

EXHIBIT 3

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Executive Summary

In mid-2014 I was asked by the National Prison Project of the American Civil Liberties Union and the Southern Poverty Law Center to opine on the adequacy of the system for delivering medical care to prisoners housed at the East Mississippi Correctional Facility (EMCF) in Meridian, Mississippi. I produced a report, dated June 16, 2014, which I incorporate by reference where appropriate. In that report I concluded:

- The components of a minimally safe and adequate health care system are missing at EMCF.
- The health care system at EMCF is simply incapable of meeting the serious medical needs of the inmate population.
- The health care system at EMCF therefore puts the entire inmate population at EMCF at constant and substantial risk of serious injury.
- The dysfunction in the medical care delivery system at EMCF permeates every essential aspect of the system; health care operations are broken at every level, and there is massive evidence of widespread neglect on the part of medical and security staff at the facility as well as their supervisors. These failures, taken together, expose prisoners at the facility to serious risks of harm to their health.
- The state-level system that is supposed to oversee medical operations at EMCF is practically non-existent, and therefore broken.

In mid-2016 the same two organizations asked me to return to EMCF to determine whether the conditions I described two years earlier still exist. The results of that visit are the subject of the current report.

The lens through which I conducted this and my previous examination of conditions at EMCF was whether the health care system was adequate to provide minimally safe conditions for patients. There are many components to such a health care system. Each component is critical; the failure of any one of them makes the whole system dangerous. By analogy, there are scores of component systems rendering an aircraft airworthy and safe. Finding a deficiency of even just one of them, for example faulty engines, is sufficient to conclude that the aircraft is not safe. At EMCF, I found 13.

I organized the 13 deficient components I identified at EMCF according to the following typology which also corresponds to the Sections of this report.

<u>Category</u>	<u>Description</u>
A	Lack of Access to Urgent Care
B	Lack or Delay of Access to Non-Urgent (Episodic) Care
C	Lack or Delay of Access to Chronic Care
D	Failure to Provide Adequate Care in Infirmary
E	Failure to Provide Health Care Consistent with What is Expected of Health Care Providers

F	Failure to Execute and Follow-up on Medical Orders
G	Failure to Maintain an Adequate Medical Record and Accurate Logs
H	Failure to Obtain Informed Refusal
I	Failure to Maintain Patient Confidentiality
J	Failure to Have or Maintain Necessary Equipment
K	Lack of an Adequate Headquarters-Based System for Monitoring the Quality of Care Delivered by the Vendor
L	Inhumane and Unsafe Living Conditions

This typology captures the depth and breadth of deficiencies at EMCF, touching on many of the major steps in providing health care. It is consistent with nationally recognized typologies in the industry (e.g. the standards promulgated by the National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2014). The typology is also consistent with case law and treatises on correctional health care (e.g. Correctional Health Care: Guidelines for the Management of an Adequate Delivery System, 2001, U.S. Department of Justice, National Institute of Corrections), which describe the need for inmates to have access to health care, to benefit from a professional clinical judgment, and to have the orders that issue from that judgment executed.

The findings of my current report are essentially the same as the findings of my previous one. They are also consistent with reports generated five years ago, two years ago, and currently by Ms. Madeleine LaMarre, MN, FNP-BC,. In the interim since Ms. LaMarre and I produced our 2014 reports, MDOC has engaged a new health care vendor to provide health care at EMCF. Despite the passage of two years, despite MDOC having access to my 2014 report – as well as a companion report produced by Ms. LaMarre – both of which provided a detailed road map of the conditions at EMCF that were broken and required repair, and despite MDOC’s engagement of a different vendor of health services at EMCF, I conclude, sadly, that little has changed at EMCF. Medical conditions created and/or allowed to exist by MDOC are still systematically inadequate. Medical conditions are just as dangerous as they were two years ago and continue to put inmates at a risk of serious harm and even death.

Qualifications and Disclosures

I am a board certified internist specializing in correctional health care. I have managed health care operations and practiced health care in multiple correctional settings. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections.

In the course of my career I have regularly investigated, evaluated, and monitored the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts; the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails.

On behalf of the National Commission on Correctional Health Care (NCCHC), until 2013, I taught the Commission’s correctional health care standards semi-annually to correctional health care administrators at NCCHC’s national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and was the principle instructor for this course at its inception. Additional details of my education, teaching and work experience, and publications, are contained in my Curriculum Vitae, which is attached at Attachment 8.

I am being compensated for my work in this matter at a rate of \$225 per hour.

The facts or data I considered in forming my opinions below are contained within this report. A list of the documents I reviewed and upon which I relied appears in Attachment 1.

Methodology

I visited EMCF from July 12 to July 15, 2016. I was accompanied by Ms. Madeleine LaMarre, MN, FNP-BC, another medical expert with whom I coordinated review of the delivery of medical and dental care at the prison. During the course of the visit I spoke with EMCF's Health Services Administrator (HSA), Mr. Ollie Little, various custody staff, and dozens of patients.

I visited non-isolation housing units 3 and 4, isolation housing unit 5, the Intake Unit, and the Medical Unit. Based on my knowledge of the facility structure gained during my previous visit when I toured all housing units, I chose these housing units because I felt they would be sufficiently representative while allowing efficient use of my time.

I also spoke with and/or reviewed the medical records ("charts") of 60 individuals currently or previously incarcerated at EMCF. Most of these individuals received care from the current health care provider. Of these 60 individuals, 11 did not contribute to this report for various reasons (six individuals offered no opinion about healthcare at the time of the interview; two individuals were not at EMCF during the relevant time period; and three individuals refused an interview). I also reviewed incident reports (which included custody and medical information) concerning another six individuals. Thus I had substantive interaction with, and relied upon the information gleaned from, 55 individuals, their charts, or incident reports about them. Among these, I conducted a total of 34 interviews, reviewed a total of 31 charts, and reviewed ancillary documents (business records, logs, incident reports, etc.) concerning a total of 26 individuals, that is, for any individual, I used one, two, or all three sources of information.

I chose charts for review by sampling from a number of different sources, including the following:

- a) logs of patients sent to the emergency room (ER);
- b) logs of patients admitted to the community hospital;
- c) logs of patients admitted to the Infirmary (Sheltered Housing Log);
- d) logs of patients who submitted Sick Call Requests (SCR);
- e) logs of patients sent off-site to specialists;
- f) Chronic Care Clinic (CCC) roster;
- g) Quarterly CCC lists¹;
- h) a case referred to me by Ms. LaMarre because she had concerns about care, but had insufficient time to investigate due to her visit schedule;
- i) individuals with whom I spoke during my visit to Units 3, 4, and 5;
- j) patients who died since my last visit; and
- k) individuals with whom I spoke or whose charts I had reviewed as part of my first report.

¹ The Chronic Care Clinic roster and Quarterly CCC lists were provided by MDOC without explanation and data contained within them are insufficiently labeled. Thus, while the two documents have some information in common, it was not wholly evident to me how their information differed. The Quarterly CCC lists appears to show patients enrolled in various CCCs along with the date of a visit to that clinic – if any – during that quarter. The Chronic Care Clinic roster appears to also show patients enrolled in CCCs, though there is no temporal information. Not all patients on one list appear on the other. For patients appearing on both lists, the identity of the CCC in which they are enrolled is not always identical across the two lists.

I chose cases from the lists – a) through g) – that suggested an inmate had actually used health services and/or received care that was more substantive and presented a risk of harm if mismanaged. For example, I spoke with inmates or reviewed charts for inmates who were transported to the hospital in a van for a condition that typically requires an ambulance. I also spoke with inmates or reviewed charts for inmates with high-risk or complex conditions and inmates whose record of care included irregularities, such as appointments that were cancelled and not rescheduled. I also spoke with inmates during my visit to Units 3, 4, and 5 – i) – because they appeared elderly or infirm and were thus more likely to use medical services, asked to speak with me, were referred to me by other inmates, or were nearest to me during my visit. I selected a small number of individuals reviewed as part of my previous report – k) – by random sampling.

These categories reflect purposive sampling practices, including category k), to the extent patients in that category had not been selected randomly for my first report. As a general matter, pure random sampling would not be appropriate here, as the purpose of this report is not to determine the actual number of people exposed to a given condition (in this case, poor medical care), but rather whether the condition exists and how serious it is. As such, purposive sampling is much more appropriate as it allows one to focus on areas where the condition is likely to be present. To that end, it would make no sense to try to determine whether EMCF handles emergency medical conditions well by randomly sampling from a group of inmates who have never had an emergency. Instead, to measure the effectiveness of EMCF handling of emergency medical conditions, it is necessary to sample patients who have actually had (or are more likely to have had) emergency medical conditions.

