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Civil Rights Division

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Special Litigation Section - PHB  
950 Pennsylvania Ave, NW  
Washington DC 20530

June 6, 2016

BY US FIRST CLASS MAIL AND E-MAIL

Mr. Joe Taylor  
Grant County Attorney  
101 North Main Street  
Williamstown, Kentucky 41097

Re: Grant County Detention Center Inspection

Dear Mr. Taylor:

This letter provides our assessment regarding current conditions at the Grant County Detention Center ("Jail"). This assessment relates to the August 3, 2009 settlement agreement between the United States Department of Justice and Grant County. To conduct our evaluation, we toured the Jail from June 12-13, 2016, reviewed documents, and interviewed staff and prisoners. We thank you, Jailer Chris Hankins, Mr. Jason Hankins, Ms. Sanders, Ms. Thoman, and the other security and medical staff who assisted our review.

The County has partially implemented several of our recommendations over the past year. These include some improvements in nurse, mental health, and physician staffing, as well as policy changes. Unfortunately, we must conclude that certain conditions in the Jail remain unconstitutional. The County has not fully implemented any of our major recommendations. As a result, the Jail's system for medical and mental healthcare remains inadequate to prevent harm or risk of serious harm to prisoners.

Our more detailed conclusions and recommendations follow:

**I. BACKGROUND**

The Jail housed over 270 prisoners at the time of our inspection, which is significantly lower than during our 2014 inspection.<sup>1</sup> The County recently replaced its medical contractor. Southern Health Partners now runs the Jail's medical program.

**II. CONTINUING VIOLATIONS OF PRISONER RIGHTS**

The Agreement between the County and the Department requires the provision of medical and mental health services to address the serious needs of Jail prisoners. The County

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<sup>1</sup> The Jail population has fluctuated substantially over time, however, so we cannot yet assume that this is a sustainable population reduction.

continues to violate both the terms of the Agreement and minimum constitutional standards. As detailed below, the County needs to improve the Jail's medical and mental health system concerning staffing, policies, screening, treatment, medication practices, chronic care, and record-keeping.

**1. The County will continue to ensure the adequate and timely identification of, and provide adequate and timely services to address, the serious medical and mental health needs of all inmates regardless of ability to pay.**

Rating: Partial Compliance.

The last medical contractor and Jailer were unable to improve medical and mental healthcare. Conditions became so poor that the County had been non-compliant with this provision of the settlement. Because the new Jailer and medical contractor have made some improvements to Jail medical care, we have upgraded our rating to "partial compliance." However, most of the changes were put into place only recently, and implementation of policy changes has been sporadic.

The Jail reports no deaths in the past year. Alarming, however, the treatment in some of the cases reviewed during our recent tour parallel past incidents that did result in death or other serious consequences. Prisoners therefore continue to face the risk of serious harm or death from constitutionally inadequate medical care. The County has not fully implemented the settlement's remedies designed to prevent the same mistakes from repeatedly occurring. Moreover, the Jail's quality assurance and internal oversight systems are ineffective, and have not flagged deficiencies that required corrective action.

Examples of poor medical care include:

JC sustained serious trauma prior to his arrival in the Jail. On January 8, 2016, the Jail staff sent JC to the hospital for care. The hospital staff determined that he had an open fracture to his hand and needed follow up with an orthopedist in three days. JC returned to the Jail. Over the next week, he was not seen by the nurse practitioner or the physician. No follow-up appointment to the orthopedist was ever made. The medical staff finally made the appointment after our consultant raised the case with them. An open fracture is a serious medical condition, which can lead to a severe bone infection, loss of function, or even amputation if not managed aggressively.

MA had a history of liver failure and cirrhosis. When he entered the Jail on July 8, 2015, staff noted an abnormal finding of swelling in MA's legs. Staff never scheduled MA for referral, evaluation, or treatment by the physician or nurse practitioner. The abnormal finding was an indication of liver failure -- a potentially serious medical condition. MA needed to be seen promptly. On July 12, 2015 staff had to send MA to the hospital. MA was suffering from internal bleeding, which was most likely a complication of his liver disease. After returning to the Jail, MA was not seen by the physician or nurse practitioner until July 18, 2015. Staff sent MA back to the hospital on August 4, 2015, again for complications related to liver disease. Upon his return to the Jail on August 8,

2015, MA was again not seen by the physician or nurse practitioner. MA's hospitalizations may have been prevented if staff had treated him when he arrived in the facility.

