



U.S. Department of Justice

Civil Rights Division

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

November 13, 2007

The Honorable Ron Sims
King County Executive
701 Fifth Ave. Suite 3210
Seattle, WA 98104

Re: King County Correctional Facility,
Seattle, Washington

Dear Executive Sims:

I write to report the findings of the Civil Rights Division's investigation of conditions at the King County Correctional Facility ("KCCF").¹ On October 30, 2006, we notified you of our intent to conduct an investigation of KCCF pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On March 6-8, 2007 and August 1-2, 2007, we conducted on-site inspections at KCCF with expert consultants in corrections and custodial sexual misconduct, medical care and contagious disease prevention and treatment, and suicide prevention. We interviewed security staff, medical staff, administrative staff, and inmates. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, investigative reports, grievances from inmates, staff personnel files, unit logs, orientation materials, and staff training materials. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary findings to King County officials at the close of each of our on-site visits.

¹ The King County Correctional Facility, also referred to as the King County Jail, is located at 500 5th Avenue, Seattle, Washington.

During our August 2, 2007 exit meeting, and by letter on August 8, 2007, we notified King County officials of life-threatening deficiencies in medical care for certain inmates at KCCF. In particular, we indicated that certain inmates were being deprived of urgent medical attention. On August 10, 2007, the County responded by indicating that a number of corrective measures were being implemented to address our concerns.

We commend the staff at KCCF for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation with our investigation and appreciate the County's receptiveness to our consultants' on-site recommendations. It is particularly noteworthy that King County provided us with unfettered access to records and personnel, and responded to all of our requests in a transparent and forthcoming manner. We have every reason to believe that the County is committed to remedying all known deficiencies at KCCF.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at KCCF violate the constitutional rights of inmates. In particular, we find that inmates confined at KCCF are not adequately protected from harm, including physical harm and custodial sexual misconduct. In addition, we find that inmates are not adequately protected from self harm. Finally, we find that inmates do not receive adequate medical care.

I. BACKGROUND

KCCF serves King County, including inmates from the City of Seattle. The facility houses both pre-trial inmates and inmates serving sentences of up to one year. The facility opened in 1986 and has a capacity of 1,700. The average daily population for January 2007 was 1,368, with a high count of 1,443 and a low count of 1,298. KCCF is currently undergoing rolling renovations, with one floor closed at a time. Security functions at KCCF are administered by the King County Department of Adult and Juvenile Detention ("DAJD"). Health care services at KCCF are provided by Jail Health Services ("JHS"), a division of Public Health Seattle-King County, the County's public health department.

II. LEGAL STANDARDS

CRIPA gives the Attorney General authority to seek injunctive relief when a jurisdiction violates the constitutional rights of inmates. See 42 U.S.C. § 1997; U.S. Const. amend. VIII, XIV. In defining the scope of jail inmates' Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell v. Wolfish, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment); Hydrick v. Hunter, - F.3d -, 2007 WL 2445998 (9th Cir. 2007) (stating right to reasonably safe conditions clearly established for prisoners and civilly committed persons); Hoptowit v. Ray, 682 F.2d 1237, 1250 (9th Cir. 1982). Providing "humane conditions" requires that a corrections system must satisfy inmates' basic needs, such as their need for safety, medical care, food, clothing, and shelter. Id. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse and the use of excessive force. See Hydrick, 2007 WL 2445998, at *15; Hoptowit, 682 F.2d at 1250.

The duty to protect inmates from physical abuse includes protecting inmates from custodial sexual abuse. Schwenk v. Hartford, 204 F.3d 1187, 1197-98 (9th Cir. 2000) (the Eighth Amendment right of prisoners to be free from sexual abuse has been unquestionably and clearly established.). "'Rape, coerced sodomy, unsolicited touching of women prisoners' vaginas, breasts and buttocks by prison employees are simply not part of the penalty that criminal offenders pay for their offenses against society.'" Schwenk, 204 F.3d, at 1197, quoting Women Prisoners of the Dist. of Columbia Dept. of Corrections, 877 F. Supp. 634, 665 (D.D.C. 1994).

The federal courts have also held that the right to "humane conditions" includes a right to adequate medical care. Hoptowit at 1255 (citing Estelle v. Gamble, 429 U.S. 97, 104 (1976) (quoting Gregg v. Georgia, 428 U.S. 153, 182-83 (1976))). Under the Supreme Court's standard for relief, a jurisdiction fails to meet constitutional requirements if local officials exhibit "deliberate indifference" to inmates' serious medical needs. The standard for relief has three components: (1) subjective knowledge of the risk of serious harm; (2) disregard of that risk; and (3) conduct that is more than mere negligence. Farmer, 511 U.S. at 834. The Supreme Court has said that "prison officials show deliberate indifference to serious medical needs if prisoners are unable to make their medical problems known to

the medical staff." Estelle, 429 U.S. at 103-04. The Ninth Circuit has stated that deliberate indifference may appear "when prison officials deny, delay, or intentionally interfere with medical treatment, or it may be shown by the way in which prison physicians provide medical care. Jett v. Penner, 439 F.3d 1091, 1096 (9th Cir. 2006). Moreover, the Ninth Circuit has explained that the "medical staff must be competent to deal with prisoners' problems." Gibson v. County of Washoe, 290 F.3d 1175, 1187 (9th Cir. 2002), (quoting Hoptowit, 682 F.2d at 1252-55) (internal quotation marks omitted). The prison must provide "adequate facilities and staff to handle emergencies within the prison." Id.

