcerated people and 314 stabbings in the Jail. In 2023, the rate of stabbings at the Jail was 1.5 times the rate of stabbings in the New York City Jails and more than 27 times the rate of all incidents involving an edged weapon in the Miami-Dade County Jails. The Jail had as many stabbings in a single month as the Miami-Dade County Jails—which house 1.5 times more people—had all year.



We also analyzed violence in the Jail by examining violent incidents in the same two months in consecutive years. More people were injured in violent incidents during February and August 2023 than during February and August 2022. Generally, violence in the Jail appears to have increased from 2022 to 2023. And from February to August 2023, the amount of violence remained high, even as the population declined.



In the first nine months of 2023, there were over 200 emergency transports of incarcerated people to an outside hospital for injuries from assaults. In one case in August 2023, medical staff at the Jail treated an incarcerated person after several other

incarcerated people reportedly stabbed him in the face and beat him. He reported pain and difficulty breathing, and medical staff sent him to the hospital for a possible rib fracture. In July 2023, an incarcerated person was sent to the hospital after another assault by multiple people. He had nine total stab wounds and required care for complex lacerations and to rule out a tendon injury to his hand. In May 2023, an incarcerated person was sent to the hospital for injuries to his scalp, chest, arm, thigh, back, and hand from a stabbing. His assailant used a 16-inch shank in the attack.

There were more emergency medical transports from the Jail for injuries from assaults over this nine-month period in 2023 than there were in all of 2022 (233 emergency transports following assaults from January 1 to September 23, 2023, compared to 199 emergency transports following assaults in 2022).

In some cases, officers have allowed or initiated violence at the Jail. In February 2023, a detention officer opened a door to let an incarcerated person leave his assigned housing zone and enter another housing zone, where he and multiple others attacked someone. Although the officer witnessed the assault, she did not report it or get medical help for the victim, and she later sprayed cleaning solution on the blood. The officer was terminated and criminally charged for her conduct. In April 2022, a Jail deputy was fired after he opened an incarcerated person's cell, brought him to another person's cell, then stood by and watched as the two men fought.

When a federal court ended a prior consent decree over conditions at the Jail nine years ago, the Sheriff's Department had reported two physical assaults with a weapon in the Jail in January 2015 and three such assaults in December 2014. By comparison, there were seven stabbing incidents in January 2024 and ten stabbings in December 2023—over three times the reported number of assaults with any type of weapon at the end of the court's oversight.

There is also reason to believe that the Sheriff's Office data does not capture the true extent of the violence inside the Jail. Not all violent incidents at the Jail are reported and appropriately documented. For example, in September 2023, we advised counsel for the County and Sheriff's Office of a report that an incarcerated person had been stabbed the week before and required medical attention. In response, the Jail's medical staff met with this person and confirmed that he had multiple stab wounds to his chest, back, and hands. No incident report documents this assault, and the person told medical staff that although he reported the stabbing to an officer, he was not taken to medical for treatment until we alerted counsel of the incident. We also identified instances of incarcerated people transported to an outside hospital for injuries consistent with violent assaults without incident reports documenting what had occurred.

Low staffing levels in the Jail, described in Section 3, contribute to the failure to report many violent incidents. Another factor is victims' fear of retaliation for disclosing violence. For example, in March 2024, a victim "suffered through the night" until the next morning, because he was afraid to report that he had been stabbed. Although this victim ultimately reported the assault, he refused to identify the assailants, saying that doing so would put him in danger anywhere in the Jail. In a separate incident that month, an incarcerated man with multiple puncture wounds to his back and arm denied having been assaulted, instead insisting he fell out of bed.

1.2 The Jail fails to protect vulnerable populations from violence.

People with serious mental illness, people identified as gay or transgender, and younger people with less experience in the jail system are particularly vulnerable to violence in the Jail.

As mentioned, two people with serious mental illness were killed by cellmates in the Jail's mental health unit in the fall of 2022; one of these victims had an intellectual disability. In February 2023, five serious assaults occurred against people in the mental health unit by their cellmates. In some cases, people perceived as mentally ill or who act strangely are forced out of housing areas by other incarcerated people. In April 2023, an incarcerated person reported that he feared for his life, because he heard people on the zone announce, "these mental health n[*****] going on the door tonight," and believed that he and others with mental health needs would be forced to leave the housing area.

People perceived to be gay or transgender also have a high risk of experiencing violence in the Jail. We identified multiple instances of incarcerated people being targeted for violence based on perceived sexual or gender identity. In April 2024, an incarcerated person reported that another incarcerated person assaulted him because he was gay. The victim had visible scratch marks, bruises, and cuts from the assault. In October 2023, a person reported to officers that he was not safe because people in his housing area were accusing him of being gay. He was stabbed later that day. That same month, a person who presents as a transgender woman and uses a female name was stabbed while asleep on a temporary bed (a "boat") on the floor of a housing unit. The victim told an investigating officer that the assailants targeted her because of her sexuality and that it was a hate crime. She shared with us that her assailants called her "faggot," "bitch ass," and "gay" while attacking her. In June 2023, an incarcerated person reported that multiple assailants attacked him in his sleep because of his sexuality, telling officers "I am bisexual, and it has gotten out and now everyone is at my head." He said that he was moved after being assaulted on another floor for the same reason. The officer observed, "one of his fingers [is] broken, his elbow looks out of place, and he has several b[ruises] on his face."

Additionally, 17-year-old boys at the Jail have a substantial risk of experiencing violence, particularly in the period shortly after their arrival. We identified a pattern of 17-year-olds "initiating" other newly admitted boys to the Jail with violent assaults, including five cases where boys were seriously assaulted within two weeks of admission to the Jail and required outside medical care for their injuries. In June 2023, a 17-year-old boy submitted a grievance saying he was not safe, as "[other 17-year-olds] try to make every new person . . . crash out . . . having people fight me and try to stab me." Despite only around 30 17-year-old boys living in the Jail, they were assaulted and required off-site emergency medical care on multiple occasions, including in incidents in February, April, and June 2023, when 17-year-old boys were choked, stabbed, and beaten.

In September 2023, an incarcerated adult attacked a 17-year-old boy who was living in a unit with adult men, despite Jail policy requiring separation of 17-year-olds from adult detainees.

1.3 The Jail leaves incarcerated people unprotected from sexual violence.

There is a substantial risk that people incarcerated in the Fulton County Jail will experience sexual abuse by other incarcerated people. Poor supervision, poor classification practices, the proliferation of weapons inside the Jail, and poor conditions, including faulty door locks and lighting, contribute to an environment in which sexual assaults can and do readily occur.

The Jail has inadequate systems for reporting sexual harm and misconduct that make it difficult to quantify the level of sexual violence and to stop it. The National Standards for the Detection, Prevention, and Punishment of Prison Rape, 28 C.F.R. § 115 ("PREA standards"), require jails to distribute clear, accurate information to incarcerated people about the jails' zero-tolerance policy for sexual abuse and how to report sexual misconduct. Typically, jails share this information in handbooks and posted signs. Jails should also provide multiple internal ways for incarcerated people to privately report sexual abuse, as well as access to an outside agency that will receive and forward reports of sexual misconduct to agency officials. This access often comes from a no-cost telephone line to a knowledgeable and supportive third-party organization (commonly known as a "PREA hotline"). Jails should have a "PREA Coordinator," who is an agency-wide administrator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with PREA.

These measures are necessary and appropriate in light of the well-established risk of sexual violence inside jails, and the risk that it would otherwise be unreported. Yet the Jail does not consistently implement accepted measures to identify and respond to sexual abuse.

The Jail's handbook has information about PREA and how to make a complaint about sexual misconduct, but the handbook is not distributed to incarcerated people upon admission. An electronic copy of the handbook is available on kiosks inside the housing units, but many of these kiosks were missing or inoperable during our inspections.

Since August 2023, the Jail has a new PREA Coordinator who has implemented some new PREA policies.[9] The PREA Coordinator advised us that people can report sexual misconduct to her by phone or to a rape crisis center associated with Grady Hospital, but neither option is free.[10]

The other options for reporting are to file a grievance (electronically on a kiosk, which may be inoperable), have a third-party such as a family member or attorney submit the report, or report to jail staff inside the housing units. In several cases, however, incarcerated people have reported that officers refused to accept or take seriously complaints involving sexual assault. For example, in February 2023, a woman reported that she alerted staff to a sexual assault the morning after it happened, but staff did nothing to help her. The PREA Coordinator was not alerted until three days after the reported assault, and the woman did not go to the hospital for a sexual assault examination until four days after the reported assault.

The Jail's poor recordkeeping practices with regards to sexual abuse also make it difficult to state the volume of such incidents. We originally asked for all complaints made pursuant to or falling under PREA, which would include all complaints of sexual abuse and sexual harassment,[11] plus all PREA investigations, findings, and related

[9] These policies, Fulton County Sheriff's Office Policy No. 400-12.01 ("PREA Zero Tolerance Policy Towards Sexual Abuse and Sexual Harassment") [https://perma.cc/4T72-JBLL] and No. 400-12.02 ("PREA Investigation Procedures") [https://perma.cc/3SCN-2U95], are posted on the Sheriff's Office website: www.fcsoga.org [https://perma.cc/W96Y-29H7].

[10] The Jail handbook also states that incarcerated people can report sexual abuse or harassment to the Grady Rape Crisis Center. Most rape crisis centers are required to maintain confidentiality, and so would not qualify as an external reporting entity under the PREA standards. We did not identify any instances where anyone at the Jail acknowledged receipt of a complaint from a PREA hotline or opened an investigation based on such a complaint.

[11] The Fulton County Sheriff's Office's PREA policy defines sexual abuse and sexual harassment. Sexual abuse of an incarcerated person by another incarcerated person includes nonconsensual contact between penis and vulva or penis and anus; contact between mouth and penis, vulva, or anus; penetration of anal or genital opening by a hand, finger, object, or other instrument; and intentional touching, either directly or through the clothing, of genitalia, anus, groin, breast, inner thigh, or buttocks, excluding contact incidental to a physical altercation. Sexual harassment includes non-contact behavior that subjects another person to verbal or written statements or gestures of sexual or romantic nature, and creating an

documents, as well as all reports of investigations by the Sheriff's Office into misconduct of any kind inside the Jail. Yet we initially received just one PREA complaint file for 2022, and two PREA complaint files for 2023. In reviewing incident reports from the Jail, we found many allegations of sexual abuse and harassment that were referred to PREA investigators but were not identified to us as PREA incidents. Requests for additional documentation regarding these incidents yielded little additional information.

For example, in March 2023, an incarcerated person reported bleeding, soreness, and pain in his rectal area, and alleged that he had been raped twice by the same person. A sergeant submitted an incident report stating that the victim was transported to Grady Hospital for an examination and recommending that the report be turned over to the PREA investigator for further investigation. Despite requests, we received no documentation reflecting any additional investigation or the results of the sexual assault examination.

The PREA Coordinator is working to improve file management and the Jail's tracking of PREA complaints moving forward, and we received a number of sexual abuse investigation files in a recent document production.

Even though the records we have are likely incomplete, they show a pattern or practice of sexual abuse in the Jail. In our review of incident reports and other documentation from January 2022 to June 2024, considering only incidents where both the alleged perpetrator and victim were incarcerated, there were 99 total allegations of sexual misconduct: 78 were allegations of sexual abuse, and 21 of sexual harassment.

The Jail did not have posted signage on how to report sexual violence until 2024. Given that victims of sexual abuse are generally reluctant to report it, and the lack of adequate systems in place for people to report such incidents or seek protection, the true volume of sexual violence in the Jail is likely much greater.

Multiple incidents reviewed illustrate the risk of sexual violence in the Jail. In March 2024, an incarcerated person told medical staff he had been sexually assaulted; he provided a written statement alleging that two incarcerated people cornered him in a room and forced him to perform oral and other sex acts. In January 2024, an incarcerated person reported that his cellmate had sexually assaulted him over the course of three days, and that his cellmate had bound his hands and feet together whenever they were in the cell. In May 2023, a man reported that his cellmate was

---

atmosphere of intimidations, hostility, or offensiveness as perceived by the individual who observes the sexually offensive behavior or act.

forcing him to engage in sexual activity and had threatened him with a sharpened weapon inside the cell.

In September 2022, days after turning 18, an incarcerated person reported that another incarcerated person assaulted him by burning him in the face and ordering him to open his mouth. Officers observed burn marks on the victim's face. He also sent mental health a suicide note stating that when previously housed in the youthful offender unit, three people had entered his cell, held him down, and groped him. He said he did not report this incident sooner because he was afraid he would be assaulted again, as the doors in that unit were broken. The victim was relocated, but within weeks, he reported that his new cellmate sexually abused him by forcing him to provide and receive oral sex and to perform other sex acts.

As described in Section 5.2 below, when the Jail does investigate sexual abuse reports such as these, the investigations are often inadequate.

1.4 Violence in the Jail causes long-lasting trauma.

The harm from the violence inside the Jail is lasting and extends beyond physical pain and injury.

We spoke with one man who was beaten and/or stabbed in the head in a random attack while he was asleep in a "boat" (a temporary bed) in the dayroom of his housing unit. He now has a metal plate in his head as a result of the attack. When we spoke to him, he had been in the Jail for nearly four years. He developed Post-Traumatic Stress Disorder (PTSD) after the attack, has had trouble sleeping in the Jail since his assault, has flashbacks, and described jumping unintentionally when believing he may be attacked again.

Our mental health expert identified another man as potentially having PTSD as a result of experiences in the Jail. The man described being housed in a unit that people referred to as the "Thunder Dorm." He recounted gang members taking him to a cell behind a staircase, out of view of the security cameras, and threatening him with a long piece of metal, like a fire poker. He was then made to call his family and instruct them to send money via CashApp to another incarcerated person. He also described a time when power went out in the unit and feeling that anything could happen to him in the dark. When our mental health expert spoke with this man, he described thinking about his experience often, having intrusive thoughts about it, nightmares, restlessness, and agitation, all of which are symptoms associated with PTSD.

Another person reported lasting effects from an assault inside his cell in which multiple people tried to steal his commissary. About a month later, an officer tased him after he refused to turn over a sharpened weapon that he had hidden in his pants. The person

explained that he had stress after the assault and carried the weapon "because he just wants to go home to his kids." Yet another person, speaking with mental health staff following a suicide attempt, said simply, "I'm tired of seeing people get stabbed."

2. The Jail does not house people appropriately to reduce the risk of violence.

Jails should use correctional practices such as classification, housing plans, assessment of the likelihood of victimization, and consideration of gang affiliations to manage the incarcerated population and reduce the risk of violence. The Jail's failure to effectively implement these jail practices contributes to the dangerous nature of the Jail.

2.1 The Jail's deficient classification system and housing plan increase the risk of violence.

Sound classification and housing assignment systems are a core feature of safe jails. The lack of an objective, penologically sound classification system increases the risk of harm from violence, as vulnerable people may end up housed with more violent or predatory people, and incarcerated people requiring heightened supervision may be inadequately monitored.

Initial classification and housing assignments should consider objective criteria about individual person's propensity for behavioral problems or other risks while in custody. Established criteria for determining this risk at the time of arrest include the severity of the current offense, severity and frequency of past offenses, prior institutional violence, known escape risk, and age. Other factors that should be considered in classification are the risk of suicide and any heightened need for protection. A re-classification should occur every 60–90 days after the initial assessment and also after discipline for serious misconduct in the Jail. The re-classification should give more weight to institutional behavior and less weight to the charged offenses, so as to more accurately predict the risk of violence. Repeated disciplinary actions should usually result in higher custody levels, while lower custody levels reward positive institutional behavior with better living environments and privileges. Jails should use a housing plan to separate custody levels and should designate space in the facility for each level, as well as special needs housing.

Fulton County Jail's classification system does not conform to generally accepted jail practices, because it relies almost exclusively on arrest charges and ignores other risk factors, including in-custody conduct. Jail policy contemplates reviewing an individual's classification every 90 days and as needed, but in practice, re-classifications do not occur. We reviewed the classification histories for 21 people who had been in custody at the Jail for five or more consecutive years, 15 of whom were still in the Jail at the

time of our review. The most recent classification for any of these people occurred upon admission to the Jail in 2019.

Rather than reclassifying people at regular intervals, jail staff move people around to different zones if they pose a problem. If problems persist, staff may eventually move the person to a higher floor of the Main Jail, which generally corresponds to higher custody levels. Classification staff confirmed, however, that this shuffling among floors often results in multiple custody levels in the same housing zone.

The Jail also mixes all custody levels together on the second floor of the Main Jail for about two weeks when incarcerated people are first admitted to the Jail. This mixing of incarcerated people with different custody levels in the same zone is unsafe. In the South Annex, the housing plan does not even seek to separate people according to their custody levels, instead identifying every unit as "LOW-MED-MAX."

The Jail also fails to use classification and housing assignments to keep 17-year-old boys safe from violence. The Jail places all 17-year-old boys together in the "Youthful Offender Unit" but does not separate them according to custody levels. Without effective supervision, the failure to separate this population by likelihood of violence increases the risk of harm.

2.2 The Jail does not use housing assignments to effectively mitigate the risk of gang violence.

Gang activity creates a risk of harm in corrections facilities because gangs exert control through violence and the threat of violence. When faced with a high level of gang activity, jail leadership must provide adequate supervision and classification of the jail population and should implement a comprehensive gang control strategy that considers gang affiliation when making housing assignments.

We found gang involvement in a significant amount of violence at the Jail. In May 2024, six incarcerated people with gang affiliations entered someone's cell with knives and stole his commissary. In September 2023, three people were injured in a violent incident believed to be retaliation for a gang-related murder that had happened in the Jail. In August 2023, five people with brooms and a "man made knife" attacked an incarcerated person, and the victim reported that this happened because he was no longer in a particular gang.

Despite the violence associated with gang activity at the Jail, the Jail fails to identify and track many gang-affiliated people in the Jail. Without such identification and tracking, the Jail cannot use known gang affiliations to keep members of any one gang from gaining influence and separate rival gangs.

Violence can occur when a significant number of people from one gang are assigned to the same housing area, and they assume control of it. This creates a dangerous situation for people who are not affiliated with the gang. A security captain stated that Jail staff try to separate gangs when making housing assignments. But due to constraints on the Jail's housing capacity and the number of gangs represented in the facility, he reported this is virtually impossible to do. In December 2023, an incarcerated person reported that, because he was not a gang member, he was told to pay $100 per day to stay in the housing zone. In October 2023, another person alerted officers that gang members were "extorting him for protection money to live in the zone without being violently attacked." In a separate incident, an incarcerated person was assaulted over a commissary dispute, and a witness reported that a gang was running the zone and controlling commissary.

3. The Jail does not provide adequate staffing and supervision to keep people safe.

Inadequate supervision puts incarcerated people at substantial risk of serious harm from violence and can violate their constitutional rights, especially when other conditions like easy access to weapons contribute to the danger. Fulton County Jail staff are rarely present in the housing units and do not perform adequate security rounds or otherwise monitor people to prevent harm. As a result, staff fail to intervene to stop violence between incarcerated people and often fail to promptly respond to violent incidents.

The Jail regularly operates without enough security staff to provide appropriate supervision and prevent violence. The most recent staffing analysis was conducted in 2015 and adopted minimum staffing levels from a previous consent decree. According to the minimum staffing levels, there should be three detention officers for each housing unit in the Main Jail and one other person posted in each tower, for a total of four security staff on each of 13 units. Often, however, the Main Jail has just one or two security staff for each unit.

Records from a six-day period in August 2023 reflect that the Main Jail was below the minimum level of staff on all floors for four out of six day shifts. Both homicides in August 2023 occurred in the same unit during this period, when only two staff were assigned to the unit. Staffing levels overnight were even worse. The Jail was below the minimum level of sworn staff on all housing floors of the Main Jail for each of the night shifts in this period. One night in August 2023, staffing in the Main Jail was one-third of the minimum staffing level, with multiple floors having a single officer assigned to supervise 150–250 people.

There should also be one supervisor assigned for each floor, for seven total supervisors working in the Main Jail's housing units. Yet we found multiple shifts with four or fewer supervisors, and at times as few as one supervisor on a night shift for all seven floors.

Given the short-staffing, a watch commander told us that her goal in staffing the Main Jail is to aim for at least two "floor" officers who go into the housing units, and one officer in the tower (three total). Our review of deployment rosters shows that the Jail does not meet this reduced level of staffing in the housing units either, as often there are just one or two officers assigned to a unit. As a result, when officers leave their post to assist with an emergency on another floor, they may leave their unit unsupervised—or supervised only by a tower officer who cannot enter the housing unit—even for units with cell doors that do not lock or people mix in a dayroom.

Violence occurs as a direct result of the understaffing. In August 2023, a single detention officer was assigned to monitor a housing unit of nearly 100 incarcerated people overnight. He left the unit to get ice. Upon returning at about 1:00 a.m., he saw three incarcerated people fighting in the dayroom; two were "drenched in blood." One person involved in the fight told officers that he saw one of the other people trying to leave the cell or zone, and "took it upon himself to stop [him]." Similarly, the September 2022 homicide occurred when the floor officer left his assigned unit of around 100 incarcerated people to deliver paperwork and exchange his Taser cartridge. While he was gone, incarcerated people alerted the tower officer that someone was "laid out on the floor." The tower officer called the floor officer assigned to another unit to respond. When that officer arrived, the victim was face down in a puddle of blood with no signs of movement.

Officers reported having to work inside housing units with no one posted in the tower, and we observed vacant towers during our site inspections. Without staff in the tower, there is no one with eyes on all six housing units, no one to call for backup if a floor officer becomes incapacitated, and no one to respond when incarcerated people call the tower to ask for help.

