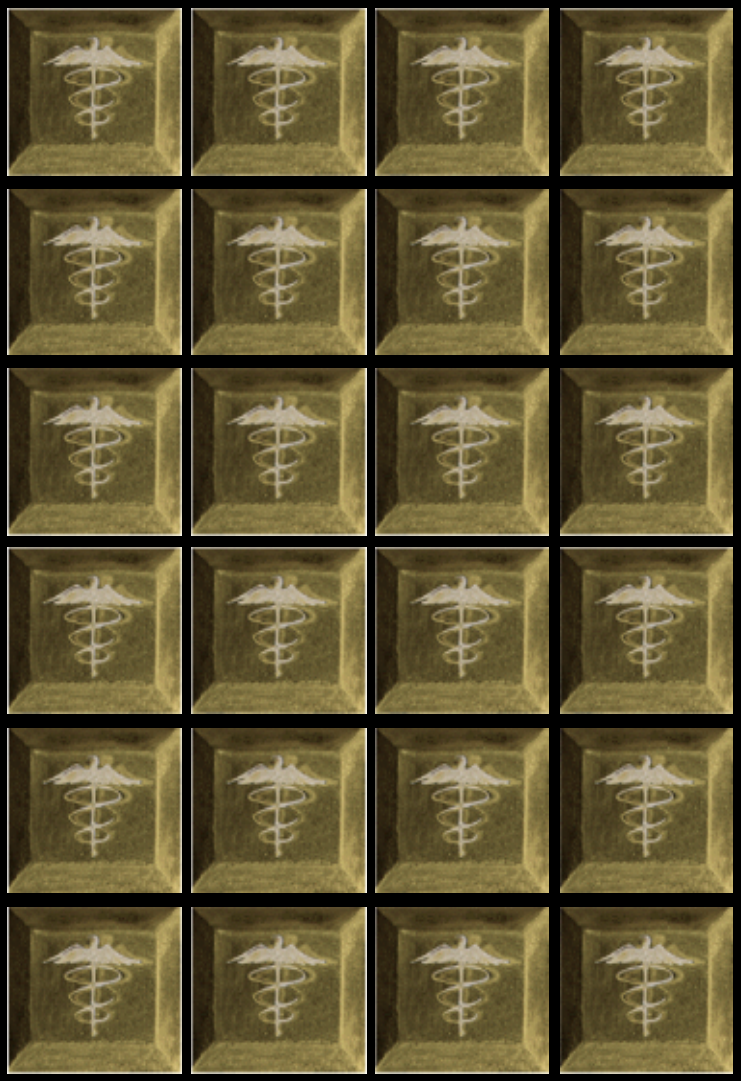
ACCOUNTABLE TO NO ONE

THE VIRGINIA DEPARTMENT OF CORRECTIONS AND PRISONER MEDICAL CARE



American Civil Liberties Union of Virginia

May 2003

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Preface

Ask anyone who corresponds with Virginia's prisoners, and invariably they will relate a story about inadequate or indifferent health care in one or more our correctional facilities. The ACLU of Virginia, as an example, receives hundreds of letters each year from inmates complaining about medical treatment. Their stories are often horrific.

A near lethal confluence of factors makes the practice of medicine in prison a risky proposition. First, it is only one part of a massive government bureaucracy that must oversee practically every minute of the lives of 30,000 individuals. Second, inmates do not elicit a great deal of sympathy from those appointed to care for them. Third, because prisons are virtual islands, where security is paramount, they function with little public oversight. Fourth, who believes the stories prisoners tell anyway?

We began this study with the idea of analyzing government documents to shed light on a health care institution that we only knew through anecdotes. What we discovered was that bad attitudes, bad laws and bad policies make getting to the bottom of health care in Virginia's prisons an arduous, if not impossible, task.

Although far better informed than when we started, we end our study where we began: Health care in Virginia's prison system, based largely on anecdotes, is woefully inadequate and leads to much unnecessary suffering and, in some instances, death. Along the way we discovered that Virginia's correctional facilities are breeding grounds for Hepatitis C both inside and outside prisons, and that Virginia promotes cruelty and indifference by walling off the truth about prison health care from the public.

As a society, how civilized we are is reflected in the way we treat those whom we punish for not being civilized. It is our sincere hope that legislators and others will read this report and use it to begin addressing this problem of health care in Virginia's prisons.

Kent Willis
Executive Director
ACLU of Virginia

Introduction

During the past decade, as Virginia implemented policies to abolish parole and require prisoners to serve at least 85 percent of their sentences, the state's prison population doubled. Virginia now incarcerates roughly 30,000 men and women. Their median age is 35.

Predictably, the cost of providing medical care to these prisoners has also soared. In Fiscal Year 1995, the state spent $50 million on prison health care. By Fiscal Year 2002, that number had risen to more than $91 million – roughly $3,000 per prisoner per year. But in spite of the high price, there is evidence that the medical care delivered in Virginia's prisons is inadequate and substandard.

In recent years, complaints to the ACLU of Virginia about medical care in the state's prisons have grown increasingly strident. Inmates and their families have written of purposeful neglect, unnecessary deaths, botched surgeries, negligible surgical aftercare and policies that place cost concerns above the health, lives and welfare of patients. Consistent with these complaints are reports that the Virginia prison system has one of the highest rates of Hepatitis C of any prison system in the country,[1] statistics demonstrating that only a small percentage of Hepatitis C-positive prisoners are treated[2] and general conclusions from a recent survey of 41 prison systems -- including Virginia's -- that the quality of care is not as high as it might be, resulting in unnecessary morbidity, premature mortality and increased costs.[3]

In recent years, complaints to the ACLU of Virginia about medical care in the state's prisons have grown increasingly strident. Inmates and their families have written of purposeful neglect, unnecessary deaths, botched surgeries, negligible surgical aftercare and policies that place cost concerns above the health, lives and welfare of patients

Prompted by these circumstances, the ACLU of Virginia began a review of state prison medical care in the fall of 2002. In embarking upon this review, we resolved to look beyond prisoners'claims of mistreatment and neglect and to assess the quality of the Department of Corrections' medical care through published statistics and reports, public records and department policies. Toward this end, we sought access to every relevant record, database, contract, policy and report we could document, reviewed every relevant state law and regulation pertaining to prison health care we could find, requested interviews with agency administrators and filed numerous requests under the Virginia Freedom of Information Act (FOIA).

We also contacted other agencies, both state and federal, in an effort to obtain information we were unable to get from the Virginia Department of Corrections (VDOC).

We found that, despite the money Virginia spends on medical care for inmates, the VDOC produces no public reports monitoring or assessing the quality of that medical care.[4] We found that there is no database anywhere in the state that specifically tracks the deaths and causes of deaths of state prison inmates, that there is no reliable or consistent source of information about the prevalence or treatment of communicable and chronic diseases among inmates, and that there is no reliable or consistent source of information about the prevalence or treatment of mental health conditions among inmates. Other findings included:

- Virginia's failure to aggressively treat the high incidence of Hepatitis C among its prisoners is putting the state's law-abiding population at risk.

- While statistics published on the VDOC's website claim that no inmates died of Hepatitis in 2001, results of autopsies performed by the Officer of the Medical Examiner of Virginia show that at least seven inmates died of Hepatitis in 2001.[5]

- Classifying all information about the deaths of prisoners as "medical records," The Virginia Department of Corrections employs a combination of exclusions to the Virginia Freedom of Information Act to withhold almost all information about such deaths, including post-mortem reports on how medical treatment was handled, the names of prisoners who died and the causes of their deaths.[6]

- Prison medical department administrative records from five prisons were either non-existent, inconsistently filed, incompletely filled out, and/or varied so much in format so that the information conveyed was statistically useless.

- Eight VDOC inmate medical files analyzed by an expert in prison health care were incomplete, contained poor health histories, lacked planning for follow-up care and contained no documentation that patients had received educational information about the spread of infectious diseases.

Because the VDOC produces almost no public information about the care it delivers or the condition of the population it treats, the ACLU of Virginia was able to draw only these conclusions about the quality of the medical care the Department delivers. They are based on individual state prison medical files analyzed by an expert on prison medical care, anecdotal information from inmates, various pieces of information we were able to get from the VDOC and information gleaned from medical literature and public documents.

Our work on this project also enabled us to assess the state of the public's access to information about the expenditure of public money on inmate health care. In short, there is virtually none.

This is not acceptable, especially in light of the potential public impact of inmate medical care. The ACLU spent six months and more than $20,000 in an effort to get information that should be accessible to any citizen of Virginia. We urge the legislature to make the VDOC accountable for the money it spends and the kind of care it dispenses.

Three Deaths: Troubling Signs of Care and Cover Up

In the autumn of 2002, three prisoners died at three different prisons in three different ways. The ACLU heard about their deaths from other prisoners and questioned the VDOC about the circumstances in which they died. In each case, we were told, essentially, that it was none of our business.

Because of "privacy concerns," we had no right to know if a man was left unattended in his cell during three days of seizures before he died.

Because bleeding to death is a medical issue involving a "medical record," and because the incident took place in a "penal institution," we were not entitled to know whether a man bled to death in a prison infirmary.

Haywood Johnson lay in his bunk having seizures for three days in early October, 2002, while his fellow inmates at Sussex 1 State Prison pestered guards to call the medical department or at least bring him some food

Because "no foul play was involved," we were entitled to no further information about a man who may have died because corrections officers declined to administer CPR.

This is the way FOIA operates to shield the prison system from scrutiny.

1. Haywood Johnson

Haywood Johnson lay in his bunk having seizures for three days in early October, 2002, while his fellow inmates at Sussex 1 State Prison pestered guards to call the medical department or at least bring him some food. The medical staff was "aware of the situation," the inmates were told. But Johnson got no food or help. On October 7, the 32-year-old prisoner was finally taken to the medical department.[7] Two days later, he was dead.

A week after his death, Johnson's name had disappeared from the Virginia Department of Corrections' website. Typing his DOC identification number into the Inmate Locater database yielded the following message: "No DOC record was found for the Inmate Identification Number entered."

Informed by the VDOC that Johnson's death was "expected" and that he had been "monitored" in anticipation of it, the Office of the Virginia Medical Examiner did not perform an autopsy.[8] Asked directly about Johnson's death, a VDOC spokesman said it was the result of "natural causes" and referred questions back to the medical examiner.[9] For "privacy" reasons, "and because it is part of an inmate's file," VDOC would reveal nothing about Johnson, his family or where he came from.[10] In this way, the death of Haywood Johnson has been forever shielded from public scrutiny. Beyond the accounts of his fellow inmates, there is no chance of documenting why or how he died.

2. Lewis Brewer

A month before Johnson's death at Sussex I, Lewis Brewer, an inmate at Augusta Correctional Center in Craigsville, died of internal bleeding in the Augusta medical department following a laparoscopic cholecystectomy, a kind of surgery to remove the gallbladder.[11] Brewer, fellow inmates maintain, was operated on at a local hospital and prematurely released back to the prison soon afterwards. He was then left in Augusta's understaffed and ill-equipped medical department for the weekend. He died there on Saturday September 7, 2002.[12]

Asked for any reports about the Brewer incident, Augusta Warden George M. Hinkle responded that "any reports concerning inmate Brewer are specifically excluded from disclosure under the Virginia Freedom of Information Act.

"He had no intravenous fluids administered nor did I see any machines that would alert staff if his condition worsened, no monitors whatsoever," wrote one inmate who visited Brewer on the day he died.

Wrote another: "Their biggest mistake was to bring Mr. Brewer back to this institution's medical department which lacks adequate care and competent nurses especially during the two-nurse weekends, knowing they don't have the proper medical equipment to rightfully care for and adequately treat a post-surgery patient…He did not have to die that way."

Asked for any reports about the Brewer incident, Augusta Warden George M. Hinkle responded that "any reports concerning inmate Brewer are specifically excluded from disclosure under the Virginia Freedom of Information Act, section 2.2-3706 (F) (6), which excludes "all records of persons imprisoned in penal institutions in the Commonwealth provided such records pertain to the imprisonment."

