U. S. Department of Justice

Civil Rights Division

Assistant Attorney General

Washington, D.C. 20530

SEP - 6 2012

VIA U.S. MAIL

Mr. James Garnett
Chairman, Board of Directors
Piedmont Regional Jail
801 Industrial Road
Farmville, VA 23901

Re: Investigation of Piedmont Regional Jail, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997, and the Religious Land Use and Institutionalized Persons Act of 2000 ("RLUIPA")

Dear Mr. Garnett:

The Civil Rights Division of the United States Department of Justice has concluded its investigation of conditions at the Piedmont Regional Jail ("Piedmont," "the Facility," or "the Jail"), pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Religious Land Use and Institutionalized Persons Act of 2000 ("RLUIPA").

Our investigation found reasonable cause to believe that the Jail is denying necessary medical and mental health care, and consequently places prisoners at an unreasonable risk of serious harm, in violation of the Constitution. These lapses, if not corrected, have a likelihood of resulting in unnecessary injury and/or loss of life. By implementing the corrective measures set forth below, the Jail will fulfill its duty to protect the health and safety of those in its custody.

We also found that the Jail does not currently violate RLUIPA. During our tour, we identified practices that may have created a substantial burden on the religious exercise of prisoners. The Jail immediately made changes in response to our recommendations that resolved the issue.

During our exit briefing, the Piedmont leadership expressed a desire and intent to rectify any problems identified by the investigation. We look forward to discussing our findings with you after you have had the opportunity to review this letter. The Jail is an integral part of the public safety system. The remedies we propose will ensure respect for the rights of prisoners

confined there and will also provide for the safety of staff and promote public safety in the community.

I. Investigation

On March 4, 2011, we notified you that we were opening an investigation of Piedmont pursuant to CRIPA and RLUIPA. Our initial inquiry was prompted, in part, by a series of allegedly preventable deaths in the Jail between 2006 and 2009.[1] We learned from our inquiry that the circumstances of some of these deaths indicated a possible pattern of deliberate indifference to prisoners' serious medical needs and we thus opened a formal investigation. In addition, we had received information that Piedmont was placing undue burdens on Muslim prisoners' ability to observe the tenets of their religion.

We requested and reviewed documents provided by Piedmont and, on June 16-17, 2011, we conducted an onsite inspection of the Jail. During our onsite inspection, we were accompanied by a correctional medical care consultant. We toured the Facility, observed Facility processes, interviewed staff and prisoners, and reviewed an array of documents, including policies, procedures, and medical records. Consistent with our pledge of transparency, and to provide technical assistance where appropriate, we conveyed our preliminary determinations to Piedmont administrators during a telephonic exit presentation following our onsite visit. We conducted a brief follow-up site-visit on March 6, 2012.

Piedmont leadership was cooperative and professional throughout our investigation. We are particularly grateful to Superintendent Ernest Toney and the entire Piedmont staff. Piedmont has provided us with access to prisoner records and personnel, and responded to our requests before, during, and after our onsite visit in a transparent and forthcoming manner. We also appreciate Piedmont's receptiveness to our consultant's onsite and post-tour recommendations, and note that the Piedmont administration has, to date, consistently followed through on its expressed commitment to working with the United States to provide prisoners with reasonably safe and humane conditions of confinement, as required by the Constitution.

II. Background

Piedmont is a minimum to high-security facility located in Farmville, Virginia, situated between the cities of Richmond and Lynchburg. The Jail serves six counties (Amelia, Buckingham, Cumberland, Lunenburg, Nottoway, and Prince Edward), and is administered by a board consisting of two members from each county. The current Superintendent of the Jail is Ernest Toney.

Piedmont opened in 1988 with capacity for approximately 100 prisoners, but has expanded over the years. The Jail's capacity is now approximately 800, and at the time of our onsite tour, there were approximately 660 prisoners housed at Piedmont. Piedmont houses pre-trial detainees and convicted prisoners.

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[1] It is our understanding that after the last death during this time period, the U.S. Immigration and Customs Enforcement ("ICE") concluded that medical practice at Piedmont was below accepted community standards, and determined that the Facility could no longer be used to house ICE detainees.

III. Findings

We find that deficiencies in the medical and mental health care provided to prisoners at Piedmont place prisoners at a substantial risk of serious harm. We further find that, during our investigation, the Jail acknowledged and began respecting the religious rights of all prisoners. Our findings are detailed below.

A. Medical Care at Piedmont Is Deficient and Creates Substantial Risks

Piedmont's system for the delivery of medical services places prisoners at an unreasonable risk of harm. The Eighth Amendment affords convicted prisoners protection from cruel and unusual punishment. U.S. CONST. amend. VIII. The constitutional rights of pre-trial detainees are guaranteed by the Fourteenth Amendment, which, the Supreme Court has consistently held, provides protection at least equal to the Eighth Amendment. *Bell v. Wolfish*, 441 U.S. 520, 545 (1979). The Eighth Amendment requires prison officials to "provide prisoners with adequate food, shelter, clothing, and medical care." *Smith v. Davis*, No. 7:10-cv-00263, 2011 WL 3880944 (W.D. Va. Sept. 1, 2011) (citing *Farmer v. Brennan*, 511 U.S. 825, 832 (1994)).

The Constitution protects prisoners not only against ongoing harms, but also against the risk of future harm. *Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("That the Eighth Amendment protects against future harm to inmates is not a novel proposition . . . . It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them."). Conditions posing a substantial risk of serious harm to prisoners therefore violate the Constitution, even if no prisoner has suffered actual harm at the time the violation is found. *See Farme*r, 511 U.S. at 845-47; *Helling*, 509 U.S. at 35 (finding that risk of future harm to prisoner's health stated a cause of action under the Eighth Amendment); *Harden v. Green*, No. 01-6393, 27 Fed. App'x. 173, 177 (4th Cir. 2001) (noting that the Eighth Amendment "embraces the treatment of medical conditions which may cause future health problems"). The Supreme Court has clearly stated that "a remedy for unsafe conditions need not await a tragic event." *Helling*, 509 U.S. at 33.