WV was sent to the hospital on November 2, 2015, for possible internal bleeding. The medical records from the hospital revealed a nodule in his lung that needed additional medical care to rule out cancer. When he returned, he was not seen by the physician or nurse practitioner. The Jail staff never provided or arranged for the follow-up cancer assessment. No one even discussed the results with the prisoner. So it is unclear whether the prisoner even knows that he needs further assessment to rule out a cancer diagnosis.

We discuss some of the more specific reasons why problems persist elsewhere in this letter. Immediately below, however, we address three broad deficiencies that impact the entire system. Basically, the Jail does not have organized and adequate nursing, physician, and mental health coverage to meet the needs of its prisoners.

#### A. Nursing Care.

Since our last tour, the County has retained a registered nurse ("RN"). This is an improvement. However, nursing care remains problematic for the reasons identified in previous compliance letters. Generally, the nurses continue to act as gatekeepers to necessary care when they are neither qualified nor authorized to do so.

The licensed practical nurses ("LPNs") conduct 14-day health assessments that they lack the training and skills to do. It may be acceptable to assign 14-day health assessments to an RN, but only under a physician's supervision. When the RN currently conducts assessments, the physician is not providing such supervision.

The nurse practitioners can handle clinical assessments and treatment that normally fall within a physician's responsibilities. But again, they still need some physician oversight. At minimum, they need to be communicating regularly with the physician, especially with regards to more challenging cases, and the physician should be periodically assessing their work to make sure they remain in compliance with medical policies and clinical guidelines. Again, that is not happening.

Instead, the Jail provides care based on who may be available to see a prisoner, instead of making sure a prisoner is routed to someone who can actually provide the necessary care. In many cases, an LPN, or sometimes the RN, is the only caregiver, and their care is simply inadequate.

As we have noted in other correspondence, the Jail needs to implement a combination of on-site staffing, on-call coverage, nursing protocols, and clear procedures on when to transport sick prisoners when the facility cannot provide the necessary care (e.g. medical emergencies). The medical staff should comply with nursing protocols written for different scenarios and medical conditions. For instance, if someone has chest pain, the protocols should require an immediate nursing assessment by a registered nurse, or in some situations, immediate transport.

Assuming, however, that a nursing assessment is the appropriate first step, the protocols should also require the nurse to notify the physician in case the physician may have further instructions. Similarly, the detoxification protocols should spell out what a nurse must do when a person first arrives and appears to be suffering from drug withdrawal. This would include immediate assessment by a registered nurse, implementation of withdrawal protocols, and prompt notice to the physician so he can order appropriate treatment and arrange follow-up under the protocols.<sup>2</sup> As a general principle, while the RN can triage cases, the RN needs to discuss final disposition with the physician. The Jail has some policies and procedures for such a system, one which more clearly defines the role of different staff. But it has made no progress at actually implementing such procedures.

#### B. Physician Care.

Physician coverage has also slightly increased since our last tour. The Jail now has a physician or nurse practitioner on-site approximately 8 hours per month. The physician provides only direct care, and his hours remain low. The Jail still does not have a physician medical director. While the current physician could fill that role, he does not actually do so. In other words, the physician must provide both more direct clinical care and oversight of the Jail's entire medical program.

Clinically, the physician is still not overseeing the assessment and care provided for patients with serious conditions. The staff order medications for months at a time, presumably with the physician's approval, but the patients receiving the medications have not actually been seen by either the physician or a nurse practitioner. Patients develop serious conditions, such as seizures or drug withdrawal, and the physician never sees the patients.

