IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.,*	*	
Plaintiffs,	*	
v.	*	Civil Action No. ELH-94-2541
LARRY HOGAN, *et al.,*	*	
Defendants.	*	
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BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR REOPENING THIS CASE, RESTORING IT TO THE ACTIVE DOCKET, AND TEMPORARY RELIEF

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INTRODUCTION

For generations, the Baltimore City Detention Center[1] has repeatedly promised to provide conditions of confinement that conform to constitutional requirements. Yet for a half-century, the City, and subsequently the State, have continued to expose detainees and prisoners serving sentences at the jail to unreasonable risks that too often have resulted in serious harm, including death. Those unreasonable risks still exist, the promises of government officials are still unfulfilled, and only court intervention will put an end to the endless cycle of new promises followed by failure to honor those promises.

Under the PSA, the Plaintiffs have the right to file for reopening this case and restoring it

[1] Throughout this brief, the following abbreviations will be used: BCDC (the entire jail complex); MDC (the Men's Detention Center); WDC (the Women's Detention Center); BCBIC (the Baltimore City Booking and Intake Center); MTC (the Metropolitan Transition Center); IMHU (the Inmate Mental Health Unit, located within BCBIC); PSA (the Partial Settlement Agreement, including its subsequent amendments); MARS (medication administration records); and EMR (electronic medical record).

to the docket following notice to Defendants of violations of their agreement. Because Plaintiffs have not had the benefit of their bargain and Defendants have failed to implement substantial portions of the PSA, reopening of the case is warranted. *See* PSA at 23 ¶ 124, August 18, 2009 (Dkt. No. 374-2).[2]

The Statement of Facts and Proceedings demonstrates the extent to which Defendants have failed to comply with multiple provisions of the PSA. These failures include such simple and routine matters as the requirement for status reports on their compliance efforts. Defendants achieved this thorough failure despite having been given a significantly longer period to achieve compliance than was contemplated under the PSA. Such failures, however, pale in importance to one even more critical: Defendants after all these years have still failed to come into constitutional compliance, and continue to place all members of the Plaintiff class at excessive risk despite obvious notice to Defendants that their failures were of constitutional dimension.

The PSA contemplates the filing of this motion in the event that Defendants fail to comply with each of the provisions of the agreement as amended, following the filing of a notice of non-compliance. *See* PSA at 23 ¶124; *see also* Exh. 45 (Pls.' Notice of Non-Compliance, Oct. 22, 2014). Under the PSA, given that Plaintiffs filed a timely notice of non-compliance and have now filed a timely motion,[3] the sole specified ground on which Defendants are allowed to oppose reopening is that they are in fact in compliance with the PSA. *See* PSA ¶ 124. Accordingly, Plaintiffs will demonstrate below that Defendants are still not in compliance with the PSA as amended. Moreover, although a violation of law is not required by the PSA to

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[2] None of the subsequent amendments modify this section of the PSA.

[3] This filing is timely pursuant to the most recent amendment to the PSA. *See* Order, March 24, 2015 (Dkt. No. 508). Plaintiffs also filed a timely notice of non-compliance. *See* Certificate of Service, Oct. 22, 2014 (Dkt. No. 503).

support reopening, these failures of compliance are of constitutional dimension.

As Plaintiffs will demonstrate below, despite a half-century of litigation, and repeated promises by city and state officials, BCDC remains a dank and dangerous place, where detainees are confined in dirty cells infested with vermin. The showers are full of drain flies, black mold, and filth. Detainees with disabilities are assigned to cells and units that cannot meet their needs and they are often denied health care supplies, ranging from urinary bag and catheter changes to properly working wheelchairs, that are essential to preventing further damage to their health and also essential to human dignity. Detainees continue to be exposed to excessive levels of heat and humidity that threaten their health. Plaintiffs' expert found that about half of the mattresses that he examined were so damaged or compromised that they could no longer be sanitized between users, and BCDC still lacks a functional system to launder personal items for detainees. As a result, detainees continue to do personal laundry in sinks, mop buckets and other containers that allow the spread of disease. Despite the requirement that 700 beds in temperature-controlled housing be available to detainees at highest risk of heat injury, over the last summer an audit by Defendants of some of the H1 (highest risk) detainees in MDC found that 35 such detainees assigned to regular housing had urgent health care evaluations for complaints regarding exposure to excessive heat. In many cases, these detainees were experiencing symptoms such as shortness of breath and wheezing, and were treated by providing fluids and use of an inhaler or nebulizer.

Detainees with serious medical needs, including mental health needs are still routinely and predictably harmed by jail confinement. Among many other hazards, detainees still face an unreasonable risk of disruptions of their critical medications at the time of arrival at the Baltimore City Booking and Intake Center ("BCBIC") and during the transfer process to the Men' Detention Center and other facilities. These extended interruptions of medications include

insulin and HIV anti-retrovirals – medications in which even short-term interruptions can have life-threatening consequences. The system for providing mental health care still works by fits and starts; sick call slips raising mental health issues are routed through medical care, which builds delay into the referral process. The death records indicate major problems with the patients' health care, including failures to follow up on critical health care information and implement an appropriate plan of care.

BCDC also remains a violent place – an issue not addressed in the original Consent Decree – and an issue that management pervasively failed to address before that failure became a public scandal. Moreover, the root causes of these failures lie in more fundamental failures of public policy. The Baltimore Commissioner of Public Health described some of these root causes recently:

> Among Baltimore's population of 622,000, more than 73,000 arrests are made every year. The most common reason for arrest is a drug offense. Eight out of 10 people behind bars use illegal substances; four out of 10 have a diagnosed mental illness. Nearly 7,000 juveniles are arrested every year and 25 percent of all those in jail are younger than 25. While African Americans make up 62 percent of the population in Baltimore, they constitute 95 percent of juveniles arrested.

Lena S. Wen, "A Prescription for Baltimore's Health," *Washington Post*, May 24, 2015, available at http://www.washingtonpost.com/opinions/a-prescription-for-baltimores-health/2015/05/22/582cbb4c-fa83-11e4-9030-b4732caefe81_story.html.

Pervasive management failures also affect the ability of custody and treatment staff to implement the changes to which the State agreed in the PSA. Because of issues with custody staff, for example, routine x-rays for MDC detainees take twice the amount of time set by policy.

Ii is even more concerning that one of the deaths in the facility was caused by a security failure; the autopsy determined that the cause of death for Death Case 5 [redacted] long after admission to the jail, was methadone intoxication, despite the fact that he was not enrolled in the methadone program. *See* Exh. 30. Even Defendants have acknowledged the failures of staffing and management that have paralleled and reinforced the failures to maintain the physical structure and functions of the facilities:

> The problems of gang activity and corruption in the BCDC are aggravated by the deteriorating physical condition and obsolete design of the facility. The configuration of the building makes it difficult to directly supervise inmates and maintain the accountability of staff, as well as control movement through the facility. Security improvements are needed, but the age of the infrastructure requires significant expenditures just to maintain minimal functionality of plumbing and heating systems, building envelope and life safety systems.
>
> The Department recognizes the need to replace unsatisfactory facilities and that continuing to defer the projects [listed in the document] will . . . prolong the state's exposure to legal liabilities.
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> ***
>
> Continuing the replacement of antiquated institutions such as the BCDC is critical to the safety of the community, staff and inmates.

Exh. 61 (2013 Facilities Master Plan) at 1-8.

It must be remembered that the great majority of those confined in BCDC are awaiting trial, and so, under our Constitution, may not be punished. Moreover, even for those confined in the jail who have been convicted, the Constitution does not permit them to be punished by denial of medical or mental health care, or by subjecting them to conditions of confinement that are unreasonably dangerous or inconsistent with human dignity. Yet every minute spent in the jail is punishment; too often such confinement becomes life-threatening punishment, and routinely such

confinement involves conditions that bring shame to this City and State.

STATEMENT OF FACTS AND PROCEEDINGS

A. Procedural History

This case has a long history. Following a trial in this class action, consolidation with a separate class action, and various agreements between Plaintiffs and the City and State Defendants, the parties negotiated the current Consent Decree, which was approved by the Court on July 9, 1993. On October 9, 1997, Defendants filed a motion to terminate the relief granted by the Consent Decree, pursuant to the provisions of the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626(b). Plaintiffs opposed that motion, and subsequently, by consent, the Court administratively closed the case, subject to reopening by a party. In 2002, following a motion by Plaintiffs, the parties entered into a Consent Order approved by the Court that acknowledged a constitutional violation from the failure to protect detainees at the WDC and also acknowledged that the remedy specified in the Consent Order met the requirements for injunctive relief imposed by the PLRA. Consent Order, Aug. 23, 2002 (Dkt. 84).

The following year, Plaintiffs filed a second motion to reopen additional portions of the Consent Decree related to medical care and physical plant issues. Defendants thereafter filed a new motion to terminate relief under the PLRA. After full briefing, the submission of evidence, and oral argument, the Court granted the Plaintiffs' motion for partial reopening and denied Defendants' motion without prejudice. After Defendants filed a Notice of Appeal and following a remand from the Court of Appeals, the Court modified its order to hold the motion to terminate in abeyance.

Defendants ultimately did not pursue that motion but instead negotiated the initial version of the PSA. *See* PSA, Aug. 18, 2009 (Dkt. No. 374-2). In the original PSA, Defendants agreed

to resolve all issues dividing the parties with the exception of measures to reduce the risk of heat injury to detainees; they also agreed to provide Plaintiffs with periodic reports of their progress. The initial version of the PSA provided that, if Defendants failed to achieve compliance with its substantive agreements, Plaintiffs could file a motion to reopen the case within two years of the time of court approval. The PSA allows Defendants to oppose a reopening of the case, but only on the ground that Defendants had achieved compliance with its contested provisions. *See id.* at 23, ¶ 124. Following a Rule 23 hearing and a recommendation for approval by the Magistrate Judge, the Court approved the original PSA on April 6, 2010. (Dkt. No. 394). The parties subsequently filed an amendment to the PSA that resolved the issue of the necessary measures for failure to protect from heat injury, which the Court approved May 9, 2012 (Dkt. No. 465). Pursuant to that amendment, the time for Plaintiffs to file a motion to reopen was extended to June 30, 2013. Subsequently, as a result of continued failures of Defendants to file the monitoring reports required under the PSA, the parties stipulated to two more extensions of the PSA to June 3, 2015 that were approved by the Court. *See* Order, Apr. 10, 2014 (Dkt. No. 502); Order, March 24, 2015 (Dkt. No. 508). In accordance with the provisions of the amended PSA, Plaintiffs served a Notice of Non-Compliance with the PSA on October 23, 2014. *See* Exh. 45 (Pls.' Notice of Non-Compliance, Oct. 22, 2014). The Notice alleges substantial non-compliance with 32 medical provisions and 29 physical plant provisions of the PSA. Pursuant to the provisions of the PSA, the parties engaged in settlement discussions that were unsuccessful in resolving the issues separating the parties, and Plaintiffs have accordingly filed the instant motion.

B. <u>Failures to Comply with the PSA as Amended</u>

Plaintiffs set forth below the provisions of the PSA with which Defendants are not in

compliance, along with a description of the evidence that Plaintiffs will offer to prove these failures. Defendants have defaulted on their obligations, despite the more than five years since the original PSA was signed. Plaintiffs' medical evidence is based in large part, aside from admissions and class members' declarations, on the death cases from 2013 to date and 24 medical records (for Detainees 1 through 24). With one exception, the medical records for these 24 detainees were obtained pursuant to medical releases obtained by Plaintiffs' counsel after these detainees were randomly selected from lists of those prescribed antiretrovirals, insulin, or psychotropic medications, and from interviews with detainees housed in the unit that houses persons who use wheelchairs.[4]

These records produced abundant documentation of dangerous failures to deliver medical and mental health care. The death cases showed multiple failures that were frequently implicated in the fatal outcomes; the other medical records also showed a continuing pattern of health care that poses obvious dangers to detainees and has caused serious injuries, such as interruptions of prescriptions for insulin and HIV antiretrovirals; failures to respond to hypertensive crises; failures to attend to detainees' need for placement in disabilities-accessible housing; and the denial of necessary medical supplies. These latter failures not only produce serious medical risks, but in some of the disabilities cases has denied the detainees basic human dignity.

For example, the sample of 24 records included three patients receiving antiretrovirals for

[4] One additional medical record came from [redacted] Detainee 24, interviewed later after he contacted counsel. Of the 24 medical records, all four of those for women detainees were, when first received by Plaintiffs' counsel, apparently missing the EMR portion of the record. On February 26, 2014, Plaintiffs' counsel contacted Defendants regarding the missing portions, using the record of Detainee 23 [redacted] as an example. Defendants supplemented Detainee 23's record, but have not yet supplemented the other records. Despite the missing portions, Plaintiffs were able to use the medical records of Detainees 9 [redacted] and 12 [redacted] based on the documentation in the other portions of those records. Only one of the women's records was so fragmentary that Plaintiffs could not use it in this brief.

HIV infection and four patients with diabetes sufficiently serious to require the use of insulin. As will be discussed in more detail below, out of that group of seven, one patient prescribed antiretrovirals experienced an interruption of his medications during the intake process and a second experienced an even longer interruption a month after intake. Both of these patients had a history of an undetectable level of virus at the time of entrance and a normal level of CD4 cells, a measure of the health of their immune system. Following the interruptions in their medications, both had a detectable level of virus and their CD4 counts had fallen.[5] Two of the four patients with diabetes experienced an interruption of their insulin during intake; one of those had a blood test showing a dangerous level of glucose in his blood. Strikingly, every detainee with serious disabilities experienced failures to accommodate those disabilities in safe housing and to provide needed supplies. The failures of the medical care system are thus so frequent and pose such obvious dangers that even this small database demonstrates how far Defendants are from complying with the PSA's requirements designed to protect the lives and health of members of the class. Accordingly, Plaintiffs set forth below summaries of the most important of the PSA provisions that Defendants have violated along with summaries of their evidence of violation of these provisions:

Medical Provisions

§ 11. If reported medications are not continued at intake pursuant to a clinical

[5] An interruption of HIV medications has significant implications for the public health, as such interruptions promote the development of viral resistance to the medications. A meta-analysis of 16 studies of the effects of interruption of antiretroviral treatment reported the following: "Recently, the deleterious impact of interruptions greater than 48 h, with an average of 11 days, on the development of resistance was demonstrated, findings that are consistent with the results presented here." U.S. National Library of Medicine, Becky Gensburg et al., "Patterns of antiretroviral therapy adherence and impact on HIV RNA among patients in North America," available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3655551/.

judgment, staff must make efforts to get outside medical records within 24 hours (for HIV medications), 48 hours (for other weekday arrivals) or 72 hours (for arrivals on weekends or holidays, if the medical provider makes a determination it is safe to do so). Detainees who can describe their HIV medications will receive them promptly.

§ 12. If a medication interruption would pose a risk of adversely affecting health, that medication or its equivalent will be provided within 24 hours unless determined to be unnecessary after physical examination.

Plaintiffs' Evidence: Detainees continue to experience frequent problems with continuation of medications, including HIV medications, that they report at intake. [redacted] Detainee 18 came into BCBIC around July 10, 2014, reporting that he was prescribed antiretroviral medications, which he identified specifically. When he did not get his antiretrovirals, he reported that he had not received them, and on July 13 medical staff noted that he had a normal viral load and normal CD4 count. On July 15, he had his health assessment and staff noted recent laboratory reports with an undetectable viral load and a CD4 count of 1105. He received one of his antiretrovirals, Truvada, the following day. He reported that his HIV medications were taken from him during the admission process. A July 2014 MARS includes nursing notes indicating that on a total of five additional days between July 15 and July 23, he did not receive all his antiretrovirals because they were "not available." On September 2, he had a viral load of 92 and a CD4 count of 935. Exh. 18. His Celexa prescription to treat his psychiatric condition was also interrupted despite the fact that he was being held in the IMHU, the highest level psychiatric unit. *Id.* (Chart Update 7/15/14).

[redacted] Detainee 8 came into BCBIC no later than July 30, 2014, following treatment in a hospital. He is prescribed antiretrovirals for his HIV, and he also undergoes renal

dialysis and has very serious hypertension problems that require medications. Exh. 8. A note in the MARS for that month indicates that there was no delivery of his medications on July 31 because "unable to locate patient." The only day during the first week of August showing delivery of medications is August 4. This problem received no follow-up until August 6 when Detainee 8 had his intake evaluation and had sick call the same day. *Id.*

Death Case 8 [redacted] similarly did not receive any HIV retrovirals in the jail until a few days before his death, even though the records available to the jail staff showed that he was prescribed them in the community and that his CD4 count was so low that prescribing them was standard practice. Exh. 33. While antiretroviral treatment is recommended for all persons diagnosed with HIV infection, the urgency is greater for persons with low or rapidly falling counts.[6]

Death Case 2 ([redacted] had been confined in the jail in May of 2013. At that time he was prescribed Clonidine, Lisinopril and HCTZ for hypertension, and he was undergoing heroin withdrawal. The one blood pressure recorded from that stay is 178/108, a seriously abnormal reading.[7] He was medically screened again at the jail again on June 20, 2013, at which time he reported a prescription for Norvasc, another heart and blood pressure medication. The medical records do not show that he received that medication, that he saw any subsequent medical provider, or that he was monitored for drug withdrawal symptoms before he collapsed of

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[6] AIDS.gov, available at https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/cd4-count/. A normal CD4 count is above 500.

[7] *See* Sheldon G. Krebs, "High Blood Pressure," available at http://www.mayoclinic.org/diseases-conditions/high-blood-pressure/expert-answers/hypertensive-crisis/faq-20058491(defining a hypertensive crisis as a systolic blood pressure of 180 or more *or* a diastolic pressure of 120 or more).

on June 22, 2013. There is not even a single recorded blood pressure during his June confinement; the autopsy indicated that he died of hypertensive cardiovascular disease. Exh. 27.

Detainee 10, [redacted] who has Type 2 diabetes, had his initial screening on August 11, 2014 but the first insulin administration shown on the MARS is August 20. Exh. 10 (*see* Medical Record 9/20/14 stating that initial medical screening ("IMMS") was 8/11). Detainee 19's ([redacted] insulin prescription was changed to an older type of insulin from the long-acting newer medications (Humalog and Lantus) he had been using; the older form of insulin causes him problems at the injection sites and did not keep his diabetes in control. Exh. 19. [redacted] Detainee 1 arrived no later than Feb. 28, 2013 but the first indication of medication for his diabetes is not until March 2. At various times his prescriptions for his two inhalers to control his chronic obstructive pulmonary disease (COPD), his Norvasc for his hypertension, his Humalin and Metformin for diabetes, and all three of his psychotropic medications were interrupted. Exh. 1.

Other similar cases involve ([redacted] Detainee 5, with Type I (insulin-dependent) diabetes who missed two days of insulin at the time of initial admission to BCBIC; his afternoon blood sugar reading on Aug. 17, 2014, the first day of any medications, was 300. Exh. 5; *see also* Exh. 22 ([redacted] (Detainee 22, who uses a wheelchair and has bowel and bladder dysfunction related to neurological injury, experienced an interruption of his flexeril (muscle relaxant) prescription).[8] Exh. 22.

§ 15. Defendants shall implement a reliable system for renewing chronic medications, or making a determination not to renew them, that is not dependent on the detainee signing

[8] Plaintiffs have discussed these two PSA provisions together because of their overlapping requirements.

up for sick call.

Plaintiffs' Evidence: There is no evidence that Defendants actually have a medication renewal system that functions automatically. First, the system appears to function so that appointments for medication renewals frequently occur on the same day or after the prescription runs out. Given how Defendants' system actually works, this practice guarantees that these chronic prescriptions will be interrupted. This problem is greatly exacerbated because scheduled appointments so frequently take place after the prescription has expired or is on the verge of expiration, given the large numbers of encounters that must be rescheduled.

Large numbers of sick call slips involve requests to renew a medication, and detainees who do not keep track of their own medications can count on even longer interruptions in their medications. Indeed, in the most recent mental health compliance report, there are hand-written notes indicating that the most common sick call request was a request to renew expired medications, check into medications that had not yet started, or other medication issues. Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (MHM) (*see* § 44 excerpt).

This problem is illustrated by the case of Detainee 20, [redacted] who came into BCBIC in July 2014. After the intake mental health entrance screening on July 20, Detainee 20 was referred for an urgent mental health appointment. On July 23 he was seen by a nurse practioner who prescribed Celexa, an anti-depressant. The medication was scheduled to run out on November 23, and he was scheduled for a follow-up appointment on that date. According to a note on November 24, he saw a provider on that day but the medication was not reordered, although an urgent follow-up with mental health was ordered. A follow-up note on December 11 indicates that Detainee 20 met with someone on December 1, 2014, that the provider indicated that the medications were being ordered, but that the medications were not renewed in the

prescription section of the EMR. The patient was scheduled for urgent follow-up. The medication was actually ordered on December 15, which means that the patient experienced a three-week interruption in his medication. Exh. 20.

