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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

WALTER D. BALLA, *et al.*, Plaintiffs, v. IDAHO STATE BOARD OF CORRECTION, *et al.*, Defendants.	**Case No. CV 81-1165-S-BLW** **DEFENDANTS' RESPONSE AND OBJECTIONS TO SPECIAL MASTER'S REPORT (DKT. NO. 822)**

Defendants (hereinafter "the Department"), by and through their attorneys of record, and pursuant to Federal Rule of Civil Procedure 53(f) and this Court's Order dated March 8, 2011 (Dkt. No. 819), hereby submit this Response to the Special Master's Report (Dkt. No. 822) (hereinafter "the Report") in this matter.

This Response provides information which the Department believes will be supported by information obtained during the course of discovery in this matter concerning the Special

Master's Report (Dkt. No. 822). Discovery is ongoing in this matter, and the Department is presently unable to respond to some allegations in the Report due to lack of identifying patient information and/or no identification of sources of information relied upon for various conclusions. The Department reserves the right to amend this Response as additional information becomes available. Unless expressly admitted by the Department, nothing contained herein should be construed as an admission by the Department, or used as such in any subsequent proceeding. Further, a failure by the Department to respond to a specific allegation does not constitute an admission.

I. RESPONSES COMMON TO THE ENTIRE REPORT

A. The Isolated Incidents Cited Do Not Establish Eighth Amendment Violations.

Prison officials violate a prisoner's Eighth Amendment right to be free from cruel and unusual punishment if they are deliberately indifferent to the prisoner's serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 106 (1976). To prevail on such a claim, the prisoner must satisfy both an objective element and a subjective element. *Farmer v. Brennan,* 511 U.S. 825, 834 (1994). The prisoner must first demonstrate the existence of an objectively serious medical condition of which the prison officials were or should have been aware. *Estelle,* 429 U.S. at 104-05. A serious medical need exists if the failure to treat a prisoner's condition could result in further significant injury or the "unnecessary and wanton infliction of pain." *Estelle,* 429 U.S. at 104. The threshold state of mind requirement under the deliberate indifference standard is exceptionally stringent. Deliberate indifference lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other," and should be tested as under the "subjective recklessness" standard in criminal law. *Farmer v. Brennan*, 511 U.S. at 836, 838-40.

The Ninth Circuit has acknowledged that the deliberate indifference standard is a higher standard than gross negligence. *Wood v. Ostrander*, 879 F.2d 583, 588 (9th Cir. 1989).

Once the prisoner's medical needs are identified and the defendant's response to those needs have been established, the court determines whether an adequate showing of "deliberate indifference" has been made. Prison officials are deliberately indifferent to a prisoner's serious medical needs when they "deny, delay or intentionally interfere with medical treatment." *Hutchinson v. United States,* 838 F.2d 390, 394 (9th Cir.1988). Delay in providing a prisoner with medical treatment, standing alone, does not constitute an Eighth Amendment violation. *Hunt v. Dental Dep't,* 865 F.2d 198, 200 (9th Cir.1989). Deliberate indifference involves more than mere unconcern, negligence, or even malpractice. *Hutchinson,* 383 F.2d at 394 ("mere negligence in diagnosing or treating a medical condition, without more, does not violate a prisoner's Eighth Amendment rights"); *Estelle,* 429 U.S. at 106 ("[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner"). Inadequate treatment from malpractice, or even gross negligence, does not violate the Constitution. *Estelle,* 429 U.S. at 106, 104.

The Special Master's conclusions that the Department is deliberately indifferent to offenders' rights are without support. For the reasons set forth herein, none of the information referenced in the report evidences a denial, delay or intentional interference with medical treatment that resulted in harm to the patient. Rather, the care provided by the Department is constitutionally adequate and the conclusions contained in the Report are without evidentiary support.

B. The Report's Deficiencies Discredit the Opinions Contained Therein.

The Report fails to set forth the specific factual data on which the findings and conclusions are based. In many instances it is unclear whether the Special master reached a finding or conclusion based solely on the anecdotal reference(s), or based on the anecdote(s) plus additional information. Even more troubling is the lack of any explanation of how the Special Master selected the inmates he interviewed and files and other documents reviewed. The Report indicates he reviewed approximately 45 patient medical records, which reflect only 2.66% of the inmate population at ISCI. It is unknown whether the Special Master selected charts and records for review based solely on information obtained from inmates, or whether he employed a random sampling method. The difference in selection criteria directly impacts the validity of the Report's findings and conclusions. As explained in further detail below, the Special Master's failure to completely review documents made available to him resulted in incomplete and inaccurate statements of purported fact. The true facts, to the extent the Department has been able to identify patients from information in the Report, establish that the Department has provided constitutionally adequate care.

II. RESPONSES TO SPECIFIC CONCLUSIONS

A. The Evidence Does Not Support the Generalized Conclusions in the Executive Summary.

The Department denies that serious problems exist with the delivery of medical and mental health care at ISCI. While the Department agrees that, "many instances of health care delivery at ISCI are good or excellent" (Report (Dkt. No. 822), p. 4), the Department denies that the "examples of problematic health care" set forth in the Report either resulted in serious harm or created risks of serious harm to offenders at ISCI. The Department denies that the examples

recited in the Report are accurately reported, and further denies that the Eighth Amendment rights of the offenders mentioned were violated. The Department is not deliberately indifferent to the serious health care needs of offenders at ISCI, and continues to reform and improve the medical and mental health care delivery system at ISCI.

It is also unfortunate that the Special Master chose not to audit to changes implemented during the 6 month period between visits, because some of those changes have eliminated some of the practices described in the Report, thereby mooting one or more of the conclusions contained in the Report. The Court specifically charged the Special Master to offer opinions as to whether offenders are experiencing "current and ongoing" violations of their Eighth Amendment rights. *See* Order Appointing Special Master (Dkt. No. 806), ¶ 6. The failure to audit the current state of operations violates this charge.