In addition, in reviewing charts, I generally limited my review to care provided since Centurion took over from Health Assurance LLC in July 2015; a notable exception is a death which took place less than a month prior to the take-over.² I also coordinated my selection of individuals with Ms. LaMarre to avoid duplication. Ms. LaMarre reviewed and reported on an additional 20 cases from the relevant time period. Thus, between us, our reports were informed by a total of 75 cases. Finally, I reviewed and relied upon my previous report, which is attached (see Attachment 7).

Background

At the time of my visit, the population at EMCF was approximately 1,100. The structure and composition of EMCF is much the same as documented in my last report: EMCF is operated by MTC, Inc. and houses inmates at the entire spectrum of custody levels, with a concentration on mentally ill inmates. However, there has been one significant change: As of July 2015 health care has been contracted to a new vendor, Centurion, which provides all medical, dental, and psychiatric care to the prisoner population at EMCF. Unfortunately, other procedural aspects of the health care operation have not changed since my last report, with the exception that registered nurses (RN), as opposed to licensed practical nurses (LPN), are much more heavily involved in the delivery of care at sick call.³ However, LPNs are still relied upon in other contexts such as emergency care, post-assault

² I thought that focusing on the systems of care being provided under the new vendor (i.e. beginning in July 2015) was reasonable as it allowed me to gain insight into the relative roles of the underlying MDOC system and MDOC's choice of a specific vendor in creating the health care conditions present at EMCF. However, this date does not correspond to any legal cut-off, i.e. conditions extant prior to and after July 2015 are relevant to the case at hand. As a death can be a critically important event in understanding a health care system, I therefore chose to include its review.

³ LPNs receive significantly less training than RNs (generally one and a half vs. four years, respectively, of formal training, though there are a small number of RNs who are able to achieve their licensure in two years), making it unsafe for LPNs to conduct independent examinations and evaluations, for example, independently caring for patients in the setting of sick call, emergency care, post-assault evaluations, and screening for admission to isolation cells. In recognition of this difference in training and ability, Mississippi state law states that RNs are authorized to perform "assessment, diagnosis, planning, intervention and evaluation services" (Mississippi Nursing Practice Law, Section 73-15-5 (2)),

evaluations, and screening for admission to isolation cells. Some of these activities are arguably as – if not more – clinically complex than sick call. Thus, while the health care provider at EMCF has changed, the abysmal state of health care at EMCF has not.

Findings and Opinions

Section A. Lack of Access to Urgent Care

In my last report I stated that access to urgent care – receiving attention for a medical need in a timely manner – is an essential element of a safe health care system, and I found ample evidence that inmates at EMCF do not have timely access to urgent care. Yet, despite my outlining EMCF's shortcomings as to urgent care, ample evidence supports that EMCF patients' access to urgent care is still seriously deficient, posing a threat to the safety of any inmate housed at EMCF.

In most prisons, including EMCF, inmates generally access urgent health care by making an oral request to an officer who should then notify a nurse, who in turn should evaluate the patient's health care need. Inmates with whom I spoke during this visit reported the same difficulties accessing urgent care as were reported to me during my previous visit. They continue to have difficulty getting the attention of officers at night when they are locked in their cells. For example, when Patient 32 noticed his roommate lying on the floor, unarousable, in his own urine and feces, he could not get the attention of an officer until the officer happened to pass the cell a full hour later. There are panic buzzers located in some, but not all cells, and many inmates with whom I spoke reported that even if they have a buzzer in their cell, no one responds. I did not determine if this lack of response was due to a mechanical malfunction or officers not hearing or failing to respond, but the outcome was the same. One inmate, Patient 21, pressed his panic buzzer at the beginning of our interview; nothing happened and no one responded.

Instead, inmates resort to yelling and banging and kicking on the door of the zone leading to the hallway (if their cells are left unsecure or the locks do not work, which is not uncommon), or banging and kicking on their cell door to attract the attention of correctional officers (CO). The following case illustrates this:

- Patient 3 is housed in general population. When a fellow inmate had a seizure, the panic buzzers did not work, so he and other inmates resorted to banging on doors. It took 10 minutes for staff to respond. This is too long a response to a seizure and can result in death.

If banging and kicking on doors is not successful, which inmates reported often happens, they must wait until the next CO rounds, which, according to the interviews I conducted, can be up to two hours apart. In the isolation unit (Unit 5) inmates (including Patient 40) informed me that they sometimes resort to starting fires to attract the attention of COs when they (or a peer) have a medical need. Absent a fire or some other method of attracting COs' attention, the patient must wait, regardless of the urgency of the situation, as the following case illustrates:

- Patient 7 is housed in general population. He has an extensive history of serious heart disease; he had had at least one heart attack in the past due to blockages of the arteries in his heart, and had received five coronary artery bypass grafts. One afternoon in January 2016, he began experiencing chest pressure with pain radiating from this chest into his shoulder, along with

whereas LPNs may perform services "which do not require the substantial skill, judgment and knowledge required of a registered nurse... [and are] performed under the direction of a registered nurse or a licensed physician or licensed dentist..." (Mississippi Nursing Practice Law, Section 73-15-5 (5)).

difficulty breathing. Fully aware of his heart history and cognizant (correctly) that these symptoms probably signified an evolving life-threatening cardiac event, he immediately attempted to notify a CO by pushing his panic alarm button. No one responded. It was not until approximately 45 minutes later, when a CO was making a scheduled round of the housing unit, that any notice was taken of his need.

Despite noting this issue in my last report, inmates reported to me that, even if they are able to get the officer's attention, they *still* have difficulty convincing the officer that they need medical attention, as the following case illustrates:

- Patient 17 is housed in general population and has a history of serious heart problems (blockages of the arteries). One day the patient had palpitations. He is aware of his serious heart condition, so asked a CO to notify medical staff immediately. The CO informed him to wait until pill line (which would be a few hours later) and did not notify a medical professional. These may have been symptoms of a heart attack, and failure to provide this patient immediate access to health care placed him at significant risk of death.

Further, even if inmates do get the officer's attention, and the officer does communicate the request to a nurse, nurses may not respond immediately or at all.

In Case Excerpts appended at the end of this report, I provide other examples of barriers to access to urgent care (Patients 15, 18, 26, 27, 36, and 37). However, the following frightening and tragic case illustrates in one case history a "perfect storm" of many of these barriers, culminating in what was probably a preventable death:

- Patient 8 was housed in general population. His roommate, Patient 32, related that around 01:00 he noticed the patient on the floor, staring into space. He was unable to get the patient to respond to his questions. The patient had defecated and urinated on himself. The cell did not have a functioning panic buzzer. The roommate tried, but could not get the attention of COs by banging and yelling. Finally, during the 02:00 count when a CO made rounds, he informed the CO of the serious situation and the need for medical assistance. That CO brought another officer to the cell who said "those damned drugs" and left. The roommate did not observe the COs taking any other action. Approximately five hours later, the unit supervisor came to the cell, noted the individual's condition (which included a subnormal level of consciousness) and finally instituted an emergency medical response. The patient was then sent to the ER and returned to EMCF, shortly after which he died.

Thus, as noted in my previous report, there remains a high risk that inmates at EMCF who have an urgent health need will either not be able to make their need known to staff, or, even if they do make their needs known, will not receive timely – or any – care. The high risk that inmates at EMCF will suffer harm as a result, remains.

Section B. Lack or Delay of Access to Non-Urgent (Episodic) Care

As noted in my previous report, it is essential that inmates be able to access care for non-urgent medical needs in a timely manner, which is generally accomplished by submitting a written sick call request (SCR). Two years ago I found as a systemic matter that inmates at EMCF did not have reliable access to non-urgent care, and, unfortunately, two years later my assessment has not improved.

Inmates continue to report that the SCR forms themselves are not always available. When inmates do fill out an SCR, they either receive no response or have to submit multiple SCRs. Some receive care, but only after an unacceptably long delay, which can range from several days to weeks.