Short staffing affects the annex facilities, as well. When we inspected the South Annex in January 2024, there were only two officers in the housing units, with one assigned to each wing of around 130–150 people.

Properly conducted well-being checks, referred to as "security rounds" in the Jail, are critical to the safety and security of people incarcerated in the Jail. During security rounds, officers verify that all incarcerated people are alive and well, learn of any urgent needs like medical distress, identify security concerns like contraband or broken locks, and provide a presence in the housing units to deter misconduct. Security

rounds should occur at irregular intervals, with no more than 60 minutes between rounds.

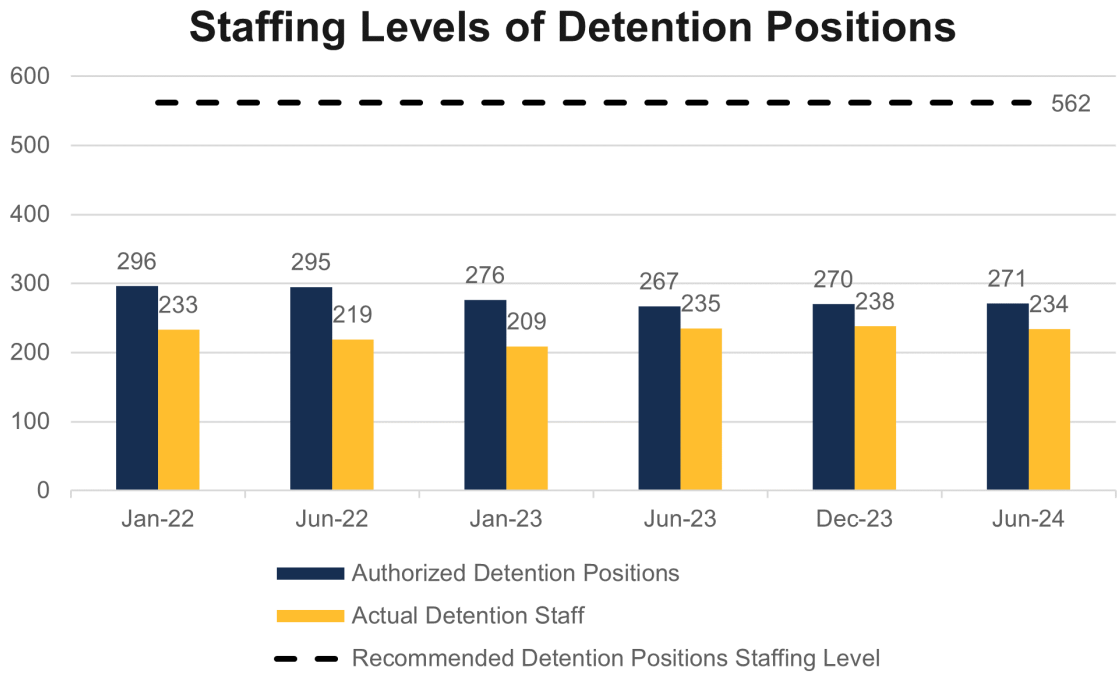
Our review of the Jail's records found gaps of many hours between recorded security rounds, and officers recorded performing only a fraction of required safety checks. When staff do perform security rounds, they often only conduct a "visual security round" from inside the tower, but Jail staff cannot see all areas of the unit from there, including inside cells. Jail staff generally confirmed that floor officers do not perform hourly security rounds inside the housing units, and they cited short staffing and the need to handle other tasks, such as medical or attorney visits, as the reason.

Surveillance cameras can be monitored from central control and the towers to improve supervision, but do not substitute for the regular presence of deputies and detention officers inside the housing units. Staff are not always in the towers to monitor the camera feeds, and the cameras do not show inside showers, cells (other than padded cells), and holding areas, where violence may occur.

Staff are often unaware of extreme violence, leading to lengthy delays in response times and medical care. In May 2024, despite an obvious assault where two incarcerated people fell down a staircase in a housing zone, over two hours passed before officers found the victim wrapped in a bloody towel. In January 2023, an incarcerated man reported that he was brutally assaulted over four days, but officers were unaware of the attacks until the man passed a note asking for help. And when the November 2022 killing occurred, the overnight floor officer on the mental health unit was actually working inside the tower. When the officer eventually conducted his security rounds, he found the victim lying on a cell floor with his hands tied behind his back and his ankles bound. Medical determined that he was already dead and "extremely cold."

Jail leadership is aware of chronic short staffing at the Jail. The Sheriff told a Georgia Senate Subcommittee in May 2024 that there should be 50–60 staff for each 12-hour shift at the Jail, and that the Jail had never achieved that staffing level. In 2023 the County and Sheriff's Office increased salaries for people working in the Jail (to $60,000 for deputies and $54,000 for detention officers) and approved paying double overtime. In March 2024, the Board of Commissioners rejected the Sheriff's request to continue the double overtime payments, describing them as a temporary measure. In July 2023, the Sheriff's Office contracted to have private security specialists work in the towers and mitigate understaffing. But in August 2024, the private security officers walked off the job after the contractor said it had not been paid in three months, was owed over a million dollars, and was ending the contract with the Jail. The Sheriff's Office described a "significant budget crisis" that led to the nonpayment of this contract and left the Jail scrambling to cover abandoned posts.

From January 2022 to June 2024, the number of detention positions allocated to the Jail declined, and the number of detention staff working in the Jail remained far below the minimum staffing level. The following chart shows the recommended detention staffing from the 2015 staffing analysis compared to the allocated detention positions and actual detention staffing levels in the Jail.



In light of the danger associated with short staffing and the long-standing nature of the problem, we find that Jail leaders have not taken adequate measures to improve staffing and supervision at the Jail.

4. Poor maintenance and pervasive contraband contribute to the violence.

The County and Sheriff's Office have not taken adequate measures to maintain the Jail facilities. Poor supervision, jail maintenance, and security practices contribute to a large amount of contraband, including weapons and drugs, and unsafe facilities. The result is a highly dangerous jail. Jail leadership is aware of the danger these conditions pose to incarcerated people, but has failed to take adequate action to make the facility safe.

4.1 Unmaintained parts of the Jail jeopardize safety.

Due to poor maintenance and inadequate supervision, the Jail itself is a source of dangerous weapons and exposes people to violence.

In many high-risk housing areas, almost none of the pipe chase doors close and lock, because the locks have been vandalized and not repaired.[12] As a result, incarcerated people can access pipes, controls, and pipe fittings, which they easily make into weapons. In October 2023, about a dozen people attacked another incarcerated man, stabbing him in the head and arm, and hitting him across the head with an eight-inch pipe. In August 2023, four men attacked another incarcerated man with make-shift weapons described as knives and metal switch plates.

During our site visit in February 2024, in one maximum-security zone, almost every pipe chase door could not lock and large pieces of metal, easily made into weapons, were lying on the floor. The officers escorting us during the site visit appeared unfazed by this situation. When one of our expert consultants identified a significant piece of metal found in a pipe chase, an officer said to drop it on the floor of the dayroom—where incarcerated people could easily access it—and that they would get it later. Just a month before that visit, an incarcerated person used a metal plate and a long, sharpened nail in an attack in which two people received serious injuries.

Unsecured pipe chases in the Jail

[12] "Pipe chase" refers to the area where plumbing and other pipes run through the housing zone. Recent documentation reflects that new, higher-quality locks for the pipe chases have been ordered. However, it is unclear when replacement locks will be installed throughout the facilities.

Fulton County Jail reported confiscating 2,157 man-made, sharpened weapons in 2023 and 1,370 such weapons in 2022. The Jail confiscated at least 139 man-made weapons in the first month of 2024 alone. The number of weapons in the Jail is much greater than should be expected in a correctional facility of its size. For example, in the Miami-Dade County Jails, with an incarcerated population of around 4,600 (roughly 1.5 times the population of the Fulton County Jail), staff confiscated 346 weapons in 2023 and 519 in 2022.

Weapons recovered in the Jail and shown to DOJ team in October 2023

Light sources throughout the Jail have also been tampered with, further increasing the danger inside the facility. Incarcerated people pull lighting fixtures out of the wall to access wiring, hide contraband, and obtain metal switch plates for weapons. We inspected multiple cells in the Main Jail that were dark due to broken light fixtures.

In August 2024, a County inspection identified multiple areas with broken lights, including entire housing zones that had no working lights at all. In September 2023, one housing zone had missing electrical switch plates in five cells and multiple broken dayroom light fixtures, all with wires exposed. In August 2023, the Jail reported finding 543 broken electrical fixtures, with 292 still needing repair. The poor lighting increases the risk of violence and means that some people in the Jail live in darkness.

On top of broken light fixtures, extended power outages have threatened the safety of the incarcerated population. We identified seven power outages at the Jail since January 2022. In July 2023, a power outage left the Main Jail pitch dark for several minutes, with no emergency lighting in the corridor. Eventually the lights were restored, but the electrical and HVAC system outage lasted six days.

Jail leadership is aware of the dangers caused by the facility's poor condition, including providing materials for weapons. In March 2023, a search conducted by the Sheriff's Office identified over 200 man-made weapons. Sheriff Labat acknowledged that

"[i]nmates are literally crafting shanks from the crumbling walls of the dilapidated facility."

In August 2023, the County and Sheriff's Office began a repair "blitz" of housing units in the Main Jail to make repairs, including fixing broken locks, doors, windows, and lighting. The County and Sheriff's Office have now repaired multiple housing units in the Main Jail. The Sheriff also sought funding from the Board of Commissioners for a new jail. In June 2024, the Board of Commissioners voted against a proposal to move forward with a new jail, and in July 2024, the Board approved a counter-measure to instead assess the current Jail for renovations.

Before the repair blitz, there was no concerted effort to remedy poor conditions in the Jail, and until supervision in the Jail improves, it is likely to remain in a state of disrepair that fosters violence. Indeed, six weeks after the completion of repairs to one housing unit, it had already been seriously damaged: 39 light switches were broken, and an electrical plate was missing from the wall.

4.2 Poor door security in the Jail threatens the lives of incarcerated people.

Door locks throughout the Main Jail do not work. In March 2023, a deputy reported to jail leadership that only five out of more than 100 doors on a unit were working. In August 2023, the Sheriff's Office reported that it had identified 732 broken door locks in the Main Jail and still needed to repair 653 of them.

The incidents we reviewed demonstrate that malfunctioning doors are a major security failure and a serious risk to the safety of incarcerated people. In August 2023, multiple incarcerated people left their housing zone armed with sharpened weapons. They opened the door of their zone by wedging a dustpan in the door and manipulating the lock to slide the door open.

On certain floors, incarcerated people have been able to trigger emergency release mechanisms and "pop" open all the doors on a tier at once. In March 2023, two separate stabbings occurred over the course of one night after incarcerated people manipulated the override mechanism to open doors and attack people.

In July 2023, in another incident involving the door locks on that same zone, three assailants stabbed and beat someone. A sergeant who reviewed the assault wrote in his report:

> [T]his attack happened in a lockdown [restrictive housing] zone with sliding cell doors that the inmates can open and close at will, by manipulating the manual override mechanism that controls the cell doors in the zone. This is a VERY WELL DOCUMENTED ISSUE that has been

> going on for months, yet never rectified. Due to this security breach, inmates are no longer protected from other inmates because the cell doors are so easily opened by [incarcerated people].

Three months later, in October 2023, the situation on this zone had gone from bad to worse, and the locks did not work. A deputy assigned to the zone reported: "All the doors in this zone are broke[n] with also inoperable manual release boxes. No inmates should be housed in this zone due to the fact that no one can be secured behind a lock[ed] and operable door." The Jail continued to house people on this unit for another month before shutting it down.

The Jail could provide secure cell doors and keep door locks in good repair; the failure to do so is the product of inattention. The Jail's contracted maintenance worker reported that the locks work if not vandalized. He described locks being jammed, torn up, broken, and unable to be opened or closed because materials were stuffed in the locking mechanisms.

The County and Sheriff's Office are replacing and repairing broken locks and doors as part of the repair "blitz" of the Main Jail. But as recently as our site inspections in January and February 2024, many doors in the Main Jail still did not lock. Without adequate supervision in the housing units and prompt repairs of broken doors and locks, the problem will continue.

4.3 People move through the walls of the Jail to attack others.

Inadequate supervision and the poor condition of the Jail have allowed incarcerated people to create large holes in the walls through which they can travel and cause harm. The Sheriff's Office has publicly acknowledged this issue.

In January 2024, officers reported a hole in the shower of 6 South, zone 600 leading into the pipe chase of zone 500. Days later, a floor officer on zone 500 noticed two people inside the pipe chase and reported a "big hole" in the wall leading to the zone 600 shower. It is concerning that this hole had not been repaired, and that the floor officer was unaware of the hole's existence even though staff had already discovered it.

In September 2023, one zone was found to be severely compromised when officers found that multiple cells had holes leading to a pipe chase door that had been forced open and did not lock, allowing people to exit their cells at will. Officers determined that incarcerated people were "chiseling through the concrete" to make these holes.

In May 2023, an assailant dug a hole through a shower wall to enter an incarcerated person's housing zone and stab him. Later that month, a fight broke out between

people on two different zones, and an incarcerated person told officers that he was lying on his bed when an assailant came through a hole near the toilet via a pipe chase and stabbed him.

In March 2023, an officer observed that an incarcerated person had made a “massive” hole in the wall of his cell, leading into the pipe chase and a neighboring cell. Later, the same person was on another zone when he climbed from a hole in his cell, through a pipe chase, and into the dayroom, where he chased another person about the zone.

The widespread availability of metal pieces about the facility may be contributing to the number of holes, as is overall poor maintenance of the Jail and inadequate supervision. With regular and thorough inspection of housing units, incarcerated people likely would be unable to create large holes in living areas.

4.4 Drug use is common and leads to violence.

The widespread availability of drugs in the Jail also contributes to the violence.

Significant amounts of drugs are trafficked into the Jail. A search in January 2024 uncovered over 400 suspected ecstasy pills along with suspected marijuana, Percocet pills, 10 cellphones, and drug paraphernalia, including a digital scale. During a site inspection at the Main Jail in October 2023, staff informed us that an incarcerated person we were interviewing was suspected of being high on fentanyl, and staff found fentanyl in two separate housing areas at the South Annex in August 2023.

Drug use in the Jail includes the use of “strips”—pieces of paper soaked in chemicals and unknown substances, then dried and smoked for narcotic effect. One incarcerated person told us that strips bring “chaos” to the housing units, likening the ensuing violence to war.

While we were on-site for inspections, odor from people smoking unknown substances filled the air. Security and medical staff have reported getting contact high from breathing the air in the Jail. And we observed burnt and rolled papers left on the floor of the Jail—on more than one occasion, still burning—during our inspections.

Drug use plays a clear role in violence. In March 2023, an officer observed a fight between two incarcerated people. One was incoherent and unable to be interviewed after the fight, due to his “high level of drug usage.” The other person involved said he had been defending himself from attack. In another incident that same month, multiple people assaulted and stabbed a person who was so high that he could not stand up or walk straight.

People may also incur debt over drug use, creating a risk of violence. For example, in July 2023, parents called the Jail to ask for a welfare check on their incarcerated son.

The son told an investigating officer that he was scared because his life was in danger, and he “can’t send any more [money].” The officer observed the son was visibly shaking and suspected that he was in trouble because of drug debt incurred on the zone.

Incarcerated people with drug dependency do not have many options for treatment, as the Main Jail has just one residential drug-treatment program that operates on one zone.

4.5 The Jail does not take appropriate measures to prevent the movement of contraband into and around its facilities.

Poor security practices contribute to the large amounts of contraband that move into and about the Jail. Jail staff do not conduct adequate security rounds to identify and remove contraband. Planned housing searches are not conducted with necessary frequency, and searches of incarcerated people, including pat searches, are not conducted appropriately. Jail staff appear apathetic towards the problem.

Staff have found man-made weapons on people in the medical clinic, and medical equipment has gone missing from the Jail.

One officer reported that to reduce the number of weapons in a zone, he would announce to the incarcerated people housed there that he needed to find 10 weapons on the table when he returned to the zone. He would leave the zone, and when he returned, there would always be the right number of weapons on the table, which incarcerated people presumably placed there to prevent a search. This approach to contraband control is concerning for several reasons. First, it suggests that additional weapons remain in the zone. Second, incarcerated people likely pressure the most vulnerable people on the unit to surrender their weapons.

Incarcerated people have burned holes into windows with the apparent purpose of receiving contraband from drones. In May 2024, officers found various contraband inside a cell that had a hole in the window. More than two weeks before this incident, officers had identified that a burned-out window in the cell left a “huge opening for contraband.”

When we inspected the Jail, window holes were visible from the parking lot. Security staff seemed to be aware of this issue, but still housed people in the cells with holes in the windows.

Burned holes in cell windows observed during DOJ October 2023 inspection

Corrupt staff are also a significant source of contraband. Multiple staff members have been arrested for trafficking contraband into the Jail. In August 2024, four private security officers working in the Jail were arrested for contraband trafficking and improper relationships with incarcerated people. We were told in August 2023 that officers working at the South Annex were not screened upon entering the facility, because they were a specially selected group. A few months later, a Fulton County detention officer assigned to the South Annex was arrested on charges of having an inappropriate relationship with an incarcerated person and bringing contraband into the facility.

In the past few years, efforts to address contraband include body-scanner machines to improve searches, machines to scan incoming mail for contraband drugs, a restriction on jail staff bringing personal bags into the facility, and using fire-retardant glass when replacing windows. Without improving supervision and monitoring, however, these efforts are unlikely to make a significant impact on the Jail's contraband problems.

5. The Jail has inadequate systems for identifying, investigating, and preventing violence.

Given the amount of violence at the Jail, procedures to identify dangerous circumstances and investigate misconduct are critical. The Jail does not meaningfully respond to grievances and complaints from incarcerated people, does not investigate the root causes of violence in the Jail, and does not implement corrective action plans to improve safety.

5.1 The Jail's grievance system does not offer incarcerated people an adequate way to report and avoid danger.

Grievances are an important part of a jail system. They provide incarcerated people with an avenue to have problems corrected and jail administrators with a source of information to identify and solve system-wide issues. The Jail, however, fails to adequately investigate and respond to grievances filed by incarcerated people, including those submitted for personal safety.

Incarcerated people are supposed to submit grievances through kiosks in the housing zones. Yet we observed inoperable or missing kiosks in various units during site inspections. There are paper grievance forms, but they are not readily available in the housing zones.

The grievance coordinator admitted that most grievances raise safety concerns. Our review of the Jail's responses to those grievances revealed gross deficiencies. We reviewed many grievances with serious complaints, to which jail staff responded by stating that the incarcerated person needed to direct their issue to another staff member or file the grievance again on another type of form.[13] This kind of response improperly avoids investigating and substantively responding to a person's grievance, and risks missing opportunities to address unsafe conditions.

One homicide victim submitted 13 grievances in August 2023, the month he died. In five of these grievances, he reported experiencing violence from other people at the Jail. In a grievance submitted shortly before he was moved to 7 South, he reported that officers were trying to move him to a more dangerous location because he had reported them for misconduct. He explained that moving him was dangerous because he had had issues with people on multiple other floors. The grievance officer did not respond until a month later, at which point the officer wrote: "[T]his grievance is over 30 days old. If your issue is still unresolved, please re-submit your complaint. This office apologizes for the delay." By the time of this response, the person had already been moved to 7 South and killed there.

Grievances about violence are routinely ignored. In August 2023, an incarcerated person submitted an emergency grievance alleging that he was assaulted that day by another person in his zone. He further alleged that his assailant had assaulted someone else two days before the attack, and that officers had failed to remove the assailant from the zone. The grievance officer decided the grievance was improperly

[13] Both the Jail handbook and the grievance policy state that an incarcerated person should attempt to resolve a grievance informally before filing a grievance, and direct incarcerated people to submit an "inmate request form" and wait 5–7 days for a response before filing a grievance. The grievance coordinator told us that this is not a requirement.

filed as an emergency, told the person to refile on a general grievance form, and closed it.

Even a grievance about the sexual assault of a 17-year-old boy triggered no apparent action to address the violence. In June 2023, a 17-year-old submitted an emergency grievance reporting that he had been anally penetrated and was bleeding. The grievance officer responded that she had turned the grievance over to the Jail's investigations unit, provided no other information, and closed the grievance. Later that week, the same person filed another emergency grievance from the same housing location, reporting that he was being sexually harassed and made to perform sex acts, and requesting a move to another location. The grievance officer responded that she forwarded the grievance to the PREA investigator, again provided no other information, and closed the grievance. Despite a request, we received no incident reports or documents indicating that anyone investigated these complaints.

5.2 The Jail does not use quality investigations and corrective action planning to identify dangerous situations and avoid violence.

After an incident of serious violence occurs or when jail staff are alerted to a potential for serious violence, sound correctional practice includes a thorough investigation to identify the source of the violence, determine what led to the violence or threats, and identify corrective actions. Corrective actions may include increasing staffing, addressing blind-spots, counseling staff to improve the quality of security rounds, re-balancing the mix of different gangs on a housing zone, and identifying the source of involved contraband. Without such investigations and corrective actions, staff cannot adequately identify or respond to patterns of violence and prevent it from recurring.

When jail staff do investigate allegations of violence or sexual abuse, the investigations are minimal. These investigations lack an effort to understand the precipitating factors to violence, follow-up on leads that might connect the violence to other misconduct, findings, and proposed corrective actions to help avoid future violence.

For example, in August 2023, an incarcerated person summoned an officer to his zone because he was bleeding from the head. The victim told an investigator that multiple people stabbed him while he was sleeping in his cell, and that they did so at a nurse's request, because he had spit at her. The investigator interviewed no one except the victim and the officer who found him. The investigator did not review surveillance video because there was "no accurate time table" for the stabbing. No one was charged (for a disciplinary violation or criminally) in this stabbing, and the only corrective action recommended was to move the victim to another housing area. The investigation report does not explain how people were able to enter the victim's cell while he was

asleep, whether the zone would be searched for the weapon used in the assault, whether the nurse might have had some involvement, or how the assault occurred undetected.

