



**U.S. Department of Justice**

Civil Rights Division

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*Assistant Attorney General  
950 Pennsylvania Avenue, NW - RFK  
Washington, DC 20530*

December 7, 2009

Roosevelt Allen, Jr., Commissioner, 1st District  
Gerry Scheub, Commissioner, 2nd District  
Frances DuPey, Commissioner, 3rd District  
Board of Commissioners  
Lake County, Indiana  
2293 North Main Street  
Building A, 3rd Floor  
Crown Point, Indiana 46307

RE: Investigation of the Lake County Jail

Dear Commissioners Allen, Scheub, and DuPey:

On September 12, 2008, we notified your office of our intention to investigate conditions at the Lake County Jail ("LCJ") pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. Consistent with CRIPA's requirements, we now write to report the current findings of our investigation and to recommend remedial measures needed to ensure that conditions at the LCJ meet federal constitutional requirements. See 42 U.S.C. § 1997b.

On December 15-17, 2008, the Department of Justice toured LCJ with correctional experts in the fields of suicide prevention and mental health care, medical care, and environmental conditions. These experts assisted us in reviewing records, interviewing staff, interviewing inmates, and inspecting facility living conditions. Before, during, and after our on-site inspection, we reviewed a large number of documents, including policies and procedures, incident reports, medical and mental health records, and other materials. During this investigation process, Lake County, Sheriff Roy Dominguez, and other LCJ officials cooperated fully with our review. We appreciate the assistance of Sheriff Dominguez and the LCJ staff and their level of professionalism and courtesy.

Consistent with our commitment to provide technical assistance and conduct a transparent investigation, we provided a exit debriefing at the conclusion of our on-site inspection. During this debriefing, our experts provided their initial

impressions and tentative concerns. Some of the concerns we expressed during the exit debriefing regarded LCJ's dangerous and inadequate suicide prevention practices. We reiterated those concerns in a letter to Sheriff Dominguez dated January 7, 2009, regarding the urgent need to address suicide prevention measures.

We now write to advise you of the current overall findings of our investigation, the facts supporting them, and the minimum remedial measures that Lake County needs to take to address the deficiencies we identify. Pursuant to 42 U.S.C. § 1997b, we conclude that certain conditions at the LCJ violate the constitutional rights of inmates. We find that the LCJ engages in a pattern or practice of conduct that subjects inmates to systemic violations of federal constitutional rights, specifically in regard to: (1) suicide prevention, (2) mental health care, (3) the medical care, and (4) sanitary and safe living conditions.

## **I. BACKGROUND**

### **A. FACILITY DESCRIPTION**

The LCJ is located in Crown Point, Indiana, approximately twenty miles south of Gary, Indiana, and is operated by the Lake County Sheriff's Office.<sup>1</sup> The Chief Warden of the LCJ works for the Sheriff's Office's Corrections Division.<sup>2</sup> The LCJ houses adult male and female inmates who are felons, gross misdemeanants, misdemeanants, pre-trial detainees, juvenile offenders, witnesses, or others being detained in protective custody.<sup>3</sup> The LCJ has an inmate capacity of approximately 1040,<sup>4</sup> and employs approximately 179 sworn merit correctional officers and 26 civilian employees.<sup>5</sup> During our December 2008 tour, the LCJ inmate population counted at approximately 1053. The LCJ comprised two buildings labeled the old and new jail and situated on five floors.

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<sup>1</sup> <http://www.lakecountysheriff.com>.

<sup>2</sup> <http://www.lakecountysheriff.com>.

<sup>3</sup> <http://www.lakecountysheriff.com>. Throughout this letter we use the term "inmates" to refer to those persons confined at the LCJ, regardless of status.

<sup>4</sup> Lake County Jail Annual Report 2007.

<sup>5</sup> Lake County Jail Annual Report 2007.

## B. LEGAL FRAMEWORK

CRIPA authorizes the United States Attorney General to investigate and take appropriate action to enforce the constitutional rights of jail inmates subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997. The Fourteenth Amendment mandates that jails must provide pre-trial inmates “at least those constitutional rights . . . enjoyed by convicted prisoners,” including Eighth Amendment rights. Bell v. Wolfish, 441 U.S. 520, 545 (1979). Under the Eighth Amendment, prison officials have an affirmative duty to ensure that inmates receive adequate food, clothing, shelter, and medical care. Farmer v. Brennan, 511 U.S. 825, 832 (1994). The Constitution imposes a duty on jails to ensure an inmate’s safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dep’t of Soc. Servs., 489 U.S. 189, 199-200 (1989)). This duty includes the duty to prevent the unreasonable risk of serious harm, even if such harm has not yet occurred. See Helling v. McKinney, 509 U.S. 25, 33 (1993). Thus, jails must protect inmates not only from present and continuing harm, but also from future harm. Id. This protection extends to the risk of suicide and self-harm. See Matos v. O’Sullivan, 335 F.3d 553, 557 (7th Cir. 2003); Hall v. Ryan, 957 F.2d 402, 406 (7th Cir. 1992) (noting that prisoners have a constitutional right “to be protected from self-destructive tendencies,” including suicide).

The Constitution also mandates that jails provide inmates adequate medical and mental health care, including psychological and psychiatric services. Farmer, 511 U.S. at 832. Prison officials violate inmates’ constitutional rights when the officials exhibit deliberate indifference to inmates’ serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 102 (1976).

Jails must provide “reasonably sanitary and safe” living conditions. Farmer 511 U.S. at 832. The Constitution requires jails to ensure that environmental conditions do not pose serious risks to inmates’ health and safety, such as deficient sanitation, inadequate fire safety, inadequate ventilation, and pest infestation. Vinning-El v. Long, 482 F.3d 923, 924-25 (7th Cir. 2007).

## II. FINDINGS

### A. SUICIDE PREVENTION

The Constitution requires the LCJ to protect inmates from suicide and self harm. See, e.g., Hall, 957 F.2d at 406. This constitutional requirement mandates adequate suicide prevention measures, including appropriate screening by a qualified mental health professional to assess suicide risk, appropriate supervision,

observation, and monitoring of those inmates identified as at risk of suicide, appropriate communication between correctional health care and correctional staff, and appropriate multi-disciplinary treatment plans. The suicide prevention and management process at the LCJ is grossly inadequate.

Staff we interviewed reported that there have been seven completed suicides in the past four years. Five completed suicides occurred in the past two years, a rate which is more than five times the national average.<sup>6</sup> As we explain in further detail below, the LCJ lacks the appropriate structure, staff, and training to adequately protect inmates at risk of self-harm.

At intake, unqualified non-mental health clinicians conduct suicide screenings. These screenings fail to provide any estimate of risk of self-harm or to document any management plans. Screenings are not reviewed by a licensed and credentialed mental health professional for quality and timeliness. Moreover, access to appropriate mental health professionals is poor, as is communication between correctional and mental health staff. The following example highlights inadequate and contradictory initial suicide risk assessments, inadequate psychotropic medication management, inadequate treatment and overall attention from mental health staff, and inadequate mental status exams and suicide reassessments:

- On February 27, 2008, the LCJ conducted an initial suicide risk assessment of inmate A.A.,<sup>7</sup> with contradictory findings. One portion indicated no past psychiatric history (medication or treatment) and no previous suicide attempts, while other portions simultaneously listed three current psychotropic medication prescriptions, and described his medical complications as “bipolar/depression.” The assessment found “no need for mental health treatment indicated at this time.” Thus, the inmate was not provided with a psychiatric assessment or psychotropic medications.