As before, the impediments to timely – or any – action on SCRs is sometimes caused by custody factors. Many visits for episodic care were cancelled with an explanation of “custody-related” or “no custody escort available.” Within a prison environment, there are legitimate reasons that normal business, such as medical care, must be modified or halted for security reasons. For example, after a riot or large fight, the facility might be “locked down” until order is restored. However, such serious events are rare and short-lived in a well-run prison. Based on my review of records, occasions when no custody escort was available for medical purposes are not rare at EMCF and occur at a frequency that is unacceptable and creates a dangerous situation. Further, depending on the nature of the patient problem, if there is a *bona fide* custody-related reason that the patient cannot come to the clinic, clinic staff should attend to the patient in his housing unit. However, based on my review of EMCF records, this doesn’t happen, as illustrated by the following case:

- Patient 28 submitted an SCR for an acute injury to his face, believing he might have a fractured facial bone. Based on the sick call log, the patient was scheduled to have a medical examination, but it was cancelled by custody due to transportation issues. No nurse or practitioner came to his cell and he would not be seen by an appropriately licensed professional for this acute problem for another three days. Fractures of the facial bones can involve damage to the sinuses, eyes, or even brain, and as such, require evaluation and attention within hours to prevent serious infection, loss of vision, and even death. Thus, had this patient had a fracture, a three day delay would have been clinically dangerous.

A second reason given for cancelled appointments is “patient refused.” In some of these cases, I do not believe the patient actually refused or, if they refused, properly understood the clinical implications of their refusal; these refusals are discussed further under Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs) and Section H (Failure to Obtain Informed Refusal).

The following illustrate some examples of barriers to access to non-urgent care; others are described within the Case Excerpts (see Patients 5, 6, 11, 13, 26, 31, 34, 38, and 39):

- It took EMCF medical staff two weeks to schedule Patient 33 to be seen after submitting an SCR for severe pain (“sharp blinding pain in my rectum this morning. The pain was bad until I broke out in a cold sweat and I felt nauseous... [The pain is] 20 on a scale from one to 10.”). No explanation was provided in the medical record for this delay. These symptoms could be the result of a catastrophic life-threatening abdominal event, such as rupture or an abscess of an internal organ and thus would require immediate attention.
- EMCF failed to provide Patient 43 with timely access to care for an episodic problem. It took two weeks from the time the patient submitted an SCR to be seen for a headache, despite instructions from an eye doctor who had seen the patient previously that the patient should be seen as soon as possible if his head ever started hurting. And even when seen after waiting two weeks, the quality of the encounter was very poor; the physician’s note was devoid of any evidence that he actually examined or evaluated the patient.

- After submitting an SCR for a toothache, it took almost a month for Patient 41 to receive treatment from the dentist. This is an inhumanely long time to leave a patient suffering in pain.

Section C. Lack or Delay of Access to Chronic Care

The third general category of care is chronic care. Here too, EMCF either fails to provide, or delays, access to care. As with visits for non-urgent episodic care (Section B - Lack or Delay of Access to Non-Urgent (Episodic) Care), the cancellation or delay of access to chronic care is often blamed on custody-related factors. And, as with visits for non-urgent episodic care, a second reason given for cancelled appointments is “patient refused.” In some of these cases, as noted above, I do not believe the patient actually refused or, if they refused, properly understood the clinical implications of their refusal; these refusals are discussed further under Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs) and Section H (Failure to Obtain Informed Refusal), respectively. A third reason given for cancelled appointments is “no show.” Based on extensive interviews with patients, it is clear that for many if not most of these appointments, the patient did not willfully miss his visit. Rather he had not been informed of the visit and was not given the opportunity to attend. For example, clinic logs show that Patient 16 “no showed” for his CCC appointment. The patient’s medical record, however, shows that on the day of his clinic appointment, he was in an Infirmary bed. Both the Infirmary and the CCC are co-located in the Medical Unit, separated by a few feet. Staff marked the patient “no show” for the chronic care visit and it was cancelled. That medical staff a) could not or would not determine that the patient was already in the medical area, and b) blithely documented that the patient elected to no-show for his appointment is emblematic of the slipshod nature of the medical care delivered at EMCF. For the remainder of failed or delayed appointments to chronic care, I could find no explanation other than the patients inexplicably falling through the cracks of a fractured health care system.

The following cases illustrate some examples of failed or delayed access to chronic care; others are described within the Case Excerpts (see Patients 2, 3, 4, 9, and 16):

- Patient 41 carries diagnoses of hypertension, hepatitis C, hyperlipidemia, and seizures. Upon transfer from his previous facility to EMCF two years ago, an order for him to be seen in follow-up in CCC six months hence (November 2014) went ignored by medical staff at EMCF. Despite at least two visits with Dr. Abangan at EMCF during which the error should have been caught and corrected (both of which occurred after July 2015, when Centurion became the medical provider), EMCF continued to ignore his need for chronic disease follow-up. Thus, two years after his last chronic disease visit (at which time follow-up was ordered for six months hence), this patient still had not had access to comprehensive chronic disease management. All four of this patient’s chronic diseases have serious, if not fatal, long term consequences. For example, untreated hypertension can lead to heart attack and stroke. However, these consequences can be attenuated or completely avoided with regular (i.e. chronic) monitoring and care. Failure to provide him with such chronic care thus increases the risk of these serious effects.
- Patient 25 had a history of stomach reflux, glaucoma, bipolar disorder, hypertension, and obstructive airway disease. He was supposed to be seen in follow-up for the latter two conditions in the CCC in mid-June 2014. Instead he wasn’t seen until December 2014, nearly a half year late. Both of these diseases have serious, if not fatal long term consequences. For example, untreated obstructive airway disease can lead to frequent respiratory infections, hospitalizations, and death. As stated above, these consequences can be attenuated or completely avoided with regular monitoring and care.

- Patient 38 carries diagnoses of hypertension, cancer, heart condition, and bipolar disorder, and was enrolled in a CCC for the first three conditions. He was not evaluated for two scheduled clinic visits due to the unavailability of custody staff to escort the patient. The risks of failing to provide chronic care for all three of these conditions described in the previous two examples would also apply to this patient.

Health care cannot be safe when serious chronic diseases like heart disease, hypertension, diabetes, and asthma, among others, are not managed on a timely basis and this cannot happen when appointments do not take place as scheduled (or, when appointments are not made in the first place). Such is the case at EMCF.

Section D. Failure to Provide Adequate Care in Infirmiry

In my previous report, I described the important role of a prison infirmiry as a place where patients who are too unstable to live in the main prison can receive more intensive health care, including close and frequent monitoring by nurses, and found that the Infirmiry at EMCF fails to fill this role. In that report, the main problem I identified was poor quality health care. Two years later, that problem continues. Medical staff, practitioners and nurses alike, too frequently fail at monitoring the patients' conditions or providing care. Given that patients placed in the Infirmiry are the most acutely ill inmates in the facility, failure to provide adequate health care continues to put their health – and lives – at risk as the following case illustrates:

- Patient 27's jaw was fractured. After a delay of 20 days, he finally received surgical repair which included having his jaw wired shut. Upon return to EMCF, he was admitted to the Infirmiry. Admission to the Infirmiry was clinically necessary due to the need to monitor his vital signs post-operatively and monitor for complications of surgery, such as pain, swelling, infections, and difficulty breathing. With the exception of one day, he received no medical care or even monitoring during the entire week he was in the EMCF Infirmiry. Thus, had he developed any of these serious complications, their discovery and treatment would have either been delayed or missed. The patient was also at risk of death due to having his jaw wired shut. Indeed, if a patient in his condition vomits (which can happen after surgery), the vomited material cannot be expelled and can be aspirated into the lungs. To prevent this, a wire cutter is normally placed in proximity of the patient, and staff are instructed in its location, indications for use, and method of use, so that it can be deployed in a moment's notice to release the wires. I found no indication that such a wire cutter was readily available to the medical staff. Finally, the patient was discharged from the Infirmiry, but there is no indication that any medical authority clinically discharged him; as far as I can tell, this change in medical care level was ordered by custody staff. As an inpatient clinical care setting, it is mandatory that patients only be discharged from an infirmiry after evaluation by a clinician and determination that it is clinically safe for the patient to return to a general population bed, i.e. that the period of risk of complications from surgery has passed. In this patient's case, no such determination was made, exposing the patient to the risk of having these complications develop unnoticed and untreated.

In addition to the problem of poor care in the Infirmiry, which has gone unaddressed since my last visit, I found an additional problem during this visit. When patients with medical (as opposed to mental health) problems require admission to the Infirmiry at EMCF, there are often no available beds. The reason for the lack of bed space in the Infirmiry appears to be that the beds are densely occupied by patients with acute mental health needs. Patients are then either placed in the Intake

Unit, or left in their original bed, neither of which is sufficient because the more intense monitoring and care that they require is not available in these locations. For example:

- On the night Patient 27's jaw was fractured, no bed was available in the Infirmary, so medical staff placed him in a bed in the Intake Unit where he received no medical monitoring or treatment for at least 10 hours.
- During my walk through the Intake Unit, I observed Patient 15 living in one of the Intake Unit cells. He had been moved out of general population due to acute suicidal risk, but could not be placed in the Infirmary because it was full. In the Intake Unit – intended for short term stays of a few minutes to hours – he was without a mattress, blanket, or any way to keep warm. Not only are these conditions inhumane, but they can add to the mental distress (and risk of self-harm) in a patient already at risk of suicide.