"The inmate's medical records are further excluded from disclosure in accordance with sections 2.2-3705(A) (5), excluding "medical and mental health records," 53.1-40.10, governing prisoner medical records, and 32.1-127.1.1:03, governing the release of patient medical records generally. Therefore your request for this information is denied."

3. Anthony Simms

On September 16, 2002, Anthony Simms collapsed and fell to the asphalt while playing basketball with fellow inmates at the Greensville Correctional Work Center in Jarratt.[13] As he fell, Simms' head hit the corner of the players' bench and began to bleed.

A prisoner ran for help. Three correctional officers appeared, and one of them radioed a shift commander to call the medical department. An inmate offered to administer CPR, but the officers kept the prisoners away from Simms, saying he needed breathing space. Ten minutes passed. "Who is going to give him CPR?" shouted a prisoner. No one answered. Two more officers showed up. Simms began gasping for air. Five more minutes passed. The prisoner yelled again. "Who is going to give him CPR? After 20 minutes, a nurse arrived. But she had no medical equipment.

Leaving Simms where he lay, the nurse left to get a stretcher. After 30 minutes, Simms was taken to the medical department. Later, he was pronounced dead.

A half-hour emergency response time is not unusual for a prison nurse, particularly if that nurse is the only nurse on duty at the time,[14] according to Katherine Maeve, an expert in prison medical care and former prison nurse who teaches at the University of South Carolina.[15] Had the Greensville nurse been delivering medication to a lockdown unit when the call came in, for example, she would have had to collect the medication, return it to the medical department, lock it up, and then travel through a series of security entries in order to get to the fallen inmate.

Simms began gasping for air. Five more minutes passed. The prisoner yelled again. "Who is going to give him CPR? After 20 minutes, a nurse arrived. But she had no medical equipment.

The real issue of Simms' death, said Maeve, lies in the officers' refusal to either administer CPR to Simms or to allow one of the prisoners to do it.[16] Correctional officers are trained to administer CPR in emergencies, and with three to five officers present, one of them could have been spared to administer it, she said. More than likely, she speculated, none of them wanted to touch Simms because they feared infectious disease. To prevent this, officers in some prison systems are issued one-way valve resuscitators – devices that fit over their mouths to prevent contact with the bodily fluids of CPR recipients. In Virginia, these devices are on hand in all units.[17]

The Medical Examiner's Office performed an autopsy on Simms and ruled that his death was caused by hypertensive cardiovascular disease. In short, a heart attack. Had this happened in the free world, in public and among people, Simms almost certainly could have been saved, either by a witness administering CPR, or an EMT team arriving within minutes of the event.

An inmate contacting the ACLU of Virginia about Simms' death wrote that he had also contacted the Internal Affairs Unit of the VDOC requesting an investigation.

Asked if such an investigation took place, a VDOC spokesman said yes. "Our investigation concluded that this was a death by natural causes and that no foul play was involved."[18] He would not comment further.

A Near Epidemic: Hepatitis C In (and Out) of Prison

Hepatitis C (HCV), a blood-borne, potentially fatal virus spread primarily through needles and sex, has become epidemic in U.S. prisons. Virginia, with an estimated 39 percent of its inmate population afflicted, has one of the highest prison system infection rates in the country.[19]

HCV infects and damages the liver, an organ that involves the body's energy production, detoxification, immune functions and digestion. A small number (about 15-25 percent) of people who contract HCV resolve the virus without incident. All others develop chronic infection, which is almost never cleared without treatment. Of those who become chronically infected, 20 to 30 percent develop irreversible cirrhosis of the liver, end-stage liver disease or liver cancer.[20]

Although it is estimated that up to half of chronic HCV infections can be cured, only 50 Virginia inmates out of an estimated 12,800 infected were receiving Hepatitis C treatment as of November 1, 2002

Although it is estimated that up to half of chronic HCV infections can be cured if treated early with an appropriate regimen of interferon and ribaviron,[21] only 50 Virginia inmates out of an estimated 12,800 infected were receiving Hepatitis C treatment as of November.1, 2002, and only 320 have received the therapy since the treatment protocol was implemented.[22] Liver biopsies – procedures performed to assess liver damage prior to initiating HCV treatment – have fallen considerably in recent years. Only 33 inmates were scheduled for biopsies as of November 1, and the number of liver biopsies dipped dramatically last year, from 204 in 2000 to 127 in 2001.[23]

The main reason for the low treatment rate in Virginia and elsewhere appears to be cost. Monthly doses of the two drugs are estimated to cost between $10,000 and $15,000 per inmate per year.[24] Another reason, or perhaps a related reason, may be the fact that the VDOC has designed treatment eligibility requirements capable of excluding just about everyone.

Inmates seeking HCV treatment must first meet a long list of medical criteria in order to qualify for the treatment. [25]

Next come the social requirements: potential patients must have at least 18 months left to serve in prison, a life expectancy of at least 20 years, no documented drug use during the preceding 12-month period,[26] no poorly controlled major psychiatric illnesses or history of suicide and no poorly controlled other major illnesses.

In addition, anyone with a "medical or criminal history of substance abuse" must be presently active in drug rehabilitation and "must have been active for at least three months preceding."

Prisoners who meet all of these qualifications must then manage to get themselves treated during the window of time in which they still qualify. In a prison system of more than 30,000 with a potential HCV treatment waiting list of 39 percent of the population, this is no easy feat. Inmates describe being eligible for treatment when they enter the prison system, only to be subjected to delays and transfers from one prison to another until their eligibility lapses.

Michael Ray Harvey, who qualified for HCV treatment when he first entered the system in 2000, wrote medical requests and grievances for months before being told he no longer qualified because he had less than 18 months left on his sentence. In the meantime, Harvey was transferred to five different prisons.

Randall Bowman, who was diagnosed with chronic Hepatitis C while in jail, tried desperately to get treatment after entering the VDOC in February 2001. Instead, he was transferred to three different prisons while his requests were ignored. Bowman filed a federal lawsuit in October. His family settled the case after he died of end-stage liver disease[27] in May 2002.[28]

Michael Ray Harvey

Michael Ray Harvey was diagnosed with Hepatitis C and a blood disorder when he entered the Department of Corrections in May of 2001. Harvey, serving time for violating his parole on a third offense petty larceny conviction, was transferred to Staunton Correctional Center where he asked immediately for treatment. He got none.

Instead, Harvey was transferred to Haynesville Correctional Center where another blood test showed that he had Genotype 2B, the most curable form of the virus if treated before cirrhosis sets in.

Harvey filed requests for treatment and wrote grievances and letters. In July of 2001, he received a letter from the warden of Haynesville advising him that he was ineligible for treatment under VDOC's Hepatitis C treatment protocol because he had less than 18 months left to serve on his sentence. At the time he received the letter, Harvey actually had 19 months left to serve.

Harvey was transferred again, this time to Lawrenceville Correctional Center where he asked again to be treated. Next he went to Brunswick Correctional Center where, he claims, authorities began to punish him for continuing to agitate for treatment. They did this, he says, by saddling him with bogus institutional charges, taking away his good time and, ultimately increasing his security level and sending him to segregation in Red Onion, a Security Level 6 prison built to house "the worst of the worst."

The only shoplifter at Red Onion, Harvey filed suit in July 2002 pursuant to 42 U.S.C. § 1983, alleging, among other things, denial of medical treatment for Hepatitis C and his blood disorder and seeking relief and monetary damages. His request for an injunction was denied by U.S. Magistrate Judge Glen E. Conrad of the U.S. District Court in Roanoke and the case is now on hold pending an interlocutory appeal to the U.S. Court of Appeals for the 4th Circuit.

On January 30, Harvey was released from prison. He ended up in Newport News where he began attending Narcotics Anonymous meetings. At the meetings, he sees friends with whom he used to shoot heroin. All are alumnae of the Virginia Department of Corrections, according to Harvey. All have Hepatitis C.

(Account is based on letters and interviews with Harvey as well as court and medical records.)

It is unclear how many Virginia prisoners have died of Hepatitis C or Hepatitis C-related causes.[29] The VDOC maintains that it did not keep track of prisoner deaths until it was required to fill out federal "Inmate Death Report" forms in 2001. Among 106 documented deaths between January 1, 2001 and June 6, 2002, seven were of Hepatitis-related causes, three died of cirrhosis, one of end-stage liver disease and one of liver failure/sepsis.[30]

However, causes of death for inmates represented on ten of the forms could not be determined. The VDOC itself maintains that no inmates died of Hepatitis during 2001 – a period during which records from the state medical examiner's office indicate seven Hepatitis deaths.

Public health experts regard HCV as a problem still in its infancy. The virus was first identified in 1988, and many infections in the U.S. occurred before 1990 when blood banks first began screening for it.[31] Since the disease is asymptomatic in its early stages and can take up to 20 years after initial infection to cause death, many people are unaware they have it until they become sick. Experts believe that most HCV carriers have yet to be diagnosed.

In a recent report to Congress, the National Commission on Correctional Health Care emphasized that prisons present a unique opportunity to treat diseases like HCV before they threaten the lives of individuals and the community and become a chronic drain on public health dollars.

It is currently estimated that 1.8 percent of the U.S. population is HCV infected, and that the virus causes 8,000 to 10,000 deaths in this country per year. That rate is expected to triple during the next decade. In prisons, the infection rate is thought to be from 15 to 40 percent, because so many IV drug users pass through prisons.

. In a recent report to Congress, the National Commission on Correctional Health Care emphasized that prisons present a unique opportunity to treat diseases like HCV before they threaten the lives of individuals and the community and become a chronic drain on public health dollars. Points stressed were:

- Despite the cost of prevention, screening and treatment, it is cheaper than the cost of care and treatment for conditions caused by Hepatitis C.

- Prisons provide access to a large and concentrated population of persons at high risk for disease who are underserved and difficult to identify and treat in the general community.

- Medical instructions are more likely to be followed in prison where patients are not preoccupied with pressing survival concerns such as the need for employment, housing and food.

In Virginia, many prisoners with HCV appear to be unaware that a treatment program exists.

"I have not had any treatment for Hepatitis C," wrote one such prisoner. "When I inquired about treatment, Dr. (Moises Eladio) Quinones at KMCC (Keen Mountain Correctional Center) informed me that I did not need any treatment. That all treatment for HCV was in experimental stages and could do more harm than good. That all I needed to do was to avoid alcohol."

A 2003 class action lawsuit filed against the Michigan Department of Corrections alleges, among other things, that the Department is contributing to an HCV epidemic by releasing undiagnosed, untreated and uneducated inmates to spread the virus to the public.

Phyllis Beck, of the Hepatitis C Awareness Project, believes that Virginia and other states let HCV-positive prisoners languish without treatment at their peril.

"This idea that we can do whatever we want to prisoners and it won't affect us is absurd," she says.

"If we don't treat the prisoners inside the prisons, we'll have to pay twice as much to treat the complications of their disease after they're released – complications that would never have developed had they been properly treated in the first place. It only makes sense to take care of them. By taking care of them, we take care of ourselves. The way we treat these people will and does come back to haunt us."

"These prisoners are released back into our community on a daily basis. Very few stay in forever. They get out. They have family members. They have children. They are among us. Hepatitis C is an infectious disease. If they have it now, it's a matter of time before we get it, too.

We should also consider the health care costs. If we don't treat the prisoners inside the prisons, we'll have to pay twice as much to treat the complications of their disease after they're released – complications that would never have developed had they been properly treated in the first place. It only makes sense to take care of them. By taking care of them, we take care of ourselves. The way we treat these people will and does come back to haunt us."