The physician sees some patients for physician sick call or if the nurses identify a chronic condition. But the physician does not plan or oversee care, so there is no continuity of care or long-term monitoring of patients. While many prisoners enter and leave the Jail quickly, some may stay months or even years. Since the Jail is the only provider of care, the Jail needs to have procedures in place to make sure those suffering from serious illnesses receive more care than may be needed for short-term prisoners. For instance, prisoners with chronic conditions may be in the Jail, awaiting trial for months. Their condition can fluctuate over time, and they need closer monitoring. Their medication regimens may even require periodic laboratory testing and monitoring for side-effects. Similarly, a prisoner with an infectious disease, such as tuberculosis, may spend so much time in a dorm that the risk of spreading infection becomes significant. The

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<sup>2</sup> Assigning a nurse practitioner or other more advanced practitioner would also be acceptable, and indeed, may be preferable. More difficult cases require better trained staff. The County could mitigate the problem in some cases by more readily transporting prisoners to a hospital. But as some of the examples in this letter suggest, the Jail staff have sometimes waited too long before arranging medical transport. The delays suggest there may be institutional barriers to seeking outside care. Providing routine care to those with serious conditions can be less expensive, and safer, than waiting until the prisoner needs emergency room treatment. We note also that the Jail relies heavily on overtime to cover security posts. Inadequate security staffing can sometimes limit a facility's ability to transport prisoners who require care. If that is the case, the County needs to also consider improving security staffing. Because security issues were not a focus of our inspection, we make no other recommendation about security staffing at this time.

Jail should therefore have a testing program for all prisoners who may be in the facility for more than a few days.

Finally, the Jail physician does not oversee staff or handle administrative or quality assurance duties associated with the role of a medical director. For instance, no qualified clinician is conducting chart reviews, making sure staff comply with the healthcare provider's policies, reviewing restraints ordered by security staff, signing off on labs, and making sure the nursing and mental health staff are carrying out the physician's treatment instructions. As discussed above, the nurses and nurse practitioners are operating much too independently, and even patients with clearly difficult cases do not always receive proper clinical care and management.

### C. Mental Health Care.

Since our last tour, the County has expanded the hours of care provided by the Jail's "qualified mental health professional" ("QMHP"), a master's level psychologist. He now works 24 hours per week, which is an improvement on the 16 hours per week of coverage provided at the time of our last tour. This improvement, however, does not otherwise remedy a host of problems with Jail mental health care.

As we have warned in the past, the Jail's QMHP is only trained and licensed for certain tasks, such as providing some counseling and psychological assessments.<sup>3</sup> The Jail population has serious needs that cannot be met with the current mental health staffing.<sup>4</sup> Most evidently, the Jail needs access to a licensed psychiatric professional who can make appropriate judgments about medications and provide more specialized care. Unfortunately, the Jail still has no regular psychiatric staffing coverage; nor does it have a mechanism in place to ensure effective access to outside psychiatric services. The physician cannot substitute for a psychiatrist. Indeed, some of the current physician's mental health practices are highly problematic. For instance, the staff order mental health medications for months at a time without a physician necessarily seeing the patient or monitoring for medication side effects.<sup>5</sup> Also, prisoners with serious mental health

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<sup>3</sup> Our consultants noted that staff and prisoners refer to the QMHP as the "doctor," even though the QMHP has neither a doctorate nor a medical degree. The use of the term may simply be a sign of familiarity or respect, and is not itself a constitutional concern. But, the County should take note that the medical staff have such free rein in the facility that they routinely do things they really should not be doing. A skilled nurse may be better at diagnosis than a physician and the QMHP may be familiar with many medications, but for a medical system to function safely, one cannot assume that is the case. Safeguards need to be in place, and those include physician and psychiatric oversight of matters that fall within their area of expertise.

<sup>4</sup> According to the provider's own data, the QMHP sees only 5-6 patients per day. At present, the Jail's mental health coverage does not address the needs of all prisoners with serious mental health issues. We recommend that the medical provider evaluate its system of care, identify priority reform, and address the most important ones as soon as possible. For instance, suicide prevention, detoxification, restraint use, use of force on prisoners with serious mental illness, and medication monitoring, are all areas associated with serious adverse consequences.

<sup>5</sup> This lack of physician oversight of labs, treatment planning, and medication review, applies to treatment for other medical conditions as well. It is, however, particularly notable for prisoners with serious mental illness and other chronic conditions. We do not expect the physician to personally review the use of every medication in the jail. For example, it is often acceptable for a nurse practitioner to give a prisoner medications for some minor ailment. But if a prisoner has a serious condition, it is not appropriate to leave the management of the patient's condition almost

conditions often have complex histories and require fairly specialized assessment and treatment, which cannot currently be provided by the Jail.