Corrections officials may be constitutionally liable when they "know or should know of a particular vulnerability [of an inmate]," such as an inmate in severe emotional distress, and fail to protect the inmate from that vulnerability. Redman v. County of San Diego, 942 F.2d 1435, 1443 (9th Cir. 1991) (citing Colburn v. Upper Darby Township, 838 F.2d 663, 669 (9th Cir. 1988)). The prison must provide "adequate facilities and staff to handle emergencies within the prison." Hoptowit, 682 F.2d at 1252-55. Further, these requirements apply to mental health care. Id. Delay in providing hospitalization to a prisoner in need of immediate psychiatric care constitutes deliberate indifference. Gibson v. County of Washoe, Nev., 290 F.3d 1175, 1190-91 (9th Cir. 2002), cert. denied, 537 U.S. 1106. Finally, prison officials have an obligation to act when there is a strong likelihood that an inmate will engage in self-injurious behavior, including suicide. See Funtanilla v. Rubles, 5 Fed. Appx. 590 (9th Cir. 2001).

III. FINDINGS

We find that KCCF fails to adequately protect inmates from harm and serious risk of harm by staff, fails to adequately protect inmates from self harm, and fails to provide inmates with adequate medical care.

A. INADEQUATE PROTECTION FROM HARM

Corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Providing "humane conditions" requires that a corrections system must satisfy inmates' basic needs, such as their need for safety. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse.

To ensure reasonably safe conditions, officials must take measures to prevent the use of unnecessary and inappropriate force by staff. In addition, officials must provide adequate systems to investigate staff misconduct, including alleged physical and sexual abuse of inmates. For the reasons set forth below, KCCF fails in both these regards.

1. Unnecessary and Inappropriate Uses of Force

A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Generally accepted corrections practices provide that appropriate uses of force in a given circumstance should include a continuum of interventions, and the amount of force used should not be disproportionate to the threat posed by the inmate. Lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

Inmates at KCCF are routinely subjected to unnecessary uses of serious force. Staff at KCCF are quick to resort to serious physical force or pepper spray, even when the inmate is passive or poses no immediate security threat. In addition, inmates are pepper sprayed often, despite being confined in mechanical restraints, making the use of pepper spray unnecessary. Also, staff use pepper spray on inmates even when several staff are present and could gain control of the inmate using far less severe methods. Further, there is little evidence that staff employ a continuum of interventions when faced with a resistant inmate.

We also found the frequent and routine use of a technique known as the "hair-hold technique." Specifically, the hair-hold technique, involves grabbing and pulling the inmate's hair in order to direct the inmate's movement, or otherwise obtain compliance. According to our corrections consultant, the hair-hold technique is a highly painful and degrading technique that carries a high risk of injury when compared to equally effective control techniques commonly taught in self-defense training courses at correctional academies. It is an especially dangerous tactic when utilized as a takedown technique on a

The following examples of unnecessary and inappropriate uses of force are taken from KCCF's incident reports:

- On January 23, 2007, a restrained female inmate in the Intake Release Unit ("ITR") was "angry and uncooperative as soon as she arrived at the facility." Staff used hair-hold and counter joint techniques "to restrain her against the counter" although nothing in the use of force report provided justification for use of the hair-hold technique. Thereafter, staff applied pepper spray on the inmate while she was in a fetal position and posing no threat to the staff. Accordingly, the use of force in this incident was both excessive and unnecessary.
- On January 10, 2007, a female inmate in the ITR was being "verbally abusive," threw her clothes on the floor, and then picked them up and threw them at staff. Staff grabbed her by the hair and "spun" her to the floor, at which time the inmate sustained a head injury (bleeding ear). The hair-hold technique was excessive and disproportionate to the nature of the threat posed by the inmate.
- On October 16, 2006, a female inmate in the ITR who was to be housed on the psychiatric floor for suicidal statements refused to "pick up her underwear and put them in a bag." Security staff applied a hair-hold on the inmate in order to gain compliance. The hair-hold technique was an extreme and unnecessary use of force given the nature of the inmate misconduct.
- On September 11, 2006, a female inmate showing signs of mental distress was being escorted to the mental health unit on the seventh floor. She was placed in a wheelchair with both waist and leg restraints. As she was wheeled from the elevator to seven North, she "continued to yell, scream, and tried to stand up out of the wheelchair." Staff used hair-holds "to keep her in her wheelchair until [they] got to seven North." The use of the hair-hold technique against an inmate in arm and leg mechanical restraints is inexplicable.
- On September 9, 2006, an inmate who is developmentally disabled was observed having a seizure on the seventh floor. When staff arrived, the inmate appeared "disoriented." He was moved to a cell for psychiatric care. The inmate was in an "agitated" state when he was subjected to pepper foam, which had "little or no effect." He was then re-handcuffed

with a hobble cord. There is no explanation for why pepper spray was justified against a disabled inmate who was in medical and mental distress.

Effective measures to prevent excessive and inappropriate uses of force include adequate staff training, and adequate use of force policies and procedures. KCCF fails to provide adequate use of force training for staff and relies upon inadequate and outdated policies and procedures.

a. Inadequate Staff Training

Comprehensive annual staff training in appropriate use of force techniques is an essential element of a jail's required in-service training. However, training personnel at KCCF conceded that there is currently no in-service training of staff in use of defensive tactics. In addition, as described below, the remainder of the use of force curriculum is inadequate. This lack of training contributes to the prevalence of inappropriate uses of force at KCCF, and creates a significant danger of inmates being unnecessarily subjected to serious bodily harm and even death.

b. Inadequate Policies and Procedures

Adequate policies and procedures regarding proper use of force are essential to ensuring that inmates are not unnecessarily injured by security staff. The policies should be comprehensive and clear, and should reflect currently accepted practices. KCCF's policies and procedures are lacking on all three counts.

