U.S. Department of Justice

Civil Rights Division

Disability Rights Section - NYA
950 Pennsylvania Avenue, NW
Washington, DC 20530

June 6, 2011

<u>**SENT VIA FIRST CLASS MAIL AND EMAIL**</u>
Mr. Peter Govorchin
First Attorney Corrections Division
Office of the Attorney General
525 West Ottawa Street
Lansing, Michigan 48913

Re: DJ 204-37-333; 204-37-334; 204-37-335; 204-37-336

Dear Mr. Govorchin:

As you know, the Civil Rights Division of the United States Department of Justice (Department), along with the U.S. Attorney's Office for the Eastern District of Michigan, has been investigating numerous complaints that were received by the Civil Rights Division alleging that the Women's Huron Valley Correctional Facility (Huron Valley), Ypsilanti, Michigan, is in violation of Title II of the Americans with Disabilities Act of 1990 (ADA). Our investigation was also conducted under the authority of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and the Department's implementing regulation, 28 C.F.R. Part 42, Subpart G. Thank you for your ongoing cooperation with our investigation.

During our investigation, including on-site visits on October 21-22, 2010, accompanied by an architect; January 24-26, 2011, accompanied by a medical doctor and a suicide prevention expert; and February 24, 2011, accompanied by a sign language interpreter, we substantiated the complainants' allegations that Huron Valley is in violation of Title II of the ADA, 42 U.S.C. §§ 12131 - 12134, and its implementing regulation, 28 C.F.R. Part 35 and the ADA Standards for Accessible Design, 28 C.F.R. Part 36, Appendix A, in some key areas.

This letter provides our findings as well as the modifications required to remedy the identified violations regarding medical care for inmates with disabilities consistent with the requirements of Title II of the ADA.[1] In order to rectify the identified deficiencies and protect the statutory rights of the inmates confined at the facility, Huron Valley should implement the stated remedial measures within **twelve (12) months** of the date of this letter, unless a different time frame is specified:

[1] We will soon follow up with our findings regarding architectural barriers and a separate letter addressing suicide prevention issues.

Findings:

The Michigan Department of Corrections (MDOC) provides medical care for prisoners at Huron Valley both directly through state employees of the Department of Corrections and Department of Community Health (MDCH) and through contracts for various personnel and other services with Prison Health Services, Inc. (PHS) and MHM, Inc. (MHM). Health care staff members report through their agencies and/or their employers to the Bureau of Health Care Services in Lansing, Michigan.

MDOC has been aware of confusing and confounding reporting relationships, especially among the MDOC, MDCH, and MHM staff who each have different roles in mental health care and MDOC and PHS staff who provide physical health care and control access to care. MDOC indicated that it is working to remedy this situation and anticipated having consolidated control by March 2011. To the extent this happens, timely access to an appropriate level of care may improve.

The minutes of the Monthly Performance Improvement Meetings (the latest reviewed were dated October 26, 2010), report that approximately 50% of the registered nurse positions are vacant, with some, but not all, filled with contract nurses. These minutes do not reflect any performance measurement of the timeliness of access to care or the quality of care provided to Huron Valley prisoners during 2010. According to central office staff, the statewide quality management database has no facility-specific performance measurements (Conference call, January 25, 2011).

Huron Valley had two completed suicides in 2008 and three completed suicides in 2010. Between October 1, 2010, and our January 24 - 26, 2011 tour, Huron Valley had two completed suicides and 13 suicide attempts by 11 different inmates. Suicide, suicide attempts, and self-injurious behavior reflect serious medical needs. It is disturbing – in addition to be in violation of ADA requirements -- that, by policy, the MDOC may charge prisoners for expenses incurred for self-injurious behavior (PD 03.04.100; Monthly Performance Improvement Meeting minutes, dated May 25, 2010). This policy was implemented as an effort to decrease "frivolous hospital runs" (Minutes, dated May 25, 2010).

The MDOC has a policy directive and operating procedure for mortality review (PD 03.04.100; OP 03.04.106). MDOC refused to provide the mortality reviews on the five suicides in 2008 and 2010. As a result, our medical consultant was unable to determine if there was sufficient self-critical analysis for MDOC to address any staff or system deficiencies that may have been apparent. The Department renews its request for our medical consultant to be able to review these records, so that our medical consultant can provide any constructive feedback that may be needed for ADA compliance.