The Jail's ability to manage prisoners with serious mental health conditions is very limited for many reasons. Screening procedures are poor. For instance, a nurse goes to booking to pre-screen prisoners for serious conditions, but this is not a formalized process. The nurse may take vitals and ask some questions, but there is no specified format for the procedure. Additionally, the staff do not keep any records associated with the pre-screen. Similarly, medical staff conduct some pre-admission screenings, but again the process is haphazard, and staff throw away the records. Jail medical and mental health screening procedures are also conducted without adequate respect for patient privacy. Security staff screen new prisoners for medical and mental health issues in a well-trafficked part of the Jail and sometimes within close proximity of other prisoners. Policies for classifying and housing prisoners often relegate anyone suspected of having a serious mental health condition to an isolation cell or a few other segregated housing areas that have little space for therapeutic programming or services. The Jail does not have any specialized mental health or transition ("step-down") units. The Jail does not offer much in the array of services needed for persons with serious mental illness. It is particularly troubling that the Jail routinely places prisoners in isolation for suicide prevention or mental health observation, when this practice is often clinically inappropriate for such prisoners. Moreover, the Jail does not necessarily require mental health staff to regularly check those prisoners and oversee their care.

The Jail has only two basic options for assessing and treating prisoners with clear signs of mental illness or suicidality. The Jail can call "Bluegrass," a telephone hotline, which in turn may order the use of restraints or other restrictive procedures without anyone from Bluegrass seeing the patient.<sup>6</sup> If Bluegrass recommends action, the Jail may then call its mental health staff, or "North Key," a local organization that can send a mental health worker to assess the most seriously ill prisoners. After that, Jail nursing staff take over assessment and care, with limited physician involvement.

As with medical care generally, the Jail relies too much on nursing staff to handle suicide prevention and mental health care. After initial screening, nursing staff or the QMHP take over much of the assessment and treatment responsibilities for prisoners with serious mental illness. Again, the Jail is asking its own staff to handle more than they should. More specifically, the RN and QMHP can do some assessments and help determine whether a prisoner may need mental health watch or be removed from mental health watch, but they need to be regularly consulting with a physician or other specialized clinicians. So if the RN thinks someone may no

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entirely to the nursing staff. The Jail physician should not be considered just a consultant, brought in only to see patients on the sick call list. The Jail physician is actually responsible for all medical care provided by the Jail, and should therefore see his role as one that includes staff supervision and overseeing the system of care. If the current physician will not take on such broader responsibilities, someone needs to be put in charge over him.

<sup>6</sup> For purposes of full disclosure, we should note that our mental health consultant provided some technical assistance, on behalf of the National Institute of Corrections, to the Lexington Jailer and a Bluegrass administrator about setting up a crisis triage system and screening protocols. The consultation reportedly occurred before the implementing legislation and was limited to advice on the types of questions that should be included in any screens.

longer need suicide observation, the RN should still consult with a physician and obtain physician approval. Such decisions certainly should not be made by security staff alone, which currently happens. County officials should bear in mind that someone from Bluegrass or North Key may have already identified a prisoner as a critical suicide risk well before key medical staff receive notice of the situation (if they receive notice at all). Even after the immediate crisis, the prisoner may need careful follow-up by a skilled clinician. That may not occur if the Jail has no system for medical tracking and management of its high risk prisoners.

Psychotropic medication practices are also poor. We found orders for mental health medications that ran for an entire year. Yet during that period, there was no physician review of the patient's condition. More generally, there is little or no documented corroboration between the QMHP and the Jail's physician. The QMHP has not met the Jail physician, and the physician has apparently never requested a consult with the QMHP. The QMHP does make medication therapy recommendations to a nurse practitioner, but the nurse practitioner works only six hours per month. The nurse practitioner does not have any specific training in psychopharmacology, and rarely sees an inmate personally to evaluate the inmate before ordering the medications. The Jail still provides little or no physician and psychiatrist follow-up for prisoners placed on suicide watch and detoxification protocols. Indeed, these prisoners are not necessarily even seen by the QMHP. Contrary to the Jail's policies, the QMHP does not routinely follow up on prisoners, seen by Bluegrass or North Key personnel, after a mental health crisis. Also, security staff continue to remove prisoners from suicide watch without any review by a mental health professional.<sup>7</sup>

**2. The County will continue to evaluate the adequacy of all medical and mental health policies and procedures on a regular basis and, where necessary, make revisions to address any gaps identified.**

Rating: Partial compliance.