As of the time of our March 2007 corrections tour, KCCF was operating with outdated use of force policies and procedures. The basic policy is undated and contains numerous handwritten interlineations. Moreover, it includes unauthorized control tactics such as the choke hold and carotid sleeper hold; however, both of these control holds have handwritten annotations prohibiting their use. The policy is devoid of guidance on the use of chemical agents such as pepper spray, which is routinely used by security staff at the facility. The policy contains no guidance on the use of non-lethal weaponry on restrained inmates. Further, the policy contains no guidance or reference to a continuum of force or interventions.

We were provided with a copy of a single-page chart entitled "Use of Force Continuum" that simply lists response tactics equated with resistance levels. The continuum contains responses

that are either no longer authorized or may be unlawful. In a stark departure from generally accepted corrections practice, the continuum authorizes "lethal force" as a response to "active aggravated aggressive" but fails to define "active aggravated aggressive." This lack of definition causes a serious danger that lethal force may be used without adequate justification. Moreover, we reviewed a document that classified two incidents as an "aggravated aggressive," where neither of the presented circumstances would have justified the use of lethal force.

2. Inadequate Systems to Investigate Staff Misconduct (Physical and Sexual Abuse)

The number and nature of allegations involving custodial sexual misconduct at KCCF are generating an abnormally high number of Internal Investigations Unit ("IIU") investigations. A review of IIU's report on "Internal Investigations 2006-Current" indicates in excess of twenty-five investigations related to allegations of staff misconduct of a sexual nature. A number of these investigations remain open, while others have been closed with "undetermined" or "non-sustained" findings and "no discipline due to timeliness." However, sustained investigations or incidents resulting in suspensions, terminations, and criminal charges since at least 2002 reflect a pattern of sex-related staff misconduct by an alarming number of security staff.²

To ensure reasonably safe conditions for inmates, correctional facilities must develop and maintain adequate systems to investigate staff misconduct, including alleged physical and sexual abuse by staff. Essential elements of an internal investigation system includes a comprehensive investigation procedures manual, and adequately trained investigators to implement the investigations process. KCCF is lacking in both of these essential elements.

a. Lack of Investigative Policies and Procedures

Generally accepted correctional practices require clear and comprehensive policies and procedures governing the investigation of staff use of force and misconduct. Adequate policies and procedures include, at a minimum, screening of all use of force

² Three former KCCF staff have recently been convicted of crimes relating to custodial sexual misconduct, including Harland Richmond (second-degree sexual misconduct), Cedric McGrew (second-degree custodial sexual misconduct and third-degree assault), and Louis G. Laurencio (custodial sexual misconduct).

incident reports, specific criteria for initiating investigations based upon the incident report screening, specific criteria for initiating investigations based upon allegations from any source, timelines for the completion of internal investigations, and an organized structure and format for recording and maintaining information in the investigatory file.

As of the time of our March 2007 corrections tour, KCCF had no policy for conducting investigations. The IIU is guided by a regulation of the General Policy Manual, Section 3.01.000. This regulation provides only that the IIU "establish methods and procedures to investigate complaints." However, there was no formal investigatory methods and procedures manual.

b. Lack of Training in Investigatory Techniques and Procedures

Adequate internal investigation systems require investigators to receive appropriate training in investigatory processes, techniques, and procedures. While we found the IIU staff to be committed and professional, we determined that the IIU leadership and staff lacked any formalized training requirement or process. For example, the IIU commander has substantial experience as a correctional administrator, but lacks any prior experience, expertise, or training in managing and conducting internal correctional investigations. Similarly, the IIU sergeants are not required to complete formal investigative training prior to or during their assignment to the unit.

* * *

As a result of these failures, there are serious operational deficiencies in KCCF's internal investigations. Investigations are inadequate, poorly documented, and often disorganized. For example:

- Case Number 0605-018 - Reported Sexual Assault

The IIU case file indicates that a female inmate purportedly submitted a four-page grievance to staff alleging that she was sexually assaulted on October 26, 2005. The inmate also supplemented the grievance the following day. IIU staff could not locate either the grievance or the supplement, and closed the case as non-sustained. There is no evidence that staff conducted appropriate follow-up or contacted the inmate to discuss her complaint.

- Case Number 0612-008 - Sexually Explicit Behavior

A KCCF captain was accused of engaging in sexually explicit behavior while on the job in the presence of another captain and a female sergeant. The captain has acknowledged that he did indeed simulate a sexual gesture in the presence of the two staff. This same captain, on three prior occasions, between January 2005 and October 2006, has been counseled for inappropriate workplace behavior. He was promoted to captain in June 2006 after having been assigned as an IIU investigator from approximately 2003 through January 2006. It is noteworthy that this commander/supervisor, who himself was recently in charge of conducting investigations of staff sexual misconduct, has been allowed to develop a chronic record of workplace misconduct while being promoted to positions of greater authority at KCCF.