Inmates with physical disabilities and those on psychotropic medication have particular problems with bodily heat regulation, making them prone to discomfort and to serious medical consequences. During our tours, prisoners with disabilities housed in the Gladwin housing unit complained that the housing unit was often cold, with the temperature as low as 55° F. Facility staff affirmed that providing adequate heat was a challenge at Gladwin. All prisoners need to be housed in an environment with adequately controlled heat and ventilation. This is especially important for

patients with physical disabilities and patients on psychotropic medication. A prisoner with a hearing impairment, whose cell window was taped with plastic to keep out the cold, developed pneumonia during an especially cold period on the housing unit (this case is discussed below).[1]

Prisoners with disabilities complained repeatedly of their difficulty in obtaining timely access to medical care. The MDOC would not provide us with the prisoners' requests for care, so it was difficult to determine if reasonable time standards are being met, depending on the degree of urgency of the complaints. At Huron Valley, prisoners request care in writing on forms called "kites." These kites are not filed in the medical record. Nevertheless, there were clear indications that timely access to care is not provided at Huron Valley and that the prison administration is unresponsive to complaints in this regard, thereby denying disability-related medical care to prisoners with disabilities which is required by the ADA. After prisoners' kites for medical care are ignored or denied, prisoners resort to the grievance system to obtain care. For example, on November 15, 2010, a prisoner with viral hepatitis C filed a grievance regarding her abnormal laboratory tests and asked to see the infectious disease specialist.[2] When her case was reviewed, the grievance was noted to be resolved, when in fact it had not been resolved; the patient was not scheduled for the infectious disease specialist until March 2011. The response to this grievance, therefore, was false, and the access to medical care was untimely.

Similarly, a prisoner with a hearing disability, known to have significant coronary artery disease, seizure disorder, hypertension, and chronic lung disease, filed a grievance on October 15, 2010 complaining that she was having difficulty accessing care for shortness of breath and chest pain.[3] Six days later, a social worker responded that the grievance was rejected because it was "vague." A Deputy Warden countersigned this response. With her medical history, this prisoner's original kite for care should have been timely granted. Further, the tone of the response to the grievance was inappropriate and unprofessional.

This was not the only example of cynicism and inappropriate behavior by staff. Several prisoners[4] in the Residential (psychiatric) Treatment Program reported that several staff members[5] told them repeatedly to go ahead and kill themselves. Two other prisoners complained about the attitude of one of the officers who is accused of telling them to kill themselves.[6]

Serious harm can result from delayed access to appropriate care. A prisoner on medication for thyroid disease complained of constipation on May 4, 12, 22, and 26 and on June 10 and 18, 2010.[7] She had not been seen for chronic care for more than a year, and it had been more than a year since her last laboratory test to determine if she was getting under-dosed with the medication, which is a known cause of constipation, among other things. She was repeatedly rescheduled for evaluation of this serious medical need. A nurse finally saw her on June 18, 2010, but failed to examine her. The nurse prescribed milk of magnesia instead of referring the prisoner to a physician. On June 19, 2010, the prisoner was hospitalized for a perforated colon, secondary to prolonged impaction of feces (obstruction of the colon). She spent 32 days in the hospital, after having surgery to create an ileostomy. The prisoner may have to live with this diversion of her colon for the rest of her life because of her inability to obtain timely access to the care of an appropriate health care practitioner.

This is an example of serious, life-threatening harm as a result of Huron Valley's barriers to medical care for a prisoner with a disability.

Another prisoner, who has a hearing impairment, complained of shortness of breath on December 21, 2010.[8] The nurse recorded a highly abnormal pulse of 112 beats per minute and an abnormal peak expiratory flow of 250. Following appropriate medical care procedures, she should have called the physician, but did not. Instead, the nurse prescribed albuterol, a rescue medication for asthma, and levaquin, an antibiotic. Prescribing medication is outside the scope of the nurse's practice. Later, the patient was hospitalized and treated for pneumonia. She saw a physician on December 28, 2010, who did not record a physical examination. The physician ordered a follow-up chest x-ray but the x-ray had not been performed in the four weeks since this order when our medical consultant interviewed her.