Unqualified staff made a similarly flawed second, March 10, 2008, suicide risk assessment, again indicating no current or past psychotropic medications, and no treatment history. Compared to the

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<sup>6</sup> The national average suicide rate in jails in the United States is 0.47 suicides per 1000 inmates per year. Thus for the LCJ’s average inmate population of 1000, 7 suicides in 4 years equals an average of 1.75 suicides per year, and 5 suicides in 2 years equals an average of 2.5 suicides per year.

<sup>7</sup> To protect inmates’ privacy, we have used fictional inmate initials.

first assessment, the March assessment changed medical complications to “none/unable to confirm anxiety with doctor.” Again, the second assessment found “no need for mental health treatment indicated at this time.” Contradicting this assessment, however, a medical screen conducted the same day indicated that A.A. had been admitted to the LCJ previously in 2005 and 2007, had been taking psychotropic medications, and the LCJ had previously treated him for “depression/anger.”

A.A. was not seen by a psychiatrist until March 18, 2008, nearly three weeks after his admission. The psychiatrist’s assessment described a bipolar disorder for the past six years, listed a history of several psychotropic medications, and a history of suicidal ideation/attempt, including an incident where the inmate cut his wrists related to family issues a few months earlier in December 2007. The psychiatrist ordered psychotropic medications and a return to the clinic in four weeks. Thus, the record shows that the inmate was not seen by a qualified mental health professional or given psychotropic medications until at least three weeks after his admission.

The inmate’s record indicates that, throughout April 2008, the inmate made multiple requests for counseling regarding changing his medications (because he was only sleeping two to three hours a night), and made several suicidal statements, which staff assessed as ploys to get out of his present unit. In one suicidal note, the inmate concludes with “last night when everybody was sleeping I tried to hang myself but my string broke. Tonight I’m going to try with my blanket. I will succeed.”

On April 29, 2008, a counselor put the inmate on full suicide precautions. The inmate’s record reveals that two days later, on May 1, 2008, the psychiatrist performed a cursory assessment, concluding that the inmate was on medication, was not depressed, did not have suicidal ideation, but had a history of suicidal ideation/attempt. Based on this cursory assessment, the psychiatrist took the inmate off suicide precautions and returned him to general population. Three days later, on May 5, 2008, the inmate hanged himself in his cell.

If the LCJ identifies an inmate at intake as possibly representing a suicidal or self-harm risk, staff may place the inmate on “full suicide,” which requires an LCJ correctional officer to monitor the inmate. Because a physician or qualified mental health professional often does not review this designation, it results in the LCJ placing many inmates on suicide watch who do not require that level of

supervision, which places an unreasonable demand on LCJ staff to supervise a large number of inmates. The LCJ monitors inmates on suicide watch with staff making visual checks every 15 minutes or by remote video camera. The LCJ fails to adequately monitor inmates with both these systems.

Regarding the visual 15 minute checks, LCJ custody staff should be making these checks at least every 15 minutes and noting the check on the inmate's suicide check log. We observed that staff failed to make these checks every 15 minutes, yet they would inaccurately record on the inmate's suicide check log that such checks were completed every 15 minutes. We also reviewed log sheets with multiple blanks and log sheets with single signatures purporting to cover several 15 minute periods. One inmate, B.B., reported that staff failed to check on her every 15 minutes, but rather would "take the sheet with them."

We also found inadequate LCJ's camera supervision. We observed one correctional officer attempt to monitor up to 18 cameras at any given time from a control office where that officer had multiple, additional responsibilities. The example below highlights the deadly consequences of the LCJ's failure to properly monitor its cameras:

- Shortly after his arrest in September 2006, C.C. committed suicide by hanging himself with his T-shirt in an LCJ intake cell. The EMTs who initially assessed C.C. stated that C.C. told them that he suffered from anxiety and depression, and was currently taking Xanax. Our review of the LCJ camera video of the intake cell shows C.C. tying his T-shirt into a ligature and securing the T-shirt ligature around his neck and a bathroom stall. The video further shows C.C. hanging from the bathroom stall for approximately eighteen minutes before LCJ staff discovered him. The video further reveals that staff let another inmate out of the holding cell - after C.C. had already been hanging for approximately eight minutes - and still did not discover C.C. hanging from the stall for an additional nine minutes.

As detailed below, we note that even after this tragic incident, the LCJ has not rectified its substandard monitoring of inmates at risk of suicide. Beyond the obvious failure to monitor surveillance cameras, this example further highlights that the LCJ needs to assess an inmate's suicide risk with a qualified mental health professional. A qualified mental health professional might have placed the recently arrested inmate, who indicated that he took Xanax and suffered from anxiety and depression, on suicide precautions.

In addition to the alarming number of recent past suicides, we found that the inadequate suicide management processes and inherently dangerous care of

inmates with a risk of suicide continues at the LCJ. The following examples show that, like the completed suicide examples above, the LCJ continues to ignore inmates on full suicide watch and fails to properly assess inmates with suicidal ideation:

- During our December 2008 tour, we observed medical, mental health, and custody staff ignore inmate D.D., who was screaming for assistance while on “full suicide” camera watch. Additionally, this inmate had just been discharged from a hospital the previous day. When a counselor eventually visited the inmate, and alerted both the Director of Nursing and the mental health manager, the staff still did not promptly assess the inmate for her mental health needs and suicide potential. Instead, staff responded that the psychiatrist, who happened to be at the LCJ for one of the psychiatrist’s two four-hour shifts per week, would eventually see the inmate. Beyond this potentially harmful delay, this procedure fails to account for who would see inmates in obvious acute distress if the psychiatrist happened to not be on site that day.
- In November 2008, a correctional officer found E.E. standing on a toilet stating that he wanted to kill himself. The correctional officer called a mental health counselor, who after speaking only with the correctional officer, agreed that the inmate was “just kidding.” The counselor conducted no face-to-face assessment and completed no suicide risk assessment form.

The LCJ’s inadequate medication administration, further detailed in the medical section below, also increases the danger to inmates at risk of suicide. The LCJ’s medication administration system improperly gives inmates all of their medications for the day at a single time, expecting inmates to self-administer their medication throughout the day. This inherently dangerous practice provides inmates with medications to be taken at whatever time the inmate chooses, and allows the inmate to hoard, trade, or overdose their medications. The LCJ does administer medications to a few inmates on a “split and watch,” basis, where the nurse splits the inmate’s daily medication, and watches the inmate take a morning dose and an evening dose, however this practice is inconsistent.