- Case Number 0610-015 - Excessive Use of Force

On September 23, 2006 a nurse in the ITR believed she had witnessed excessive force when she observed staff "slamming [an] inmate's head on the counter, holding the inmate on the floor with his knee/foot, and yelling at the inmate." She further alleged that the staff's supervisor took no action to intervene in the incident. The nurse contacted the ITR shift commander to report the incident. The commander advised her to report the matter to the ITR sergeant, who was the very supervisor the nurse had claimed failed to intervene in the incident. The shift commander, in a memo entitled "Preliminary Investigation," in effect exonerated both the sergeant and staff based on his general discussion, rife with his personal opinions, of the difficulty in dealing with inmates during the intake process. The memo did not in any fashion address the actual substantive evidence related to the incident notwithstanding that the staff acknowledged in his report, among other things, that during the use of force incident, he held the inmate by the ear and told him he was going to "rip his ear off." The IIU investigator entered a finding of "non-sustained," notwithstanding the nurse's initial detailed observations of the incident. The investigator did note that a letter of corrective counseling "may be in order" for the staff's threatening remark. However, there was no record of the staff having received any form of disciplinary action.

- Case Number 0612-005 - Unnecessary Use of Force

An inmate, handcuffed behind his back, was under escort by two staff when a verbal exchange occurred regarding escort procedures. The inmate was returned to his cell and was asked to get on his knees for the handcuffs to be removed. He refused and was taken to the floor. While the inmate was handcuffed and on the floor, staff administered two applications of pepper spray because he was "refusing to cooperate." According to a grievance filed by the inmate, he was "slammed" to the ground while handcuffed, hitting his head on the "metal side of [his] bed." He was then subjected to pepper spray while another staff member held him by the neck. The investigation concluded that the allegation of unnecessary force was "unfounded." Nothing in the case file indicated an assessment of why it was necessary to utilize the chemical agent on a handcuffed inmate who had been taken to the ground with no fewer than four staff present. In addition, there is no indication that the involved staff were recommended for remedial or corrective training in escort procedures and available options.

In addition, some incidents that merit an investigation are never investigated. Our review of a sample of incident reports revealed that none of the following incidents were investigated by IIU or even questioned by supervisors:

- On January 22, 2007, a handcuffed inmate was not cooperative during an escort. The inmate was "placed" against the wall and then taken to the floor, at which time security staff applied pepper spray. Staff then placed his head under the bunk, ostensibly "to facilitate a safer way to take the handcuffs off." The inmate sustained a nose injury, a swollen cheek, and an eye laceration that required hospitalization for sutures. The number and nature of the injuries sustained by a handcuffed inmate clearly merited some level of investigative inquiry.
- On January 1, 2007, an intoxicated inmate was being moved from a holding cell in the ITR when he "raised a sandal in the direction of staff." He was restrained and "pinned" against the cell wall. Pepper spray was utilized with "little effect." The inmate was then handcuffed by utilizing "wrist locks and hair-holds." While on the floor in handcuffs, another burst of pepper spray was administered. The inmate sustained multiple head contusions, including an injury to his eye. In reviewing

the matter, a supervisor commented that staff were unaware of how the injuries occurred because they "were focused on getting him processed into clean clothing and did not notice the facial contusions." Unexplained multiple head injuries and the use of a chemical agent on a fully restrained inmate in the control and presence of a supervisor with no less than five staff present, merits some level of investigative inquiry.

- An inmate alleged that, on November 7, 2006 in the ITR, security staff placed his boot on the head and neck of the inmate. Nursing staff "noted some swelling to the left side of the face and contusions to the back of the head." The incident report failed to explain the injuries. This incident came to the attention of a supervisor only when nursing staff notified a sergeant of the allegations and injuries. Indeed, contrary to generally accepted practices, the security staff did not promptly report the use of force, but instead provided a report two days after nursing staff notified the supervisor.

B. INADEQUATE PROTECTION FROM SELF HARM

Corrections officials have the obligation to protect vulnerable inmates from harm, such as those who are at risk of suicide. Three inmates committed suicide in the past three years under circumstances that indicate that KCCF fails to take reasonable measures to prevent and manage these risks. An adequate suicide prevention program requires that all staff be adequately trained and be active participants in executing a comprehensive plan.

1. Lack of Training in Suicide Prevention Measures

Correctional facilities must provide adequate suicide prevention training to staff to ensure the safety of all inmates. Pre-service and annual in-service training requirements should be clearly set forth in the relevant policy and should include an array of topics to ensure that staff are able to recognize the verbal and behavioral signs that indicate a suicide risk, what to do when such a risk is suspected, and how to respond when there is a suicide attempt. Successful suicide prevention is a collaborative process among all staff; however, training is particularly critical for security staff because they are often the only staff available 24 hours per day and have regular contact with inmates. Because KCCF policy fails to specify

adequate suicide prevention training requirements, and the facility fails to provide adequate hours of training, suicide prevention training at KCCF falls far below generally accepted correctional practices.

First, pre-service and in-service training requirements are not clearly set forth in DAJD or JHS policies. For example, during our March 2007 suicide prevention tour, DAJD Policy 7.02.006 (Suicide Prevention and Psychiatric Procedures) required only that "all staff that have regular contact with inmates shall be trained in the identification and management of suicidal inmates . . . officers receive on-line training each year related to suicide prevention." JHS Policy (Suicide Prevention Program) requires "training for staff members who work with inmates." These statements are too general to be useful. For example, they do not state how many hours of pre-service and in-service training staff are required to complete.

Second, KCCF does not provide significant training hours, and the training that is provided is cursory at best. Specifically, training for new staff is limited to three hours during a four-week training program provided at the Washington State Training Academy, and only one hour completed during the 11-day New Employee Training Program provided by KCCF. As for existing staff, training on suicide prevention is even more limited, consisting of a one-hour computer course of 25 PowerPoint slides and a rudimentary true/false test of ten questions. The course refers to DAJD's suicide prevention policy, but merely advises employees to review it. Monthly workshops offered by JHS have included topics concerning suicide; however the workshops are only offered to security staff assigned to the mental health housing units and participation is not required by policy.