Darlene Anderson

Darlene Anderson was one year into a three-year sentence for violating her probation on a heroin possession conviction when she was diagnosed with Hepatitis C-caused cirrhosis and end-stage liver disease. In a letter to the ACLU, Anderson described what happened following her January 2001 diagnosis: Dr. Mary Clarke of the Virginia Correctional Center for Women informed her that the MCV doctors who treat Hepatitis C-positive prisoners had refused to treat her. Therefore, said Clarke, it would be a good idea if Anderson applied for medical clemency because, in Clarke's opinion, she had three to five years to live.

Anderson, 43 at the time, applied for clemency in March of 2002. She didn't get it. In April, she was sent to the MCV emergency room, coughing up blood. In May, she was seen in the Gastroenterology Clinic where an endoscopy showed holes in her stomach lining (1), and a bacterial infection was found. There was no follow-up

In September of 2002, wrote Anderson, Clarke spoke to her again about medical clemency, encouraging her to re-apply. "Along with my deteriorating condition, she expressed concern that I might not live to see my release date," wrote Anderson.

Through the fall and winter, Anderson's health worsened. From October through December, the medical staff stopped testing her blood. "Now Dr. Clarke seems to be ignoring me and my condition completely," she wrote. "I have written several grievances. None have been answered." In January, after months of requests, Anderson got copies of lab reports on her blood tests. Handwritten notations on the reports scared her. "Rare reactive lymphocytes present in blood," they said. "Platelets decreasing." "Large platelets found in blood."

On January 7, 2003, Anderson wrote:"I have re-petitioned Governor Warner for clemency on the grounds of inadequate health care for my illness, as well as the severity of the illness itself. My family has also written on my behalf. I am aware that the state is in the midst of a budget crisis, but what cost does one put on human life? If they cannot care for me, or provide treatment for me…they why not release me so I can pursue help through the private sector? I was sentenced to three years, not life.

I am due to be released April 14, 2003. I pray each day I will make that date." Anderson died February 14, 2003.

This account is based on letters from Darlene Anderson, as well as interviews with friends and family members.

(1)This may have been esophageal varices, or bleeding from the varicose veins in the lower esophogas, often seen in Hepatitis C patients

Doctoring in the Dark: The Public Information Vacuum

The Virginia Department of Corrections is required to produce three categories of public records pertaining to inmate health matters. These are:

- Data about "the types of and extent to which health-related problems are prevalent" among inmates. The agency's director has been required by statute to supply this data annually to the governor and the General Assembly since 1997.
- Administrative records required by the Virginia Administrative Code.
- State Prison Inmate Death Reports required from states in order to be eligible for federal Violent Offender Incarceration and Truth-In-Sentencing Incentive Grants.

These reports to the General Assembly and the Governor are the only published reports pertaining to inmate health statistics the state requires the VDOC to produce. However, the ACLU could find no indications that the agency has ever complied with the terms of the statute.

Data from the Director

Among the listed statutory powers and duties of the director of the Department of Corrections is:

> To collect data pertaining to the demographic characteristics of adults and juveniles who are adjudicated as adults, incarcerated in state correctional institutions, including but not limited to, the race, ethnicity, age and gender of such persons, and the types of and extent to which health related problems are prevalent among such persons. Beginning July 1, 1997, such data shall be collected, tabulated quarterly, and reported by the Director to the Governor and the General Assembly at each regular session of the General Assembly thereafter. §53.1-10

These reports to the General Assembly and the Governor are the only published reports pertaining to inmate health statistics the state requires the VDOC to produce.[32] However, the ACLU could find no indications that the agency has ever complied with the terms of the statute. The General Assembly lists every report presented to it since 1902 on its website. A search of the list since 1997 revealed no reports from the VDOC or its director. Efforts to locate the report through the General Assembly's Legislative Services Office, the Legislative Information Office, the Office of the Clerk of the House of Representatives, the Office of the Clerk of the Senate and the Governor's Office were also unsuccessful.

A request under the state Freedom of Information Act (FOIA) to the VDOC yielded charts for the years 2000 and 2001 containing data relating to inmate age, race, ethnicity, gender, offenses, "alcohol habits," "drug use type" and "mental health status."[33]

In summary, the only inmate health statistics published by the state concern the "alcohol habits" of inmates, the types of drugs inmates use and their "mental health status." These statistics cannot and do not encompass the only types of health related problems among inmates. This statutorily required information, therefore, is both haphazardly and inadequately kept. In addition, although the stature requires the information to be reported to both the Governor and the General Assembly, it is currently only available thru the FOIA.

Administrative Records

Under the Virginia Administrative Code, each prison medical unit must have a designated health authority who is a "physician, a head nurse or a health administrator."

> The health authority meets with the warden/superintendent at least every three months and submits reports of the health care delivery system and health and environment of the institution. 6VAC15-31-190(3).
>
> The health authority submits monthly activity reports to the Office of Health Services.6VAC15-31-190(4).

These records are not published, but are kept on the premises of each prison. Therefore, the ACLU filed a request under FOIA for five years' worth of reports made by the prison health administrators to the wardens of five prisons -- Nottoway, Powhatan, Mecklenburg, Greensville and Coffeewood Correctional Centers.[34]

In response to the request, three of these five prisons sent no reports at all. The remaining two sent copies of reports to the VDOC Office of Health Services, but no wardens' reports. In lieu of warden's reports, they sent minutes of meetings between wardens and medical staff.

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Because the forms used for the reports to the Office of Health Services varied over time, available information from these reports was inconsistent and statistically useless, even within the same institution. In addition, although state regulations require the health authorities of all prisons to submit monthly reports to the Office of Health Services, some of the reports were submitted quarterly, some semi-annually, and some annually.

The kind of information elicited by the forms was also inconsistent. Some of the forms tracked patient deaths, physician hours worked, the number of patients seen by physicians compared to the number of patients seen by nurses. Others asked for different data altogether.

At Nottoway Correctional Center**,** for example, forms submitted by the health authority to the Office of Health Services between February 28, 2001 and September 2002 reported little more than the total number of inmates seen (regardless of whether they were seen for emergencies, new intakes, laboratory tests or treatment visits), a breakdown of patients by condition and a listing of reportable diseases.

Prior forms, used between June 1998 and January 2001, were more detailed. In addition to the basic information cited above, the prior forms report the names of physicians who provided care, the number of hours they worked, the number of inmates waiting to see doctors and the reasons for any delays, the kinds of ancillary services and surgical procedures performed on site, and the kinds of off-site services delivered.

Earlier forms, employed before 1998, were more detailed still. They report, among other things, the number of patients seen by nurses, the number of patients seen by doctors, the ancillary and laboratory services provided on site, the number of prescriptions issued and the number of inmates on prescriptive medicine.

None of the forms used at Nottoway were used at Powhatan Correctional Center, which also used varied forms over the years.

Powhatan's form for the year 2001 has the word, "Month," crossed out at the top, with the word, "Year," written over it. This form simply lists cumulative chronic and infectious disease statistics for the year. It asks for no information about deaths, emergencies, staffing rates or services provided.

Powhatan used a more detailed form with an attachment for the previous periods of "July-Dec. 2000" and "July 1999-June 2000." Prior to those years, a range of different forms were filed annually for "June 1998-June1999," "07/01/97-06/30/98," and "July 1, 1996-June 30, 1997."

Because these disparate forms ask for different information, and because they are filled out with varying degrees of completeness, data contained in them cannot be tracked over the months and years in any useful or significant way.

"Dr. Huzek made a suggestion to cut the budget. The suggestion was made to discontinue providing dental prosthetics to inmates. It is more cosmetic than a necessity. Warden Baskerville stated that the suggestion was excellent."

The minutes of the Powhatan medical staff's quarterly meetings with the warden were also of limited value. Some excerpts follow:

> "Why do we have to send patients to MCV who have cut on themselves for sutures when surgical techs could see them?" - Aug. 14, 2001
>
> "Mr. T. Ray….questioned what to do with inmate(s) M. Foley. Mr. Foley conveniently has medical emergencies on the weekends." March 23, 2000.
>
> "Mr. Welch (medical administrator) stated he has concerns about inmates filling their rooms with litigation papers." August 5, 1999.

"Dr. Huzek made a suggestion to cut the budget. The suggestion was made to discontinue providing dental prosthetics to inmates. It is more cosmetic than a necessity. Warden Baskerville stated that the suggestion was excellent." October 28, 1999.

In lieu of reports to the warden, the medical departments at Mecklenburg, Greensville and Coffeewood Correctional Centers also sent minutes of quarterly meetings between the warden and medical staff. At Mecklenburg and Greensville, meeting discussions appear, for the most part, to have centered on procedural issues.

For example, during a May 9, 1996 meeting, the Greensville medical director "stated that the DOC is now sending terminally ill patients to GRCC (Greensville) that previously would have remained in a hospital to die."

Because of the sporadic and inconsistent way the VDOC has chosen to allow its health authorities to report to its Office of Health Services and to its wardens, no detailed accurate data can be gleaned from them regarding the incidence, prevalence and outcome of medical and mental health disorders within the prison system.

In another 1996 meeting (July), a nurse complains about guards who are supposed to transport sick inmates during emergencies refusing to do so because they are "too busy."

The Coffeewood minutes are generally perfunctory. From June 24, 1999: "Medical followed appropriate procedures and provided appropriate medical care and coverage for recently deceased inmate. [The Warden] has personally reviewed case and sees no difficulty with case."

The entire minutes from the March 26, 2002 meeting are as follows:

"Dr Reese discussed the following issues:

- "There have been many improvements in the medical department. We want to improve the morale, increase communication and watch out for each other.
- The medical department is still short-staffed. Paperwork needs to be brought up to date.
- The nurses are doing a great job."

Nurse Hart stated that she is reviewing issues that will need to be discussed when she comes on board April 10.

Dr. McCall discussed the following issues:

- Things are going well in the Dental department."

Because of the sporadic and inconsistent way the VDOC has chosen to allow its health authorities to report to its Office of Health Services and to its wardens, no detailed accurate data can be gleaned from them regarding the incidence, prevalence and outcome of

medical and mental health disorders within the prison system. Given this state of affairs, it is not surprising that the VDOC does not appear to keep any databases containing medical data.

An ACLU state FOIA request for an index of all of the department's databases showed no databases containing inmate health or medical information, statistics or data. Requests under FOIA for clear statistics regarding inmate deaths and the incidence and prevalence of infectious and chronic disease among inmates were unsuccessful.[35]

State Prison Inmate Death Reports

Since 2001, in order to receive "Truth-In-Sentencing Incentive Grants from the federal government, states must provide assurances to the U.S. Attorney General that they will report, on a quarterly basis:

> …information regarding the death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail, State prison, or other local or State correctional facility (including any juvenile facility), that, at a minimum, includes: (A) the name, gender, race, ethnicity, and age of the deceased; (B)the date, time and location of death; and (C) a brief description of the circumstances surrounding the death. 42 U.S.C.A. §13704

Prior to this, corrections officials maintain, the only place Virginia kept information about inmate deaths was in individual prisoners' criminal and medical files.[36] And since such files are confidential, the state has no publicly available information regarding prisoner deaths prior to 2001.[37]

That is when the Department began filling out federal "State Prison Inmate Death Reports." The ACLU received 106 of these forms as the result of a September 2002 FOIA request. All but two of the forms received were not completed on the back --- the place where the circumstances surrounding the death – or the cause of the death -- are supposed to be described. However, according to the director of Correctional Statistics at the Bureau of Justice Statistics,[38] all the forms that the VDOC sent to his office arrived completed on the back.[39]

The VDOC's behavior in regard to death statistics has been less than forthcoming. In response to one FOIA request, agency officials maintained they kept no record of inmate deaths prior to 2001. In response to another, they produced an incomplete log of inmate deaths dating back to 2000. In the meantime, they sent copies of Inmate Death Reports to the ACLU that were not true and accurate copies of those they sent to the federal government.