The current Jail administration provided us with copies of the medical provider's policies and procedures for technical assistance. While the County does not have an ongoing, internal process for reviewing and modifying its policies, we appreciate Jailer Hankins' willingness to open a dialogue on these issues. However, staff are not necessarily following the acceptable policies, and other provider's policies have not been customized for the facility.

There are inconsistencies between the medical policies, related security policies, and actual practices.<sup>8</sup> For example, Jail security and mental health policies have never been

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<sup>7</sup> The Jail continues to use prisoner companions to monitor suicide prisoners. The Jail should not assume that such companions are preventing suicides. They receive little training, and the Jail does not screen companions for the types of personality traits that are needed when supervising mentally ill prisoners. At least one of the companions described duties that may count as a prisoner controlling access to services (phone calls) for another prisoner. The Jail needs to screen and train watchers more carefully, because this system is not an adequate substitute for a mental health program.

<sup>8</sup> When reviewing and implementing policies, the Jail administration should also refer to the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601 (PREA). Among other things, the Jail must screen personnel, provide medical and mental health care to victims of sexual abuse, and implement reporting and monitoring mechanisms to

customized to reflect local practice and the Jailer's expectations.<sup>9</sup> In theory, North Key and Bluegrass triage prisoners experiencing an acute mental health crisis, and then the Jail medical staff take over. In reality, there are large gaps in the Jail's mental health system. The QMHP does some emergency evaluations and individual therapy, which is limited to only a few "motivated" prisoners. The QMHP thus supplements or replicates the same work done by the outside organizations, but does not necessarily provide the more comprehensive case management required by some of the Jail's medical policies. Indeed, the QMHP's caseload omits some prisoners who need mental health assessment and care, but may not be acutely suicidal. For example, the QMHP should be assessing patients recently placed on suicide watch or detoxification, as well as those who received psychotropic medications while in the community and have continued on those prescriptions while in the Jail. That does not consistently occur. In other words, the Jail's mental health system focuses on suicide prevention, but still needs to take care of other prisoners who have serious mental health conditions. Even for the most acute cases, the Jail does not have systems in place to make sure that medical staff receive timely and routine notice about patients identified by North Key, Bluegrass, or other personnel, as having serious mental health conditions.<sup>10</sup> Indeed, a prisoner may be placed on suicide watch, without anyone notifying the QMHP.

Coordination between security and medical staff needs significant improvement, and policies used by the different departments need to be more integrated. For suicidal prisoners, the need for such coordination should be obvious. If a prisoner tries to hurt him or herself, responding security staff should notify medical personnel. To some degree, the Jail does require such a response, mainly through the Bluegrass and North Key mechanisms. But there are other situations as well that also require coordination. A prisoner's security/behavioral incident may actually involve a serious medical or mental health condition that is not obvious to lay security staff. For instance, a prisoner behaving aggressively may trigger the use of force or a cell extraction, or an agitated prisoner suffering from withdrawal effects may respond erratically and refuse to comply with officer instructions. Normally, jails have systems in place for a medical or mental health assessment of prisoners involved in serious incidents or who cause concern to security staff. Such assessments help identify unmet medical needs. They also serve as a check and balance on security staff. For example, if security uses force, requiring a post-incident

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help identify sexual misconduct. Unrestricted and unsupervised interactions between prisoners with prisoners, and staff with prisoners, are problematic. So staff oversight, classification procedures, and housing/movement controls are also required. See <http://www.prearesourcecenter.org/about/prison-rape-elimination-act-prea>. Although we have not focused on protection from harm issues in this letter, our original findings noted issues with correctional practices, and we recommend that the new administration make every effort to maintain and improve general security and supervision. Given the history of the Jail and recent allegations against some personnel, we recommend strict compliance with federal standards in this area.

<sup>9</sup> The medical provider policies were mostly acceptable. We note, however, that in practice, the QMHP refers to diagnostic standards (the DSM-IV) that have been superseded.