While the documents LCJ produced did not identify suicide attempts related to inadequate medication management practices, our interviews with inmates and staff revealed that inmates have attempted to overdose on their medications and possibly the medications of other inmates, and that the clinical staff and custody staff routinely fail to watch inmates take their medications, placing those at risk of suicide in significant peril. We found many dangerous examples, including:

- Inmate F.F. reported that he was in the mental health crisis unit because he attempted to kill himself by overdose on numerous psychotropic medications in December 2008. Despite his record indicating that he previously attempted suicide by overdose in 2004, and that he indicated “yes” on his suicide screening to a past history of attempted suicide, LCJ’s self-administration practice allowed him to hoard his medications and attempt suicide. This inmate told us “I stored it up, took it all - tried to kill myself.”
- The LCJ gives G.G. all his medications once a day to take as he chooses, despite his self-reported suicidal ideation and being placed on suicide watch.
- Inmate H.H. reported that LCJ gives him five different psychotropic medications, to self-administer throughout the day. LCJ has given him as much as 1300 mgs of Haldol at a single time, a potentially lethal amount if ingested all at once.<sup>8</sup> His medication administration record shows nursing initials that inaccurately indicate that nurses personally administer his medication twice a day.
- Inmate J.J. attempted to hang himself approximately two months before our visit. Despite this suicide attempt, his counselor sees him only once a month, and the LCJ gives him psychotropic medications to self-administer throughout the day.
- Inmate K.K. reported that she has a chemical dependency problem and had just attempted suicide in August 2008. She stated that a counselor does not see her on a regular basis and that she did not see a counselor until two weeks after her admission. Despite her suicide attempt and a self-reported chemical dependency problem, LCJ gives her psychotropic and other medications to self-administer.

In addition to the risk of self-overdose, this practice allows inmates to take dangerous medications without a prescription. One inmate confirmed that he saves his psychotropic medications and makes them available to other inmates.

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<sup>8</sup> The maximum dose of Haldol is 100 mgs per day, but prescriptions over 60 mgs per day are extremely rare, and appropriate only in a hospital setting. Overdose dangers include seizures, respiratory depression, and possibly death.



Overall, the LCJ's suicide prevention and management processes fail to properly screen and assess inmates, and fails to adequately monitor and treat inmates with suicide risks.

## B. MENTAL HEALTH CARE

The Constitution requires LCJ to provide inmates adequate mental health care, including psychological and psychiatric services. Farmer, 511 U.S. at 832. Our investigation revealed that the LCJ's mental health care and suicide prevention practices fall below the minimum constitutionally required standards of care. Particularly, we found the LCJ's mental health care services were constitutionally deficient in the following areas: (1) staffing; (2) intake and referral process; (3) sick call process; (4) treatment planning and services; (5) medication management; and (6) quality improvement and quality management program. These deficient LCJ practices cause inmate harm and create an unreasonable risk of harm.

### 1. Inadequate Staffing

We found that the LCJ employs an inadequate number of staff to provide inmates with a constitutionally adequate mental health program. At the time of our tour, the LCJ employed the full time equivalent ("FTE") of 3.2 mental health staff, comprised of 3 mental health counselors and 0.2 (i.e., 8 hours per week) of a psychiatrist's services.<sup>9</sup> This allocation of staffing is inadequate for LCJ's average daily population of approximately 1,000 inmates, and an intake service that processes 15,000 intakes per year. For its population, the LCJ needs at least 7-10 mental health counselors and 1.5-2.0 FTEs in psychiatry.

Under-staffing currently limits the LCJ to a response-oriented, crisis management mental health program, rather than the preventive program that the Constitution requires. This under-staffing causes gaps in care, for example:

- Inmate H.H. reported that he currently was taking five different psychotropic medications, but that he had not seen the psychiatrist in three months.
- Inmate L.L., a juvenile, reported that he has only seen a counselor "three or four times" despite being incarcerated at the LCJ for the previous seven months. Mental health staff should have counseled

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<sup>9</sup> We also note that the LCJ was unable to produce credentialing records for its counselors and psychiatrists.

this juvenile inmate at least monthly, according to LCJ policy and the generally accepted professional standard.

- Inmate J.J., reported that he had attempted to hang himself in the last four months, has Bipolar disorder, and currently was taking two different psychotropic medications. Despite these special needs, the counselor sees him only once a month, and the psychiatrist does not regularly see him to monitor his medication compliance or his symptoms of mental illness.

Compared to LCJ's crisis response-oriented program, an adequate proactive mental health program includes comprehensive assessments, psychosocial evaluations, multi-disciplinary treatment planning, individual and group therapies, and services specific to special need inmates, such as juveniles and women.

## 2. Inadequate Intake and Referral Process

EMTs and psychology technicians perform the intake mental health screenings and evaluations. These intake functions should be performed by qualified mental health staff. Consequently, the LCJ appears to fail to identify many inmates who need mental health services. The LCJ identifies 14% of inmates as needing mental health services, but the national average for its population is 18-30%.

In addition, the staff who do perform the screenings fail to adequately complete them. Staff take these screenings at booking, usually in a non-confidential setting. This process conflicts with professional standards that require confidential mental health evaluations to be completed after the inmate has been in jail for up to 14 days. Further, no qualified mental health staff review the screenings for adequacy. These flawed screening evaluations hurt the adequacy of the referral process, which is based on these evaluations.

Referrals between mental health and medical staff suffer serious communication problems. Our interviews revealed that both groups expect the other group to perform direct patient assessment and care duties, for which both groups should take responsibility. For example, as detailed above, we witnessed medical staff ignore a screaming inmate who was clearly in distress and on suicide camera watch because they claimed the inmate had a "mental health" problem, and mental health staff ignored this inmate because the inmate had a "medication problem." Custody staff monitoring the camera called for neither medical nor mental health staff. These types of collaboration and communication failures can cause serious injury or death.

### 3. Inadequate Sick Call Process

The LCJ sick call process is not consistent with generally accepted correctional standards of triaging and responding to sick call requests within 24 hours. Contrary to this 24-hour standard, documents we reviewed showed that the LCJ's sick call process envisioned that medical staff should respond to sick call card requests within 48 hours. We found that the process relies on custody staff giving inmates sick call cards upon request, custody staff delivering these cards to a central location, nursing staff triaging the sick call cards and then providing them to mental health staff. While documents envisioned the completion of this process within 48 hours, an LCJ audit revealed that the delay in medical receiving sick call requests ranged from 72 hours to several days. Moreover, this delay simply marked the receipt of the sick call card and did not consider the additional delay of actually responding to the sick call request. Therefore, this process allows for harmful extended treatment delays for inmates in serious crisis and in need of emergency or urgent evaluation. Further, the LCJ does not track whether responses are as prompt as necessary, addressed by the appropriate provider, or resulted in a reasonable outcome such as modification or assignment of services or treatment.

The flawed intake and referral process described above compounds this problematic sick call process, because the flawed intake and referrals leave inmates with only this flawed sick call process to alert staff to their needs.

### 4. Inadequate Treatment Planning and Services

Generally accepted correctional standards require that the LCJ develop and use comprehensive multi-disciplinary treatment plans and services. Documents and interviews with staff and inmates revealed that the LCJ violates this standard by having no treatment plans, other than an initial treatment plan that the psychiatrist may author for the few individuals that he may see during the eight hours per week that he works at the LCJ. We found no comprehensive treatment planning process, no scheduled treatment planning conferences, and no special needs treatment plans for juveniles. Policies and procedures fail to require: (1) that a treatment plan begin as an initial plan when the mental health clinician first sees the inmate; (2) the completion of a more comprehensive treatment plan within 10-14 days of admission; and (3) the periodic reevaluation of treatment plans for those inmates residing at the LCJ for extended periods.