We also found no evidence that the Jail conducts meaningful investigations into security lapses after violent deaths in the Jail. For example, we found no investigation into potential security failures related to the homicide of a person on the mental health unit in 2022, even though the assailant in that case had been arrested just two weeks before for a serious stabbing outside the Jail in which the victim later died. A proper investigation may have identified corrective actions related to classification and housing assignments, and may have determined that the assailant should not have been in the mental health unit or had a cellmate. But we found no record of any such investigation.

The Jail's failure to prevent harm through quality investigations was particularly notable with regards to sexual abuse investigations. PREA standards direct that correctional agencies should investigate all allegations of sexual abuse "promptly, thoroughly, and objectively," even if the victim or witness is challenging or unwilling to cooperate.[14] To conduct a thorough investigation, investigators must "gather and preserve direct and circumstantial evidence," and "interview alleged victims, suspected perpetrators, and witnesses."[15] Investigations should be "documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings."[16]

As discussed in Section 1.3 above, the Jail has poor processes for reporting, identifying, and tracking sexual abuse allegations. In most cases we reviewed with a sexual abuse allegation, the Jail failed to conduct a sexual abuse investigation, or if it did conduct one, failed to do so properly or made no findings.

We found dozens of incidents that should have been investigated under PREA, where the County and Sheriff's Office produced no documentation showing that a meaningful sexual abuse investigation was conducted. In these incidents, an officer often did some initial investigation, including taking initial statements and beginning a cell relocation, and then referred the incident to the Jail's investigation unit for a PREA investigation. Based on the information we reviewed, however, no follow-up investigation occurred. It was unclear whether the failure to investigate was based on

[14] 28 C.F.R. § 115.71(a).

[15] 28 C.F.R. § 115.71(c).

[16] 28 C.F.R. § 115.71(f)(2).

a decision that the allegations did not warrant further investigation, a lack of resources, or some other reason.

For example, in March 2023, an incarcerated person filed a grievance reporting that he was sexually assaulted. An officer submitted a report stating that he went to speak with the person, who confirmed that he had been sexually assaulted. The officer brought the person to medical, and then notified his watch commander and the PREA Coordinator. Despite requests, we received no other documentation regarding this incident or any subsequent investigation—no investigation file, no copy of the grievance or the victim's statement, no information about a statement from the alleged perpetrator, no information about whether the victim went offsite for a sexual assault examination, and no evidence that findings were made as to the truth of the allegations.

When we received documentation reflecting that some type of sexual abuse investigation occurred, we found investigators did not take basic investigatory steps. In March 2024, the Jail failed to bring an incarcerated person to an outside hospital for a medical exam, even though he reported to nursing staff that he had been sexually assaulted the night before, and the nurse shared this information with an officer. Three weeks later, the person saw another member of the medical staff, a physician, and complained that he had been sexually assaulted weeks ago and never evaluated. The physician alerted the PREA Coordinator, who confirmed that he was not taken to the hospital "due to an error in communication." Four months after this person reported the sexual assault, the investigation file showed no record that Jail staff interviewed the victim or witnesses, reviewed surveillance video, or made a finding of whether the allegation was substantiated.

There are some indications that the new PREA Coordinator has improved the quality of investigations into sexual violence and other sexual misconduct in the Jail. The PREA Coordinator appears to be notifying incarcerated people about the status of sexual misconduct allegations, checking in with complainants to make sure they have not faced retaliation, and identifying some investigatory deficiencies.

Major problems with the Jail's sexual abuse investigations remain, however, particularly with regards to closing investigations. Between August 2023 and June 2024, the Jail received 39 new allegations of sexual misconduct by an incarcerated person against another incarcerated person, including 28 allegations of sexual abuse and 11 allegations of sexual harassment. By August 2024, investigators had closed just 15 of these cases: 9 were declared unfounded, 6 unsubstantiated, 0 substantiated, and 24 were unresolved. PREA standards require facilities to conduct sexual abuse incident reviews with upper-level management officials after every substantiated and unsubstantiated sexual abuse investigation, during which they are to

consider changes to policies and practices to better prevent, detect, or respond to sexual abuse.[17] These critical after-action reviews do not occur when investigations are left open.

Excessive Force

Fulton County Jail officers have a pattern or practice of using excessive force against incarcerated people. Staff frequently resort to unnecessary force—especially the Taser—when people are not actively resisting or posing a danger to themselves or others. When force is justified, staff use a greater degree than necessary based on the circumstances. The Jail lacks adequate policy or training to guide staff to use appropriate force techniques. The Jail fails to adequately investigate uses of force or take sufficient steps to prevent excessive force by holding staff who use excessive force accountable.

A correctional officer's use of unreasonable force against pretrial detainees violates the Fourteenth Amendment. Courts assess the constitutionality of a correctional officer's use of force under an objective reasonableness standard that examines whether "the force purposely or knowingly used against [an incarcerated person] was objectively unreasonable," regardless of the officer's state of mind.[18] "[O]bjective reasonableness turns on the 'facts and circumstances of each particular case,'" and a "court must make this determination from the perspective of a reasonable officer on the scene, including what the officer knew at the time, not with the 20/20 vision of hindsight."[19] In weighing the reasonableness of a use of force, courts also consider:

> [T]he relationship between the need for the use of force and the amount of force used; the extent of the [incarcerated person's] injury; any effort made by the officer to temper or to limit the amount of force; the severity

[17] 28 C.F.R. § 115.86.

[18] *Kingsley v. Hendrickson*, 576 U.S. 389, 397 (2015); *accord id.* (in determining whether a pretrial detainee has been subjected to excessive force, the "relevant standard is objective not subjective"); *Myrick v. Fulton Cnty.*, 69 F.4th 1277, 1300–01 (11th Cir. 2023) (citing *Kingsley* for the same principle).

[19] *Kingsley*, 576 U.S. at 397 (citation omitted); *Myrick*, 69 F.4th at 1301 (quoting *Kingsley*, 576 U.S. at 397).

> of the security problem at issue; the threat reasonably perceived by the officer; and whether the plaintiff was actively resisting.[20]

Courts also acknowledge the "legitimate interests that stem from the government's need to manage the facility in which the individual is detained."[21] Correctional officers often face challenging and quickly evolving circumstances that can threaten their safety or the safety of other officers and incarcerated people.

The County produced use-of-force reports and incident reports describing uses of force from January 2022 through October 2023. These reports include officer accounts, summaries of interviews with involved staff and incarcerated people, and supervisory reviews. We reviewed a sample of these reports, including surveillance and body-worn camera footage.

Many uses of force appear to occur because incarcerated people refuse orders to return to their cells or housing units. In some cases, people expressed fear of returning because of the risk of violence. This strongly suggests that the Jail's inability to control violence among incarcerated people contributes to many uses of force.

Relatedly, the lack of adequate supervision and staff discussed in Protection from Harm, Section 3 creates the conditions for staff to use excessive force. When a single officer is alone in a housing unit with multiple incarcerated people, it is more likely that they will resort to using Oleoresin Capsicum (OC) spray[22] or a Taser to assert control instead of first attempting de-escalation or less dangerous force techniques. After using OC spray against a man who refused to return to his cell, one officer told a colleague, "I didn't want to get hands on 'cause I was up here by myself."

We found a pattern or practice of excessive force by correctional officers against people in the Jail's custody, in violation of the Fourteenth Amendment. Officers regularly use force when no force is necessary and routinely use force that is disproportionate to the threat. Officers resort to force to obtain immediate compliance without attempting meaningful de-escalation, such as using mental health staff to talk to someone experiencing a mental health crisis. The Jail also lacks adequate policies

---

[20] *Kingsley*, 576 U.S. at 397; *Myrick*, 69 F.4th at 1301 (quoting *Kingsley*, 576 U.S. at 397).

[21] *Kingsley*, 576 U.S. at 397 (citation omitted); *Myrick*, 69 F.4th at 1301 (quoting *Kingsley*, 576 U.S. at 397).

[22] OC spray is a non-lethal force agent commonly used by law enforcement agencies and militaries worldwide. OC spray causes acute burning pain and irritation, especially when it makes contact with the eyes. It can also cause oral, nasal, and respiratory pain, and in rare cases, respiratory problems and death.

and systems to train staff to use appropriate force and hold staff accountable for using excessive force.

1. Officers regularly use force where unnecessary and to a greater degree than necessary.

Fulton County Jail officers routinely use unreasonable force, often without first attempting to resolve the situation peacefully. Officers frequently use force on incarcerated people for violating rules even where they pose no threat to the safety or security of anyone. Although Jail policy requires all available alternatives to be used before resorting to physical force, officers rarely if ever try de-escalation techniques or even call for assistance before using force. In some cases, officers do not even give commands or verbal warnings before resorting to force.

Most of the unreasonable force we observed involved officers' use of conducted electrical weapons, or Tasers. Tasers can be activated in two modes—probe or drive stun. In probe mode, an officer fires two barbs, or "prongs," that pierce the skin. When the officer pulls the trigger, the Taser sends a painful, incapacitating jolt of electricity. In drive-stun mode, an officer presses the Taser against a person's body and pulls the trigger, resulting in a burning electrical charge but not disrupting muscle control.

We found that officers at the Jail respond to minor transgressions with force. For example, in August 2023, an officer told a man to retrieve a basketball and give it to the officer. According to the officer's report, the man did not comply, so the officer fired his Taser.

Officers also use force in the absence of a threat and when faced only with passive resistance or no resistance at all. Among the use of force incidents we reviewed, the overwhelming majority involved passive resistance (not active resistance or assaultive resistance). In those situations, officers often do not attempt de-escalation but instead default to using force. For example, in August 2023, an officer sprayed a man with OC spray without warning for failing to pack up items after an officer ordered him to do so. In June 2023, an officer twice used a Taser on a man who was yelling and swearing in protest of a television removal. The officer did not give any commands or use any de-escalation techniques. In July 2023, officers fired a Taser at a man who argued and refused to hang up a phone. The man eventually hung up, but one of the officers fired a Taser at him anyway.

Excessive force is so commonplace in the Jail that officers have a cavalier attitude when it occurs. In July 2023, a sergeant sprayed OC at two incarcerated people in two different contexts within ten minutes. Body-worn camera footage shows that neither person physically or verbally threatened staff or others. The sergeant called both

people “idiot[s]” after using OC spray on them, and another officer told the sergeant, “man Sarge, you’re on fire today.”

Jail officers use force on people experiencing mental health crises without first involving mental health staff or attempting to de-escalate. In September 2023, an officer punched and OC sprayed a 17-year-old boy during a struggle that followed the officer’s removal of a zipper from the boy’s uniform. The boy had a recent history of using zippers to cut himself, but the incident report recounts no attempt to summon mental health staff or otherwise de-escalate before the officer ripped the zipper off by force. Jail officers also tased a man with serious mental illness and a known seizure disorder five times in a year, including three times in August 2023. We obtained video of two of the Taser uses, and both involved the unnecessary and disproportionate use of force. In March 2023, officers tased an incarcerated man who said he felt like hurting himself and needed to see mental health. Rather than taking the man to mental health, the officers tried to make him return to his housing zone; a sergeant tased the man when he held onto a bench to avoid being forced back into the housing zone.

In a few cases at the Jail, excessive force has led to criminal prosecutions. In June 2023, two Jail officers were criminally charged for separate unreasonable force incidents.

In the first incident, a detention officer grabbed a woman’s throat while she was being booked into the Jail. The woman was swearing and resisting the booking process, but did not pose a serious threat. The officer told the woman, “I choke folks” and “hold your face before you lose your breath,” as he held the woman’s neck and she lost consciousness. Officers from a local police department at the scene reported the incident. The Fulton County officer pleaded guilty to federal civil rights violations and, in August 2024, was sentenced to four years in prison for the assault.[23] The Fulton County officer’s supervisor was present during the incident and failed to intervene, instead commenting, “Oh, now she is trying to pass out. Really!” The supervisor received a one-day suspension for her conduct.

In the second incident, a detention officer held an incarcerated person’s neck while pressing his Taser to the man’s head. The officer kept his hand on the incarcerated person’s neck for 19–20 seconds, during which time the person was seated, handcuffed, and did not pose a threat. The officer said he acted in response to the

[23] Press Release, U.S. Atty’s Off., N.D. Ga.: Former Fulton County Detention Officer Sentenced to Federal Prison for Using Excessive Force (Aug. 7, 2024), https://www.justice.gov/usao-ndga/pr/former-fulton-county-detention-officer-sentenced-federal-prison-using-excessive-force [https://perma.cc/LPD8-87SK].

incarcerated person leaving the zone without authorization, threatening the officer's sister, and forming spit in his mouth as if to spit on the officer. After the incarcerated person submitted an emergency grievance and threatened legal action, investigators reviewed security footage of the incident and filed criminal charges.

2. Staff use Tasers too often and in an unreasonable, unsafe manner.

Tasers have a greater potential to injure a person than many other force options available to Jail officers. Taser probes can cause injury if they enter a sensitive part of the body, such as the eyes or genitals. These risks are real. A woman tased in July 2022 had Taser probes embedded in the back of her neck that were not removed until she went to the hospital. In March 2022, an incarcerated man was hospitalized with Taser probes embedded in his bone. Furthermore, people shot with Tasers are temporarily paralyzed and cannot protect themselves as they fall—this is especially dangerous if the person is on stairs or an elevated surface. The Taser can also be dangerous for people with certain medical conditions.

Despite these risks, officers use their Tasers far more often than would be expected given the size and population of the Jail. Among use-of-force reports from February through August 2023, the overwhelming majority involved at least one Taser use. We found that Jail officers use Tasers quickly and in multiple cycles without consideration for the risk of harm. Taser use is so common that individual officers sometimes tase multiple people in a day.

Officers often cycle the Taser repeatedly, past the point where it is necessary or effective. In July 2022, two officers fired Tasers at a man who had just had a seizure. They reportedly tased the man because he reached his hands toward a lieutenant's belt while they were putting him on a stretcher. The man fell or jumped from the stretcher and screamed and writhed on the floor. When he tried to sit up, the officers tased him again. They used several additional Taser cycles on the man while he thrashed on the floor and continued screaming. After the last cycle, the man said, "I can't breathe." Medical staff approached and told the officers to stop because the man had had or was having a seizure.

Officer conduct during use-of-force incidents demonstrates improper use of the Taser. Officers often do not warn people before using the Taser, even when warnings are feasible. In many incidents, officers appear to target the legs rather than the torso. Aiming at the legs makes it less likely for the Taser probes to hit their target and be effective, in addition to increasing the risk of striking sensitive areas such as the genitals. Officers often miss their target when firing Tasers, even at close range.

3. Policy, training, and accountability systems are inadequate to prevent excessive force.

The Jail lacks adequate policy and training to guide officers in the appropriate use of force. The Jail also lacks systems to identify excessive force and address it. Supervisors almost never identify instances of excessive force and rarely hold officers accountable for using excessive force.

3.1 Policies, procedures, and training do not provide appropriate guidance on use of force.

The Jail's use-of-force policy does not adequately advise officers on how to assess the need for force or whether force is proportionate and reasonable under the circumstances, as required by law. For example, the policy includes a use-of-force continuum that describes various levels of force officers may use to respond to corresponding levels of resistance. The policy/continuum authorizes officers to use certain force techniques (e.g., arm locks, restraining, takedown techniques, OC spray, and blocking or strike techniques). Resistance warranting force may range from "verbal noncompliance" or "passive or defensive resistance" to "active aggression." But the policy does not explain the distinctions between these terms, and the use-of-force continuum is silent on the level of resistance that would justify firing a Taser.

The Jail's Taser policy also fails to explain the amount of resistance and the degree of threat that may justify Taser use. We found that officers use Tasers unreasonably when encountering people with behavioral health needs. But the Taser policy explicitly authorizes officers to discharge Tasers at "emotionally disturbed persons exhibiting violent behavior" or against "suicidal persons," without requiring that such people pose an immediate danger to themselves or others and that there be no reasonable alternatives to ensure their safety.

The Jail has a use-of-force procedure that allows officers to use the "amount of [non-deadly] force necessary to regain control of his or her duty, task, or assignment" when someone interrupts their work. This directive erroneously suggests that officers may use force as a tool to save time, rather than addressing a specific threat posed.

Jail training we reviewed did not address the gaps in policy. Good training is essential to help officers understand constitutional standards and develop the skills to safely resolve situations they commonly encounter during their work. The training slides we reviewed do not explain or apply key aspects of the use-of-force policy, including the use-of-force continuum. And the training lacks examples to illustrate situations in the Jail in which officers should deploy Tasers to address "escalating resistance from passive physical resistance towards active physical resistance." It is also not clear that those responsible for overseeing force training in the Jail are familiar with the use-of-

force policy—one training supervisor insisted that the Sheriff's Office does not use a use-of-force continuum or train on it, despite its presence in the force policy.

3.2 Inadequate force reviews contribute to the pattern of excessive force.

Jail officers document when they use force in their incident reports, and Sheriff's Office procedure also requires them to complete a use-of-force report in all cases where they use force. Often, however, this does not happen. We found multiple examples of incident reports describing uses of force that had no corresponding use-of-force report, including for incidents in which officers used serious force. For example, officers completed no use-of-force reports after an incident in October 2023, where officers fired shots from a PepperBall launcher at a man who left his cell and climbed up the rafters of his housing unit. The County produced no use-of-force report or video related to this incident, and no materials indicating that supervisors reviewed the officers' conduct. When supervisors do review force incidents, they seldom assess the necessity or reasonableness of the force. Of the 271 use-of-force reports that the Jail produced from February to August 2023, supervisors found just one officer's use of force to be out of policy. Our review of the same reports found dozens of unreasonable uses of force.

When supervisors do evaluate force for reasonableness, they often conclude that force was justified because the incarcerated person failed to comply with instructions. For example, one captain found that an officer reasonably shot a man with the Taser for refusing the officer's orders to stop using the phone, writing "it was not excessive and was necessary considering [the incarcerated person] failed to comply with the [officer's] lawful order." There was no discussion of whether the officer could have resorted to alternative measures or used some lesser force to gain compliance.

Staff repeatedly describe incarcerated people as "combative" or "assaultive" based solely on verbal statements or comments, without reference to any physical action or behavior. In one case, the officer wrote that a man was being "combative" and exhibiting a "heightened level of aggression," leading the officer to shoot him with a Taser. In fact, the man was merely sitting on top of a dayroom table and refusing to go to his cell. The Supervisor's review approved the use of force.

Supervisors also fail to point out or act on obvious inconsistencies and misrepresentations or to to look behind conclusory statements in use-of-force reports. For example, in December 2023, officers justified using OC spray and firing a Taser at a man because he "refused" orders and was "continu[ing] to give resistance," according to their report. Video of the incident shows that the man was not physically resisting or threatening anyone—he was just demanding to speak to a superior officer and refusing to return to his cell when one officer, without warning, sprayed him from a

few feet away. Disoriented, the man stood by a wall with his eyes closed when a second officer tased him without warning. The man then fell to the ground and broke his arm. Supervisors approved the use of force as necessary and appropriate.

Supervisors failed to resolve conflicting accounts related to the tasing of a 17-year-old boy in June 2023. One officer reported that officers removed the boy from his cell because of an "aroma of smoke," but another reported the boy had a weapon. The officers fired a Taser at the boy through a flap in a cell door and gave contradictory reasons for the force. A third officer at the scene submitted a report with many identical passages to another officer's report; supervisors did not flag this issue, either.

> **"I'm done talking."**
>
> - **Officer before firing multiple cycles of his Taser at an incarcerated person**

Even when supervisors learn that an officer used an excessive number of Taser cycles, the supervisor may not find the force unreasonable. In April 2022, an officer tased an older man who refused to stand up from a seat because he wanted medical attention. The man said he had been in an accident and hurt his shoulder, and he screamed when the officer tried to grab his arm. The man threatened and argued with the officer, and the officer reported that he started to fear for his safety. The officer stepped back, aimed his Taser, and fired immediately and without warning, yelling "I'm done talking." As the man writhed on the floor, the officer fired multiple additional Taser cycles. In his report, the officer only admitted to around four total Taser cycles. Although a supervisor reviewed body camera footage of this incident and determined that the officer fired between six and eight cycles at the man, the supervisor deemed the force reasonable.

3.3 The Jail does not consistently discipline staff who use excessive force.

Officers at the Jail are rarely disciplined for using excessive force. When they are disciplined, the discipline is light.

Out of 338 staff disciplinary hearings in 2022 and the first eight months of 2023, 18 people were charged with "mistreatment of prisoners" or "use of force" violations.

According to County policy, staff who physically abuse incarcerated people should be dismissed.[24]

We found that even when investigators sustained excessive force allegations and County policy indicated that dismissal was the appropriate sanction, officers often received only counseling or one-day suspensions. In January 2023, Jail investigators found that a detention officer tased a handcuffed person in the back while escorting him out of a housing zone. The investigation concluded that the incarcerated person posed no imminent threat to the officer and was not actively resisting when the officer tased him. The Sheriff's Office gave the officer a one-day suspension, with a directive to enroll in a training course on Verbal Judo.

Several officers who received counseling or single-day suspensions for sustained force violations used excessive force again. In January 2023, the Chief Deputy—who ranks just below the Sheriff and oversees all Jail operations, patrol, and administrative investigations—recommended dismissing an officer, but the officer received a one-day suspension. A higher ranking officer had observed this officer walking around a housing unit yelling "Get the fuck up!" at incarcerated people during head count, and slapping one incarcerated person across the face. Three months later, the officer used a Taser against another man who, according to the incident report she wrote, had his "fist balled up" and was about to hit another officer. But the officer's body-worn camera footage shows the man was not a threat—he had turned his back to the officers, did not have his hands balled, and was starting to crouch down when the officer tased him.

