IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE

UNITED STATES OF AMERICA, PLAINTIFF, v. ROBERTSON COUNTY; HOWARD BRADLEY, COUNTY MAYOR, in his official capacity; ROBERTSON COUNTY COMMISSIONERS, in their official capacity; BILL HOLT, ROBERTSON COUNTY SHERIFF, in his official capacity; DEFENDANTS.	)	CIVIL ACTION NO: 3:13-cv-00392

COMPLIANCE REPORT

PLAINTIFF, THE UNITED STATES OF AMERICA, hereby files the Eighth Compliance Report.

Respectfully submitted,

/s/ William G. Maddox
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Settlement Agreement Between the United States Department of Justice and Robertson County, Tennessee, *8th Monitoring Report*

Summary

The following is an abbreviated summary of the most recent on-site assessment by the Independent Consultant in the *Settlement Agreement Between the United States Department of Justice and Robertson County, Tennessee*. The on-site assessment occurred during the two-day period of May 2-3, 2017. As discussed during the exit debriefing on May 3, the Independent Consultant's on-site assessment was divided into the following four (4) categories:

1) Review of medical charts of six (6) inmates placed on, and discharge from, suicide precautions during the assessment period. With one exception, the review found that all required documentation was completed as required. The exception was the case of Inmate HD, who entered the RCDF on February 5, 2017 and was placed on suicide precautions two weeks later on February 20, 2017. The inmate had been placed on suicide precautions during a previous RCDF confinement from July 8 through July 11, 2016. Contrary to the Settlement Agreement and RCDF/SHP policies, the inmate was *not* referred to mental health staff by either correctional officers or nursing staff upon her February 5 admittance. In addition, despite the fact that the inmate was subsequently placed on suicide precautions for three days from February 20 through February 22, 2017, the mental health clinician suggested in the medical chart that "no treatment plan was indicated."

The Independent Consultant recommended that RCDF and SHP officials develop a corrective action plan ensure that all inmates placed on suicide precautions during a prior RCDF confinement be referred to the QMHP for further assessment upon intake. In addition, any inmate on suicide precautions for more than 24 hours is required to have a treatment plan developed to reduce future suicidal ideation.

2) Review of 43 medical charts of inmates placed on the Mental Health Chronic Care List during the assessment period. The review found that timely assessments (both initial and/or follow-up QMHP and psychiatric) were provided in 93 percent (40 of 43) of the cases.

3) Review of data regarding the provision of group therapy treatment at the RCDF from January through April 2017. The data indicated there were approximately 218 inmates scheduled for group treatment during the time period, but only 56 percent (117 of 208) of inmates attended the schedule groups. There were various explanations for the low attendance rate, including scheduling groups during the early morning hours, scheduling groups that conflicted with other activities, availability of escort staff, allegation that certain correctional officers were discouraging inmate participation, and inmates' general lack of interest.

The Independent Consultant recommended that RCDF and SHP further explore ways to increase group attendance, including finding alternate times/venue, increasing availability of escort officers, as well as determining whether any correctional officers are deterring inmates from attending group (e.g., determining whether certain housing units are responsible for higher group attendance rates).

4) Review of all documentation regarding the suicide of Jerry Barlow that occurred in the RCDF March 9, 2017. The inmate did not have a history of suicidal behavior and there was no evidence to suggest that RCDF or SHP were aware that he was currently suicidal. The review found that, with one exception, there were no deficiencies noted. The exception was that correctional officers failed to conduct a security check within 40 minutes of the inmate being found hanging.

The Independent Consultant recommended that the subsequent Mortality Review report be revised to include the date of the Committee's review, as well as note the above security check violation. The Mortality Review report was revised and provided to the Independent Consultant on May 2, 2017.

Conclusion

There are 48 provisions to the Settlement Agreement, including 21 for Suicide Prevention, 25 for Mental Health Treatment, and 2 for Quality Improvement and Risk Management. Consistent with the findings from the previous assessment (in December 2016), all 48 provisions remain in Substantial Compliance.

Pending one final on-site assessment, the Agreement remains on schedule to be successfully completed in August 2017.

Submitted by:

Lindsay M. Hayes, Independent Consultant
June 5, 2017