A multi-disciplinary comprehensive treatment model includes mental health, medical, and nursing staff because of the essential roles that they play in the treatment and management of inmates in a correctional environment. Compared to this multi-disciplinary comprehensive model, the LCJ's current practice is for counselors to write a "Diagnostic Formulation," without a qualified mental health

staff completing a mental health evaluation, and without the psychiatrist writing a progress note/medication review. Medical records that we reviewed contained no problem list to allow a reader to easily ascertain for what a specific inmate is being treated, including mental health problems, such as Schizophrenia or Depression, but also medical problems such as asthma, diabetes, or hypertension. Examples of inmates with inadequate treatment plans include:

- Inmate M.M., who had been at LCJ for four months, reported that he had been taking psychotropic medications for approximately the previous nine years, and received residential treatment for approximately the last two years. LCJ's mental health suicide risk assessment and psychiatric screening of this inmate list "no" as answers to medications before admission and a past history of treatment. The medical history and screening listed similar "no" answers, and failed to refer him to the mental health department. After approximately three months, a mental health professional completed a Diagnostic Formulation. The LCJ eventually diagnosed him with Schizophrenia, and put him on suicide precautions. LCJ discontinued his suicide precautions with no indication that a physician interviewed the inmate in-person. The record contained no evidence of a long or short-term treatment plan, with the only treatment references dealing with medications and placement on suicide precautions when the inmate was in a crisis.
- We interviewed inmate G.G. on the mental health crisis unit. He reported that LCJ placed him on the crisis unit for the previous 15 days because he had stated he was suicidal. His record indicated that back in April 2008 he answered "yes" on his suicide risk assessment, but that no one referred him to mental health staff. Eventually, a nurse practitioner saw him a month later. A November 2008 psychiatric note was illegible, and therefore unhelpful in determining what treatment LCJ provided to this inmate. This inmate's record contained no comprehensive treatment planning or discussion of his needs.
- Inmate N.N.'s record indicated he entered the LCJ on December 11, 2007, with an incomplete suicide screening and no mental health evaluation. On December 22, 2007, a progress note labeled him as a "full suicide" risk. His medication records indicated orders for Paxil and Trazodone in January, June, July, and September 2008, without a psychiatrist ever seeing him. His record contained no evidence of a comprehensive or multi-disciplinary treatment plan.

Regarding actual treatment services, the LCJ improperly delegates most services to the nursing staff, including medication management, the “split and watch” process for administration of medication, the writing of “full suicide” designations for inmates, and the discontinuation of medications if nursing staff believes that an inmate may be hoarding medication. The mental health staff conduct limited psychosocial “contact” or “rounds,” but they fail to give any form of individual therapy or group therapy, despite the policies and procedures that state that the LCJ will provide group therapy, individual therapy, and psychosocial interventions.

#### 5. Inadequate Medication Management

As described above with regard to the management of potentially suicidal inmates and also detailed in the medical care section below, the LCJ practices seriously flawed and dangerous medication management, including nurses improperly writing and discontinuing medical orders and inadequate security controls.

#### 6. Inadequate Quality Improvement and Quality Management Program

Generally accepted correctional mental health standards call for adequate quality assurance review and quality improvement tools. These tools are necessary to examine the effectiveness of the mental health care delivered and to implement corrective action so that the quality of care is improved.

The LCJ poorly manages its existing Continuous Quality Improvement (“CQI”) process. While the quality improvement committee’s membership includes the mental health manager, no psychiatrist or licensed independent mental health professional sits on the committee. Moreover, our review of the minutes of meetings revealed that the committee meets only quarterly, that even these meetings do not consistently take place as scheduled, and that the discussion topics primarily deal with medical issues, rather a balance between medical and mental health issues. This quality improvement committee does not produce meaningful corrective action plans, nor does it assign these action plans to specific personnel with a requirement to report and document plan implementation.

Specifically related to mental health issues, the LCJ does not meaningfully measure, follow, or document the quality or timeliness of important mental health processes such as assessments, suicide prevention evaluations, suicide management, treatment planning, medication management, and treatment services. The LCJ needs to completely revise its quality improvement and quality management program.

## C. MEDICAL CARE

The Constitution requires that LCJ provide adequate medical care to address inmates' serious medical needs. Farmer, 511 U.S. at 832; Estelle, 429 U.S. at 102. The LCJ must employ functional systems to provide adequate medical care and treatment to its inmates, particularly in a jail the size of LCJ. These systems should include an initial screening process, a comprehensive health assessment for longer-term inmates, a sick call process, acute and chronic care clinics, infection control mechanisms, medical record keeping, medication administration, qualified medical staff, a professional management structure, and a quality assurance component to evaluate and improve the above systems. Our investigation revealed that the LCJ's medical care practices fall below the minimum constitutionally required standards of care. Particularly, we found constitutionally inadequate LCJ's: (1) medical staffing; (2) access to medical care; (3) acute and chronic medical care; (4) comprehensive health assessments; (5) medication administration; (6) medical records; and (7) quality improvement. These deficient practices cause inmate harm and create an unreasonable risk of harm.

### 1. Inadequate Medical Staffing and Organization

Medical care at LCJ is disorganized and understaffed. Consequently, the LCJ inadequately trains and supervises the clinical staff. Many of the issues relating to the LCJ's inadequate medical care discussed below derive from this poor organizational structure, low level of professional staffing, and lack of professional health care oversight of clinical employees and contractors.

LCJ provides medical care for its inmates through several personnel each reporting to separate entities: EMTs who report to Lake County; psychology technicians, nurses, dentists, and physicians who report to a contractor; and counselors and psychiatrists who report to a different contractor. In January, the LCJ planned to move the EMTs onto the Med Staff contract. The aforementioned providers engage in little formal communication, and each provider reported through a different deputy warden. None of these wardens had any health care administration experience.

The above chaotic health care structure results in inadequate supervision of the system's health care providers. Outside of non-health care related administrative functions such as patient counts, the LCJ does not monitor the performance of any clinical activities. The director of nursing does not supervise the EMTs, who are responsible for intake screening, and these EMTs receive little training and supervision. The mental health staff do not supervise the psychology technicians, and these technicians receive little training and supervision. We found no lesson plan for training and supervision of the EMTs and psychology technicians.

A physician does not formally supervise the nurse practitioner. Furthermore, the LCJ does not provide inmates a copy of the inmate handbook, and has established a co-payment system at least double that of a typical similar sized jail.

The current number of LCJ staff cannot accomplish the critical clinical and administrative objectives of an adequate health care system. LCJ has only 1 to 5 hours of physician time per week, 2 hours of dentist time, and 1.2 FTE nurse practitioners. Similar sized facilities employ at least 2 FTE licensed independent practitioners and a full-time dentist. At the time of our tour, the LCJ had failed to fill a nurse practitioner vacancy for more than a year.

Insufficient dentist time inappropriately limits dental care to prescription for antibiotics and extractions. Similarly deficient, the infectious disease physician visits the LCJ for only two hours, two to four times per month.

In sum, poor organization, the absence of communication between disparate health care providers, the lack of appropriate supervision of clinical staff, and overall inadequate staffing contribute substantially to the LCJ's inadequate medical care practices.

## 2. Inadequate Access to Medical Care

We found that the LCJ provides inmates constitutionally inadequate access to medical care. As detailed below, we found problems with medical screenings and sick call, poor training, long waits for medical attention, infection control, high co-payments, confidentiality, and poor and non-existent documentation

Inmates' access to medical care through screening and sick call requests is inadequate. As stated above, untrained and unsupervised EMTs conduct the initial screening of inmates. Once booked, inmates' only access to medical care comes through sick call requests. The mental health section above detailed the overall flaws with access to, processing, and tracking of sick call slips. Particular to medical care, we further note that a health care clinician only sees inmates once per week. This sick call process falls well below nationally-accepted standards of correctional care.