[24] Fulton Cnty. Gov't, Guidebook: Personnel Policies and Procedures 305-16-26 (updated July 2023), https://www.fultoncountyga.gov/-/media/PERSONNEL-POLICIES-AND-PROCEDURES-July-2023-Update-121423.pdf [https://perma.cc/9YK9-5TAV]. The County policies do not define what "physical abuse" means. The Sheriff's Office has its own guidelines for determining appropriate discipline when an officer uses excessive force; one Sheriff's Office policy we reviewed suggested a written warning and the other a 10-day suspension for a first offense.

Environmental and Health Hazards

The Jail is hazardous and unsanitary. Housing units are full of flooded water from broken toilets and sinks. Cockroaches, rodents, and other pests abound, and the Jail takes insufficient steps to control infestations. Cells and common areas are filthy and unhygienic with dangerous exposed wires. The Jail does not provide enough food, and food preparation and distribution services are not sanitary. These conditions make the Jail unsafe; people incarcerated in the Jail have suffered from pest infestations, malnourishment, and other harms due to these conditions.

The Eighth and Fourteenth Amendments of the Constitution require jail officials to maintain facility conditions in a manner that promotes the safety and health of incarcerated people and prohibit housing people in unsanitary conditions. The right to basic sanitation includes access to the basic elements of hygiene. The Eleventh Circuit has also recognized the right of incarcerated people to "a reasonable level of food."[25]

Jail officials may be deemed to "kn[o]w of a substantial risk from the very fact that the risk [i]s obvious."[26] Here, it is open and obvious to Jail officials that (1) living conditions within the Jail are unclean and unhygienic, (2) there are inadequate parasite and pest control measures, (3) chemical control measures are inadequate and fail to prevent misuse, (4) food is insufficient and nutritionally inadequate, and food preparation and delivery services are unsafe. It is also obvious that Jail officials' failure to remedy these conditions jeopardizes the health and safety of the incarcerated population.

1. The Jail fails to maintain clean, hygienic, and safe conditions.

Poor Jail conditions have contributed to serious injuries from accidents, allowed the spread of pests and pathogens, and put incarcerated people at risk of serious harm.

Widespread and persistent plumbing failures create safety hazards and health risks. Many cells and dayrooms are filled with large pools of flooded water that can lead to the growth of mold and other pathogens. In recent years, at least two incarcerated people have been hospitalized after slipping and falling in these water pools, including a 17-year-old who sustained a "gaping wound" to his leg and a man who received a laceration and possible fracture to the back of his head. Another man was discovered

[25] *Hamm v. DeKalb Cnty.*, 774 F.2d 1567, 1573 (11th Cir. 1985).

[26] *Farmer v. Brennan*, 511 U.S. 825, 842 (1994); *see also Brooks v. Warden*, 800 F.3d 1295, 1305 (acknowledging that "the health risks of prolonged exposure to human excrement are obvious").

lying in cold water on his cell floor; his skin was cold and he was found to have hypothermia.

In August 2024, a County inspection of four housing units found 33 cells with broken sinks. Most cell sinks that we tested during our inspection did not operate properly; some had no running water, and others only sprayed water directly onto the floor. Many incarcerated people had rigged their sinks with straws in an attempt to control the flow of water. We found many toilets had leaks causing standing water or flooding inside the cells.

Leaks in Jail pipe chases are also a systemic problem. We observed leaking pipes in most of the pipe chases we inspected, many of which had large pools or deep standing water because of prolonged leaks. The water often seeped through the walls into adjacent cells. We observed incarcerated people trying to mop up the pooled pipe chase leaks in their cells with bedding, clothing, and linens.

Showers and shower door frames are full of mold, dirt, and peeling paint, and shower curtains are improperly hung up by strings, posing a security and safety risk. Drains in showers, padded cells, and individual sinks were full of dirt and debris. The drains in some of the padded cells—which function as toilets—had trash and apparent human waste in them, and several padded cells smelled strongly of feces. One padded cell also appeared to have fecal matter on the ceiling and walls.

Drain inside a padded cell

Individual cells are dirty and unsanitary and appear not to be cleaned for long periods of time, if at all. Cell sinks contain so much dirt and grime that many are unsafe for use. Toilets are filthy, and we observed clothing items in them, indicating unsafe self-laundering practices as discussed below. The bunks on which incarcerated people sleep were rusty and had dirt and debris on the platform where the mattress sits, allowing for bacterial growth and facilitating the spread of harmful pathogens.

Toilet and sink unit in a cell

Air quality and ventilation in housing units is poor. Ceilings in housing areas are covered in dust, mold, and mildew. Air vents are dirty and blow dust and debris onto ceiling tiles in housing areas. The vents in cells are rusted and contain debris, and others are obstructed with paper.

As discussed in Protection from Harm, Section 4.1, there are exposed wires throughout the Jail, including in dayrooms, cells, and pipe chases. The exposed wires and the ways people use them are an electrical hazard and a fire hazard. One incident report described an officer receiving an electric shock from exposed wires. A medical provider noted that a person with serious mental illness had pulled wires out of a wall and talked about electrocuting himself.

Exposed wires inside housing areas

Contact with exposed wires is extremely dangerous because of the risk of electrocution. But many people insert plastic objects into vandalized light switches to operate cell lights. Staff know that incarcerated people do this, and they watched as incarcerated people showed us how to use one of these plastic objects to turn on a light. Incarcerated people also use exposed wires as lighter devices called "stingers" and to heat water.

In December 2023, an incarcerated person set a "blazing fire" inside a restrictive housing area, resulting in evacuation of fifteen incarcerated people and closure of an entire housing zone. Despite smoke from the fire filling the zone and becoming so dense as to obscure the view of cameras, officers only realized there was a fire when they heard loud banging from the housing area. One incarcerated person reported that the residents, locked inside their cells, felt they were suffocating and attempted to get air from under their cell doors. Time stamps on security footage indicate that residents were evacuated 21 minutes after the fire was first seen on video. It is unclear how the incarcerated person started this fire, but the extent of the damage and the slow response demonstrate the risk of serious harm from fire hazards in the Jail.

The Jail's laundry service also fails to ensure safe and sanitary conditions to prevent the transmission of harmful pathogens and disease. Some incarcerated people resort to washing their own clothes in unsanitary ways, including in sinks, toilets, or buckets with bar soap, because of issues with the laundry service. The lack of adequate laundry service increases the risk of infections, fungus, disease, and disease-causing microorganisms. The Jail does not use soil bags for soiled laundry, which are critical to protect laundry staff and incarcerated workers from potentially harmful pathogens on soiled clothes. The laundry area included spilled and poorly stored chemicals, and dryer lint screens full of lint, a fire hazard.

In July 2024, carbon monoxide leaks in the Jail's kitchen affected multiple kitchen workers and required the Jail to shut down its kitchen and stop food services. The Sheriff's Office reported that two of its eight kettles were leaking carbon monoxide, and that multiple exhaust fans that ventilate the kettles were broken beyond repair. The kitchen had to be closed for three weeks while these issues were addressed.[27] An internal investigation revealed that routine preventative maintenance was not being done.

[27] In August 2024, the Board of Commissioners approved funding for new kettle stoves and other needed kitchen renovations.

2. The Jail has poor parasite and pest control.

The Jail is infested with lice, cockroaches, rodents, and other pests, and takes inadequate steps to control them. Rodents and insects carry bacteria and diseases that can be transmitted to humans through bites, exposure to their urine and feces, and contamination of food or surfaces. Such pests have infested the bodies of people at the Jail, making them sick or causing them significant pain and discomfort.

As discussed above, Mr. Thompson was covered in lice when he was found dead in his cell in the mental health unit in September 2022. Jail and healthcare staff were aware of lice infestations on this unit and poor living conditions before Mr. Thompson's death. A NaphCare report prepared after his death found that every person in the mental health housing unit, meaning about 100 people, had lice, scabies, or both. The month Mr. Thompson died, an infection control report documented 204 ectoparasite[28] cases in the Jail, and there were also outbreaks in preceding months: 36 ectoparasite cases in June 2022, 151 in July 2022, and 55 in August 2022. Both medical and custodial staff were aware of the extent of the issue, as the infection control reports were shared at meetings both medical and custodial leaders attended.

When incarcerated people arrive at the Jail, qualified healthcare personnel should check for the presence of parasites such as lice, bedbugs, mites, and ticks as part of an initial health examination, and if there is an outbreak in the facility, they should do this examination before the person enters general population. After Mr. Thompson died and the entire mental health unit was found to have lice or scabies in September 2022, the Jail's medical provider created an action plan that included requiring vermin assessments upon entry into the facility. This suggests that these examinations had not been happening or had not been happening consistently, despite months of outbreaks. Indeed, we found multiple cases of people who entered the Jail before Mr. Thompson's death who did not get these examinations. The Jail's medical provider also recommended to the Sheriff's Office that they allow showers at least three times weekly and enforce weekly laundry exchange, indicating that these basic hygiene measures had not been happening, either.

After Mr. Thompson's death, the Sheriff's Office approved $500,000 for decontamination and clinical cleaning inside the Jail in September 2022 and December 2022. The April 2023 emergency funding included an additional $485,000 for sanitizing and decontaminating all medical and psychiatric observation units in the Jail. In 2023, there were an average of 48 ectoparasite cases per month at the Jail.

[28] An ectoparasite is an insect, such as lice, bedbugs, flies, or mosquitoes, or an arachnid, such as mites, ticks, or spiders, that lives on the skin or within skin layers.

Funding for regular sanitization of the medical units lapsed in the fall of 2023, and the Jail continues to have major problems with pest control.

In March 2024, officers discovered two incarcerated people in the mental health housing area had active lice infestations after noticing that one man had an open sore that was bleeding onto his uniform. In February 2024, we observed that the Jail's barber cart moves between housing units and has clippers that are reused without adequate cleaning or disinfection between uses, which creates a risk of spreading infestations and infections. When we inspected the Jail in January 2024, we were told to leave one of the mental health housing zones because of a lice outbreak.

NaphCare's policy requires that a full health assessment is done for each new intake, even if one has been completed within the last year. We found several occasions, however, where providers cancelled initial physical examinations for newly admitted people because they had a recent physical examination from a previous stay in the Jail. This means that people could re-enter the Jail and not receive skin checks for infestations or infections that they acquired in the community.

Cockroaches also roam throughout the Jail. Cockroaches spread disease, filth, and are an allergen source. They contaminate food and surfaces by intermittently discharging partially digested foods from their mouth and dropping feces. We observed cockroaches scurrying out from under the Jail's kitchen ovens, showing that an infestation was present. Several of these cockroaches were carrying egg casings, indicating breeding activity. We also saw cockroaches in housing units.

Four people on a unit had confirmed cases of bedbugs in May 2024.

There is also evidence of rodent activity in the Jail kitchen where food is prepared and stored for incarcerated people and staff. While touring onsite in February 2024, we observed that rodent traps previously placed in ceiling panels in the kitchen storage room had been disturbed, showing that rodents had eaten them.

Despite the presence of numerous pests throughout the Jail, the pest control practice is reactive rather than preventative. The Jail's pest control technician will go into housing units when an outbreak has been identified, but does not regularly service housing units. The pest control technician services the kitchen weekly, but cockroach infestations in the kitchen are persistent and rodents are still present in food storage areas.[29]

[29] The pest control technician sprayed insecticide in the kitchen while food preparation was in progress. This practice is dangerous if the insecticide entered the food and was consumed.

The lack of cleanliness throughout the facility—including in critical areas like the kitchen—exacerbates the Jail's infestation problems. Rodents and roaches feed on food particles and water from any source, including standing water.

3. The Jail lacks adequate chemical control to prevent against misuse and ensure safety.

Controlling the use of and exposure to chemicals, including cleaning and disinfecting chemicals, is critical to protect incarcerated people from harm. The Jail lacks appropriate and safe chemical control practices, and it fails to store or handle chemicals in a manner that controls access and prevents misuse. As a result, incarcerated people have easy access to dangerous, high-concentration chemicals that they have used to harm themselves and others, leading to serious and life-threatening injuries.

At least two people have attempted suicide by ingesting bleach that they procured in the Jail. An incarcerated person who was hospitalized after being found vomiting in her cell was discovered through surveillance footage to have taken chemicals from central control and walking them back to her cell while staff were not watching. Another person in a mental health observation area grabbed a bleach bottle and threatened to drink it or throw it on officers, which led the officers to use force to retrieve the bleach bottle. In another case, an incarcerated person threw bleach at two others during a fight, hitting one person in the eyes. One incarcerated man swallowed a cup of bleach believing it was water and had to be transported to a hospital for treatment.

Easy access to poorly secured, high-concentration chemicals also poses a substantial risk of serious harm to incarcerated people through inadvertent exposure, for example for people working in the Jail's janitorial and laundry services.

4. Food is insufficient and nutritionally inadequate, and food preparation and delivery services are unsafe.

90%

of people living in a mental health unit of the Jail were "significantly malnourished with obvious muscle wasting."

There is substantial evidence that people in the Jail are malnourished. Mr. Thompson lost over 30 pounds in just three months that he lived in the Jail. In September 2022, medical staff determined that 90% of the people living in the mental health housing unit where Mr. Thompson resided were "significantly malnourished with obvious muscle wasting." Medical records show that other people in the Jail have suffered from malnutrition and hunger. Incarcerated people we spoke with described experiencing hunger. They explained that extortion for food is common because of the limited food supply. In one case, an incarcerated person who was tased after he took an extra lunch sack explained that he did so because he has diabetes and was hungry.

The food the Jail provides is nutritionally inadequate. Breakfast and dinner are hot meals, while lunch is two lunch meat or peanut butter sandwiches and sandwich cookies. The Jail's vendor claimed that its meals contain enough calories as well as vitamins and minerals, but it did not provide documentation to support this. Our own analysis of the vendor's menus found that the caloric and nutrient content of those menus was lower than reported. In addition, the meals we observed being served had even less variety and nutritional value than what the menus reflected.

The meals for people with medical needs that require special diets, such as diabetes and cardiac disease, are especially unhealthy and unsafe. We observed that the meal trays for diabetes and cardiac diets did not appear to be different and contained almost all the same food items as the regular diets, with almost no difference in portion size. The carbohydrate content of the special diet meal—which included cornbread, rice, and cake—was too high for someone with diabetes, and the sodium content was too high for someone with high blood pressure or cardiac disease.

Food preparation and delivery services are also unsafe. The kitchen facilities and loading dock where food enters the kitchen are unclean, with cockroach and rodent infestations as discussed in Section 2 above. We observed bird droppings around food racks on the loading dock and food grease left on the ground near a poorly maintained grease bin just outside the kitchen, a rodent attractant.

In addition, food prepared in the kitchen is not prepared or kept at safe temperatures.

Only one of 14 hot food items we measured in the kitchen was a safe temperature. Once the food left the kitchen, it took nearly 30 minutes to reach incarcerated people in their cells, and many food trays were left uncovered during transport from the kitchen. This stretched the period at which food items sat at dangerous temperatures, increasing the risk of foodborne illness. In July 2024, the Sheriff reported that the kitchen's air conditioning had been out since April, and that air temperatures in the kitchen had reached 90º Fahrenheit. Preparing food in such hot conditions is dangerous, because it is difficult to keep the food at safe temperatures.

In some cases, incarcerated people have attempted to heat food on their own using open flames, which creates a safety hazard. In April 2024, officers discovered that incarcerated people were using a cell desk as an oven, and had been doing so for some time. One officer reported "extremely strong" fumes created by the makeshift oven. Officers apparently failed to shut down the cooking operation when they found it; several days later, an officer noticed an incarcerated person inside the cell with the oven, attempting to put out a fire.

Medical and Mental Health Care

Fulton County and the Fulton County Jail fail to provide constitutionally adequate medical and mental health care to people at the Jail. Gross deficiencies in the Jail's provision of medical and mental health care expose incarcerated people to an increased risk of injury, serious illness, pain and suffering, mental health decline, and death.

Incarcerated people have a constitutional right under the Eighth and Fourteenth Amendments to "medical treatment for illness and injuries."[30] This protection "encompasses a right to psychiatric and mental health care, and a right to be protected from self-inflicted injuries, including suicide."[31] Finding that medical or mental health care is constitutionally inadequate requires evidence (1) of objectively serious medical or mental health needs that, if left untreated, pose a substantial risk of serious harm

[30] *Cook ex rel. Est. of Tessier v. Sheriff of Monroe Cnty.*, 402 F.3d 1092, 1115 (11th Cir. 2005) (quoting *Belcher v. City of Foley*, 30 F.3d 1390, 1396 (11th Cir. 1994)).

[31] *Id.* (quoting *Belcher*, 30 F.3d at 1396).

and (2) that jail officials acted or failed to act with deliberate indifference to the need for adequate medical or mental health treatment.

Jail officials exhibit deliberate indifference when they act or fail to act knowing that there is an excessive risk to incarcerated people's health from their actions or omissions. Jail officials may demonstrate deliberate indifference by failing to provide medical or mental health care, providing grossly inadequate care, using "an easier but less efficacious course of treatment," or providing "care that is so cursory as to amount to no treatment at all."[32] Providing "unsafe and unsanitary living conditions that hamper effective delivery of medical . . . care" may also constitute deliberate indifference.[33]

A serious medical need is a condition that a physician has diagnosed as needing treatment or that is "so obvious that even a lay person would easily recognize the necessity for a doctor's attention."[34] A significant number of people in the Jail have serious medical needs—either as a result of a preexisting condition, or because they develop a serious medical condition while incarcerated or experience a violent or traumatic injury in the Jail.[35] There are also a significant number of people with serious mental health needs in the Jail population. At least 60% of people in the Jail have mental health or substance use needs. Hundreds of people detained in the Jail have a serious mental illness that impairs their functioning.[36]

The Jail's Health Program Manager works for the Sheriff's Office, and is charged with ensuring that the healthcare provider provides clinically appropriate services under the contract. Fulton County and the Fulton County Sheriff's Office remain responsible for the medical and mental health care provided at the Jail, even though they contract with a private corporation to provide healthcare services.

---

[32] *Bingham v. Thomas*, 654 F.3d 1171, 1176 (11th Cir. 2011).

[33] *Brown v. Plata*, 563 U.S. 493, 519 (2011).

[34] *Bingham*, 654 F.3d at 1176 (quoting *Farrow v. West*, 320 F.3d 1235, 1243 (11th Cir. 2003)).

[35] Since January 2022, over 12,000 people have received care for one or more chronic medical conditions in the Jail. Jail medical records show that in December 2023, 657 incarcerated people had records reflecting alcohol or opioid withdrawal, 156 people had records reflecting a seizure disorder, 36 people had insulin dependent diabetes, and 121 had records reflecting an HIV or AIDS diagnosis. More than 1,500 people have required transportation from the Jail to an outside hospital for emergency medical care.

[36] The precise number of people with serious mental illness is difficult to know, because although the medical record system allows providers to "flag" people as seriously mentally ill, this is not done consistently.

1. Unsafe Jail conditions restrict access to medical and mental health care and lead to constitutionally deficient care.

The conditions in the Jail—including high levels of violence, poor supervision, poor management, and an inadequately maintained facility—unreasonably impede incarcerated people with serious medical and mental health needs from accessing necessary care. Jail officials are aware of the inadequate medical and mental health care in the Jail but have failed to take reasonable measures to improve care.

Last year, the Jail's healthcare provider, NaphCare, notified officials with the County and Sheriff's Office that the substantial safety and security risks at the Jail impede access to care. In March 2023, the NaphCare CEO stated in a letter to the Sheriff, the Chairman of the Fulton County Board of Commissioners, the Fulton County Manager, and the County's Chief Operating Officer, that Fulton County Jail was "the most dangerous jail or prison facility where NaphCare is contracted to provide services in any location in the Country."[37] He described the environment in which healthcare providers work as "not adequately safe and secure," and cited healthcare staff resignations due to "safety-related concerns."[38]

In April 2023, NaphCare notified the Sheriff that it intended to terminate the healthcare contract because "despite . . . numerous requests to leadership, conditions have worsened," and because of the need to "operate in a clean and safe environment."

In June 2023, NaphCare, the County, and the Sheriff's Office agreed to an amended contract providing that NaphCare would have a dedicated security force that escorts healthcare staff during medication administration in the housing units and clinic operations. NaphCare staff report improvements as a result of the security escorts, but there are still not enough security escorts to accompany all medical and mental health staff who need to access the housing units in the Jail.

In November 2023, the County found ongoing issues with NaphCare's staffing at the Jail, but renewed the contract for another term. NaphCare continues to be the medical and mental health care provider for the Jail today.

Conditions in the Jail continue to obstruct the delivery of medical and mental health care. The impacts include medical and mental health services at the Jail being put on

[37] NaphCare provides services in 83 jails and prisons.

[38] The NaphCare CEO reported that NaphCare staff had been assaulted or put at risk in 11 incidents since the start of 2023.

hold because of a lack of custody staff, and patients missing appointments with physicians and nurses.

In August 2023, after medical staff responded to the homicide on the 7th Floor in which cell doors were unlocked and multiple incarcerated people were stabbed, NaphCare directed its staff to no longer enter the 7th Floor housing units to provide care. Instead, medical staff were instructed to dispense medications and conduct sick call only at the entrance to the unit. Some security staff escort patients from the 7th Floor to the medical clinic, but that is not an option for mental health appointments, so mental health staff must meet with 7th Floor patients at the floor entrance. This setup impedes access to care because medical and mental health staff cannot observe patients who may be faring poorly in their cells and must rely on correctional officers to report patient refusals. Confidential conversations cannot be held, impeding the ability of medical and mental health staff to determine whether someone needs care.