<sup>10</sup> This is part of a broader coordination problem. For instance, when security calls in Bluegrass to assess a prisoner experiencing a serious mental health crisis, they do not consistently notify the medical staff at all, let alone the QMHP. This can create a gap in care. However, the QMHP does respond promptly when he receives a medical referral or other staff notify him of a Bluegrass screening. We note also that the QMHP is routinely shredding referrals from Bluegrass and other providers. We recommend the Jail preserve such records.

medical exam helps ensure both adequate follow-up care and establishes a record for any use-of-force investigation. The Jail currently does not have clear, consistent policies for such coordination and communications between security and medical staff. In situations that should result in automatic coordination between security and medical, nothing actually happens. For instance, the provider policies call for physician review of restraint use, but the physician is not actually on-call and admitted that he is not involved in restraint decisions. Similarly, security staff screen prisoners for drug or alcohol withdrawal. If they suspect a prisoner may be intoxicated or high, they can place the prisoner on medical watch. Yet, when we checked five prisoners on medical watch, we discovered that not one of them was assessed by medical staff for drug or alcohol withdrawal. Basically, security staff were putting people on medical watch, and taking them off medical watch, without telling medical staff.<sup>11</sup>

Many of our recommended policy and practice changes are already required by the Jail medical provider's policies. For instance, our recommendations about assessments, suicide/mental health monitoring, the medical director's role, and physician care parallel the framework established by the medical provider's policies. For reasons discussed throughout this letter, the Jail staff do not actually comply with those policies, or there is some confusion about what policies apply. As the County updates its policies, it should increase training on Jail medical policies. And when staff do not comply with those policies, Jail managers, including the medical director and lead nurse, should play a role in educating staff and taking corrective action.

**3. The County will continue to provide receiving screens by health services staff for new inmates, and inmates transferring from other correctional institutions, within twenty four (24) hours of each inmate's arrival at the facility. The County will ensure that health services staff performing receiving screens are trained to complete the assessments. For this receiving screen, health services staff record and seek the inmates' cooperation to obtain: (1) medical, surgical, and mental health history, including current or recent medications; (2) current injuries, illnesses, evidence of trauma, and vital signs, including recent alcohol and substance use; (3) history of substance abuse and treatment; (4) pregnancy; (5) history and symptoms of communicable disease; (6) suicide risk history; and (7) history of mental health treatment, including medication and hospitalization. Health services staff also will attempt to elicit the amount, frequency and time of the last dosage of medication from every inmate reporting that he or she is currently or recently on medication, including psychotropic medication. The information obtained through the receiving screen will be made a part of an inmate's medical record.**

Rating: Partial compliance.

See 1 and 2. The Jail has a process to determine if a new arrival should be admitted to the Jail. If security staff believe a new arrival has a serious condition, they can ask medical staff to do a screen before admitting the individual. The Jail does not maintain any records associated

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<sup>11</sup> To the Jail's credit, security staff do sometimes call medical when they think a prisoner may have a medical or mental health issue. As noted above, such notice may lead to pre-admission screenings and other ad hoc medical interventions. However, this is not a systematized process, and depends too heavily on staff discretion.

with this process. Additional medical screening also occurs in the booking area, but again, the Jail does not maintain all of the records. The County needs to do so.

**4. The County will continue to conduct 14-day health assessments and examinations and will make appropriate referrals for treatment or evaluation. As part of the fourteen-day health assessment, the County will screen inmates for infectious diseases, including tuberculosis and sexually transmitted diseases. The health assessment will include a review of the receiving screen, a complete medical and mental health history, a physical examination, and a mental health assessment. Appropriate plans will continue to be developed and implemented with this information.**

Rating: Non-compliant.

See 1-3. The Jail is doing initial tuberculosis skin tests, but not the annual tuberculosis screens.

Follow-up care after screenings remains generally problematic. As already noted, a physician is not automatically notified even in circumstances when physician follow-up would be appropriate. At a more basic level, the Jail still has not implemented simple procedures to help manage prisoners who need more thoughtful treatment planning. For instance, the Jail still does not allow prisoners to carry rescue medications, such as asthma inhalers and heart medication. So even if staff determine that a prisoner may have such a chronic condition, they do not develop an appropriate plan to manage the condition. The entire system of care has large gaps that allow patients to go without care even after staff receive information indicating the prisoner has a serious condition.

**5. The County will continue to ensure that inmates are seen by health services staff in a timely manner after submission of a sick call slip.**

Rating: Partial compliance.

See 1-4.