Detainee 3 [redacted] also experienced repeated interruptions of his psychotropic medications. About six weeks after he arrived, his medications expired and after two days without them he filed a sick call slip. He ultimately experienced an interruption of over a week in his medications. *See* Exh. 3 (sick call slip 8/21/13; medication management note 8/27/13 re Celexa and hydroxyzine (Vistaril). In April 2014 he reported auditory hallucinations when his psychotropic medications again ran out without being renewed. *Id.*

[redacted] Detainee 8, who undergoes dialysis, suffers frequent hypertensive crises, and is prescribed antiretrovirals for HIV not only experienced an interruption of his HIV medications when he came into BCBIC at the end of July 2014, but he had a two-week interruption that October. His antiretrovirals stopped when the prescriptions expired on October 5 or 6 and were not restarted until October 21, 2014. Exh. 8. This demonstrates again the failure of the claim that Defendants have in fact established an automatic medication renewal system for detainees who need to have medications continued.

Similarly, the medical record of Detainee 7 [redacted] illustrates how the problem of medication interruptions is exacerbated by the unreliability of the system for ensuring that detainees are brought to medical appointments. For significant periods of time, when medical staff requested that Detainee 7 be brought to an appointment, custody staff reported that he was not on the roster of the facility, and multiple scheduled appointments did not take place because custody staff reported that he was not on the roster. *See* Exh. 7; *see also* Exh. 35 (Detainee 7 Decl.) (describing two-week interruption of bipolar medications resulting from his admission to

the IMHU).

Detainee 16 ([redacted] who was admitted to BCBIC on June 7, 2014, reported at entrance that he had his HIV medications with him and that he had recently received a laboratory report of undetectable viral load. Exh. 16 [9] Nonetheless his HIV medications were allowed to expire without a renewal on July 18, 2014. *See id.* (Detainee 16 Medical Records) (entry for 6/18/14). The medications were not renewed until July 29 and the first indication that they were again provided does not occur until August 1. *Id.* (MARS for Aug.) Detainee 16 subsequently had a laboratory test reporting a detectable level of virus. *Id.* (consultation request, 8/27/14).

([redacted]) Detainee 1's medical record demonstrates a variety of dangerous medication interruptions. He did not receive any medications for diabetes for at least two days following his arrival, and at various times his prescriptions for COPD, hypertension, diabetes (again), and all three of his psychotropic medications were interrupted. Neither his diabetes nor his blood pressure were controlled. Exh. 1.

Other examples of dangerous medication interruptions include the following: Death Case 5 ([redacted] (Exh. 30) (experienced a three-day delay in renewal of his hypertension medication); Death Case 13 ([redacted] (was transferred to BCDC but his medications and medical records stayed at BCBIC); Death Case 9 ([redacted] (his medical record shows repeated missing documentation for his ordered blood pressure checks as well as for his prescription medications) (Exh. 34): Detainee 22 [redacted] (detainee who is assigned a defective wheelchair and experiences back pain suffered a five-month interruption of his prescribed Flexeril, a muscle relaxant) (Exh. 22); Detainee 11 ([redacted] (following a

[9] Some of the medical staff still use I-99 to refer to HIV infection.

transfer to MDC he did not receive his Metformin (a medication for Type II diabetes) or his Zocor (a medication for high choresterol) for two to three weeks) (Exh. 11; see also Exh. 56) (Detainee 11 Decl.); Detainee 9 ([redacted] (she experienced an interruption in receipt of her Robaxin, a muscle-relaxant related to her scoliosis and backache, without any indication that there was any therapeutic purpose in the timing of the breaks in the three prescriptions; her various prescriptions were written for 9/23/14-10/7/14; 9/29/14-10/13/14; and 11/11/14-11/19/14) (Exh. 9); [redacted] Detainee 21 (needed Oxybutynin (ditropan) because of his bladder problems, this medication is not on the institutional formulary; he received the medication for two days; when reordered for him after an interruption, he did not receive the prescription for six days in March 2014) (Exh. 21); Detainee 6 [redacted] (detainee returned from a stay in an outside mental hospital in February 2014; although he reported active suicidal thoughts at the time, received no medications beyond a one-time emergency dose for the first four days) (Exh. 6). Moreover, the records submitted by the mental health contractor show that during the weekly segregation sick call rounds detainees repeatedly complain about the failures to provide their medications. Exh. 46 (Defs.' Third Quarter 2014 Report (MHM) (§ 44).[10]

[10] It is hard to tell if the failure to maintain appropriate MARS is the major cause of providers' failures to address medication failures, since the records suggest that the typical response to indications that a patient is not taking his or her medication is to end the prescription. Moreover, even when the record indicates that a medication was not delivered because the patient did not appear at sick call, the record does not generally disclose whether the patient refused the medication or there was some other reason for the patient's failure to receive the medication. Incidentally, the records of sick call rounds in segregation conducted by mental health staff also call into question the accompanying assertion that they show that all rounds were actually completed pursuant to the requirements of PSA § 44, as there are hand-written notations on the forms indicating that several scheduled rounds were not completed due to flooding or security conditions on the unit. *See id.*

§ 17. Medication Administration Records ("MARS") will be routinely completed in an appropriate manner.

Plaintiffs' Evidence: Essentially every medical record reviewed presented examples of failures to maintain the medication records appropriately. At times multiple MARS covering the same time period, sometimes inconsistently, exist. The MARS, contrary to basic rules for medication delivery records, frequently contain blanks without explanation. As a result, it is often impossible to ascertain and address effectively the reasons for the failure of a patient's illness to respond positively to a prescription.

For example, Death Case 6 [redacted] died two days after entry while undergoing withdrawal from illicit drugs. His MARS record does not properly note missed medication doses. Exh. 31. Detainee 6 [redacted] complained on February 18, 2014 that after he returned from an outside mental health facility on February 5 he had not received his medications. Consistent with his claim, the only MARS in the file for the month covers only February 18-28 and the only evidence for any medications are a one-time dose immediately after he returned. Exh. 6. Similarly, the MARS forms for Detainee 8 [redacted] include several forms covering the overlapping time periods, making tracking of a particular medication difficult. Exh. 8 (8/14 MARS).

Multiple other examples exist. Detainee 15's [redacted] MARS have missing entries. At times, there are also multiple MARS for the same time period, such as six different MARS sheets for the month of April 2014 including three that cover April 21. Exh. 15. The medical record for Death Case 13 ([redacted] was transferred to MDC although he remained in BCBIC. *See also* Exh. 2 ([redacted])Detainee 2's medical records show that finger stick tests for blood sugar and blood pressure readings were ordered; many readings are missing from

MARS without explanation; when both ordered, only blood sugar measurements recorded); Exh. 4 ([redacted] Detainee 4's medical records include examples of MARS with a number of missing entries without explanation).[11] *See also* discussion of Defendants' compliance with § 33, *infra*.

§ 19. The plan of care developed at intake must guide care for acute and chronic disorders including medications and specialty referrals.

§ 20. The plan of care shall be updated and reliably executed.[12]

Plaintiffs' Evidence: Defendants say that the plan of care can be found "at the end of the detainee's medical encounter [in the EMR] and may be included in the Reason for Visit portion of the provider's documentation." Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (§§ 19-20). Thus, Defendants claim that every medical visit with a provider is part of the plan of care. This is manifestly not what a plan of care is, or needs to be, in a system like a jail in which multiple different providers interact with each detainee. If the medical leadership actually relies on this as Defendants' plan of care, that decision ensures that a provider seeing a patient will be unable to review an up-to-date plan of care summarizing the medical status and needs of the patient, because of the sheer number of different entries that a provider would need to review.[13]

The failure to have something that functions as an integrated and updated plan of care is a

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[11] When a medication dose is missed for any reason, under policy the nurse attempting to administer the medication is to enter the nurse's initials and document on the back of the form that the medication was not delivered, and the reason for non-delivery.

[12] Plaintiffs discuss these two sections together given their close relationship.

[13] Moreover, the problem list, which if properly maintained is the core component of the plan of care, barely seems to exist in the EMR. On the rare occasions that it is included in the medical records that Plaintiffs received, it almost never shows that the problem list has been updated from intake and often it has little to do with the detainee's current problems.

major cause of many if not most of the catastrophic medical failures of the system. Death Case 4 ([redacted] came into the Chesapeake Detention Facility on February 13, 2013, transported by the U.S. Marshal's Service. Prior to entry into the jail, he had a recent history of hospitalization for sinusitis and a mastoid infection in his jaw with no "definite" intracranial extension. There is a note with the transfer to the facility that he had an ear infection. When seen at screening, he was given a "routine" referral to a practitioner, despite a temperature of 103°.[14] His intake screening form also has a reference to ear drops, and the problem list indicates he had an ear infection. Death Case 4 first received an order for antibiotics two days later, but there is no indication that he received any antibiotics until February 16 or 17. The following day he was transferred in a wheelchair to the MTC infirmary that serves the jail complex. The infirmary provider described him as "alert" but also noted that he had an unsteady gait, was unable to stand and was a poor historian. The nurses documented that he was confused and unable to sign various forms. On February 19 he was transferred to a hospital where he died from his infection on March 3. Exh. 29. It is obvious that the delay in antibiotics was dangerous for him and in view of symptoms that suggested an intracranial extension of the infection, he should have been transferred substantially earlier to a facility that could treat him.[15]

Death Case 11 ([redacted] came into the jail with a history of sickle cell and was never seen for medical intake. He also never had a physical examination prior to placement

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[14] Plaintiffs do not suggest that Defendants can be held accountable in this case for the medical care at the Chesapeake facility. The infirmary to which Death Case 4 was transferred, however, serves BCBIC and BCDC, and the facilities share the same medical contractors and policies, so this care is relevant to members of the class here.

[15] *See* MedlinePlus, "Mastoiditis," http://www.nlm.nih.gov/medlineplus/ency/article/001034.htm (listing the following complications of mastoiditis: destruction of the mastoid bone; dizziness or vertigo; epidural abscess; facial paralysis; meningitis; and partial or complete hearing loss).

in the IMHU, where he succumbed to physical causes of his mental confusion that had not been investigated prior to his placement in the IMHU on the assumption that his symptoms were the result of mental health issues.

[redacted] Death Case 7 came into the system on Feb. 22, 2014 with known diagnoses of HIV infection, end stage renal disease on dialysis, HIV, hypertension and chronic obstructive pulmonary disease. On February 24, the doctor assigned to treat him noted that he had been advised to start the patient on antiretroviral medication, but that medication was never started. The physician did not comment on the patient's elevated temperature. No CD4 tests or viral load tests were found in the records sent to Plaintiffs, but a laboratory report on March 4 indicated that Death Case 7 had a hemoglobin of 5.8 – far below the normal range for males of 13.5-17.5. There is no suggestion in the records received that he ever was prescribed antiretrovirals. Although Aranesp was prescribed in March to treat his severe anemia, the relevant MARS from BCBIC and MTC show no delivery of the medication. A chest x-ray ordered on March 13 was not reported until March 19 and the results were not reviewed until March 20.[16] That report indicated that the right lung showed characteristics "suggestive of likely acute infection," suggesting that it should have been reported on a faster schedule. The x-ray also showed an enlarged heart and mild congestive heart failure in both ventricles. There are five separate orders for a renal diet in the month of March 2014, suggesting again that the special diet system is not working. Exh. 32.

In fact, the provision of special diets is a recurrent problem at the jail, as the previous

[16] At the time of the most recent Quarterly Report by Defendants, they noted that the x-ray machine at BCDC had been down for some time, and that in the most recent quarter mentioned only 39% of the x-rays ordered at MDC had been timely completed. Exh. 46 (Defs.' Third Quarter Monitoring Report) (§§ 25-26).

food contractor appeared to resist providing them by requiring the medical providers to provide very detailed information; when the information is not included in the medical order, the diet is denied. *See* Exh. 34 (Death Case 9) [redacted] (listing ten separate items that must be addressed, such as the provider used an outdated form or failed to date the request). Moreover, often the providers seem to respond by simply continuing to send more forms without resolving the problem with the food contractor; there are four such forms in the record of Death Case 9. Detainee 1 [redacted] also has four overlapping diet orders in his record (5/21/13; 7/11/13; 5/5/14; 6/21/14),with the dates suggesting that when a diet order did not result in its provision, the medical staff simply reordered it. Exh. 1. Similarly, there are four special diet orders in the file of Detainee 4, as well as various sick call complaints about the lack of a high-calorie diet. [redacted] Exh. 4. There is actually a signed special diet order in the file of Detainee 12 [redacted] that does not even specify what special diet has been ordered. Exh. 12.[17]

([redacted] Detainee 19 suffers from diabetes, hypertension, asthma, and recurrent prostate cancer. He is supposed to receive injections for his recurrent prostate cancer at six-month intervals and was due for an injection in July 2014, the month he entered the jail. The report of his need for chemotherapy was noted on July 28, but he did not receive the injection until October after three separate requests for approval of specialty care. Exh. 19; *see also* Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (§ 24) (documenting reviews of Detainee 19's need for chemotherapy). When Detainee 19 finally received the injection, it was administered into his upper arm rather than into his buttocks, as had previously been done. He

[17] As it happens, Detainee 19, [redacted] discussed immediately below in this section, also has four cardiovascular diet orders along with one diabetic diet, over the course of less than a year. Exh. 19.

experienced pain and other symptoms as a result. Exh. 36 (Detainee 19 Decl.).

Detainee 19 indicates that he came into BCBIC on July 22, 2014; his first medical appointment was early the morning of July 23, but the first delivery of his diabetic medications is recorded as July 25. In the community, Detainee 19 was prescribed Lantus and Humalog, both newer forms of long-lasting insulin. He was first changed to Levimir, a different long-lasting insulin, as his sole diabetes medication, but his blood sugar readings showed that his diabetes was not in control. Although a provider ordered finger stick checks to monitor Detainee 19's [redacted] diabetes, there was a lack of urgency in reviewing his highly abnormal results. For example, he had a blood sugar reading of 470 on July 26, 2014, which appeared on a glucose monitoring report included in a follow-up of an oncology report on August 29, but was not otherwise mentioned in the report and received no other attention. Exh. 19; *see also* Exh. 36.

[redacted] Detainee 13 has uncontrolled Type II diabetes. He was taken off all forms of insulin and without explanation prescribed only Metformin on August 19, 2014. He cannot tolerate Metformin because of its gastrointestinal side effects. On October 5, he was seen by a physician assistant ("PA") (a mid-level medical provider in some ways similar to a nurse practitioner) for a blood sugar of 411. The PA noted "I have no idea why he is taken off insulin." Detainee 13 also failed to receive a special diabetic diet despite repeated requests and repeated orders from staff for a diabetic diet. There was also a delay of more than a month between the jail's receipt of his test result for syphilis and the beginning of treatment, and also a delay in completing his treatment. Exh. 13.

Death Case 3 ([redacted] had a medical history that included obesity, hypertension, seizure disorder, and enlarged heart with congestive heart failure. He was also diagnosed with bipolar disorder, anxiety disorder and schizophrenia. While confined in the jail during an earlier

incarceration he experienced an episode that left him with an apparent cognitive deficit. In the incarceration that led to his death, little attention was paid to his medical problems. For example, during a period in 2013 when he was confined at an outside mental hospital, he received medication for his blood pressure and heart problems. But subsequently in November 2013 after returning to the jail he was no longer given any medications other than those prescribed for his seizure disorder and psychological problems. Thereafter, up to the time of his death in March 2014, he received no medications for his cardiac or vascular issues. Exh. 28.[18]

Death Case 5 ([redacted] had no follow-up for three consecutive significantly elevated blood pressure readings. There was a three-day delay in renewal of his hypertension medications, and they may have been interrupted. He did not receive neurological checks after he complained of dizziness, headaches, and blurry vision. His medical record was transferred to MDC although he remained in BCBIC. Exh. 30.

Death Case 12 ([redacted]) was given an urgent referral to a psychiatrist after the intake suicide screening, but did not see a psychiatrist in response to the referral. The staff member who performed her 7-day intake mental health review did not look at her medical record. The psychiatric provider did not document a reason for not starting medications during the initial patient encounter. There was no documentation of a plan for dealing with the detainee's allegation of a recent rape and there was a lack of documentation of coordination between medical care and mental health regarding her care. She was ultimately prescribed Risperdal, for bipolar disorder, despite an allergy to the medication. She did not have any psychotropic medication from her arrival in July 2012 until a week before she committed suicide in April

[18] It appears that significant records were missing from the copy of his record received from Defendants.

2013.

Death Case 6 ([redacted] had a blood pressure of 203/130 while undergoing substance withdrawal. He received one dose of anti-hypertensive medication following admission, but did not subsequently receive any hypertension medication, despite a history of hypertension and alcohol abuse. Nor were blood pressure readings repeated after episodes of elevated blood pressure and bradycardia (abnormally slow heart beat). Ordered checks of his drug withdrawal status were not performed. Exh. 31.

Multiple cases illustrate the failures to follow up on red flags requiring diagnosis and treatment. Death Case 8 ([redacted] had a history of HIV and Hepatitis C. Although his medical record is substantially incomplete, the following can be gleaned: he apparently came into the jail around April 22, 2013. Prior to incarceration, he had been receiving medical treatment, including prescriptions for antiretrovirals, and an outside medical provider again prescribed them in July 2013. Following entry into the jail, although he was known to have CD4 laboratory values so low that standard practice would have required prescriptions for these medications, the only MARS showing administration of antiretrovirals in the jail relate to August 2013, the month that he died. *See* Exh. 33 (entries for 5/7/13; 7/15/13).

On June 15, 2014, the jail received a laboratory report that Death Case 8's BUN (a standard medical test related to kidney function) was measured at 139. The normal range was reported as 7-18.[19] No one at the jail responded to this critical value until June 17, when he was sent to the hospital. He had suffered a severe kidney injury, and following hospital admission he

[19] A "critical value of 100 mg/dl indicates serious impairment of renal functioning." The Free Medical Dictionary. "Blood urea nitrogen (BUN)," available at http://medical-dictionary.thefreedictionary.com/BUN+test (citing Gale Enclyclopedia of Medicine (2008).

was also found to be suffering from septic arthritis, sepsis, severe anemia, and a urinary tract infection. In the hospital, he improved after being given fluids and antibiotics, but then suffered a deep vein thrombosis. The hospital at discharge noted that he needed physical therapy and repeat urine cultures. The record does not disclose whether he received a follow-up culture, and he certainly received no physical therapy. On July 21, he was noted to have a Stage III sacral (lower back) ulcer. *Id.*

University of Maryland Hospitals (UMMS) recommended an urgent colonoscopy on October 14, 2014 for Death Case 9 ([redacted] because of renewed concerns that his lung problems were caused by spread of an underlying malignancy, probably colo-rectal cancer, but the medical record does not contain any records regarding follow-up of that request.[20] In December 2014, he was again hospitalized and an x-ray showed a mass in both lungs. He was diagnosed with UGIB (upper gastro-intestinal bleeding) and possible malignancy in his lungs. There was a delay of about six weeks in a report from UMMS reaching the medical staff at the jail without any apparent attempts to locate the report. [redacted] He died in mid-January 2015 with cause of death listed as sepsis complicated by pleural effusion. At the time of his death, neither cancer of the colon nor of his lungs had been definitely ruled out. Exh. 34.[21]

Death Case 13 ([redacted] was allowed to become severely dehydrated leading to hospitalization and a diagnosis of kidney injury, because his fluid intake and excretion were not monitored while he was in the infirmary. There was no follow-up for six days of highly

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[20] While earlier lung biopsies had been negative, the symptoms of Death Case 9 now indicated a new need to perform a lung biopsy as well as colonoscopy. *See* Consult 10/31/14.

[21] Pleural effusion refers to fluid in the lungs, which can be caused by various problems, including congestive heart failure, infection, and malignancy. U.S. National Library of Medicine, Medicine Plus, "Pleural Effusion," available at http://www.nlm.nih.gov/medlineplus/ency/article/000086.htm

abnormal test results including his blood sugar reading of 659 and a BUN of 40. He was transferred to BCDC but his medications and medical records stayed at BCBIC. Similarly, Death Case 1 [redacted] had no follow-up on an MRI reporting multiple hepatic (liver) nodules of an unknown nature, which could have represented malignancy. Nor was an earlier recommendation for colonoscopy in two weeks given any response. Exh. 26.

Detainee 1 [redacted] provides an example of a related deficiency: the pervasive and mutually reinforcing inability of the medical system to note known medical history or to provide treatment consistent with that known history. Detainee 1 had a medical history including diabetes, hypertension, COPD and significant mental health issues, and he experienced interruptions of the medications for each of his serious medical problems, including several interruptions upon arrival. It is extremely difficult to determine which medications were actually given to him. For example, in September 2013 the EMR indicates that he had a prescription for Metoprolol, a heart and blood pressure medication that was good until December 9, 3013. Yet the only September 2013 MARS that addresses this prescription appears to indicate that the medication was discontinued on August 22, and that he was not subsequently given the medication until it was given as a keep-on-person on September 16. Similarly, the Norvasc prescription is marked discontinued, then that entry is marked as an error. Certainly the patient frequently complained of medication interruptions. Exh. 1.