Many of the lapses we identify below are directly related to Piedmont's inadequate medical staffing. There is too little onsite coverage by properly licensed staff members, forcing certified nursing assistants (CNAs) to practice and provide medical care beyond their training and licensure. The lack of sufficiently trained and available medical staff for the management and evaluation of serious medical conditions places prisoners at risk of unnecessary harm and is deliberately indifferent to prisoners' serious medical needs. Prison officials, including doctors, "violate the civil rights of inmates when they display 'deliberate indifference to serious medical needs.'" *Gordon v. Kidd*, 971 F.2d 1087, 1094 (4th Cir. 1992) (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). Prison officials knowingly disregard, or act with deliberate indifference to, prisoners' rights by "intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Smith v. Smith*, 589 F.3d 736, 738-39 (4th Cir. 2009) (citing *Estelle*, 429 U.S. at 104-05). Officials also violate the Constitution when they are deliberately indifferent to "an unreasonable risk of serious damage to . . . [a prisoner's] future health." *Helling*, 509 U.S. at 35.

1. *Piedmont exposes prisoners to risk of harm by relying on unqualified staff to perform essential medical functions.*

Perhaps the most significant single concern we have with the provision of medical and mental health care at the Facility is that staff members routinely perform medical services beyond what they are trained and credentialed to do. Piedmont's failure to ensure properly trained and credentialed staffing is to be expected, given its physician's indifference to such standards: while testifying under oath in March 2012, he stated that he was not aware of the staffing standards mandated by Virginia regarding medical staff at correctional facilities. Our finding is also consistent with the findings of other experts and inspecting bodies, who have made similar findings in recent reviews of Piedmont's medical services.

The Facility has one physician and two Licensed Professional Nurses (LPNs). The lead LPN is the primary liaison for medical services at the Jail. The rest of the medical staff consists of eight CNAs, and one mental health counselor. CNAs are not nurses, and must not be substituted for nursing staff. Per the Virginia Nursing Board, CNAs cannot be used to perform the following: activities involving nursing assessment, problem identification, or outcome evaluation requiring independent nursing judgment; coordination or management of care involving collaboration, consultation and referral; and emergency and nonemergency triage. Despite these prohibitions, CNAs perform many of these tasks at Piedmont, including receiving verbal medication orders. This is a dangerous practice that violates state licensure laws. CNAs' activities should be limited to taking vital signs, prepping patient charts, and other support functions.

A further concern involves "medical" security officers. We reviewed several incidents in which security staff were used to evaluate prisoner injuries, and cleared the prisoners without any medical input or consultation. Any clinical support by corrections officers must be limited, must be overseen by the medical department, and must be guided by clear protocols. Corrections officials may, and in fact, should, respond to medical emergencies in acute, life-threatening situations and be properly trained to do so. They should never, however, evaluate prisoners for medical reasons, perform sick call, or provide any type of non-emergency care. There are no protocols in place at Piedmont to guide corrections officers in the very limited medical tasks they may perform, and the current level of medical department oversight of officers is insufficient.

CNAs and nurses are forced to practice beyond their licenses because properly credentialed staff are simply not onsite for adequate hours to provide sufficient care for the prisoner population. The National Commission on Correctional Health Care (NCCHC) recommends that for every 100 prisoners, there should be at least 3.5 hours of physician time each week. Based on that recommendation and the census at the time of our visit to the Facility, there should be roughly 23 hours of physician time each week at Piedmont. The physician, however, is only onsite for 15 hours each week. As a result, he is not able to see all the prisoners that require physician care. While the physician asserted that he is available on an "on call" basis 24 hours per day, 365 days per year, the bulk of our review did not support this assertion.

When unlicensed staff members are permitted to play a key role in the delivery of health care, the probability for harm is greatly increased. Medical staff members are not

interchangeable. Registered Nurses (RNs), for instance, can perform functions that LPNs cannot, and LPNs can perform functions that CNAs cannot. While highly trained and supervised nurses are the foundation of most effective correctional medical programs, a physician provides the medical program with clinical leadership and direction. A nurse cannot independently make a medical diagnosis. It is critical that nurses, or any other staff members, are not placed in positions in which they find themselves delivering health care that is beyond their scope of training. This concern arises in numerous areas at Piedmont, including, for example, practices related to prisoners experiencing alcohol withdrawal, who should be closely monitored by a physician to ensure their safety. Although Piedmont does have an alcohol withdrawal protocol, nurses implementing the protocol are not supervised by the physician.

These concerns should be addressed as soon as possible. Current practice, in which health support personnel are functioning well beyond their qualifications, compromises access to care for prisoners and puts prisoners at risk of injury or even death. Current practices also put staff members at risk of losing their licenses, and both staff and the Jail at risk of legal liability. Where medical staff members "are continually called upon to perform services for which they have not been trained and for which they are not qualified," a correctional facility effectively denies prisoners access to medical care. *Newman v. Alabama*, 349 F. Supp. 278, 283 (M.D. Ala. 1972), *aff'd in part*, 503 F.2d 1320 (5th Cir. 1974), *vacated in part on other grounds*, 522 F.2d 71 (5th Cir. 1975) (en banc); *see also Ramos v. Lamm*, 639 F.2d 559, 575-76, 578 (10th Cir. 1980) (affirming district court's finding that use of non-physician medical personnel to make decisions and perform services for which they were neither trained nor qualified demonstrated deliberate indifference to serious medical needs and constituted effective denial of access to adequate medical care); *Garner v. Winn Corr. Ctr.*, No. 1:08-CV-01977, 2011 WL 2011502, at *5 (W.D. La. May 18, 2011) (providing LPN to evaluate and "diagnose" prisoners "is a failure to provide appropriate medical care to the inmates for which responsible prison officials may be liable"); *Gibson v. County of Washoe, Nev.*, 290 F.3d 1175, 1187 (9th Cir. 2002) ("In order to comply with their duty not to engage in acts evidencing deliberate indifference to inmates' medical and psychiatric needs, jails must provide medical staff who are 'competent to deal with prisoners' problems.'"), *citing Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir.1982).