Despite this, the ACLU was able to discern the causes of death of 96 of the inmates who died between Jan.1, 2001 and June 6, 2002 by matching their death dates and ages to the same numbers on a database kept by the state medical examiner. This database contains the age, race and date and cause of death of every state and jail inmate who dies in Virginia.[40] Of the 96 prisoners whose causes of death could be determined from this database, eight died from Hepatitis or Hepatitis-

related causes in 2001.[41] However, this compares to a list of causes of death for 2001 on the VDOC's website. Under "Hepatitis," the VDOC lists no Hepatitis-related deaths in 2001.

Although death statistics by themselves are not indicative of quality of medical care, they are important in that they can show trends, clusters, increases and decreases in mortality rates from various causes, and increases and decreases in median age of death. They can also be compared to like populations in other prison systems or to populations outside prison.[42]

The VDOC's behavior in regard to death statistics has been less than forthcoming. In response to one FOIA request, agency officials maintained they kept no record of inmate deaths prior to 2001. In response to another, they produced an incomplete log of inmate deaths dating back to 2000. In the meantime, they sent copies of Inmate Death Reports to the ACLU that were not true and accurate copies of those they sent to the federal government. Finally, they reported death statistics that did not reflect the findings of the state medical examiner.

Given this history and behavior, it seems unlikely that the Department will ever produce reliable and accurate inmate death statistics until it is required to do so in conjunction with the Office of the State Medical examiner or the Department of Health.

Steven Schultz

In June of 2002, Schultz, who was serving time for violating his probation on a robbery conviction, fractured his right arm and wrist at the Deep Meadow Correctional Center. He was taken to the Medical College of Virginia (MCV), where doctors inserted 625 pins during emergency surgery to repair the break.

They planned to remove the pins in four weeks. But Schultz was never taken back to MCV. Instead, prison medical staffers took out the pins themselves. Then, shortly afterwards, Schultz was tightly handcuffed for transfer to Indian Creek Correctional Center in Chesapeake. His hand and arm have never recovered.

Despite grievances and requests, Shultz waited a month to see a doctor at Indian Creek, only to be told he didn't rate treatment.

"The doctor here will not send anybody anywhere for treatment," he wrote the ACLU from Indian Creek. "She said if the patient is not dying or life-threatening [sic], there is nothing she can do."

As time has passed, Schultz's hand and arm have not improved. Two of his fingers are now immobile. A commercial fisherman who shucked scallops for years prior to being locked up, Schultz worries about his hand. He has a 2004 release date. What will he do if he can't shuck scallops?

I need to get something done before it's too late," he wrote. "I need my right arm. The nurse here said it didn't look very good. When I try to open my right hand, it turns real white and pain shoots down my wrist…What should I do?"

(This account is based on letters from Steven Schulz and an interview with his mother.)

An Unlikely Barrier to Access: The FOIA

The Virginia Freedom of Information Act exempts "All records of persons imprisoned in penal institutions in the Commonwealth provided such records relate to the imprisonment."

In all, the ACLU filed 11 requests for roughly 5,000 pages costing in excess of $1,000. In 11 responses, the VDOC cited exclusions to FOIA 16 times. The following is a comprehensive description of the ACLU's FOIA requests.

With no public information about VDOC medical care, the ACLU looked to the state's Freedom of Information Act (FOIA). But the Act was a poor substitute for statutorily-required public reporting. The VODC answered requests for data and statistics with incomplete and partial lists and/or assertions that it does not keep the requested information and is not required under FOIA to create information it does not already have. Citing FOIA exclusions, it refused to release reports on inmate deaths. Citing a statute pertaining to "patient safety data," it refused to release reports on inspections of prison medical departments. A request for an index of all the Department's computer databases revealed that, of 43 databases, only three are fully accessible to the public.

In all, the ACLU filed 11 requests for roughly 5,000 pages costing in excess of $1,000. In 11 responses, the VDOC cited exclusions to FOIA 16 times. The following is a comprehensive description of the ACLU's FOIA requests.

On September 3, 2002, the ACLU sent FOIA requests to 33 prison wardens asking for copies of all written procedures and practices governing the operations of their medical units pursuant to various state Administrative Code regulations. These included:

- Copies of all procedures and practices governing prison health care units
- Requests for administrative reports
- Written job descriptions of health care personnel
- Copies of the procedure governing the process by which those designated by an inmate are notified in case of serious illness, injury or death.

In response, the ACLU received a letter from VDOC Deputy Director John Jabe stating that the requests would be considered "a single request to the department," but that each warden would inform us separately of the cost of copies from his or her institution. Subsequently, we received nearly identical letters from each warden informing us of the cost of all documents.

However, the letters informed us that the procedure governing the process by which families are notified of inmate illness, injury or death would not be disclosed because it was "a security procedure…excluded from disclosure under §2.2-3705(A)(69)." This statute, stated the letters, "excludes procedures 'the disclosure of which would jeopardize the security of any governmental facility, building or structure or the safety of persons using such facility, building or structure,'" the wardens wrote. "Therefore you will not be provided with this document."

In the wake of these letters, we limited our request to five prisons, as noted above in the Administrative Records section. In response, we received the administrative documents described above, a set of medical department operating procedures, the inmate grievance procedure, 11 employee work profiles from Coffeewood, seven from Mecklenburg, 18 from Powhatan and three from Nottoway.

Citing FOIA exclusions, it refused to release reports on inmate deaths. Citing a statute pertaining to "patient safety data," it refused to release reports on inspections of prison medical departments. A request for an index of all the Department's computer databases revealed that, of 43 databases, only three are fully accessible to the public.

As a result of the VDOC's refusal to provide DOP 706, the policy regarding family notification of inmate injury illness or death, we sought an opinion from the Virginia Freedom of Information Advisory Council. On October 31, the Council released its opinion, saying that the policy "does not rise to the level of jeopardy set forth in the exemption."[43] We then wrote back to the VDOC, enclosing the opinion. On November 18, the VDOC provided us with the policy.

<u>On September 10, 2002,</u> the ACLU of Virginia filed a FOIA request for the names, ages, dates of death, causes of death and institutions of residence of all state inmates who have died in state custody from January 1, 1992 "to the present."

In response, we received 106 "Inmate Death Reports" filled out between Jan. 1, 2001 and June 6, 2002. Outside of individual medical and criminal records, these reports comprised the only accounting of inmate deaths available, according to an accompanying letter from VDOC Deputy Director John Jabe.

Inmate Death Reports are required to contain the name, age, race, date of death, cause of death and facility of residence of each deceased prisoner. The forms sent to the ACLU had the prisoners' names blackened out. In addition, most of the forms were blank on the back where information about cause of death is supposed to be entered. The ACLU would find out later that the same forms, when submitted by the VDOC to the federal government Bureau of Justice Statistics were complete on the back. (See footnote 39.) The missing names, Jabe explained in his letter, are "specifically excluded from disclosure under the Virginia Freedom of Information Act §2.2-3706(F)(6), which excludes 'all records of persons imprisoned in penal institutions in the Commonwealth provided such records pertain to the imprisonment,' §2.2-3705(A)(5), which excludes 'medical and mental health records,' §53.1-40.10, governing prisoner medical records, and §32.1-127.1:03,governing the release of patient medical records generally."

On October 9, 2002, the ACLU of Virginia filed a FOIA request for the index of computer databases that the VDOC is required to annually compile for public scrutiny. The VDOC asked for a seven-day extension to comply with this request.

On October 31, the VDOC complied with the request, charging $317.80 for 1,589 pages. However, the information was incomplete. There were no descriptions of the contents of the databases, as required by FOIA. Nor were there any indications of when the databases had last been updated, which data fields had public access restrictions or the formats in which the databases could be copied.

Citing these deficiencies, the ACLU wrote a letter of complaint to the VDOC. On December 17, 2002, we received updated Index Reporting Forms containing the missing information. Of the 43 databases listed, only three were described as fully accessible to the public. None appeared to contain any health-related information, although two were possibilities: the Executive Information System (EIS) was described as containing "the most frequently needed information concerning inmates…intended for use by management." The Offender Based State Correctional Information System (OBSCIS) was described as "the major inmate management information system for the Department." Both were described as restricted from the public.

On October 28, 2002, the ACLU filed a FOIA request with the VDOC asking for the agency's Hepatitis C treatment guidelines. We also asked for documents containing information about the treatment the agency had given, and was giving to inmates testing positive for the virus.

On November 1, 2002, we received the treatment guidelines plus a letter from VDOC Deputy Director John Jabe. In the letter, Jabe stated that there were no documents responsive to our request but that he would provide the information. He went on to answer most of our questions. Jabe declined to give an estimate of the number of Virginia inmates infected with the Hepatitis C, although the department had previously provided an estimate of 39 percent to a newspaper, a scientific journal and a pharmaceutical company newsletter.

On November 27, 2002, the ACLU filed a FOIA request asking for recent documents pertaining to the reduction of medical staff, services and supplies in Virginia prisons, and the implementation of cost-saving measures having to do with inmate medical care. Citing §2.2-3705(A)(6), the FOIA exclusion for "governor's working papers," the agency refused to honor the request.

The ACLU then called the Governor's office to inquire whether documents pertaining to cuts and reductions already made were considered "governor's working papers." The answer was no. As a result of this call, the ACLU was put in touch with an official at the Office of Public Safety who provided us with the information we sought.

On December 9, 2002, the ACLU filed a FOIA request with the VDOC based on the DOP 706, the policy that the agency released to us on November 18. According to the policy, the agency's chief physician is supposed to prepare a report on every inmate death and the Office of Health Services is supposed to keep a log of all inmate deaths. In addition, inmate deaths are supposed to be discussed at quarterly physicians' meetings held by the Office of Health Services.

The ACLU therefore asked for copies of the death reports since January1,1992, a copy of the log dating back to January 1, 1992, and an opportunity to view the minutes of the physicians' meeting since January 1, 1992.

On December 17, the ACLU received a seven-page list of deaths from May 2000 through August 2002. The list contained the gender and race of the dead, but no names. Three pages contained some dates of birth and causes of death but the remaining four pages were blank in both those categories.

Accompanying this list was a letter from VDOC Director of Health Services Fred Schilling. The chief physician's reports, said Schilling's letter, were "medical records of identifiable inmates and are excluded from disclosure under the Virginia Freedom of Information Act §2.2-3706(F)(6), which excludes 'all records of persons imprisoned in penal institutions in the Commonwealth provided those records pertain to the imprisonment,' §2.2-3705(A)(5), which excludes 'medical and mental health records,' §53.140.10, governing prisoner medical records, and §32.1-127.1:03. governing the release of patient medical records generally. Therefore these records will not be provided."

As for the log of inmate deaths, said Schilling, no log had been kept prior to 2000 and, "in accordance with §2.2-3704(D) of the Virginia Freedom of Information Act," the department was not required to create a new record where one did not exist. In regard to the missing names on the copy of the log sent, the information identifying individual inmates is "specifically excluded from disclosure under the Virginia Freedom of Information Act §2.2-3706(F)(6), which excludes 'all records of persons imprisoned in penal institutions in the Commonwealth provided those records pertain to the imprisonment,' §2.2-3705(A)(5), which excludes 'medical and mental health records,' §53.140.10, governing prisoner medical records, and §32.1-127.1:03 governing the release of patient medical records generally."

On December 31, 2002, the ACLU filed a FOIA request asking for copies of all contracts and agreements between the VDOC and Prison Health Services (PHS), a company that provides medical services to six of the agency's prisons and, as of October 2002, has a contract to approve all major and outside medical services recommended for prisoners. This is sometimes called a "gatekeeper contract."

On January 9, we received copies of VDOC's request for proposals for medical services, a copy of PHS's proposal, a copy of a general contract between the two entities and various addenda to the contract. One of the addenda, the October contract for gatekeeper services, was missing the page describing the terms of the contract. The proposal for the gatekeeper contract, on which the contract was based, was also absent. Both documents were subsequently forwarded upon request.

On January 20, 2003, the ACLU filed a FOIA request asking for data relevant to the number and nature of requests for medical services made since the implementation of the PHS gatekeeping contract and the number and nature of requests approved.