Four hours of suicide prevention training for new staff and one hour of annual training for existing staff are grossly inadequate. Moreover, the one-hour computer course observed by our consultant does not ensure that staff are adequately trained on this critical topic. Suicide prevention is a collaborative process. If all staff are not adequately trained on how to prevent and manage suicides, they will be unable to identify the risks and respond appropriately.

2. Lack of Adequate Supervision of Suicidal Inmates

Correctional facilities must protect inmates from suicide by providing adequate supervision. When an inmate attempts suicide, his or her life depends on the time it takes for staff to learn

of the event and respond to it. The promptness of staff's response to a suicide attempt is often driven by the level of supervision.

KCCF inmates who have been identified as suicidal and who are placed on suicide precautions are purportedly observed every fifteen minutes. However, in addition to the 15-minute observation usually performed by security staff, suicidal inmates must also be assessed daily by a mental health professional. Currently, KCCF mental health staff only assess inmates once per week, which falls far short of generally accepted correctional practices. Moreover, each assessment is only five to ten minutes in length. This is not adequate time to evaluate the inmate's status to properly determine whether he or she should remain on suicide precautions. Thus, mental health staff may overlook an inmate whose status is in rapid decline. On the other hand, it is also critical for mental health staff to identify those inmates who are no longer in need of being on suicide precautions because the restrictive environment can quickly become anti-therapeutic. Five to ten minutes, once per week, is not adequate to make this determination.

C. INADEQUATE MEDICAL CARE

Jail officials are responsible for providing adequate medical care to inmates. Moreover, a jail may not deny or intentionally interfere with medical treatment. A delay in providing medical treatment may be so significant that it amounts to a denial of treatment. Our investigation revealed that medical care provided at KCCF falls below the constitutionally required standards of care. We found the following serious deficiencies: (1) inadequate assessment of acute conditions; (2) inadequate treatment of chronic conditions; (3) inadequate emergency care; (4) inadequate medication management; (5) inadequate prevention and treatment of communicable diseases, particularly skin infections and MRSA; and (6) inadequate intake screening.

1. Inadequate Assessment of Acute Conditions

Jail officials are required to adequately assess inmates so that jail officials can provide appropriate and timely treatment. KCCF fails to provide adequate assessments, which has resulted in serious delays in treatment for inmates who require urgent medical attention. Delays, and outright denials, can cause unnecessary pain, suffering, and morbidity in inmates, and can contribute to the unnecessary transmission of illness.

The most egregious example of KCCF's systematic failure to adequately assess and treat inmates -- and the grave harm that can result -- is a recent inmate death, which we found was likely preventable. The inmate had a history of alcohol withdrawal seizures and active skin infection on his legs and buttocks. The day he was admitted to the jail, he was sent to the emergency room at Harborview Medical Center. There, he was diagnosed with multiple abscesses, profound anemia and either cellulitis (a potentially serious bacterial infection) or deep vein thrombosis. Although the hospital arguably should have admitted him, it did not do so. Upon his return to KCCF, the inmate was not seen by a physician, even though he should have been. Instead, he was forced to wait more than 30 hours to receive his first dose of the antibiotic that had been prescribed for his skin infection. When the inmate requested care and was finally examined by a KCCF physician, he had a tender abdomen with questionable bowel sounds, highly abnormal and unstable vital signs, and a very low oxygen saturation. Even after observing this, the KCCF physician failed to send the inmate back to the hospital. Early in the morning on his third day back at KCCF, the inmate developed severe abdominal pain, was sweating and doubled over, and had a tender abdomen. Nonetheless, he was forced to wait for seven hours before he was examined by a physician, who ultimately sent him to the hospital. The inmate died at the hospital, apparently of a perforated gastric ulcer. KCCF's inadequate diagnosis and inordinate delays in providing treatment likely contributed to this inmate's death.

Under KCCF's current health care system, inmates who request or present for medical attention are prioritized by using the designations P1 through P4. These priority designations are designed to represent a need for follow-up care within one day, three days, one week, and four weeks, respectively. Due to perceived staffing and resource shortages, however, KCCF's current practice is to deny follow-up scheduling and treatment to any inmate classified as P3 or P4. Instead, inmates classified as P3 or P4 are expected to re-request medical care if their conditions do not improve in one or three weeks, respectively.³ As we explained in our August 8, 2007 emergency letter regarding an inmate whom we encountered during our August tour, we found that misclassification of inmates as a P3 or P4 has had

³ Medical staff routinely do not record P3 or P4 designations because inmates classified as such are not being seen. Accordingly, an unknown and undocumented number of additional inmates have informally been determined to fall under this category.

life-threatening consequences. Specifically, one day prior to our tour, the inmate presented to a KCCF physician with shortness of breath and a lump in his neck. The physician classified him as P3 and sent him back to general population without orders for referral or any follow-up. However, a physical exam by our consultants revealed that the inmate required urgent evaluation at an acute care hospital to rule out the risk of sudden death from obstruction of his trachea. The physician's failure to adequately assess the inmate falls far below generally accepted standards of correctional health care and placed the inmate's life in jeopardy.⁴

In reviewing the medical records of seven inmates who had been classified as P3 or P4, we found that six had been misclassified. The following inmates required prompt medical attention and should have been designated as P1 or P2 so that they would receive follow-up care accordingly:

- An inmate with a skin infection had been treated with three failed courses of antibiotics and never received a wound culture.
- An inmate on medications for a pituitary tumor had no evaluation, medication, or lab tests.
- An inmate had bladder symptoms related either to a sexually transmitted infection or acute prostate disease who should have had an evaluation and treatment but did not receive them.
- An inmate had a sustained tachycardia (elevated heart rate) for four days. Notably, this inmate had seen nursing staff, who did not provide for immediate access to a physician. By the time a physician finally examined the inmate, the inmate's medical problems had exacerbated significantly, and he was complaining of serious urinary symptoms. Rather than working him up to finding a diagnosis, the physician coded the inmate for no further follow-up. These symptoms could indicate a potentially life-threatening condition, such as alcohol withdrawal or shock, and should not have been ignored.