Poor technological infrastructure also impedes access to healthcare at the Jail. NaphCare's electronic medical records system relies on information from the Jail's data management system to locate patients and provide them with necessary medications and care. But the Jail's data management system has failed on multiple occasions, showing, for instance, that people who are still incarcerated have been released. As a result, healthcare staff trying to access some patient medical records cannot do so; at other times, providers go to one location in the Jail to find patients, only to learn they are housed somewhere else.

Frequent power outages at the Jail further impede NaphCare's data systems. These outages have disrupted the delivery of care to incarcerated people at the Jail for long periods of time.

These care disruptions contribute to serious injury and death. For example, NaphCare policy requires evaluating people for ongoing suicidality within 24 hours of removing them from suicide observation. But in June 2023, after one man on the mental health unit jumped off the top tier of his housing unit in a possible suicide attempt, mental health staff were blocked from conducting a timely post-suicide observation evaluation because the floor officer was passing out food trays and would not allow the provider into the unit. Mental health did not complete the post-suicide watch assessment for this man until two days later. Mental health staff tried to meet with him six more times, but could not find him because his housing unit was not up to date in the computer system. Medication administration records show that he did not receive any of his prescribed medications, which included antipsychotic and antidepressant medications, for nearly a month. At least some of the reason for this gap in medication administration was that medical staff did not know where he was. He reported having a mental breakdown, and later died in an apparent homicide at the Jail.

Security and staffing problems affect all aspects of healthcare in the Jail, including medication administration, sick calls, and specialty care. They create unsafe or hazardous conditions in housing units that result in cancelled and delayed care. For example, in June 2023, medical staff could not provide medications to an entire housing zone because of flooding on the zone. And in July 2023, jail staff reported that they could not accommodate 18-to-20 outside hospital appointments daily because of staffing shortages. Mental health staff have also been unable to provide group therapy in the Jail because of inadequate security.

There are deadly consequences for failing to prioritize medical and mental health care at the Jail. Mr. Thompson died after the Jail failed to transfer him to a higher level of care: Mental health requested that he be transferred to the Jail's medical observation unit (MOU) for psychiatric observation, but he was never transferred and died five days later.

2. Inadequate medical care exposes incarcerated people to a substantial risk of serious harm, including death.

The mortality rate at the Jail in 2023 and 2022, excluding deaths by suicide or homicide, exceeded the mortality rate for local jails nationwide by a substantial margin. In 2023, there were seven non-homicide, non-suicide deaths at the Jail, and the mortality rate for deaths other than homicides and suicides was more than twice the national rate for local jails in 2019 (the last year for which data is available). In 2022, there were 11 non-homicide, non suicide-deaths, and the mortality rate at the Jail was three times the 2019 national rate.

This Fulton County Jail data is likely an undercount because the Jail does not track the numbers of people who die out of custody, including those injured or inadequately treated at the Jail. For example, the Jail's data does not include one person who had a medical emergency in the Jail's mental health unit, was released from custody to a hospice center, and died there.

We examined the cases of four incarcerated people who died from poor care at the Jail since January 2022—Mr. Thompson and three others, referred to here as A.A., B.B., and C.C. All four were incarcerated on low-level offenses. Two were unhoused upon admission to the Jail and had serious mental illness; two were withdrawing from substances and died shortly after admission. All four people were Black. Many more people who died at the Jail also experienced deficient care, though we could not determine whether the deficient care led to their death.

We find that the Jail provides constitutionally inadequate medical care to incarcerated people. The egregious problems with the Jail's provision of medical care include: a

lack of appropriate specialty care, testing, and follow-up; poor medication administration practices; multiple other care deficiencies including lack of confidential screening; poor responses to medical emergencies; and inhumane conditions in medical housing. Many of these issues stem from the Jail's failure to provide a reasonably safe facility in which incarcerated people have appropriate access to care. Constitutionally inadequate medical care already has led to serious injury and death, and it continues to pose a substantial risk of serious harm to people incarcerated in the Jail.

2.1 The Jail fails to provide adequate treatment including referrals, testing, and follow-up care.

Constitutionally adequate medical care requires that providers evaluate patients for potential medical conditions, order testing, make referrals when appropriate, and follow-up with patients as needed. We reviewed multiple cases where this fundamental care was not provided at the Jail, including cases where people died.

Mr. Thompson received inadequate medical care at the Jail before his death in 2022. During his three months in the Jail, he lost 32 pounds. Mental health staff documented his decompensation in the days leading up to his death, and at the time of his death, his body was "infested with an enormous number of small insects." One medical examiner found no clear cause of death, but suggested that the severe lice infestation could have caused significant anemia and contributed to his death. Another medical examiner found Mr. Thompson was dehydrated, malnourished, had a severe insect infestation, and died from complications of severe neglect.

Medical providers also failed to provide adequate care to A.A. before his death in 2022. A.A. died from pneumonia caused by prolonged seizure activity from hyponatremia (low blood sodium levels). A.A. had apparent seizures four months before his fatal seizure, but medical staff did not adequately assess his seizure symptoms. Instead, they relied on brief observations and determined that he did not have genuine seizures. Medical staff failed to order laboratory tests, imaging, or assessment by a neurologist, all of which are basic steps for assessing potential seizure disorders.

Medical staff also failed to have A.A. assessed for weight loss, even though he lost 24 pounds in less than three months. A.A. may have developed low blood sodium levels from drinking excessive amounts of water, a well-established cause of hyponatremia in incarcerated people with serious mental illness such as A.A. Had the Jail's healthcare staff conducted a basic clinical assessment for A.A.'s documented weight loss, they may have learned he was drinking too much water, identified his hyponatremia or seizure disorder, and provided effective treatment before his death.

In another case in 2022, a man died of a heart attack after making multiple reports of chest pain. Medical providers at the Jail who assessed him for chest pain failed to refer him for a cardiology evaluation. He requested an electrocardiogram (EKG) to check his heart, but did not receive one until the day he was sent to the hospital—where he died, five months into his incarceration.

2.2 The Jail's medication administration puts incarcerated people at substantial risk of serious harm.

Medication administration is a basic and essential healthcare function in jail settings. Proper medication administration requires consistent medication availability, and procedures to ensure that patients have an opportunity to receive prescribed medications, that medication administration is documented, and that patients who miss repeated doses of their medication are identified and their nonadherence is addressed.

We reviewed multiple occasions when patients missed medications without appropriate interventions from medical staff to address the missed doses. In 2022, medical staff failed to respond appropriately when Mr. Thompson had repeated missed medications. The month before he died and in the days leading up to his death, Mr. Thompson did not receive any of his prescribed medications, including medications for psychosis.

Medical staff also failed to respond to poor medication adherence before A.A. died. In the month leading up to his death, A.A. refused or was documented as not coming to the medication cart for his prescribed medications 55 times, and there were at least 10 other instances when A.A. did not take his prescribed medications because medication administration was cancelled or the medication was unavailable. A.A. missed his prescribed medications 10–12 times each week in the months leading up to his death.

Jail and medical staff also fail to take adequate measures to ensure that people on the unit know that medication administration is occurring. As a result, people reported missing medication administration because they were asleep, using the bathroom, or did not hear the medication administration announcement due to a hearing impairment.

Further, as described in Section 1, conditions in the Jail frequently interrupt medication administration, so that it does not reach all patients.

We also found that medication administration records were incomplete and unclear. Medication administration records must document whether the patient took the medication, and if they did not take the medication, the reason why not—whether due to refusal, medication administration disruption, unavailability of medication, or some other reason. But medication administration records from the Jail often fail to provide any reason at all when someone does not take their prescribed medication. When medication is not dispensed and the records do not make clear if someone refused

medication or if the medication was not provided, healthcare providers cannot effectively intervene to ensure patients receive medications necessary for their health.

Finally, safe medication administration requires that medical staff dispensing medications verify the identity of the person to whom they are providing medication. But staff dispensing medications do not consistently verify patients' identities before dispensing medication. This creates a risk for someone to come to the medication cart when another's person name is announced and receive the other person's medications.

Staff also must ensure that the patient takes their medication in view of medical staff. For patients who are taking controlled substances, psychotropic medications, or who have a specific order relating to medication adherence issues, this aspect of medication administration should include observing patients swallowing the medication in crushed or pill form and checking their mouth afterward to ensure the medication was swallowed. When medical staff fail to take these measures, there are risks that medications may be administered to the wrong patients and that patients may divert, hoard, or fail to take their medications as prescribed. We observed medical staff fail to verify that patients swallowed medications dispensed to them, even though controlled substances and psychotropic medications were administered in each medication pass observed. Medical staff told us mouth checks are done on a case-by-case basis, but we saw no mouth checks performed. The Jail's failure to verify medications are swallowed creates a substantial risk that patients could divert or hoard medications and take more than the prescribed dosage. This can be deadly. We identified four suicide attempts at the Jail where someone required medical care after taking a large number of pills.[39]

2.3 Multiple additional care deficiencies expose people to serious harm.

The Jail's failure to provide adequate medical care inside the Jail includes failure to provide confidential healthcare screening, failure to provide sick call slips and respond to sick call requests promptly, failure to provide adequate treatment and monitoring for people withdrawing from substance use, failure to provide access to physical therapy services and supportive medical equipment when needed, and inadequate language interpretation services.

[39] In July 2023, a young woman died at ACDC from olanzapine toxicity, which suggests that she was able to hoard multiple doses of a prescribed medication and then take more than the recommended dosage.

2.3.1 Confidential Screenings

When people enter the Jail, healthcare staff must obtain accurate information about their health condition and any medications they were taking prior to incarceration so that their needs can be identified and addressed. The Jail impedes healthcare staff from receiving this information by conducting healthcare screening of new jail admissions in a small, crowded room that does not allow for confidential conversations. Three patients may be speaking with Jail medical providers at the same time, answering questions on sensitive topics like recent substance use, mental health history, and sexual activity, within feet of each other. An incarcerated person told us that concern about the lack of confidentiality during his screening led him to not disclose his HIV-positive status upon admission to the Jail.

To attempt to provide confidentiality, healthcare providers whisper to new patients and point to computer screens to pose sensitive questions, asking patients to circle "yes" or "no" on a piece of paper to answer the question. This method of medical screening is likely to result in medical information being miscommunicated or withheld. The lack of confidentiality in the Jail's intake screening puts patients at substantial risk of poor health outcomes in the Jail.

2.3.2 Sick Call

The sick call process at the Jail does not provide adequate access to care because there are significant delays and impediments to access.

When people submit requests for care (e.g., sick call slips), NaphCare's policy requires that healthcare staff triage the request in a face-to-face encounter within 24 hours to ensure that anyone with an urgent medical issue is seen right away. But people at the Jail regularly wait more than 24 hours to be assessed and scheduled for clinical care. This includes people with potentially life-threatening complaints like chest pain.

Additionally, sick call slips are not available in the housing units. Incarcerated people must ask medical staff for a sick call slip during medication administration. But when we observed medication administration at the South Annex, the medical provider did not have sick call slips to distribute, and she did not offer an alternative way to request care when someone asked her for a sick call slip.

2.3.3 Withdrawal Management

The Jail does not appropriately manage and treat people withdrawing from dangerous substances. We found that in multiple cases, people were not appropriately placed on withdrawal monitoring and medications when they should have been, and detox assessments were missed or delayed. The Jail should, but apparently does not, have

a practice to continue or initiate medications for the treatment of opioid use disorders when it is appropriate and medically necessary to do so.

Failure to properly manage withdrawal can be deadly. In 2023, the Jail failed to monitor and treat B.B. for benzodiazepine withdrawal and a seizure disorder before his death. Medical providers identified B.B. as having a seizure disorder and listed a seizure medication as a current medication, but they failed to place an order for the medication. Three days after B.B.'s admission, he submitted a request for medical care and reported drug withdrawal, chest and head pain, and not receiving any medications. Another two days later, B.B. told medical staff he was taking Xanax, a benzodiazepine, before entering the Jail. Medical staff should have provided B.B. his seizure medication, monitored his seizure disorder, and managed his benzodiazepine withdrawal. Instead, they just said they would review his medications. B.B. died at the Jail seven days after his admission, likely from a fatal seizure.

In 2022, the Jail failed to appropriately manage C.C.'s benzodiazepine withdrawal, leading to her death from a seizure shortly after admission. During her intake screening, C.C. reported daily benzodiazepine use. Medical staff at the Jail started her on a detox protocol that included a seizure medication, but they removed C.C. from detox monitoring after just three days and transferred her to the South Annex. For the next five days, C.C. missed one or both doses of her seizure medication daily. Medical staff should have continued to monitor her for withdrawal symptoms or prescribed a long-acting benzodiazepine replacement to stabilize withdrawal symptoms, and they should have intervened when she missed repeated doses of her seizure medication. On the fifth day of missed medications, C.C. was found unresponsive after having a seizure. Medical staff at the Jail transferred C.C. to a local hospital for treatment, where she died.

2.3.4 Rehabilitative Therapy

Rehabilitative therapy is a necessary medical service that includes therapies prescribed to improve patients' movement, strength, and independence, and to reduce pain. It is routinely ordered for patients following acute injuries and surgical procedures to improve their recovery, and it is an essential aspect of care for multiple chronic health conditions.

As discussed, significant numbers of people incarcerated in the Jail experience traumatic injuries in custody and have chronic health conditions. The Jail fails to provide adequate rehabilitative therapy to incarcerated people despite the need for this care. Rehabilitative therapy services are provided off-site at Grady Hospital, which requires custody staff to transport patients to and from the Hospital for multiple sessions. The transport may involve an entire day in restraints that can cause

significant pain and discomfort for a 30-minute treatment. By not offering rehabilitative therapy on-site at the Jail, the Jail makes it much more likely that these services will be out of reach for incarcerated patients, and they may become temporarily or even permanently disabled as a result.

For example, an incarcerated person suffered blunt head trauma and was stabbed in an assault in June 2023. He experienced difficulty standing, headaches, and dizziness. In August 2023, it was discovered he had bleeding near his brain, requiring cranial surgery. Afterward medical providers referred him for physical therapy and occupational therapy for limb strengthening. There is no record of him having physical therapy. The occupational therapist recommended weekly sessions for the next four weeks, but the Jail did not schedule him for the follow-ups, and he did not return to therapy. When we met this person in January 2024, he was using a wheelchair and expressed a need for rehabilitative therapy services. He previously worked in construction, but it is unlikely that he could return to that work in his physical condition.

2.3.5 Medical Devices

Medical and assistive care devices may be necessary to prevent people with physical disabilities from experiencing a deterioration of their physical condition, further injury, or an inability to access critical services. Despite the significant number of people at the Jail with physical disabilities, the Jail does not ensure that medically necessary devices and supports are provided. We identified multiple failures to provide medical equipment to people with physical disabilities that put them at risk of serious harm. For example, we met a man with cerebral palsy who was unable to obtain specialty footwear that would allow him to walk with a normal gait. As a result, he wears socks without shoes in the Jail, putting him at risk of falling and injuring himself. We met another man with a hearing impairment who only received hearing aids in September 2023—five months after an audiologist recommended them. And then, until we raised the issue with counsel, the man could not use the hearing aids because he could not charge their batteries. He missed medication administration because he could not hear it being announced.

These are in addition to the Jail's failures to provide adequate sleeping surfaces for people with physical disabilities, described in Section 2.5 below.

2.3.6 Language Access

Finally, the Jail does not consistently use language interpretation services when providing care to incarcerated people with limited English proficiency (LEP).[40] We spoke with a Spanish-speaking person who has serious medical needs related to prostate cancer. He reported that he does not receive interpretation services during his medical appointments and that the nurses do not speak Spanish. As a result, he cannot effectively communicate his needs and is experiencing a lot of pain. NaphCare staff explained that they have access to a telephonic language interpretation service, but it requires using a landline and officers need to pull the patient out of the housing area to access it. The failure to provide language interpretation services for people with serious medical needs means they may not receive treatment necessary to resolve their condition or reduce pain and suffering.

2.4 The Jail fails to provide appropriate medical aid in life-or-death situations.

Jail and medical staff have an obligation to respond to people experiencing medical emergencies in the Jail. Medical records, surveillance video, and body-worn camera footage reveal grossly deficient responses to medical emergencies at the Jail by security and medical staff.

When deputies or detention officers encounter an incarcerated person experiencing a medical emergency, they should notify medical staff and provide a basic first-responder level of care. This includes, as appropriate, starting CPR, applying bandages to wounds, using an automated external defibrillator (AED), administering naloxone, or placing the patient in a recovery position to open the airway. In multiple deaths at the Jail, however, the first responding officers failed to provide basic first-responder care. While a proper emergency response may not have resulted in a better outcome, the pattern of poor emergency responses poses a substantial risk of harm.

For example, officers who responded to the fatal stabbing in August 2023 did not provide first responder care, so emergency medical care was delayed 3.5 minutes waiting for medical staff to arrive. Two officers who responded to the homicide in September 2022 can be seen on surveillance video standing around while the victim was on the ground, unresponsive. The same month, Mr. Thompson was found

[40] Title VI of the Civil Rights Act of 1964 (Title VI) prohibits Fulton County from discriminating against incarcerated people on the basis of race, color, and national origin, which can include failure to provide meaningful language access to LEP individuals. *See* 42 U.S.C. § 2000d-1; 28 C.F.R. §§ 42.104(b)(2), 42.405(d)(1). The Fulton County Jail has a legal obligation to treat LEP people in a nondiscriminatory manner and to ensure meaningful access to jail programs and services, including medical services. *See* Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41455, 41469–70 (June 18, 2002).

slumped over in his cell, and the first responding officer did not perform CPR, delaying chest compressions several minutes. Officers reported that they do not routinely participate in "man down" or other medical emergency response drills with healthcare staff.

In a death at the Jail in December 2022, a medical provider failed to promptly assess a 24-year-old man brought to the MOU on a stretcher for complaints of severe constipation. Although the man was unable to stand, he was left alone in a cell in the MOU. After 10 minutes, a medical provider briefly checked on him. When the provider returned 19 minutes later, the man was on the floor outside the cell mostly not moving. Another 4–5 minutes passed with the man lying mostly motionless on the floor before the provider took his vitals or assessed him.

2.5 Conditions in the Jail's medical housing put people with serious medical needs at risk.

The Jail houses male patients with the most serious medical needs in the MOU and female patients in the Female Observation Unit (FOU). These patients are the Jail's most medically fragile population, yet conditions in the MOU and FOU are dangerously inadequate.

First, there is a lack of adequate nursing and medical assistant staff in these units to support patients who need assistance with toileting, bathing, eating, and transferring in and out of bed. We observed a patient in the MOU who was on the floor wearing only a diaper. Medical staff reported that he is partially paralyzed from a stroke, and that they give him a walker every day for an hour for exercise. Medical staff did not appear alarmed that the man was otherwise on the floor and did not attempt to help him use the walker. This man required constant help with mobility, which the Jail was not providing him and did not have the staffing to provide.

A 75-year-old partially paralyzed person we observed in the MOU could not get out of bed, could not get into a wheelchair, was bowel incontinent, and had pressure ulcers on his back. This person reported waiting hours and even days for medical staff to help change his diaper. He reported that nursing staff bathe him in his bed every few months. We observed him in a small, cramped cell, with no television or source of stimulation. He told us that before getting a cellmate, he was alone in this cell for eight months and lost track of reality and family ties. In early 2024, he fell from his bed and fractured his hip. There is a substantial risk that with this person's weakened state and the lack of appropriate nursing care, he will continue to decline in the MOU, will have worsening malnutrition, and that he will contract a fatal infection.

Medical records of a 65-year-old man who died in the MOU further underscore the need for nursing care in this unit to assist patients with daily living activities. This man

was described upon admission to the Jail in February 2023 as “disheveled” and having “disorganized” thoughts, and providers at Grady Hospital later prescribed him dementia medications. A mental health status examination in March 2023 noted that his “boat,” or temporary bed, was covered with toilet paper, apparent feces, and soiled clothing, and that the floor in his cell was wet. Another mental health encounter that month documented that the man was visibly dirty, had hands soiled with feces, and that feces were spread on the wall of his cell and on his bed and sheets. In April 2023, a psychiatrist observed him drinking from the toilet in his cell. When the psychiatrist had an officer open the man’s cell, they found boxes of uneaten food trays, indicating that he was not eating. The psychiatrist reported that the man had developed infections in his legs from picking at skin ulcers with fingernails that had fecal matter on them. The mattress and floor in his cell were soaked in urine and he had no clothes on. Days later, this man was found unresponsive in a cell described as “foul smelling and dirty”; he was transported to Grady Hospital where he was pronounced dead. A medical examiner attributed his death to heart disease. He needed skilled nursing and memory care, with support for his activities of daily living, including eating, bathing, and using the toilet. His inability to receive this care in the MOU increased his pain and the risk of infections.

Second, the physical conditions in the MOU and FOU put people with serious medical needs at risk of serious harm. Many cells in the MOU and FOU lack basic safety features, such as grab bars on the walls to help people with mobility impairments to transfer between beds, wheelchairs or walkers, and toilets. We observed multiple people in the MOU and FOU using steel frame beds that did not meet their needs, including people with heart and lung problems that require elevation during sleep, and people who are at risk of skin ulcers without special mattresses and the ability to elevate parts of the bed. We also observed people sleeping on the floor of the MOU and FOU on temporary beds or mattresses. Patients who are a fall risk should not be sleeping on the floor, because they may fall getting up from their beds or down onto the floor. Having medically fragile patients sleep in beds on the floor also creates a risk that they will decline physically because of the difficulty of getting off the floor for daily activities. Recent documentation from the Jail indicates some medical beds have been added, but it is unclear if they will be adequate for the needs of the population.