Consequently, this wait for medical care violates constitutional minimums, leaving significant inmate medical needs inadequately addressed or completely unmet. For example, inmates wait approximately eight weeks for dental care. This wait is significantly too long, particularly for urgent problems such as abscesses and pain. From our records review, we found that several inmates had up to a four-day lag for care for skin abscesses and received no follow-up care. In another instance, an inmate acquired a skin infection in LCJ and waited five days for medical staff to

see him. The LCJ never provided follow-up care to several other inmates with skin wounds. Another inmate had a lump that the LCJ never addressed. Still another inmate suffered a two-month lag for care of symptoms suggesting a sexually transmitted disease. In all these cases, the LCJ provided substandard and poorly documented care.

With regard to the care and treatment of skin infections, the LCJ fails to maintain any logs. This absence of logs makes it impossible to track the incidences of skin infections within the LCJ to appropriately monitor the frequency and prevalence of such infections. Additionally, the LCJ fails to take the vital signs of the inmates it monitors for potentially life-threatening withdrawal from alcohol or other substances.

Nurses do not adequately review inmates whom staff electrically shock with TASERs during use of force incidents. We reviewed the use of TASER force on ten inmates over a three month period. Nursing evaluations were missing in five of those records and the LCJ could not find two of the records. Furthermore, the LCJ knew that seven of the ten inmates had mental illnesses, but their records contained little information regarding their mental illness or mental health interventions. We found that the LCJ could have possibly avoided at least six of these use of force incidents if the LCJ had adequately evaluated these inmates for mental health issues.

The LCJ's medical record progress notes from sick calls are poor or non-existent. When we showed the director of nursing the progress notes for eight inmates seen by the nurse practitioner, the director of nursing found the notes illegible. Medical records for several inmates contained no progress reports or documented examination at all. Regarding primary physicians, we reviewed numerous medical records of inmates scheduled for sick call. Over half of these records contained no progress note, and the LCJ's unacceptably high no-show rate of over fifty-percent makes it likely a physician never saw these inmates. Furthermore, the inmates were not seen within seven days following the scheduled visit. Finally, we found that the physician interviewed several patients with significant health care needs such as HIV infection and/or viral hepatitis, but the physician failed to document findings in the medical records. This lack of documentation made it impossible to evaluate access to or quality of care for these inmates. We did note several inadequate infection control practices dangerous to the health and safety of both staff and inmates. For example, the examination room in the booking area contained unsecured hazardous waste, chemicals, and sharps. Medications laid unsecured in the clinic area. Many of the mattresses in the housing units were cracked, making them impossible to disinfect.



LCJ's co-payment system departs from minimally accepted correctional standards. LCJ's co-payment is at least double that of a typical similar sized jail. These high co-payments along with the lack of adequate waivers in specialized circumstances bar inmates' access to care. Jails similar to LCJ typically waive co-payments for communicable disease (such as skin infections), chronic disease care, comprehensive health assessments, and pregnancy care. LCJ does not waive these co-payments. Several inmates indicated that these high co-payments barred their access to care. Thus, this non-waiver and high co-payment system forces inmates to go without necessary care for serious medical problems. Moreover, in the case of communicable diseases, not only does this system harm the inmate, but it also puts the general public at risk of harm.

Finally, inmates are often interviewed in the clinic areas in the presence of, or within earshot of, correctional officers, thus compromising inmates' privacy and ability to communicate their medical needs.

### 3. Inadequate Acute and Chronic Medical Care

LCJ fails to provide inmates constitutionally adequate acute and chronic medical care. Regarding inadequate acute care, LCJ records revealed several instances of jail-acquired skin infections. Jails should provide inmates with skin infections daily documented wound care and regular follow-ups by a physician or mid-level practitioner. The LCJ diagnosed and treated the majority of these infected inmates without a physician evaluation or physician order for the antibiotic prescribed. The LCJ's documentation of wound care and physician follow-up was nearly absent.

We noted a startling case of an inmate, O.O., with a history of prostate disease who had difficulty urinating without medication. He waited three days until a physician saw him, even when nursing staff had already catheterized him on at least two occasions. Proper medication, which was never ordered, could have prevented this unnecessary catheterization. Further, the inmate, who was withdrawing from alcohol, is another example of the LCJ's failure to document vital signs during withdrawal. Moreover, we reviewed the charts of ten inmates whom the LCJ had treated for withdrawal from alcohol or other substances and only two records showed documented vital signs and appropriate treatment for the withdrawal.

We also reviewed the medical record of an inmate, P.P., diagnosed with syphilis, based upon a test that indicated an old infection or, alternatively, liver disease. The LCJ improperly gave him three unnecessary intramuscular injections as if he had acute syphilis. Furthermore, the clinical staff never checked with the county health department's database for his history of treatment.

Regarding chronic care, LCJ fails to follow generally accepted correctional care practices for treating chronic illnesses, which causes inadequate care for inmates' chronic conditions. LCJ has no system to track and monitor inmates with chronic care conditions nor a chronic care clinic to adequately manage inmates needing chronic care treatment and follow-up. From our record reviews and interviews, we discovered that the LCJ failed to give inmates with asthma a comprehensive health assessment, even though these inmates had stayed in the LCJ for more than 30 days, nor had the LCJ appropriately measured or monitored their condition. Another inmate with known hypothyroidism, Q.Q., did not receive a comprehensive health assessment and had no prescription for life-sustaining thyroid medication. The LCJ also fails to adequately monitor inmates with diabetes. Of the records we examined of inmates with diabetes, the LCJ had measured the hemoglobin of only 67% within the past 3 months and measured the cholesterol of only 58% within the past 12 months. Furthermore, only 1 inmate had any documentation of a urinary measurement within the past 12 months. These practices fall well below generally accepted minimal standards for correctional care for diabetes. For inmates with seizure disorders, despite inmates reporting medication at booking, the LCJ failed to place these inmates on seizure medications, and their records showed no clinical documentation justifying the discontinuation of these medications. Medical records for inmates with HIV and viral hepatitis C had no progress notes, which prevents other clinical staff from coordinating or providing continuity of care or from evaluating the inmate's care.

#### 4. Inadequate Comprehensive Health Assessment

The LCJ fails to perform comprehensive health assessments that generally accepted correctional practices require. Longer term inmates require a more comprehensive health assessment in addition to the screening at booking. The generally accepted profession standard of care in jails is for a jail to conduct a physical examination, including a comprehensive medical history, within 14 days of booking. Longer-term juveniles also should have immunization records.

We reviewed the medical records of 33 inmates in custody beyond fourteen days. None of the 33 inmates had a comprehensive health care assessment. As noted above, this lack of a health assessment can have increased harmful risks for inmates with acute or chronic illnesses. We also evaluated the records of all of the juveniles at the LCJ; none had a comprehensive health assessment, immunization record, or mental health evaluation.

#### 5. Inadequate Medication Administration

The LCJ practices seriously flawed and dangerous medication management. The LCJ's medication administration staff engage in several inappropriate

medication administration practices, including inappropriate nursing decisions and inadequate security controls.