A summary of medication orders on September 23, 2013 shows additional interruptions in his medications for his inhalers for COPD (Ventolin, Qvar) since he arrived; as well as a discontinuation of his psychotropic medications, with Haldol (haliperidol) set to end on September 18 and Wellbutrin (bupropion Hcl) on September 30. The October MARS does not show a prescription for Humalin (a modern form of insulin) after September 9. For most if not all

of these prescriptions, there is no indication that these prescriptions were deliberately ended. *Id.*

Detainee 1's [redacted] blood pressure was repeatedly significantly elevated and staff response was repeatedly significantly delayed. Similarly, his blood sugar levels were frequently elevated to dangerous levels while the response from staff was also significantly delayed. A pharmacist asked the medical staff to review Detainee 1's medications, pointing out several apparent problems with the prescriptions. In April 2013, he developed a sore on his buttocks that was not cultured at the jail when he sought treatment for it. Four days later he was hospitalized when the prescribed antibiotic did not work and he developed an abscess leaking pus. He then suffered pulmonary edema during a medical procedure to drain the abscess, and treatment required intravenous antibiotics. Four months later, he developed a cyst at the same spot, which was treated with the antibiotic that had previously failed, again without a culture to determine possible resistances and no apparent reference to the April hospitalization history. In fact, the antibiotic was given for only five days. *See id.* (Medication summary 9/23/13 for 8/13 Bactrim prescription).

In August 2013 he also was found to have a mass of unknown cause in his abdomen that was apparently never diagnosed. Although he repeatedly complained that his vision was deteriorating, and staff twice attempted to refer him to an ophthamologist, there is no indication in the record that Plaintiffs reviewed that he ever saw a specialist, although diabetic retinopathy is a common complication of uncontrolled diabetes like his. Nor could he get his broken glasses fixed. Custody did not bring him to medical appointments on July 18, 2013; September 23, 2013; April 11, 2014; and April 20, 2104. *Id.*

Other similar lapses in obviously critical care are routine. These cases include that of [redacted] Detainee 5, who saw a physician in late 2014. The physician noted that Detainee

5's diabetes was both "uncontrolled" and "stable." Even though within two days of the appointment Detainee 5 had a blood sugar above 300, the physician ordered no changes in his diabetic medication to obtain control. Exh. 5 (*see* entries for 10/21/14 at 2 and 11/20/14 at 1). Such cases also include the failure to ensure that life-saving medications are even continued, such as the antiretrovirals for Detainee 16 (which were allowed to expire without a renewal on July 18, 2014, resulting in a two-week interruption. He subsequently had a laboratory test reporting a detectable level of virus. Exh. 16.

Another failure to deliver critical care involved Detainee 8. He is diagnosed with HIV infection and undergoes renal dialysis because of kidney failure. He also experienced an interruption in one of his antiretroviral medications of at least four days at the time of entrance into the jail in July 2014 and a two-week interruption in September. Between August and November 2014 his blood pressure readings followed an upward trend, reaching 215/194. This blood pressure reading shows that Detainee 8 experienced a severe hypertensive crisis, for which the appropriate response would have been immediate medical attention. *See* note 7, *supra*. In fact, his blood pressure readings met the definition of a hypertensive crisis on multiple occasions. The first such readings elicited no response, or even comment in the record, from staff. The physician did eventually order medicine for hypertension and he was admitted to the MTC infirmary, but after a few weeks Mr. was again experiencing blood pressure readings that not only met the definition of hypertensive crises but also were even higher than the previous crises, including readings of 210/120, without further attempts at intervention by staff. By January 5, 2015, as the readings continued a general trend upward, a reading of 245/137 was recorded. An ordered culture test in the infirmary was never performed. Exh. 8.

[redacted] Detainee 23 provides an example of medical staff appearing to simply ignore the need to update the plan of care. She had a health assessment on July 9, 2014, two days after entering the jail. At that time, her weight was 250 and her body mass index ("BMI") 38. Given her height of 5'8", she was 85 pounds over normal weight and fifteen pounds away from meeting the definition of morbid obesity. Medline Plus, "Obesity," available at http://www.nlm.nih.gov/medlineplus/obesity.html. Her listed diagnoses, however, were limited to asthma, backache, and drug dependence. In August she was placed on Vistaril, Risperdal, and Celexa.[22] On August 3, her blood pressure was 153/95 and her weight was not measured. There was no comment on the abnormal blood pressure reading. On August 29, her weight was up to 279, and she more than met the definition of morbid obesity. There was still no comment from the provider and morbid obesity was not added to the problem list. Although the provider noted the morbid obesity at the next chronic care visit on September 26, the blood pressure as recorded is not readable from that visit, nor was a weight recorded or a test for blood sugar level repeated.[23] Her blood pressure was again elevated when measured on September 30 and on October 8 (156/100). On October 24, Detainee 23 herself asked the provider whether she might be diabetic. Not until that time was a test for diabetes repeated. Exh. 23.

That test was noted on November 1 to be diagnostic for Type 2 (non-insulin dependent) diabetes and she was placed on Metformin. The patient was scheduled for sick call on November 30, but custody did not bring her. Her first chronic care visit for diabetes was on February 2, 2015. At that time, Detainee 23 was not on a diabetic diet and there is no documentation that a

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[22] Risperdal (risperdone) is associated with weight gain. *See* Web MD, "Risperdone," available at http://www.webmd.com/drugs/2/drug-9846/risperdal-oral/details/list-sideeffects.

[23] The glucose level had been normal in the laboratory results reported on July 23.

diabetic diet had been considered for her. Detainee 23 reported that she had not received her Metformin for the last three days and that she did not go to her morning blood sugar checks; her pass for a daily check of her blood sugar levels had expired; and she had not yet seen an ophthalmologist. Her weight was listed as 312 and her BMI was above 47. This record, in short, illustrates a dangerously delayed and apathetic response to a known serious diagnosis of morbid obesity. There was an absence of timely medical education and intervention for either the patient's morbid obesity or diabetes, as well as a lack of monitoring of the patient for common consequences of the diagnosis of morbid obesity.[24] *Id*.

[redacted] Detainee 22, who entered BCBIC in August 2013, requires a wheelchair because of lower body paralysis. He also suffers from significant muscle spasms related to his disability. These spasms are relieved by use of a muscle relaxant, Flexeril, which he has repeatedly requested. The UMMS Rehabilitation and Orthopaedic Institute recommended Flexeril for him, but it is a non-formulary medication which requires re-approval by the contractor each time a prescription expires. Two of the provider requests to approve Flexeril do not show action by the reviewer in his medical record. According to the MARS included in Detainee 22's medical record, the only times that Flexeril was actually provided to him were the following dates in 2013: September 25-30; October 21-30; and December 3-25. In 2014, the MARS indicate Flexeril delivery January 1-10; March 13-20; June 4-26; July 1-6; July 12-30; August 13-20; and October 1-31. There is no indication that this pattern of sporadic medication

[24] *See* Mayo Clinic, "Diseases and Conditions: Obesity Complications," available at http://www.mayoclinic.org/diseases-conditions/obesity/basics/complications/con-20014834 (listing in this order as high triglycerides, Type 2 diabetes, high blood pressure, metabolic syndrome, and heart disease).

delivery was pursuant to a planned course of treatment. *Id.*[25]

Detainee 22's spinal injury has resulted in bowel and urinary dysfunction, so that he needs to catheterize and manually remove his bowel contents (disimpact) himself. The facility has not adequately accommodated either of these necessities. The only disabled-accessible bathroom to which he has had access, for most of his stay, is not sanitary because of a leak and flooding. In addition, at times he has experienced interruptions in his supply of clean catheters and the facility has frequently not stocked the type of catheter that he needs. At least one of the interruptions in September 2014 was associated with his reuse of a used catheter and the development of a urinary tract infection. Custody informed him that he would need a written order from medical staff to be allowed to use the shower that is accessible for persons with mobility disabilities. *Id.*

An entry in his record on August 10, 2014 indicates that multiple referrals to providers did not result in appointments. He was approved for physical therapy to relieve his back pain and muscle spasms, and the physical therapy program indicated that he needed six appointments beyond the evaluation session. He received only four of those appointments. Detainee 22 reports that the missed appointments occurred because no disabilities van was available. On November 14, 2014 he sent a sick call request inquiring about the status of an x-ray order for his back and shoulder from two weeks earlier. *Id.*; Exh. 54 (Detainee 22 Decl.).

Detainee 13 ([redacted] is diabetic. On August 19, 2014, a physician discontinued all of his diabetic medications on the ground that his diabetes was "controlled." A PA assessed him on October 5, noting that Detainee 13 had experienced a blood sugar reading of 411, and writing that "I have no idea why he is taken off his insulin, per [EMR]; his blood sugar

[25] This summary omits periods of non-deliveries of medications apparently related to administration problems (such as the patient not being brought to medication line) as distinct from prescription problems.

level was never controlled. . . . Referred to the attending who is monitoring his Diabetes." The MARS orders related to insulin are internally inconsistent and inconsistent with the orders reflected in the EMR print-outs. Exh. 13 (*See, e.g.,* 11/14 MARS reflecting delivery of Levemir for the month of November although the order indicates that it expired on November 6). A separate November MARS contains a separate prescription for a different form of insulin prescribed throughout the month that was apparently not administered but with no explanation as to its presence and the reason it was not carried out. *Id.*

[redacted] Detainee 14 has experienced a below-the-knee leg amputation and suffers from constant pain. Although he has raised the issue of pain in his interactions with staff and "generalized pain" is part of his problem list, he has been given only an over-the-counter analgesic (Naproxen). His joint pain may be aggravated by injuries from the same accident that led to the amputation, or the strain of walking with crutches may have placed extra strain on his hip, which is the major source of his concern. In any event, there is no explanation in the record for the uniform practice of the medical staff of simply refusing to evaluate his pain. While Naproxen may be an appropriate medication for him, there has been no investigation of his symptoms to determine that. *See* Exh. 14.

[redacted] Detainee 4 saw a PA on August 28, 2013 for a worsening infection in his leg. The PA ordered another ten days of Bactrim, an antibiotic. It was described as a "chronic wound" when he was seen at the infirmary in October at a time that he was no longer receiving Bactrim. On December 10, 2013 and January 7, 2014, the medical staff received laboratory reports and a "panic value" telephone call identifying the wound as infected

with MRSA.[26] On January 8, 2014, a nurse recorded that the physician had been "made aware" of the MRSA report while Detainee 4 was in the MTC infirmary because of an unrelated injury. When he was released to BCDC later that month, there was no mention of the chronic MRSA infection. On January 13, Detainee 4's medications did not include antibiotics, other than an ineffective topical (Bacitrin). In March and April, he again complained in sick call about his leg infection, and in April a provider decided that no antibiotic was needed. In May another provider noted that the wound was purulent, but neither the April nor the May provider seem to have seen the earlier laboratory reports. The May provider did order antibiotics, and that prescription ended May 24. Exh. 4.

After that there were a series of sick call requests from Detainee 4 related to his leg. For example, his sick call request about his infected leg was triaged on July 10, 2014 and the nurse referred it to a provider on July 12, but he was not actually seen until mid-September, apparently as a result of a September sick call slip. He again sent a sick call slip on November 1 regarding his leg and a dental problem. A copy of the sick call slip was triaged for dental services on November 3 and he was seen on November 5. The infection complaint was marked triaged on November 8 and indicates that he was seen that day. On November 4, he saw a chronic care provider who indicated that an appointment would be scheduled. None of these providers noted the known history of MRSA in the wound. *See id.*

Finally, there is a specific problem that provider orders are not reliably implemented, the ultimately critical point of having a plan of care. In addition to the many other failures to carry out medical orders discussed above in this section, Death Case 10 ([redacted] for example,

[26] Methicillin Resistant *Staphylococcus Aureus* (various strains of bacteria resistant to most standard antibiotics).

died of hemo-pericardium (presence of blood in the sac around the heart).[27] A number of her ordered laboratory tests were not performed.

Detainees' problems with obtaining a special diet are a particularly common occurrence, even after the diet is ordered. Detainee 1 [redacted] did not receive his ordered diabetic diet from April to July, 2012. Exh. 1. [redacted] Detainee 5 also reported that he was not receiving his diabetic diet in September 2014; about a month later, the diet order was refaxed to dietary. Exh. 5. [redacted] Detainee 2, who has diabetes among other diagnoses, reported that he did not receive his special diet tray after he was moved to F Unit. His record shows several different dietary orders. Exh. 2. Detainee 13 ([redacted] received a diabetic snack bag at BCBIC,[28] and his record also shows multiple orders for a diabetic diet, but after his transfer to MDC none was provided. A number of sick call slips indicate that he has not received that diet. Exh. 13.

§ 21. Orders for laboratory testing shall be reliably executed. Abnormal results shall be given appropriate follow-up.

Plaintiffs' Evidence: There has been a pattern of failure to provide timely response to abnormal test results. For example, a critically abnormal kidney function test in the record of Death Case 8 ([redacted] was given no follow-up for two days, resulting in severe

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[27] Hemo-pericardium has various causes, including heart attack, wounds, surgical complications, malignancy, and coronary artery disease. *See* David H. Skolnick, "Bloody Pericardium: Clinically Significant Without Intrinsic Diagnostic Specificity," *Chest Journal (1999)*, available at http://journal.publications.chestnet.org/article.aspx?articleid=1078346.

[28] Diabetic snack bags are typically prescribed for those diabetics who experience periods of low blood sugar following insulin injections. Abnormally low blood sugar (hypoglycemia) episodes can cause seizures, coma and death. The Mayo Clinic, "Hypoglycemia," available at http://www.mayoclinic.org/diseases-conditions/hypoglycemia/basics/complications/con-20021103.

kidney injury added to his other illnesses, with the result that he essentially never recovered and died about two months later. Exh. 33. In Death Case 13 ([redacted] involving a detainee who died of pancreatic cancer, there was no follow-up for six days of kidney and blood sugar tests with highly abnormal results ("panic values"). In addition, his standard intake test for tuberculosis infection did not have a result recorded. Similarly, a number of ordered laboratory tests were not performed for Death Case 10 ([redacted] who died of hemo-pericardium. [redacted] Detainee 1's blood pressure was repeatedly elevated without comment (or treatment) from the medical staff. The institutional pharmacist requested that medical staff review his prescriptions, with no apparent response from staff. Exh. 1

By policy, every detainee is supposed to receive a syphilis test during intake. The jail received a positive test result for Detainee 13 [redacted] around April 2, 2014. It appears to have been first noted in the file on April 28. A prescription for medication was first written on May 6, and again on May 18. Treatment was not completed until June 1. Exh.13. This demonstrates an almost non-functional system for following up on tests with critical implications for the public health.

In general, the syphilis tests (RPRs) are casually handled. Eighteen days after an RPR, no results were in the record for Detainee 6. [redacted] His medical record also does not show the results of a PPD (tuberculosis) test that same month. Exh. 6 (entry 6/29/13). The RPR results for Detainee 14 ([redacted] were not in his record as of January 3, 2015, although he is listed as arriving on September 30, 2014. Exh. 14. Detainee 21 [redacted] arrived at BCBIC on January 19, 2014, but as of March 2, 2015, his medical record still lacked a result for the test. Exh. 21.

Moreover, Defendants' most recent monitoring report shows that only 80% of BCBIC

and 87% of WDC laboratory reports included documentation that providers reviewed them within 48 hours of receipt. Exh. 46 (§ 21). Further, Defendants' report does not include any audits of the timeliness of the laboratory's processing and reporting on the test results themselves. Also, and of critical importance, Defendants do not attempt to measure whether abnormal findings were given follow-up consistent with standard medical practice. A large majority of the laboratory results, according to the tracking log for July 2014, included abnormal results, underlining the importance of reliable follow-up for these tests. *Id.*

§ 24. Monitoring and treatment of chronic diseases involve specialist referrals where appropriate.

Plaintiffs' Evidence: If a request for a consultation is initially denied because information is missing, there is unnecessary built-in delay in the process. Exh. 46, Defs.' Third Quarter 2014 Monitoring Report § 24 ("In most instances of denial, additional documentation is required before approval is granted and requires the [Regional Medical Director] to gather requested documentation for presentation in the next collegial review hearing"). The great majority of the requests for consultations that appear in the medical records of class members are not accompanied by responses to the request, but no subsequent consultation can be found in the record. When that happens, if a consult is eventually approved, it often seems to occur because a completely new request for consultation was prepared. The log also does not track the time between submission and approval or disapproval of the request and does not appear to include rejected requests. It thus seems likely that the delay in consultations is frequently due to the utilization review process rather than waiting lists for appointments with the specialists. *See id.* (Utility Review Log).

After Detainee 16 [redacted] experienced an interruption of his HIV medications

within the jail and he was discovered to have a detectable level of virus, the issue of the interruptions of these critical medications was not noted; Detainee 16 was simply referred for a consultation regarding "confusion" about the medication regime. Exh. 16. [redacted] Detainee 11 was known to have loose bone in his knee that resulted in June 2014 in a recommendation for surgery as soon as possible. *See id.*; *see also* Exh. 46 (Defs' Third Quarter 2014 Monitoring Report § 24) (Consultation Log at 7). Detainee 11's medical record shows that he was again injured in July 2014. He reported that he was unable to walk and he received crutches and a knee immobilizer. Shortly thereafter an on-site *consultation* was ordered, despite the earlier urgent recommendation for surgery. A few days later he saw a second consultant who again recommended surgery and noted the loose bone in the knee. In September, another provider noted the recommendation for surgery as soon as possible. In October he fell while on crutches and suffered a deep puncture wound. Two weeks later yet another request for approval of surgery was written. Not until December 2014 did the surgery occur. *Id.*; *see also* Exh. 11; Exh. 56 (Detainee 11 Decl.).

Similarly, there were three separate reviews to determine whether [redacted] Detainee 19 needed treatment for his recurrent prostate cancer, including a review by the Regional Medical Director, before he was approved for what turned out to be a delayed October 2014 injection of chemotherapy. Although he had reported at entrance that the chemotherapy was due in July 2014 when he arrived, the referral approval process was not completed until September 24 and he did not receive treatment until October. *See* Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report § 24) (Consultation Log at 4, 5, 7).

Two major concerns emerge from a review of the consultations for [redacted] Detainee 11 and [redacted] Detainee 19. First, the consultations ordered for the two patients were for the

purpose of determining whether to allow treatment for them; during the period covered by the log neither received any actual treatment from a specialist as a result of the referral process. *See* Exh. 46 (Consultation Log). Second, cases such as these raise questions about the cause of the delays in the referral process and the possible financial incentives that the contracts between Defendants and the private medical providers establish. It is common among contractual medical providers to negotiate for a financial bonus if they reduce the cost of outside medical care, and that incentive can have an adverse effect on care. Contractors may also use the reduction in the costs of referrals that the contractor has produced as an argument for continuing to award the contract to that company.

When [redacted] Detainee 1 complained of poor vision, a staff member recorded that he would be referred to an ophthalmologist, but there is no referral in the record. This outcome is particularly dangerous because Detainee 1 has diabetes and is therefore at risk of diabetic retinopathy. Exh. 1.[29] [redacted] Detainee 8 was similarly referred to an infectious disease specialist but no follow-up to that request for a referral can be located. Exh. 8.[30] A

[29] Because **Mr.** [redacted] Detainee 1 has uncontrolled diabetes, he is at significant risk of diabetic retinopathy, the leading cause of blindness in Western nations. M. Abbate et al., "Prevention and treatment of diabetic retinopathy: evidence from clinical trials and perspectives," available at http://www.ncbi.nlm.nih.gov/pubmed/2143885. The National Institutes of Health recommends that persons with diabetes receive yearly dilated-eye examinations. The National Eye Institute, "Facts About Diabetic Eye Disease," The National Institutes of Health, available at https://www.nei.nih.gov/health/diabetic/retinopathy. In none of the records of diabetics at BCDC did Plaintiffs locate records of yearly dilated eye examinations.

[30] Plaintiffs did not include § 56 in their Notice of Non-Compliance. That provision requires, *inter alia*, that detainees who report that they are receiving HIV antiretroviral therapy, but whose prescriptions are not confirmed by staff, be seen by an infectious disease specialist within fourteen days of arrival. Should Defendants attempt to claim that this omission demonstrates that this provision has actually been implemented, Plaintiffs will present evidence that it has not been implemented – not to argue that the non-compliance with § 56 is an independent reason to reopen the PSA, but to refute claims that other sections included in the Notice are in compliance. The same goes for any other assertions from Defendants regarding

request for an abdominal ultrasound referral for diagnostic purposes related to repeated urinary tract infections was written for [redacted] Detainee 22 on September 8, 2013. There is no response to the consultation request in his medical record, and no record that the ultrasound occurred. Instead, he received an x-ray that poorly visualized the renal area, noted in the record on September 26. Exh. 22.

The medical records of detainees with HIV infections, uncontrolled diabetes or hypertension, in particular, demonstrate a surprising absence of consultations with specialists. For example, Death Case 8 clearly needed a consultation with an infectious disease specialist, given the failure of the regular staff to start antiretrovirals despite his depleted immune system reflected in his low CD4 count. Two requests from medical staff for a consultation did not produce approval of the referral until two months had passed. At that point, the patient was less than three months away from death. *See* Exh. 33.