The Jailer has implemented changes to the sick call process. Medical staff now collect sick call slips, instead of security staff. Moreover, prisoners reported being seen by nursing staff fairly promptly after submitting their requests. These are improvements, and we commend the Jailer for making the changes. We cannot yet find compliance, however, because of the array of other problems involving access to care after prisoners are seen by the nurses.

**6. The County will continue to ensure that all inmates with serious or potentially serious acute medical conditions receive necessary examination, diagnosis, monitoring, and treatment, including referrals to appropriate outside medical professionals when clinically indicated.**

Rating: Non-compliant.

See 1-5. Whether a prisoner will get any examination or treatment is still arbitrary and too sporadic. Staff discover that a prisoner may have a serious acute condition, or a serious incident occur, but then there is little follow-up. For instance:

Inmate CC entered the Jail on December 24, 2015. Our consultant decided to speak to the prisoner and review his chart after nursing staff advised him that the prisoner was on nitroglycerin. The prisoner had apparently experienced some chest pain during his incarceration and also voiced concerns about having to wait for a nurse to come and give him his nitroglycerine.<sup>12</sup> Yet, the prisoner's medical record included no documentation regarding the incident, or for that matter, any order for the nitroglycerine. There were no medical evaluations in the chart except for an initial screening. This prisoner's condition should have been considered worrisome given his initial screening, and he should have received physician follow-up. Instead, he did not even get a 14-day health screen. His care was left largely to the nursing staff. With a history of heart disease and chest pain, the patient needed some physician care.

Inmate VM experienced seizures, and a nurse had to be called to her dorm three times over a two day period in December 2015. The prisoner appeared unresponsive at least twice, and the nurse noted that the prisoner needed monitoring. But no monitoring was documented, and the nurse did not notify the physician.

Inmate HD was placed in a restraint chair without medical monitoring.

Inmate RC was placed in a restraint chair without medical monitoring.

**7. The County will continue to implement appropriate clinical guidelines for the management of chronic diseases such as HIV, hypertension, diabetes, asthma, elevated lipids, and mental illnesses.**

Rating: Partial compliance.

See 1-6.

Chronic care remains poor, in part because of inadequate physician and mental health follow-up. More generally, the Jail still does not have a system for managing prisoners with serious chronic conditions, a system which should include a schedule for periodic assessment and treatment of such patients. For instance:

Inmates HC and JM receive lithium. Neither of them is being monitored to determine whether the medications are working, and for the medication's potentially toxic side effects.

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<sup>12</sup> The Jail should consider allowing keep-on-person medications. Life-saving medications, such as asthma inhalers and nitroglycerin, need to be particularly accessible and are not necessarily a security risk.

TL is on medication for HIV. Since she entered the Jail in July 2015, she has not been evaluated by a physician or nurse practitioner for her HIV. The prisoner herself knew she needed to have blood work and a medication check. Jail records suggest she asked for the check in December 2015. But the physician declined to do the work. Patients with HIV need periodic monitoring of their immune system to ensure the medications are working. Additionally, they need periodic blood work done to ensure they are not susceptible to potentially lethal opportunistic infections. Inmate TL had none of this monitoring done, although she had been at the Jail for roughly 6 months. Notably, staff ordered months of medication for these prisoners, presumably with physician approval, but there is no documentation that the physician has actually been seeing and monitoring these patients.

These types of practices are all gross deviations from the standard of care. The Jail needs a chronic care program that includes chronic care treatment protocols, and a schedule for patient monitoring and periodic exams by appropriate clinicians.<sup>13</sup> The program should also include a record to identify and track which prisoners may have chronic conditions.

**8. The County will continue to ensure that inmates with chronic illnesses, including mental illnesses, receive necessary examination, diagnosis, monitoring, and treatment. The County will provide and document routine tests and follow-up appointments.**

Rating: Partial compliance.

See 1-7.

The Jail provider has a written chronic care policy but has not implemented the program. The lack of a more organized care program places prisoners with relatively easily managed conditions, at risk from serious harm.<sup>14</sup> For instance:

Inmate JL is pregnant. She has been in the Jail for 2 months without ever being seen by a physician to make sure she is stable, and the Jail has not arranged any obstetrician care to monitor her fetus.

**9. The County will continue to provide appropriate special medical diets when medically required.**

Rating: Compliance.