Piedmont should adjust staffing to increase the number of higher-trained staff, such as LPNs and RNs, as well as the number of hours that nurses and the doctor are onsite. Specifically, the Facility should hire at least two RNs, and add 6 LPNs, thus reducing the need for CNAs. In addition, the physician should be onsite no fewer than 23 hours per week. Further, corrections officers should never evaluate prisoners for medical needs, except as necessary to provide emergency care. Finally, Piedmont should revise its policies and procedures to establish clearly the expectations for all medical staff.

2. *Piedmont's medical policies lack specificity and thoroughness.*

While Piedmont does have a medical manual, many of the policies are lacking in detail or specificity. There are no policies on chronic care, infection control, or quality assurance. The policies related to mental health care, and specifically those regarding potentially suicidal prisoners, do not provide the guidance necessary to prevent harm. Furthermore, Piedmont's policy to address the health concerns of pregnant women is limited in scope. In addition, the

policy and protocol related to alcohol withdrawal are deficient. Problems related to medical policies and procedures at Piedmont are underscored by the recent, troubling testimony of Piedmont's physician, under oath, in which he confirmed that he has not reviewed medical policies and procedures for several years, despite the fact that he has signed forms stating that he did review them.

The Facility should review the 2008 NCCHC Jail Standards and use those standards as an outline to create and adopt policies specific to the Facility, focusing from the outset on the standards deemed "essential" by the NCCHC and supplementing those as necessary to meet the medical needs of prisoners at Piedmont. Piedmont should also consider implementing an assessment tool, such as the Clinical Institute Withdrawal Assessment tool, which would set up parameters for nurses who need to monitor prisoners placed under observation.

3. *Intake screening procedures do not promptly identify medical problems.*

Jails must provide a prompt medical screening upon intake, and refer prisoners with medical needs to doctors and nurses for further evaluation and treatment. *See Dawson v. Kendrick*, 527 F. Supp. 1252, 1307 (S.D. W. Va. 1981) ("It is generally recognized that prompt medical screening is a medical necessity in pre-trial detention facilities."). Failure to properly screen prisoners for communicable diseases may constitute deliberate indifference in violation of the Eighth Amendment. *See Portee v. Tollison*, 753 F. Supp. 184, 186 (D. S.C. 1990), *citing with approval Smith v. Sullivan*, 553 F.2d 373 (5th Cir. 1977); *Madrid v. Gomez*, 889 F. Supp. 1146, 1257 (N.D. Cal. 1995) ("The facility should screen newly arrived inmates to identify potential medical problems and communicable diseases."), *citing Lightfoot v. Walker*, 486 F. Supp. 504, 524 (S.D. Ill. 1980) ("Health care admission screening procedures, including a physical examination performed by a physician, are an essential element of a constitutionally adequate system.").

The intake screening is the jail's first opportunity to identify the needs of new prisoners and consider treatment options. Without a proper screening mechanism, prisoners may be improperly denied necessary care or medication. Absent screening, prisoners may also enter the jail with communicable diseases that can, if undiagnosed upon arrival, spread to the rest of the population.

Although Piedmont conducts some initial screening, the screening provided is inadequate, those conducting the screening are often not properly trained, and the results of the screening are documented inadequately, if at all. Some prisoners at the Facility are initially screened only by corrections officers, who are not trained in identifying medical or mental health needs and are not provided guidance regarding referrals to physicians. While corrections officers may perform an initial screening in rare, limited circumstances—such as during one or two quiet overnight shifts each week where medical personnel are not present—those officers must be adequately trained, and the screening must be followed by a full screening conducted by a member of the medical staff within hours.

Proper documentation, including any referrals for further evaluation, is vital for determining future treatment plans and ensuring that prisoners can be monitored. We reviewed

numerous medical records that did not contain any documentation reflecting the results of the initial screening. While we did observe some screenings, and received assurances that screenings are regularly conducted, it was impossible for us to verify that the Jail does indeed conduct a screening of each new prisoner.

We also found problems with subsequent screening for access to medical care. Like corrections officers, nurses, too, require guidance regarding which situations necessitate referrals to the physician, but Piedmont has not promulgated policies that would provide such guidance. Indeed, this deficiency was confirmed by the physician in March 2012, when he conceded that Piedmont currently has no medical manual of protocols available for the medical staff to consult. Finally, as noted earlier, Piedmont permits CNAs to perform medical screening, which they should not be doing.

In order to correct these deficiencies, Piedmont should develop and implement an intake screening system that instructs screeners regarding which prisoners should be referred to physicians and when; ensures documentation of all information obtained through the screening process; and ensures that individuals conducting screenings and controlling access to medical care are appropriately trained and qualified.