Prisoners also complained of not getting medication that was prescribed by their physician. Our medical consultant validated some of these complaints. For example, a prisoner reported that she had medication ordered for her elevated blood lipids that she had not received.[9] Her medical records showed an order for medication but it had not been administered for the preceding two months. Another patient had stool softeners prescribed for her chronic condition, originally ordered on July 14, 2010.[10] Despite multiple written requests for care, she had a 30-day lapse in medication in October 2010 and an eight-day lapse in November 2010. A patient who may have multiple sclerosis had a three-month lag to the first dose of her MS medication which was prescribed on July 23, 2010.[11] This latter patient also has elevated blood lipids, which have thus far been untreated. Further, a patient who had prescriptions for psychotropic medication had her medications abruptly withdrawn because of a medication error, leaving her without the treatment that had been ordered by her physician.[12]

Prisoners also complained about delayed access to specialty care. For example, a prisoner with viral hepatitis C had been waiting more than five months for a telemedicine appointment with the MDOC infectious disease specialist.[13] This prisoner has a physical disability and has been complaining of rectal prolapse. There is no indication in the medical record that she has been evaluated for this condition. Another prisoner with viral hepatitis C, diabetes, asthma, hypertension, and hypercholesterolemia was referred to the infectious disease physician, yet there is no record of such a visit, and no appointment had been scheduled as of the time of our medical consultant's review.[14] A third prisoner, who has diabetes, hypothyroidism, and hypertension, has highly abnormal liver function, associated with viral hepatitis C, according to her laboratory records, yet she has not had an evaluation to determine if she is a candidate for treatment.[15] A fourth patient had an abnormal pap smear in March 2010, but had no documentation of any follow-up in the medical record.[16]

Many patients with hearing impairments can benefit from an audiology evaluation for hearing aids. Prisoners with hearing impairments at Huron Valley have no indication of any audiology evaluations in the recent past and no pending appointments.[17]

Prisoners complained of difficulty accessing mental health care. Numerous prisoners told us that, although they had requested access to mental health services, they were never seen by mental health staff. Prisoners with mental illness reported lags to mental health evaluation and treatment. For example, a prisoner with a history of mental illness arrived at Huron Valley on December 20, 2010.[18] She was seen by a psychologist on January 19, 2011, but was not seen by the psychiatrist for evaluation and treatment by the time of our January tour. Another patient requested help on November 19, 2010, to assist her in dealing with a suicide that occurred in October 2010, was found by the psychologist to have a "contracted affect" and "tears," yet she was not referred for further evaluation.[19] Two patients say that they have requested mental health care during the past year, yet there is nothing in the medical record that acknowledges these requests.[20]

A patient with serious mental illness developed abnormal involuntary movements when her dose of antipsychotic medication was increased.[21] The attending psychiatrist was aware of this reaction to the medication and was adjusting her medication dosage; however, the reaction to the medication was not documented in the patient's medical record, and there was no written treatment plan.

Another patient on heavy doses of psychotropic medication had a sign on her door noting that she needed to be restrained, while the mental health staff believed that she posed no danger.[22] This conflict in opinion poses a conundrum and tension for staff at the facility and should be reconciled through a treatment team meeting.

PHS has clinical guidelines for chronic diseases, such as asthma, hypertension, diabetes, seizure disorder, and elevated blood lipids. These guidelines are available to PHS physicians on a website. They conform to nationally accepted clinical guidelines. Most of the women whose records were reviewed by our medical consultant had chronic diseases in addition to other disabilities. The medical records of these patients demonstrated chronic disease care that conformed in some instances to the PHS guidelines, especially for diabetes. The guidelines for asthma, however, were not being followed with periodic measurement of peak expiratory flow. The intervals between chronic care visits were, in many cases, spaced farther apart than recommended in PHS guidelines.

Conclusions and Remedies:

The medical care at Huron Valley for prisoners with disabilities falls far below the standard of correctional medical care and the standard of correctional care. It is also in noncompliance with the requirements of Title II of the ADA. MDOC must make reasonable modifications of policies, procedures, and practices for patients with disabilities, which includes, at a minimum, the following remedies:

1. There are systemic and systematic barriers to timely access to an appropriate level of medical care for Huron Valley patients who have physical and mental disabilities, including chronic care. These barriers to effective care at Huron Valley present significant risk of harm and, in some cases, demonstrate actual harm.

Remedy: MDOC must reduce barriers to timely access to an appropriate level of care for Huron Valley patients with disabilities.

a. MDOC needs to continue to refine lines of authority and accountability to enhance its ability to provide timely access to an appropriate level of care for Huron Valley prisoners with disabilities.

b. Timeliness and appropriateness of care cannot be improved without performance measurement and meaningful quality management activities to respond to self-critical analysis with constructive program change. Develop meaningful performance measures to monitor deficiencies and implement remedies for identified problems. Performance measurement needs to be tracked and trended until there has been sustained compliance with program objectives.

c. File prisoners' requests for care (kites) in the medical record so as to evaluate timely access to an appropriate level of medical care by prisoners with disabilities.

