

MAIN JAIL HEALTH CARE

Issue

Would a modification of health care delivery procedures improve service to inmates at the main jail?

Reason for the Investigation

As the result of a Grand Jury tour of the main jail, as well as various complaints received by the Grand Jury, an investigation was conducted of various aspects of health care delivery in the jail.

Method of Investigation

The Grand Jury received and reviewed the following documents:

- Medical policies
- Budget summaries
- Vacancy and turnover reports
- A listing of jail healthcare complaints for a one year period
- Summaries prepared by a jail nurse of inmate complaints with statistics on the number of valid complaints covering the period from May 2003, to October 2005
- Incident reports involving medical issues and/or medical personnel
- Implementation schedule for new pharmacy software
- Written responses from the Sacramento-Sierra Medical Society, in which it refused to provide the Grand Jury with peer review reports related to jail health care
- Patient Care Policy Committee minutes
- Prior Grand Jury Report for 2003-2004 relating to the jail pharmacy system (www.sacgrandjury.org)
- Written response to Grand Jury questions from the Chief, Correctional Health Services, Sacramento County Sheriff's Department, dated March 13, 2006
- Written response to Grand Jury questions from the Assistant Chief, Correctional Health Services, Director of Nursing-Main Jail
- Written report from the Board of Corrections, State of California, entitled "2002/2004 Biennial Inspection"

In addition, the Grand Jury interviewed the following jail personnel:

- Six Registered Nurses
- One Licensed Vocational Nurse
- Director of Nursing
- Medical Director

Background and Facts

The Grand Jury received various complaints regarding health care delivery at the main jail. In addition, the Grand Jury conducted a tour of the main jail, as well as other correctional facilities throughout the county. As the result of the information obtained from these sources, the Grand Jury requested various documents from the Sheriff's Department. Based on a review of these documents and the interviews listed above, the Grand Jury determined the following:

1) In response to the 2003-2004 Grand Jury recommendation that a computerized pharmacy system needed to be installed, the Sheriff's Department informed the Grand Jury that such a system would be established by late 2004 or early 2005. That did not occur. Instead, the effort referred to by the Sheriff's Department was scrapped and a new initiative was undertaken. The Grand Jury was informed by correspondence dated January 5, 2006, that the new system would be operational in the main jail in the middle of 2006.

2) Vacancy data submitted by the Sheriff's Department indicated there was a nurse vacancy rate of approximately 30%. The July 2005 Vacancy Report indicated there were 15 vacant registered nurse positions, which represent 30.61% of the authorized positions. In interviews, the Grand Jury confirmed this was an accurate number and it represents a chronic problem related to difficulties in recruiting and hiring nurses. The Grand Jury was informed the problem was addressed to some extent by the use of nurses from the Nurse Registry, at additional cost. The Grand Jury was also informed that, as a result of the vacancies and nurse absences due to illness and vacation, there were occasions when nurse sick call could not be conducted. Data provided at the request of the Grand Jury established that in the 54 week period from February 28, 2005 to March 13, 2006, inmates were seen on six floors of the jail from a low of 175 days on one floor to a high of 256 days on another floor. In some weeks during this time period, inmates on some floors had access to nurse sick call on only one day. The average for all floors for the 54 week period was 211 days.

3) Based on interviews and a review of the minutes of the Patient Care Policy Committee, the Grand Jury determined inmates have access to health care in four ways:

a. At intake, the interviewing nurse can determine that an inmate needs to be expedited to doctor sick call. This means the inmate is to be seen by a nurse or a doctor within two hours of completing the booking process. No record was kept of whether or not this goal was consistently met. However, nurses faxed the expedite form to a receiving nurse. If that nurse did not receive the inmate within the two hour time period, an inquiry would be initiated with custody staff to determine why the inmate had not been brought to the nurse.

b. Inmates can request to be seen during nurse sick call by filing a request. The requests are compiled at the end of each day, and medical charts are pulled and left for the next day's nurse sick call. The list is not triaged, which means inmates are seen in the order they are brought to the nurse by custody staff. If an inmate is not seen, either because nurse sick call was not held or because the inmate was not available, the inmate must start over again at the next available date. While a chart entry is supposed to be made

indicating the inmate was not seen, no other record is kept which would indicate whether the inmate is a carryover from the previous list. Such inmates are not given priority at the next nurse sick call. This fact, combined with the fact that sick call is not always held Monday through Friday, means there is potential for an inmate to not be seen for up to four days, or even longer in rare instances.

c. An inmate can press the call button in the cell and ask a guard to take him to a doctor or nurse. Whether this happens is dependent totally on the custody staff.

d. An inmate can sign up for doctor sick call.