4. *Piedmont's lack of a chronic care program places prisoners at risk of harm.*

Piedmont's lack of a chronic care program places prisoners at an unreasonable risk of harm. A chronic care program is crucial to ensure that prisoners with known medical and mental health illnesses are identified and seen for an initial comprehensive evaluation, and then tracked to ensure periodic follow-up. A correctional institution's failure to implement policies and procedures that ensure that prisoners with chronic illnesses are identified and appropriately treated exposes prisoners to serious risks of future harm. *See Shepherd v. Dallas County*, 591 F.3d 445, 453-54 (5th Cir. 2009) (finding that jail's lack of chronic care exposed detainee to risk of serious injury and death); *Scinto v. Preston*, 170 Fed. App'x. 834 (4th Cir. 2006) (failure to provide adequate treatment for chronic diabetes constitutes deliberate indifference). The NCCHC categorizes a chronic care program as an essential element of correctional medical care, and has developed guidelines for disease control for diabetes, hypertension, HIV, pulmonary diseases, and seizures.

Chronic care programs prevent avoidable injuries and deaths by keeping chronically ill individuals medically stable through mechanisms such as routine, scheduled clinic visits. At present, Piedmont has no defined systems in place to track or manage prisoners with chronic conditions. By the Facility physician's own admission, medical care at Piedmont is episodic or complaint-driven, rather than proactive. For example, a prisoner who suffers from migraines and had been at the Facility for over six months at the time of our visit, had to be sent to the hospital after experiencing numbness in his body, but after returning to the Facility, had never been checked by the physician. This case reveals weaknesses in both physician coverage and chronic care follow-up. Piedmont's lack of preventative/chronic care can result in harm or risk of harm to prisoners. The following examples are illustrative:

- Prisoner A[2] entered the Jail with a history of seizures. He was placed on Dilantin, a drug that can cause both neurological and cardiac side effects, but, despite the fact that he had been at the Jail for over eight months at the time of our inspection, was never evaluated for proper medication dosage or toxicity level.

- Prisoner B reported a history of chronic obstructive lung disease and hypertension upon entering the Jail on March 18, 2010. He was placed on Theophylline, a toxic medication that should be used with caution, yet at the time of our review, he had never had a drug level to assess the toxicity and therapeutic levels of the medication, and had never been evaluated for complications associated with hypertension or cardiac risks, as would be expected. In fact, he had not had a visit with the physician to address his chronic conditions at all. Prisoner B was evaluated by a CNA on May 21, 2010 for chest pain, and was eventually sent to the hospital for his pain, yet he never had a follow-up visit with the physician for his chest pain.

- Prisoner C, at Piedmont since March 30, 2010, was placed on Coumadin, a potent blood thinning medication, for heart disease, and Simvastatin for high cholesterol. Both of these medications can be toxic and need to be monitored for therapeutic effect. At the time of our review, no drug tests had been conducted and the physician had not scheduled any chronic care visits with Prisoner C.

- Prisoner D entered the Jail with a history of hypothyroidism, mental illness, and hypertension. He was given medications to address these conditions, but no blood work was ever done to determine if his thyroid condition was responding to the medication or if he received the proper dosage. Piedmont medical staff also failed to monitor the drug used to adjust Prisoner D's cholesterol level, which placed him at great risk for undetected liver toxicity.

As the above examples illustrate, Piedmont's lack of a chronic care program exposes prisoners to a substantial risk of significant harm. To remedy this, Piedmont should establish a chronic care program that defines what illnesses qualify for inclusion in the program (for example: diabetes, hypertension, dyslipidemia, HIV, cardiovascular diseases, seizure, pulmonary illness, and mental illness); ensures that prisoners with chronic care issues are identified and examined by the physician; tracks prisoners in the program and schedules periodic assessments; provides for diagnostic tests at an initial comprehensive visit; makes lab work available at appointments in order to determine the status of disease control; and outlines a clinical plan for each chronically ill prisoner.

5. *The lack of comprehensive health assessments places prisoners at risk.*

Comprehensive health assessments, conducted within fourteen days of arrival, are an integral part of a correctional medical system, because they may identify medical problems that were not discovered during the initial screening process. *See, e.g. Roberts v. Mahoning County*,

[2] Prisoners are referred to by letter to protect their privacy.

495 F. Supp. 2d 719, 769 (E. D. Ohio 2007) (consent judgment requiring that new medical providers contracted by jail conduct comprehensive health assessments within fourteen days of prisoners' arrival at the jail).

Thorough health assessments, conducted after the prisoner has adjusted to the jail setting, are an essential tool for jail clinicians. Such assessments, in addition to identifying problems that were not raised or addressed in the initial screening, allow medical staff to develop more complete treatment plans for prisoners with known medical problems, including, for example, diabetes, asthma, and depression. Without a detailed evaluation of each prisoner, chronic or less immediately apparent problems can go undiagnosed or mistreated. The evaluation further allows medical staff to develop a medical baseline for each prisoner. Moreover, health assessments can assist in identifying and treating the spread of communicable diseases that can impact prisoners, staff, and the wider community. Deficiencies related to health assessments have been a subject of concern for other experts and inspecting bodies reviewing Piedmont's medical services in the past.

Piedmont should develop and implement a system to provide a comprehensive health assessment within fourteen days of the arrival of each prisoner. A physician, physician assistant, or nurse practitioner should conduct the health assessments. However, RNs could perform health assessments, provided that a physician provides documented supervision and training.

6. *Piedmont's sick call system places prisoners at risk of harm.*

Sick call systems are essential to the provision of adequate correctional medical care. *Todaro v. Ward*, 431 F. Supp. 1129, 1146 (S.D.N.Y. 1977) ("Courts have held that a sick call procedure for prompt referrals of those in need to a physician is constitutionally required."), *aff'd sub nom. Todaro v. Coughlin*, 652 F.2d 54 (2d Cir. 1981), and *aff'd*, 565 F.2d 48 (2d Cir. 1977) (citations omitted). The sick call system must be run by medical personnel who are appropriately trained in meeting the medical needs of the prisoner population. *Madrid*, 889 F. Supp. at 1258 ("While medical technical assistants or their equivalent may permissibly be the first to examine inmates with physical ailments, they must be properly trained to perform this function and adequately supervised.").