Housing of these and other patients in need of intensive monitoring and health care could, at times, better be described as warehousing than care taking and therefore endangers patient health.

Section E. Failure to Provide Health Care Consistent with What is Expected of Health Care Providers

In my previous report, I described the lack of appropriately licensed professionals operating within the limits of their licensure, training, and ability, and using sound judgment and a reasonable degree of competency in making clinical decisions and delivering care. While there has been one partial change (regarding the use of LPNs, described below), the condition I described in my previous report continues substantially unabated and continues to place inmates at EMCF at daily risk of harm.

The one partial change relates to the use of LPNs. LPNs generally only receive about 18 months of post-high school training. As such, Mississippi (and most other states') law limits their function to gathering of information (to be transmitted to more highly trained personnel) and executing care plans (developed by more highly trained personnel), and bars them from making clinical assessments (i.e. using the information they collect to arrive at a diagnosis). The use of a comprehensive set of clinical nursing protocols (e.g. a protocol for nurse management of chest pain), if, in fact, such protocols are used by LPNs at EMCF, cannot substitute for the legally required training and licensure. Under the auspices of the new health care vendor there has been a decrease in the use of LPNs to perform work beyond their legal (and safe) scope of practice. However, this decrease is limited to use of LPNs to care for patients in sick call. LPNs are still relied upon in other contexts such as emergency care, post-assault evaluations, and screening for admission to isolation cells. Some of these activities are arguably as – if not more – clinically complex than sick call. Thus the dangerous state remains. The following illustrate some examples of the dangers posed by LPNs at EMCF; others are described within the Case Excerpts (see Patients 26, 27, 28, 34, 38, 46, 48, and 49):

- Patient 6 presented to the clinic at 03:00 complaining of stomach pain. His vital signs were normal. The only other clinical history taken by the LPN was “Stated that what was wrong with him could be cured with a good woman. States he has been hurting for 3 years.” The LPN, acting independently and beyond the legal scope of practice, did nothing further. Later that day he grabbed an officer and attempted to kiss her. When seen by a psychiatric practitioner, it was determined that he was in a manic state. It is likely he was in that state earlier in the day, and it was missed by the LPN. Had the patient been cared for by an RN or practitioner, it is possible the bizarre behavior earlier in the day would have been recognized as an acute manifestation of his psychiatric emergency, leading to treatment and avoiding an assault on a CO.

- Patient 16 was involved in an altercation. He was examined by an LPN, practicing independently and beyond the legal scope of practice, who found his right hand visibly swollen. She treated him with an ice pack and ibuprofen and referred him to the doctor “for placement on the x-ray list.” The order for medications was not signed by anyone above her until four days later, yet the patient received the medication. The patient’s fracture was not immobilized, which was required for such an injury. An x-ray was done, but there is no evidence of an order from a practitioner, so it appears to have been done based on the LPN’s order, which is outside the scope of practice of any nurse (i.e. RN or LPN). The patient was not seen by Dr. Abangan until a full three days later when it was finally realized that he had a complicated fracture of his hand. The LPN’s actions contributed to the delay in the patient receiving proper care, which may contribute to permanent disability.
- Patient 45 was assaulted by another inmate, resulting in an injury to the patient’s head. He received a post-injury examination by an LPN. The examination was wholly inadequate, failing to elucidate where and how the patient was injured, and failing to examine important elements such as neurologic function. The patient was at risk for serious complications of the head injury, such as concussion, bleeding in or around the brain, and paralysis from neck fracture, all of which, if they existed, would have been missed by the nurse’s evaluation.
- Patient 47 cut his throat. He was taken to the clinic where an LPN attempted to conduct a post-injury evaluation. While being treated, custody staff recovered a substance in his cell believed to be an illicit drug (“spice”). The patient refused examination or treatment. The LPN documented this and then apparently released the patient back to custody staff. After refusing treatment, while being escorted back to his cell, he threatened to harm staff and property and was taken to an isolation cell. The encounter was not competently conducted. The fact that the patient had harmed himself (and in a possible suicide attempt), on its face indicates that the patient probably did not have the capacity to refuse examination. Beyond any immediate medical needs (which were not met), the patient was at an on-going risk of self-harm and death, and, in addition, the failure to treat also put staff at risk as evidenced by his behavior after seeing the LPN. Thus the medical professional taking care of him at that point should have immediately placed him in a protected environment (i.e. suicide watch cell) and notified a mental health professional. Instead the LPN allowed him to be placed back in general population where he was at exceedingly high risk of committing suicide.

As I noted in my first report, poor clinical decision-making at EMCF that places patients at grave risk is certainly not limited to LPNs. The types of problems with RN, nurse practitioner (NP), and doctor departures from expected clinical practice that I described in my first report continue unabated. In fact, in some cases professionals provided such a paucity of actual hands-on care, that it was doubtful that these events should be classified as clinical encounters at all; they might more properly be classified as examples of complete lack of access to care. Licensed health care professionals are individually responsible for the quality of care they deliver, and when that care – as the care delivered by too many professionals at EMCF – has fallen to a dangerously deficient state, the professional should be held accountable. However, responsibility extends beyond the individual providers at EMCF. Health care delivery by health care providers at EMCF has consistently fallen to a dangerously deficient state. This problem was described previously in my first report and two reports by Ms. LaMarre, and continues unabated. While individual failures can be blamed on medical staff, the consistency of this poor performance despite repeated warnings of this condition, makes MDOC squarely responsible for the failure to deliver minimally sufficient health care to inmates, which in turn places inmates at substantial risk of serious harm.

RNs still fail to properly evaluate patients with acute problems or refuse to treat patients; NPs still do incomplete evaluations of acute and chronic problems; staff still send acutely ill, unstable patients to the ER by van rather than ambulance; and decision-making by the new facility doctor is exceedingly poor and is worse than that of the previous doctor.⁴ Examples of the failure of RNs, NPs, and the physician, to follow standard medical practice, placing patients at serious – sometimes grave – risk, follow (other examples are contained within the Case Excerpts appended to this report):

RNs:

- Patient 20 reported that, on occasion, inmates are locked in their cells for disciplinary reasons. When this happens, they do not receive their medications from the nurses. Instead, a nurse hands the medication to another inmate, who slides the medication under the cell door. Patient 20 stated that this, in fact, has happened to him. It is a nurse's responsibility, when administering medications, to assure that he/she is administering the right medication to the right patient, and that the patient is actually taking the medication. The situation described by this patient, wherein nurses give medications to a "runner" inmate to bring to the patient, violates this basic tenet of safe medication administration in *any* setting. In a correctional setting, such behavior is even more proscribed because it puts one inmate in a position of power over another (i.e. the "runner" could leverage delivery of the medications to extort something from the patient) or risks the medication being diverted. Thus this delivery method is unheard of in prisons.
- Patient 22 was evaluated by an RN for headaches. The nurse obtained vital signs (BP 92/60) and noted that he complained of "frequent throbbing frontal headaches. sinus drainage noted. on Claritin. denies dizziness, nausea, and photosensitivity. no neck stiffness." However, other than this, the nurse elicited no other history or performed any other examination (in fact, it is difficult to tell from this note which of the problems are based on what the patient said or the nurse examined). The nurse prescribed ibuprofen for five days. Not only was the evaluation inadequate for the first evaluation of a severe headache, but the expectation that "frequent" headaches would be solved with a one-time 5-day supply of medications is unreasonable.
- Patient 23 submitted an SCR for a rash and an eye problem. He was evaluated by an RN who evaluated him for the rash, but ignored the eye problem. The patient submitted another SCR, again asking for care for the eye problem. The nurse who triaged the second SCR did not see the patient in person and simply referred the patient to an eye doctor, who did not see him until another nine days later. Regardless of the nature of the complaint (in this case, the patient thought he needed glasses) it is incumbent on the nurse to conduct an in-person evaluation to determine if, in fact, the problem is as simple as the need for glasses and can wait nine more days. Indeed, some very serious eye problems can produce the same symptoms as caused by poor glasses, yet can cause blindness in hours or days without proper treatment.
- Patient 24, housed in the Infirmary for depression, informed an RN that he had been hoarding medications and "took a lot." The nurse failed to conduct any examination (beyond checking vital signs). He was sent to the hospital by van. Among the most important missing examinations was an evaluation of the patient's level of consciousness. Had his level of consciousness been subnormal, he would have required close monitoring of his airway at the prison and by an ambulance crew during transportation to the hospital, to ensure that he did

⁴ It is my understanding that this is not the doctor's first tenure at EMCF. Ms. LaMarre reviewed the care of this same doctor in 2011 and came to the conclusion that "The physician should be immediately removed from the facility" It is truly remarkable that he was rehired.

not choke and die. Instead, no such evaluation was conducted, his airway was not monitored at the prison, and it was certainly not monitored during the trip to the hospital by van. Had the patient suffered from a lowered level of consciousness, and had he been unable to maintain an open airway, he would have been at tremendous risk of asphyxiation, brain damage, and possible death.