⁴ By letter dated August 10, 2007, the County responded to our emergency letter and stated that it was "taking immediate steps" to address the deficiencies we identified.

2. Inadequate Treatment of Chronic Conditions

KCCF fails to provide adequate treatment to inmates with chronic conditions or diseases that require monitoring and follow-up medical care. This failure places inmates who are already physically and/or mentally ill at risk of even greater suffering and harm.

Specifically, in examining a sampling of medical records of inmates who have chronic conditions and/or are on certain medications, we found the following serious deficiencies:

- We reviewed the records of 20 inmates who were on lithium, Dilantin, or valproic acid. (The first is commonly used in the treatment of bipolar disorder and the latter two are anti-seizure medications.) These three medications have very narrow therapeutic indexes; if an inmate is given too little, the medication will be ineffective, but if the inmate is given too much, he or she will experience substantial detrimental effects. It is absolutely critical that patients' blood levels are monitored to ensure that there are appropriate levels of the medication. Accordingly, laboratory measurement of the levels of these medications in a patient's blood is a nationally accepted standard of care. Only six of the twenty inmates whose records we reviewed had their levels checked and documented in the record. Some of the records contained no orders for such checks, and others contained orders that nurses had failed to pick up.
- Similarly, we reviewed the records of the six inmates at the facility who are on coumadin, a blood-thinner prescribed for those at high risk for a blood clot and for some heart conditions. Like the medications discussed above, coumadin has a very narrow therapeutic index. Accordingly, frequent measurement of the blood-clotting ability of inmates taking it is critical. We found that one of the inmates on coumadin was not being monitored appropriately, putting him at risk for a potentially life-threatening blood clot or a hemorrhage.
- We reviewed the records of nine inmates on antipsychotic medications. Inmates on antipsychotic medications should have documented screening for abnormal involuntary movements and for metabolic syndrome, a forerunner to diabetes. Not one of the files contained documentation indicating that the inmates had been screened for either of these potentially dangerous side effects.

- In reviewing the records of nine diabetic inmates who had been at KCCF for more than a month, we looked for seven nationally accepted interventions.⁵ There is substantial evidence that selective interventions with diabetics will prevent organ failure such as blindness, stroke, heart disease, kidney disease, and peripheral vascular disease. Review of the inmates' files revealed that KCCF does not adequately monitor these inmates through chronic care visits or consistently screen them for the conditions that they are at risk of developing.⁶
- We reviewed the treatment of 14 inmates with moderate or severe asthma, as determined by their medications. Chronic follow-up care and regular monitoring of peak expiratory flow (a test that measures how well the airways are working) are critical in the proper care of asthmatics. Only five had been seen for chronic care within the past three months and only three had any measurement of their peak expiratory flow.

3. Inadequate Emergency Care

KCCF fails to provide adequate emergency care to inmates, putting them at risk of grave harm. We observed a life-threatening example of this during our first tour, when we encountered a female inmate who was known by KCCF staff to be depressed and suicidal. While we were on her housing unit, the inmate swallowed multiple medications. Disturbingly, despite the unfolding emergency, security staff did not call for medical help for a crucial eight minutes after the inmate had swallowed the medications. A nurse did not arrive at the housing unit with the crash cart for a total of 15 minutes after the incident. And, it took a total of 25 minutes for EMS to arrive. Further compounding this situation, this suicidal inmate did not speak

⁵ These interventions are: measurement of sugar levels upon intake, measurement of urinary microalbumin, dilated examination of the retina, cholesterol measurement, measurement of Alc hemoglobin, chronic care visit with physician, and aspirin therapy.

⁶ For example, not one of the inmates had had a measurement of his or her urinary microalbumin or a dilated examination of the retina. Only one had had a cholesterol measurement, only two had had their Alc hemoglobin measured, only three had had a chronic care visit at all, and only four were on aspirin.

English. The mental health staff who prescribed medication for her had done so without the use of a translator, even though one was reportedly available by telephone.⁷

In observing this incident, we learned of some unwritten "policies" that, according to security staff, must be followed before a medical nurse may respond to an emergency call. First, a psychiatric nurse must evaluate the inmate, even if the inmate is experiencing clearly life-threatening physical symptoms, like crushing chest pain or hemorrhaging. Second, the page system must be used, even if it would be much faster to summon the nurse from an adjacent medical office or housing unit. These "policies" favor process over provision of critical care of inmates whose lives are at risk.

Moreover, although correctional facilities typically keep logs of inmates they send to hospital emergency rooms, KCCF lacks such logs, making it difficult to ascertain the full extent of the KCCF's deficiencies in this area. We were able to review care for 11 inmates who were sent to the emergency room, however, and found that one of them was forced to wait two days to see KCCF's in-house physician for an infection before finally receiving treatment in the emergency room. This inmate's trip to the emergency room may have been prevented altogether if KCCF had provided the inmate with timely care.

4. Inadequate Medication Administration and Management

We found numerous systematic problems with medication administration and management. KCCF places inmates at risk of grave harm through significant delays and lapses in providing critical medications to inmates and the practice of giving nurses "standing orders" to administer antibiotics for skin infections.