Prisoners rely on a jail's sick call system as an entry point to medical care within the facility, and jails rely on a sick call system to ensure that medical problems are addressed as early as possible to prevent unnecessary suffering, avoidable injury or death, and the increased medical costs associated with illnesses that have been allowed to linger and worsen.

Currently, Piedmont's sick call system places prisoners at an unreasonable risk of harm, because under-qualified LPNs and CNAs manage the sick call system without the supervision of a physician. CNAs are not sufficiently credentialed to perform sick call or evaluate prisoners. The LPNs at Piedmont, although credentialed, currently lack the training necessary to develop long-term treatment plans. Furthermore, Piedmont lacks standardized forms for nurses to use in their evaluations. These forms, if properly developed, would guide nurses and establish protocols for referrals to the physician. Indeed, this deficiency was confirmed by the physician when he testified in March 2012 that Piedmont currently has no medical manual of protocols

available for the medical staff to consult. Problems with Piedmont's sick call system are longstanding, and have been noted by other experts and inspectors in the past.

While changes to the current sick call system are required, we do note with approval that prisoners seem to be able to access the medical staff when necessary. Most prisoners we spoke with reported being seen by someone on the medical staff within days of submitting a sick call slip, and none reported problems accessing medical care for true emergencies. Our concern is whether prisoners' initial contact with medical staff via the sick call system routinely results in the prisoner being referred for the appropriate level of care based on the prisoner's medical needs. Nonetheless, prisoners' ready access to sick call and emergency medical care is a positive development, and seems to represent improvement, as a lack of access to care allegedly led to several deaths and numerous other issues at the Facility in the past.

In order to address the problems related to sick call, Piedmont should establish standardized tools for use during sick call evaluations. These tools will allow nurses to properly triage prisoners' medical needs and ensure they are referred for and provided appropriate treatment in a timely manner. CNAs should not be allowed to perform clinical evaluations, and their role in the sick call process should be limited to prep work, such as taking vital signs. Further, the physician should provide oversight of the sick call process by periodically reviewing the nurses performing sick call, in order to ensure that personnel are not practicing beyond their clinical training.

7. *The lack of any quality assurance program at Piedmont puts prisoners at risk of harm.*

Quality assurance ("QA"), or quality improvement, is an important tool for any correctional medical staff. *See, e.g., Cody v. Hillard*, 599 F. Supp. 1025, 1058 (D. S.D. 1984) ("Several courts have held the lack of quality control over medical care, when considered among other health care deficiencies, unconstitutional under the Eighth Amendment."), *aff'd*, 799 F.2d 447 (8th Cir. 1986) *on reh'g*, 830 F.2d 912 (8th Cir. 1987).

A functioning, effective QA program will identify problems in the delivery of medical care, and create mechanisms to rectify those problems. One of the major components of a QA system is to share findings with staff so that they can learn from past mistakes. QA often involves the physician reviewing and analyzing nursing assessments and other critical clinical activities, such as chronic care and sick call. It should also involve the review of all deaths at the Facility, in order to ascertain compliance with the standard of care and educate staff about trends and causes of prisoner deaths. An effective QA process will improve the clinical care provided and reduce poor outcomes.

Piedmont currently has no QA program, which means that it cannot be proactive in identifying problem areas before a poor clinical outcome occurs. The Facility should develop a QA program to review the clinical performance of sick call, health assessments, intake, chronic care, medication administration, and emergency care. This QA program should include a comprehensive and documented mortality review and response after any deaths.

8. *Training gaps increase the likelihood of harm.*

As noted above, we reviewed several incidents in which security staff were used to evaluate prisoner injuries, and cleared the prisoners without any medical input or consultation. Corrections officials may and should respond to medical emergencies in acute, life-threatening situations. But they must be properly trained to do so and should not be asked to make the clinical-level evaluations they are asked to make at Piedmont A failure to train security and medical staff can cause serious medical harm and subject an agency to legal liability. *See, e.g.*, *Doe v. Broderick*, 225 F.3d 440, 456 (4th Cir. 2000). While Piedmont does conduct training for medical and security staff, the training on suicide prevention and mental health is severely lacking. Training is necessary even where officers can call medical staff at any time, as officers are nearly always the first responders to a medical crisis and, with proper training, may be able to prevent more serious injury or even save a life.

Piedmont should ensure all officers are trained in providing first-responder medical care. The Facility should also develop and implement training for suicide prevention and mental health.

9. *Piedmont's co-pay system can result in denial of access to care.*

Policies which require that a prisoner pay a co-payment for health care do not constitute *per se* deliberate indifference to a serious medical need in violation of the Eighth Amendment. However, such co-payment policies can rise to the level of a constitutional violation where prisoners are denied access to necessary health care due to their inability to pay. *See Johnson v. Dep't of Pub. Safety & Corr. Services*, 885 F. Supp. 817, 820 (D. Md. 1995); *Gonzales-Reyna v. Ellis*, No. 1:09-cv-522-AJT/TCB, 2009 WL 2421482, at *3 (E.D. Va. July 27, 2009); *Collins v. Romer*, 962 F.2d 1508, 1513 (10th Cir. 1992). Therefore, while jails may charge small co-pays for medical care, co-payment policies must be flexible to enable indigent and chronically ill prisoners to access health care without imposing unnecessary hardship. *See Johnson*, 885 F. Supp. 817, 820. Where these exceptions are not in place, even relatively small co-pays can create barriers to access to necessary health care.