The number of cases of detainees who experienced hypertensive crises without recognition of the need for an evaluation and consideration of treatment needs suggests the desperate need for consultations on cardiac and vascular issues. *See, e.g.,* the descriptions *supra* of the medical records of Death Case 2, Death Case 9 and Detainee 8. Similarly, the number of patients whose uncontrolled diabetes required a specialist consultation included Detainee 1, Detainee 5, Detainee 13, and Detainee 19; *cf.* Detainee 23's medical record (showing that while her diabetes is not uncontrolled, it has been fundamentally mismanaged and possibly could have been prevented or reversed with behavioral support) (Exh. 23) (*see* discussion in §§ 19-20 of Detainee 23, *supra*).

§ 25. X-rays and other tests are performed timely consistent with urgency.

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other sections that were omitted from the Notice.

Plaintiffs' Evidence: Defendants admit that they have been unable to perform routine x-rays in a timely manner because of the failure of custody staff to reliably transport detainees from MDC and WDC to BCBIC, combined with the failure to repair the x-ray equipment in MDC. The need to transport detainees from MDC arises from the fact that the x-ray at MDC has been broken and unrepaired for a substantial period. As a result, all routine x-rays for all three facilities must be performed at BCBIC. Accordingly, only 39% percent of patients from MDC received routine x-rays within 48 hours and only 80% of patients from WDC. The average time interval between order and x-ray was four days. Moreover, as of the time of the report, the facility had no approval to proceed with repairing the MDC equipment. *See* Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (§§ 25-26).

The systemic x-ray issue is only a small part of the overall problem of failure to accomplish timely testing and response to medical issues. There was no follow-up for six days of kidney and blood sugar tests with highly abnormal results ("panic values") for Death Case 13 ([redacted] who died of pancreatic cancer. As noted above, [redacted] Detainee 1 apparently never received an ophthalmologist examination although he was complaining of vision problems and had uncontrolled diabetes. Exh. 1.

The failure to perform appropriate surveillance and testing for the dangerous presence of MRSA is another source of danger to the detainee population. [redacted] Detainee 24 noticed a red rash on his arm in August 2014. He sent repeated sick call slips about the rash. When he was seen by a physician, the doctor entered a diagnosis of "spider bite" in the record and gave him antibiotics that did not work.[31] Two days later, when the infection had substantially

[31] The physician's failure to diagnose potential MRSA is highly surprising and disappointing, given the correctional setting. Detainee 24 [redacted] had a classic case of jail-acquired MRSA. MRSA is notorious for being dismissed as a "spider bite" in correctional

worsened, he returned to sick call and a different physician placed him on intravenous vancomycin, an appropriate antibiotic. By that time, however, the infection had too much of a head start. By the following day, he had a "huge cellulitis involving the whole right arm." Despite the medication, he had to be sent out to a hospital where, predictably, an abscess from MRSA infection and sepsis (blood poisoning) were diagnosed. Exh. 24.

A further dangerous failure was that all that was entered into his problem list was cellulitis/abscess, which dramatically understates the diagnosis. Thus, when Detainee 24 was transferred to prison, his medical record there shows that providers did not know that he had a history of a very serious MRSA infection. *Id.* Recurrent MRSA skin infections are a well-known problem. *See* the discussion of Detainee 4 [redacted] in § 21, *supra* (involving another case of delayed treatment of recurrent MRSA combined with the failure to maintain a updated problem list and plan of care).[32] Detainee 24 continues to experience skin rashes at the new prison, but the lack of a specific diagnosis of a history of MRSA abscess and sepsis in the record fails to alert the practitioners there to the need for heightened vigilance. Exh. 24.

There are numerous other examples of testing failures, many of which have been covered in previous sections. [redacted] Detainee 5's afternoon finger-stick records repeatedly

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facilities, and one expects medical staff at a jail to be alert for such cases. *See* Centers for Disease Control, "Managers: Protect Correctional Staff from MRSA" (noting the high prevalence of MRSA, a potentially deadly disease, in correctional facilities; describing common MRSA symptoms of red, painful, swollen skin, accompanied by pus and fever; "MRSA lesions are often mistaken for spider bites. . . . A healthcare provider should promptly examine skin sores with any of these features among staff or inmates, so they can be diagnosed and treated"), available at http://www.cdc.gov/niosh/docs/2013-120/pdfs/2013-120.pdf.

[32] *See also Consultant 360*, "Prevention of Recurrent Skin Infections: What You Need to Know," available at http://www.consultant360.com/content/prevention-recurrent-mrsa-skin-infections-what-you-need-know.

showed that his diabetes was uncontrolled without attention from staff. Exh. 5 (*see* finger stick record for 8/24/14 health assessment). [redacted] Detainee 10's skin test for tuberculosis (PPD) was not performed for approximately a month after his entrance into BCBIC. Exh. 10. The results of an x-ray ordered for [redacted] Detainee 22 on September 9, 2013, were not noted in the record until September 26. There was no follow-up from that x-ray, although the radiologist noted that the renal area was poorly visualized. Exh. 22. Another x-ray was ordered for Detainee 22's wrist on January 3, 2014, but the radiologist did not read the film until January 9, and the results were not noted in the EMR until January 10. *Id.*

§ 26. Specialist referrals shall be timely, with urgent referrals within 48 hours. Non-urgent laboratory tests shall take place within 48 hours. A reliable tracking system for such tests shall be implemented.

Plaintiffs' Evidence: In Death Case 10 ([redacted] a number of ordered laboratory tests were not performed. In Death Case 8 ([redacted] it took more than a month after a renal ultrasound was authorized to perform it and two months for an infectious disease referral to be approved. Exh. 33. As noted above, in Death Case 9 ([redacted] UMMS recommended an urgent colonoscopy on October 14, 2014 because of concerns that his lung problems were caused by an underlying malignancy, such as colo-rectal cancer. In December 2014, he was again hospitalized and an x-ray showed a mass in both lungs. He was diagnosed with UGIB (upper gastro-intestinal bleeding) and possible malignancy in his lungs. There was a delay of about six weeks in a report from UMMS reaching the medical staff at the jail without any apparent attempts to locate the report. **Mr.** [redacted] Death Case 9 died in mid-January 2015 with cause of death listed as sepsis complicated by pleural effusion. Exh. 34.

Almost a year after [redacted] Detainee 22's arrival for screening at BCBIC, there

was no RPR result in his file. His order for physical therapy, needed in connection with his multiple physical problems, has never been fully carried out because of lack of access to a disabilities-accessible van to transport him. In fact, a transfer summary lists several orders for treatment or diagnosis in his records that had not been carried out. Exh. 22. *See also* discussion in §§ 20, 24-25 *supra*.

[redacted] Detainee 11 sustained an injury to his knee in the course of being assaulted several times in the summer of 2014 in the jail. After a July incident, he was unable to walk by himself, and was ordered crutches for two weeks. About a week later, a nurse practitioner saw him and suggested that he probably had loose bone in his knee, which was the correct diagnosis and one that required surgery. Another provider asked for a surgical consultant who confirmed the diagnosis and advised surgery. In September he was seen at Bon Secours Hospital, which recommended surgery as soon as possible. In October, the patient fell while using crutches and suffered more injuries. He was seen in the clinic, the recommendation for surgery noted, and a new request for approval of surgery written. He finally received surgery in December 2014. Exh. 11; *see also* Exh. 56. As noted above, the major cause of the unreasonable delay is the utilization review process, which considered referrals to determine whether surgery was necessary three times before the patient actually received the needed treatment. *See* discussion in § 24, *supra*.

The record for [redacted] Detainee 7 shows that a provider requested a hypertension consultation on May 23, 2014. Although apparently approved, there is no obvious documentation that any consultation took place. Exh. 7; *see also* the cases of [redacted] Detainee 1 (Exh. 1), [redacted] Detainee 4 (Exh. 4), and [redacted] Detainee 5 (Exh. 5), cited in the discussion of § 25, *supra*.

In addition, Defendants' own monitoring report documents that urgent referrals for mental health evaluations are completed within 24 hours only 42% of the time, and evaluations based on routine referrals are completed within five days only 81% of the time. Although Defendants' Third Quarter Monitoring Report asserts that all mental health emergency referrals were seen on the day of referral, Defendants' summary of the referrals does not support that claim, calling into question the validity of the audit results. *See* Third Quarterly Report (MHM) (Exh. 46) (§ 48) (entry for 2585638) [redacted] (listed as emergency referral on 9/10; seen 9/12); [redacted] (entry for 3523427) (listed as emergency referral on 9/11; seen 9/12); [redacted] (entry for 2950649) (listed as emergency referral on 9/30; seen 10/3); [redacted] (entry for 1348717) (listed as emergency referral on 9/25; seen 9/29)); *cf. id.,* [redacted] (entry for 3970968) (listed as emergency referral 7/3; allegedly seen 7/2).

§ 27. Necessary accommodations for disabilities shall be provided, including housing, services and supplies.

Plaintiffs' Evidence: Contrary to Defendants' statement in their Third Quarter 2014 Monitoring Report that "all detainees with disabilities are medically provided with reasonable accommodations," *see* Exh. 46 at §§27-28, there is abundant evidence that patients with disabilities frequently suffer because of failure to accommodate their disabilities, and not infrequently are treated in ways that are inconsistent with core concepts of human dignity. In fact, in the 2013 Facilities Master Plan, Defendants admit that the facilities are not in compliance. Exh. 61 at 3-3 ("Numerous shortfalls of varying degrees exist at [the Department's Baltimore facilities], including inadequate housing for inmates/detainees, lack of space for program expansion, aging infrastructure and structures, inefficient facility design, life safety and *accessibility issues*"). One example of the inability to provide safe and appropriate housing for

detainees with disabilities is the restrictions on treatment for detainees who need assistive devices such as canes who are also suicidal, because no assistive devices are allowed in the IMHU. *See* Exh. 2 [redacted] (entry 11/21/14 3:20 pm). The lack of attention to issues related to disabilities is illustrated by the problems of Detainee 14 [redacted] He is blind in one eye and has a below-the-knee amputation, so that he relies on crutches for mobility. His transfer form from BCBIC fails to check the box for disability, or otherwise describe his mobility restrictions. Exh. 14.

The case of Detainee 22 ([redacted] demonstrates the egregious violations of health and safety, as well as dignity that some detainees suffer in the jail. He must catheterize himself several times a day. Periodically, he has been unable to obtain from staff supplies of clean catheters for periods of five to seven days. As a result, on at least one occasion, he had to reuse a used catheter, resulting in a urinary tract infection. [redacted] Detainee 22 was for a substantial period of time housed with no access to a private and sanitary location where he could disimpact himself to take care of his bowel needs. Following a stay in the jail infirmary at MTC, he was returned to BCBIC housing that lacked access to an appropriate area to disimpact. Exh. 22; Exh. 54 (Detainee 22 Decl.). Defendants similarly ignored the needs of Detainee 11, ([redacted] who needed crutches as a result of injuries sustained at the jail. He was given broken crutches and later fell on stairs he was required to climb. Exh. 11; Exh. 56 (Detainee 11 Decl.).

Defendants' Third Quarter 2014 Monitoring Report includes a page from their ADA Assessment Report that happens to cover several patients for whom Plaintiffs have information. Detainee 20 [redacted] who is listed as in Defendants' spreadsheet as crutches-cane (Exh. 46 §§ 27-28), does not ordinarily have either a cane or crutches available. *See* Exh. 38 (Detainee 20 Decl.). He came into the facility with an open wound on his leg and using crutches in July

2014, but they were taken away from him and he was given just a cane instead at his health assessment on July 27. When he was transferred to MDC on that day, no disability was listed on the transfer form despite the cane order. While by August 5, 2014 he had temporarily regained crutches, as of November 2014, he has access to a cane only when he required to travel off his housing unit. Detainee 20 [redacted] indicates that he is required to sleep on a top bunk, which is unsafe and painful for him, and that he has been denied pain medications he needs to deal with pain from previous automobile accidents. *Id*. The transfer review form does not note the cane order, demonstrating a flaw in Defendants' policies and procedures in that there appears to be no requirement that ordered accommodations be listed on the form, even if the detainee is listed as having a disability.

[redacted] Detainee 21 is paraplegic although he has some feeling below his waist. On January 19, 2014 he requested an extra mattress to prevent the development of bed sores. He continued to write frequent sick call requests about the matter. On February 5, he was informed that the warden did not allow extra mattresses in the facility. He pressed on with sick call requests. On February 9, a PA indicated that the Chief Medical Officer would be notified about the need, as well as his unmet need for compression stockings due to swelling of his legs. On March 12, there was a note in his medical record that an extra mattress was not approved, but that after staff spoke to Chief Barnes an eggcrate mattress was approved and "will be ordered." When he actually received the mattress is unclear. Exh. 21.

Similarly, after Detainee 21 was admitted to the jail on January 14, 2014, he experienced a significant delay in receiving dental treatment spanning parts of February and March 2014 because the elevator that served his unit was out of order, and no other arrangements were made for him to receive dental care. He also had to wage an extended campaign to get the compression

stockings he needed. On November 5, 2014, after he received a substitute wheelchair because the one he had been using had a flat tire, he could not use it because it was not designed for a person of his height. Use of such a wheelchair would put him at great risk of a new pressure sore in light of his history of pressure sores. *Id.*

[redacted] Detainee 17, also on the spreadsheet for both wheelchair and urinary/bowel special needs (*see* Exh. 46 (§ 27)), is a prime example of the mishandling of disability needs. He is paralyzed below the third thoracic vertabra; he must use a urinary catheter to empty his bladder; recently after a change of policy he was denied daily changes of urinary bags and was only provided a clean bag once a month, which puts him at high risk of a urinary tract infection, as well as being inconsistent with human dignity in light of the smell that would accompany a bag changed so rarely. *See* Exh. 17; Exh. 55 (Detainee 17 Decl.).

Detainee 17 also has a gunshot wound in his right leg, which means that this leg cannot bend to a normal extent. He uses a wheelchair for mobility and must use a urinary catheter to empty his bladder. The wheelchair he uses is too small for him; his legs, particularly his right leg, hang partially off the footrests. The small wheels for changing direction are broken. Staff have not provided him with a wheelchair in working condition or one that is the right size. Exh. 17; Exh. 55.

This problem exacerbates the pressure on his buttocks, where he previously suffered from a pressure sore. In addition, he was unable to clip his own toenails because of his disabilities, He repeatedly filed sick call slips describing the problem with his nails and their deteriorating condition. Ultimately, two of his toes developed gangrene and he needed wound debridement in a hospital. Dental services for him were not provided while he continued to report pain because the elevator that was supposed to provide transportation to detainees in the disabled unit was

broken between January 2013 and April 2015. Custody denied him permission to wear tennis shoes, a standard accommodation for persons at risk of pressure sores to prevent complications from draining wounds of the foot, and custody also repeatedly denied the double mattress he needed before the problem was addressed. He also had a purulent sacral ulcer for which he had to be transferred to the MTC infirmary. Exh. 17; Exh. 55.

The February 8, 2014 Report of Plaintiffs' environmental expert on health and safety, Eugene Pepper (the "Pepper Report"), confirms the pervasive failure to make accommodations for detainees with physical disabilities. Exh. 49 at 17-18. In the housing unit for persons using wheelchairs in BCBIC, the designated shower for persons with such disabilities lacks safety bars and a shower seat, standard accommodations to minimize the risk of injury. The shower was in fact being used to dump mop water. As a result, a detainee who needed this shower accommodation was being taken to another housing unit for a shower, and as a result had last had a shower a week earlier. His cell also lacked a grab bar or other devices to assist in transfer to and from his wheelchair. *Id.* at 18.

Staff in the unit did not know of another shower with accommodations for disabilities in the building. A second shower designated for persons with mobility limitations "is so slimy with mold that it is not only unsanitary but unsafe to use." *Id.* The Pepper Report also noted that a detainee in another housing unit who used crutches was housed on an upper tier, placing him at particular risk of a fall. Detainees on crutches also have to deal with showers that have very high curb edges, no shower chair, no grab bars, and nowhere to place the crutches while showering. *Id*. ; *see also id.* at Photo 33 (one of the supposedly disabilities-equipped showers); 34 (cell to which prisoner who uses wheelchair confined); 44 (another supposedly disabilities-equipped shower).

§ 28. Medical supplies including dressing changes shall be provided timely.

Plaintiffs' Evidence: [redacted] Detainee 22 uses a wheelchair and has neurological damage precluding normal bowel or urinary control. He needs a particular type of straight catheter, consistent with his latex allergy, to allow him to avoid use of an indwelling (Foley) catheter, which poses additional risks of urinary infection. For substantial periods the type of straight catheter he needs has not been provided to him, including the period of time that he was placed in the MTC infirmary. He now uses a Foley catheter because of this failure to provide the correct supplies. He also requires a sanitary and private area where he can lie on a surface to handle his bowel needs by disimpacting himself, but such an area was not provided to him for most of his stay in the facility. Exh. 22; Exh. 54 (Detainee 22 Decl.). Detainee 1 [redacted] who has multiple problems including uncontrolled diabetes and poorly controlled hypertension, neuropathy, and an abdominal mass the size of an orange, repeatedly and unsuccessfully requested a cane because of problems walking stairs. Exh. 1. *See also* §27 *supra* (descriptions of supplies and equipment problems of Detainees 11, 17, 20 and 22).

§ 29. An appropriate protocol for bed sores shall be implemented.

Plaintiffs' Evidence: As noted above in § 20, Death Case 8 ([redacted] died from sepsis from an infected foot. He had ulcers on both legs and the ulcers smelled. Ordered laboratory tests were not performed. The first attempt to get his outside medical records was in July 2014. At that point, he had a Stage 3 sacral ulcer that was not given follow-up; the ulcer had a foul odor. Exh. 33.

The failures involving Death Case 8 were far from isolated. [redacted] Detainee 1 complained of a sore on his buttocks. A later note in his medical record indicates that he had to be hospitalized for six days. In the hospital he suffered complications during a medical

procedure to drain his abscess, resulting in pulmonary edema requiring intubation. The abscess required intravenous antibiotics. A subsequent note from BCBIC indicates that this was a recurrent ulcer that had been previously treated with Bactrim (an oral medication) and that the patient sought treatment when it developed drainage. Exh. 1

Nonetheless, there is no reference in the medical record to the jail ever culturing the wound, which could have indicated the need for intravenous antibiotic treatment at an earlier point, avoiding the complications. Four months later, he again reported that he had a cyst at the same spot. The response was to treat him with Bactrim; again, there is no indication that laboratory tests were ordered to determine the antibiotics to which the wound was resistant. *Id.*

Similarly, the fact that a physician serving in a correctional facility could see [redacted] Detainee 24 with obvious cellulitis and accept that the most likely explanation was that it resulted from a spider bite suggests a basic lack of vigilance against the specific health threats that must be expected at BCDC. Moreover, the subsequent failure to document the medical history sets the stage for a recurrence of his MRSA infection at his new prison. *See* Exh. 24.

Although not a pressure sore, the treatment of [redacted] Detainee 4 also illustrates concerns about the failure to culture open lesions that are suspicious for MRSA. As previously discussed, after a laboratory report that he had MRSA, there was a delay in starting him on antibiotics. When the wound continued to cause problems, a long series of providers apparently did not read his record, or otherwise alert to the serious danger. The leg was still infected more than a year after he first saw a provider at the jail, despite his multiple attempts to get treatment through the sick call process, but there is no indication that another culture was even ordered. Exh. 4. His record illustrates a dangerously casual approach to the diagnosis and treatment of a potentially deadly disease. *See also* § 27 *supra* (discussion of [redacted]

Detainee 21 and [redacted] Detainee 17).

§ 33. Providers shall document review of abnormal test results and the indicated staff response. All abnormal results shall be posted within 24 hours. Blood sugar, blood pressure and similar readings shall be recorded in the EMR. Nurses shall document in the MARS and sign and note their professional licensure.

Plaintiffs' Evidence: The medical records for ordered blood sugar and blood pressure readings are frequently incomplete without explanation. Further, the medical records provided to Plaintiffs contained virtually no laboratory reports. Even when the record indicates that an abnormal result was received, no actual laboratory record is in the file. It is therefore impossible to determine the actual frequency of missing reviews of abnormal test results. In fact, the only time that the record reveals that such tests results exist is when a nurse or other staff comments upon the results, or the absence of any results.

Death Case 5 ([redacted] did not have any follow-up noted in response to significantly elevated blood pressure results, and many of the ordered blood pressure checks were not carried out or recorded by the nurses. Exh. 30. There was also no follow-up for six days of kidney and blood sugar tests with highly abnormal results ("panic values") for Death Case 13, ([redacted] who died of pancreatic cancer, and the result of his entry testing for tuberculosis was never recorded. In the one form documenting a standardized review of [redacted] Death Case 6's withdrawal symptoms, the nurse failed to document the patient's blood pressure shortly before the hypertensive crisis that resulted in his death. Exh. 31. The medical record of Death Case 9 ([redacted]) also has gaps in documentation in the MARS. Exh. 34. The MARS of Detainee 12 [redacted] show problems with the documentation of drug withdrawal symptoms, blood sugar readings and the administration of insulin, as well as the

review of readings. Exh. 12.