Finally, the Jail has an inadequate emergency alert system for high-needs patients to contact medical and jail staff in case of a medical emergency. There are emergency call buttons in MOU and FOU cells, but they are not reliable. In the FOU, women reported that if they need medical attention overnight, they bang on their cell doors to alert two women who are housed in a cell with a broken lock. It is then up to the women in that cell to leave their cell and go to the outer door of the FOU to bang on that door and get staff attention so they can render aid. Two women who were being

treated for active seizures expressed their fear that they will be unable to get care at night if one of them has a seizure. The call buttons in the FOU alert to a security post that is unstaffed overnight, when it is most needed.

3. People with mental health needs experience poor Jail conditions and deficient mental health care.

3.1 The Jail environment is harmful to people with mental health needs.

A majority of the people who have died in the Jail in recent years had a mental illness. We found that 75% of those who died in the Jail since January 2021 had a current mental health diagnosis or reported a history of mental illness.

The physical conditions of the Jail create substantial risks for people with mental health needs. As described above, there is easy access to contraband that may be used for self-harm. For example, in August 2023, a person was able to possess a man-made weapon while on suicide watch; in April 2024, a person was found in his cell using a needle to puncture a vein on his arm, causing severe blood loss.

The Jail has padded cells for people who are acutely suicidal or self-harming. But the padded cells are often in disrepair and not suitable for this purpose. Jail leaders are aware that the padded cells have been unavailable for extended periods, and the cells have remained intermittently unavailable even after repairs. We observed padded cells in varying states of usability during our visits to the Jail. On one visit, we observed a padded cell with padding ripped off the walls, exposing concrete. The cell had dried excrement, food, and other unknown organic materials stuck to the walls, with litter, discarded clothing, and cockroaches in a drain on the floor. Two padded cells had broken drainage grates with sharp edges that could be used for self-harm. We also viewed a padded cell with a metal sprinkler on the ceiling that could be used to tie off a ligature or for self-harm. During one visit, we encountered a person on suicide watch in a padded cell that had broken floor pieces which could have been used for self-harm.

Mental health staff reported that custody staff use the padded cells for reasons other than their intended use, as mental health staff have “discovered” people in those cells without having been consulted or notified of suicidal ideation. Such use may contribute to problems with the physical state of the padded cells.

Conditions on the mental health unit remain poor. Recent County inspections of the mental health unit documented one housing zone where both showers were inoperable, and a “foul-smelling odor” in another zone caused by pooling water that had been an issue for months. In June 2024, inspectors found that ten cells in the

mental health unit had broken lights. In some zones on the mental health unit, people are locked down and held in isolation for 23 hours a day in these conditions.

These problems are exacerbated by a culture among custody officers where mental health issues are deprioritized. Incarcerated people told us that custody staff disregard mental health complaints and requests for treatment. Mental health staff reported repeat instances where custody staff would not respond appropriately to concerns. In January 2024, we spoke with an incarcerated person who was detained in the Psychiatric Observation Unit (POU). He shared that he was considering suicide and showed us a clearly visible fabric noose tied to the vent in his cell. We asked him to take it down, and he handed it over to DOJ representatives. But when DOJ representatives notified nearby Jail staff, the staff told us to throw it away in a nearby unsecured trash can and appeared to take no further action.

The cumulative effect of poor physical conditions, security problems, and a culture of disregard is an environment in which mental health needs go unmet and serious mental health conditions are exacerbated. For example, in the August 2023 incident described above, when officers realized that a person on suicide watch had a man-made weapon, they repeatedly tased and sprayed the person with OC "to gain compliance." Despite the person being on suicide watch and "silen[t] and in a daze," there was no documented effort to deescalate or contact mental health staff before using force. In June 2023, a person made multiple threats of self-harm and attempts at self-harm after reporting assaults and ongoing threats of both physical and sexual assault. Mental health staff noted his focus on "violence and unsanitary conditions of the jail."

3.2 The Jail does not provide adequate treatment to people with mental health needs.

Necessary mental-health-related interventions, treatment, and rehabilitative services are mostly unavailable at the Jail, even for people with mental health needs residing in specialized housing.

Professionals responsible for mental health treatment in the Jail are unable to provide services that meet minimum standards. The Jail's contract with NaphCare requires that NaphCare provide people with mental health disabilities "psychosocial and medication therapies," and "individual or group therapy as indicated," in order "to relieve symptoms, achieve a level of appropriate functioning and prevent a relapse." But record review and interviews with Jail staff, mental health staff, detained people,

and advocates confirmed that such services are unavailable in the Jail.[41] Non-clinical mental health staff document educating patients about their mental health conditions, but not providing them therapy. Mental health staff described their services as limited to crisis stabilization and medication management.

Responses to requests for mental health care are often delayed because officers are unavailable to escort mental health staff to see patients. We heard numerous reports of requests for mental health care that went unanswered.

The check-ins mental health staff provide to people with mental health needs throughout the Jail are brief and superficial. "Cell-side" check-ins, lasting about five minutes and with limited or no confidentiality, are common. Some check-ins happen in public view while the mental health provider stands in the hallway at the entrance to a housing zone.

Incarcerated people in specialized mental health units lack access to minimally adequate mental health care. People on 3 North—the housing unit for those with mental health needs—generally receive the same low level of mental health care they would receive if they were housed in general population. This includes medications and the possibility of a brief check-in with a member of the mental health staff. But even medication and monitoring/check-ins are frequently unavailable or disrupted. Mental health staff told us it was not safe to have groups at the Jail given the lack of custody staff, and so there is no group therapy provided.[42] Being placed in the Jail's other specialized mental health housing, the POU, only means that a person

[41] Women at ACDC receive mental health services as a result of a class action lawsuit. *See* Settlement Agreement Regarding Women who Experience Psychiatric Disabilities in the Fulton County Jail System ¶¶ 29, 33, *Ga. Advoc. Off. v. Labat*, No. 19-cv-1634 (N.D. Ga. Apr. 4, 2022), https://www.schr.org/wp-content/uploads/2022/04/Order-approving-settlement.pdf [https://perma.cc/F6TH-7353] (requiring the provision of "therapeutic activities" according to a curriculum that may include, but not be limited to, "medication management, art therapy, music therapy, group counseling, meditation, and maintenance of personal hygiene").

[42] There is one specialized unit on 3 North where a group affiliated with Emory University provides jail-based competency restoration services to a small portion of the people who have been found incompetent to stand trial. Competency restoration services are different from mental health treatment, which aims to help individuals achieve recovery and stability. *See How Does Restoring Mental Competence Differ from Standard Mental Health Care?*, Am. Psych. Ass'n (June 1, 2022), https://www.apa.org/monitor/2022/06/feature-restoration-treatment [https://perma.cc/X4CZ-AWYK].

experiencing a mental health crisis, such as suicidal ideation, is separated from others, may be in a padded cell, and is available for more convenient monitoring.[43]

Mental health staff should develop and implement treatment plans for all patients with serious mental health needs. These treatment plans should describe treatment methods and set goals for the patient's progress. But we found that even patients on the mental health unit did not have clearly defined treatment plans in their records.

Finally, there are not enough psychiatric staff to meet the needs of the incarcerated population. There is only one full-time psychiatrist for the Jail who is supported by a part-time psychiatrist and several psychiatric nurse practitioners. Given the significant mental health needs of the Jail population, this is not sufficient psychiatry staffing. Staffing records reveal that the South Annex does not have any dedicated psychiatric coverage, despite the high needs of the population there, which includes 17-year-olds and people in restrictive housing. A psychiatric nurse practitioner reported traveling to the South Annex about once per week to provide services, but this is not reflected in the schedule. Without consistent psychiatric coverage at this facility, it is likely that patients requiring psychiatric care at the South Annex will have significant delays in accessing care and that their care needs will not be met.

3.3 Suicides at the Jail reflect deficient mental health care and suicide prevention practices.

Fulton County Jail fails to provide minimally adequate suicide prevention care to at-risk people. This failure creates substantial risks for incarcerated people.

Problems with lack of confidentiality at intake and availability of security staff, as discussed above in Sections 1 and 2.3, make it harder for people to report suicidal feelings during the initial suicide screen and to receive help when needed.

When people are identified as at risk for suicide, the Jail's suicide prevention practices do not provide sufficient protection. People needing observation due to suicide risk may be held in cells with tie-off points that could be used for hanging, objects or surfaces that could be used for self-harm, insufficient visibility into the cell, or other unsafe conditions that may increase risk of suicide or self-harm. While inspecting the POU, we saw officers bring in a person who had attempted suicide by jumping off the top tier of his housing unit. Despite this, he was placed in a POU cell that was not

[43] *But see* 28 C.F.R. § 35.152(b)(2)(ii) (requiring jails to generally avoid "plac[ing] inmates or detainees with disabilities in designated medical areas unless they are actually receiving medical care or treatment").

suicide-resistant. Some people are also placed on suicide watch in restrictive housing units, instead of cells designed for suicide prevention.

Once people are placed on suicide observation, the Jail does not provide "constant observation" on a "continuous, uninterrupted basis" as required by the provider's suicide prevention policy. Although there must be no more than 15 minutes between documented checks for a person on suicide watch, there is often insufficient jail staff to meet this requirement. A December 2023 review found that the 15-minute checks for suicidal patients were completed as required in 0% of 33 cases reviewed. Aside from observation and medication, no additional supports, therapy, or services are provided to people on suicide watch. As with others in the Jail, people on suicide watch do not receive counseling or talk therapy, skill-building, or adequate crisis or safety planning.

The Jail's suicide watch practices, which consist only of isolation, monitoring, and medication—and failure to deliver even those aspects safely and reliably—put people in the Jail at risk of serious harm.

Moreover, the Jail's failure to conduct routine security rounds hourly, as described in Protection from Harm, Section 3, makes it less likely that staff can prevent suicides from occurring in the housing units.

Finally, incarcerated people are often taken off suicide watch quickly, in some cases the same day they were placed on watch, and without appropriate assessment of suicide risk. In one case, a man died by suicide just a few hours after a post-suicide watch assessment found he was not a danger to himself, raising questions about the adequacy of the assessment. Adequate safety planning—where underlying triggers and reasons leading to suicidal thoughts or attempts are addressed and mitigated using a plan agreed to by the incarcerated person—does not occur before release from suicide watch. And although the applicable policy requires reassessment within 24 hours of being discharged from suicide watch by a qualified mental health professional, such follow-ups are inconsistent and may occur after 24 hours.

These deficiencies create a substantial risk of serious harm. The Jail reported 133 instances of self-harm or suicide attempts resulting in the need for medical treatment since 2021. This number includes serious suicide attempts, including a September 2022 attempt by hanging where an incarcerated person broke his neck. In that same period, there have been four deaths by suicide at the Jail. All four deaths involved hanging and self-strangulation. In multiple deaths, the person likely had been dead for a long time before they were found.

We found that the Jail failed to provide adequate mental health care and monitoring to an incarcerated person with suicidal ideation and serious mental illness, D.D., who died

by suicide in the Jail. During intake screening, D.D. reported severe depression and auditory hallucinations. He expressed an intention and desire to kill himself and was placed on suicide observation. A psychiatrist evaluated D.D. but did not order psychiatric care or medication.

D.D. was placed in restrictive housing for protective custody. Over the next several weeks, D.D. reported visual and auditory hallucinations on multiple occasions and was smearing feces in his cell. But there were no changes to his care. After about a month in restrictive housing, D.D. threw himself down the stairs in an apparent suicide attempt. Following this incident, mental health staff placed D.D. on and took him off suicide watch the same day. A psychiatrist evaluated him after the suicide attempt and prescribed him antipsychotic and anxiety medications. D.D. was intermittently medication compliant in the weeks that followed. One month after his suicide attempt, D.D. hanged himself in his cell. He left a bizarre and disorganized note and drawings in his cell suggesting he had active psychosis when he killed himself. The officer who completed the last security round before finding D.D. hanging in his cell did not observe him because D.D. had covered his window with a blanket.

The Jail also failed to provide adequate mental health care to E.E., an incarcerated person with psychosis, depression, and PTSD who died by suicide. Upon entering the Jail, E.E. reported anxiety, past trauma, and a traumatic brain injury from a motor vehicle accident that he described as a suicide attempt. He also reported both auditory and visual hallucinations. A psychiatric nurse practitioner diagnosed him with anxiety and prescribed anti-anxiety medication but did not screen him for PTSD or psychotic disorders.

During subsequent mental health encounters, E.E. reported visual and auditory hallucinations and asked for medications he received in a prior incarceration. But he was not referred back to psychiatry for four months. A psychiatric nurse practitioner then continued E.E. on the same medications despite his reported symptoms.

E.E. was found dead in his cell a few weeks later, hanging from a noose. First responders noted that his body was cold to the touch and had signs of rigor mortis (stiffening). They estimated he had been dead for hours. He was found during morning headcount, and review of security footage show that security staff did not complete rounds in his housing unit overnight.

3.4 Poor discharge planning puts people with serious mental health needs at risk of harm.

An adequate mental health program requires sufficient discharge planning for people exiting custody. Incarcerated people with mental health needs must have access to discharge planning that “includes a sufficient quantity of medication to allow continuous

use," "a pre-discharge assessment," "appointments with community providers," and "medical records . . . transferred to community providers."[44] Though the Jail provides some discharge planning services through NaphCare, we learned that access to those services is only by request or referral. People whose medical or mental health conditions preclude them from effective self-advocacy, or whose attorneys do not request discharge planning and coordination, often fall through the cracks.

Advocates told us that people with mental health needs frequently leave the Jail without a meaningful plan to support them in receiving crucial follow-up care. On discharge, they receive a boilerplate flyer that includes contact information for various resources and providers in the area—not a written plan related to their individual needs.

One mother told us that her son with schizophrenia was released with active psychosis. The mother had wanted to arrange services for him before discharge so that he would not end up re-incarcerated due to probation violations, as had happened previously. But she reported that he was discharged without notice to her and after he had been unable to speak with her for several days. He was released to the street and had a stranger call her for help. She then had to have a ride-share pick him up while he was still experiencing psychosis and bring him to a detox facility.

We reviewed the medical records of another person, who was discharged while possibly in active opiate withdrawal. We found no documentation of discharge planning or any documented consideration of services and supports upon discharge for this person.

Similarly, people who take prescription medication are generally offered only four days of medication upon discharge. Re-entering people are directed to obtain this medication on a weekday between 8 a.m. and 4:30 p.m. after their release, which may be difficult for people discharged outside of those hours. Although the norm is four days, people can receive up to 30 days of medication with a court order. But not every re-entering person will get a court order. And for people with serious mental health

[44] *Charles v. Orange Cnty.*, 925 F.3d 73, 82–85 (2d Cir. 2019) (holding that deliberate indifference to the need for such discharge planning services could violate constitutional requirements); *see also Wakefield v. Thompson*, 177 F.3d 1160, 1164 (9th Cir. 1999) (holding that a correctional facility must provide a re-entering person "who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply").

needs, four days may be insufficient to allow them to obtain medication from a provider in their community.[45]

These inadequate services increase the likelihood that people with mental health needs will be rearrested and returned to the Jail, beginning anew a cycle of inadequate mental health care, exacerbation of mental health problems, and recidivism.[46]

4. Inadequate mortality reviews, psychological autopsies, and oversight practices fail to correct deficient care.

Jail and medical staff should review all deaths in custody to identify problems with the decedent's treatment, areas for improvement, and solutions to any problems identified. The County and Sheriff's Office should have an active role in these reviews. They should also monitor NaphCare's services to ensure that quality care is provided.

The Jail's medical provider conducts morbidity and mortality reviews following deaths at the Jail, but they are cursory and fail to identify care deficiencies. For example, following C.C.'s death, the morbidity and mortality review found no reason to analyze the root cause of C.C.'s death and found no areas of care that were deficient or needed improvement, even though she had missed multiple consecutive doses of a seizure medication and died of a seizure.

We found deficiencies in care provided in many non-homicide jail deaths we reviewed. The Jail's medical staff, however, concluded half of its mortality reviews with no recommendations, no findings of deficiency, and no need for improvement. Mortality reviews and psychological autopsies for deaths from suicide have minimal detail, and lack analysis and corrective action plans.

Additionally, the County and Sheriff's Office do not closely monitor NaphCare's services in the Jail to ensure adequate healthcare is provided. The Sheriff's Health

---

[45] *See Charles*, 925 F.3d at 84 (noting that the National Commission on Correctional Health Care, American Psychiatric Association, American Psychological Association, American Medical Association, and others agree that individuals must be discharged with adequate medication to allow continuity).

[46] *See* Substance Abuse and Mental Health Servs. Admin., Best Practices for Successful Reentry from Criminal Justice Settings for People Living with Mental Health Conditions and/or Substance Use Disorders 9 (June 1, 2023), https://store.samhsa.gov/sites/default/files/pep23-06-06-001.pdf [https://perma.cc/VJN9-5G36]; *see also* Fulton Cnty. Just. & Mental Health Task Force, 2017 Report – Executive Summary 11, https://fultoncourt.org/sites/default/files/task_force/fulton_county_justice_and_mental_health_task_force_executive_summary.pdf [https://perma.cc/U7U6-RAW4] (identifying gaps in re-entry planning for people with mental health needs that can lead to recidivism); *Familiar Faces Project*, Fulton Cnty. Sup. Ct., https://fultoncourt.org/task-force-familiar-faces [https://perma.cc/82LM-9NVN].

Program Manager monitors NaphCare's services by reviewing staff vacancies—NaphCare credits money back to the County that is not used because of understaffing—and by attending regular meetings with healthcare providers. Some corrective actions are identified and discussed during these meetings, but the Health Program Manager does not track them to make sure they are put in place, and she does not assess the adequacy of the contractor's medical care. The Health Program Manager's background is in mental health, yet she does not monitor NaphCare's provision of mental health services in the Jail.

Restrictive Housing and Discipline

Conditions in restrictive housing in the Fulton County Jail expose people to a substantial risk of serious harm including self-injury, decompensation, and acute mental illness. The Jail routinely holds people with serious mental illness and youth in restrictive housing despite their vulnerability to such harm. The Jail imposes lengthy terms in restrictive housing as a form of punishment, without accommodations for people with mental health disabilities or due process protections.

1. Restrictive housing conditions at the Jail pose a substantial risk of serious harm.

Jails use restrictive housing, sometimes referred to as solitary confinement, to manage incarcerated people who threaten jail safety. Restrictive housing conditions violate the Eighth and Fourteenth Amendments when they create a substantial risk of serious harm to incarcerated people, and when the officials who oversee a jail's restrictive housing practices act with deliberate indifference to the risks.

The isolation resulting from restrictive housing can pose a substantial risk of psychological, emotional, and physical harm including depression, anxiety, psychosis, self-injury, and suicide. The potential for serious harm may depend on the length of placement in restrictive housing and whether the conditions cause the "deprivation of [an] identifiable human need," such as the right to food, warmth, exercise, or basic sanitation and hygiene.[47] Certain populations, including youth and people with serious mental illness, are particularly vulnerable to the harms associated with restrictive housing and are especially impacted by it.

[47] *Melendez v. Sec'y, Fla. Dep't of Corrs.*, No. 21-13455, 2022 WL 1124753, at *10 (11th Cir. Apr. 15, 2022) (citation omitted); *see also Sheley v. Dugger*, 833 F.2d 1420, 1429 (11th Cir. 1987) (per curiam).

In light of the well-established risks associated with restrictive housing,[48] qualified mental health professionals must assess people before they are placed in restrictive housing (or immediately thereafter if that is impossible) to determine whether restrictive housing is likely to cause them harm. People with serious mental health needs and youth should not be subjected to prolonged periods of restrictive housing in inadequate conditions and without appropriate services. Qualified medical and mental health staff must regularly monitor all people in restrictive housing to watch for signs of decline and recommend removal from restrictive housing when necessary.

Despite the well-known and serious risks to psychological and physical health, the Jail has a practice of holding people, including people with serious mental health needs and youth, in harmful restrictive housing conditions for long periods, without adequately assessing and monitoring them for harm.

The Jail's restrictive housing policy does not require that mental health assess people before they are placed in restrictive housing to determine whether restrictive housing is contraindicated because of a risk of harm. NaphCare policy states that there should be a record review when someone is placed in segregation to assess them for contraindications, but it does not explain what is a contraindication to segregation. When conducting rounds in restrictive housing units, NaphCare staff fill out a form that includes "yes" and "no" checkboxes to indicate whether there are any contraindications to segregation. But these assessments appear to occur after someone is already placed in restrictive housing, and healthcare staff rarely note a contraindication to restrictive housing. The form appears to auto-populate "no" responses to both the questions for segregation contraindication and the question for suicidal ideation.

As a result, people at risk for serious harm from prolonged restrictive housing are routinely confined in restrictive housing conditions. On one restrictive housing zone in October 2023, 13 of 17 people on the zone had a current or recent diagnosis of a serious mental illness (76.5%). These diagnoses include bipolar disorder, schizophrenia, depression, and psychotic disorders, all of which are conditions that may be made worse by restrictive housing.

The Jail's restrictive housing units are highly isolating and often unsanitary. Restrictive housing involves confinement inside a cell for 22, 23, or 24 hours a day. Showers may

[48] Restrictive housing, also known as segregation, is any type of detention that involves three basic elements: (1) removal from the general incarcerated population, whether voluntary or involuntary; (2) placement in a locked room or cell, whether alone or with another incarcerated person; and (3) inability to leave the room or cell for almost all day, typically 22 hours or more. U.S. Dep't of Just., Report and Recommendations Concerning the Use of Restrictive Housing 3 (Jan. 2016), https://www.justice.gov/dag/file/815551/dl [https://perma.cc/2L4J-S8TN].

only happen three times a week, and following out-of-cell time on Friday, incarcerated people stay in their cells until allowed out on Monday.