- Patient 26 was evaluated by an RN for chest pain. The nurse obtained a history of sharp chest pain for two to three weeks and no history of heart disease. She failed to obtain any further basic information about cardiac risk factors nor other key symptoms possibly associated with the pain (e.g. shortness of breath, radiation of the pain, etc.). Moreover, other than obtaining vital signs, she conducted absolutely no physical examination of the patient, but on this basis apparently diagnosed him with a stomach problem (I inferred the diagnosis from her prescription for Mylanta). The evaluation conducted by the nurse was so poor as to have been tantamount to no care at all, and was thus dangerous.
- Patient 28 was seen by an RN for an upset stomach and diarrhea. Aside from determining that he had had this symptom for three days, and checking his vital signs, the nurse failed to collect any further history or perform any physical examination. Sometime later, this same patient saw an RN for an eye injury due to an assault. Other than obtaining vital signs and eliciting some more symptoms, the nurse failed to conduct any examination of the patient's bones (for possible fracture) or eye.
- Patient 30 was evaluated by a nurse for "bad chest pain." The entirety of the history she elicited was "c/o [complains of] having bad chest pain near the mid of chest on L side." The entirety of the examination, aside from vital signs, was "chest sounds clear no acute resp or cardiac distress noted at this time." The nurse's nursing diagnosis was "chest pain" for which she provided an antacid for three days. This evaluation was grossly inadequate and exposed the patient to significant risk. The information the nurse collected was grossly insufficient to be able to rule out some serious medical problems. A patient presenting with chest pain – even a 22 year old patient – requires at a minimum questioning about the nature of the pain, personal history and family history of serious conditions which might cause chest pain, examination of the heart and, possibly, veins of the neck, and possibly obtaining of an EKG. Failure to perform these (and other) investigations may result in missing such life-threatening problems as a heart attack, ruptured lung, or blood clot in the lung (embolism).
- Patient 31 submitted an SCR for "excruciating pain...trouble eating along with sleeping." He was seen by an RN. The entirety of the nurse's note was "wants some pain medication. Objective: R[ight] shoulder pain wants pain meds." Her diagnosis was "Wants some pain meds." The nurse provided ibuprofen for five days. The evaluation conducted by the nurse in this case was so vacuous as to be non-existent and reflect a lack of access to care. There are myriad medical conditions, some less serious, some more serious, which a minimally competent health professional needed to consider in this scenario, such as infection of the bone or muscle, blood clot to the lung (embolism), and ruptured lung, among others. The nurse failed to explore any of these or other possibilities. Thus it was impossible for her to have safely arrived at a diagnosis and treatment plan.
- Patient 34 was seen by a nurse for a "very bad tooth with a whole showing the nerve an it hurting badly it's needs to be pulled asap." Other than vital signs, the nurse did not examine the patient, but prescribed ibuprofen for five days and referred him to the dentist. The nurse

failed to conduct even the most rudimentary of clinical exams to determine the nature of the patient's problem and whether it required emergent treatment.

- A few days later, this same patient saw an RN for a boil. The entirety of the nurse's note was, "Inmate to medical for wound care. Has large non-draining boil on left arm. Needs to see the doctor." This is a wholly inadequate examination.

NPs:

- Patient 19 had a widespread rash over 80% of his body. The NP prescribed him a 0.5 oz. tube of antifungal antibiotic cream and instructed him to apply this antibiotic to his entire rash twice a day for 30 days, but gave him less than would be needed for a single application (0.7 oz.). Further, 20% of the rash was on the patient's back, an area to which he could not possibly apply the cream himself.
- Upon transfer to EMCF, Patient 38's medical records indicated that he had cancer, and during his intake health assessment at EMCF, an LPN noted that he had "liver cancer." The patient was subsequently seen in CCC by an NP. The NP ignored the patient's history of "cancer" and "liver cancer." If it required further evaluation and treatment, none was provided at this point nor were any plans made for future evaluation and treatment. It simply "fell through the cracks." At the same visit, the patient complained of loss of weight, so the NP measured his weight (172 pounds) and made a plan to follow up on the weight issue at the next CCC visit. At that next visit, the patient's weight was 166. Yet despite the previous plan to assess the patient in the future for loss of weight and despite the current evidence that indeed the patient had lost weight, the NP ignored this finding. In light of a history of cancer, this loss of weight is worrisome, and ignoring of it is potentially dangerous. (When his weight finally dropped to 158 eight weeks later, accompanied by vomiting blood and blood in his urine – a full five months after arriving at EMCF with a life-threatening diagnosis of cancer – medical staff at EMCF finally paid attention to Patient 38 by urgently referring him to the physician. Because this referral was made on the day of my visit, I do not know the final outcome of this case. If it does turn out the patient has cancer, the five month delay in care may have converted a curable cancer into a terminal one.)
- Patient 42 was seen by an NP in CCC for the specific purpose of monitoring his seizure disorder. The NP noted that the patient had had a seizure a few days before the clinic visit, but then failed to evaluate the implications of this fact (e.g. Was the disorder getting worse? Were the medications not working?) or formulate any plan of care. Seizures put patients at risk of injury, and thus failure to control seizures increases that risk.

Dr. Abangan:

- Patient 17 has a known history of serious problems due to blockages of the arteries of his heart, having had stents placed in the arteries in the past to keep them open. He developed chest pain with radiation to the left arm and nausea. When examined, his heart rate was 182 (dangerously rapid) and irregular. In any patient, but especially in one with Patient 17's history, this constellation of findings constituted a medical emergency. The patient should have been considered highly unstable, meaning that at any moment his heart might stop. Under such circumstances, he needed to remain under monitoring by trained health care staff with emergency resuscitation equipment within easy reach. Instead, when learning of this patient's condition, Dr. Abangan ordered the patient sent to the ER by van (staffed only by correctional officers) rather than ambulance.

- Patient 22 was referred to the facility doctor by a nurse for a headache. When the doctor saw him, his evaluation was limited to obtaining the following history: “Headache comes and goes.” His examination was limited to obtaining vital signs – no other examination was performed. The doctor prescribed ibuprofen. A minimally competent doctor evaluating a patient for a headache is required to obtain basic information about the history of the problem (e.g. When did it start? Was there any head trauma? What makes it better/worse? etc.) and then actually lay hands on the patient and conduct an examination. None of this happened. While most headaches are benign and self-limited, it is impossible to distinguish those caused by more serious problems (such as strokes, tumors, etc.) without an evaluation.
- Patients 33 was seen by Dr. Abangan for rectal pain. After the examination, the doctor did not propose any explanation for the patient’s pain. Then, 2.5 months later, when the patient requested a refill for antacid (which he used for stomach problems), Dr. Abangan instead wrote a prescription for laxatives. Whether the doctor thought he was treating the rectal pain (from the visit 2.5 months earlier) or had a different thought process is speculative. In either case, the prescription for laxatives was a careless prescribing error on the part of the doctor.
- Patient 38 was seen by Dr. Abangan because the patient thought his foot might be broken. Dr. Abangan ordered an x-ray that showed a displaced fracture of his ankle. The doctor requested a specialist appointment. However he did not immobilize the fracture nor provide the patient with crutches or any way to avoid weight bearing. Failure to immobilize a fracture and have the patient avoid weight bearing would not only cause pain but also could cause the fracture to become more severe.
- Patient 42 was seen by Dr. Abangan pursuant to a referral by the sick call nurse after the patient requested vitamins “to improve his health.” Other than checking the patient’s vital signs, including his weight (BMI=25), the doctor failed to elicit any other history from the patient or conduct any examination. While the request for vitamins can be a benign request from an uninformed patient, such a request can be a proxy for an evolving medical symptom (and underlying disease, for example, cancer), especially in a patient in a mental health institution or with poor health literacy, as is common in prisons. Thus this request required at least a minimal exploration by the doctor of the reasons for the request and the presence of any new symptoms. This did not happen.
- Patient 43 had a low platelet count in early 2013. At the time of my visit in mid-2014 it had not yet been addressed, so I brought it to the attention of EMCF medical staff at that time. Despite this notification, no action was taken by anyone, including by Dr. Abangan at a visit in late 2014. At a visit in early 2015, Dr. Abangan repeated the platelet count test. It was still abnormally low, yet Dr. Abangan continued to ignore it. Platelets are blood cells which are important to help a person’s blood clot after an injury. A number of diseases can cause this, for example cancer, so failure to look for and treat the cause can lead to serious health problems. Further, until the underlying cause is found, failure to recognize the bleeding risk and take steps to prevent trauma or bleeding can be harmful, if not fatal. Despite this, as of my visit in mid-2016 – more than three years after the blood abnormality was first detected, and almost two years after I alerted EMCF staff of it – the low platelet count had not yet been addressed.