First, orders for diagnostic tests and medications are picked up by nursing staff on an inconsistent basis. The failure to perform this important task regularly results in significant delays and lapses in providing critical medications to inmates. For example:

- An HIV-positive inmate who had an abscess was forced to wait 26 days for his first dose of antibiotics and medications for HIV.

⁷ Since our first tour, DAJD and JHS staff have made increasing use of telephonic translation services.

- An inmate was admitted to the jail on linezolid, a medication for drug-resistant staph skin infections. Once at KCCF, he received only one of his six prescribed doses, putting him at risk of a more serious infection and further drug resistance.
- An inmate had a persistent skin infection because of a ten-day lag between the day he was prescribed an antibiotic and the day he received his first dose.
- An inmate who arrived at intake with infectious skin lesions did not get the necessary antibiotic treatment until his fourth day at KCCF, by which time he had developed cellulitis. (Cellulitis is potentially serious bacterial infection, which left untreated, may turn into a life-threatening condition.)

Moreover, KCCF nurses have standing orders to administer antibiotics to inmates with skin infections. Standing orders for prescription drugs are beyond the scope of nurses' licenses. The only acceptable standing orders are for over-the-counter medications, vaccines, standard treatment for sexually-transmitted infections, and emergency medications. KCCF's standing orders for antibiotics puts inmates at risk of harm.

5. Inadequate Prevention and Treatment of Communicable Diseases

Prevention and treatment of communicable diseases is particularly critical in places where individuals live in confined quarters, such as jails. Skin infections among inmates, including methicillin-resistant staphylococcus aureus ("MRSA"), a potentially dangerous drug-resistant bacteria that can cause serious systemic illness, permanent disfigurement, and death, is rising across the United States. Transmission among inmates and staff can be prevented through attention to laundry and personal hygiene, as well as environmental cleaning. We found serious deficiencies in these critical areas at KCCF. Moreover, we found that KCCF fails to provide adequate treatment for inmates with skin infections, which places the infected inmate, other inmates, and staff, all at risk of harm.

To prevent the transmission of infection, jails must ensure that inmates are able to maintain proper hygiene and that inmates' living quarters are kept reasonably clean. Laundry is also an important component. Inmates should have access to clean underwear and regular changes of uniform. KCCF, however, fails

to launder inmates' underwear at all, thereby increasing the risk of infection transmission. Inmates informed us that the only way to obtain clean underwear is to purchase it from the commissary or to wash it themselves in the cell area using their hand/shower soap. Inmates further informed us that even when they do wash their own underwear, they are prohibited from hanging it to dry in the cell area.⁸ Moreover, the jail provides only one uniform per week. These deficiencies greatly increase the risk of intramural transmission of skin infections.

Surface disinfection is also critical to the prevention of skin infections. We learned that, while most of the cracked mattresses we found on our first tour had been replaced, and the mattresses used in the jail are cleaned with quaternary ammonium disinfectant, this disinfectant is not being used properly. Quaternary ammonium disinfectant should have ten minutes of contact time with a mattress surface before it is wiped dry. Currently, the disinfectant is being wiped dry nearly immediately after it is sprayed, which likely makes it ineffective at killing bacteria and viruses.

Moreover, KCCF fails to provide adequate treatment to inmates with skin infections. Not only does inadequate treatment place the inmate at risk of harm, but it also increases the risk of transmission to other inmates and staff.⁹ For example, prior to our investigation, in January 2004, a 40-year-old inmate who had been held at the Jail for about 20 days died from a combination of flesh-eating disease and MRSA, which was linked to chronic injection drug abuse. The inmate's wound purportedly had spread to 10 inches and was leaking fluid for two days before he received medical attention.¹⁰ Staff have expressed concern over

⁸ We certainly appreciate that this restriction is likely intended to ensure line of sight for security and to minimize fire risk.

⁹ According to a King 5 News investigative report, staff have reportedly contracted MRSA at KCCF and passed the infection on to family members. Additionally, seven staff have filed workers compensation claims involving MRSA, and have missed an aggregate of 530 days of work due to the illness. Investigators: Dangerous Infection Thriving at King County Jails, King 5 News, November 7, 2005.

¹⁰ Contagion in the Jail, Seattle Weekly, December 7, 2005.

transmission of communicable diseases to the media stating that the KCCF is understaffed, lacks an efficient medical record-keeping system, and puts inmates at risk unnecessarily.¹¹

During our tour, we reviewed the charts of nine inmates who were seen in sick call in June 2007. Of those nine inmates, four had skin infections, and all four experienced serious deficiencies in treatment, as follows:

- The most dangerous situation was that of an inmate who had been seen for his skin infection on five separate occasions. Each time, KCCF practitioners prescribed the same medication, and each time, the medication was ineffective. The inmate had developed cellulitis and an abscess, neither of which could improve until the abscess was drained.
- Another inmate with a skin infection was forced to wait three days to get medication and five days to see a nurse practitioner.
- The third inmate had to wait four days before receiving a prescription for his skin infection.
- For the fourth inmate, medication was ordered, but the order was never picked up by nursing staff. There was no indication that the inmate ever received the medication.

Our investigation also revealed that KCCF performs very few diagnostic cultures of skin infections. A culture, which is an examination of a sampling of cells taken from the affected area, may be done to identify the microorganism causing the skin infection and to determine the antibiotic or other treatment that will effectively treat it. KCCF reported that it performed only 13 to 21 diagnostic cultures per month for the six months prior to our second tour. KCCF was unable to produce laboratory records for recent months, so we were unable to quantify bacterial cultures actually performed.