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<sup>13</sup> For instance, a nurse can do a follow-up physical exam, but a physician should review the results and may need to see the patient if there has been a significant change in condition.

<sup>14</sup> The National Commission on Correctional Healthcare has recently determined that chronic care is an essential standard, not just an important one. A Jail must have a system for managing prisoners with chronic medication conditions. Simply relying on a sick call system is not adequate, given the type of monitoring and advanced treatment needed to keep prisoners healthy when they have serious chronic conditions.

The County provides an adequate diet for prisoners, including those with special medical needs.

**10. The County has contracted with a mental health care provider to provide all services for inmates' mental health treatment. The County will continue to ensure that the mental health care provider will continue to promptly perform a comprehensive mental health evaluation of any inmate whose history or responses to initial screening questions indicate a need for such an evaluation. The comprehensive mental health evaluation shall include, if indicated, a recorded diagnosis section conforming to generally accepted professional standards.**

Rating: Partial compliance.

See 1-8.

As noted above, the County increased the QMHP hours. It has not made other recommended improvements to mental healthcare, so all of our previous concerns remain.

**11. The County will continue to provide appropriate mental health treatment to any inmate whose evaluation indicates a serious mental health condition that requires such treatment. Where possible, and where consistent with security concerns, the County will provide an appropriate confidential environment for psychological testing and counseling.**

Rating: Partial compliance.

See 1-8, 10.

The QMHP meets patients one-on-one in a private office. But other aspects of the mental health program still have privacy issues. For example, medical and mental health screens take place in well-trafficked parts of the Jail, such as the booking area.

**12. The County will continue to provide sufficient on-site staffing by mental health care providers to ensure adequate mental health care. The County will ensure that the mental health prescribing practitioner is adequately trained and supervised by a psychiatrist.**

Rating: Non-compliance.

See 1-8, 10-11.

**13. The County will continue to ensure that appropriate psychiatric evaluations are conducted any time psychotropic medications are prescribed or changed.**

Rating: Non-compliance.

See 1-8, 10-12.

**14. The County will continue to ensure that an appropriate individual mental health treatment plan is prepared in a timely manner by a mental health care provider for each inmate requiring treatment for mental illness.**

Rating: Non-compliance.

See 1-8, 10-13.

**15. The County will continue to maintain on-site complete, confidential, and appropriately organized medical and mental health records for each inmate. The County will continue to ensure that such records include sufficient information (including symptoms, the results of physical evaluations, and medical staff progress notes) to ensure that health services staff have all relevant information available when treating inmates.**

Rating: Partial Compliance.

Jail records remain poor and disorganized. Progress notes, multi-disciplinary treatment plans, histories, physicals, physician assessments, laboratory test results, and other critical materials are missing in medical files even for prisoners with complex and serious conditions. Staff had difficulty navigating the electronic medical record system when interviewed by our consultants.

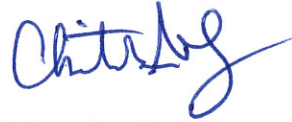
The Electronic Medical Record (EMR) needs to be replaced. It is very cumbersome and disorganized. The Jail physician will not use it at all. The EMR has several tabs or categories for information, but no one has defined what type of information should be placed in each category. For instance, there is no tab for mental health notes. The QMHP enters his notes in the physician record even though he is not a physician. An EMR is usually considered more accurate and sophisticated than paper records. But in this case, the EMR has so many flaws, our physician recommends that the Jail staff go back to using a written record until the County can fix or replace the current EMR.

\* \* \*

As we have previously agreed, we affirm that no person or entity is intended to be a third-party beneficiary of the provisions of the Agreement for purposes of any civil, criminal, or administrative action. Accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under the Agreement. The Agreement is not intended to impair or expand the right of any person or organization to seek relief against Grant County or its officials, employees, or agents for their conduct; accordingly, the Agreement does not alter legal standards governing any such claims, including those under Kentucky law.

We will be contacting you and your clients shortly to discuss next steps. If you have any questions, however, please do not hesitate to contact me directly at (202) 514-8892.

Sincerely,

A handwritten signature in blue ink, appearing to read "Chris Cheng", with a stylized flourish extending from the end.

Christopher N. Cheng  
Attorney  
Special Litigation Section

cc:

Chris Hankins  
Jailer