At Piedmont, prisoners are required to pay considerable fees for most clinical services. Piedmont prisoners pay $12.50 to see a nurse and $20.00 to see the doctor, while emergency visits cost $50.00. Prisoners are charged $10.00 per month for medication. The amounts Piedmont charges far exceed the generally accepted co-payment amounts across the country. Most state correctional systems charge co-pays in the two to five dollar range, and rarely are they more than $10. *See, e.g.*, http://www.michigan.gov/documents/corrections/03_04_101_268638_7.pdf ($5 co-pay in Michigan prisons); http://www.drc.ohio.gov/web/medical.htm ($3 co-pay in Ohio prisons); http://www.portal.state.pa.us/portal/server.pt/document/919468/820_co-payment_for_medical_services_pdf ($5 co-pay in Pennsylvania prisons). In fact, the Virginia Department of Corrections charges a five dollar co-pay for most medical services. Virginia Dept. of Corrections, *Operating Procedure 720.4: Co-Payment for Health Care Services*, (amended Nov. 15, 2011), www.vadoc.state.va.us/about/procedures/documents/700/720-4.pdf. Moreover, the co-pays charged by Piedmont are well in excess of most fees which have

previously been found constitutional. *See Johnson*, 885 F. Supp. at 818 (co-pay of two dollars constitutional); *Collins*, 962 F.2d at 1517 (three dollar co-pay constitutional); *Gonzales-Reyna*, 2009 WL 2421482, at *3 (five dollar co-pay constitutional).

While the Piedmont inmate/detainee handbook and medical protocols make clear that prisoners cannot be denied access to medically necessary services based upon their inability to pay, there can be no doubt that, in actuality, inability to pay impacts whether prisoners request medical care. Numerous prisoners we spoke with said that the co-pay fees adversely affected their decisions whether to seek needed medical care, especially when paying for a medical appointment would mean foregoing hygienic or other items that the prisoner could otherwise purchase with the money he or she would have to use as a co-pay. Universally, the prisoners we spoke with who had been incarcerated at multiple facilities told us that Piedmont has the highest co-pays of any facility they had encountered.

The NCCHC has recognized numerous problems, like that illustrated above, created by medical co-pays, all of which are only exacerbated when the co-pays are exceedingly high, as they are here. For example, co-pays place prisoners in the position of having to choose between paying for other much needed items, such as hygienic products, or receiving medical attention. Nat'l Comm'n on Corr. Health Care, *Position Statement: Charging Inmates a Fee for Health Care Services* (Oct. 2005), http://www.ncchc.org/resources/ statements/healthfees.html. Further, when prisoners avoid medical care for what may initially be minor situations, those situations may deteriorate, leading to serious consequences for the inmate or the infection of others. *Id.* Accordingly, the NCCHC has recommended a number of guidelines, including the following:

- Only services initiated by the inmate should be subject to a fee or other charges. No charges should be made for the following: admission health screening (medical, dental, and mental) or any required follow-up to the screening; the health assessments required by facility policy; emergency care and trauma care; hospitalization; infirmary care; prenatal care; in-house lab and diagnostic services; pharmacy medications to maintain health; diagnosis and treatment of contagious disease; chronic care or other staff-initiated care, including follow-up and referral visits; and mental health care including drug abuse and addiction.
- The assessment of a charge should be made after the fact. The health care provider should be removed from the operation of collecting the fee.
- Charges should be small and not compounded when a patient is seen by more than one provider for the same circumstance.
- No inmate should be denied care because of a record of non-payment or current inability to pay for same.
- The system should allow for a minimum balance in the inmate's account, or provide another mechanism permitting the inmate to have access to necessary hygiene items (shampoo, shaving accessories, etc.) and over-the-counter medications. *Id.*

It remains an open question whether a $50 co-pay for emergency visits is *per se* unconstitutional. But even lower co-pays may be unconstitutional if they are shown to effectively deter legitimately needed medical treatment. At Piedmont, the exceedingly high co-

pay fees, in combination with information indicating that they may be serving as a barrier to prisoners receiving necessary medical care, may well run afoul of constitutional requirements.

Accordingly, Piedmont should immediately revise the co-pay policy to exclude all health care required by the Facility, including health assessments and mental health care. In addition, Piedmont should establish exceptions to the co-pay requirement for necessary medical care, including chronic care and emergency visits, so that prisoners are not dissuaded from seeking and receiving care that is essential to their health. Furthermore, the Jail should require only a single, lower co-pay fee to see a nurse, with no further fee to see the doctor if the prisoner is referred for further evaluation. In addition, Piedmont should establish a minimum balance in the prisoner's account, in order to ensure that a prisoner who is charged a co-payment will retain the ability to purchase hygiene items and over-the-counter medications.

B. Mental Health Care at Piedmont is Sub-Standard and Places Prisoners at Risk of Harm

Jails are constitutionally required to treat prisoners with mental health needs. *Estelle*, 429 U.S. at 104. Failure to properly treat and monitor individuals with suicidal thoughts or behaviors is a violation of the Eighth Amendment. *Buffington v. Baltimore County, Md.*, 913 F.2d 113, 120 (4th Cir. 1990) ("where police know that a pretrial detainee is on the verge of suicide, that psychological condition can constitute the kind of serious medical need to which state officials must, under the due process clause, not be deliberately indifferent"). Officials are also required to provide appropriate psychiatric services, including evaluation, treatment, and supervision, to protect prisoners from harming themselves or others. *De'Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003) (protection against self-mutilation is serious medical need to which prison officials may not be deliberately indifferent); *Dawson*, 527 F. Supp. at 1308 (". . . failure to provide timely access to . . . psychiatric or psychological personnel" contributes to deliberate indifference).

Without proper evaluation and treatment, prisoners with serious mental illness may needlessly suffer and cause significant security challenges, becoming actively psychotic, aggressive, violent, or difficult to control.

While many mental illnesses are treatable with the right medications and therapy, a disjointed mental health system places prisoners at risk of injury and illness from improper medication or dosage levels, suffering the ongoing impact of untreated serious mental illness, and self-harm.