Moreover, while KCCF tracks the incidence of skin infections in its surveillance log, this log apparently does not present the full state of skin infections at the jail. This is because the log is likely incomplete due to problems with intake screening, access (appointment backlogs and inadequate physician staffing), inadequate methods of tracking data (absence of emergency room utilization logs), poor medical records (notably, lack of charted

¹¹ Id.

wound culture results), and inadequate laboratory testing (few wound cultures). Thus, it was not possible for us to determine the full extent of the jail's problem with intramural transmission of skin infections.

6. Inadequate Intake Procedures

Adequate intake procedures are essential for ensuring that inmates are properly screened by staff who are trained to identify and triage serious medical needs. KCCF fails to adequately train and supervise intake staff, and exhibits serious lapses and delays in treatment during its intake process. These failures prevent inmates from receiving adequate treatment for acute or chronic medical needs, placing them at risk of serious harm. For example:

- We witnessed the processing of an inmate who had been stopped by a state trooper. The trooper told us the inmate was staring into space and had been arrested for driving under the influence. The inmate clearly had an altered state of consciousness, either from drugs or psychosis. Neither the intake officer nor the intake nurse recognized this altered state of consciousness. Only after our expert noted the inmate's condition to several staff members did the inmate receive appropriate monitoring and treatment.
- An inmate who had sustained a sexual assault and was suicidal on intake was seen by psychiatry, but KCCF made no attempt to determine whether she had a sexually transmitted infection or to conduct its own tests.
- We encountered a seriously ill inmate on the women's housing unit, whom the booking officer found had "no observed medical problems." Her medical intake was not completed because the nurse said the inmate was manic and could not be interviewed. Despite the knowledge that the inmate was mentally ill, neither the nurse nor anyone else called for any, much less the necessary immediate, psychiatric or medical evaluation. By the time we observed the inmate on the housing unit, it was evident that she was seriously ill. The inmate was shaking, vomiting, and showing signs of serious malnourishment.
- We witnessed an inmate who reported a history of bipolar disorder. She had been screaming and pounding her fists on the door for two hours in the intake area, yet she had not had a medical screen and no one called for a mental health evaluation.

- A sixty-year-old inmate arrived at the jail uncooperative and lethargic, with sutured head wounds, a stiff neck, and unequal pupils (possibly a sign of acute brain damage). He was not seen by a physician for 24 hours.
- KCCF failed to provide evaluation or treatment at intake to a hypertensive alcoholic who had abnormal vital signs consistent with alcohol withdrawal syndrome.
- KCCF also failed to evaluate and treat a woman with a history of suicide attempts and alcohol withdrawal seizures who had an abscess and cellulitis upon admission.

IV. REMEDIAL MEASURES

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

A. Protection from Harm

1. Develop and maintain comprehensive and contemporary policies and procedures regarding permissible use of force.
2. Ensure that staff receive adequate competency-based training in use of force and defensive tactics.
3. Develop and maintain comprehensive policies, procedures, and practices for the investigation of alleged staff misconduct.
4. Ensure that incident reports and inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, referred for investigation.
5. Ensure that IIU management and staff receive appropriate competency-based training in conducting investigations.

B. Suicide Prevention Measures

1. Ensure that the number of hours of pre-service and annual in-service suicide prevention training are adequate.

2. Provide a curriculum for pre-service and annual in-service competency-based suicide prevention training that includes an array of topics so that staff are adequately trained to identify and manage suicide.
3. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff who work directly with inmates have demonstrated competence in identifying and managing suicide.
4. Ensure that DAJD and JHS suicide prevention policies include an operational description of the requirements for both pre-service and annual in-service training.
5. Ensure that any staff who are exempt from suicide prevention training, i.e. "contract" JHS staff, have limited inmate contact and are prohibited from working in the ITR area.
6. Ensure that inmates on suicide precautions receive adequate mental status examinations by a mental health clinician.

C. Medical Care

1. Provide adequate and timely medical care for all inmates.
2. Provide adequate medical intake procedures.
3. Ensure that medical staff classify inmates properly and examines and treats inmates in a timely manner.
4. Ensure that inmates with chronic diseases receive adequate medical care, including appropriate monitoring and diagnostic testing.
5. Develop and implement a system to review emergency room visit and hospitalization logs to effectively monitor the care of ambulatory-sensitive conditions (e.g., preventable deaths, diabetic ketoacidosis).
6. Provide adequate competency-based training to security staff, medical care staff, and intake staff regarding responding to medical emergencies.
7. Ensure that mattresses are frequently and effectively sanitized.

8. Provide adequate and sanitary laundry services to inmates.
9. Develop and implement adequate clinical guidelines regarding skin infections.
10. Ensure that reliable data on the incidence of skin infections are maintained, and analyze this data to identify sources of intramural transmission.
11. Ensure that inmates with skin infections receive timely and appropriate wound cultures, case identification, treatment, wound care, and monitoring.
12. Ensure that inmates with persistent and recurrent skin infections are referred to a physician.
13. Ensure that inmates receive adequate and timely medication management.
14. Eliminate standing orders for nurses to administer antibiotics for skin infections.

* * *

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

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

We are obligated to advise you that, in the entirely unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a

lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

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

Sincerely,

/s/ Rena J. Comisac
Rena J. Comisac
Acting Assistant Attorney General

cc: Dan Satterberg
Interim King County Prosecuting Attorney

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Director
King County Department of Adult and Juvenile Detention

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The Honorable Jeffrey C. Sullivan
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