B. <u>The Department Is Compliant With the Plan Concerning Special Diets, and Agrees That the Other Plans Are Unworkable.</u>

The Department agrees that the passage of time in this case has made it very difficult to identify with certainty the compliance plans that were originally entered in this matter. Furthermore, due to significant changes over the past twenty years in the provision of health care and available health care resources, as well as significant changes at ISCI, the terms of the original compliance plans related to provision of medical and mental health care are likely outdated and therefore inapplicable to the modern-day ISCI. To the extent the original compliance plan concerning special diets remains applicable and workable, the Department concurs with the Special Master's conclusion that it is in compliance with that plan. The Department therefore agrees with the first and third conclusions set forth on pages 5-6 of the Report (Dkt. No. 822). The Department further agrees with the Special Master's second

conclusion that most of the elements of the Medical Care Compliance plan are no longer relevant and that the Department is compliant with the handling of medical records. (Dkt. No. 822, p. 6). However, the Department maintains that the current handling of pharmacy and therapeutic diets meet Constitutional standards and therefore disagrees with the Special Master's findings on these two issues.

C. The Department Appropriately Provides Special Diets Ordered by Medical Practitioners.

The Department agrees with the fourth conclusion on page 8 of the Report that the provision of medically prescribed diets at ISCI is constitutionally sufficient. With nearly 1700 offenders housed at ISCI on any given day, it is inevitable that occasional confusion or inadvertent delays will occur with regard to the communication and provision of special diets ordered by medical practitioners. It is well-established through *Estelle* and its progeny that such instances of inadvertent delays or mistaken exclusion cannot form the basis of any allegation of "deliberate indifference." Therefore, the Department denies that such occasional or inadvertent confusion and delays occurs on a regular basis or otherwise constitutes a constitutional violation.

D. Patients Are Not Deprived Access to Care or the Opinion of a Qualified Health Care Professional.

1. Responses to Health Service Requests Are Generally Timely.

The Department's contract medical provider, Corizon, Inc., recently conducted an audit of randomly selected Health Service Request ("HSR") forms submitted at ISCI, which demonstrated that offenders were usually seen the same day they submitted the HSR. All of the 225 randomly selected HSR's received a response. The random sample represented approximately 10% of all HSR's submitted at ISCI during the prior six month period. The

Special Master opined that patients should be seen within 2-3 days of submitting an HSR. *See* Report (Dkt. No. 822), 8. Corizon's audit demonstrated that the vast majority of patients are seen within this timeframe. There were approximately 6 instances where a patient was seen beyond this 2-3 day timeframe, but isolated instances of delay are to be anticipated in a health care system with the number of patients at ISCI. Isolated instances of delay, without more, do not establish a constitutional violation in any of these individual cases, much less a class-wide constitutional violation.

The Special Master refers only to three specific cases in support of his conclusion that alleged delays in responses to HSRs are a persistent problem that violate offenders' constitutional rights. *See* Report (Dkt. No. 822), p. 8. It is unknown whether the Special Master relied on additional information beyond these three anecdotal instances. Further, the three referenced patients are not identified, so it is impossible for the Department to respond to the allegations that there was a delay beyond 2-3 days in responding to the three HSRs.

The Special Master does not indicate that he relied on any other information to support this conclusion. The Special Master indicated at the beginning of the Report that he met with over 60 patients and reviewed more than 45 patient files. At no time did the Special Master request a patient list, nor did he ask staff at ISCI or its medical provider to generate a random list of patients. Rather, the Special Master approached the records clerk in the medical unit with a handwritten list of names and asked for those specific files to be pulled. Due to the method by which the Special Master requested these files, it is not believed the files were randomly selected.

For the reasons set forth above, the Department denies conclusion 1 on page 11 of the Report, indicating that, as a whole, there are either no response or delayed responses to HSR's.

2. LPNs Provide Appropriate Care Through Use of Written Protocols.

Corizon utilizes Licensed Practical Nurses ("LPNs") to provide some medical care during sick call at ISCI. The LPNs provide care by referring to written protocols, which guide them through the appropriate questions and processes to treat patients. These written protocols are developed by Registered Nurses, medical doctors and other medical professionals. Written protocols are commonly used throughout the medical community, including in medical offices, emergency rooms, surgery clinics and subspecialty clinics. Importantly, a RN supervisor and on-call or on-site providers are available for consultation with the LPN.

Corizon advised the Department that during a recent audit of 225 randomly selected HSRs and 100 randomly selected patient charts, 85% of charts reviewed noted the patient's vital signs. Not all patient encounters, however, require taking of vital signs. Additionally, the majority of charts revealed the LPN selected the proper protocol for the patient encounter. However in any medical system even physicians and other medical providers will sometimes approach a patient encounter from the wrong perspective. These occasional mistakes do not establish care is constitutionally deficient.

The Special Master concluded that allowing LPNs to provide care during sick call through use of written protocols constituted deliberate indifference. The Special Master provided no description of the information on which he bases this conclusion. He did not explain how he reached the conclusion that LPNs do not always use the protocols and he failed to account for times when a protocol is not necessary to properly respond to an HSR. For

instance, an inmate may ask for a medication renewal. In such circumstances, the nurse can refill a medication if a current order exists or can refer to the provider to determine if the medication should be continued. The Special Master also theorized that LPNs lack the judgment or resources to select the correct protocol for a patient encounter, but provided no examples or other evidence supporting his conclusion, aside from his own hypothesizing. In reality, the Special Master suggests that LPNs are not clinically authorized to document the nature of a patient's complaint. Based upon the Department's initial research into this contention, the Department cannot identify any jurisdiction which prohibits an LPN from documenting the nature of a patient's complaint. Moreover, the contention of the Special master is wholly inconsistent with the experience of Department's medical provider, which is currently providing medical care in correctional facilities in thirty-one (31) different states.

The Special Master also stated that "it is not uncommon" for LPNs to omit any examination of the patient, including the taking of vital signs. He stated he personally observed this with two patients. Even if true, the two isolated instances do not establish deliberate indifference in the care provided to the two unnamed individuals, much less a class-wide constitutional violation. Rather, a review of 100 randomly selected patient charts revealed LPNs conduct an examination, including the taking of vital signs, on the vast majority of patients.

The Special Master also referred to one case involving the failure of a patient with an abscess tooth to respond to an initial course of oral antibiotics as evidence that the overall care provided is poor. This one, isolated case is the only evidence cited in support of his conclusion of a class-wide constitutional deprivation. The Department is unable to identify the patient involved from the information provided, and therefore cannot provide a response to this

allegation. That such a situation may have happened in one case does not establish that all care provided at ISCI is poor, nor does it establish a constitutional deprivation, much less a class-wide violation of constitutional rights. *See, e.g.*, *Lewis v. Casey*, 518 U.S. 343, 357-59 (1996). The Department denies conclusion 1 on page 11 of the Report that use of LPN's for sick call constitutes deliberate indifference.