On February, 3, the ACLU sent Schilling a letter, advising him that more than five business days had elapsed since he had received the January 20 request and informing him that he was out of compliance with the requirements of FOIA.

On February 12, the ACLU wrote to Schilling again, advising him again that he was out of compliance.

On February 13, the ACLU received a letter from Schilling stating that "The Department of Corrections' Office of Health Services does not have the information requested."

On January 22, 2003, the ACLU filed a FOIA request for a copy of the PHS Utilization Management Manual, a document that, according to materials received in a previous FOIA request, spells out the policies and procedures of the PHS gatekeeping contract. In response, a letter dated January 31 but postmarked Feb. 4 arrived from Health Services Director Fred Schilling. "I do not have this document, therefore (sic) cannot provide you with it," he wrote.

On January 27, 2003, the ACLU filed a FOIA request for documents and/or reports pertaining to the cumulative number of VDOC inmates currently receiving prescription drugs for a mental health condition, the number of inmates currently receiving mental health treatment without prescription drugs,, and the prevalence of chronic diseases and/or conditions among inmates including but not limited to: diabetes, cancer, sickle cell anemia, TB and HIV.

We also asked for copies of the "documented quality assurance reviews" which we had discovered were supposed to be conducted pursuant to 6VAC15-31-180(D). Under the terms of this regulation, "action plans" are supposed to be "written for all areas of deficiency." We therefore asked for those as well. We requested these documents dating back to January.1, 1995.

On February 5, we received a letter from Schilling in response to this request. The most recent month for which the agency had statistics on the number of inmates receiving psychotropic drugs was November of 2002, he wrote. For that month, 1,716 inmates were receiving such medications. The agency had no information on the number of inmates receiving mental health care, he wrote. In accordance with §2.2-3704(D) of the Virginia Freedom of Information Act, "no public body shall be required to create a new record if the record does not already exist."

In regard to the information on chronic diseases, Schilling wrote, "the Department does not keep statistics on the prevalence of or the number of inmates diagnosed with cancer, sickle cell anemia or other chronic conditions or diseases. In accordance with §2.2-3704(D) of the Virginia Freedom of Information Act, "no public body shall be required to create a new record if the record does not already exist."

However, wrote Schilling, the VDOC did have recent some information on some of the diseases. He went on to list statistics for diabetes, TB and HIV on different dates last year. On June 30, 2002: 1,009 diabetics. On December 31, 2002: 5 prisoners with TB. On April 2, 2002: 442 HIV positive inmates.

As for the quality assurance reports, Schilling wrote, "these reviews are privileged communications in accordance with §8.01-581-17 and may not be disclosed."

The statute cited by Schilling renders privileged all reports and records of "patient safety organizations" that collect data for the purpose of improving patient safety and health. By statutory definition, however, such organizations must be "independent and not under the control of" the entity reporting the data. The relationship between the Office of Health Services and the prison medical departments it supervises and reviews does not appear to qualify as independent under the meaning of the statute.

On February 3, 2003, the ACLU filed a FOIA request to Gene Johnson, Director of the VDOC, for "copies of all data collected, tabulated and reported by the Director of the Department of Corrections to the Governor and the General Assembly pursuant to Virginia Code §53.1-10(7)." Among this data was supposed to be data "pertaining to "the types and extent to which health-related problems are prevalent" among inmates.

On February 12, the ACLU wrote to Johnson, advising him that more than five business days had elapsed since his receipt of the February 3 request, and that he was out of compliance with the requirements of the Virginia FOIA.

On February 14, the ACLU received an answer from N.H. Scott, Deputy Director, Division of Administration. These charts contained data for the years 2000 and 2001. relating to inmate age, race, ethnicity, gender, offenses, "alcohol habits," "drug use type" and "mental health status."[44]

Also enclosed were documents containing the same data for 1998 and 1999.

Illustrating the Deficiencies: Eight Case Studies

In the absence of any comprehensive public information documenting the quality or extent of inmate medical care, the ACLU of Virginia collected the medical files of eight inmates and submitted them to an expert in prison medical care for evaluation. Katherine Maeve, has a doctoral degree in nursing, teaches nursing at the University of South Carolina's College of Nursing, has worked as a nurse at several prisons and has written numerous scholarly articles on prison health care.

This was not an ideal way to measure or examine prison health care. Ideally, our sample of inmate medical files would have been randomly selected and representative of the general prison population. However, because inmate medical files are considered private and are specifically excluded from the state's Freedom of Information Act, we had no possibility of general access to them. Therefore, our sample had to be largely self-selected, from prisoners who wrote to us complaining of substandard care and who then agreed to give us access to their files. Two of the files belonged to deceased inmates, and were obtained by other means.

Only one of the files contained the basic pre-incarceration medical histories taken from inmates during the physical examinations they undergo upon entering the VDOC. Such histories would include the results of tests that may have been administered at that time as well as basic information about infectious diseases such as Hepatitis C and HIV.

These files were expensive, costing 20 cents for each page, and took months to procure from the various prison medical departments where they were kept. None appeared to be complete. Only one contained any mental health information, and subsequent specific requests for mental health information yielded only a few more pages for one additional file. Another file was inexplicably missing two years' worth of data. Among Maeve's general findings:

- Only one of the files contained the basic pre-incarceration medical histories taken from inmates during the physical examinations they undergo upon entering the VDOC. As a result, the file of one woman who says she has been told she is dying of cirrhosis caused by Hepatitis C contains no documentation that she has actually been diagnosed with Hepatitis C.

- Although most of the patients whose files were analyzed had the kind of chronic conditions that are most efficiently treated by periodic monitoring, their charts bore no indication that this kind of monitoring takes place.

- Several inmates had been prescribed and/or taken off psychotropic medications, but their files contained no indications or notations regarding the reasons for these decisions.[45]

- None of the files contained any documentation that inmates had received information about the spread of infectious diseases.

- The charts contained little evidence of dental evaluations or indications of dental care.[46]

Maeve examined each medical file we sent her and provided us, to the extent she was able, with written commentary regarding the care each inmate received. However, her ability to analyze care was limited by the condition and completeness of each file, the information included and the extent to which care was documented. Following are brief summaries of each case, interspersed with her comments.

1. Jeffrey White, Powhatan Medical Unit

Jeffrey White has served his entire prison sentence attached to a Foley catheter in the Powhatan Medical Unit. So far, it's been more than three years.

White is serving a five-year sentence for involuntary manslaughter. In the Bristol Jail following his sentencing, White came down with a bladder infection and asked for a doctor.

Born with a neurogenic bladder which had been fitted with an artificial sphincter when he was 10, White knew what he was talking about. But days went by before a health worker took a urine sample and gave him some antibiotics. They didn't work. White's testicles began to swell. He asked to go to a hospital. More days went by. Finally, a nurse examined White, found he had a temperature of 104 and called an ambulance. White was hospitalized for two weeks. In December of 1999, he went straight from the hospital to the Powhatan Medical Unit.

White underwent two surgical procedures at Powhatan. The first removed stones from his bladder, and the second removed the artificial sphincter which had been rendered useless by his ordeal in Bristol. Unable to self-catheterize or urinate on his own, White was attached to the Foley catheter. He has been attached to it ever since.

White wants a new artificial sphincter so he can return to self-catheterization. Dr. Thomas Lanyi, a urologist who once treated him at Powhatan thinks his bladder may be too damaged for this to work. He suggests a diversion, or surgery to divert urine to an external opening or ostomy in the abdominal wall.[47]

But no kind of surgery appears to be in White's immediate future, at least not at Powhatan. His file documents what Maeve called "unending urinary tract infections," with "no substantive documentation that Mr. White was afforded any meaningful evaluation by a physician," and no "apparent or substantive oversight by an RN."

Maeve also noted White's "poor state of nutrition," a factor in the breakdown of skin. Since White's chart shows "occasional acknowledgement" that the site of insertion of his catheter is infected, nutrition "should have been a major focus of his care."

"White's condition has deteriorated rather than improved under the care he has received," said Maeve. "My guess is that the prison's medical administrators made the

decision that Mr. White had this condition prior to his incarceration in their system, and they should bear no particular responsibility for providing corrective surgery – expensive corrective surgery—even though the record suggests they are directly responsible for the deterioration of his condition."

Because the urinary tract infections caused by Foley catheters can involve the urethra, bladder and kidneys, their use for prolonged periods of time is not recommended except for the terminally ill and the severely impaired. In White's case, the infections could leave him with damage requiring dialysis or a kidney transplant, according to Maeve.

"Mr. White could have, and should have received a much higher standard of care," wrote Maeve. "….Prison health care for this young man was very short-sighted and unnecessarily brutal, in my opinion."

2. Ronald Cash, Augusta Correctional Center

The first medicine VDOC inmate Ronald Cash got for his leukemia was a nitro glycerin pill. When that didn't work, an LPN at the Augusta Correctional Center gave him some Tylenol. When that didn't work either, medical staff told Cash he must be faking it.

"They do this around the holidays," the prison's medical director told Cash's sister, Vicki Hill, when she called to express concern about her brother's condition. "It's probably emotional issues."

It was late November, 2001. Cash, who was serving a three and a half year sentence for being a habitual offender, was dead by the following May. He was 40.

Once diagnosed, Cash's leukemia was treated "conservatively," according to Maeve.

There is no indication in Cash's medical file that his doctors even considered a bone marrow transplant, which would have been the best treatment option for his kind of leukemia, wrote Maeve. Vicki Hill, Cash's sister, says the subject came up, but that both Cash's doctor and a woman at MCV's bone marrow transplant unit told her the hospital would not perform bone marrow transplants on inmates.

"She said even if it worked, the aftercare at the prison would kill him," said Hill. "They said they just didn't have the facilities there [at prison medical units] to care for him."

Cash had a couple of chemotherapy cycles that made no difference. There are no indications in his file that his doctors tried to locate any clinical trials or experimental protocols that might have given him some kind of chance to live. According to Maeve, this is typical prisoner medical treatment.

"It pretty much depends on the individual doctor and the tradition of the institution," Maeve said in an interview. "If the institution discourages its doctors from making any kind of special effort on behalf of prisoners, they usually don't."

Had Cash been released to his family, he would probably have been able to procure a bone marrow transplant and a chance at survival, observed Maeve. In view of his non-

violent offense (drunk driving convictions) and serious illness, justice and the state coffers would not have been ill-served to release him. As it turned out, the governor's decision to retain him in custody until eight days before his death was a costly one, both for the state and for Cash.

"Perhaps the VDOC needs a catastrophic illness plan for inmates who pose no real threat to the community," wrote Maeve. "If he had gotten out, he would have qualified for Medicaid."[48]

3. Rose White, Virginia Correctional Center for Women at Goochland

Rose White is convinced she's dying of Hepatitis C-caused cirrhosis and she can't understand why, in view of this fact, the governor won't let her out of prison.[49]

"I'm serving time for checks. "I didn't hurt or kill anyone,"[50] she insists. White, 53, has written countless letters to the Secretary of the Commonwealth, the Office of the Governor and the ACLU of Virginia. She begs for help, pleads that she is dying and reports that the doctor has told her she has a fatal disease for which there is no cure.

But while notes in White's medical file refer to Hepatitis C, there is no actual diagnostic lab report documenting that she has it. And while the file contains some lab reports and radiologic studies indicating cirrhosis, they indicate only minimal liver damage. There is no discussion of any treatment for White, or whether she might be eligible for the VDOC's Hepatitis protocol.

According to Maeve, "notes only indicate they (prison medical staff) discussed the worst-case scenario of complete liver failure (with White), however there is no indication that the physician believes this is an imminent possibility." There is no indication that any kind of Hepatitis C treatment was ever considered for White.

Like her fellow inmate Darlene Anderson, White says she was also told she had three to five years to live. The doctor suggested she apply for medical clemency, and she did so several times without success.