2. It is a violation of Title II of the ADA to impose charges on prisoners for disability-related medical care. It is also inappropriate and punitive to hold prisoners responsible for the cost of medical care for self-injurious behavior. To have such charges for patients with disabilities implies that their disabilities are willful or voluntary. Self-injury, including suicide and suicide attempts, are not necessarily willful. Punishment for these conditions is not likely to reduce "frivolous" trips to the hospital. Describing these trips as "frivolous" implies that patients with disabling conditions should not be treated with respect.

Remedy: Immediately abandon this inappropriate and punitive policy of charging prisoners for disability-related medical care, including medications and other medical care for self-injurious behavior. Adopt an ADA-compliant policy that ensures that prisoners with disabilities are not charged for disability-related medical care or medications and that access to disability-related medical care is not restricted for cost-related reasons.

3. Huron Valley staff minimize patients' requests for care and minimize their legitimate grievances regarding lags and lapses in care. This is cynical and harmful. There are lags in access to physician evaluation for serious medical needs, specialty care, and medication. These pose a risk of serious harm, and in the cases of the patients with bowel perforation and pneumonia, caused serious harm to patients and unnecessarily increased expense to the State.

Remedy: Train and supervise staff systematically to assure timely and appropriate responses to requests for care and eliminate cynical attitudes. Performance in this area needs to be monitored, with appropriate corrective actions taken, as part of a quality management program.

4. Prisoners with hearing impairments do not get audiometric evaluation and are thereby

denied access to hearing aids and other auxiliary aids required pursuant to the effective communication obligations under Title II of the ADA.

> *Remedy:* Provide patients with hearing disabilities timely access to audiometric evaluation, hearing aids, and other auxiliary aids and services necessary to ensure effective communication in accordance with Title II of the ADA. Please note that the requirement to provide auxiliary aids and services for prisoners with disabilities applies with respect to auxiliary aids for prisoners with all disabilities affecting hearing, vision, and/or speech.

5. Patients with chronic disease are not always seen in conformance with PHS guidelines and have lapses in their medication. Patients with potentially-life threatening conditions, such as viral hepatitis, have lapses in care or serious delays in access to specialty care.

> *Remedy:* Monitor and ensure conformance with nationally-accepted clinical guidelines for chronic disease, such as those promoted to PHS clinicians.

6. Patients with disabilities must travel to the medication line to get their medications. For some, this is cumbersome and difficult.

> *Remedy:* Ensure that patients with disabilities have facilitated access to care, including medication prescribed for them, as required by the reasonable modification and program accessibility obligations of Title II of the ADA.

7. A component of adequate medical care is appropriate and accessible medical equipment, which is lacking at Huron Valley.

> *Remedy:* As Huron Valley acquires and replaces medical equipment, provide accessible medical examination and treatment tables and chairs, accessible scales, accessible radiological diagnostic equipment, etc., to provide prisoners with disabilities equal access to services. 28 C.F.R. §35.160. For information on accessible medical equipment, please refer to the Department of Justice's technical assistance publication entitled "Access to Medical Care for Individuals with Mobility Disabilities" at http://www.ada.gov/medcare_ta.htm.

We hope to work with the State in an amicable and cooperative fashion to resolve our outstanding concerns regarding Huron Valley. In the unexpected event that we are unable to reach a resolution regarding our concerns, the United States Attorney General is empowered to institute a lawsuit pursuant to the American's with Disabilities Act. We would prefer, however, to resolve this matter by working cooperatively with you. We have every confidence that we will be able to do so in this case. We will contact you shortly to confirm that you agree to undertake and implement these measures and maintain compliance.

This letter does not address other potential incidents of discrimination on the basis of disability that may exist or arise. Rather, it is limited to the findings developed in the investigation that are reflected in this letter.

Thank you, again, for your continued cooperation. If you have questions or would like to discuss this proposed resolution, please contact Mellie Nelson via email or at (202) 616-3198 or Susan DeClercq via email or at (313) 226-9149.

Sincerely,

BARBARA L. McQUADE
United States Attorney

Mellie H. Nelson
Supervisory Attorney
Disability Rights Section

Susan K. DeClercq
Assistant United States Attorney

cc: Warden Millicent Warren (email only)

Confidential Endnotes:

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