Interviews and the LCJ's medical records revealed that nurses practice beyond the scope of their licenses by improperly writing and discontinuing medical orders without specific direction from a physician. Regarding improperly writing orders, the LCJ has standing orders authorizing nurses to diagnose illnesses, and to prescribe and administer non-emergency medications without a physician's order. These standing orders authorize nurses to record administration of these medications as "T.O. [telephone order] Dr. Pierce/nurse's name." These practices go well beyond the scope of a nurse's license and misrepresent that the administration of the medications was pursuant to a direct and individualized telephone order.

Regarding discontinuation of medication, nursing staff automatically stop medications, without a physician's order, for patients who do not adhere to their prescriptions. Rather than automatically stopping the medications, generally accepted correctional standards counsel that any patient who does not follow his or her prescription regimen should be counseled and asked to sign a refusal form for medications missed on three consecutive days and should be reported to the prescribing physician. Again, these nurses falsely designate these orders "as per physician" because LCJ policy requires that they write that designation on the order.

This practice obviously puts inmates at risk of harm from ill-advised medical orders. We found many examples where nurses improperly discontinued medications, not for medical reasons, but because the nurse thought an inmate was hoarding medication. For example:

- Inmate R.R.'s record indicated a history of suicide watch, diagnosis of Schizophrenia, and a prescription for a psychotropic medication. His record showed that a nurse unilaterally discontinued his medication as "per Dr. Robbins," based on finding 14 tablets of the psychotropic medication hoarded in his cell. This inmate's record failed to document any psychiatrist involvement in the discontinuation of his medication or any psychiatric progress note describing any assessment or treatment of his suicide risk.

Beyond nurses practicing outside their licenses, we found medication security problems. The medication room was unsecured. Staff leave the room unlocked, giving inmates access to drugs and sharps. Medications laid loose in a box on the floor of the nursing stations. We note that these loose medications included controlled substances, a particularly dangerous substandard practice. Staff also inappropriately used the medication refrigerator to store food.

We also reiterate that, as explained in the suicide prevention section above, LCJ generally administers medications only once per day. This practice encourages hoarding and diversion of medications. The staff also inaccurately document that they have directly observed inmates taking these medications throughout the day.

Finally, LCJ lacks a Pharmacy and Therapeutics Committee or a process to determine whether certain types of medications may be appropriately prescribed at LCJ. This process would correct the conflicts we noted between the medical director and the corporate administrator of Med Staff over the use of particular drugs prescribed by the medical director.

#### 6. Inadequate Medical Records

Medical records are disorganized and lack essential information. At the time of our visit, LCJ had a two to three-month lag in filing medication administration records. The psychiatrist and nurse practitioner wrote illegible notes, making their clinical notes unhelpful. The infectious disease physician did not document his clinical encounters in the records at all. Furthermore, staff did not organize notes in any coherent fashion, such as the standard format of Subjective information, Objective information, an Assessment, and a Plan (“SOAP”). The records also did not contain an index sheet, which medical professionals generally refer to as a problem list. As stated earlier, because LCJ fails to provide a sufficient number of sick call forms for the inmates, inmates use scraps of paper that staff often randomly staple into the medical records. These scraps are often undated and contain no indication of when they were reviewed or of the clinical disposition. Finally, we reviewed over 150 medical records and never encountered a single record with a plan of care for an inmate with special needs (e.g., inmates with chronic conditions, acute illnesses, infectious diseases and/or skin conditions, etc).

#### 7. Inadequate Quality Improvement

As noted above in the mental health section, the LCJ’s quality improvement program is poor. While the LCJ has begun quarterly quality management meetings, the LCJ has no quality management plan and has no set performance measures regarding access and quality of medical care. The Department of Health conducts quarterly reviews of ten medical records; these reviews have found problems similar to the aforementioned lack of comprehensive health assessments, chronic care clinics, and insufficient psychiatric attention.

### D. FIRE SAFETY AND SANITATION

The Constitution grants inmates the right to reasonably sanitary and safe living conditions. Farmer 511 U.S. at 832; Vinning-El, 482 F.3d at 924-25. Our

investigation revealed that the LCJ's fire safety and sanitation programs fall below the minimum constitutionally required standards of care. Particularly, we found constitutionally inadequate the LCJ's: (1) fire safety; (2) housing and maintenance; (3) housekeeping; (4) laundry service; and (5) food service. These deficient practices cause inmate harm and create an unreasonable risk of harm.

### 1. Inadequate Fire Safety

Inadequate fire safety at LCJ presents a grave risk of harm from smoke, fire, and the serious security concerns that arise during an emergency. We found no active fire safety program at the LCJ. The LCJ could not produce any fire drill logs. As detailed in the inadequate laundry service section below, we observed fire extinguishers in the laundry building that no one had inspected for at least ten years. For other LCJ areas, fire extinguisher inspections were spotty and inconsistent. We witnessed an automated cell block locking mechanism fail to work, which demonstrates that the LCJ needs to have pre-prepared reliable alternate life safety measures when these normal procedures fail. Thus, LCJ staff need readily accessible emergency keys that, according to fire codes, staff can easily identify by both sight and touch. The set of emergency keys we observed were not marked for identification by touch.

### 2. Inadequate Housing and Maintenance

Maintenance problems permeated throughout the housing units and covered a wide range of deficiencies. We observed that shower walls and ceilings were in poor repair, shower control valves did not function properly, if at all. For example, in a 32 bed housing unit (3-C), only one of four showers functioned. In the Geriatric Unit, only one of three showers worked. We also found uncovered light switches in shower rooms, which exposed inmates to live electrical wires in a wet environment. We observed numerous totally or partially-blocked floor drains, and stopped-up and inoperable sinks. These plumbing issues generally existed throughout the LCJ.

While we found ventilation generally satisfactory, we did observe supply ducts that were either plugged with paper or had heavy accumulations of dust or debris that inhibited the air movement through the housing units. For example, a significant amount of dust blocked the exhaust duct grates in the Intake Center, effectively blocking air movement through the cells.

We found many mattresses and pillows that were torn or worn beyond their ability to be cleaned and disinfected between users. These deteriorated mattresses cause security problems, because inmates can easily conceal contraband under the mattress cover, and they create a risk of disease transmission because the mattresses cannot be adequately disinfected.

### 3. Inadequate Housekeeping

LCJ's housekeeping operations are grossly understaffed and conducted poorly. Only 1 officer and 1 civilian worker cover housekeeping duties for the entire jail; they supervise approximately 50 inmate workers. The LCJ also charges the housekeeping officer with responsibility for re-supplying control rooms, and maintaining adequate cleaning supplies in each janitor's closet.

The LCJ fails to properly control chemicals. The LCJ essentially fails to supervise all inmate workers' use of chemicals. No uniform mixing system for chemicals exists. For example, inmate workers use pine cleaner for cleaning the "old jail." The LCJ fails to supervise these inmates' dilution of this pine cleaner before these inmates take the chemical to the floors. Moreover, the LCJ generally leaves chemical closets unsecured specifically to enable inmate workers to go in and out at will. Beyond being a cleaning safety hazard, inmates could potentially fashion these chemicals into a weapon.