White's medical file indicates that cirrhosis isn't her only problem. But it is less than enlightening in regard to other diagnoses. Two years of the file – 1998 through 2000 – are missing. According to Maeve, "notes are largely scant and do not fully explain diagnoses, treatments nor plans for treatments."

Also according to Maeve:

- Records indicate White had a breast mass noted on her mammogram in 1990 without any apparent follow-up. In 2001, she had two mammograms, with a mass of 8mm noted in the progress notes. There is no indication that White understands that she has these masses.

- Someone ordered a psychotropic drug for White which was discontinued after some months because it was found to have an adverse effect on her liver. Her file does not indicate who ordered it or why.

- White was diagnosed with diabetes, but subsequent lab tests indicated low blood sugar instead of high blood sugar. All diabetic treatments, including a special diet, were subsequently discontinued without explanation.

- Records show White was given four gynecological exams in two years without any explanation or obvious abnormalities.

- Records from 1990 through 1992 indicate that White has a history of Hepatitis A and B. How these diagnoses relate to her present liver disease is unknown.

Like her file, White's care, said Maeve, "appears inconsistent and disorganized. Four gynecological exams in two years for no apparent reason is a good example. While she doesn't appear to be in imminent danger of dying, there are other aspects of her care that decidedly put her at risk – particularly the apparent lack of follow-up on the breast mass."

4. Randall Bowman, Indian Creek, Lunenburg, & Augusta Correctional Centers

Randall Bowman entered the Virginia Department of Corrections in February 2001 to serve two years and four months on a habitual offender conviction for drunk driving. Diagnosed with Hepatitis C while awaiting trial in the Danville City Jail, he knew he needed treatment. The VDOC doctor who performed his entry physical assured him that's what he would get.[51]

Bowman was transferred to Indian Creek Correctional Center in Chesapeake but got no treatment there. After two months, he was transferred again to Lunenburg Correctional Center in Victoria. While at Lunenburg, Bowman was taken to the MCV where he was diagnosed with connective tissue disease. Doctors there ordered follow-up treatment, but Bowman never got any.

Instead, after two months at Lunenburg, he was transferred a third time to Augusta Correctional Center in Craigsville. At Augusta, Bowman underwent a "Telemed" exam by a doctor affiliated with the University of Virginia. That doctor ordered a series of tests, including a liver biopsy preliminary to treatment for Hepatitis C. Bowman never got the biopsy.

His condition worsening, Bowman sued VDOC in U.S. District Court in October of 2001, claiming deliberate indifference to his serious medical needs and asking the court to order an immediate biopsy and treatment. The court eventually did so, but by then, Bowman's condition had deteriorated to such an extent that a biopsy was no longer possible. The court then ordered VDOC to look into the feasibility of a liver transplant.

According to Bowman's medical chart, he was an "unsuitable" candidate for a liver transplant. This may be because, among the criteria for eligibility for a liver transplant is: "Failure of conventional therapy to treat the condition successfully."[52]

According to Maeve, Bowman may have been an unsuitable candidate for the same reason he needed a liver transplant in the first place: the VDOC never treated him.

"As I understand how these systems work," she wrote, "he would be denied a place on the (transplant) list just because his treatment options had not even been tried, let alone failed."

On May 12, 2002, Bowman died. He was 35. The medical examiner listed his cause of death as "end-stage liver disease." The state paid his mother $49,000 to settle the case.

5. Howard Poteet, Sussex I State Prison & Buckingham Correctional Center

Shot three times before being locked up for robbery and trying to shoot a police officer, Howard Poteet has a urinary stent, Hepatitis C and AIDS. Much of his time in the VDOC has been spent arguing with medical staff at Sussex I State Prison about getting his HIV medication on time.

According to the 49 year-old Poteet, the medical staff there often discontinued his medication for a period of several days or a week, telling him they had run out, or it was on order. Poteet's file shows that these complaints were "validated by the nursing staff on a couple of occasions," Maeve noted.

Feeding Poteet's frustration was the knowledge that sporadic and/or delayed ingestion of his medicine can lead to a drug-resistant strain of the virus. At some points, he refused the medication entirely. Then, in 2002, he was transferred to Buckingham Correctional Center where the situation appears to have improved.

According to Maeve, Poteet's predicament was not unusual. Because of the number of dosages of HIV drugs and the complex regimen that must be followed in regard to ingesting them (some drugs must be taken with meals, some between meals, etc.), prisons are not the best places to be treated. Security issues, drug delivery methods and the general inefficiency of prison life tend to conspire against inmates with AIDS.

Another of Poteet's complaints - that he was unable to get treatment for copiously bleeding hemorrhoids - is problematical according to Maeve because his blood is a biohazard and he shares a cell with another inmate. Poteet describes mopping up the blood with his clothes and with disposable adult diapers. The clothes go to the prison Laundromat, where they are handled by other prisoners. It is unclear if anyone is exposed to the diapers.

""It is very difficult for bio-hazardous blood to be managed in batch living conditions," wrote Maeve. "There is no documentation that acknowledges this issue or that Mr. Poteet was given information on how to safely clean up his own blood."

Finally, Maeve noted that Poteet's chart contains no indication that he has been evaluated for TB. This is particularly important for anyone with HIV, she noted.

6. Richard Lee, Powhatan Correctional Center

Richard Lee had his first heart attack at age 40. By 47, he had nine cardiac catheterizations behind him and seven stents in his heart. That's when he entered the VDOC. Within two weeks, he was in MCV, having another cardiac catheterization and an eighth stent installed. A cardiologist told him he needed immediate bypass surgery to correct a 100 percent blockage in an artery on the left side of his heart.

But instead of having the surgery, Lee was transferred to the Powhatan Correctional Center. "I have since been told by my doctor at Powhatan, Dr. Swetter, that I cannot have the surgery because it is too expensive," he wrote in February of 2002.[53]

"I feel, as does my family, that they, the DOC, are trying to keep me alive on medicine, a great deal of medicine, to keep from giving me the surgery I need to survive."

Fifty miles from the nearest hospital, with medical staff who "don't even know how to insert an IV," Lee assessed his chances of survival as dim. But survive he did until August of 2002 when he somehow got back to MCV.

At that point, the bypass surgery was performed, probably, speculated Maeve, because "the hospital medical staff made it happen." Prisoners with chronic and worsening problems have a much better chance of surviving if they can get to a hospital before they become helpless, Maeve noted. Some of them realize this and, through a combination of luck and effort, manage to get to one before it becomes too late.

"Mr. Lee was…correct in his evaluation of the competency of typical medical staff to respond in an emergency," wrote Maeve. "Prison staff are usually not highly skilled in emergency responses – those that are tend to work in situations where they can put those skills to use on a more frequent basis, such as in hospital emergency rooms. He also notes that the prison was more than 50 miles from a hospital. In all likelihood, if he had a major cardiac problem, it would have taken some time to get an ambulance there and through security, and then another substantial length of time before he could arrive at a hospital."

Lee's other complaints – problems getting his medication and lack of dental treatment – are also typical of prison health care, noted Maeve. But for a person with his heart condition, lack of dental care is especially dangerous. According to Maeve, infected teeth can "seed" the heart so that heart valves also begin to grow the infection.

"Anyone with heart disease should receive aggressive and thorough dental care," she wrote.

Lee's chart contained no records or progress notes following his surgery. In a January 24, 2003 letter to the ACLU, Lee wrote that he awoke from the surgery with pain and numbness in his neck, that he continues having trouble getting his medicine, and that he still fears he won't get home alive.[54]

7. Michael Mills, Sussex II State Prison

As the result of a motorcycle accident years ago, Michael Mills has back problems, one kidney, one elbow fused straight and, as he puts it, "no right knee." These injuries were apparently compounded by a fall in the shower two years ago. He is unable to walk without leg braces or a wheelchair. He is 42 years old.

According to Maeve, the biggest shortcoming in Mills' medical chart is the fact that it lacks x-rays and x-ray reports documenting the extent of Mills' musculo-skeletal injuries and consequent limitations. Without these, there is no baseline with which to make subsequent comparisons should his condition appear to worsen, and there is no way to know what kind

of recovery is possible. Such x-rays must exist somewhere, Maeve believes, but they are not in Mills' chart where they belong.

Most of Mills' complaints focus on his desire for knee surgery, his frustration with his wheelchair and leg braces, and the failure of prison and medical staff to do anything to help him. But according to Maeve, his chart shows that he has been his own worst enemy.

"The notes indicate that he did not use the braces and equipment in ways they (medical staff) recommended, preferring to get around primarily in the wheelchair," she wrote. "Because of this lack of exercise…he has weakened his leg muscles to the point where he really does have increased difficulty getting around and… increased pain."

Many patients behave this way, incarcerated or not, Maeve said. Believing that surgery will solve their problems, they are unwilling to put forth much effort. On the other hand, Mills' file bears no indication that he was ever evaluated by a physical therapist or given a chance to work with one.

Mills' file also documents a number of trips to the medical department because of falls, respiratory problems and chest pain. But notes written by nurses and physicians show that his vital signs on these occasions were always normal. For this reason, Maeve believes that these incidents do not "sound legitimate," and that medical staff "documented fairly clearly" that Mills was "trying to manipulate the system into rebuilding his knee."

Even so, Maeve believes Mills should have regular access to physical therapy, and that he should be in a unit for inmates with disabilities in part because his condition makes him vulnerable to other prisoners. "My guess," she wrote, "is that he actually does have difficulty getting about and is in pain. The notes have made a fairly convincing case, however, that he significantly contributed to his physical decline himself."

8. Richard Mullen, Greensville Correctional Center

Richard Mullen has served prison time on and off since 1983 for breaking and entering and check forgery. After an arrest for violating probation in 1999, be became sick in the Hampton Roads Regional Jail. He was transferred to prison and ended up at MCV where, he says, surgeons removed his colon without his permission. During the surgery, he went into cardiac arrest.

After recovering, Mullen, 36, was transferred to the Greensville Correctional Center. There, he maintains his subsequent chest pains were diagnosed as mania and treated with psychotropic drugs. Eventually, he was re-admitted to MCV and diagnosed with coronary artery blockages requiring emergency bypass surgery.

Next, says Mullen, he was locked in an isolation cell at Greensville because of incontinence caused by his colon surgery. Medical staff refused to give him the catheters he needed to self-catheterize his neurogenic bladder, saying he didn't need them. Mullen began filing lawsuits. They keep being thrown out of court, he says, because he is indigent.

That is Mullen's story.

According to Maeve's chart analysis, there is another story, perhaps inspired by Mullen's lawsuits.

Mullen's chart, Maeve said, shows that his medical care "appears to have been quite substantial, actually at a higher level than most medical care given at most prisons, and certainly higher than what I have seen in other (Virginia) charts."

"It is possible," wrote Maeve, that Mullen's "care is simply a reflection of what the nursing director termed his 'litigious' nature. In the free world, this kind of patient is frequently over-treated, and it would come as no surprise if Mr. Mullen has also been over-treated, but clearly at his own instigation."

While it does appear that "one person, on one occasion" did try to deny Mullen some catheters, his chart indicates that "he reacted in a way that caused the system to quickly remedy the situation," according to Maeve. There is no indication that he was harmed or injured as a result of the incident," she wrote.

Mullen's chart also shows that he "frequently and continually" refused to come to the "pill line" to get his medications, according to Maeve.

Mullen wanted to administer his medications himself and objected to having to stand in the pill line, but several of his medications do not qualify for self-medication and the staff at Greensville have "legitimate concerns about whether Mr. Mullen was purposefully not taking medicines in an attempt to exacerbate his illnesses towards his own ends," Maeve wrote.

"Therefore, it would be completely appropriate to schedule Mr. Mullen to take each dose in front of a nurse."

Nevertheless, Mullen's file contains "diligent documentation" of the many times he did not show up for his medicine, Maeve noted. "Not taking medicines for blood pressure, cardiac disease (particularly after having the kind of a heart attack that requires a bypass) is a curious action for someone concerned about his health," she wrote.