3. Sick Call is Conducted Confidentially.

The Special Master's conclusion that offenders are currently experiencing a violation of their constitutional rights because sick call is not conducted confidentially is wrong and based on antiquated facts. As the Special Master himself notes in footnote 8 on page 11, he was advised that during the 6 months between his first and second visits, the sick call system was changed and patient complaints are no longer discussed at a window in the lobby. The Special Master ignored that change in his Report. Offenders now present their HSR at the lobby window, and are then taken to a separate room for a confidential consultation. The Department therefore denies conclusion 1 on page 11 of the Report.

E. Responses to Emergency and Urgent Situations Are Constitutionally Adequate.

During a recent Corizon audit, 20 patient charts were randomly selected for review from the ISCI Emergency Transport log. In all cases reviewed, the medical response was timely, vital signs and a focused assessment was completed, and a progress note documented the care provided. When necessary, the charge RN was notified and the on-call provider contacted, and patients were transported to a local emergency room. Appropriate care was provided.

The Special Master concluded there was either no response or a delayed response to emergencies, and that medical care provided during responses was poor. *See* Report (Dkt. No.

822), p. 11. Again, his conclusion is based on three instances of care, which do not appear to have been randomly selected for review. Patient names are not provided, and therefore it is impossible for the Department to respond to the version of events contained in the Report. However, the recent audit of randomly selected charts does not support the conclusion that emergency or urgent care is deliberately indifferent. The Department denies conclusion 2 set forth on page 14 of the Report that there is either no care or delayed care or poor care in response to emergency or urgent situations.

The Report also stated the Special Master found nurses sometimes interpreted EKG results on their own, however, he provided no basis for this finding. Corizon advised its audit indicated its nurses call providers to interpret EKG results. In the course of receiving the results and contacting the provider, nurses also view the results and may form some impressions in doing so, but the Department and its medical provider are not aware of a situation where a nurse interpreted the results on his or her own and therefore denies this conclusion.

With regard to continuity of care, the audit of randomly selected charts also revealed that upon return from the emergency room, all but one patient was placed in the infirmary or on 23-hour observation. The one exception was a case involving a return from a fourth visit to the hospital for what was determined to be a minor complaint. Over half the patients were seen the same day they returned from the hospital, or the following day. Six more were seen within a week of their return. Another requested to be discharged before follow up, and a provider was called and approved the discharge. The Department's medical provider also randomly selected 10 patient discharges from inpatient hospitalizations for review. In all but one instance, the

patient was placed in the infirmary upon return to ISCI, orders were obtained from the on-call providers, and discharge orders were followed.

The Special Master stated on page 13 of the Report that there is poor continuity of care upon return from the emergency room. There is no evidence referenced for this conclusion. Based on Corizon's recent audit appropriate follow-up occurred after return from the hospital. The Department therefore denies conclusion 2 set forth on page 14 of the Report that there is poor continuity of care upon return from the emergency room.

The Special Master also concluded emergency supplies were not kept in order or carefully tracked. *See* Report (Dkt. No. 822), pp. 13-14. The oxygen tank referenced in the Report was an unfortunate situation that has since been corrected. It should be noted, however, that multiple full tanks were present in the same room as the empty tank, and therefore oxygen was always available for patient care. Corizon advised that its recent audit found the emergency equipment log book was neat and in order and equipment appeared to be in good working order. With regard to the endotracheal airways referenced in the Report, such airways are not kept at the facility because medical staff are not ACLS trained (rather, they are BCLS trained), which is required for endotracheal airway use. As such procedures are not performed at the facility, the airways are therefore unnecessary and not "missing". The Department denies conclusion 2 set forth on page 14 of the Report that emergency equipment is not maintained in proper working order.

F. <u>Outpatient Medical Care Meets the Standard of Care.</u>

Corizon also advised the Department that it recently audited 50 randomly selected sick call encounters with medical providers. All encounters were documented, including a plan of

care. Corizon also audited 114 randomly selected chronic care clinic charts, and found the vast majority of patients were seen according to schedule and the visits were properly documented. Corizon indicated its audit of clinic charts demonstrated appropriate follow-up, including appropriate testing, took place and required medications were adjusted accordingly. The audit confirmed that patients had access to care, received the care ordered and had access to professional medical judgments when making decisions about their care.

The Special Master only referenced three situations in support of his conclusion that outpatient care at ISCI was deliberately indifferent. The Special Master provided no identifying information about the patients involved, and it is therefore impossible for the Department to respond to these specific allegations. However, even if accurately reported, the three isolated instances do not establish a class-wide constitutional deprivation at a facility with a daily average inmate count nearing 1700 individuals. This example demonstrates an unrealistic and unjustifiable view of the delivery of health care not only in a correctional setting, but also in free world health care facilities. For example, the National Commission on Correctional Health Care does not mandate 100% compliance with all of its accreditation standards, but utilizes an 85% performance standard for all of its standards denominated as "Important Standards." (See Substantial Compliance Definition, http://www.ncchc.org/accred/glossary.html#S-Z). In sum, the Special Master's apparent insistence upon 100% compliance with his purported standards is unrealistic and completely divorced from the well-known standards for constitutional health care.

The Department therefore denies conclusion 3 set forth on pages 15-16 of the Report, stating that the quality of medical opinions at ISCI is at times so poor as to render them unqualified and a deprivation of patients' constitutional rights.

G. All Essential Elements of Long-Term Care Are Provided Consistently.

The Department's medical provider has one LPN and two Certified Nursing Assistants (CNAs) to provide care for patients in the long-term care unit. Of six current long-term care patients, there is one who cannot feed or hydrate himself. That patient periodically refuses meals. That patient's weight, however, has actually increased during the approximately nine years he has been in the long-term care unit, and thus indicated he was not suffering harm. Corizon advised that it conducted an audit of the six charts of long-term care patients currently in the ISCI infirmary, which revealed that patients who cannot move independently were bathed and/or showered at least three times per week, received daily oral care, and had their sheets changed at least three times per week or as needed. For these same patients, documentation confirmed they were routinely moved and repositioned multiple times per day, and their undergarments were changed in a timely manner if soiled. The same chart review revealed that long-term care patients received medications as ordered by their provider(s).