Piedmont's mental health care system is deficient in a number of ways:

Inadequate Psychiatric Staff: The Jail has no psychiatrist available to prescribe psychotropic medications or evaluate their effects. This is a gross violation of standard medical practice. Instead, a clinical counselor, who is not a trained or licensed physician, serves as the sole mental health staff member, and is only present at the Jail for one day per week. She meets with patients only upon their request or upon a report of suicidal ideation or a suicidal act. Prisoners who are given psychotropic medication are not monitored for side effects or proper

dosages. The American Psychiatric Association recommends that there be one full-time psychiatrist for every 75-150 patients with serious mental illness on psychotropic medication in prison. At the time of our visit, there were 75 prisoners on mental health medications in the Facility, indicating the need for at least 20-40 hours of onsite psychiatric care. The Jail, in contrast, provides none.

Inadequate Assessments and Follow-up: Additionally, no routine mental health evaluations are performed, even for prisoners with a history of mental illness or those on psychotropic medications, and there are no documented assessments or treatment plans for prisoners with mental illness. Diagnostic blood tests, which are needed when certain medications are prescribed, are not routinely conducted or properly documented. For example, Prisoner E was prescribed Tegretol and Lithium for his mental illness. Both of these medications require periodic drug levels, due to their toxicity. Lithium, in particular, can be lethal if not managed correctly. Nevertheless, no drug levels were taken and Prisoner E had not, at the time of our review, had any follow-up to assess his mental status. We also reviewed the records of several other prisoners prescribed Lithium without blood work or other follow-up being performed.

Inadequate Suicide Prevention: Prisoners at Piedmont who exhibit suicidal behavior or express suicidal thoughts are dealt with inappropriately. Prisoner F, who reported a history of suicidal ideation, was prescribed Haldol, but never received a comprehensive mental evaluation or any follow-up on the effects of the medication. Other suicide precautions are also lacking, such as staggered 15-minute checks of prisoners on suicide watch, and the availability of cut-down tools for officers. Significantly, because prisoners can only be released from suicide watch after being seen by the counselor, who works only one day a week, prisoners can be—and have been—on suicide watch for up to a full week unnecessarily. Maintaining prisoners on suicide watch unnecessarily is punitive and can discourage those who truly need help from seeking it. The physician should be actively involved in evaluating prisoners on suicide watch, but currently is not. For example, Prisoner G was placed on observation for almost a week with no physician evaluation, and there were no notes or documentation in her file regarding her treatment or progress.

To remedy these problems, Piedmont should ensure that prisoners with mental health needs are properly evaluated, treated, and monitored by a licensed psychiatrist who is onsite at least 20 hours per week. That psychiatrist should be supported by the clinical counselor, who could work in conjunction with a nurse practitioner to provide a sufficient number of hours of coverage each week. All prisoners with a known mental illness should be referred to the psychiatrist within fourteen days of arrival, assuming an initial screening is completed, and individuals with more acute needs—such as those who are suicidal or grossly psychotic—should be seen and treated as soon as the Facility becomes aware of their condition. Prisoners who are prescribed psychotropic medication should also be evaluated by the psychiatrist within two weeks of starting a new medication. Piedmont should develop and implement policies to ensure monitoring of individuals with chronic mental health illness, and completion of blood work and other follow-up as necessary. Finally, all prisoners on suicide watch should be actively monitored to ensure that no prisoner is restricted longer than necessary.

C. RLUIPA

We note, as a general matter, that we were pleased to see a number of recent changes that Piedmont has made to ensure that it is in compliance with RLUIPA. These changes should be maintained, as they are both necessary under the law and beneficial to the Facility and society at large. Prisoners who are permitted to practice their religion are less likely to engage in misbehavior or otherwise cause disruptions to the jail environment, and religious worship supports rehabilitation. *See* 146 CONG. REC. S6678-02, at S6689 (daily ed. July 13, 2000).

RLUIPA provides that no institution owned or operated by, or on behalf of, any State or local government, including correctional facilities, "shall impose a substantial burden on the religious exercise of a [resident]." 42 U.S.C. § 2000cc-1(a). This prohibition includes a substantial burden on religious exercise resulting from a rule of general applicability. *Id.* "Religious exercise" is defined to include "any exercise of religion, whether or not compelled by, or central to, a system of religious belief." 42 U.S.C. § 2000cc-5(7)(A). In order to overcome this prohibition on burdening religious exercise, a government must demonstrate that imposition of the burden is: (1) "in furtherance of a compelling governmental interest"; and (2) "the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000cc-1(a). The Fourth Circuit, in interpreting RLUIPA, has held that a substantial burden occurs when an act or omission "put[s] substantial pressure on an adherent to modify his behavior and to violate his beliefs." *Lovelace v. Lee*, 472 F.3d 174, 187 (4th Cir. 2006) (quoting *Thomas v. Review Bd. of Indiana Employment Sec. Div.*, 450 U.S. 707, 718 (1981)).

Below, we briefly address our observations about several discreet issues within the RLUIPA context. Because allegations we had previously received focused mainly on the denial of religious rights to Muslim prisoners, our comments center largely on that population.

1. Religious Meals

Piedmont serves a pork-free diet, which allows it to meet the needs of many of those prisoners who may adhere to a religious diet. Piedmont also provides special meal service to those observing Ramadan.

While the food service at Piedmont for religious observers thus seems to be adequate at present, the Jail should be aware that simply providing a pork-free diet may not be sufficient to accommodate all prisoners' religious exercise. Piedmont should ensure that prisoners can at least purchase from the commissary religiously acceptable foods to augment the diet provided.