Asked about his documented absences from the pill line, Mullen called the notations in his chart "false."[55]

"Since my arrival at this facility, I have been on the 'Self-Medication Program,'" he wrote. "I do not have to go to the pill line to take any of my medications. I am provided with all my medications upon (the) medical (department) receiving such from the pharmacy. I take my medications in my cell. Attached hereto is (sic) the tabs (labels) from the medications which I am currently prescribed and have possession of…Each and every time these medications are issued to me, I have to sign for them upon issuance."[56]

Stuck to a sheet of paper included with Mullen's letter were labels from 16 medications and a 12-pack of urological catheters.

Inmate Care of the Future: Private Health Providers

In October of 2002, the VDOC chose to slash more than $6 million in inmate medical care, food and clothing for fiscal years 2003 and 2004 and more than $2 million in money to fund mental health care positions for the same period. These cuts, made in response to Governor Mark Warner's call for departmental sacrifices, dwarfed all other reductions made by the agency.

During the same month, however, VDOC Director Gene Johnson signed an expansion of the agency's contract with Prison Health Services, Inc., a for-profit corporation already providing medical services to four Virginia prisons. Under the expanded contract, all medical "therapies, services and procedures" provided to inmates throughout the Virginia system must be authorized by PHS.[57] For this, the VDOC would pay an additional $64,833 on top of the roughly $2 million it already pays the company per month.

This change does not auger well for Virginia's prisoners in two ways:

First, PHS, which contracts to provide care to state and jail inmates across the country, has come under fire in New York, Maine, Philadelphia, Maryland, Lee County, Florida, Fort Pierce, Florida, Broward County, Florida, Pinellas County, Florida, Pulaski County, Arkansas and Las Vegas, Nevada for neglecting prisoners' serious medical needs and contributing to their deaths.[58]

Second, the amended contract indicates that the Department of Corrections is considering hiring PHS to take over health care at more prisons in the future.[59] In fact, since the contract was signed, PHS has taken over medical care at two more VDOC facilities: Indian Creek and Powhatan Correctional Centers.

It is unclear if or how the PHS contract will affect the VDOC's treatment of HIV and HCV-positive inmates. The contract unequivocally states that the company will not pay for any HIV or HCV-related drugs. On the other hand, it also states that the VDOC will pay for such drugs when PHS recommends them.[60]

It is also unclear how the PHS gatekeeping contract has affected overall medical treatment. Asked for information about the number of requests for treatment made since the contract was implemented last October compared to the number of requests approved by PHS, the VDOC's Health Services Director claimed not to have any.[61]

Recommendations

- Repeal the provision that excludes from the Freedom of Information Act "all records of persons imprisoned in penal institutions in the Commonwealth provided such records relate to the imprisonment," providing that such documents may be redacted to protect the privacy of individual prisoners.

- Require the VDOC to maintain a public database of statistics on the prevalence of chronic and infectious disease within the prison system. This database will enable the VDOC director to provide to the Governor and General Assembly the report on prisoner health statistics that he is statutorily required to provide.

- Require the VDOC to maintain public information about the extent and quality of the medical care it is providing.

- Require the Office of the State Medical Examiner to change the way data is stored on its "Death in Custody" database. Information fields should include the name of the institution from which the inmate came as a way of distinguishing state prison inmates from local jail inmates.

- The Governor should appoint a Mortality Review Board to review prisoner deaths. This Board should consist of physicians not employed by the state. Its findings should be public.

- In view of limited treatment options and dubious medical care available through the VDOC, the Governor should reconsider the way medical clemency is handled.

- The VDOC should change its Hepatitis C Protocol to conform with the recommendations of the Centers for Disease Control (CDC)[62] and the National Institutes of Health (NIH)[63].

- VDOC medical staff should receive training in medical file and record keeping procedures.

Endnotes

[1]According to information provided to *The Philadelphia Inquirer* by the Virginia Department of Corrections in July 2002, an estimated 39 percent of Virginia inmates are infected with Hepatitis C. Mark Fazlollah and Jennifer Lin, "A Prison Epidemic," *The Philadelphia Inquirer* July 21, 2002. The same information was provided to *The HEPP Report*, a monthly journal published by HIV Education/Prison Project at Brown University. At 39 percent, Virginia's prison population had the highest estimated incidence of Hepatitis C of 14 states surveyed. The chart was based on a *HEPP Report* phone survey conducted in 2002." *HEPP Report: Infectious Diseases in Corrections*, "Recommendations for those on the Frontline Against Hepatitis C, Jules Levin, Joseph Bick, M.D., and Elizabeth Stubblefield, *The Hepp Report*, August/September 2002. *Positive Populations*. a bimonthly newsletter put out by Roche Pharmaceuticals also recently published data that put the Virginia Department of Corrections' Hepatitis C-positive population at 39 percent.

[2] According to the Virginia Department of Corrections, 320 inmates had undergone treatment for Hepatitis C as of Nov. 1, 2002. Fifty were in treatment as of the same date. Letter from Deputy Director John Jabe, Nov. 1, 2002.

[3]*The Health of Soon-To-Be-Released-Inmates*, National Commission on Correctional Health Care, p. xvii, January 2002.

[4] The director of the VDOC is required by statute to produce one public report per year to the Governor and General Assembly that includes "the types of and extent to which health-related problems are prevalent" among inmates. However, as details that appear later in this document will show, only two of these "reports" exist, the ACLU had to file requests under the state Freedom of Information Act to obtain them, and the "health-related problems" they listed were limited to "alcohol habits," "drug use type," and "mental health status."

[5] 1. Peritonitis d/t Cirrhosis of Liver d/t Hepatitis C, Greensville Correctional Center, Jan. 27, 2001.
2. Hepatocellular Carcinoma d/t Hepatitis C, Greensville Correctional Center, Feb. 15, 2001.
3. Hepatic Cirrhosis d/t Hepatitis C, Greensville Correctional Center, Feb. 17, 2001.
4 Progressive Hepatic and Renal Failure d/t Hepatitis C, Powhatan Correctional Center, April 17, 2001.
5. Granulomatous Hepatitis, Greensville Correctional Center, Oct. 23, 2001
6. Hepatic Encephalopathy d/t Cirrhosis d/t Alcohol Abuse & Hepatitis C. Deerfield Correctional Center, Dec. 19, 2001.
7. End-Stage Hepatitis, Sussex II Prison, Dec. 9, 2001.

[6] While other states have medical records laws similar to Virginia's, most keep -- and are generally willing to release -- at least some information about prison deaths. Georgia publishes the annual number of prison deaths and their causes on its DOC website. Florida will release the names of dead inmates, but not the causes of their deaths. North Carolina will release the number of deaths and their causes, but not the names of the inmates who died.

[7] This account is based on a series of letters from an inmate in Johnson's cellblock. These letters were written in October 2002.

[8] Dec. 6, 2002 phone conversation with Rochelle Altholz, state administrator, Office of the Chief Medical Examiner.

[9] Dec. 9, 2002 e-mail from VDOC Communications Director Larry Traylor

[10] Id.

[11] The Medical Examiner's Office did perform an autopsy on Brewer, determining that he died of "hemorrhage from laparoscopic cholecystectomy."

[12] This account is based on letters to Brewer's family and friends from inmates at Augusta Correctional Center. Two of the letters are dated September 8, 2002.

[13] This account is based on a letter from a prisoner who witnessed the event. The letter is dated September 18, 2002.
[14]It would not be unusual to have one nurse on duty at a time at a prison like Greensville, which houses more than 3,000 medium-security prisoners, according to Maeve.
[15] Maeve has a doctoral degree in nursing and teaches nursing at the University of South Carolina's College of Nursing. She has worked as a nurse at several prisons and has written numerous scholarly articles on prison health care.
[16] Under DOC Operating Procedure 710, Inmate Workers and Medical states "Inmates may render medical attention when emergency first aid may be necessary to save a life and no employee is immediately available to render first aid."
[17] E-mail from VDOC spokesman Larry Traylor, January 8, 2003.
[18] Id. January 23, 2003
[19] The VDOC represented by letter to the ACLU on Nov. 1, 2002 that "the Department has no estimate [of the rate of HCV among]…inmates incarcerated in its facilities." However, Assistant VDOC Director Michael Leininger told Mark Fazlollah of *The Philadelphia Inquirer* in July of 2002 that an estimated 39 percent of Virginia inmates were infected with Hepatitis C. *The Philadelphia Inquirer,* Mark Fazlollah and Jennifer Lin, "A Prison Epidemic," July 21, 2002. In addition, a chart published in the August/September 2002 edition of the *HEPP Report*, a monthly journal published by HIV Education/Prison Project at Brown University, also listed Virginia's prison population at 39 percent, the highest of 14 states surveyed. The chart was based on a HEPP phone survey conducted in 2002." *HEPP Report: Infectious Diseases in Corrections*, "Recommendations for those on the Frontline Against Hepatitis C, Jules Levin, Joseph Bick, M.D., And Elizabeth Stubblefield, August/September 2002.
[20] National Institutes of Health Consensus Development Conference Statement: Management of Hepatitis C: 2002. June 10-12, 2002.
[21] Susan Okie, "Prompt Use of Antiviral Drug Lessens the Toll of Hepatitis C," *Washington Post*, Oct. 2, 2001. (Quoting Jay Hoofnagle of the National Institute of Diabetes, Digestive and Kidney Diseases).
[22] Letter from John Jabe, Nov. 1, 2002.
[23] Id.
[24] This estimate is based on an average. Virginia's estimate, between $15,000 and $29,000 per year, is high compared to other estimates.
[25] Medical requirements are as follows: An inmate's Bilirubin level must be less than 3. Also must have checked AST, ALT, Alk Phosphatase, Cholesterol. Creatinine must be less than 1.5. Albumin must be less than 3.0, INR must be less than 1.2. WBC must be greater than 3.0. ANC must be greater than 1500. Hct must be greater than 30 percent. Plt must be greater than 80K. Chest x-rays must be negative. Must have normal ANA, AMA, Alpha antitrypsin and ceruloplasmin. Anyone with an autoimmune disorder is disqualified from treatment. All chronic diseases, such as cardiovascular disease, COPD, diabetes mellitus and psychiatric conditions must be under control.
[26] These guidelines do not reflect the community standard of care. As laid out in a June 2002 Consensus Panel discussion at the National Institutes of Health, that standard does not exclude drug users from HCV antiviral therapy. According to the Consensus Panel, the best way to approach HCV among prisoners is to:

- Identify the disease by providing ready access to testing for those with HCV risk factors.
- Educate prisoners to enable those who have the disease to better care for themselves, and to prevent transmission, to the extent possible, to those who are not infected.
- Evaluate those who test positive for treatment. This includes confirming an active infection by measuring what is called "the viral load," or the amount of virus in the patient's liver enzymes. Although the viral load measurement does not indicate the severity of infection, it is an indicator of a patient's likely response to anti-viral therapy. Evaluation may also include a liver biopsy, which grades the severity of disease and the degree of fibrosis and permanent damage to the liver. However, experts emphasized that lack of access to a biopsy should not exclude otherwise appropriately selected patients from treatment.
- Treatment with a 24 to 48-week course of combination therapy with ribavirin and pelegated interferon while monitoring the viral load to indicate the patient's response to therapy.

HEPP Report: Infectious Diseases in Corrections, "Recommendations for those on the Frontline Against Hepatitis C, Jules Levin, Joseph Bick, M.D., And Elizabeth Stubblefield, August/September 2002.

[27]

[28] Delaying treatment for chronic HCV is not a good idea. It is one of the leading causes of cirrhosis, which is a serious disease with a number of potentially deadly symptoms. These include: edema, jaundice, gallstones, toxins in the brain and blood, increased sensitivity to medication and its side effects, infections in other organs, kidney dysfunction and failure, coma and death. Both Hepatitis C and cirrhosis can lead to liver cancer, a disease that kills 90 percent of its victims within five years. Goldman, Raphael, *Hepatitis C in Michigan Prisons*, Centers for Disease Control, "National Hepatic C Prevention Strategy.