[redacted] Detainee 7 complained about not receiving his psychiatric medications as well as not getting mental health appointments, and it appears that this clearly happened but it is impossible to ascertain the extent because the MARS are so poorly maintained. For example, the record contains three separate MARS, one from WDC and two from BCBIC, all covering July 2014 with indications of medication administration at both facilities on some of the same days and significant differences in the prescriptions listed. The IMHU MARS for Benadryl indicates that the prescription ended on July 15, but the WDC MARS shows administration of Benadryl through July 22. Exh. 7.[33]

None of the MARS in January 2014 shows any results for the blood pressures checks that were ordered during the health assessment on January 19, 2014 for [redacted] Detainee 21. Exh. 21. Only two of the ordered daily blood pressure tests are documented in the October 2014 MARs for Detainee 12. [redacted] Exh. 12.[34] Documentation of many ordered checks of blood sugar levels and withdrawal symptoms are also missing from her records. Detainee 2 [redacted] at times experienced great difficulty in getting the nurses to record his blood pressure results, or his finger stick blood sugar results twice a day, as ordered. Exh. 2. *See also* additional examples in the discussion of § 14, *supra*.

§ 34. The detainee's medical record must be available for consultation when a detainee has sick call and other encounters.

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[33] Most of the entries from WDC after the Benadryl was discontinued are circled. *Id.* This has been used by nurses to indicate non-delivery but it is not an approved form of documentation because the entries are so hard to distinguish from initials.

[34] Detainee 12 has spent her entire jail time in WDC, so like the other records of women detainees, her record is particularly fragmentary because it contains nothing from the EMR.

Plaintiffs' Evidence: There is a pervasive absence of any EMR entries in the medical records of detainees during the periods of time when they were confined in WDC. Despite raising this issue with Defendants after the first group of records was received, no explanation has been provided and all of the medical records supplied to Plaintiffs appear to lack such entries. Of the four women whose records were included in the group of 24 drawn from various lists, only the one that Defendants supplemented to supply the electronic portion and a small part of two other records were usable. The records of a number of men who spent time in WDC housing show the same effect for the time periods confined there. While this problem may be limited to a failure to reproduce the EMR section of the records, it is nonetheless serious because it is another way that current medical staff are not informed by existing medical history that is pertinent to current treatment.

There are other issues that affect all three parts of the BCDC complex. The medical record for Death Case 13 ([redacted] was transferred to MDC although he remained in BCBIC. The EMR is frequently not available to staff because of technical problems. This particular problem seems most pronounced at BCBIC, where staff frequently refer to the problem of the EMR not working for periods of time and thus delaying medical entries. *See, e.g.,* [redacted] Detainee 22 (entry for 9/14/14 indicates that EMR is not working; the handwritten record is difficult to read) (Exh. 22); [redacted] Detainee 15 (EMR entries for May 7, May 13, June 24 and July 3 indicate late entries related to problems with EMR) (Exh. 15); *see also* Exh. 4 (EMR not available during sick call or a similar encounter with [redacted] Detainee 4) (5/21/14); Exh. 5 (same problem in Detainee 5's [redacted] record); Exh. 10 (same problem in Detainee 10's [redacted] record); Exh. 7 (EMR not available on 4/4/14 during dental appointment for [redacted] Detainee 7); Exh. 21 (noting on 11/5/14 that the EMR not

available at time of segregation assessment of Detainee 21 [redacted]

§ 35. There shall be enough intake staff to ensure initial screening within four hours.

Plaintiffs' Evidence: None of the medical records that Plaintiffs originally received contained initial medical screenings for newly arriving detainees at BCBIC. When Plaintiffs pointed out this issue and requested the screenings specifically, the documents that Defendants supplied showed neither the time nor the date of the medical screenings, and in every single case the print-outs purported to show that the detainee, including those who use wheelchairs, had denied any medical needs and any prescribed medications. In fact, there is no evidence in the medical record of Death Case 8 [redacted] that he received an intake medical screening, which may have been the cause of the failure to prescribe the antiretrovirals he needed, despite the fact that he had been receiving them in the community.

Moreover, Defendants' staffing schedule in § 45 of their most recent monitoring report indicates that, over the month of July 2014, there were eight 12-hours shifts during which no one was assigned to the women's sally port entrance post at WDC, and one such shift at the men's sally port entrance. There were 19 sally port/dispensary floater shifts that were not occupied. (12:30 am- 8:30 am only). As a result, there were a number of shifts in which only one of the three positions were filled, although the posts are in different locations. While Defendants say that these posts are covered through other staff, they have presented no evidence that this type of coverage actually prevents delayed intake screening, and indeed, no evidence of appropriate and consistent medical screening. Exh. 46.[35]

[35] There are suicide screenings in some, but not all records, but where other evidence of the arrival date exists, those records indicate that the suicide screening generally does not occur on the day of entry.

The absence of reliable immediate screening and referral frequently causes irreparable injury. *See* §§ 11-12, *supra* (describing multiple cases in which detainees did not receive necessary medications or other treatment after entry, despite known medical needs, with resulting injury to their health, and in some cases death). All that Plaintiffs received from Defendants from the medical records of the initial screenings was a group of forms with the detainee's name and date of birth, but no other relevant information.[36] Nor did Plaintiffs find in the records specific references to information transmitted from the person conducting the intake screening to medical staff. Some people, but far from all, received medications after intake at BCBIC. It is unclear, however, to what extent these medication orders resulted from the intake process. The medical screening process, considered as a system, is one of the most critical functions that a jail medical system must reliably perform. The BCDC process fails the reliability test and is one of the leading sources of harm at the jail.

§ 36. The physician shall document a diagnosis and treatment plan within seven days.

Plaintiffs' Evidence: Because the medical records provided to Plaintiffs do not document the time or date of entry into BCBIC, Plaintiffs have been unable to determine the extent to which Defendants fail to provide diagnosis and initial orders (the closest Defendants come to providing a treatment plan) within seven days of initial entry into BCBIC. *See* Exh. 25. As previously discussed, no formal treatment plan is prepared; there is simply an initial list of diagnoses and orders, if any. The problem list, which is a core element of any treatment plan, is not routinely updated in the EMR, with the result that practitioners are frequently unaware of new diagnoses over the course of a detainee's stay at BCDC.

[36] *See* Exh. 25 (sample of the screening forms received from Defendants).

Any failure to document medical assessments within seven days, however, pales before the failure to prepare and update meaningful problem lists and plans of care at any point during detainees' stays in the jail. Multiple cases demonstrate the harm and excessive risk these failures produce. Death Case 11 ([redacted] was not medically cleared for placement in the IMHU, so medical issues that would be affected by such placement were not ruled out. This was a critical failure because he had a serious history of substance abuse, along with known sickle cell; his medical history from previous admissions to the jail included multiple complaints of chest pain. During the intake process he was seen taking two pills, apparently the Oxycodone he had been given during a recent hospital admission, and after his death, the jail could not account for a Fentanyl patch (a powerful painkiller) he was known to have had. He was also given Haldol and Benadryl by the jail staff.

The autopsy gives the cause of death as cardiac arrhythmia associated with cardiomegaly (enlarged heart) and increased cardiac fibrosis (stiffening of the heart muscle associated with heart failure). He needed medical screening for assessment and appropriate treatment of his symptoms immediately followed by placement in the withdrawal unit or a medical setting rather than the IMHU. *See also* the discussions in connection with §§ 19-20, *supra*.

§ 37. Sick call slips shall be triaged upon receipt with appointment within 48/72 hours, except that urgent or emergent appointments must be quicker.

Plaintiffs' Evidence: The parties discussed this issue several years ago regarding a dispute over whether a sick call request was received at the time the detainee placed the request in the sick call box, so that it was in the physical possession of Defendants, or when it was received by health care following delivery to medical staff. That dispute was resolved by Defendants promising that the sick call requests would be consistently picked up and triaged the day of pick

up by health care staff. Despite that agreement, the majority of sick call slips from current medical records contain only dates for their review by a nurse, with no date for their receipt by medical care staff. Few of these sick call slips show a triage date that matches the date that the detainee sent the sick call slip. The sick call slips are almost always being triaged at least one day after the detainee indicated that the request was submitted; often the delay is two days or more.

This problem is compounded for sick call requests that concern mental health issues. Such requests are first triaged by medical staff, then sent to mental health where they are again triaged – a process that builds in needless delay. Moreover, Defendants have repeatedly, in meetings with Plaintiffs' representatives, insisted on measuring compliance with the PSA exclusively based on the time that the sick call request was triaged by mental health. Thus, the delay between the submission of the sick call slip by the detainee, triage by medical, and receipt of the triaged sick call request by mental health is excluded from consideration as part of the timeliness audits. The mental health provider's own policy regarding sick call is completely inconsistent with the requirements of the PSA, and allows such patients to be seen in fourteen days. *See* Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (MHM) (§ 37) (Policy E-07 at 1).

The resulting delays in seeing persons in response to sick call requests pose a serious risk of harm. Death Case 13 ([redacted] who died of pancreatic cancer that had spread to his neck and spine, sent a sick call slip on November 19, 2013, complaining of a "pinched nerve" in his shoulder, neck and arm. That request appears to have been triaged over a month later on December 24, and he was seen by a PA two days after that.

Death Case 9 [redacted] sent a sick call slip on January 14, 2014, asking for help because

of head aches, stomach problems, cough and chest pain. He indicated that it was the sixth sick call slip he had sent. He did not see a nurse until almost two weeks later. At the time, he was known to have multiple problems, including serious hypertension, renal failure requiring dialysis, and a history of multiple hospital admissions. This was, moreover, a time period during which medical staff had apparently done nothing to follow up on urgent diagnostic recommendations from UMMS and the patient was about three months from death. Exh. 34.

On December 10, 2013 and January 7, 2014, laboratory reports identifying the leg wound of [redacted] Detainee 4 as infected with MRSA were received at the jail. As of January 13, 2014, his medications did not include antibiotics. After those laboratory reports came months of sick call requests from him that seem not to have resulted in seeing a provider who reviewed the laboratory reports. Responses to some of these requests were also markedly delayed. For example, Detainee 4's sick call request for an infected leg was triaged on July 10, 2014 and the nurse referred it to a provider on July 12, but he was not actually seen until mid-September, apparently as a result of a September sick call slip. He again sent a sick call slip on November 1 regarding his leg and a dental problem. A copy of the sick call slip requesting care for his leg infection and for dental care was triaged for dental services on November 3 and he was seen on November 5. The infection complaint was marked triaged on November 8 and seen that day. On November 4, he saw a chronic care provider who indicated that an appointment would be scheduled. Exh. 4. There is no indication that a repeat culture was performed, incision and drainage was considered, or that an appropriate antibiotic for chronic MRSA was chosen; the treatment departed in almost every conceivable way from recommended guidelines for the

treatment of MRSA.[37]

[redacted] Detainee 17 uses a wheelchair and has neurological impairments that require him to use a urinary catheter, as well as an inability to have normal bowel movements. On September 25, 2014, he sent a sick call slip indicating that he had not had a bowel movement for ten days. He was not seen until October 1, at which point he said the problem had resolved. Exh. 17. Detainee 22 [redacted], who also uses an (ill-fitting) wheelchair and experiences serious back pain including spasms, sent a sick call request because he was not receiving his back pain medication on May 27, 2014. It was triaged on May 29; he was referred to a practitioner for a medication order on June 2; and he was seen on June 4. Exh. 22.

§ 39. Registered nurses shall practice within the scope of their licensure.

Plaintiffs' Evidence: An infirmary nurse noted that Death Case 10 ([redacted] was too weak to lift her head but neither referred her to a more appropriate level of practitioner nor examined the patient personally. This failure presumably delayed her transfer to a hospital equipped to diagnose and treat her.

[redacted] Detainee 8 receives dialysis three times weekly. When he goes to dialysis, his blood pressure is checked by a nurse, and his readings have been consistently too high. Between August and November 2014 the readings followed an upward trend, reaching 215/194. Mr. [redacted] Detainee 8 thus experienced a hypertensive crisis on the basis of either of his readings, for which the nurse's appropriate response should have been to seek immediate medical attention for him. *See* note 9, *supra*. In fact, this was the third time that his blood

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See Infectious Disease Society of America, "Clinical Guidelines by the Infectious Diseases Foundation of America for the Treatment of Methicillin-Resistant *Staphylococcus Aureus* Infections in Children and Adults" 1-4, 6 (2011), available at http://www.idsociety.org/uploadedfiles/idsa/guidelines-patient_care/pdf_library/mrsa.pdf.

pressure reading was so high that it met the definition of a hypertensive crisis. The two previous readings had not elicited any apparent response from the nurse. After this third crisis, the physician did order medicine for hypertension, but after a few weeks Mr. [redacted] Detainee 8 was again experiencing seriously elevated blood pressure readings that met the definition of hypertensive crises, including a reading of 210/120. There is no further indication that the nurse alerted a provider about these readings. Exh. 8.[38] Similarly, the nurses required to perform blood sugar checks almost never appear to flag highly abnormal results for a physician or mid-level. *See, e.g.,* Exh. 1 ([redacted] Exh. 5 ([redacted] Exh. 13 ([redacted] *cf.* Exh. 23 ([redacted] (ordered blood sugar tests rarely performed); Exh. 12 ([redacted] [redacted] (ordered blood pressure checks rarely performed).

§ 40. Referrals from the sick call nurse to an internal provider shall be timely, and routine appointments shall be scheduled within five days.

Plaintiffs' Evidence: As noted above, Death Case 13 ([redacted] who died of pancreatic cancer that had spread to his neck and spine, sent a sick call slip on November 19, 2013, complaining of a "pinched nerve" in his shoulder, neck and arm. That request appears to have been triaged on December 24, and he was seen by a PA two days later. On January 22, 2014, he sent another sick call request about pain in his arm and neck for two months. A week later he was sent to an outside hospital, which indicated that upon arrival he had altered mental status.

Death Case 6 [redacted] should have been referred immediately to a physician, rather than to a mid-level provider to be seen the next day, in view of the nurse's recording of a blood pressure of 203/130, a reading clearly documenting a hypertensive crisis. He was also not

[38] Detainee 8's case is not an isolated event. [redacted] Detainee 1's blood sugar and blood pressure readings repeatedly reached dangerous levels before there was any indication that the readings were brought to a physician's attention. Exh. 1.

seen the following day, which was the day he died, because custody had not moved him to the withdrawal unit as ordered. Exh. 31. This event indicates the critical importance of developing and implementing nursing protocols that address the observations that must automatically prompt nurses to follow up to ensure that patients are seen by appropriate providers in urgent situations. When the patient experiences a hypertensive crisis or other sign of the need for immediate medical attention, the system must have a reliable detainee locator system as well as staffing capable of processing sick call requests promptly and with appropriate nursing judgment.

[redacted] Detainee 3 sent a sick call slip on July 11, 2013 that was triaged on July 13 and sent to mental health services as urgent. He was screened by the medical nurse but not seen by a psychiatric nurse until July 24. On April 1, 2014 he was screened as an emergency psychiatric referral but not seen until April 7. Exh. 3. On three occasions, custody transport issues prevented his attendance at sick call. *See id.* (entries for 9/23/13, 5/1/14 & 6/12/14). Death Case 1 [redacted] sent a sick call request that one of the reviewers classified as urgent, but there is no documentation in the record that he was seen that month. Exh. 26.

§ 41. A system shall be implemented to ensure timely rescheduling for missed appointments.

Plaintiffs' Evidence: The mental health provider's audit of rescheduling of missed appointments found that in only 40% of the sampled cases were the detainees seen by staff within the follow-up time frame. According to the pie chart provided, about half the rescheduled appointments were accomplished between eleven and 24 days following the missed appointment. Unfortunately, Defendants do not provide a break-down of the reasons for missed appointments. Another inappropriate policy of the mental health contractor is that "no inmates should be scheduled for a follow up appointment more than once every 75 days following their last face-to-

face encounter with a psychiatric provider." Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (MHM) § 38.

§ 42. Sufficient custody staff shall be available to transport detainees to sick call.

Plaintiffs' Evidence; As noted previously, Defendants admit that they have been unable to perform routine x-rays in a timely manner because of the failure of custody staff to reliably transport detainees from MDC and WDC to BCBIC, combined with the failure to repair the x-ray equipment in MDC. As a result, only 39% percent of patients from MDC received routine x-rays within 48 hours and only 80% of patients from WDC. The average time interval between order and x-ray was four days, double the appropriate time established under Defendants' policy. *See* Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (§§ 25-26) (discussed in more detail in § 25, *supra*).

[redacted] Detainee 7's file also illustrates the dysfunctional relationship between custody and medical staff. Detainee 7 frequently reported that he was suicidal and in psychiatric crisis. He was also frequently absent from scheduled sick call and other appointments; between March 4 and October 16, 2014, he was not brought to ten appointments, with no indication that he had refused the appointment. In four of these missed appointments, the no-show is attributed to the patient no longer being at the facility, with no apparent attempt to find out whether he was discharged or in another part of the jail. Exh. 7; Exh. 35 (Detainee 7 Decl.).

As another example of the pervasive problem with custody staff's failure to provide the needed assistance to allow the delivery of medical care to detainees, Death Case 6 ([redacted] did not receive the bottom bunk ordered by medical; he was lying in a top bunk when found not breathing. Nor did custody provide the ordered transport to the detox unit, where he would have been more closely monitored so that he might have received intervention. Exh. 31.

This is accordingly a case in which, had custody performed as expected, Death Case 6 might possibly have survived his incarceration. Finally, and also possibly related to his death, custody staff also failed to follow policy when they did not start CPR when he was discovered non-responsive in a cell two days after entrance into the jail. Exh. 31. Death Case 1 [redacted] experienced three occasions in which dental sick call was delayed because of a lack of custody transportation. The mental health referral was triaged as urgent by one of the reviewers, but there is no documentation in the record that he saw mental health that month. *See* Exh. 26. Similarly, Death Case 5 [redacted] missed a dental appointment because of a lack of transportation. Exh. 30.[39]

Although Plaintiffs have repeatedly raised the issue of the medical section of the monitoring reports not addressing issues that actually require actions by custody staff, Defendants have never responded by addressing the issue. Defendants' Third Quarter 2014 Monitoring Report does not even contain a section addressing § 42. Among the staff notations that custody did not bring a detainee to a sick call appointment are the following: [redacted] Detainee 1 (Exh. 1) (7/18/13); (9/23/13) (custody did not bring because of construction); (4/11/14); and 4/20/14);[40] [redacted] Detainee 3 (Exh. 3) (4/30/14 & 6/12/14); [redacted] Detainee 5 (12/15/14) (Exh. 5) (not transported from segregation); [redacted] Detainee 10 (Exh. 10) (1/18/15) (not transported to sick call on 9/26/14, 9/30/14 and 1/8/15); [redacted]

[39] Although custody staff are supposed to be trained in CPR and are to administer CPR when called for, custody failed to initiate any CPR when Detainee 5 was discovered pulseless. There was a resulting 8-minute delay in initiating CPR until health care staff arrived.

[40] Of note, Mr. [redacted] Detainee 1 had particularly serious needs for reliable sick call access because he experienced continuing problems with his medications running out without being reordered, including medications for his uncontrolled diabetes, asthma, hypertension and anti-psychotic medications and, at one point, a mass in his abdomen the size of an orange (entries for 3/2/13; 3/18/13; 9/17/13). *See* Exh. 1.

[redacted] Detainee 9 (Exh. 9) (custody said they could not find her on 9/26/14 for sick call).

[redacted] Detainee 8 provides a particularly egregious example of the failures of custody staff. On August 28, 2014, Detainee 8 signed a sick call request that mentioned his anxiety and feeling that the walls were closing in on him. The request was triaged as urgent, but he was not seen by a nurse until September 3. The following day he was a no-show for his appointment with mental health; the correctional officer is unclear about why he was a no-show; as of October 1, there had been no attempt at rescheduling the appointment. On October 14, 2014, custody did not take him to his telemed appointment. *See* Exh. 8; *cf.* discussion in § 27 *supra* (noting that detainees who could not walk were subject to extended delays in receiving dental care because of broken elevators in the housing unit where detainees with mobility disabilities are held).

§ 43. The staffing plan shall ensure sufficient staff to complete triage of sick call timely.

Plaintiffs' Evidence: *See* discussion of § 37 *supra*. Moreover, Defendants' records show that the contract mental health provider has often left the BCDC mental health RN position (five days per week) uncovered, including on July 4, July 7, July 21, July 23, July 27, July 30, and August 1, 2014. The WDC RN position was uncovered on August 26; other than that day, the same RN covered every assigned shift without any other day off, suggesting a lack of back-up coverage. Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (§§ 43 & 45). *See also* Plaintiffs' evidence of the failure to cover the intake health screening posts in Plaintiffs' discussion of § 35, *supra*.

§ 45. Staffing shall be sufficient to permit medical staff to respond to health needs.