Unknown provider:

- Patient 38 informed EMCF staff that he carries a diagnosis of hepatitis C, an infection of the liver. EMCF staff members persistently informed him that he did not have the disease. In fact,

he does have the disease as proven by outside medical records (which became available when I easily obtained them after my conversation with the patient). After one of his recent requests for treatment of his liver disease, a blood test was ordered. The test result was normal. The blood test that was ordered is a test related to the liver. Based on the timing of the test, it appears to have been done in response to the patient's concern about having liver disease. When the normal result returned, EMCF staff took no further steps to diagnose his purported hepatitis C. The lack of clinical judgment is reflected in the fact that EMCF staff ordered the wrong test to diagnose hepatitis C. Thus the fact that this liver test was normal did not rule out hepatitis C infection.

The following examples demonstrate how different types of deficiencies at EMCF occurring simultaneously compound each other, creating even more risk of harm to patients:

- As discussed above, Patient 41 was transferred from another facility to EMCF in May 2014, with the instruction that he be seen in CCC in six months, due to his diagnoses of hypertension, hepatitis C, hyperlipidemia, and seizures, and a history indicating significant risk of a heart attack. As also noted above, as of my visit on July 15, 2016, more than two years after his last CCC visit at the previous facility, no such visit had occurred at EMCF. And, indeed, what care the patient sought on his own was woefully inadequate. On March 31, 2016, during this "chronic care vacuum," the patient complained of chest pain. He was seen by a nurse. Given his age (44) and significant risk factors, there was a significant chance that this chest pain was signaling an actual, or impending, heart attack. Thus a minimally competent nurse should have arranged for him to be evaluated by the physician immediately. Instead the nurse generated a referral to the physician. Due to the ineffective system for executing orders at EMCF, the referral never materialized. As of the date of my visit on July 15, 2016, more than three months after the referral, this patient had still not seen the doctor.
- Patient 7 has an extensive history of serious heart disease; he had had at least one heart attack in the past due to blockages of the arteries in his heart, and had received five coronary artery bypass grafts. This very significant heart history was documented in his medical record and also easily available from the patient himself. Thus it was known – or should have been known – by EMCF medical staff. When a patient with such a history presents with any symptom that might be heart-related, minimally acceptable standard of care dictates that medical care providers maintain a high level of suspicion that he might be having a heart attack. In early January 2016, he complained of chest pain. When he finally arrived in the clinic, a nurse misdiagnosed him as having an upset stomach, provided an antacid, and sent him back to his cell. The nurse failed to document the encounter, but the patient's description of events to me as well as indirect evidence in the medical record support this fact set. When the patient was finally seen by an NP two days later, the practitioner, although suspecting the possibility of a heart attack, failed to take the minimal actions any NP would be expected to take, including failing to send the patient to the ER, mis-ordering aspirin by ordering it to be swallowed rather than chewed⁵, failing to follow up on the patient's condition, and failing to arrange for monitoring of the patient overnight. Nurses also failed to follow critically important orders written by the NP, such as obtaining an EKG, giving the patient nitroglycerin, and obtaining blood tests, and also failed to notify the NP that her orders were not completed. The health care manager, when informed by a nurse of staff's inability to complete certain medical orders, failed to notify the ordering NP or to instruct that the patient be sent to the ER. Finally, when the physician examined the patient in the morning and found

⁵ Due to the delayed effect of aspirin when it is swallowed, and the urgency with which a patient with a suspected heart attack needs to be treated, it is nationally accepted practice that aspirin taken in this situation must be chewed.

his blood pressure had dropped and his heart was racing, he failed to order the patient transported to the ER emergently by ambulance (rather than van). When the patient was finally taken to the hospital and evaluated, he was found to be in the middle of an acute heart attack, and was rushed to the Cardiology Procedure Room to unblock his heart artery.

That the above patient did not die at the hands of EMCF staff over the three day course of his evolving heart attack is truly remarkable.

- Patient 8 was not as lucky. Over the course of two months of care I reviewed, there were numerous failures in care by multiple staff (including COs, nurses, an NP, and Dr. Abangan). Finally, in the early morning hours of the day of his death, Patient 8's roommate discovered Patient 8 lying on the floor in his own urine and feces, staring into space, and unresponsive to his questions. When, after a full hour, Patient 8's roommate was successful in attracting the attention of a CO, his concerns were brushed off by custody staff. Hours later, a custody supervisor finally appreciating the seriousness of the situation, instituted an emergency response, and the patient was sent to the ER. He was returned from the ER that afternoon with no definitive diagnosis, but a recommendation from the ER that he be monitored by medical staff. The patient returned without any medical records from the ER, and EMCF nursing staff perpetuated this error by failing to make any attempt to obtain them. Thus they cared for this patient in a relative information vacuum. The nursing staff also failed to contact the prison physician to discuss the patient's care and obtain instructions. They did place the patient in the Infirmary, but for the four hours from when Patient 8 returned from the ER, until he was found dead on the floor, no monitoring took place: He was ignored. In the absence of any medical records from the ER, any clinical evaluations from the nurses upon his return, or an autopsy report, I could not determine Patient 8's cause of death or whether anything medical staff might have done differently could have saved his life. However, the fact set suggests that any chance of his surviving was squandered by EMCF's medical staff's failure to obtain critical information about his evaluation in the ER and failure to follow the ER physician's recommendation to monitor this patient upon his return.

Section F. Failure to Execute and Follow-up on Medical Orders

In my previous report I described the importance of carrying out medical orders after they are generated by a practitioner and observed the frequency with which staff fail to do so at EMCF. During the visit described in this report, I found that medical staff at EMCF continue to fail in this regard. By far the most common error I found was the failure of nursing staff to administer medications as ordered by a practitioner. Failure to provide medications, many of which are prescribed to treat serious medical conditions, puts patients at serious risk of harm.

One frequent reason nurses document for failing to administer a prescribed dose of medication is that the patient "no showed." "No show" is rarely, if ever, a legitimate reason for failing to administer needed scheduled medication in a custody institution, especially one with a high concentration of patients with serious mental health diagnoses. The reason it is unacceptable is that there are reasons for a patient to not show up for medication other than an informed and competent decision to decline, which is the only acceptable reason for a patient to miss a dose of medication. These illegitimate reasons generally fall into three categories: a) custody-driven; b) other-inmate-driven; c) self-driven, all of which result in missed doses of necessary medications which, in turn is a threat to health. Custody-driven missed doses result when custody staff interfere with medication administration. COs may neglect to inform an inmate that the nurse is present or may be too busy to escort the patient. In the most troubling cases, the CO may be indifferent or even intend for an inmate to miss medication. Other-inmate-driven missed doses occur when other inmates exert pressure on the patient. The

pressure may be an instruction (sometimes gang-related) to not take medications. The pressure may be extortion to obtain the (desirable) medication the patient is taking, and the patient may not want to risk being accused of diverting his medication. Or, a patient taking a medication for an embarrassing or reviled condition such as HIV/AIDS, may not want others to see nurses giving him a recognizable pill. Finally self-driven misses may be the result of lack of understanding of the need for the medication, especially in the face of side effects. While a patient with full cognitive abilities may have the capacity to weigh the risks and benefits of such a decision and make a good decision in his own best interest, patients with serious mental illness – the focus of EMCF’s mission – may not. (I discuss this in greater detail in Section H: Failure to Obtain Informed Refusal.) Lastly, occasionally patients do not show up for their medications for medical reasons: weakness or altered mental status due to a side effect of the medication or progression of the disease being treated.