4) There is no formal process for maintaining data regarding the operation of the jail health care system. Thus, while various procedures such as the two hour expedite process are in place, there are no data as to whether and to what degree the system is successful. There are no data to show how many inmates are not seen once they sign up for nurse sick call. There are no data available regarding the number of times that inmates who have signed up for nurse sick call are seen on the day they submitted their request, or on a subsequent day.

The one area where data are informally maintained is in regard to inmate complaints. One of the supervising nurses diligently reviews inmate complaints regarding health care and makes a determination whether the complaint has merit. This information is maintained on hand written spread sheets, and the summary numbers are reported to the Director of Nursing and the Medical Director. However, no standards have been developed as to whether the number of overall complaints, or the number of complaints that have been determined to have merit, are significant, i.e., have reached a threshold that should cause the supervisors to take some action.

For example, a review of the spread sheets indicates a range of complaints over the period from May 2004 to October 2005, from a high of 189 in one month to a low of 70 in another. These same records indicate that approximately 5 to 10% of these complaints have merit, ranging from items such as incorrect medications being given inmates, to being denied access to medications. No one to whom the Grand Jury spoke could state whether these numbers exceeded rates of acceptability established by the jail medical staff.

5) The lack of quantified standards and measured results is exacerbated because the jail health care system is not accredited. In 2003, the Institute for Medical Quality conducted a preliminary review to determine whether the jail could meet its standards. The Institute found several problems. Among them, the jail lacks a pharmacy dispensing system meeting the minimum Institute standards. In addition, jail nurses are required to collect forensic evidence, which is in opposition to accreditation standards. Sacramento County Jail nurses are the only nurses in the state of whom this is required. These factors have prevented accreditation.

However, the Grand Jury believes accreditation would provide the types of documents and concrete standards that allow the public to better judge the operations of the jail health care system. Accreditation would also allow the public to compare the Sacramento County Jail with other jails that are accredited throughout the state. This type of accountability is vital to maintain public confidence in an area that will always be contentious. For reasons stated below, the

Grand Jury takes the position that the county should halt the process of nurses collecting forensic evidence. This would allow the jail to seek accreditation, since the pharmacy issue is being addressed.

6) The Grand Jury learned of several incidents involving attempted assaults on nurses during the past year. These incidents occurred when nurses were alone with the inmate in the examination room during nurse sick call. No custody staff was immediately outside of the examination room. As a result of these incidents, the nurse conducting sick call is now accompanied by a nurse's assistant during the examination. However, the option of having custody staff outside the examination room has not been implemented.

A second potential risk to nurses is posed by the practice of having nurses collect forensic evidence. This practice conflicts with the nurse's role of providing care to the inmates, in that the nurse takes on an investigatory role. This means when the nurse encounters the inmate again, after taking the evidence, the inmate may act out against the nurse. Thus, the practice not only creates a potential conflict of interest for the nurse, but also creates the possibility of harm. This practice was cited by the Board of Corrections in its biennial inspection report as a violation of California Code of Regulations, Title 15, which establishes minimum standards for local adult detention facilities.

7) While the Grand Jury received complaints in regard to specific cases of inmate care, it was not able to evaluate those complaints for several reasons. First, the only medical review the Grand Jury was able to determine exists is conducted by the Sacramento-Sierra County Medical Society. The Grand Jury sought copies of those reviews, but was told by jail staff the reviews were confidential and would have to be obtained from the Medical Society. However, when the Grand Jury contacted the Medical Society, they adamantly refused to provide any specific information about the reviews, citing legal provisions making such medical reviews confidential. The Medical Society indicated it would not provide the information, and any effort to obtain it by the Grand Jury would be met with legal action.

Thus, while the Grand Jury was able to determine that such reviews do occur and are reviewed by the Medical Director, there was no practical way for the Grand Jury to determine the nature of the problems found by the reviews and what, if any, actions have been taken by the medical staff to address those problems. In addition, the Grand Jury does not have access to health care specialists who could review medical records and provide an independent medical evaluation.