The Special Master recited two instances of allegedly unconstitutional care, but provided no identifying information for the patients involved, and the Department therefore cannot provide a response to the specific allegations. The recent audit by the Department's medical provider indicated long-term care patients were receiving all essential elements of long-term care and the Department therefore denies conclusion 4 on page 16 of the Report that care provided to patients who cannot fend for themselves is cruel and unusual.

H. Medications are Dispensed Appropriately.

Corizon personnel recently reviewed all active medications in the on-site pharmacy and found no expired medications. Corizon personnel also recently audited 52 medication

administration records (MARs), listing approximately 250 medications. Out of 2500 potential entries, Corizon found only two entries were not marked. This indicates non-expired medications are being provided as ordered.

The Special Master stated on page 17 of the Report that medication record-keeping was very poor. There was no explanation for why he believed it was poor, other than a reference to one MAR, which he indicated demonstrated a patient missed five doses of a medication for tuberculosis. The Department is unable to explain the basis as to why the inmate missed the doses as the inmate's identity is unknown. However, established procedures are for the patient to be brought to the clinic for education if they fail to show for a dose of INH. INH is not a critical or "can't miss" medication as no resistance develops during a missed dose, and the offender would resume medication. In any event, missing MAR entries do not necessarily establish the medication was not provided, but instead represent possibly several isolated instances of poor record-keeping. There has been no tuberculosis outbreak at ISCI, so fortunately, if medications were missed there was no harm suffered as a result. It is unknown how many MARs were actually reviewed by the Special Master.

The Special Master also identified concerns with "keep on person" ("KOP") medications, but cites no documentation in support of his conclusion. *See* Report (Dkt. No. 822), pp. 17-18. Since the medications are maintained by the patient, it is incumbent on the patient to notify medical staff when the medication is running low and a refill needs to be ordered. The Department recognizes this is an area for improvement, and that patients who fail to properly notify staff of the need for refills may need to be removed from the KOP program, so staff can ensure they receive their medications as prescribed.

The Special Master also expressed concerns about an alleged lack of staff knowledge about the critical medication list and what to do if a patient missed a critical medication, but again it is unknown how many or which persons he spoke with about the subject. *See* Report (Dkt. No. 822), pp. 17-18. Corizon has advised the Department that its staff is well-trained on the processes and procedures to be employed when patients refuse medications or otherwise miss doses of medications. It is impossible for the Department to respond to these allegations without more explanation where this information came from.

Based on Corizon's recent audit of the pharmacy and MARs, it does not appear that pharmacy recordkeeping is poor or that medications are not being dispensed. The Department therefore denies conclusion 5 on page 18 of the Report that medication management practices at ISCI violate offenders' constitutional rights.

I. Patients in Segregation Are Seen and Receive Ordered Medications.

Corizon's recent audit of randomly selected charts revealed that offenders housed in segregation receive welfare checks a minimum of three times per week and sometimes more often. The checks are performed by going door to door through the unit and visualizing the patient. Sick call is performed on a daily basis. Patients requiring evaluation for sick call are removed from their cells and seen in a sick call area in the segregation unit. Corizon randomly selected six charts from those offenders currently in segregation and found in all cases that the MARs for those individuals were contained in the segregation unit's MARs logbook and that medications were available and administered in a timely fashion.

On page 19 of the Report, the Special Master faulted the method by which welfare checks are conducted, but then admitted the situation has improved. He then stated that nurse-inmate

interaction may be too limited, but provides no basis for his conclusion. He also failed to set forth the basis for his conclusion that medications are not provided to offenders in segregation for days after their arrival on the unit. Corizon's audit of randomly selected charts indicated this is not the case. The Department therefore denies conclusion 6 contained on page 19 of the Report that conditions of confinement in the segregation unit violate offenders' constitutional rights.

J. Medical Staff are Trained and Competent.

The Special Master concluded on page 20 of the Report that actions concerning one dialysis nurse constituted a class-wide violation of offenders' constitutional rights. However, this one instance does not establish a constitutional violation, much less a class-wide violation. There was no evidence that the nurse's actions harmed the patients involved. However, the same day the Department became aware of the allegations against the nurse in question, the Department barred the nurse from the facility and required Corizon to continue providing dialysis to the patients involved. The Department acted swiftly and therefore was not deliberately indifferent to the patients involved. As such, the Department denies conclusion 7 on page 20 of the Report.

K. Medical Records Meet Constitutional Standards.

The Special Master correctly noted on page 20 of the Report that medical records at ISCI are well organized and complete. His unsolicited hypothesis about the past state of medical records and statutory access to records goes outside the scope of his charge and should be disregarded. The Department agrees with conclusion 8 on pages 20-21 of the Report, but only to the extent it concerns the current state of medical records.

L. Systems Exist To Support a Constitutionally Adequate Healthcare System.

The Special Master correctly noted on page 21 of the Report that the systems he discussed do not cause care to be unconstitutional. As this section of the Report does not concern whether offenders are experiencing current and ongoing violations of their Eighth Amendment rights, it is therefore beyond the scope of the Special Master's Charge and should be disregarded.

Should the Court decide to review the Special Master's conclusion on this issue, the Department disagrees that the policy and procedure structure, the grievance process and death reviews at ISCI are dysfunctional. First, it is not unusual for a department of correction and the contract medical provider to each have their own set of policies and procedures. In this case, and likely in other instances, the Department's policies relate to the administration of the healthcare system, while the medical provider's relate to the actual care provided. Since the Special Master did not purport to speak with everyone at the facility, it is difficult to understand how he could conclude on page 21 that "everyone had difficulty finding relevant policies and procedures." In reality, the Special Master provides no specifics concerning how many people he spoke with about policies and procedures, what was said, what policies he requested or what difficulties he experienced when trying to locate policies and procedures. Without these specifics, it is impossible for the Department to address the concerns contained in this portion of the Report.

The Special Master next criticizes the grievance process at ISCI, arguing that based on his review of 100 concerns and 75 grievances, that with "rare exception" staff "never" talk to the offender before responding and that responses are often non-responsive and flippant. *See* Report (Dkt. No. 822), p. 21. In actuality, Department staff does speak with offenders when the subject

matter of the concern or grievance is unclear, but often there is no need for a face-to-face meeting because the grievance or concern clearly sets forth the issue. The Special Master fails to identify the specific concerns and/or grievances he has concerns with, and it is therefore impossible for the Department to provide a more specific response to the allegations.