However, all of these reasons assume that the nurse is fairly recording what he or she believes happened (the patient did not show up). Based on extensive interviews, chart reviews, and observation of operations over four days (in addition to four days previously spent at the facility), it is my opinion that at times EMCF nurses document “no show” or “refused” even when they know that it is not the correct explanation for the missed dose. (I discuss this in greater detail in Section G: Failure to Maintain an Adequate Medical Record and Accurate Logs.)

It is for these numerous reasons that “no show” is simply not a legitimate excuse for failing to administer medications to patients at EMCF. Yet patient Medication Administration Records (MAR, the paper document on which nurses document the administration of each dose of medication) are peppered with missed doses due to “no show.”

The following cases illustrate some examples of failure to execute or follow up on orders; others are described within the Case Excerpts (see Patients 3, 8, 9, 16, 20, 21, 25, 38):

- Nurses failed to provide Patient 1 with his seizure medications on numerous occasions, including a stretch of a whole month. Some of these misses appear to have been due to the facility running out of the patient’s medications as evidenced by a lapse in orders, others due to a failure to administer medications despite their being available for the patient on the medication cart. It should be noted that running out of medications is not sufficient reason to put patients at risk of harm. Further, none of these medications are highly specialized that are difficult to obtain from local pharmacies in a matter of hours.
- Patient 42 requires two medications to control his hypertension. Nurses failed to execute medication orders for this patient. Depending on the time period I examined, nurses failed to administer between 33 and 40% of the patient’s needed doses with no, unclear, or inadequate (e.g. “no show”) explanation.
- As noted in an earlier example, nurses simply failed to give Patient 7 nitroglycerin when ordered by the NP during an episode of acute cardiac chest pain.
- At the conclusion of Patient 34’s visit with an RN on June 14, 2016, the nurse’s stated instruction was that the patient needed to see the doctor for a boil. Despite this follow-up plan, the doctor visit had not yet happened as of my visit on July 15, 2016. This failure to execute on an order requiring follow-up with the doctor is an omission in patient care with potentially serious health repercussions for the patient.

- As noted in Section C (Lack or Delay of Access to Chronic Care), as of July 15, 2016, Patient 41 had yet to be seen by a doctor to treat his four chronic diseases – hypertension, hepatitis C, hyperlipidemia, and seizures – despite an order from a doctor at his previous facility ordering that he do so *two years ago*.
- Patient 5 had a drop in his platelet count in early 2015. No action was taken on following up these abnormal results until mid-summer of 2015. At that time a practitioner ordered a repeat platelet count test. It was reported to the facility on August 2, 2015 and showed his platelets had dropped further from 56,000 to 33,000 (normal is greater than 144,000). This report shows a rapid and potentially dangerous drop in the patient's platelet count. This critical lab result was not reviewed by a practitioner until October 2, 2015, two months later, so no clinical action was taken at EMCF prior to his transfer out of EMCF on September 3, 2015. Platelets are blood cells which are important to help a person's blood clot when they are injured. A number of diseases can cause this, including cancer, so failure to look for and treat the cause can lead to serious health problems. Further, until the underlying cause is found, failure to recognize the bleeding risk and take steps to prevent trauma or bleeding can be harmful, if not fatal. Finally, when critically abnormal test results are reported back to the ordering physician, they should be reviewed immediately. Sometimes the laboratory will phone the facility as soon as the results are ready. But as a safety measure in the event they do not, a health care system will mandate and monitor that test results are reviewed within a few days of receipt. Clearly this did not happen at EMCF.

These failures to execute orders and follow up on care plans are systemic and place patients at EMCF at significant risk of serious harm. They were present at the time of my previous visit and, despite my bringing it to the attention of MDOC and a change in health care vendor, the problems continue.

Section G. Failure to Maintain an Adequate Medical Record and Accurate Logs

In my previous report, I described the serious inadequacies of the medical record and logs maintained at EMCF and how such poor record keeping can threaten patient safety. Those deficits flowed from: 1) the design of the electronic medical records system (EHR), 2) the way staff use it, and 3) documentation practices that are independent of the EHR (i.e. would likely exist if EMCF were using a paper-based record system). EMCF continues to use the same EHR it used two years ago. Thus, deficits flowing from the design of the EHR would not be expected to have changed and have not. The other deficits, which are user-dependent, are amenable to change even if the same EHR is in use (with changes in software design, policies, staff training, and staff supervision). However, these also have not changed appreciably since my last visit. I describe these three broad types of deficits below.

Type 1: Deficits due to poor design of the EHR: As noted in my previous report, the design of EMCF's EHR makes information retrieval difficult, which in turn, makes safe patient care challenging. For example, it is very difficult to discern a patient's medication history. Review of scanned external paper documents (such as hospital records) is laborious and time consuming (e.g. each page of multi-page documents is stored separately and must be opened one at a time).

Type 2: Deficits due to the way staff use the EHR: Staff carelessly scan some documents sideways or upside down, making it time consuming to rotate each image when trying to read the document. Staff assign file names and/or dates to scanned documents that do not always correspond to their contents, so they cannot be found when searched. For example, Patient 8 had a MAR filed as a Medical Segregation form. Other deficits resulting from the way staff use the EHR include:

- Stale patient information, which is no longer accurate, continues to appear as current information in clinician progress notes for months or years. If other caregivers using the EHR to guide patient care are not aware that the information is old (and no longer correct), they may make erroneous decisions, putting the patient's health at risk. For example, Patient 32's chart contains the following passage: "Reports dental problems;...reports sores in head that may be MRSA [staphylococcal infection]." This passage appeared in the section of the note that practitioners use to document what the patient reports to them contemporaneously, i.e. at that particular visit. The same passage was documented on May 8, 2013 by NP Ellis, on March 12, 2014 by Dr. Edwards, and on four occasions in 2015 and 2016 by Dr. Abangan. I captured a handful of additional examples of this misleading documentation in Case Excerpts below; however, this issue was present in almost every chart I reviewed. I do not know if this is a design flaw in the EHR software, or misuse of the EHR by users. In either case, when this happens, a health care provider who relies on this misinformation may make an incorrect treatment decision. The medical practice axiom cited may have to be modified to "If it isn't documented in the medical record, it didn't happen, but if it is documented, it may not have really happened."
- Problem Lists – that is, a list of all a patient's diagnoses – are inaccurate. The Problem List is an essential tool in a medical record that assists all users of the record to quickly know what health problems a patient currently suffers from. But, for example, Patient 38's chart has conflicting information about critically important information. His Problem List in the "Summary" tab of the EHR lists his medical problems as:
 - Leg pain, right
 - Hip pain
 - Back pain
 - Bipolar disorder
 - Hypertension
 - Routine General Medical Exam

However, under the "History" tab, the patient's medical problems are:

- Cancer
- Heart Condition
- Hypertension
- Surgeries
- Other

It is thus impossible for someone using this patient's chart as a guide during medical decision-making to rely on the information therein contained. In the example above, a treating physician would have many questions, for example: Does the patient have cancer or not? What kind of cancer (and is it cured, or a current problem that requires my attention)? Does the patient have a heart condition or not? What kind of heart condition is it? What kind of problem is "Other"? Is it something serious that requires ongoing care, or is it something minor that can be ignored? In Case Excerpts, I only captured one or two examples of inaccurate Problem List documentation because it was present in almost every chart I reviewed.

- One EHR entry I found contained imaginary information. In a chronic care visit note for Patient 38, EMCF medical staff documented that the patient's height for the visit was 71

inches, and that he verbalized current information about his medical history and family history . . . except Patient 38 no-showed for the visit.

- On a positive note, one problem I noted with great frequency during the last visit now appears to be a rare event. All previous MARs were scanned and filed in the EHR of each of the charts I reviewed.

Whereas the problems with documentation listed above are either the result of the design of the EHR or user error, for a third problem – unclear CCC notes – I am unable to determine if it results from a poorly designed EHR, user error, or both. The EHR contains templates for use during scheduled follow-up visits for various chronic illnesses, e.g. diabetes, pulmonary disease, etc. While the intent of such templates (which exist in other EHRs and in paper charts) is to ensure that clinicians cover all essential elements of a disease maintenance visit for a specific disease and that the information is easily retrievable for future visits, the outcome at EMCF are chart notes which are disjointed, unclear, ambiguous, and sometimes internally contradictory (for example, a chronic care visit note for Patient 8 indicates in one section of the note that a diabetic foot exam was completed, but the exam is missing, suggesting it was not done). Because this deficit was present in almost every chronic care chart I reviewed, in the interest of expediency, in Case Excerpts, I only show two examples of this misleading documentation (Patient 8 and Patient 42).