Conditions are particularly restrictive for people placed in restrictive housing for disciplinary reasons. The Jail's disciplinary segregation policy indicates that people in disciplinary restrictive housing need only be let out of their cells for one hour a day, five days a week. Some people in disciplinary restrictive housing reported not receiving this minimum allowance, instead only getting out of their cells two days a week, or going a week without leaving their cell. When people in disciplinary restrictive housing do get out of their cells, there is nothing productive for them to do, because they generally cannot use the phone to speak with loved ones, participate in programming, or order commissary products other than basic hygiene items.

At the time of our initial inspection in August 2023, the Main Jail had six designated restrictive housing zones with 32–36 people in each, and they were some of the most dangerous and poorly maintained zones. One suicidal person confined to such a zone complained that his unit was dark and lacked electricity, describing it as "the hole." An officer told us that people had set fires and hanged themselves to get out of these cells.

There were repeated incidents of self-harm in these restrictive housing zones. In August 2023, an incarcerated person with borderline personality disorder and major depressive disorder was found in his restrictive housing cell with a sheet wrapped around his neck. He was put on suicide watch for one day after this attempt, then returned to restrictive housing. The person described struggling "[b]eing behind the door," and told mental health, "I can't go in the hole." Records reflect that medical and security staff discussed moving the incarcerated person out of restrictive housing "within 2–14 days." Instead, he remained in restrictive housing for more than two months.

In December 2022, an incarcerated person with major depressive disorder and PTSD who had been in restrictive housing for 41 days attempted suicide by hanging. He suffered respiratory failure and was hospitalized for a week following this attempt. After officers cut him down and while they were searching for an AED machine to revive him, they were alerted that another person was hanging from a light fixture in his cell at the same time and in the same zone. In May 2022, an incarcerated person who had been in restrictive housing over 50 days attempted suicide by hanging. Days later, this person was back in restrictive housing and started a fire in his cell. He said that he started the fire because he was having a mental health crisis and wanted help; he reported that he had cut his wrist, was bleeding, and had swallowed two zippers.

In the fall and winter of 2023, the Jail took many of the restrictive housing units in the Main Jail offline due to security and maintenance issues and moved most restrictive housing to the South Annex. Conditions in the South Annex are intentionally punitive; writing supplies (pens, paper) are not allowed, medical request forms are not available, personal property is limited, and books, including religious texts, are restricted.

> **"It's nothing to do. We just be locked in the cage."**
>
> - **Description of conditions in the South Annex after a self-harm incident**

There is a high frequency of suicidal threats, gestures, and self-harm in restrictive housing at the South Annex. In September and October 2023 alone, there were multiple such incidents. During this period, an incarcerated person with serious mental illness had three incidents of suicidal gestures in the same restrictive housing unit. In the first incident, he was observed standing on a sink in his cell with a rope around his neck and the other end of the rope tied to a sprinkler. About two weeks later, he required medical care for banging his head. He told mental health staff that being confined in his cell for 24 hours was a trigger for him, and that he would bang his head "wide open" if kept in these conditions. Several days later, he reported being suicidal, put a screw in his mouth and threatened to swallow it. At the time of the third incident, he was 74 days into a 90-day disciplinary restrictive housing sanction.

Also during this period, an incarcerated person with PTSD and major depressive disorder put a noose around his neck and tied it to his bunk. When officers entered his cell, there were feces spread all over his body and the cell. He remained in restrictive housing and continued to self-harm, cutting his wrist with a zipper and banging his head on the wall. In another incident, an incarcerated person was observed in a restrictive housing cell with a torn piece of uniform around his neck. The incarcerated person told an officer, "as long as I am here, I am go[ing] to try and kill myself," and the officer had to use a cutting tool to get him down. At the time of this incident, the person had been in disciplinary restrictive housing for 52 days on multiple consecutive sanctions totaling 188 days.

Despite the serious mental health needs in these restrictive housing units, mental health care is difficult to access at the South Annex. There is no mental health clinic for confidential mental health sessions, there are no suicide-resistant mental health observation cells, and medical request forms are not provided. People who express suicidal ideation or attempt suicide at the South Annex generally go to the Main Jail for brief periods of observation before returning to restrictive housing, even in cases where

there is a clear connection between the self-harm and the restrictive housing conditions.

> **“That room is doing it to me.”**
>
> - **Person in restrictive housing explaining his self-injury**

We also found that in multiple cases, officers refused to transport or significantly delayed transporting people from the South Annex to the Main Jail for suicide observation and assessment. In January 2024, a man attempted suicide in restrictive housing by hanging and ingesting a melted down ice pack. Correctional officers did not contact medical or mental health staff to evaluate this man for over 90 minutes, and did not transport him to an outside hospital for treatment until the next day.

In September 2023, several people designated for suicide watch were left in shackles in the South Annex’s holding cage for four days before going to the Main Jail. That same month, an incarcerated person was observed banging his head in his restrictive housing cell, and mental health staff at the Main Jail asked that he be brought there for a suicide risk assessment. A sergeant at the South Annex said that they had no one to transport this person, and he would have to wait until the next shift. The person was sent back to his cell, banged his head against the wall again, lost consciousness, and woke up on the floor in a puddle of blood.

In August 2023, when a mental health provider completed a housing transfer form for someone who was actively suicidal in restrictive housing, a South Annex sergeant told her that the patient would not be transported due to short staffing. The next day, the provider learned that the person was still at the South Annex. The provider visited the person in his cell and found him with a noose around his neck. She completed another transfer form for the person to go to the Main Jail for suicide observation, but again a sergeant told her that the person would stay at the South Annex. A day later, the person was found “entwined up in the rafters and pipes with strips of synthetic materials around his neck like a noose.” Fire Rescue and police officers from Union City were called to get the person down from the ceiling, and he was then transported to an outside hospital for evaluation.

The difficulty incarcerated people have accessing mental health care in the South Annex increases the risk that people in restrictive housing there will suffer harm.

People in restrictive housing in the Jail spend long periods in isolation conditions. The Jail imposes disciplinary restrictive housing sanctions up to 90 days for one serious rule violation, and multiple violations for a single incident can be stacked for a much

longer term. In 2023, the Jail issued 172 disciplinary restrictive housing sanctions of 90 days or more, including 14 sanctions of 180 days or more in restrictive housing. The longest restrictive housing sanction imposed was 188 days. These lengthy terms in disciplinary restrictive housing exceed what is described in the Jail handbook and Jail policy.

People also experience lengthy non-disciplinary periods in restrictive housing. In December 2023, one person with a diagnosed serious mental illness had been in administrative segregation for 692 days. Another person had been in restrictive housing on protective custody status for 701 days. These long periods of segregation, particularly in a Jail that fails to provide adequate mental health monitoring or treatment, pose serious risks of harm.

Even people in mental health housing may be subject to extremely isolating conditions. When people with mental health disabilities are considered "acute," "high-risk," or "non-compliant" with medication, they are placed in a restrictive zone of the mental health housing unit to "stabilize" them. There they experience an extremely restricted confinement, with only one hour of out-of-cell time each day.

Spotlight: Children in Restrictive Housing

As widely recognized in the medical, psychiatric, and correctional treatment communities, restrictive housing is exceptionally risky for children and young adults due to their developmental immaturity and lack of well-developed coping mechanisms. The National Commission on Correctional Healthcare warns: "Psychologically, children are different from adults, making their time spent in isolation even more difficult and the developmental, psychological, and physical damage more comprehensive and lasting."[49] Courts, too, consider the impacts of adolescent development on the rights of children to be free from overuse of restrictive housing. One federal court found "no dispute that solitary confinement has a very negative [e]ffect on the developing brain of adolescents," and explained that for young people, being held in isolation "exacerbates already existing mental health problems, . . . can exacerbate or cause the onset of mental illness and depression, and . . . causes an

[49] Nat'l Comm'n on Corr. Health Care, Position Statement: Solitary Confinement (Isolation) 2 (Apr. 2016), https://www.ncchc.org/wp-content/uploads/Solitary-Confinement-Isolation.pdf [https://perma.cc/Y8SN-BR8A].

increased risk of suicide."[50] Brain development continues into young adulthood, and particular attention must be paid to the impact of restrictive housing on young adults.[51]

The Jail has a practice of confining 17-year-old children in restrictive housing conditions, thereby placing them at a serious and particular risk of harm. In September 2023, five 17-year-old boys at the South Annex submitted grievances complaining that they were not getting out of their cells. When we toured the South Annex in October 2023, 17-year-olds in the Youthful Offender Unit were confined to their cells for 22 or more hours a day. Since that visit, the Jail appears to have increased the amount of time 17-year-old boys are out of cell during the day. Still, the Jail has an ongoing practice of locking down groups of 17-year-old boys for rule violations. In April 2024, six 17-year-old boys each received 21 days of disciplinary segregation as punishment after officers found burning papers and makeshift weapons in their cell.

The Jail has housed at least one 17-year-old boy in an adult disciplinary restrictive housing cellblock. In June 2023, this 17-year-old reported stress from being in restrictive housing and concern about being there with adults. For at least a month, he was put on nutriloaf punishment and received a blended, intentionally unappetizing meal loaf on a rotating schedule (three days of nutriloaf, one day of regular tray, followed by three more days of nutriloaf) while in restrictive housing (the Jail claims that it has since stopped using nutriloaf). At one point, he flooded his cell with toilet water because he could not use the phone, and even though he was naked, an officer ordered him to lie on the floor of his flooded cell. From September to October 2023, the 17-year-old boy had multiple instances of self-harm and suicidal ideation while serving an 84-day disciplinary restrictive housing sanction, including banging his head, cutting his wrist, and jumping from the top tier of his housing pod with a noose around his neck.

Seventeen-year-old girls are also held in conditions that amount to restrictive housing. The Jail houses 17-year-old girls at the Main Jail in the FOU. There, they get out of their cell no more than 90 minutes a day and have no programming or educational

[50] *Alex A. ex rel. Smith v. Edwards*, No. CV 22-573, 2023 WL 5984280, at *18 (M.D. La. Sept. 14, 2023), *vacated on other grounds, appeal dismissed as moot sub nom. Smith v. Edwards*, 88 F.4th 1119 (5th Cir. 2023). *See also, e.g.*, *J.H. v. Williamson Cnty.*, 951 F.3d 709, 718 (6th Cir. 2020) ("A growing chorus of courts have recognized the unique harms that are inflicted on juveniles when they are placed in solitary confinement.").

[51] U.S. Dep't of Just., Report and Recommendations Concerning the Use of Restrictive Housing 59–60 (Jan. 2016), https://www.justice.gov/dag/file/815551/dl [https://perma.cc/2L4J-S8TN].

opportunities. We spoke to two 17-year-old girls living in these conditions who reported serious mental health needs and a lack of mental health treatment in the Jail.

2. The Jail's restrictive housing practices discriminate against incarcerated people with mental health disabilities.

The ADA prohibits the Jail from excluding people with disabilities from participation in, or denying them the benefits of, Jail services, programs, or activities based on their disability, or subjecting them to discrimination.[52] To avoid discrimination on the basis of disability, the Jail must make reasonable modifications to its policies and practices, unless it can show that such modifications would fundamentally alter its services, programs, or activities.[53]

We found that the Jail discriminates against incarcerated people with mental health disabilities by failing to implement reasonable modifications to avoid the inappropriate and harmful isolation of people with mental health disabilities in restrictive housing.

"When an inmate's behavior resulting from their mental illness is the reason for using restrictive housing, courts have concluded that the automatic use of restrictive housing is discriminatory, i.e., when it is imposed without a consultation with a mental health professional or when the inmate was denied mental health treatment for the behavior at issue."[54] The ADA requires the Jail to reasonably modify its disciplinary system to avoid "punishments as a consequence of behavior attributable to . . . mental health disabilities" that result in unnecessary segregation.[55] This is particularly true because "[a] mentally stable person [placed in restrictive housing] would . . . experience[ ] living

[52] 42 U.S.C. § 12132; 28 C.F.R. §§ 35.130(a), 35.152(b). Title II of the ADA applies to all public entities, including correctional facilities. *See Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) (explaining that public entities include "any department, agency, special purpose district, or other instrumentality of a State or States or local government" (quoting 42 U.S.C. § 12131(1)(B))). Title II protects any "qualified individual" with "a disability" from discrimination based on that disability. 42 U.S.C. § 12132. Incarcerated people are "qualified" to receive services and programs from a correctional facility, *see Bircoll v. Miami-Dade Cnty.*, 480 F.3d 1072, 1081 (11th Cir. 2007), and are considered to have a disability when they have "a . . . mental impairment that substantially limits one or more major life activities" such as caring for oneself, concentrating, thinking, and communicating. 42 U.S.C. §§ 12102(1), (2).

[53] 28 C.F.R. § 35.130(b)(7)(i).

[54] *Ga. Advoc. Off. v. Labat*, No. 1:19-CV-1634, 2021 WL 12102911, at *15 (N.D. Ga. June 11, 2021), *report and recommendation adopted*, No. 1:19-CV-1634, 2021 WL 12102910 (N.D. Ga. Sept. 13, 2021); *see also C.P.X. ex rel. S.P.X. v. Garcia*, 450 F. Supp. 3d 854, 917 (S.D. Iowa 2020); *A.T. ex rel. Tillman v. Harder*, 298 F. Supp. 3d 391, 416–17 (N.D.N.Y. 2018); *Latson v. Clarke*, 249 F. Supp. 3d 838, 856–57 (W.D. Va. 2017).

[55] *C.P.X.*, 450 F. Supp. 3d at 917.

conditions that—though restrictive—wouldn't . . . produce[ ] nearly the same deleterious impact."[56]

The ADA does not preclude jail officials from enforcing rules against people with mental health disabilities to address legitimate safety threats, but jail officials still are required to conduct an individualized assessment using objective medical evidence and reasonable judgment. They must consider whether there are other ways to mitigate the safety threats, including by making reasonable modifications to jail practices.[57]

The Jail's disciplinary policy includes provisions recognizing the need to involve mental health staff in the disciplinary process, but these aspects of the policy are not followed. When a person with a known or suspected mental health disorder is charged with a rule violation and placed in segregation while awaiting resolution of the charge, Jail policy requires a Jail supervisor to consult mental health professionals to determine whether the rule violation alleged is attributable to mental illness. Jail policy also provides that mental health staff participate in disciplinary hearings involving people with known or suspected mental health disorders. Despite these policy provisions, the Sheriff's Office does not consult mental health regarding disciplinary sanctions. The Jail described a "general practice" of not sanctioning people in mental health housing, but this offers no protection to people with mental health disabilities outside mental health housing.

We found that in multiple cases, people with apparent mental health needs received lengthy restrictive housing sanctions, and there was no indication of any consultation with mental health staff regarding the role their mental health played in the misconduct alleged or the appropriateness of restrictive housing. In August 2023, an incarcerated person on suicide watch in restrictive housing was charged with a disciplinary offense for resisting restraint after he refused to give up a man-made weapon hidden in his buttocks. He was placed on psychiatric observation, found to be exhibiting psychosis, and involuntarily treated with antipsychotic medication, then returned to restrictive housing four days later. Mental health followed up with him for a post-suicide watch assessment, but there is no evidence that anyone assessed whether ongoing restrictive housing was contraindicated until several days later, when they checked a box indicating it was not contraindicated. The person received a 56-day disciplinary restrictive housing sanction for his conduct during this episode of psychosis. He later died in a homicide in restrictive housing.

[56] *Finley v. Huss*, 102 F.4th 789, 821 (6th Cir. 2024).

[57] 28 C.F.R. § 35.139(b); *see also Labat*, 2021 WL 12102911, at *15.

In June 2023, an incarcerated person sought officer help because he feared people were out to get him and kill him. The incarcerated person tried to leave his housing area and hit an officer while swinging his arms. The disciplinary officer found him guilty of multiple charges in connection with this incident and imposed 60 days of restrictive housing. The disciplinary officer identified the person as "mental health," but consistent with the Jail's usual approach, there is no evidence that the officer consulted mental health staff about the impact his mental health may have had on his alleged behavior, or the decision to punish him with restrictive housing.

The Jail can reasonably modify its practices to avoid discrimination by abiding by its policy requiring consultation with mental health professionals before imposing discipline to consider whether the incarcerated person's conduct at issue is the result of disability. If so, the Jail should avoiding discipline in favor of mental health supports and treatment. When any person is being considered for restrictive housing, the Jail's treatment professionals should also conduct an individualized assessment before placement to determine whether such placement is contraindicated due to the person's mental health needs. If restrictive housing is contraindicated, the Jail should offer adequate supports and treatment to keep the person in a less restrictive setting. For people being placed in restrictive housing, mental health professionals should consider whether the harms of restrictive housing can be mitigated, or whether the length of stay in a restrictive housing unit can be reduced, through treatment or supports.

3. The Jail routinely imposes discipline, including lengthy periods in disciplinary restrictive housing, without due process.

"[B]efore . . . a pretrial detainee[ ] is punished for violating a jail rule, there must be a due process hearing to determine what rule he violated."[58] A due process hearing is one before an impartial decision-maker, in which pretrial detainees have a chance to call witnesses and present evidence when not "unduly hazardous to institutional safety or correctional goals."[59] Due process further requires that pretrial detainees receive a written statement of reasons for any disciplinary action taken.[60] Jails therefore should provide an opportunity for someone accused of violating a jail rule to present evidence contesting the charges before a neutral arbiter, and to receive a written explanation of findings from the hearing.

---

[58] *Jacoby v. Baldwin Cnty.*, 835 F.3d 1338, 1348 (11th Cir. 2016).

[59] *Id.* at 1350 (quoting *Wolff v. McDonnell*, 418 U.S. 539, 566 (1974)). An officer with substantial involvement in the investigation that resulted in the disciplinary charges is unlikely to be considered impartial. *See id.* at 1350–51.

[60] *Id.* at 1350. Due process also requires that pretrial detainees receive notice of disciplinary charges before a hearing. *Id.*

In violation of the Fourteenth Amendment's due process guarantees, the Jail punishes people by confining them to restrictive housing for lengthy periods of time without due process.

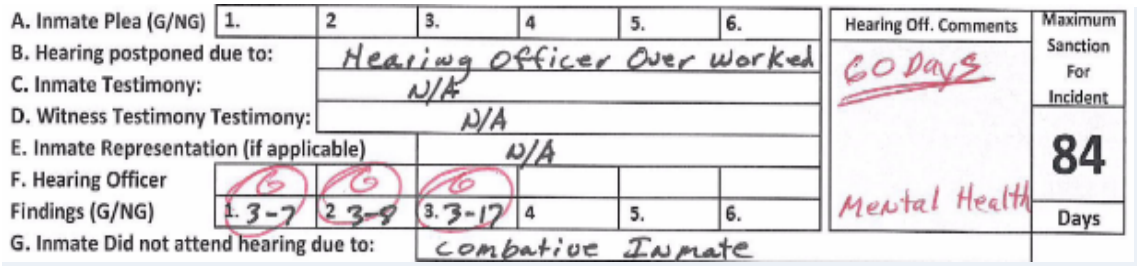
The Jail routinely disciplines people without providing them a hearing. Despite Jail policies requiring disciplinary hearings, there are not enough disciplinary officers to handle the high volume of disciplinary reports. It is also perceived as inconvenient and unsafe for a disciplinary officer to go into a housing unit to meet with people and provide them hearings.

For mid-level violations, the Jail has a practice of issuing "time-served" sanctions without providing hearings. Pursuant to this practice, after someone has been locked down awaiting resolution of a mid-level disciplinary charge for fourteen days—or as we found in some cases, several weeks or even months—disciplinary officers may issue a punishment of time served without providing the incarcerated person an opportunity to be heard at a due process hearing. For example, in August 2023, an incarcerated person with a developmental or intellectual disability was charged with throwing feces at an officer. The disciplinary officer did not rule on the charges for 106 days, citing "hearing officer overworked" to excuse the delay, and then found the person guilty of assaulting staff and issued a time-served sanction. By that point, the person had served 38 days in restrictive housing without a hearing.

In January 2024, there were 135 disciplinary reports at the Jail, and disciplinary officers issued a time-served sanction in 83 of those cases (61%). The average time-served sanction was 20 days.

In cases involving the most serious rule violations, incarcerated people are regularly found guilty and receive lengthy disciplinary sanctions in restrictive housing—60 days or longer—without a chance to contest the charges at a hearing. In September 2023, one person received a 160-day restrictive housing sanction and three people received 180-day restrictive housing sanctions, and none appear to have had a disciplinary hearing. Disciplinary officers often write "combative" on the disciplinary hearing form to justify not providing a hearing. In one case in September 2023, a disciplinary officer wrote "combative housing unit" on the disciplinary hearing form, indicating that the accused person did not receive a due process hearing because the disciplinary officer thought his housing unit was too dangerous to enter. The disciplinary officer found the person guilty of unauthorized exit from a cell or zone and imposed 28 days of restrictive housing. In August 2023, a disciplinary officer wrote "combative inmate" in place of an incarcerated man's signature on the disciplinary hearing form and, as apparent justification for not providing a hearing, commented that all the people in the lockdown zone were out and their doors were open. The man received a 90-day restrictive housing sanction.

Additionally, disciplinary officers regularly fail to provide a written statement of reasons for the disciplinary action taken. In one sample of 60 disciplinary reports from June 2023, the disciplinary officer issued a sanction in 98% of the cases, and none of the reports had a statement explaining the factual basis for a guilty finding. Disciplinary officers simply circled the charge and wrote "G" above it to indicate guilt, without providing the reasons for the decision.