With regard to use of grievances and concerns as HSRs, offenders are provided information about the differences between grievances/concerns and HSRs during orientation, which takes place in a classroom setting shortly after they arrive at ISCI. They are instructed on the situations when one should be used versus the other. The reality, however, is that some offenders will insist on using the concern/grievance process to request medical care. In order to allow offenders to be heard, the facility does not ignore medical concerns raised that way, or otherwise send the forms back because they have not been submitted as a HSR.

The Special Master provided no specific details for the one example cited on page 21 of the Report, regarding a concern filed by a patient concerning tremors while on lithium pills. Without details it is impossible to respond to the specific allegations. The Special Master does not indicate he requested the patient's medical file, but it instead appears his entire evaluation is based solely on one concern form. It is highly unlikely that the information provided on one concern form provided sufficient information to render an opinion whether care provided to the class as a whole was constitutionally insufficient.

With regard to death reviews, Corizon advised that it employs an internal peer review process, which under Idaho law, is privileged and protected from disclosure to third parties. Although the review documentation itself was not released to the Department, Corizon does share information with the Department concerning opportunities for improvement are identified

during this process. Corizon also conducts morbidity and mortality reviews at ISCI, which Department staff are invited to attend.

For the reasons set forth above, the Department denies conclusion 9 on page 22 that the policies and procedures employed, inmate grievance system and death reviews at ISCI are poor or otherwise contribute to unconstitutional conditions.

M. ISCI Has An Effective Mental Health Screening Program That Is Properly Implemented.

Offenders are screened for mental health issues during initial intake at ISCI, during transfer to or within ISCI, and prior to placement in restrictive housing (administrative segregation). The screening is done on a pre-printed form provided by Corizon, which is often completed by an LPN, who asks the offender questions and records his responses. There are 26 total questions on the form. Some questions are in bolded type and others are not. Four questions are in shaded boxes. If the offender answers yes to any of the shaded questions, the form directs the provider to immediately contact mental health. If seven or more bolded (but not shaded) questions are answered yes; if the credibility of the offender is questionable and the provider believes the offender is at risk; or if the offender's current mental status presents as disoriented, hallucinating or delusional, the form directs the provider to contact mental health immediately. The accuracy of the screening tool is directly dependent on the offender giving truthful answers to questions posed.

At times, a high number of offenders arrive for intake or transfer, and mental health professionals assist the LPNs with completing the screenings. Mental health professionals also conduct the screenings prior to an offender's placement in administrative segregation. The mental health professionals use their professional judgment when determining whether to refer

the offender for further mental health screening prior to placement. There are times when, based on their conversation and assessment of an offender, mental health professionals do not refer an offender who meets one of the criteria described above for further mental health screening. Such decisions are made only after the mental health professional assesses the patient and utilizes his/her professional judgment. A mental health clinician later reviews the screening forms within 24 hours of completion to ensure appropriate referrals took place.

On page 23 of the Report, the Special Master references three examples of individuals who he alleges were not referred for mental health screening despite meeting one of the requirements on the form. The Special Master does not provide sufficient information about two of the cases to permit the individuals at issue to be identified. As such, the Department is incapable of responding to those allegations until it receives identifying information for the individuals involved. Once again, it is unclear how many screening forms the Special Master and his Deputy reviewed, and whether the conclusion concerning mental health screening is based solely on review of the three referenced cases, or on other information as well.

With regard to the third case, concerning an offender who committed suicide, the Department is familiar with the case. The initial mental health screening was conducted by a licensed psychologist, not an LPN. During the screening, the offender denied both depression and a history of suicide attempts. The licensed psychologist assessed the individual at intake, and utilizing his professional judgment, cleared the offender for placement in the general population. The Department conducted a psychological autopsy on the individual and did not find that the licensed psychologist's initial assessment was faulty or otherwise negligent. The

Department denies conclusion 1 on page 24 of the Report that ISCI's mental health screening program suffers from poor implementation and violates offenders' constitutional rights.

N. The Mental Health Treatment Program at ISCI Appropriately Treats Offenders.

1. Mental Health Treatment Plans Are In Place For Most Offenders With a Mental Health Classification.

The Special Master incorrectly reports, on page 24 of the Report, that ISCI staff informed the Deputy Special Master that 144 offenders enrolled in the mental health program did not have adequate intake assessments or treatment plans. What was actually reported to the Deputy Special Master was that as of December 2011, approximately 144 offenders in the program did not have treatment plans. Nearly all, if not all, of the offenders' intake assessments were completed upon arrival at ISCI. This number was likely due to several factors, including the fluidity of the population at ISCI. For instance, during a seven day period in March 2012, 147 offenders were transported in and out of ISCI. Pursuant to Department policy, mental health treatment plans are developed within 14 days of intake at ISCI. It is therefore likely that at least a portion of the 144 uncompleted treatment plans, were individuals who only recently arrived at the facility. The Department admits that some treatment plans were overdue, but clinicians have worked to catch up the backlog and complete those plans. Further, some of the 144 uncompleted plans likely involved individuals waiting for an update, meaning those individuals already had a treatment plan in place. The Department does not believe that the slight delay in completion of treatment or updated treatment plans caused harm to individuals or otherwise deprived patients of their constitutional right to care.

2. Patients Are Not Overmedicated.

By statute, the Department provides the only secure mental health facility in the State. Although the Special Master indicates on page 24 of the Special Report that the percentage of individuals on psychotropic medications is unusually high compared to "national norms for a non-specialized, male, medium custody facility," he does not state the source for his national norms. In actuality, the percentage of patients identified in the Report as being on psychotropic medications is in line with the 2006 Department of Justice percentages which reflect national averages for inmates receiving psychotropic medications in state prison facilities. ISCI is not a non-specialized facility, but instead a secure mental health facility. The Special Master provided no information about national norms for such a facility.