In closing, the Grand Jury would like to emphasize that, throughout interviews with medical staff, there was no indication of any indifference to care being provided to the inmates or any lack of professionalism. In fact, the contrary certainly appeared to be the case. A commitment to providing the best possible care was expressed by all the staff.

Findings and Recommendations

Finding 1. Chronic understaffing of nurses has led to an inability to consistently conduct nurse sick call Monday through Friday. This raises the likelihood that inmates who sign up for nurse sick call may not be seen for up to four days from the date of request to see a nurse. Since nurse sick call is the primary way for an inmate to be seen by a jail physician, this means that inmates who need to be seen by a physician have their care delayed, possibly leading to serious harm to the inmate.

Recommendation 1. The 30% vacancy rate for nurses needs to be significantly lowered and the reliance on the Nurse Registry should be reduced.

Finding 2. Quality assurance and the overall collection of data about healthcare in the jail are conducted on an informal basis. This means there is an inability to measure success or failure and an inability to quantify the goals of the health care system. It also means that there can be limited oversight of the system, since it is difficult to determine exactly what is occurring.

Recommendation 2. The jail should seek accreditation by the Institute for Medical Quality through their Corrections and Detentions Survey Program. This would provide measurable performance standards that permit the jail officials and the public to better assess the quality of health care delivery.

Finding 3. Several incidents in the past year highlight the risks to nurses during nurse sick call when they are alone while examining an inmate.

Recommendation 3. A custody officer needs to be stationed outside the examination room during nurse sick call to ensure that, if an incident occurs, a response can occur within seconds.

Finding 4. The current system of dispensing medication is a manual system that increases the risk of incorrect medications being given, does not allow for the avoidance of medications being given that might dangerously interact, and does not allow for inventory control. While the jail staff has indicated for several years that the system is going to be replaced, there have been difficulties with the process, and delays have occurred. However, the latest schedule indicates a new system will be in place, at least in the jail, by the middle of 2006.

Recommendation 4. Jail officials need to regularly keep this and successor Grand Juries updated on the progress of replacing the old manual system, including progress reports on the implementation and its utilization of the system. These updates should be provided on a quarterly basis.

Response Requirements

Penal Code sections 933 and 933.05 require that specific responses to both the finding and recommendations contained in this report be submitted to the Presiding Judge of the Sacramento Superior Court by October 1, 2006 from:

- **Sheriff, County of Sacramento**

ELK GROVE CITY COUNCIL THE HANDLING OF POLITICAL DISSENT

Issue

Do Councilman Michael P. Leary and other members of the Elk Grove City Council (EGCC) promote or allow the free expression of political dissent with respect to the activities or policies of the council?

Reason for the Investigation

The Grand Jury received complaints that Councilman Leary and other members of the EGCC engaged in conduct which, by its nature, was intended or designed to intimidate the free expression of political dissent with respect to the activities or policies of the council.

Method of Investigation

The Grand Jury received sworn testimony from the following:

- Constituents and residents of the City of Elk Grove
- Two members of the EGCC, including Councilman Leary

The Grand Jury reviewed video tapes of public meetings of the EGCC, and the Code of Ethics adopted at the April 27, 2005 city council meeting.

The Grand Jury obtained by, legal process, and reviewed an exchange of electronic mail between Councilman Leary and a constituent.

The Grand Jury consulted California state and federal appellate and Supreme Court cases bearing upon the conduct of a city council.

Background and Facts

The Grand Jury received a complaint that EGCC Councilman Leary, at a meeting of the city council on April 27, 2005, threatened to deny grant funds to any organization whose members publicly criticized the council with respect to an unrelated matter. Councilman Leary did, in fact, threaten to withhold funding from an organization, one or more members of which had expressed disagreement with the EGCC, to wit:

“I will be quite frank with a situation that grinds me the wrong way. Individuals in this community want to throw darts at this council and want to trash us and say things that are

inappropriate. And then on the other hand, want to come up with their hat in their hand asking for money for different programs they are involved with. I would like to say that I am not apt to fund things that those individuals sit on.”

Mayor Daniel Briggs interjected that board members might be making comments outside the scope of their board membership, and that organizations that solicit funds from the city should take more care when selecting their board members.

Councilman Leary continued:

“Common sense would kick in and say, ‘On one hand, I am beating them up in the paper, and another time I am sitting here asking them for money.’ I am putting that particular person on notice about how I am feeling.”