Plaintiffs' Evidence: Defendants' own audits of responses to mental health urgent

referrals demonstrate that only 42% were seen within 24 hours while only 81% of routine referrals were seen within five days. Defs.' Third Quarter 2014 Monitoring Report (MHM) §48. One of the obvious causes of the serious deficiencies in medical and mental health care is the amount of work that a medical or mental health staffer must go through to perform necessary functions adequately. For example, the failures to develop, update as appropriate, and implement a plan of care places staff members in an untenable position. The conscientious provider must read the entire progress notes section, as well as the problem list. For patients who have been in the facility for some time, that's not an easy task. Absent such knowledge, however, the provider is reduced to relying, almost entirely, on the patient's own memory of his or her medical history. That's a poor bet when the stakes are so high. While Defendants may choose to claim that the staffing levels are sufficient, should they do so, they should explain what else they are prepared to change to cure the current problems that prevent the delivery of minimally adequate medical and mental health care to members of the class in a timely manner.

§ 46. Appropriate policies shall be implemented to ensure timely and appropriate response to health needs.

Plaintiffs' Evidence: Either Defendants do not have, or they have not implemented, adequate policies to guide individual discretion. For example, in Death Case 13, ([redacted] the infirmary did not chart fluid input and outgo. This is a standard measure in hospitals to avoid precisely the injury suffered by this detainee. Death Case 13 could have avoided severe kidney injury from dehydration had that simple measure been taken. This consideration underlines a point made above: Defendants need to implement clear protocols on when nurses must notify providers immediately because of a blood pressure reading, a blood sugar reading, an abnormal vital sign, and similar matters.

There are multiple additional cases in which following standard policies and practices, such as reporting critical observations, would have avoided exposing patients to unreasonable risk of injury. For example, an infirmary nurse noted that Death Case 10 (was too weak to lift her head but neither referred her to a more appropriate level of practitioner nor examined the patient personally.

Another standard policy that was not followed occurred in Death Case 11 (It is very important that when a patient appears to have an altered mental status, medical causes of that change are ruled out before the change is assumed to reflect a psychiatric issue. When Death Case 11 experienced a change in mental status, he was not medically cleared prior to placement in the IMHU; following this policy might have prevented this death.

Medical clearance was critical in his case because he had a serious history of substance abuse, along with known sickle cell. His medical history from previous admissions to the jail included multiple complaints of chest pain. Medical staff had reason to know that he might have ingested powerful painkillers with sedative effects during the intake process. He was also prescribed psychotropics including Haldol with significant sedative effects in the jail prior to his death from heart-related causes. Death Case 11 needed medical screening for assessment and appropriate treatment of his condition at the time, followed by placement in the withdrawal unit or a medical setting rather than the IMHU.

Death Case 4 (when seen at screening on February 13, 2013, was given a "routine" referral to a practitioner, despite a temperature of 103°. There is no indication that he received any antibiotics until February 16, with a second antibiotic on February 17, and those medications were delivered to the patient as keep-on-person ("KOP"), so there is no clear evidence of administration of the medications. On February 19 he was transferred to a hospital

and he died on March 3. Prior to entry into the jail, he had a recent history of hospitalization for sinusitis and a mastoid infection in his jaw with no "definite" intracranial extension. Exh. 29. Given the symptoms, an immediate physician referral and immediate provision of antibiotics and careful work-up should have been automatic. The lack of that treatment led to death.

The mental health contractor's own monitoring documents show that detainees who were denied bridge orders for medication (prescriptions that are ordered without direct contact with the patient, for a limited period of time until the provider can see the patient) were not seen for a follow-up face-to-face appointment within 72 hours more than one-third of the time – and the contractor bragged about this achievement since the compliance figure had been 16 percent in July 2014. Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (MHM) § 48.

The major cause of that improvement undermines any argument that staff productivity has increased; timeliness became much easier to achieve because the mental health contractor dramatically and intentionally reduced the total number of denied requests for bridge orders from 113 in June to 14 in September by encouraging psychiatric staff not to disapprove bridge orders: "We were equally pleased to see an overall increase of 13.5% in the August number of bridge orders that were approved compared to July totals while seeing a continual decrease in the number of denied bridge orders." *Id.* (August Update).

While it would not surprise Plaintiffs if it were true that the higher percentage of approved bridge orders is, on balance, a good development, it is completely inappropriate to encourage psychiatrists to change their prescribing practices to make it easier to achieve timely follow-up of denied bridge orders. Even more critical to evaluating the system's performance, it took a massive reduction in the number of denied requests, thus also substantially reducing the workloads of the psychiatrists, to even approach a demonstration of compliance with the

requirement for timely appointments with patients. *See id.* This fact again suggests a lack of enough psychiatric staff, or some obvious and substantial inefficiency in their performance.

§ 47. Sufficient custody staff shall be provided to ensure transport for detainees with emergency health care needs.

Plaintiffs' Evidence: Even in emergencies, there are sometimes difficulties in obtaining custody transport of detainees requiring medical treatment. For example, following an altercation in which ([redacted] Detainee 11 suffered injuries to his knee cap and ACL (anterior cruciate ligament) requiring surgery, custody staff declined to transport him to medical care, and he was unable to gain any examination or treatment of his injuries for three days. Exh. 11; Exh. 56 (Detainee 11 Decl.).

In fact, medical problems threaten to become emergencies because of failures of custody staff to provide transport and otherwise carry out their job duties related to providing medical care. For example, Death Case 6 [redacted] was not transferred to the withdrawal unit. Following his death, medical staff asserted that the failure to provide him with his ordered medications, his withdrawal checks, and his appointment with a practitioner flowed directly from custody's failure, to notify them of the actual location of Death Case 6. Exh. 31. *See also* Exh. 1 (custody did not take [redacted] Detainee 1 to an appointment on 7/18/13; on 9/23/13 he did not get to clinic because construction was occurring and custody did not bring him; on 4/11/14 and 4/20/14 custody did not bring him to sick call).

§ 48. Sufficient psychiatric staff shall be provided to ensure timely and appropriate psychiatric evaluations that include evaluation for medications and suicide risk.

Plaintiffs' Evidence: As noted above, Defendants' own audits of responses to mental health urgent referrals demonstrate that only 42% were seen within 24 hours while only 81% of

routine referrals were seen within five days. Exh. 46, Defs.' Third Quarter 2014 Monitoring Report (MHM) § 36. These failures have real-world consequences. Death Case 12 ([redacted] was given an urgent referral to a psychiatrist after the intake suicide screening, but that referral was never carried out. The staff member who performed her 7-day intake mental health review also did not review her medical record, and the psychiatric provider did not document a reason for not starting medications during the initial patient encounter. Death Case 12 was also prescribed Risperdal, for bipolar disorder, despite an allergy to the medication. There was no documentation of a plan for dealing with the detainee's allegation of a recent rape. In addition, cooperation was poor between medical care and mental health regarding Death Case 12's health care. Most significantly, she did not have any psychotropic medication from her arrival in July 2012 until a week before she committed suicide in April 2013.

Death Case 11 ([redacted] illustrates why it is important that this requirement of the PSA includes a specific mandate for review of the patients' medication needs, in light of his death from an apparent combination of prescribed and illicit drugs, while isolated in the IMHU, having received neither an intake medical evaluation or a medical evaluation to rule out medical problems before he was confined there.

[redacted] Detainee 20 came into BCBIC in July 2014. After the intake mental health entrance screening on July 20, he was referred for an urgent mental health appointment. On July 23 he was seen by a nurse practitioner who prescribed Celexa, an anti-depressant. The medication was scheduled to run out on November 23, and he was scheduled for a follow-up appointment on that date. According to a note on November 24, he saw a provider that day but the medication was not reordered. An urgent follow-up with mental health was ordered. A follow-up note on December 11 indicates that Detainee 20 met with someone on December 1,

2014, that the provider indicated that the medications were being ordered, but that the medications were not renewed in the prescription section of the EMR. Exh. 20.

The patient was again scheduled for urgent follow-up. The medication was actually ordered on December 15, which means that the patient experienced a three-week interruption in his medication. *Id.* This sequence of events does not necessarily by itself demonstrate that the cause of the problem was insufficient staffing. When considered in light of the evidence that mental health staff has never been able to demonstrate that it can ensure that referrals are seen on a schedule consistent with their urgency, however, it should place the burden on Defendants to demonstrate that the staffing pattern is in fact sufficient.

§ 49. Bridge orders shall be consistent with medical standards and shall not result in medication losses.

Plaintiffs' Evidence: *See* discussion in § 46, *supra* (noting Defendants' failure to comply with their own policies regarding follow-up of detainees denied psychiatric bridge orders, and arguing that Defendants' attempts to produce improvements in statistical measures of compliance with requirements to see patients timely by discouraging rejections of proposed bridge orders, rather than ensuring that the referrals were timely carried out, was an inappropriate strategy).

§ 50. Where medical standards require an in-person evaluation, the evaluation shall be provided timely and by an appropriate level of staff.

Plaintiffs' Evidence: A number of the death cases demonstrate failures of the system to provide in-person evaluations when they were obviously warranted. For example, Death Case 13 ([redacted] who died of pancreatic cancer that had spread to his neck and spine, sent a sick call slip on November 19, 2013, complaining of a "pinched nerve" in his shoulder, neck and arm. That request appears to have been triaged on December 24, and he was seen by a PA two days

later. On January 22, 2014, he sent another sick call request about pain in his arm and neck for two months. A week later he was sent to an outside hospital, which indicated that upon arrival he had altered mental status.

Similarly, Death Case 11 ([redacted] was never seen for medical intake. He also never had a physical examination prior to placement in the IMHU and so medical issues that would be affected by such placement were not ruled out at a time he needed placement in a hospital or withdrawal unit. Death Case 3 [redacted] experienced a parallel failure when he returned to BCDC from an outside mental health hospital, but did not receive a medical screening or review, and his prescribed Coreg heart medication was interrupted without providing any replacement heart or hypertension medication. Exh. 28.

Similarly, Death Case 6 [redacted] who was noted to have experienced a hypertensive crisis right after admission while undergoing withdrawal, was not immediately seen by a physician and died the next day without administration of any hypertension medication beyond the initial dose. He also did not receive an ordered blood pressure check. He should have been assigned to either a detox unit or an infirmary. Exh. 31. Death Case 12 [redacted] was not seen at all in response to an urgent mental health referral at the time that she was admitted to BCDC and the mental health reviewer who saw her at the standard intake evaluation did not set a follow-up mental health appointment. *See also* the discussion regarding § 48, *supra*.

§ 53. Appropriate protocols shall be implemented so that qualified mental health professionals provide timely, adequate and appropriate evaluation and treatment for detainees.

Plaintiffs' Evidence: The previous sections in which Plaintiffs discuss mental health issues note that Defendants' own audits show that the mental health contractor is not providing

important services timely. Indeed, as Plaintiffs have also pointed out, even when Defendants have asserted that they were performing timely, their own documents have been inconsistent with their claims. *See* discussion *supra* regarding § 48. Plaintiffs have also provided examples of harm from these failures. Given the breadth and persistence of the problems, it seems most likely that the root cause of the failures is lack of sufficient staffing.

For example, as noted above, among many other failures, Death Case 11 ([redacted] was never seen for medical intake. He also never had a physical examination prior to placement in the IMHU, despite many red-flag issues in his medical history, and so medical issues that would be affected by such placement were not ruled out. He needed placement in the withdrawal unit or a medical unit where he could have been monitored and treated rather than being isolated in the IMHU. Similarly, Death Case 12 [redacted] experienced multiple basic failures by mental health staff, including the failure to see her at all as a result of an urgent referral during the intake screening process and the subsequent failure to set an appointment with mental health at the time of the seven-day intake evaluation. *See also* the discussion of the treatment of ([redacted] Detainee 20 regarding § 15, *supra*.

§ 60. Objects that could be used for hanging shall be removed from the IMHU and the BCBIC holding cells or otherwise addressed.

Plaintiffs' Evidence: While Defendants took some steps to remove objects that could be used to attempt suicide from the IMHU, such hazards continue to exist there. *See* Exh. 50 (2015 Photos) (#7262).

Physical Plant

§ 67. Defendants shall keep the roof top and window fans working.

Plaintiffs' Evidence: Defendants' own monitoring report indicates that when Defendants

inspected the rooftop fans in June of 2014, 21 out of a total of 93 were not operational and many remained unrepaired near the end of July. Through August of 2014, six fans, at a minimum, were still not working, meaning that through all of the most recent summer Defendants were not in compliance with this requirement. Exh. 46 (Defs.' Third Quarter 2914 Monitoring Report) (§ 67). Of note, the failures to maintain the rooftop fans that are supposed to exhaust hot and humid air during the summer months exacerbate the failures of the air exhaust system described in the discussion of non-compliance with PSA § 68, *infra*. *See also* Exh. 59 (Pls.' Summary of Maintenance Repair Log) (summarizing Defendants' Maintenance Repair Log (Exh. 53) by type of repair, including electrical fan and air conditioning issues, and showing the time between report of a problem (not necessarily the date the problem first occurred) and repair completion) at 3.

§ 68. The air exhaust systems shall be kept working and cleaned on a regular basis.

Plaintiffs' Evidence: Plaintiffs' sanitation expert, Eugene Pepper, found that the ventilation grills and ducts are plugged with dirt and debris. The system fails to remove excess moisture in critical areas where bacteria and mold grow, and the system's failures are a major contributor to the problem of black mold in the ceiling, shower and toilet areas of the jail. A number of housing areas had high humidity, despite the fact that Mr. Pepper's inspection took place in the month of February. Tested temperature and humidity gauges were not functioning correctly. In addition to the health effects resulting from the combination of the high humidity and the lack of adequate cleaning, the clogging of the ventilation system creates a fire hazard. Exh. 49 (Pepper Report) at 9-11; *see also id*., Photo Section at 28, 30, 35. Of note, Defendants have themselves noted that this problem must be fixed. The 2013 Facilities Master Plan expresses the need for "highly insulated and moisture protected building envelopes" – in other

words, physical plant improvements to keep out the excess humidity that causes a host of problems in the facilties. Exh. 61 at 1-12.

§ 69. Defendants shall ensure that the ventilation system is maintained in proper working condition.

Plaintiffs' Evidence: *See* discussion in §§ 67-68, *supra.*

§ 70. Medical staff shall be able to place a detainee with an H1 classification in temperature-controlled housing, consistent with such available housing. Other detainees shall be protected from heat injury in the manner provided in the Heat Management Plan.

Plaintiffs' Evidence: The bottom line is that, according to Defendants' own audit, only 85 percent of detainees medically classified as H1 in July 2014 were actually housed in what is considered H1 housing; no reported month did better than 90 percent compliance. Exh. 46, Defendants' Third Quarter 2014 Monitoring Report § 72. Moreover, an audit of emergency care over the summer months had as an incidental finding that five of the detainees sent out for emergency care were classified in H1 housing but not so housed.[41]

There were 43 incidents over the studied period involving detainees who had urgent medical visits related to complaints about excessive heat. Of the 39 incidents involving detainees who were classified as H1, four involved detainees housed in either JI or F Section. These units are classified as suitable for housing H1 detainees, but these two housing units at times every summer do not in fact control temperature under the definition of temperature-

[41] Defendants' Report indicates that the emergencies were not intrinsically heat-related. *Id*. But the fact that such a large number of detainees required emergency care over a two-month span suggests how vulnerable these H1 detainees were when improperly assigned to regular housing. Moreover, many of the events involve asthma attacks, which in many persons with asthma are subject to triggering by exposure to excessive heat.

controlled housing in the PSA.[42] There were no incidents involving H1 detainees housed in temperature-controlled housing that in fact appears to stay within the mandated temperature range. *Id.*

In the 35 remaining incidents, the detainee was classified as H1 but was placed in regular housing. *Id.* Defendants have informally indicated that the major source of the problem was a glitch in the their computer records as to detainee location, which they claim to have addressed. One piece of evidence suggesting that the problem is not fully solved, however, is the case of Detainee D.J. He experienced heat-related symptoms on two separate occasions that led to urgent medical visits. The first was on July 22, 2014, when he is described as short of breath ("SOB") and wheezing. A standard test of the capacity of his lungs to move air in and out ("peak flow test") indicated that at the time he was experiencing significantly reduced lung function. He was classified for H2 housing. The reported disposition, following his reclassification to H1 status, was a transfer to H1 housing. On August 7, he reported similar symptoms. This is not particularly surprising, because he was still housed in the housing unit where the previous incident had occurred. It thus appears that either he was never actually moved to appropriate housing or was thereafter moved back to regular housing by custody staff. *Id.* (entries for 7/22/14 & 8/7/14).

Nor is any explanation offered as to why the 35 detainees classified as H1 were not properly housed, or any quantification of the total number of H1 detainees who were not safely

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[42] It is important to remember that the PSA definition of H1 housing is based only on the temperature, even though the accepted method for determining risk of heat injury is through measuring the heat index, a combination of the effects of heat and humidity. If heat index were instead measured, many more readings in areas considered temperature-controlled would show as posing risk for these detainees. The PSA definition was limited to temperature to avoid the problems that would have been occasioned by requiring staff to calculate the heat index on a continuing basis and apply that derived measurement to housing decisions.

housed. If even ten percent of H1 detainees were wrongfully housed, the audit data imply that hundreds of detainees were subjected to an unsafe housing placement. Moreover, the Heat Incidence Tracking Log 2013 indicated that medical staff simply "recommended" temperature-controlled housing, but that a number of such detainees, after they complained of heat-related symptoms, were left in regular housing. *See* Exh. 48 (Defs.' 2013 Monitoring Report) (§ 72). The Defendants' Heat Management Plan referred to in PSA § 70 provided for respite time in air-conditioned housing for both H-1 and H-2 detainees, but the respite measures for H2 detainees, to the extent that they were implemented,[43] have disappeared, and the H1 measures have been implemented only occasionally and partially when attempted.

Finally, Defendants' 2014 Heat Incidence audit was substantially incomplete, because it covered only MDC. [redacted] Detainee 2, is classified as H1 (at high risk for heat injury). He carried diagnoses including diabetes, hypertension, asthma, and obesity – all of which predispose to heat injury. On June 10, 2014, he had to be seen for an unscheduled appointment because he was experiencing heat-related problems, with tightness in his chest and shortness of breath. He requested that staff move him from F Unit, which is supposed to be temperature-controlled, but does not in fact achieve reliable temperature control, to a cooler housing unit. It does not appear that he was actually transferred, because he was still complaining of excessive heat at WDC a week later. Exh. 2 (entry 6/18/14). Thus, the total number of heat incidents in the summer of 2014 among detainees in BCDC, including JI and WDC, is unknown.

This is Defendants' longstanding pattern of failing to execute their obligations under the

[43] *See* Exh. 60 (Excerpt from Stacey Lyle-Foster Deposition, 7/22/10) at 1, 18 (staff member overseeing the operation of the contract for medical services testifies that H2 detainees are supposed to receive heat respite). Given the fact that Defendants are not following the original Heat Plan, it is unclear what difference it makes if a detainee is designated H2 or H3.

provisions of the PSA intended to prevent exposure to excessive heat. In the summer of 2013, five detainees complained of problems related to heat and humidity and were assessed and treated after receiving urgent health care encounters. Four of them had documented histories of asthma or other breathing problems. Three of the five detainees were also receiving mental health medications. *See* Exh. 48 (2013 Monitoring Report).[44] Following these incidents, two of the detainees were "recommended" for H1 status and moved to a temperature-controlled area. Another detainee was without explanation apparently not moved, although he had been recommended for H1 housing since June 2012. *Id.*

The two JI housing units, JI 600 Dorm and JI 700 Dorm, that are used for H1 housing are not truly temperature-controlled as defined in the PSA. Even during the relatively cool past summer (as compared to other Baltimore summers in this century), two of the purportedly temperature-controlled housing areas suitable for safe confinement of H1 detainees experienced temperatures above 90°, with heat indices that topped out at 95° for JI Dorm 600 (on August 28) and 104° for JI Dorm 700 (on August 27).[45] The humidity in these housing areas was recorded at up to 70 percent in Dorm 700 and up to 65 percent in Dorm 600. The heat index on May 26, 2014 reached reached 94°in JI 700, which was the highest recorded in any of the JI housing units that day. *Id.*[46]

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[44] Presumably the mental health medications were noted in the log because the specific medications these detainees were prescribed were among the psychotropic medications that predispose patients to heat injury.

[45] Temperature alone is not an accurate measure of heat risk. In hot weather the heat index is a more reliable measure of heat injury risk. *See, e.g.*, National Weather Service Forecast Office, "What is the Heat Index?", available at http://www.srh.noaa.gov/ama/?n=heatindex,

[46] The 2013 Facilities Master Plan indicates that JI should be demolished. *See* Exh. 61 at 3-8.