The number of offenders on psychotropic medications for mental health issues is likely lower than the percentage reported in the Report, because some offenders are prescribed psychotropic medications for a medical problem, i.e. a prescription for Elavil to address chronic pain. Further, upon intake at ISCI approximately 35% of offenders report they are taking psychotropic medications. The 28% figure contained in the Report is therefore a decrease, indicating ISCI has been able to remove individuals from mental health medication after arriving at the facility and presumably receiving treatment. Mental health clinicians are also working to make sure they are made aware of patients seen by Corizon's psychiatric providers for medication-related issues, so clinicians can ensure those individuals receive appropriate follow-up mental health services.

3. Group and Individual Therapy Are Both Properly Utilized.

Mental health clinicians at ISCI provide approximately 113 hours of group therapy each week. The Behavioral Health Unit ("BHU") contains 260 beds, and houses the most acutely mentally ill offenders at ISCI. Groups in the BHU average 10-12 individuals per session. Groups in the general population total average 12-14 individuals per session. All individuals with a mental health classification are eligible to participate in group therapy, if their assigned mental health clinician believes it would be beneficial based on their assessment. Group therapy attendance is documented in the Department's offender database, CIS. Medical and mental health providers at ISCI understand how to access CIS, and to the Department's knowledge do access CIS to obtain information when treating an offender.

Of those individuals in the general population with a mental health classification, nearly half fall within the Correctional Mental Health Services System CMHS-2 level of care, meaning these individuals are generally stable and asymptomatic thus only requiring a psychiatric medication management treatment plan. This plan is reviewed by the psychiatrist once every 90 days. While they are eligible to participate in group therapy, many do not require group treatment. The Report also fails to account for individuals who refuse group treatment. These factors reduce the number of individuals with mental health classifications who also participate in group therapy.

Group therapy is not limited to those individuals in the BHU. Any individual in the general population whose clinician believes, based on his assessment, that he will benefit from group therapy is eligible to participate. ISCI provides approximately 16 hours of group therapy each week in the general population. The Report cites a federal court decision, *Coleman v.*

Schwarzenegger, for the premise that mentally ill offenders should receive 10 hours per week of structured out-of-cell time. *See* Report (Dkt. No. 822), p. 24. The Report fails to recognize, however, that group therapy is not the only method of structured, out-of-cell time for mentally ill offenders. At ISCI, mentally ill offenders can also participate in structured, out-of-cell activities such as leisure activities, art, music and others.

Contrary to the statement on page 25 of the Report, patients convicted of life sentences are also eligible to participate, and in fact do participate in group therapy. There is a specific group for "lifers." Individuals with life sentences also participate in other groups offered at the facility.

The Report also incorrectly states on page 25 that the Deputy Special Master was told groups were occasionally offered to patients with SMI[1] who were 12-24 months from parole. The information actually conveyed to the Deputy Special Master was that group therapy can take place concurrently with core pathways programming. Core pathways programming is provided to prepare offenders for release from the facility. The Deputy Special Master was advised that although core pathways programming is usually provided only to individuals within 6 months of release, some exceptions are made to allow the programming to be provided to individuals within 12-24 months of release. The core pathways programming differs significantly from mental health group therapy, and has a different focus.

The Special Master claims individual therapy is under-utilized at ISCI, but provides no information concerning how he arrived at that conclusion. Correctional medicine authorities

1 The Special Master repeatedly refers to "SMI" throughout the Report, but does not define how he is using it. Within the mental health community, SMI, typically meaning "serious mental illness" is interpreted very differently among different groups. For example, it can be used to mean any individual with a mental health diagnosis, an individual with a mental health diagnosis who is on psychotropic medications, or an acutely mentally ill individual.

agree group therapy is the best mental health treatment practice in a correctional setting. Individual therapy also takes place and is directed by the mental health clinician as part of the patient's treatment plan.

Offenders may request mental health services, including participation in individual and group therapy, through use of concern forms and HSRs. Forms requesting mental health services are triaged daily by a mental health clinician and usually responded to within 24 hours. The mental health clinician reviews the concern and determines whether the offender requires a referral to a medication provider, and/or discusses coping skills and clinical interventions that the offender can use to manage symptoms. The mental health clinician then follows up at a later date.

In light of this information, the Department denies conclusion 2 on page 27 which indicates that group and individual therapy are under-utilized, depriving offenders of their constitutional right to health care.

4. Patients Are Regularly Checked During Periods of Acute Illness.

The Special Master also concludes, on page 25 of the Report, that patients hospitalized with acutely severe illnesses, other than suicidality, "invariably" do not receive close involvement by mental health professionals and that patients' right of access to health care is therefore being violated. His conclusion is based on one case, in which he claims an allegedly catatonic individual was not evaluated by a psychiatrist for 14 days after admission. This is a gross misrepresentation of the facts of the case.

The description contained in the Report permitted the Department to identify the patient at issue. A review of the patient's file revealed both a psychiatrist and a general practitioner saw

the patient within 24 hours of placement in the infirmary. The offender was seen by the psychiatrist three more times, by a mental health clinician five times and by the attending RN seventeen times while in the infirmary. Both a suicide risk assessment ("SRA") and a mental health treatment plan were developed for the patient while he was in the infirmary. Although the Deputy Special Master stated she believed the patient may have been suffering from a catatonic state, the treating psychiatrist (who saw the patient four times and was much more familiar with his case) diagnosed the patient with a toxic medication reaction. The patient subsequently experienced significant improvement. The Department was not deliberately indifferent in this case, nor does the scenario reflect a class-wide deliberate indifference to patients with acute illness. The Department therefore denies conclusion 2 on page 27 that patients with acute illness are deprived constitutionally adequate care.

5. Segregation is Not Inappropriately Utilized for Mental Health Behaviors.

The Deputy Special Master appears to consider administrative segregation cells, suicide observation cells and close custody cells as one and the same. ISCI does not. ISCI's suicide watch and close observation cells are protective in nature. Seven cells in the BHU are designated suicide watch or close observation cells. ISCI also utilized four dry cells in another unit, which had access to toileting, for generally short periods of time to manage security risks associated with mental health symptoms, manage suicidal symptoms, and/or decrease stimuli for increasingly agitated offenders. Segregation cells, on the other hand, are used for offenders who have been convicted of disciplinary offense or have otherwise engaged in behavior that requires them to be removed from the general population.