Beyond this inmate access problem, we found that the LCJ fails to properly label chemicals. Jails must properly label chemicals, whether the chemicals are in the original container or not. We frequently found ready-to-use spray bottles with cleaning chemicals that were mislabeled or not labeled at all. Any chemical that has a caution, danger, or warning label must have a material safety data sheet ("MSDS") wherever the LCJ chooses to store the chemical. Most jails typically keep these MSDS in an organized binder or folder so that staff can easily access the sheets in emergencies. We could not locate any MSDS's at the LCJ, and the housekeeping officer was not even aware of them. He also indicated that LCJ does not maintain a master list of all chemicals the LCJ uses. Nor does the LCJ maintain a running inventory of chemicals used in the LCJ. Without this inventory, the LCJ cannot account for its use of chemicals. As a result, we found inmates who were hoarding chemicals in their cells because they never knew when they would get cleaning supplies for their cells.

The LCJ fails to provide adequate supplies to the inmates for cell cleaning. The housing officer stated that he puts cleaning supplies into the housing units one time per week, but that he had not done so in the last two weeks. He also stated, "it's up to them what they do with it." Regarding procedures for cleaning sinks, staff reported that "if inmates want to take a hand towel and dip it in the mop bucket and clean the sink, that's okay to do." While the LCJ can use inmates to help with sanitation tasks, the LCJ needs to ensure proper procedures and supervision of these inmates.

No policy or procedure regarding housekeeping duties and schedules appears to exist. Staff put mop buckets into the housing areas for floor mopping each

morning. Showers and toilets are cleaned only once a week. We found showers in the female intake and dress-out areas especially unsanitary. We observed feces and a used tampon on the shower floor in the dress-out area, and the walls were in bad condition with peeling paint and what appeared to be mold growth. Generally throughout the LCJ, we found what appeared to be mold and mildew prevalent in the shower areas. Trash and other debris clog drains. Moreover, the LCJ's inadequate housekeeping practices have enabled drain flies to infest several floor drains.

The LCJ also documents housekeeping with logs that were extremely inconsistent or non-existent. According to the housing officer, the LCJ does not conduct regular inspections for quality assurance purposes, and has no quality assurance policies and procedures in place.

Housing Unit 3-C merits special mention. This unit stood, by far, as the worst of the housing units. The electric unlocking system was dysfunctional and staff had to manually unlock cell doors. We found three showers and one toilet were broken. Sinks were stopped up and the ceiling needed repair. Inmates in 3-C complained about their inability to get cleaning supplies on a regular basis. They also indicated that they washed their clothes in the toilet, rather than sending them to the facility laundry.

#### 4. Inadequate Laundry Service

Adequate laundry operations are essential to a sanitary jail environment. According to the LCJ inmate handbook, inmate clothing and bedding are laundered weekly upon request and blankets are exchanged monthly. Interviews with both inmates and staff revealed that the LCJ does not enforce the laundry policy's services and schedules. One officer stated that inmates had discretion about what laundry to send on collection day. With this discretion, many inmates refuse to send their items to the laundry and will wash their personal clothing in their cells, using sinks, toilets, or showers. We observed, and several LCJ inmates indicated, that inmates laundered their clothing in toilets and sinks. Several inmates indicated that the LCJ had not washed their blankets in six months or longer. These laundry practices create an unacceptable risk that disease causing pathogens can survive and be passed from inmate to either inmate or staff.

Beyond this inadequate enforcement of laundry policy, the LCJ's laundry center is unsanitary and contains fire hazards. The LCJ uses laundry carts to transport both clean and soiled laundry to the LCJ without disinfecting them between uses. We observed gross amounts of dust and dirt throughout the center.

We also found serious fire risks in this laundry center. Statistically, more jail fires occur in laundry areas than in any part of the jail. We found heavy accumulations of dust on top of dryers, which use gas burners, creating a severe fire hazard. The most recent fire extinguisher inspection tag that we observed in the laundry dated back to 1999. Another extinguisher located near the electrical panel box indicated a very low pressure that made the extinguisher virtually useless. The tag had deteriorated so badly that we could not read the date on it. Another extinguisher located in the basement near the compressor room had a 1997 tag and had lost adequate pressure.

#### 5. Inadequate Food Service

The LCJ fails to properly track or document food service, provides inadequate meals, and uses a kitchen with numerous health and safety violations.

The LCJ feeds inmate workers in a common dining room and all other inmates in their housing areas. The food service director indicated that the LCJ makes out a menu list weekly, but that this menu includes only the evening meal. The only menus that the LCJ could provide dated back to the summer and fall of 2007. No records of a qualified dietician approving menus for nutritional analysis were produced. Menu substitutions are not tracked.

Inmates and the food service director confirmed that inmates held in the intake area only got cold bag meals. Some inmates are held in this area for 48 hours or longer. Several inmates in the female intake unit (H-7) reported being housed there for more than a week.

Our tour of the kitchen revealed numerous health violations. The kitchen had only one hand wash sink, and access to the sink was blocked. We also found inadequately cleaned equipment, inoperable lights, and unsecured tools. Only knives are kept under lock and key, and the food supervisor could not say when inventory counts were conducted. For security purposes, the LCJ should secure all knives, utensils, and instruments, including table-mounted can openers.



### **III. MINIMUM REMEDIAL MEASURES**

In order to rectify the identified deficiencies and protect the constitutional rights of inmates confined at LCJ, the LCJ should implement, at a minimum, the following remedial measures:

#### **A. Suicide Prevention**

- a. Rewrite policies and procedures for suicide prevention and management with the duties reassigned to appropriately licensed and credentialed staff.
- b. Institute direct physical observation of persons on suicide watch, rather than the current practice of custody staff watching multiple inmates on multiple camera monitors.
- c. Institute an adequate suicide risk assessment instrument or form that a qualified mental health professional completes prior to an inmate's placement on suicide watch, and again prior to release from suicide watch or precaution.
- d. Administer prescription medications on a directly-observed basis for each dose, (unless the physician's order notes that the inmate can self-administer the medication). Ensure accurate documentation of the medication administration, without inaccurately documenting for future doses.
- e. Ensure proper follow-up care for inmates with a known history of suicide watch or precaution protocols. Include documentation of comprehensive multidisciplinary treatment planning for those inmates.
- f. Ensure suicide watch cells are suicide-resistant (e.g., suicide resistant vents).

#### **B. Mental Health Care**

##### **1. Staffing**

- a. Enhance staffing to meet the demands for timely access to an appropriate mental health professional.

- b. Ensure qualified mental health staff perform intake mental health screenings and evaluations.
  - c. Ensure adequate staff to perform comprehensive assessments and comprehensive multidisciplinary treatment planning.
  - d. Ensure mental health staff collaborate with appropriate medical staff.
  - e. Verify mental health staff have appropriate credentials.
2. Intake and Referral Process
- a. Ensure qualified mental health staff perform the intake and referral process.
  - b. Ensure inmates who show positive answers on suicide prevention screening are routinely referred to mental health.
  - c. Change the current “crisis response” mental health care model to a system that proactively identifies inmates who are in need of treatment or at risk of harm.
  - d. Ensure collaboration with medical and custody staff in those areas that overlap, such as intake assessments, confidentiality for interviews, suicide prevention and management, and treatment planning.
3. Sick call
- a. Provide inmates with a sufficient number of sick call request forms.
  - b. Ensure appropriate staff pick up and evaluate sick call slips at least five days per week. Triage slips for emergent conditions.
  - c. Ensure slips are adequately logged and tracked.
  - d. Institute quality improvement system for adequacy of the sick call process.