Nonetheless H1 detainees continued to be sent to the JI dormitories precisely because they had been classified as H1, even when non-designated housing was in fact experiencing lower heat indices than the designated H1 housing. *See id.* In such circumstances, the fact of designation to H1 housing actually increases the risk to detainee health.[47] The designated JI dormitories, the top floor of WDC, and Units E and F in MDC are all designated for H1 detainees but none actually qualifies as safe housing for detainees found to be at highest risk of heat injury. The same was true of the IMHU when it was previously operated in MDC. *Id. See also* §71 discussion *infra*; Exh. 5 (Detainee 5 ([redacted] a Type 1 diabetic with uncontrolled blood sugar levels was assigned to JI during the summer of 2013; it was extremely hot and at one point he fainted from heat but did not report it to staff); Exh. 37 (Detainee 5 Decl.).

§ 71. Temperature gauges shall be installed in all MDC housing units. When the temperature reaches 88°, a program to prevent heat injury including distribution of water and ice shall be implemented. Persons at high risk of heat injury shall be evaluated by medical staff and as necessary treated or moved.

Plaintiffs' Evidence: The gauges are not appropriately calibrated or appropriately located. Plaintiffs' initial environmental report, by James Balsamo in 2009, found that most gauges were reporting temperatures three degrees lower than his professionally-calibrated thermometer. Defendants were also not recording the temperature on the top tier of housing units; Mr. Balsamo

[47] The problems with the two temperature-controlled units in JI are not an isolated event. The entire JI building appears to be in particularly poor shape. There have been prolonged previous periods during the summers when the designated JI Dormitories have been dangerously hot and humid, while other housing units that were not so designated were in fact safer for H1 detainees. The same phenomenon occurred in the past for a significant period when the top floor of WDC was designated for male H1s until Plaintiffs discovered the issue and raised concerns with Defendants.

found a 10-degree difference between Defendants' gauge and his own instrument on a housing unit.[48] Defendants were provided with a copy of Mr. Balsamo's 2009 Report. *See also* Exh. 49 (Pepper Report) at 10 (noting that temperature and humidity gauges were not appropriately calibrated).

A second problem is that Defendants are not reporting the readings from the correct time of the day. As Plaintiffs' counsel informed Defendants' agents during discussions after Mr. Balsamo's inspection, Mr. Balsamo indicated that Defendants should record the data from 6:00 pm rather than 3:00 pm, which is the time of recording in the data that Defendants provide in their monitoring reports.[49] Moreover, working temperature and humidity gauges are not always available in the units. The temperature and humidity gauges for juvenile segregation in WDC were not installed until mid-July of this year. In fact, Defendants provide no data from any part of WDC. Yet another problem is that staff do not always record the readings. Many housing units are missing data for particular days. No data is available from BCBIC, which is now expected to provide the majority of H1 housing, because staff did not attempt to record the readings. *See* Exh. 46 (Defs.' Third Quarter 2014 Monitoring Report) (§§ 71-72) (Temperature and Humidity Readings).

§ 72. Fans shall be provided in the housing units of MDC, consistent with security,

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[48] Mr. Balsamo inspected BCDC in August 2009. Mr. Pepper performed his inspection in February 2014, so he did not repeat Mr. Balsamo's comprehensive recordings of housing unit temperatures.

[49] To Defendants' credit, in their Third Quarter 2014 monitoring report, they note several example on days in which designated temperature-controlled housing units in JI exceeded the temperature allowed under the amended PSA requirements and on which the 6:00 pm recorded temperature was higher than the temperature in the Table for 3:00 pm; Plaintiffs have relied on that 6:00 pm data in their discussion above. *See* Exh. 46 (Defendants' Third Quarter 2014 Monitoring Report) (§ 70).

to assist in ventilation. Defendants shall make available 600 beds of temperature-controlled housing, including housing in the Jail Industries Building, BCBIC, the Women's Detention Center ("WDC"), the Wyatt Building, the IMHU (Inmate Mental Health Unit), and any other area in which documented temperatures did not exceed 88° during the May-September period; Defendants shall maintain the air conditioning units installed in Units E and F and shall install an air-conditioning unit in one housing unit for juveniles. Juveniles classified as H-1 shall be housed in that unit, absent disciplinary or security reasons for housing elsewhere. H1 detainees in Units E and F shall be housed in the lowest tier of these units unless all such cells are occupied by other H1 detainees or other detainees who require the lowest tier for medical reasons. In that case, such H1 detainees shall be housed in the lowest available tier.

Plaintiffs' Evidence: As noted above, the top floor of WDC could never qualify as temperature-controlled housing. For a significant period of time until Plaintiffs' counsel complained, male H1 detainees were being assigned to the top floor of WDC. During that period, the top floor at times had higher heat indices (as a result of the limited capacity of the air-conditioning installed in WDC) than the detainees would have been exposed to if they had not been classified as H1. It is unclear whether this problem still occurs. On June 8, 2014, Detainee 2, [redacted] classified as H1 (at high risk for heat injury) and housed in WDC, had an unscheduled appointment with medical because he was hot, with tightness in his chest and shortness of breath. He requested that staff move him to a cooler dormitory. Exh. 2. The following week he experienced a similar heat-related problem. *Id.*

Similarly, H1 detainees with acute mental health needs were at one point during an inspection discovered by Plaintiffs in the MDC IMHU unit, despite the fact that the air

conditioning unit was not working, and the unit was unbearably hot and humid – and thus dangerous for many of the detainees who were prescribed any of a number common psychotropic drugs. More recently, as noted above, security has mis-assigned significant numbers of H1 detainees because of a miscommunication regarding where such detainees could be housed. *See* discussion of §70, *supra*.

In addition to the 21 inoperable roof fans, six of the window fans in the facilities were not working for all or part of this summer. *See also* Exh. 59 at 3 (Pls.' Summary of Repair Log) (noting problems with fans in O Section, K Section, Q Section and P Dorm, as well as the air-conditioning units in F Section (an area used to house H1 detainees) and Wyatt Building (same)). The Maintenance Repair Log discusses a possible problem in the JI Dorm 800 window fan circuit, but it is impossible to tell if that issue was ever resolved. *See* Exh. 53 at 14.

Detainee 3 [redacted] was housed in Dorm 700 of JI during the summer of 2014. He observed that the correctional officers often opened the windows on the catwalk of the dorm. When the windows were open, the air conditioning would be turned off. Exh. 3; Exh. 57 (Detainee 3 Decl.). Detainee 5 [redacted] who was housed in JI during the summer of 2013 and is an H2, became so hot that summer that he fainted, although he did not seek medical attention. Exh. 37 (Detainee 5 Decl.). *See also* discussion in Section II of the Argument *infra* regarding the practice of leaving detainees for days in housing units in MDC during the summer of 2013 when the sinks and toilets in the cells were not working, and detainees had access to bottled water only through custody staff during hot and fetid conditions resulting from flooding with waste water in the units.

§ 73. Defendants shall maintain the plumbing improvements in WDC designed to prevent flooding in the basement dormitories.

Plaintiffs' Evidence: Mr. Pepper encountered flooding from a broken pipe in the WDC basement dormitories during his inspection.[50] C Dormitory, one of two WDC dormitories affected by flooding, was nonetheless in use as a housing unit. Mr. Pepper identified the problem as failure to perform proper maintenance. Exh. 49 (Pepper Report) at 21; *see also id.,* Photo Section at 4-6. During the summer of 2014, there was also flooding in C Dormitory in WDC, as well as WDC Dorms L, G, and T, and a leaking ceiling in a WDC office. *See* Exh. 53 (Maintenance Repair Log) at 18. Moreover, flooding of occupied housing areas raises the prospect of compromising the facilities' plumbing and potable water systems. When such flooding shuts down toilets, showers and sinks, Defendants have failed to move the detainees, or even make any minimal arrangements for their safe confinement. *See* discussion *infra* at Argument Section II.

§ 74. Absent emergencies, all broken toilets, showers and sinks shall be repaired within 72 hours.

Plaintiffs' Evidence: Defendants' maintenance records indicate 26 occasions over the most recent three-month period for which Plaintiffs were provided records in which one or more toilets was either not repaired within 72 hours of being reported, or no repair date was reported. Exh. 59 (Pls.' Summary of Maintenance Repair Log) at 4. Many of these broken toilets affected multiple detainees. *See, e.g., id.* at 5 (12 days to repair broken toilet in BCDC receiving bullpen).[51] Four of the entries do not have an indicated repair date, and among the listed toilet repair needs, the longest elapsed time prior to repair is 32 days. *Id*. [52] For the great majority of listed sinks and

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[50] The other flooding involved two housing areas in MDC. *See* Exh. 49 (Pepper Report) at 21.

[51] *See* Exh. 53 (Maintenance Repair Log) at 26.

[52] *See id.* at 9.

showers needing repair, the repair took more than three days. The longest listed delay until repair was 68 days, but five of the entries had no repair date listed. *Id.* at 6-7. At least five of the repairs took more than a month *Id.* at 6.

Mr. Pepper reviewed the maintenance records provided by Defendants during his inspection to see if he could identify a pending request to repair a large hole in the wall in one of the showers. No such request could be found. Exh. 49 (Pepper Report) at 22; *Id*., Photo Section at 4 (noting that toilet flooding the floor had been broken for more than 72 hours); *see also id.* at 21, 24, 39-40. Moreover, most of the showers and sinks can provide only lukewarm or cold water. Standards require that hot water be provided at 105-120°, and the system clearly could not provide that. Many of the dormitories had showers that could not be shut off. A shower that was supposed to be accessible for persons using wheelchairs did not work at all. Moreover, Mr. Pepper determined that all of these conditions had existed for more than 72 hours. *Id.* at 16-17. *See also* discussion regarding evidence of non-compliance with § 90, *infra*.

§ 79. Shower temperatures shall be regularly tested and scalding hazards shall be promptly addressed.

Plaintiffs' Evidence: When Defendants some time ago provided actual records of testing the shower temperatures, readings in several showers indicated that the water temperature exceeded safe levels. *See* Exh. 49 (Pepper Report) at 17 (standards require that shower temperatures be maintained within 105-120°). More recently, Defendants confirmed that they are not monitoring the shower temperatures on a regular basis, but are responding only to complaints about improper temperatures. *See* Exh. 52 (Email 3/10/15 from Nathan to Alexander).

§ 80. Shower walls and floors shall be maintained in safe and sanitary condition.

Plaintiffs' Evidence: Walls, ceilings and floors of showers throughout the facility are a

serious threat to health and safety because of pest infestations, black mold, lack of sanitation and basic cleaning, and failure to provide accommodations for persons with disabilities. The failures start with the absence of basic cleaning and sanitation, maintained over time, resulting in layers of soil, black mold, and soap film. These failures are severely exacerbated by the lack of a properly functioning ventilation system, including the high humidity it produces, as well as leaking sinks, showers and toilets. The safety hazards are compounded by the wet and broken condition of the floors and multiple leaks from plumbing fixtures and clogged drains *See* Exh. 49 (Pepper Report) at 5-7, 9-12, 16-18, 21; *Id.*, Photo Section at 1-3, 7, 8-10, 18, 19-20, 21, 24-25, 27, 39-40, 44-46. *See also* Exh. 53 (Defs' Maintenance Log) (passim); [53] Exh. 50 (2015 Photos) (*see* Exhibit 50 Index for photographs in the following categories: showers/sinks/toilets; mold; utility closets; and ventilation).

§ 82. Defendants shall implement an enhanced laundry program with the goal that, with all good faith efforts, personal laundry will be safely and routinely returned to the owner in three days or less. Defendants shall also establish an efficient and effective system of returning lost laundry.

Plaintiffs' Evidence: Mr. Pepper's Report found a widespread practice of detainees' hand-washing personal laundry in makeshift arrangements, such as mop buckets. They do this because, if they send their laundry to the external facility used by BCDC, they lose their clothing. They certainly do not receive the clothing in three days. The loss appears to be occurring at the Central Laundry. Mr. Pepper also concluded that the laundry issue is exposing detainees to an unreasonable health risk of contracting disease. Exh. 49 (Pepper Report) at 13. Moreover, the

[53] The entries in Defendants' Maintenance Log do not generally distinguish between water problems originating in rainwater leaking from roofs or windows and leaks of potable water in contrast to leaks of sewage lines.

quasi-official recognition of the fact that the facilities do not provide laundering of underwear and other personal laundry is exemplified by the fact that one of the topics for group therapy in the Special Needs Unit (a unit in BCBIC for some detainees with mental health needs) included the need for detainees to wash their underclothes. Exh. 15 (6/10/14 entry) ([redacted][54] Detainees on the top floor of WDC, during a recent inspection, reported that correctional staff told them that the institutional laundry does not handle personal clothing, and Defendants confirm that no personal laundry was processed through that institutional location during a recent laundry cycle. Exh. 51 (Email 3/2/15 from Nathan to Alexander).

§ 85. Defendants shall replace broken lighting within 72 hours of discovery of the need for a replacement.

Plaintiffs' Evidence: Mr. Pepper found that the showers in WDC Dorms O, Q, and V had non-functional lighting. Exh. 49 (Pepper Report) at 8. Similarly, in MDC S Dorm, the readings were below three foot candles, a tiny fraction of the recognized standard for such lighting. *Id.* He also found a number of areas with broken lighting. *See id.* at 8-9 (noting that all locations in Table of light readings with foot candle readings of zero have broken lights; these areas are identified as a toilet/shower or shower areas in WDC Q, O, and V Dorms; MDC P Section; and BCBIC Dorm A and 4th South A Side. Other areas without working lighting included WDC O and V Dorms day rooms, *all* cells in MDC S Dorm, a BCBIC special needs cell, and a conference room and the utility closet in the IMHU. *Id.* at 9. *See also* Exh. 59 (Pls.' Summary of Maintenance Repair Log) at 1-2 (providing multiple examples of cells left without lighting for periods up to 15 days).

[54] Of interest, other weekly sessions of "group therapy" have been devoted to making Halloween cards and watching movies such as "War of the Worlds," "Happy Feet," and "The Transporter." *See id*. (entries for 10/8/14, 10/15/14, 11/5/14, 12/3/14, and 12/23/14).

§ 87. Defendants shall provide sufficient staffing and other resources to implement an appropriate preventive maintenance program, utilizing persons with appropriate expertise to develop the program.

Plaintiffs' Evidence: Plaintiffs rely on Exhibit 53 (Maintenance Repair Log); Exhibit 59 (Plaintiffs' Summary of Maintenance Repair Log); Exhibit 49 (Pepper Report); and Exhibit 50 (2015 Photos) (photographs listed in preventive maintenance category). Taken together, these exhibits demonstrate that the failures to perform timely and appropriate maintenance on physical plant conditions affecting the health and safety of detainees (and often staff) in the various facilities reflect a lack of sufficient staffing, adequate resources, or a combination of the two. Of note, Defendants have informally indicated that the Maintenance Repair Log they maintain indicates that they are in compliance with the timing requirements for repairs mandated in § 74 of the PSA because they are allowed to count compliance from the time that they had on hand at the facility the requisite supplies for necessary repairs. If that is correct, then Defendants are clearly not stocking sufficient supplies of plumbing materials and other supplies that are routinely and predictably required to maintain this worn-out facility, much of which dates from 1859, because the records show that they have not approached compliance with the actual requirement of this provision of the PSA.

§ 89. The preventive maintenance program shall address plumbing, heating, ventilation, the electrical system and the elevators as priorities.

Plaintiffs' Evidence: As shown in the sections above that discuss these priority issues, including the discussions of the Pepper Report and Defendants' own maintenance repair records, the preventive maintenance program is not successfully addressing these critical areas as priorities because it lacks either the staffing or other resources to do so; it is overwhelmingly likely that it

lacks both. *See also, e.g.,* Exh. 55 (Detainee 17 Decl.) ([redacted] (Detainee 17 is paralyzed below the third thoracic vertabra; he also has a gunshot wound in his right leg, so that his leg cannot bend to a normal extent; he uses a wheelchair for mobility and must use a urinary catheter to empty his bladder; the elevator that serves his housing unit was out of service from January 2013 to April 2014; if there had been an emergency need to evacuate his unit, he would have had to travel two or more tiers to exit his floor).

§ 90. Absent a general emergency, no detainee will be left in a cell with a non-functional toilet for more than eight hours.

Plaintiffs' Evidence: *See* discussion *infra* in Section II of the Argument regarding an entire tier of detainees who were left for several days in cells with toilets that did not flush and sinks that did not work, with no access to working plumbing and no access to water absent assistance from correctional officers, during a period of high heat in a housing unit with no temperature control. The atmosphere was fetid and unhealthy because the detainees had no way to dispose of their bodily wastes except by using the non-functional toilets. They complained that they did not even receive enough bottled water to drink from the officers. These conditions posed a significant risk of harm to detainees and violated basic human dignity. While Defendants do not appear to keep any records of how quickly detainees in cells with non-functional toilets are moved, the large number of broken toilets noted in the Maintenance Repair Log, as well as the history of Defendants' egregious practices, provides strong circumstantial evidence that leaving detainees in cells with non-functional toilets continues in practice if not in official policy. Moreover, the fact that Defendants appear to keep no records of when detainees in cells with non-working toilets are moved makes it particularly obvious that violations of the policy will not be noticed or addressed.

§ 92. Defendants shall employ sufficient staff and other resources to make possible

emergency, routine, and preventive maintenance.

Plaintiffs' Evidence: Plaintiffs rely on Defendants' Maintenance Repair Log (Exh. 53), the Pepper Report (Exh. 49) and the 2015 Photos (Exh. 50). Taken together, these exhibits demonstrate that the failures to perform timely and appropriate maintenance on priority matters affect the health and safety of both detainees and staff in the various facilities. Plaintiffs are not challenging the competence of the persons performing maintenance; the root cause of the failures appears to be budgetary policy of the State combined with low visibility policies and practices, such as an apparent limit on the supplies that the maintenance staff are allowed to keep on hand, and failures to hire enough maintenance staff, that make it impossible to maintain crumbling structures plagued by generations of neglect.

§ 93. An appropriate housekeeping and sanitation policy shall be implemented, including provision for cleaning supplies and their distribution as well as appropriate cleaning of toilets.

Plaintiffs' Evidence: There is no evidence that any attempts are made to ensure that individual toilets in the cells are cleaned with appropriate agents on a regular basis, or that cleaning is supervised by staff to ensure that cleaning of common facilities such as group showers, sinks and showers are properly executed. *See* Exh. 49 (Pepper Report) at 11-12, 20-21; *Id.* (Photo Section) at 1-4; 8-10, 15-25, 27-29, 31, 33, 36-40, 44-53, 55; Exh. 50 (2015 Photos) (showers/sinks/toilets; mold; utility closets; and ventilation categories).

§ 94. Supervisors shall be responsible for enforcing necessary sanitation standards. The policy shall provide that detainees involved in diluting disinfectants are properly trained and supervised, and follow all manufacturers' directions regarding protective equipment. Protective garb shall be provided to detainees who clean toilets and showers.

The policy shall provide appropriate sanctions for improper performance and self-monitoring of housekeeping tasks.

Plaintiffs' Evidence: Mr. Pepper's report, and its photographs, document that pervasive failures in implementing necessary sanitation practices abound. *See* discussion in § 93, *supra*. While Mr. Pepper's report indicates that Defendants are purchasing the appropriate cleaning agents, he also documented that the manufacturers' directions for use of the agents are not being followed. In particular, Mr. Pepper found that all of the BCDC facilities were failing to follow "basic cleaning and sanitation standards"; that these failures "are posing a risk to inmates" by not taking steps to prevent "the occurrence and spread of disease," and by not providing for proper personal hygiene. "Shower, toilet, utility closets, living and common touch areas have accumulated soil, soap film, and black mold growths which would not be present if the daily cleaning of the policy were being properly conducted regularly." Exh. 49 (Pepper Report) at 5. The 2015 Photos make clear that nothing significant has changed since Mr. Pepper inspected the facility. Exh. 50.

§ 95. Appropriate control of vermin shall be provided in the housing units.

Plaintiffs' Evidence: The Pepper Report documents that vermin are a "significant problem" in the jail. Exh. 49 at 14. Moreover, Mr. Pepper notes that the existence of such infestations indicates that proper sanitation practices are not being followed. Further, not only is the presence of vermin a sign of improper sanitation practices, but also the vermin themselves become a vector for transmission of human disease, including Salmonella and E. coli. *Id.; see also id.* at Photo 26 (dead mouse in unoccupied cell); Exh. 13 (Detainee 13 [redacted] found to have major lice infestation after being placed in cell, months after jail entry); Exh. 36 (Detainee 19 Decl.) ([redacted]) (MDC P Section, where he resides, "is full of" cockroaches; noting

presence of large cockroach during declaration interview; he is diabetic but has no way to protect his diabetic snack kept in his cell from contamination by pests);[55] Exh. 37 (Detainee 5 Decl.) ([redacted] (a Type 1 diabetic during the summer of 2013 while confined in JI developed a bad infection that left scars attributed to an insect bite);[56] Exh. 58 (Detainee 1 Decl.) ([redacted] (while housed in F Unit, a housing unit which has a serious problem with mice, cockroaches, gnats, and spiders and is used for detainees with medical or mental health problems, declarant was bitten multiple times by insects or spiders); Exh. 38 (Detainee 20 Decl.) ([redacted] (has been housed in JI, which is infested with gnats, big cockroaches, and mice).