Contrary to the Special Master's statement on page 25 of the Report, patients in suicide watch and close observation cells receive daily follow-up by a clinician and the interaction is noted on the SRA follow-up and/or clinical case notes. Patients on suicide watch and close observation participate in group therapy and receive individual therapy, if indicated. Patients in segregation also receive group therapy. Since January 15, 2012, two therapy groups were developed and are being facilitated in the administrative segregation unit.

Pursuant to Department policy, offenders with a mental health level of care of ICMHS[2], CMHS-1[3] or MHMN[4] who receive a disciplinary offense report ("DOR") are evaluated by a mental health clinician prior to imposition of any penalty. This occurs so the clinician can determine whether mental health factors contributed to the behaviors at issue in the DOR, and make recommendations for issues such as housing and alternative sanctions, if appropriate.

Offenders are not placed in the administrative segregation unit without first being screened by a medical personnel utilizing a standard screening form to determine if placement in segregation is appropriate. If the provider determines it is not appropriate, the individual is placed in alternative housing to serve his segregation time. Regardless of where he is housed, the offender receives individual and group treatment as appropriate.

The case referenced on page 25 of the Report provides an incomplete picture of the situation involving a patient with Asperger's. The description contained in the Report was sufficient to allow the Department to identify the individual. The patient at issue was involved in a fight with another offender. As he was being escorted to the administrative segregation unit

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2 Intermediate Correctional Mental Health Services, as defined by the Correctional Mental Health Services System.
3 Correctional Mental Health Services - 1, as defined by the Correctional Mental Health Services System.
4 Mental Health Medically Necessary, as defined by the Correctional Mental Health Services System.

following the fight, he assaulted staff and was placed in a holding cell because placement on the tier was inappropriate given his combativeness. A licensed clinician saw him and assessed his condition on the day he was placed in the holding cell. The clinician did assess whether the behavior was related to his diagnosis. The clinician ultimately recommended that the patient be placed in a dry holding cell to decrease stimuli, rather than the administrative segregation unit. The individual was not punished for being ill, and his illness was taken into account when decisions were made about his placement. While in the dry holding cell he received daily checks by a mental health clinician and participated in daily individual therapy with a clinician, which included homework assignments.

Documentation of mental health treatment is included in patient records and is readily available to other medical and mental health care providers. Extensive information about suicide watches, including the SRA and treatment plan is included in patient files and also readily available to medical and mental health treatment staff. The Deputy Special Master refused staff's offer to explain the organization of patient records, and therefore likely would have been able to locate the documentation if she had only requested assistance.

The Special Master also referenced a six month summary of suicide observation placements that staff provided to the Deputy Special Master at her request. While the Report accurately stated that 45 of the 137 individuals were placed in dry cells, the Report failed to state that those individuals were only placed in the dry cells because no other cells were available. Of the 45 individuals placed in dry cells over a 6 month period, 29 were moved within 24 hours. The remainder were removed as soon as cells in the BHU became available and was clinically indicated. Once an individual is placed in a protective environment, licensed mental health

clinicians make all decisions about suicide watch and protective living conditions. These decisions are reflected in notes on the SRA, clinical case notes, mental health assessments and treatment plans, all of which are contained in the patient's medical file.

The Deputy Special Master was also critical of the fact that eight individuals spent five or more days in a dry cell, with six staying ten or more days. *See* Report (Dkt. No. 22), p. 27. The patient records of those individuals, however, document multiple attempts made by clinical staff to move the patients to a less restrictive cell. The patient either refused, was too disruptive to be in the BHU with other mentally ill patients, or was so psychotic that the noise and stimuli of the BHU would have caused more distress to the individual, so the quiet environment of the dry cell, which is in a different unit than the BHU, was determined to be better for the patient.

The Special Master failed to provide any basis for the conclusion that the number of individuals on suicide watch or close observation is in excess of the number expected for an institution the size and composition of ISCI. Rather, as noted previously herein, ISCI is a specialty facility. Approximately thirty-five percent of offenders report being on psychotropic medications at the time they enter the facility. Moreover, the Department has implemented an "easy in, hard out" suicide policy that allows all staff to place an offender on suicide watch at the first sign of suicide potential. Licensed mental health clinicians then take over care and determine when the individual can be stepped down from suicide watch to close observation and then to a less restrictive environment. The use of this policy has resulted in no suicides of individuals on suicide watch during the past five-plus years.

As with other portions of the Report, it appears the conclusions concerning mental health treatment were based on several anecdotal incidents and possibly a handful of documents.

Without identifying the specific individuals or information considered, the Department is unable to respond to many of the Special Master's characterizations. In those instances where sufficient information is provided that allows the Department to identify the patient at issue, the patient file paints a different story than that contained in the Report. The Department denies conclusion 2 on page 27 that segregation is misused and constitutionally deprives offenders of their constitutional right to health care.

O. ISCI Does Have a Sufficient Number of Trained Mental Health Professionals.

The Department agrees it is difficult to establish a formula for calculating the proper staffing level of different correctional health care disciplines. Nevertheless, the Department disagrees with the Special Master and Deputy Special Master's opinions that staffing is inadequate at ISCI as the evidence for these opinions are lacking and their use of "metrics" debatable. In light of their criticisms, the Department has been informed by its contract medical provider, Corizon, and fully believes the psychiatric staffing for ISCI is appropriate. As detailed throughout this Response, there is no constitutional deprivation of care with medical or mental health services. As such, the Department disagrees with conclusion 3 on page 29 of the Report that there is an insufficient number of psychiatric practitioners at ISCI.

P. Records of Mental Health Care Are Constitutionally Adequate and Properly Maintained.

Contrary to the statements on page 29 of the Report, detailed information about patients placed on suicide watch is contained in patient medical records. Documentation of group therapy occurs by exception. Attendance at group therapy is noted in the computerized offender tracking system CIS. Medical and mental health professionals are able to access CIS, and to the Department's knowledge do access this information in CIS when treating a patient. The

Department is aware that some mental health treatment plans contained generic and boilerplate language. This is not unexpected in the initial treatment plan for many individuals, since those individuals are new to the facility and being newly educated in how to request services and obtain necessary medications. The Department has, however, recently trained clinicians on better preparation of treatment plans. Clinical supervisors are also providing regular review and feedback to assist clinicians with improving their treatment planning skills. While there are some issues of concern with treatment plans, the Department does not believe those concerns render care deliberately indifferent and the Department therefore denies conclusion 4 on page 30 of the Report.