[29] It is also unclear how many prisoners suffer from acute Hepatitis C. Although the VDOC has been required to report all acute cases to the Virginia Department of Health since December of 2001, it has clearly not been doing so since the Health Department's total tally of acute Hepatitis C cases for 2002 is 6. A Health Department official concedes that the two departments have no coordinated effort to track cases.

[30] These causes of death were found by matching information on the Inmate Death Reports to information available from the state medical examiner's office.

[31] "National Hepatitis C Prevention Strategy," Centers for Disease Control and Prevention

[32] The VDOC voluntarily publishes a variety of statistics on its webpage, including some limited death statistics. However, none of the statistics published on the VDOC webpage involve the "types and extent to which health-related problems are prevalent" among inmates.

[33] These charts were accompanied by a letter from N.H. Scott, Deputy Director, Division of Administration. "We have in our possession the official reports for the last two years, which are enclosed pursuant to your request." Scott wrote. "Also, we are providing records containing the same information for the other years covered by your request. We do not have the actual reports for those years. In accordance with §2.2-3704(D), "no public body shall be required to create a new record if the record does not already exist."

[34] This request was originally sent to all of the state's prisons. It soon became clear, however, that we could not pay the copying costs for documents from all the prisons. The request was subsequently curtailed to five prisons.

[35] Responses are as follows:

Re: Death Statistics: "The specific information you request for the years prior to 2001 was maintained only in the criminal and medical files of individual inmates. These records are specifically excluded from disclosure under the Virginia Freedom of Information Act §2.2-3706(F)(6), which excludes 'all records of persons imprisoned in penal institutions in the Commonwealth provided such records pertain to the imprisonment,' §2.2-3705(A)(5), which excludes 'medical and mental health records,' §53.1-40.10, governing prisoner medical records, and §32.1-127.1:03,governing the release of patient medical records generally." VDOC Deputy Director John Jabe, Letter to the ACLU of Virginia, Sept. 18, 2002.

Re: Health Statistics: "The Department does not keep statistics on the prevalence of or the number of inmates diagnosed with cancer, sickle cell anemia or other chronic conditions or diseases. In accordance with §2.2-3704(D) of the Virginia Freedom of Information Act, "no public body shall be required to create a new record if the record does not already exist." VDOC Health Services Director Fred Schilling, Letter to the ACLU of Virginia, Feb. 5, 2003

[36] With the exception of executions and suicides. Letter from John Jabe, Deputy Director, Virginia Division of Administration and Programs, Department of Corrections.

[37] Under VDOC Operating Procedure 706, the Department's Chief Physician is also supposed to keep a log of inmate deaths. However, the ACLU requested this log under FOIA and received a copy of an incomplete 7-page document dating back only to the year 2000. Four pages of this copy were missing information regarding inmate dates of birth and causes of death.

[38] Christopher Mumola

[39] On learning this, we made another FOIA request for the forms, this time from the Bureau of Justice Statistics (BJS). BJS withheld the forms, citing a federal statute precluding the release of medical data provided to the federal government by counties and states.

[40] Because this database does not contain the names of the institutions where the deceased prisoners resided, and does not distinguish between deaths in state prisons and deaths in local jails, the database alone is of little help to those who wish to track or analyze prison or jail deaths separately.

[41] 1. Peritonitis d/t Cirrhosis of Liver d/t Hepatitis C, Greensville Correctional Center, Jan. 27, 2001.
2. Hepatocellular Carcinoma d/t Hepatitis C, Greensville Correctional Center, Feb. 15, 2001.
3. Hepatic Cirrhosis d/t Hepatitis C, Greensville Correctional Center, Feb. 17, 2001.
4 Progressive Hepatic and Renal Failure d/t Hepatitis C, Powhatan Correctional Center, April 17, 2001.
5. Granulomatous Hepatitis, Greensville Correctional Center, Oct. 23, 2001
6. Hepatic Encephalopathy d/t Cirrhosis d/t Alcohol Abuse & Hepatitis C. Deerfield Correctional Center, Dec. 19, 2001.
7. End-Stage Hepatitis, Sussex II Prison, Dec. 9, 2001.

[42] In addition, keeping careful track of prison deaths can both alert officials to potential health care problems in particular institutions and demonstrate professionalism in the face of difficulty. In 1995, when eight out of 20 patients being treated at the Greensville Correctional Center's dialysis unit died, the Department of Corrections was unable to confirm the exact number of those who had died. "All I can really confirm, for sure, is that the number (10) is not exactly right. It's too high," a VDOC spokeswoman told a reporter for the Richmond Times-Dispatch. "It's just a lot of trouble to pull together information we don't have according to the way you're asking for it…How many of the patients who died happened to be dialysis patients?" [42] Frank Green, State Disputes Claim of 10 Inmate Deaths, Critics: Absence of Information Appalling," *Richmond Times-Dispatch*, Sept. 15, 1995

[43] Virginia Freedom of Information Advisory Council Staff Advisory Opinion, Oct. 31, 2002, Maria J.K. Everett.

[44] Wrote Scott: "We have in our possession the official reports for the last two years, which are enclosed pursuant to your request." Scott wrote. "Also, we are providing records containing the same information for the other years covered by your request. We do not have the actual reports for those years. In accordance with §2.2-3704(D), "no public body shall be required to create a new record if the record does not already exist."

[45] Concluding that the VDOC must keep mental health files separately, the ACLU obtained permission from the relevant inmates and requested their mental health files. Additional documents were sent in only one of 10 cases. In that case, however, no psychotropic drugs had been prescribed.

[46] It may be that dental charts are kept separately. The ACLU did not separately request dental charts.

[47] Letter from Dr. Thomas Lanyi, Sept. 9, 2002. Because White wanted to avoid a diversion, Dr. Lanyi referred him to Dr. Harry Koo, a pediatric specialist at MCV for evaluation. "It will be up to Dr. Koo to ascertain whether catheterization via the urethra would be appropriate for him and, if so, then I would ask that he re-implant the sphincter," wrote Lanyi. Eight months later, however, White had yet to see Dr. Koo.

[48] In Virginia, inmates with less than three months to live may qualify for medical clemency at the discretion of the Governor. However, the Governor generally acts on the recommendation of the VDOC in consultation with the Parole Board. Such clemencies came to a halt after 2001 when inmate Mikal Alyasha, was released on medical clemency, recovered his health away from the ministrations of the VDOC medical staff and re-offended. Since then, only one prisoner, Ronald Cash, has been granted medical clemency. Cash lived eight days beyond his release date.

[49] The Virginia Correctional Center for Women in Goochland.

[50] Letter from Rose White, August 13, 2002.

[51] *Bowman v. Angelone*, 3:01CV705, Complaint, Oct. 19, 2001.

[52] Black, J.& Matassarin-Jacobs, E. (1997). *Medical-Surgical Nursing: Clinical Management for Continuity of Care*, 5th Ed., pp. 645-646.

[53] Letter from Richard Lee, February 28, 2002.

[54] "I've seen other inmates such as one with cancer in his jaw. They just let the cancer eat this man up before they sent him finally for help. To me, watching it spread through his head made it too late to survive the cancer. This and many inmates cause me to fear for my life in D.O.C. …With this type of mentality, people's health care is ignored until they either fall out or they get too sick. Then their chance for survival diminishes. Please help me and all these other inmates. We should not have to fear dying because they don't have enough money or whatever reason their (sic) might be." Letter from Richard Lee, January 24, 2003.

[55] Letter from Richard Mullen, Feb. 26, 2003
[56] Id.
[57] This has been the case since Oct. 1, 2002,when the VDOC "amended" its already-existing contract with PHS to include a Utilization Management Program" contract. Under this "amendment, Virginia pays PHS $64,833 each month through January 2004. After that, the amount will vary with the amount of the Consumer Price Index "for the statistical area encompassing Richmond."

[58] Mike Hoyem, "Dying in Jail," *The Fort Myers News-Press,* December 22, 2002; Mark McDonald, "Prison Can Be Hazardous to Health: Secret Reports Show Inmate Care Inadequate"," *Philadelphia Daily News*, August 16, 2001; Mark McDonald, "Third Inmate Dies in One Week," *Philadelphia Daily News*, May 11, 2002; David Hench, "Inmate Medical Services Faulted," *Maine Sunday Telegram*, June 9, 2002; Mark Pollio, "Former Jail Nurse Alleges Shoddy Care in Lawsuit," *The Stuart News/Port St. Lucie News*, July 31, 2002; Mike Hoyem, "Critics Assail Vegas Doctor's Care: Nurses, Ex-Jail Worker Say Physician Made Calls Based on Profits," *Law Vegas Review-Journal*, May 16, 2002; Peter Geier, "MD Penitentiary Inmate Sues Prison Health Services for Half Million in Damages," *The Daily Record*, May 20, 2002; Adam Kovac, "Inmate's Death Linked to Withdrawal," *The Fort Myers News-Press*, Dec. 13, 2002; Austin Gelder, "County Jail to Take Over Medical Care: Quorum Court OKs Plan to Dump Private Provider," *The Arkansas Democrat-Gazette*, March 28, 2002; Carri Geer Thevenot, "Class-Action Lawsuit: Jail's Care Deficient, ACLU Says," *Las Vegas Review-Journal*, May 16, 2002.
[59] Section 2 of Amendment No.5 (Utilization Management Program) to Contract No. DOC 01-003 between the Virginia Department of Corrections and Prison Health Services states: "If, by separate Contract, or by amendment to this Contract, PHS undertakes to provide health care services at any or all of DOC's correctional institutions other than the four named above in this paragraph, then the those [sic] institutions shall no longer be covered by this Amendment and utilization management at those institutions shall instead be provided under the contract or amendment providing for PHS health care services."
[60] "PHS shall not be financially responsible for the cost of medications specifically required for the treatment of HIV+/Aids (antiretrovirals) or Hepatitis C. Such medications will be required by DOC upon request by PHS." Contract # DC01-003 I (G)(4).
[61] Letter from Fred Schilling, February 12, 2003.
[62] "All anti-HCV-positive inmates should be evaluated for the presence of chronic liver infection, including the presence and extent of chronic liver disease and candidacy for anti-viral therapy. Treatment of patients with chronic hepatitis C should be conducted in consultation with a specialist familiar with these treatment regimens (standard practice.

"Inmates with chronic hepatitis C should receive hepatitis B vaccination and hepatitis A vaccination if not previously immunized or known to be susceptible to infections.

"Corrections facilities or systems should establish criteria based on the latest treatment guidelines for the identification of prisoners who might benefit from antiviral treatment. For HCV-infected patients who are actively abusing substances (e.g., drugs or alcohol), appropriate substance-abuse treatment should be initiated to limit disease transmission, re-infection and liver disease progression. *Morbidity and Mortality Weekly Report,* Centers for Disease Control and Prevention, Jan. 24, 2003. Vol. 52. No. RR1.
[63] As laid out in a June 2002 Consensus Panel discussion at the National Institutes of Health, the best way to approach HCV among prisoners is to: (1)Identify the disease by providing ready access to testing for those with HCV risk factors; (2)Educate prisoners to enable those who have the disease to better care for themselves, and to prevent transmission, to the extent possible, to those who are not infected; (3)Evaluate those who test positive for treatment. This includes confirming an active infection by measuring what is called "the viral load," or the amount of virus in the patient's liver enzymes. Although the viral load measurement does not indicate the severity of infection, it is an indicator of a patient's likely response to anti-viral therapy. Evaluation may also include a liver biopsy, which grades the severity of disease and the degree of fibrosis and permanent damage to the liver. However, experts emphasized that lack of access to a biopsy should not exclude otherwise appropriately selected patients from treatment; (4) Treatment with a 24 to 48-week course of combination therapy with ribavirin and pelegated interferon while monitoring the viral load to indicate the patient's response to therapy.