Other council members verbally indicated concurrence with Councilmen Leary and Briggs. At the May 11, 2005 EGCC meeting, one council member expressly disassociated herself from the remarks made at the April 27th meeting.

In the Grand Jury’s view, Councilman Leary and concurring members, by these remarks, compromised their duty to predicate their decisions based upon the public good, rather than for the purpose of impairing political dissent. It has been held by the courts of this state:

“Governing bodies of municipalities stand in a higher category, higher than that of mere employees and directors of a private corporation; whatever other functions they may be called upon to perform, members of a municipal council or other body are at all times trustees of the public welfare. Obviously, such trusteeship does not call for competition and strife between such bodies and the interested members of the public.” (*Los Angeles County v. City Council of Lawndale* (1962) 202 Cal. App. 2d 20, 24, *Hubble v. City of Los Angeles* (1956) 142 Cal. App. 2d 1, 5.)

The Supreme Court of the United States also has held that a funding decision by a public agency cannot be aimed at suppressing criticism. (*Legal Services Corp. v. Velazquez* (2001) 531 U.S. 533, 548-549.)

The EGCC, later in the same meeting of April 27, 2005, adopted an eleven point City Code of Ethics. This Code of Ethics was in response to a Sacramento County Grand Jury Report dated February 28, 2005 (www.sacgrandjury.org). One of these points states, “I treat my fellow city officials, staff, commission members and the public with patience, courtesy, civility and respect, even when we disagree on what is best for the community and its citizens.”

The Grand Jury is also in receipt of a complaint relating to comments by electronic mail from EGCC Councilman Leary to a constituent in response to the constituent’s earlier email critical of Councilman Leary’s action at a meeting of the city council on June 16, 2004. In his response to this email and to the constituent’s ongoing criticism, which he viewed as “anti-law enforcement,” he threatened to publicly expose a past misdemeanor conviction of the constituent.

At the time, Councilman Leary was employed as a Sergeant with the Sacramento County Sheriff's Department, and made the threat through official law enforcement channels of communication.

In the Grand Jury's view, Councilman Leary's attitude to political dissent by a constituent is inconsistent with our "... 'profound national commitment,' to the principal that 'debate on public issues should be uninhibited, robust, and wide open.'" (*Boos v. Barry (1988) 485 U.S. 312, 318.*) This profound national commitment, as applied to a city council, is codified in California in Government Code section 54954.3(c): "The legislative body of a local agency shall not prohibit public criticism of the policies, procedures, programs or services of the agency, or of the acts or omissions of the legislative body."

The threat was even more egregious because it was made through official law enforcement channels, giving it the color of law.

Findings and Recommendations

Finding 1. Councilman Leary's comments in open session of a meeting of the EGCC on April 27, 2005 were inconsistent with the proper role of the legislative body of a local agency, in that the threat to deny funding was intended, designed and clearly perceived as a means of limiting political dissent with respect to the council's policies, procedures, programs or services.

Recommendation 1. Councilman Leary's comments and communications, which are the subject of this report, should be censured by the entire city council in open session.

Finding 2. With one exception, council members failed to disassociate from Councilman Leary's intimidating comments about council funding. Mayor Briggs' suggestion that boards carefully select board members confirms his agreement with Councilman Leary's threats.

Recommendation 2. Individual council members must clearly disassociate themselves from intimidating and unacceptable comments made, and behaviors expressed, by other members which are the subject of this report.

Finding 3. While the city council adopted a Code of Ethics, they did not put in place any enforcement procedures or consequences.

Recommendation 3. The city council should adopt procedures and policies related to the enforcement of the Code of Ethics.

Finding 4. Councilman Leary made threats through official law enforcement related electronic channels of communication to expose to the public a constituent's past.

Recommendation 4. Councilman Leary should refrain from using any official law- enforcement channel of communication to engage in any non law-enforcement related activity.

Response Requirements

Penal Code sections 933 and 933.05 require that specific responses to both the finding and recommendations contained in this report be submitted to the Presiding Judge of the Sacramento Superior Court by October 1, 2006:

- **The Elk Grove City Council. (1, 2, 3)**

The Grand Jury believes the public interest would be best served by, and residents of the City of Elk Grove deserve, a full and forthright response from Councilman Michael P. Leary to the Presiding Judge of the Sacramento Superior Court, and to the residents of Elk Grove.

- **Councilman Leary (1, 4)**