4. Treatment Planning

- a. Ensure adequate and appropriate treatment planning, which includes comprehensive multidisciplinary treatment team conferences. This team should include medical, nursing, and custody staff, and the inmate.
- b. Institute appropriate individual therapy or group therapy, rather than the current psychosocial “contact” and “rounds.”
- c. Ensure mental health records contain problem lists that allow the reader to quickly ascertain for what condition a specific inmate is being treated, including medical problems.

5. Medication Management

- a. Prevent nurses from improperly writing and discontinuing medical orders without specific direction from a physician.
- b. Administer prescription medications on a directly-observed basis for each dose, (unless the physician’s order notes that the inmate can self-administer the medication). Ensure accurate documentation of the medication administration, without inaccurately documenting for future doses.

6. Quality Improvement and Quality Management Program

- a. Institute effective quality improvement and quality management policies and procedures. These policies and procedures should address:
  - i. effectiveness of the intake assessment, referral, and sick call process;
  - ii. management and utilization of psychotropic medications;
  - iii. suicide prevention, including assessment of suicide risk, review and tracking of suicide attempts, monitoring of inmates on suicide observations or precautions;
  - iv. appropriate physical plant facilities such as safe cells for management of at risk inmates, and follow-up and

treatment for those who may have engaged in suicidal or self-harm activities;

- v. appropriate treatment planning and treatment interventions for inmates in the mental health program;
  - vi. discharge planning for the effective management and continuity of care for inmates leaving the system; and
  - vii. review and audits of medical records for quality and appropriateness of documentation.
- b. Ensure quality improvement committee meets on a monthly basis and that this committee includes representatives from medical, mental health, and custody staff.

## C. Medical Care

### 1. Staffing

- a. Ensure that health care structure is organized with clear lines of authority for operations.
- b. Clarify training and supervision. Ensure oversight includes performance monitoring of access to care and quality of care. Ensure accountability of staff and contractors for access and quality of care.
- c. Enhance staffing to meet the demands for timely access to an appropriate health professional, including physicians, psychiatrists, and mid-level practitioners.
- d. Provide an inmate handbook to each incoming inmate.

### 2. Access to Medical Care

- a. Institute effective sick call process. See Mental Health Care remedies outlined in Section III.B.3.
- b. Decrease missed appointments. Document reasons for missed appointments.

- c. Ensure medical records adequately document sick call with appropriate and legible progress notes. Ensure appropriate follow-up care.
  - d. Ensure dental hours accommodate the need for dental care.
  - e. Ensure physician and mid-level staffing hours accommodate patient needs.
  - f. Ensure physicians adequately supervise nurses.
  - g. Revise co-pay system in terms of amount and waivers.
  - h. Ensure better confidentiality of medical examinations.
  - i. Ensure medical records document all appropriate medical information.
  - j. Track and appropriately treat patients with skin infections.
  - k. Maintain a clean and safe environment in the medical areas, including the proper handling of waste, biohazards, sharps, chemicals, and medications.
3. Acute and Chronic Medical Care
- a. Ensure timely access to appropriate care, including physician evaluations and prescribed medications, for inmates with acute medical problems. Ensure adequate acute follow-up care.
  - b. Take and document vital signs of inmates with acute medical conditions, including withdrawal from alcohol and other substances.
  - c. Adequately manage inmates with chronic conditions in a chronic care clinic that adequately identifies, tracks, treats, and monitors such inmates.
  - d. Appropriately document chronic care in medical records.

4. Comprehensive Health Assessments

- a. Provide a comprehensive health evaluation to all inmates and juveniles within 14 days of booking that includes vital signs, a comprehensive medical history, and, for juveniles, immunization records.

5. Medication Administration

- a. Secure the medication room. Discontinue allowing food in the medication refrigerator.
- b. Prevent nurses from discontinuing medications without a physician's order. Ensure that a prescribing practitioner counsels all patients who refuse medication.
- c. Administer prescription medications on a directly-observed basis for each dose, (unless the physician's order notes that the inmate can self-administer the medication). Ensure accurate documentation of the medication administration, without inaccurately documenting for future doses.
- d. Abolish standing orders for non-emergency medication. Stop nurses from inaccurately documenting medication orders as being ordered via telephone.
- e. Ensure nurses practice within the scope of their licensures.
- f. Create some formal mechanism, such as a Pharmacy and Therapeutics Committee, to assist in creating guidelines for the prescription of certain types of medications.

6. Medical Records

- a. Ensure the uniformity and organization of medical records. Institute the use of a problem-oriented format with problem lists and SOAP format notes.
- b. Ensure nursing staff record the date and disposition of all requests for medical care.
- c. Ensure clinical notes are entered into the medical record and are legible.

- d. Ensure an up-to-date, legible, treatment plan for patients with special needs, including chronic conditions, acute illnesses, and infectious diseases and skin conditions.

7. Quality Improvement

- a. Develop a quality management plan that addresses the medical deficiencies, sets forth performance criteria, conducts data analysis (both quantitative and qualitative), and implements corrective measures to improve performance.

D. Sanitation and Fire Safety

1. Fire Safety

- a. Institute an active fire safety program.
- b. Improve fire drill logs documentation.
- c. Ensure timely regular inspection of all fire extinguishers.
- d. Ensure staff have readily accessible emergency keys that staff can easily identify by both sight and touch.

2. Housing and Maintenance

- a. Address maintenance problems with damaged or inoperable showers, toilets, drains, and sinks. Cover all light switches with exposed wires.
- b. Clear air supply ducts.
- c. Ensure proper air temperatures in cell blocks and that inmates have appropriate access to blankets.
- d. Ensure all mattresses and pillows are not damaged to the point where they cannot be properly cleaned and disinfected between users.

3. Housekeeping

- a. Ensure adequate numbers of staff to perform housekeeping duties.

- b. Ensure proper control of chemicals, including supervision of inmate workers handling chemicals, uniform chemical mixing systems, secure chemical storage, proper chemical labeling, and accessible MSDS sheets.
- c. Institute a master list of all chemicals the LCJ uses and maintain a running inventory of these chemicals.
- d. Provide inmates adequate supplies for cell cleaning.
- e. Institute a policy regarding housekeeping duties and schedules.
- f. Improve housekeeping documentation.
- g. Institute quality assurance policies and procedures.

4. Laundry Service

- a. Improve enforcement of laundry policy to ensure that inmates send their laundry to the laundry service facility rather than washing their laundry in their cells.
- b. Ensure inmates' clothing is laundered at least weekly.
- c. Ensure blankets are laundered at least monthly or between uses by different inmates.
- d. Improve the laundry facility's unsanitary environment and fire safety hazards.

5. Food Service

- a. Properly track and document food service.
- b. Provide inmates adequate meals.
- c. Eliminate kitchen's health and safety violations, including unlocked access to knives, utensils, and instruments, including table-mounted can openers.

\* \* \* \* \*



Please note that this findings letter is a public document. We will post it on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the County in an amicable and cooperative fashion to resolve our outstanding concerns regarding the LCJ. Assuming the present spirit of cooperation from Lake County is continuing, we also are willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them.

CRIPA obligates us to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the LCJ's attorney to discuss this matter in further detail. If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

*/s Thomas E. Perez*

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