A. Inmate Plea (G/NG)	1.	2	3.	4	5.	6.	Hearing Off. Comments	Maximum Sanction For Incident
B. Hearing postponed due to:	Hearing Officer Over Worked						60 Days	
C. Inmate Testimony:	N/A							84
D. Witness Testimony Testimony:	N/A							
E. Inmate Representation (if applicable)	N/A						Mental Health	Days
F. Hearing Officer Findings (G/NG)	G 1. 3-7	G 2 3-9	G 3. 3-17	4	5.	6.		
G. Inmate Did not attend hearing due to:	Combative Inmate							

Sample discipline form

The goal of discipline is to promote order and make the Jail safer. But the Jail's disciplinary practices are arbitrary and unfair, and they expose incarcerated people to dangerous conditions in restrictive housing.

Education of Children with Disabilities

The Jail's failure to provide eligible children with disabilities a "free and appropriate public education" violates their rights under the Individuals with Disabilities Education Act (IDEA).

The IDEA imposes certain requirements regarding the education of children with disabilities. Children suspected of having a disability must be properly evaluated for eligibility for special education and related services. Once children are found eligible, they must receive a "free appropriate public education," according to their needs.[61] Each child receives an "individualized education program," or IEP, which must include both "specially designed instruction" tailored to meet that child's "unique needs" and related services to permit them to benefit from that instruction.[62] The IDEA also provides procedural safeguards to students with disabilities facing disciplinary consequences, including a requirement to consider "positive behavioral interventions and supports" to address behavioral problems and an obligation to engage in a specific

[61] 20 U.S.C. §§ 1412(a)(1); 1414(a), (b).

[62] *See id.* §§ 1401(26), (29), 1414(d); *see also Fry v. Napoleon Cmty. Schs.*, 580 U.S. 154, 158 (2017).

review process when a child's behavior results in their removal from the classroom for ten or more days.[63]

The Jail typically houses around 30 17-year-olds, but it does not identify or evaluate potentially eligible 17-year-olds to provide the free and appropriate public education required by the IDEA.[64] The average length of stay for people who enter the Jail at 17 years old is 392 days. Yet during multiple visits to the 17-year-old boy pod at the Fulton County Jail's South Annex, and in visits to the unit where 17-year-old girls are held in the Main Jail, we received consistent information indicating a lack of any educational services whatsoever for these youth.

There are no educational services of any kind offered to 17-year-olds. Other than a weekly "young achievers" program on Wednesdays, 17-year-olds cannot access programming, whether educational or not. An officer who works with the 17-year-old population confirmed that these children generally "watch TV or use the phone" while out of their cells. Some 17-year-olds told us that they had been in high school before entering the Jail. We interviewed a 17-year-old with a history of ADHD and self-harm who expressed frustration that although he was in school while detained in a juvenile facility, at the Jail he had no access to education despite being one year away from graduation. We spoke to a parent who expressed concern that her 17-year-old child was not receiving educational services at the Jail despite having an IEP. Attorneys for incarcerated people lamented the lack of educational opportunities for children with disabilities. And when we asked the Jail to produce evidence of IDEA implementation—through records, lists of eligible students, or policies—the Jail could not do so.

In short, our investigation revealed no evidence that the Jail has attempted to comply with its important obligations under the IDEA. As a result, 17-year-old children who are

[63] 20 U.S.C. §§ 1414(d)(3)(B)(i); 1415(k)(1).

[64] The IDEA's requirements generally apply to "all political subdivisions of the State that are involved in the education of children with disabilities," including "[s]tate and local juvenile and adult correctional facilities." 34 C.F.R. § 300.2(b)(1), (iv). Consistent with the federal regulations, Georgia regulations also recognize the application of the IDEA in adult correctional facilities. *See* GA. COMP. R. & REGS. 160-4-7-.01(2)(a)(1)(iv), -.02(2). As the U.S. Department of Education has explained, "[e]very agency at any level of government that is involved in the provision of special education and related services to students in correctional facilities must ensure the provision of [free appropriate public education], even if other agencies share that responsibility." Melody Musgrove & Michael K. Yudin, U.S. Dep't of Educ., Off. of Spec. Educ. and Rehab. Servs., Dear Colleague Letter 2 (Dec. 5, 2014), https://sites.ed.gov/idea/files/idea-letter.pdf [https://perma.cc/E33L-KYPW]. Sheriffs in Georgia are responsible for implementing the IDEA with respect to eligible children in their custody. *See T.H. ex rel. T.B. v. DeKalb Cnty. Sch. Dist.*, 564 F. Supp. 3d 1349, 1357–58 (N.D. Ga. 2021).

eligible for special education services do not receive them while incarcerated in the Jail.

MINIMUM REMEDIAL MEASURES

1. Protection from Harm

1.1 Establish policies that ensure safety and security of all people in the Jail and ensure all staff adhere to them, including by training staff, supervising staff, and holding them accountable for violating jail policies.

1.2 Establish generally accepted classification systems and housing plans for incarcerated people that incentivize prosocial behaviors, disincentivize misconduct, and offer adequate protections to vulnerable populations.

1.2.1 Establish a contemporary objective classification tool.

1.2.2 Create a housing plan separating all incarcerated people, who are not in a closely supervised special-needs unit, by custody level.

1.2.3 Create and use a separate reclassification tool and reclassify all incarcerated people every 60–90 days.

1.2.4 Integrate the disciplinary process into the classification system so that all incarcerated people finishing serious disciplinary segregation periods are reclassified before being rehoused in general population housing.

1.2.5 Provide access to protective housing units for people in need of a heightened level of protection. Provide information about how to seek protection and report violence free of retaliation. Integrate as necessary into the classification system.

1.2.6 Implement a comprehensive strategy to reduce gang violence in the Jail, including identifying gang-affiliated people during classification and following disciplinary incidents.

1.3 Provide multiple ways for people to report sexual abuse in the Jail confidentially and freely, and make information about how to seek protection and report violence free of retaliation readily available.

1.4 Conduct regular, timely, and adequate security checks by having staff enter every zone, ensure every person's safety, and detect safety and security threats. Ensure security checks are accurately recorded.

1.5 Conduct a staffing analysis to assess the Jail's staffing needs and ensure maximum efficiencies for the safety and security of the Jail.

1.6 Provide adequate staffing to ensure safety of the incarcerated population and access to medical and mental health care on all shifts.

1.7 Assess recruitment and retention strategies to reduce vacancies at the Jail.

1.8 Conduct thorough background checks on all Jail staff.

1.9 Engage in proper contraband reduction strategies that include spot checks, contraband and safety inspections, and organized and thorough housing area searches.

1.10 Increase and improve the screening of all people entering the Jail, including staff, to deter and detect contraband at entrances to the Jail.

1.11 Prioritize and improve timing of repairs to identified vulnerabilities in the Jail's physical plant that pose major safety and security risks.

1.12 Provide clear, accurate directions about how to submit grievances and ensure the grievance system is readily accessible, both via kiosk and paper forms, to incarcerated people.

1.13 Ensure staff responsible for responding to grievances do so in a responsive and prompt manner.

1.14 Accurately document and thoroughly investigate incidents of misconduct and violence, including possession of contraband, assaults, stabbings, homicides, and sexual abuse.

2. Excessive Force

2.1 Ensure Jail policies provide sufficient guidance on the use of force and what constitutes excessive force, in compliance with constitutional standards and generally accepted practices. Require compliance with all policies.

2.2 Modify use-of-force policies to:

2.2.1 Describe clearly when force is authorized and not authorized.

2.2.2 Describe the level of force authorized for each threat level.

2.2.3 Require de-escalation where safe and clarify that force is to be used only after all other reasonable efforts to resolve a situation have failed.

2.2.4 Incorporate additional non-force alternatives, including crisis intervention methods and specific de-escalation techniques.

2.2.5 Prohibit the use of force on a person who is under control.

2.3 Ensure that all Jail staff are properly and regularly trained on policies and procedures on use of force, with particular emphasis on constitutionally permissible and impermissible uses of force, appropriate use of chemical agents and Tasers, de-escalation techniques, and use of force on incarcerated people with mental health disabilities or in crisis. Training must include scenario-based training where staff can practice applying force techniques in scenarios encountered in the Jail.

2.4 Require that staff adequately and promptly report all uses of force. Require staff to report independently and not in consultation with anyone else.

2.5 Require that all incident reports describe each use of force during an incident, including what precipitated the use-of-force, the level of resistance encountered, and any attempts at de-escalation.

2.6 Develop a manual on use-of-force investigations that includes the following requirements:

All findings made in a use-of-force investigation are based on application of a preponderance-of-the-evidence standard.

Investigators obtain and review all supporting evidence, including logs, witness and participant statements, physical evidence, body charts, photographs, and video or audio recordings.

Investigators conduct timely, thorough, and documented interviews of all relevant staff and incarcerated people who were involved in and witnessed the incident in question, to the extent practicable.

All use-of-force investigations occur promptly after the incident and include a thorough documentation of the basis for the investigator’s finding, including discussion of all evidence available and unavailable.

The investigations clearly indicate whether there was compliance with Jail policies and procedures.

2.7 Train all supervisors to investigate and review use-of-force events consistent with the use-of-force investigation policies and procedures.

2.8 Develop and implement a system to track all uses of force by Jail staff and any complaints or grievances related to the use of excessive force designed to alert the Jail administration to any potential need for retraining, problematic policies, or supervision lapses.

2.9 Require a use-of-force review committee, consisting of middle and upper-level management staff, to ensure objective oversight over and review of use-of-force events. Conduct systemic reviews of use of force to identify patterns or trends as well as to determine if there were violations of policy or opportunities to improve training or practices at the organizational and individual level. Incorporate such information into quality management practices and take necessary corrective actions.

2.10 Use appropriate discipline and retrain where there is evidence of staff misconduct related to excessive force used against incarcerated people.

3. Environmental and Health Hazards

Sanitation and Environmental Safety

3.1 Implement and ensure adherence to Jail sanitation policies.

3.2 Ensure a comprehensive housekeeping plan is written and implemented that includes procedures about cleaning, the chemicals and cleaning supplies to use, and measures to ensure accountability for sanitation tasks, such as use of a checklist.

3.3 Ensure the housekeeping plan requires regular, scheduled cleaning and sanitation for all areas of the facilities, including:

3.3.1 Cleaning and sanitation of housing units and individual cells, including floors, walls, ceilings, air vents, air returns, sinks, toilets, and showers.

3.3.2 Cleaning and disinfecting all medical areas, including exam and procedure rooms, sinks, toilets, and exam tables.

3.4 Ensure prompt repair or replacement of broken or damaged equipment in the medical areas and kitchens, including warming carts.

3.5 Ensure documented weekly sanitation inspections are conducted by designated staff and that deficiencies are promptly addressed through corrective action and follow-up.

3.6 Ensure prompt servicing and preventative maintenance of all kitchen and laundry equipment.

Physical Plant

3.7 Develop and implement a comprehensive plan to promptly inspect, clean, repair and/or replace, and maintain certain parts of the physical plant, including:

3.7.1 Promptly repair all malfunctioning cell doors, windows, sinks, toilets, and showers. Ensure all plumbing fixtures are operable with running water at appropriate temperatures.

3.7.2 Inspect all pipe chases throughout the Jail, prioritizing those in housing areas, for leaks and other damage, and repair all leaks and other damage in pipe chases.

3.7.3 Change all air filters throughout the Jail.

3.7.4 Clean all air vents and air returns throughout the Jail.

3.7.5 Clean or replace all dirty ceiling tiles throughout the Jail.

3.7.6 Clean dust and dirt from overhead pipes throughout the Jail.

3.7.7 Repair or replace all nonfunctioning light fixtures, including all exposed wiring, throughout the Jail.

3.8 Regularly inspect all doors in housing units, including cell doors, to ensure locking mechanisms are properly functioning. Promptly repair malfunctioning locking mechanisms.

3.9 Regularly inspect all windows in the housing units to ensure there are no holes or other needed repairs. Make any needed repairs.

3.10 Regularly inspect all light fixtures to ensure, among other things, that lighting is available in cells, dayrooms, all housing units, and personal hygiene areas, and is at least 20-foot candles.

3.11 Provide adequate fire suppression and alert systems throughout the Jail and test them at regular intervals to ensure they are kept in working condition.

Pest Control and Ectoparasites

3.12 Develop and implement a comprehensive Integrated Pest Management system for all parts of the Jail that uses prevention measures to keep pests from entering the Jail and control measures to reduce/eliminate pests.

3.13 Ensure that the pest control system is adequately responsive to reports of pest activity by incarcerated people, including adequate contact tracing and evaluations, and that measures to control ectoparasite infestations are promptly initiated.

3.14 Provide every incarcerated person a physical skin check by qualified medical staff within a reasonable time after entering the Jail to reduce the introduction of ectoparasites.

3.15 Take reasonable measures to reduce the introduction and spread of lice throughout the Jail.

3.16 Ensure that haircutting equipment is adequately cleaned and disinfected between uses to prevent the spread of skin infections or parasites.

Chemical Control

3.17 Ensure that chemicals are stored, labelled, distributed, and used following OSHA Standards, including keeping chemical containers, including spray bottles, secured and inaccessible to anyone other than authorized staff.

3.18 Clean and organize all janitorial closets and storage areas.

3.19 Train all staff and incarcerated people who utilize chemicals in the proper use and storage of chemicals.

Food Service and Nutrition

3.20 Ensure all food items are stored and held at the appropriate temperatures for food safety.

3.21 Ensure that meal trays are delivered to incarcerated people at appropriate temperatures for food safety.

3.22 Ensure menus for incarcerated people meet requisite nutritional and caloric requirements, including the specific requirements for special and medically necessary diets, such as diabetic diets.

3.23 Ensure that the food provided to incarcerated people is nutritionally adequate for all, including those on special diets, and that the food distributed to incarcerated people matches the food listed on the menus.

4. Medical and Mental Health Care

4.1 Modify and implement Jail policies, procedures, and practices relating to intake screening, chronic care, continuity of care, sick call, access to medical care by those in restrictive housing, mental health services and supports, suicide prevention, medical grievances, medication administration, and quality assurance, to ensure that incarcerated people receive adequate medical care in the Jail.

4.2 Ensure that the Jail's and medical provider's quality assurance programs identify and correct deficiencies with the medical and mental healthcare system.

4.3 Increase medical and mental health staffing in MOU and FOU, and in other specialized medical and mental health housing units, by hiring sufficient additional staff with appropriate credentials.

4.4 Develop a program to provide timely and clinically appropriate mental health services and supports, including therapy, skill-building, and rehabilitation, to all incarcerated people who need them.

4.5 Ensure the Jail's data management system accurately and timely communicates information to the electronic medical records system, including changes in custody status, location, and medical conditions.

4.6 Re-structure the medical and mental health intake screening area to provide confidentiality and privacy to incarcerated people when discussing their medical and mental health conditions and needs with a healthcare provider.

4.7 Ensure that all custody, medical, and mental health staff receive adequate preservice and annual in-service training on first-responder medical care, mental health care, de-escalation and suicide prevention.

4.8 Conduct joint man-down drills with medical and custodial staff and address problems identified.

4.9 Repair and rehabilitate housing units—including suicide-resistant and non-suicide-resistant cells in the MOU and FOU—to reduce physical risks for suicide and self-harm, to include but not be limited to removal of objects and fixtures that could be used for harm as well as fixtures that could be used as

ligature tie-off points. Ensure that fully suicide-resistant cells are available for use when needed.

4.10 Implement changes to all MOU and FOU cells to make them safe locations for incarcerated people with medical conditions, disabilities, or other serious medical injuries to reside, including purchasing and maintaining hospital beds for the cells; fixing the existing, or implementing a new, call bell system that rings to a staffed area across all shifts, with regular documentation by supervisors that the call bell system is working; and adding suicide-resistant grab bars to cells and bathrooms.

4.11 Improve medication administration practices and ensure that incarcerated people have adequate access to appropriate medications without gaps in medication administration, including by checking the identification of the incarcerated person receiving the medication for all medication administration, conducting mouth checks, ensuring that multiple missed medications are addressed with clinical review and encounters, training healthcare staff about the importance of consistency in medication administration, and conducting quality assurance on these areas of care.

4.12 Create a meaningful program and plan for accommodation of physical disabilities consistent with correctional standards of care, including establishing and monitoring a minimum time to accommodate disability, mobility, and physical impairment needs.

4.13 Ensure that life-saving medical aid can be promptly delivered during medical emergencies. Regularly review medical emergency responses to identify opportunities for improvement, and implement any needed changes.

4.14 Ensure compliance with hospital discharge plans and specialty recommendations, including the provision of rehabilitative therapy services.

4.15 Ensure patients receive quality medical care, including timely orders for appropriate laboratory tests, specialty consultations, and follow-up.

4.16 Revise Jail policies, procedures, and practices involving withdrawal monitoring and treatment to ensure that any incarcerated person who reports at intake or otherwise the use of medications or substances that may trigger withdrawal receive immediate initiation of withdrawal monitoring and obtain treatment consistent with USDOJ guidelines, including, where appropriate, medication for opioid use disorder.

4.17 Provide language interpretation services to LEP individuals during encounters with medical and mental health staff.

4.18 Revise Jail morbidity and mortality (M&M) processes to ensure comprehensive and well-documented evaluation of quality of care related to all deaths and serious suicide-attempts.

4.19 Ensure that suicidal people receive adequate screening, evaluation, monitoring, and mental health treatment and follow-up care, including out-of-cell counseling, as determined by a qualified mental health professional.

4.20 Ensure that people in mental health housing are held in the least restrictive conditions possible, and that they receive adequate out-of-cell time including a mix of structured and unstructured programming.

4.21 Provide discharge/re-entry planning, including services for incarcerated people in need of further treatment at the time of discharge to the community. These services should include the following:

4.21.1 Arranging an appointment with community mental health providers for all incarcerated people with mental health needs and ensuring, to the extent possible, that incarcerated people meet with that community mental health provider prior to or at the time of discharge to facilitate a warm hand off;

4.21.2 Providing referrals for incarcerated people with mental health needs that require ongoing treatment post-release;

4.21.3 Arranging with local pharmacies to have incarcerated people's prescriptions renewed to ensure that they have an adequate supply to last through their next scheduled appointment.

5. Restrictive Housing and Discipline

5.1 Train all sergeants, lieutenants, captains, and disciplinary officers in constitutional and generally accepted jail practices on discipline for incarcerated people. This includes the disciplinary process, appropriate sanctions, and disciplinary segregation.

5.2 Rewrite and implement policies regarding Jail rules and discipline, and accurately translate them into the Jail handbook. Ensure all incarcerated people have ready access to the handbook.

5.3 Establish a constitutionally compliant discipline system for when incarcerated people violate Jail rules that conforms to generally accepted jail

practices. The system must provide a meaningful opportunity for a hearing before discipline is imposed.

5.4 Before disciplinary segregation is imposed, ensure that qualified mental health professionals assess incarcerated people with mental health disabilities to determine whether the behavior was a manifestation of or the result of disability.

5.5 Do not place a person in restrictive housing if it is inappropriate due to mental health or medical contraindications.

5.6 Provide adequate opportunities for time out of cell to people in restrictive housing.

5.7 Ensure that incarcerated people with mental health needs are not placed in restrictive housing for prolonged periods and review incarcerated people in restrictive housing periodically to ensure that restrictive housing remains appropriate.

5.8 Establish disciplinary sanctions that are proportional to the misconduct, progressive in severity, and purposeful in encouraging compliance with Jail rules.

5.9 Track disciplinary processes to ensure they are consistent with policy. Report and review data regarding lengths of stay in restrictive housing, particularly with respect to incarcerated people with mental health needs, and take appropriate corrective action.

5.10 Monitor the use of restrictive housing for harmful outcomes, especially for those with mental health needs and for 17-year-olds. Ensure that if an incarcerated person shows credible signs of decompensation in restrictive housing, his/her mental health needs are assessed by a mental health professional and promptly addressed.

5.11 Provide opportunities for disciplinary sanctions to be modified based on good behavior and where there is indication of physical or mental decline in the incarcerated person.

5.12 Cease using confinement in adult restrictive housing as a sanction for 17-year-olds in the Jail.

6. Special Education and Related Services

6.1 Develop and implement a program that complies with the requirements of the IDEA and its accompanying regulations.

6.2 Create and implement an effective system to screen all entering 17-year-olds to identify children who need initial evaluations and ensure timely evaluations in all areas of need, including functional behavioral assessments.

6.3 Create and implement an effective system to identify all entering children who have previously been found eligible for special education, including those who currently have or previously had IEPs.

6.4 Develop and implement adequate IEPs based on children's individualized needs that conform to federal statutory and regulatory requirements.

6.5 Provide adequate functional behavioral assessments and behavior intervention plans for every child with a disability (or suspected of having a disability) who exhibits behavior that interferes with learning.

6.6 Provide specially designed instruction and related services to children with disabilities based on their individualized needs.

6.7 Track all classroom removals based on behavior, including children sent to any alternate setting, to determine when a manifestation determination review must be held. Conduct a manifestation determination review whenever a child's behavior results in classroom removals totaling 11 days or more in the same academic year.

CONCLUSION

In summary, our investigation found reasonable cause to believe that Fulton County and the Fulton County Sheriff's Office violate the constitutional and statutory rights of people confined at the Fulton County Jail by, with deliberate indifference to the risks of harms: failing to protect incarcerated people from violence; engaging in a pattern or practice of excessive force; failing to provide humane living conditions; failing to provide adequate medical and mental health care; confining incarcerated people in dangerous restrictive housing conditions without due process and in a discriminatory manner; and failing to provide special education services to qualified 17-year-olds.

We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this Findings Report if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this Report. 42 U.S.C. § 1997c(b)(1)(A).

This Findings Report is a public document. It will be posted on the Civil Rights Division's website. We look forward to working cooperatively to ensure that these violations are remedied.