Q. Administration of Psychotropic Medication Occurs with Appropriate Supervision and Evaluation.

The recent audit by Corizon's psychiatric team involved the review of approximately 75 randomly selected charts of inmates receiving psychiatric treatment. This review did not reveal an overmedication of patients, nor did it reveal any inappropriate prescription practices. The Special Master does not identify the basis for his statement on page 30 of the Report that the Deputy Special Master learned psychiatric practitioners sometimes write orders for psychotropic medications without a face-to-face visit with the patient. Not knowing the basis for this statement makes it impossible for the Department to provide a meaningful response to the allegation. The basis for the statement did not come from Corizon's psychiatric team as the Deputy Special Master did not discuss this issue with them. Nevertheless, the Department is aware that, on occasion, a psychiatric provider may give an order for "bridging" medication in two situations. The first situation involves an order for medication that is due to end prior the next scheduled appointment. As a result, nursing staff will alert the medical provider and an

order will be given to continue the medication until the next appointment, which usually occurs within the next couple of weeks. The second instance involves an inmate coming into ISCI and having taken psychiatric medications previously. In that instance, a provider will order continuation of the medications until the patient can be seen in clinic for evaluation. Given the information obtained from Corizon's recent audit, the Department has no reason to believe patients are deprived of a qualified medical opinion concerning psychotropic medications, and the Department therefore denies conclusion 5 on page 30.

R. The Department Maintains an Effective Suicide Assessment, Prevention and Treatment Program.

The Special Master's conclusions on pages 30-32 of the Report are based in part, on conclusions contained in prior sections of the Report. The Department denies those conclusions for the reasons identified in the sections N.4-5 on pages 24-29, section P on pages 30-31 of this Response. The two additional conclusions contained in this section relate to suicide prevention training and use of companion offenders during suicide watch.

1. Department Staff Receive Adequate Suicide Prevention Training.

The Department provides new staff with suicide prevention training at the Peace Officer Standards Training Academy ("POST"). After returning from POST, staff receive annual refresher training. While the Department believes this training is adequate, as reflected in the low number of successful suicides at ISCI, it is considering the recommendations set forth in the Report and evaluating providing additional suicide prevention training to staff. The Department, however, does not believe its current training program rises to the level of deliberate indifference, and therefore denies conclusion 6 on page 32.

2. Companion Offenders Appropriately Supplement Professional Staff Observation During Suicide Watches.

Contrary to the statements on page 32 of the Report, companion offenders are screened prior to participation in the program and are not used in place of observation by professional staff. The use of offender companions is authorized by the National Commission on Correctional Health Care. All suicide watch offender companions go through a review process prior to service, during which their medical and mental health histories are reviewed, along with their investigation and disciplinary histories. Applicants are interviewed by programs and security staff, and successful applicants receive 8 hours of companion training prior to service, and ongoing supervision thereafter. The Department does not believe that a past history of mental health issues automatically renders an otherwise stable offender unfit to serve as a companion. This approach is consistent with the National Alliance for the Mentally Ill ("NAMI") support system philosophy.

The use of offender companions supplements observation by professional staff. Staff constantly observe individuals on suicide watch and conduct regular checks of those on close observation. That observation occurs through both in-person checks and video monitoring. Professional staff are always close enough to render immediate assistance if necessary. The Department denies conclusion 6 on page 32 of the Report.

S. Systems Exist To Support a Constitutionally Adequate Mental Healthcare System.

The Special Master correctly noted on page 21 of the Report that the systems he discusses do not in and of themselves relate to the constitutionality of healthcare at ISCI. As this

section of the Report does not indicate the constitutionality of healthcare at ISCI, it is therefore beyond the scope of the Special Master's Charge and should be disregarded.

Should the Court decide to review the Special Master's conclusion on this issue, for the reasons set forth previously herein in section L on pages 17-19, the Department disagrees that the policy and procedure structure, the grievance process and death reviews are dysfunctional. The Department also disagrees that its quality control mechanism is dysfunctional.

ISCI mental health staff annually perform Program Evaluation Tool ("PET") audits, which take place over multiple days, review performance, and identify areas for improvements. Additionally, the Department's licensed Chief Psychologist reviews the SRA log on a monthly basis to identify trends, reasons for placement on watch and length of stay as a continuous quality improvement ("CQI") mechanism. The Chief Psychiatrist at ISCI also conducts a weekly meeting with clinical staff to discuss and document high risk cases, trends and areas of concern. The Department also performs psychological autopsies of successful suicides, which identify the risk factors contributing to the suicide.

Although the Report stated the Deputy Special Master believed the Department should be collecting additional metrics as part of a CQI program, there is no reference to any scientifically reliable and recognized source in agreement with her statement. For the reasons set forth herein, the mental health care provided at ISCI is constitutionally adequate and therefore the Department believes its CQI processes are effective. As such, the Department denies conclusion 9 set forth on page 34 of the Report.

CONCLUSION

For the reasons set forth herein, the Department requests the Court adopt the following conclusions set forth in the Special Master's Report (Dkt. No. 822):

- Conclusion 1 on page 5
- Conclusion 2 on page 6, with the exception of the finding concerning staffing levels for pharmacy and therapeutic diets, which should be rejected
- Conclusion 3 on page 6
- Conclusion IV on page 8
- Conclusion 8 on page 20, with the exception of the finding concerning records previously being non-compliant, which should be rejected

The Department also requests the Court reject the following conclusions set forth in the Special Master's Report (Dkt. No. 822):

- Conclusion 1 on page 11
- Conclusion 2 on page 14
- Conclusion 3 on pages 15-16
- Conclusion 4 on page 16
- Conclusion 5 on page 18
- Conclusion 6 on page 19
- Conclusion 7 on page 20
- Conclusion 9 on page 22
- Conclusion 1 on page 24
- Conclusion 2 on page 27
- Conclusion 3 on page 29
- Conclusion 4 on page 30
- Conclusion 5 on page 30
- Conclusion 6 on page 32
- Conclusion 9 on page 34

DATED this 30th day of March, 2012.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

/s/ Colleen D. Zahn
Deputy Attorney General,
Counsel for Defendants

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 30th day of March, 2012, I caused to be served a true and correct copy of the foregoing **DEFENDANTS' RESPONSE AND OBJECTIONS TO SPECIAL MASTER'S REPORT** on:

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