2. Religious Services

Piedmont currently permits Muslim prisoners to participate in a Ju'mah service each Friday. This practice began shortly after we issued our Notice Letter informing the Facility that we were opening our investigation. Piedmont should continue to allow Ju'mah services to ensure it is not in violation of RLUIPA. We observed the Ju'mah service, in which the Jail's chaplain participated, and we appreciate his commitment to allowing prisoners of all faiths to practice their religions while incarcerated.

3. Religious Possessions

After our investigation began, Piedmont started permitting Muslim prisoners to possess Korans. Prayer rugs, we were informed, are sold in the commissary, and we saw several prayer rugs being used during the Ju'mah service. Piedmont has fulfilled its legal obligation by permitting prisoners to practice their religion with the appropriate possessions. Piedmont should continue this practice to maintain compliance with federal law.

4. Religious Headwear

During our investigative tour, several Muslim prisoners informed us that, while they were allowed to wear religious headgear (the kufi) in their housing units, they were not permitted to wear them outside of those units. A Piedmont official confirmed to us that this accurately represented policy.

After we raised this issue, Piedmont changed the policy so that religious headgear can now be worn throughout the Facility, but when a prisoner wearing such headgear enters or leaves a housing area or any Jail program, the headgear will be searched for contraband. Jail directives also now provide that prisoners shall have access to religious headwear. These policy changes should also remain in place, as they are necessary to ensure that the Facility is in compliance with its obligations under federal law.

IV. Summary of Remedial Measures

To remedy the deficiencies identified above, Piedmont should promptly implement the minimum remedial measures set forth below. Specifically, the Facility should:

- Review the 2008 NCCHC Jail Standards and use those standards to create and adopt facility-specific policies, focusing from the outset on the standards deemed "essential" by the NCCHC.

- Revise medical policies to include policies on chronic care, infection control, and quality assurance.

- Increase medical staffing by hiring additional staff with higher credentials (e.g. RNs, LPNs, and a psychiatrist) and increasing the hours that current staff—most especially the doctor—are onsite. Specifically, hire at least two RNs; add 6 LPNs, which will allow for a reduction in the number of CNAs; increase the physician's onsite hours to at least 23 hours per week, and, in conjunction with hiring a psychiatrist, increase the mental health counselor's hours or hire a nurse practitioner to cover additional hours.

- Limit the tasks that CNAs undertake to those that they are credentialed to perform, and ensure that proper physician supervision is provided. Specifically, among other things, CNAs should not be performing intake screenings or clinical evaluations, and should not take medication orders.

- Ensure that security officers are not rendering medical decisions regarding prisoners' care, and make sure that there are clear guidelines in place for any security officers providing clinical support, with physician oversight.

- Ensure that all initial screenings are performed by trained staff and documented electronically, including documentation of any referrals to the physician.

- Implement a policy that provides guidance to nurses about when to refer prisoners to the physician following screening, sick call, or emergency visits.

- Conduct comprehensive health assessments of all prisoners within fourteen days of their arrival, with a physician either conducting the screening or overseeing RNs who conduct the screening.

- Provide for physician oversight, including periodic review, of sick call, with nursing protocols and clinical assessment forms that guide the nurses performing sick call.

- Develop a detox procedure that includes the Clinical Institute Withdrawal Assessment tool for prisoners at risk of alcohol withdrawal and requires physician input before nurses can treat prisoners withdrawing from abused substances.

- Implement a chronic care program that identifies prisoners for enrollment; defines illnesses to be included; ensures that enrolled prisoners are tracked and scheduled for periodic assessments; requires diagnostic tests; and ensures that all prisoners with known medical or mental health issues are scheduled for routine visits with the physician or a psychiatrist as appropriate for their condition.

- Review and revise the co-pay policy to ensure that it does not prevent prisoners from accessing health care. The review should assess the co-pay amount to determine whether it is a deterrent to seeking care and make provisions for indigent prisoners and prisoners with chronic illness.

- Provide routine evaluations to prisoners with a history of mental illness and those on psychotropic medication, with documented treatment plans, within 14 days of arrival.

- Provide immediate treatment to prisoners who are suicidal or psychotic, as soon as those conditions are known to the Facility.

- Ensure that the physician provides follow-up visits to prisoners on psychotropic medications, including diagnostic blood tests for prisoners on certain mental health drugs, based on the toxicity profile of the medication.

- Ensure that the physician sees prisoners on suicide watch when the mental health staff is not present, and ensure that prisoners are not kept on watch longer than necessary.

- Ensure that 15-minute watches for prisoners on suicide watch are staggered, and ensure that all officers have cut-down tools.

- Institute a quality assurance program that, among other things, reviews the clinical performance of sick call, the health assessment process, the intake process, the chronic care program, medication administration, and emergency care, and includes mortality reviews after any deaths.

- Implement training on first-responder medical care, mental health and suicide prevention for security staff.

- Continue to serve meals that allow prisoners to adhere to a religious diet, including special meal service for religious holidays, and establish a plan to meet the needs of prisoners who may require more than a pork-free diet in order to meet the dictates of their religion.

- Continue to permit prisoners to participate in religious services, possess religious books and other materials (such as prayer rugs), and wear religious headgear throughout the Facility.

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We hope to continue working with Piedmont in an amicable and cooperative fashion to resolve the above-outlined concerns regarding conditions at the Facility. We know that, since our onsite visit, Piedmont has committed to taking various steps to address many of the issues we raised at our exit presentation. We appreciate the Jail's proactive efforts, which give reason to believe that the Jail will be able to resolve all the matters about which we have expressed concern.

We look forward to learning of the progress Piedmont has made thus far, and to discussing the above findings with the Jail. As always, we remain available to discuss any questions or concerns that you might have regarding our investigation.

Please note that this letter is a public document. It will be posted on the Civil Rights Division's website.

Should you have any questions or concerns regarding this letter, please feel free to contact Jonathan M. Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,

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