§ 96. Appropriate actions to remove mold from showers and other areas shall be followed by appropriate steps to prevent regrowth.

Plaintiffs' Evidence: Mr. Pepper found extensive mold throughout the showers in the facility. *See* Exh. 49 (Pepper Report) at 5-7, 9, 11, 20; *id.*, (Photo Section) at 1-2, 15, 17-19, 25, 30-31, 40, 44-52, 55. When Plaintiffs re-inspected the facilities in February 2015, the showers and utility closets throughout remained filthy and apparently remained an inviting location for mold and insect infestation. Exh. 50 (2015 Photos) (*see* index for photographs listed in mold category).

§ 98. Utility closets shall be maintained in clean and sanitary condition, with adequate lighting. Defendants shall add water spigots, and implement appropriate policy for use of tiers without a utility closet.

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[55] *See supra* at note 28 regarding the medical necessity for some diabetics to have access to food between meals to prevent episodes of low blood sugar.

[56] Plaintiffs note significant skepticism that the cause was actually an insect bite. The pervasive presence of insects and spiders in the jail complex, however, contributes to an atmosphere of insufficient vigilance against potential MRSA infections in the jail, an infection that is not disseminated by vermin bites. *See* note 28 and discussion regarding PSA §29, *supra*.

Plaintiffs' Evidence: The Pepper Report documents extensive problems with the maintenance of utility closets, and a reinspection in February 2015 confirmed that the sanitation issues had not been addressed. *See* Exh. 49 (Pepper Report) at 11-12 (noting that cleaning equipment is not being cleaned and stored in a sanitary manner and that adequate storage facilities for the equipment are not being provided); *see also id.,* (Photo Section) at 12-13,22-23, 36-37.

§ 101. Defendants shall replace mattresses that can no longer be cleaned. All mattresses given to detainees shall be cleaned and sanitized before distribution. Blankets that are no longer serviceable shall be replaced.

`Plaintiffs' Evidence: The Pepper Report notes that roughly half of the mattresses examined during the February 2014 inspection "were cracked, torn, or worn so as to be no longer smooth or and easily cleanable" and that this condition exposed detainees to an unacceptable health risk from communicable diseases, skin diseases and parasites. Exh. 49 (Pepper Report) at 19; *Id.*, Photo Section at 3; *see also* Exh. 50 (2015 Photos) (*see* photos in index listed as "mattresses").

§ 104. The attorney visiting areas shall be modified to adjust sound attenuation in order to protect privacy, create opening that allow normal speech between attorney and client, and provide air conditioning.

Plaintiffs' Evidence: Excessive old paint that substantially blocks the grilles still interferes with conversations between clients and lawyers in both WDC and MDC. *See* Exh. 49 (Pepper Report) at 17; *Id.,* Photo Section at 29.

§ 113. A licensed barber shall review and approve the barbering program as well as provide periodic review of its functioning.

Plaintiffs' Evidence: Defendants supply no information in their current monitoring report

that the barbering program is now in compliance. In the most recent monitoring report that addressed this issue, they asserted that substantial progress had been made but did not claim actual full compliance with the provision. *See* Exh. 47 (Defs.' Second Quarter 2014 Monitoring Report) at § 113.

ARGUMENT

I. DEFENDANTS HAVE FAILED TO COMPLY WITH THE PSA.

For the detailed reasons set forth in the factual sections regarding medical care (including mental health care) as well as the physical plant provisions of the PSA, Defendants have failed to carry out their repeated promises to comply with the parties' agreement. Under that agreement, Defendants may argue against reopening the amended PSA only by successfully disputing their non-compliance. *See* PSA ¶ 124. Defendants' non-compliance is, however, so pervasive and obvious that it would be redundant for Plaintiffs to attempt to summarize that evidence a second time here.

II. PLAINTIFFS' EVIDENCE PRESENTS PRIMA FACIE EVIDENCE OF EIGHTH AMENDMENT VIOLATIONS.

The Supreme Court has recently emphasized the critical importance of the Eighth Amendment in ending conditions of confinement that threaten life and health:

> To incarcerate, society takes from prisoners the means to provide for their own needs. Prisoners are dependent on the State for food, clothing, and necessary medical care. A prison's failure to provide sustenance for inmates may actually produce physical torture or a lingering death. Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.

Brown v. Plata, 131 S. Ct. 1910, 1928 (2011) (quotation marks and citations omitted) (affirming

order for prisoner release when shown to be necessary to remedy deficient medical and mental health care in state prison system).

The standard for demonstrating a violation of the Eighth Amendment regarding prison conditions of confinement, including claims related to medical care and physical plant conditions, is found in *Farmer v. Brennan,* 511 U.S. 825 (1994).[57] The Court in *Farmer* begins its analysis by restating the principle that prison officials have an affirmative obligation under the Eighth Amendment to provide prisoners with humane conditions of confinement; they must ensure that prisoners "receive adequate food, clothing, shelter, and medical care." *Id.* at 832. The concept of an affirmative duty toward prisoners stems from *DeShaney v. Winnebago County Department of Social Services*, 489 U.S. 190 (1989), in which the Court noted the following:

> [W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs . . . it transgresses the substantive limits on state action set by the [Constitution].

Id. at 200.

Under *Farmer*, proof of an Eighth Amendment violation has both an objective and subjective component. The objective component requires a showing of a deprivation of a basic necessity of life, such as medical care, shelter, or reasonable safety. *Farmer*, 511 U.S. at 832. Critically, exposure to excessive risk of sufficiently serious harm violates the objective

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[57] The constitutional standard for treatment of pretrial detainees is governed by the Due Process Clause of the Fourteenth Amendment rather than the Eighth Amendment's prohibition against cruel and unusual treatment. *See City of Revere v. Massachusetts Gen. Hosp.,* 463 U.S. 239, 244 (1983). Pretrial detainees, who cannot be subjected to punishment of any description, are entitled to at least the same protection under the Fourteenth Amendment as are convicted prisoners under the Eighth Amendment. *See Young v. City of Mt. Ranier,* 238 F.3d 567, 575 (4th Cir. 2001); *Hill v. Nicodemus,* 979 F.2d 987, 991 (4th Cir. 1992). Because the class includes both convicted prisoners and pretrial detainees, Plaintiffs will discuss only the Eighth Amendment standard.

component even without additional injury. *Id*. at 844-45; *see also Hope v. Pelzer*, 536 U.S. 730, 738 (2002) (allegations in prisoner complaint that if true establish an obvious substantial risk of serious harm were correctly allowed to proceed by district court).[58] The subjective component of an Eighth Amendment violation requires a showing that a prison official acted with "deliberate indifference." *Farmer* at 837. That is, the official must have possessed actual knowledge of an excessive risk of serious harm to a prisoner or group of prisoners, and then failed to respond reasonably to that risk. *Id.*

The Court provides clear guidance in *Farmer* on how a plaintiff can prove knowledge, since most defendants are not in the habit of announcing that they knew of the risk and disregarded it:

> Whether a prison official had the requisite knowledge is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious. For example, if an Eighth Amendment plaintiff presents evidence showing that a substantial risk of inmate attacks was longstanding, pervasive, well-documented or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus must have known about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk.

Id. at 842-43 (internal quotation marks and citations omitted). The Court added that deliberate ignorance will not allow a prison official to escape liability:

> While the obviousness of a risk is not conclusive and a prison official may show that the obvious escaped him, he would not

[58] This Eighth Amendment principle was established in *Helling v. McKinney*, 509 U.S. 25, 33-34 (1993) (rejecting argument that threat of future harm is not actionable under the Eighth Amendment).

> escape liability if the evidence shows that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist[.].

Id. at 843 n.8.

Moreover, the Court in *Farmer* mandates a critical distinction between proof of deliberate indifference in a case seeking damages and a case, like the instant one, seeking only injunctive relief. In *Farmer*, the Supreme Court notes that at points prior to trial, such as the summary judgment stage, a prisoner seeking an injunction is required to show that the defendants know of, and have failed to respond reasonably to, an excessive risk. At the same time, however, the Court points out that, for the purposes of injunctive relief, once a case proceeds to trial, the prison officials are charged with knowledge of the risks that the plaintiff demonstrates:

> If, for example, the evidence before a district court establishes that an inmate faces an objectively intolerable risk of serious injury, the defendants could not plausibly persist in claiming lack of awareness, any more than prison officials who state during the litigation that they will not take reasonable measures to abate an intolerable risk of which they are aware could claim to be subjectively blameless for purposes of the Eighth Amendment[.].

Id. at 846 n.9.

The Sixth Circuit succinctly restated this principle from *Farmer* related as follows:

> In this case, we are concerned with future conduct to correct prison conditions. If those conditions are found to be objectively unconstitutional, then that finding would also satisfy the subjective prong [of an Eighth Amendment violation] because the same information that would lead to the court's conclusion was available to the prison officials.

Hadix v. Johnson, 367 F.3d 513, 526 (6th Cir. 2004).

Because the Eighth Amendment standard requires a showing of unreasonable risk, it does not defeat Plaintiffs' showing if Defendants demonstrate that not all detainees suffered actual

harm and that, with regard to specific issues, at times the system actually functioned for a particular detainee, because the overall level of risk for the class was nonetheless unreasonably high. *Cf. Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Foundation, Inc*., 484 U.S. 49, 69 (1987) ("A good or lucky day is not a state of compliance. Nor is the dubious state in which a past . . . problem is not recurring at the moment but the cause of that problem has not been completely and clearly eradicated") (Scalia, J., concurring).

In *Brown v. Plata*, the Supreme Court provided additional guidance for the evaluation of evidence in Eighth Amendment conditions of confinement class actions such as this one. The Court specifically rejected the argument that the prisoner plaintiffs had to show actual harm from each of the examples submitted as evidence of deficient health care, since the plaintiff class based its claims on system-wide deficiencies in medical and mental health care. 131 S. Ct. at 1925 n.3. Significantly, the plaintiff class in *Brown* was composed of tens of thousands of prisoners in multiple prisons, and the lower courts formulated relief based on evidence of deficiencies that posed a substantial risk to the entire class.[59]

The Supreme Court particularly relied on the evidence of unnecessary and possibly unnecessary deaths caused by failures in the system, even though such deaths were not statistically common: in the most recent year for which data was available at the time of the decision, there had been 68 such deaths out of a total prison population of 156,000. *See id.* at 1923, 1925. Given that the average daily population of BCDC, including the Baltimore City Booking and Intake

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[59] *See Coleman v. Schwarzenegger*, 2009 WL 2430820, at *12 (E.D. Cal. Aug. 4, 2009) (noting that at the time of trial of the Eighth Amendment claim, on behalf of a state-wide class of prisoners suffering from serious mental illness and the class included more than 34,000 prisoners). *Coleman* was one of the two state-wide plaintiff classes in *Brown*.

Center ("BCBIC) since 2013 is unlikely to have been as much as 3500,[60] this equates to an average at most of about 1.5 preventable or possibly preventable deaths by a year at BCDC if the facility had experienced the same rate as did the California prison system during the period relevant to the *Brown* litigation. Plaintiffs believe that they have shown far more than that.[61]

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[60] The Maryland Department of Public Safety and Correctional Services indicated that the population of BCDC including BCBIC as of November 20, 2014 was 3025 and it was 2442 on March 4, 2015 – the two dates for which Plaintiffs randomly obtained population information. Plaintiffs will use an average of the two totals, indicating a population generally in the range of 2734.

[61] In the event of an evidentiary hearing on this matter, Plaintiffs expect to present evidence that the following deaths were possibly preventable: Death Case 6 ((detainee with known history of very serious hypertension was not monitored or prescribed medication to control his pressure while undergoing drug withdrawal, beyond one dose during the admission process; he died while experiencing a hypertensive crisis; neither ordered placement in the withdrawal unit nor custody-initiated CPR occurred); Death Case 3 ((detainee confined in jail for about ten months, during which time there was no attempt to follow up on his reports of cardiac problems or hypertension; his heart medication was discontinued without explanation so that at the time of death he was receiving no medication for his heart or blood pressure; he died of cardiovascular problems); Death Case 2 (died in the jail two days after admission; an urgent medication request did not result in obtaining ordered norvasc (a heart and blood pressure medication; the last blood pressure recorded from three months earlier during a previous admission was 178/108); Death Case 10 ((died of blood in the sac surrounding the heart; ordered tests were not performed and the nurse in the infirmary did not notify the physician of symptoms that required immediate attention; she should have been hospitalized the day she was admitted to the infirmary); Death Case 11 ((detainee had no history of mental health issues; when he experienced a marked change in his mental health condition, medical issues needed to be ruled out before his problems were assumed to be related to his mental health; nonetheless he was placed in the IMHU when he needed infirmary or hospital placement; no attention was paid to evidence that he had ingested oxycodone while in jail and jail could not account for his Fentanyl patch; autopsy indicated he died of cardiac arrhythmia associated with enlarged heart and cardiac fibrosis); Death Case 12 ((she did not receive an ordered urgent referral to a psychiatrist; the psychiatric provider did not document a reason for not starting psychotropic medications; she was thereafter not started on psychotropic medications until about six days before she committed suicide); Death Case 4 ((he entered the Chesapeake Detention Facility reporting an ear infection with a temperature of 103°, but received only a routine referral for follow-up; He received no antibiotics for several days after entry. Shortly prior to admission he had been hospitalized for the ear infection and a mastoid infection; he died because the infection spread to his brain).

In both *Farmer* and *Brown*, the Supreme Court emphasizes that excessive risk to a class of prisoners can stem from multiple interacting structural deficiencies as well as other types of policies. *See Farmer*, 511 U.S. at 843 (an unreasonable risk of harm sufficient to violate the Eighth Amendment may stem from multiple causes and affect multiple prisoners); *Brown*, 131 S. Ct. at 1936-37 (comparing Eighth Amendment violations regarding prison conditions to a "spider web" because of the interdependence of the conditions that produce the violation and stating that in such cases "only a multifaceted approach aimed at many causes" will produce a solution).

As set forth in the Statement of Facts, in the long history of this case, Defendants have had chance after chance to respond to clear notice of the unreasonable risks that they were imposing on those confined in BCDC. Indeed, Defendants acknowledged their knowledge of the unreasonable risks in agreeing to the Consent Decree and later to the PSA. The Department of Public Safety and Correctional Services has similarly acknowledged Defendants' knowledge of the need for action. In the Department's 2013 Facilities Master Plan, for example, it made the following admission:

> The 1993 Consent Decree [in this case] requires that the Division maintain adequate ventilation in the housing units of BCDC including WDC. . . . The provision of the 1993 Consent Decree is in accord with constitutional requirements. *See Strickler v. Waters*, 983 F.2d 1375, 1381 (4th Cir. [1993).]

Exh. 61 at 1-7.[62] Defendants have repeatedly promised to address these risks through specific agreed-upon remedies, and yet they have routinely failed to carry through with their commitments by actually implementing those reforms. As a result, detainees and convicted prisoners have

[62] The text continues by admitting physical plant problems at WDC that interfere with mental health and related services, including inadequate facilities for withdrawal from alcohol and other drugs, inadequate facilities to perform medical examinations, inadequate infirmary areas, and inadequate facilities for psychotic and suicidal women. *Id.*; *see also* the discussion *supra* of the suicide of Death Case 12 [redacted]

continued to suffer unnecessary harm including death.

One example of Defendants' pervasive failure to comply with the specific requirements of the PSA, or with the obvious requirements of the Eighth Amendment itself, occurred in the summer of 2013, when flooding caused some housing units to lose potable water for a number of days. This has been a repeated experience at both MDC and WDC. Nonetheless, notwithstanding high temperatures and humidity within those housing units, the detainees unfortunate enough to be confined there were left in their sweltering cells, with their only access to water the delivery of bottled water by correctional officers. Many detainees reported having received too little bottled water for their needs.

Meanwhile, the toilets filled with urine, since detainees were not allowed out to places with working toilets or showers for their bodily needs. Detainees deposited feces in plastic bags on the unit. Despite the foul and profoundly unhealthy atmosphere combined with high heat and humidity, not even the detainees with asthma who reported difficulties in breathing were moved. Detainees had no way to shower or even wash their hands before meals despite their fetid surroundings. Only one fan was on an entire unit, which did almost nothing to make the air breathable in the heat and humidity. *See* Exhs. 39-44 (group of declarations from detainees held in O Unit and P Unit of MDC during this period).

The conditions in these units posed obvious serious risks to the health and safety of the detainees, yet for days nothing was done to move them, thus violating the Eighth Amendment under the standards enunciated in *Farmer*. Moreover, a jail that leaves detainees without access to plumbing or water for days, in the near presence of large amounts of human waste, like a prison system that fails to provide necessary medical care, "is incompatible with the concept of human

dignity and has no place in civilized society." *Brown*, 131 S. Ct. at 1928.[63]

III. DEFENDANTS' MOST DANGEROUS FAILURES SHOULD BE PRELIMINARILY ENJOINED BY THIS COURT.

A. Requested Relief

Although there are a multitude of problems of constitutional dimension at the jail, in light of the long history of failures by Defendants, Plaintiffs believe that constitutional conditions will be achieved most quickly by focusing on the most critical violations, including structural violations related to policy, staff, and infrastructure that are the most dangerous and the most fundamental to lasting change. For that reason, Plaintiffs request that the Court issue a preliminary injunction requiring the Defendants, their employees, agents, and all those working in concert with them, to comply with the following orders:

1. Defendants shall develop and implement in practice, including staff training, policies that provide that a detainee who is accepted for admission at BCBIC shall be screened immediately. Any detainee who remains in custody within BCBIC or BCDC for 24 hours and reports that he or she is prescribed medications that, if interrupted, would pose a substantial risk of seriously affecting the detainee's health shall be evaluated, including a physical examination by a qualified medical provider, and all medications found to be necessary to avoid such risk provided to the detainee within 24 hours of arrival at the jail.

2. Defendants shall develop and implement in practice policies that provide that medical

[63] Among the provisions of the PSA that these conditions violated are the following: § 67 (requiring maintenance of the 53 rooftop ventilation fans and the 60 window unit fans in MDC); § 72 (fans are to be provided in housing units at MDC consistent with security needs); 84 (Defendants shall implement policy to ensure that basic needs are met when detainees must be confined in temporary overflow housing including access to sanitary and well-maintained toilets, sinks, and showers, and provision of personal hygiene supplies); § 90 (absent a *general* emergency, no detainee shall be left in a cell with a non-functional toilet for more than eight hours).

staff create, maintain and update a medical plan of care that includes all unresolved diagnoses and planned treatment, including all current orders for treatment. That plan shall be consistently available to medical staff as part of the medical record when such staff are involving in providing treatment, including diagnostic services.

3. Defendants shall develop and implement in practice policies and systems to allow all medication prescriptions and medical accommodations to be reliably renewed without interruption in the absence of a specific determination by the prescriber that renewal is unnecessary.

4. Defendants shall develop and implement in practice policies that require nurses to document in the MARS when a detainee is known to have missed a dose of a prescription medication; that nurses reliably execute orders to conduct blood pressure, blood sugar levels, vital signs, and similar findings; and that nurses reliably document the results of such tests in the MARS or the EMR as required by policy.

5. Defendants shall develop and implement in practice policies that reliably provide medical staff with access to information that accurately reports the current location of a detainee.

6. Defendants shall develop and implement in practice policies that require that detainees with disabilities are housed in locations that provide them with necessary accommodations, including safe and sanitary toilets, showers, and necessary supplies, and that there is a safe and reliable method of emergency evacuation, including alternate evacuation plans if one route is unavailable, to evacuate detainees who are unable to walk.

7. Defendants shall develop and implement in practice policies that ensure that all requests for a consultation with a medical specialist that require approval by one of the medical contractors are logged in when received, along with the date of action on the request and the nature of the action and the date if any that a consultation was scheduled and provided. That

policy shall establish standards for the maximum elapsed time for contractor review for the categories of routine, urgent and emergency consultations, which standards shall be implemented in practice.

8. Defendants shall develop and implement in practice policies that address, with operational detail, foreseeable circumstances in which providing for the medical care of a detainee requires actions of custody staff. At a minimum, this policy shall address transport of detainees for medical functions; provision of suitable housing for detainees including transfers of detainees classified H1 to temperature-controlled housing and detainees with disabilities to housing that meets their needs; provision of reliable and current location of detainees; and the obligation of custody staff to provide emergency medical assistance, including CPR.

9. Defendants shall develop and implement in practice policies that provide for the employment of sufficient maintenance staff, and the provision of sufficient on-site supplies, to allow staff to house all detainees in housing where they have direct access to functional toilets, sinks with potable water, and working lights, and ensure that no detainee is left in housing where such access is lacking for more than 24 hours.

10. Common areas of housing units, including shower and toilet areas, shall be maintained in safe and sanitary condition, and absent a general emergency no detainee shall be left in housing that fails to provide reasonable sanitation or safety.

CONCLUSION

For the above reasons, Plaintiffs request that the Court, pursuant to §124 of the PSA (as amended), order reopening of the case, restore it to the active docket, set a hearing date for consideration of Plaintiffs' request for temporary relief, and following a hearing grant that relief.

Respectfully submitted,

/s/

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Dated: June 2, 2015

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