Type 3: Deficits in documentation practices that are independent of the EHR: Another problem with documentation, not specific to electronic records, relates to the way staff document uncompleted patient interventions. As discussed above, I found that many scheduled non-urgent episodic care visits (see Section B - Lack or Delay of Access to Non-Urgent (Episodic) Care) and chronic care visits (see Section C - Lack or Delay of Access to Chronic Care) were cancelled (and were sometimes rescheduled, sometimes not). I also found that many scheduled medication doses were not given (see Section F - Failure to Execute and Follow-up on Medical Orders). For all of these, one commonly documented reason was “patient refused”; for medication administration, another commonly documented reason was “no show.” These explanations imply that the patient was aware of the appointment or medication administration, that staff were prepared to execute the treatment, and that the patient chose to miss it or failed to appear. However, based on extensive interviews, chart reviews, and observation of operations over a total of total of eight days during my previous visit and the current one, it is my opinion that at times EMCF nurses (and/or other EMCF clinical staff responsible for record-keeping) document “patient refused” or “no show” even when they know that that is not the correct explanation for the missed dose.

An additional problem I identified during my walk-through of the dental clinic was a covey of patient dental x-rays loosely lying around in a tub (see Attachment 3). These were not organized in any way, and they were not filed in the EHR. Thus it is clear that these x-rays likely would not be easily found for patient care, especially if the patient were transferred to another facility.

Other examples of all of these types of deficits in documentation appear in the Case Excerpts (see Patients 2, 3, 4, 7, 18, 24, 25, 27, 28, 29, 38, 39, 40, and 43).

In summary, the medical records maintained for patients at EMCF are not complete, accurate, or clear. As such, they make it challenging to safely care for patients housed at EMCF, which in turn puts patient health at serious risk.

Section H. Failure to Obtain Informed Refusal

Many clinic visits (Section B - Lack or Delay of Access to Non-Urgent (Episodic) Care; Section C - Lack or Delay of Access to Chronic Care) and medication dose administrations (Section F - Failure to Execute and Follow-up on Medical Orders) at EMCF were cancelled with staff citing “patient refused” as the explanation. In Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs), I described that, in my opinion, some of these staff knew that the patient did not actually refuse the care, but documented that nonetheless. In a few other cases, it appears that patients did, in fact, refuse. However, those refusals were not *informed* refusals, and as such a) were not in the patients’ best interests because they may have caused the patient harm, and b) did not meet the standard of care as it relates to medical refusal.

Indeed, when a patient refuses a recommended medical intervention, health care staff have an obligation to assure that: a) the patient has the capacity to make health care decisions in their own best interests; b) understands the benefits of the intervention; c) understands the risks of refusing; and d) understands the alternatives. This must be conducted by a licensed medical professional with sufficient knowledge of the intervention and the condition for which it is being offered. Further, health care staff should seek to understand the reason for the refusal and, where possible and reasonable, find solutions that address the patient’s concerns. For example, if a patient refuses a medication because it was ordered as an injection and he/she has a fear of needles, health care staff would have an obligation to at least consider offering the medication by another route. Assuring that patients have the capacity to refuse medications is particularly relevant in an institution such as EMCF where most patients suffer from serious mental illness.

Though not immediately obvious, failure to obtain informed refusal is unsafe: Informed refusal is a variation or type of informed consent (i.e. the patient is consenting to *not* receive a recommended treatment). Consent is an accepted and mandatory part of health care. It allows a patient to choose between two or more alternatives (often a test or treatment vs. no test or treatment). As almost all tests and treatments have risks, the patient is, *de facto*, also choosing between two or more risks (i.e. harm). Barring special circumstances, such as an emergency or incapacity, weighing the relative undesirability of each harm can only be made by the patient, because that decision rests on the patient’s own values, needs, and functioning. Most patients will find one of the risks more harmful (to him) than the other. If patients are not given the information they need to make this decision (informed consent), they cannot possibly choose the less harmful option. If they choose the more harmful option by mistake, then the care was unsafe. Thus failure to provide a patient with the information to make an informed consent or refusal is inherently unsafe health care.

The following cases illustrate how staff at EMCF fail to obtain informed refusals, all with potentially serious results:

- Patient 1 failed to report for two CCC visits to manage his seizure disorder. He informed me the reason for this is that when scheduled for clinic in the afternoon (as these two visits were scheduled), he ends up sitting in the waiting area of the clinic for several hours, which he finds uncomfortable and distressing. Medical staff failed to elicit an informed refusal from the patient. Instead, they ignored the patient for three months. Had EMCF staff attempted to obtain informed refusal for the visits, as required, they would have discovered the reason and could have considered a solution, such as scheduling the patient for the morning (some of his appointments have been in the morning; he does not refuse these).
- Patient 28’s chart contains a “Refusal of Treatment” form. The entire form is blank, save for the patient’s signature. Thus it is impossible to discern what the patient was refusing. Clearly he received none of the required information to make an informed decision as this section of the form was also blank. This was not an informed refusal.

- Patient 38 fractured his foot. The patient was scheduled to go to the orthopedist, but refused. An RN spoke with the patient about this and had him sign a refusal form. While it is good that the nurse spoke with him and tried to encourage him to go, it is clear that the nurse failed to provide the patient with adequate information to make an informed refusal. The nurse's note shows that she did not inform the patient that he had a fracture, that the fracture was complicated (angulated), might not heal by itself, and, if not handled correctly, might result in lifelong disability. This was not an informed refusal.

Section I. Failure to Maintain Patient Confidentiality

A basic tenet of adequate health care is that health care is delivered confidentially. Confidentiality applies to the privacy of written communications, oral communications, and certain visualizations of the patient. The prison environment forces some limitations to this tenet, but does not eliminate it. Exceptions to confidentiality are allowed when there is a *bona fide* reason. For example, a CO may need to remain in the clinic room during an examination of a violent patient. Failure to maintain patient confidentiality not only violates patients' rights, but also puts patients at risk. Indeed, in a system where patients know that confidentiality may not be preserved, patients may demur from sharing key clinical information with staff or avoid treatment (such as treatment for HIV/AIDS) altogether; such gaps in information can result in delayed or missed diagnoses or treatment. Thus, while failure to ensure patient confidentiality violates a basic patient right, it also poses real threats to safe patient care.

At EMCF confidentiality is not always preserved, violating patients' rights as well as placing patients at risk of harm. The most common mechanism by which confidentiality is threatened is the system for accessing non-urgent episodic care. Patients fill out paper SCRs. In the isolation housing unit (Unit 5) these slips are sometimes collected by COs directly from the patient's cell. In general population housing units, patients either hand their SCR to a CO, or place it in the crack of the housing unit doorway where COs will collect it later. The COs place the SCR in a box for collection by nurses. In the isolation cell housing unit, therefore, COs can read the SCRs (in Case Excerpts, see Patients 10, 12, 13, and 14). In the general population housing units, COs can read the SCRs and other inmates can also access them while they are stuck in the door. Some patients in general population informed me that after handing the SCR to the CO, they watch the CO until the CO places it in the box. While this helps ensure confidentiality for the patients in some of the housing units where the patient are able to view the COs putting the SCRs in the box, due to the location of the box, it cannot be directly viewed from all housing units, and these patients therefore cannot know whether their SCRs are being confidentially submitted.

A less common, but particularly serious breach of confidentiality occurs with Dr. Abangan. Two different patients (Patient 32 and Patient 33) described similar experiences separated by months. In both cases, the doctor performed a rectal examination⁶ with absolutely no visual barrier to protect against other patients and custody staff viewing the exam. Both patients described that other patients were able to see the examination. In a manner parallel to other breaches of confidentiality as described above, when patients learn that medical staff at their institution will not keep their information (or exposed body) private, some will demur from seeking medical attention, fearing embarrassment more than they fear the consequences of the disease. This creates a dangerous medical situation.

⁶ In the case of Patient 32, I am only aware of the rectal examination from the patient's oral report; there is no record of it in the doctor's note. See Case Excerpts, Patient 32, for more detail.

Finally, a third type of breach of confidentiality occurs when protected medical information is somehow communicated from medical staff to custody staff and then shared – in one case widely – among other custody staff. Two examples of this were found among post-incident reports or emails (Patient 24 and Patient 66) in which the details of the patients’ symptoms, medications, and conditions were obtained and then included in the report. It is an acceptable practice, consistent with federal law, that confidential medical information be shared with custody staff if it serves a penologic need. However, in the two cases I discovered, I could not find any possible penologic need for custody staff to possess the information they possessed and disseminated.

Thus patient confidentiality is not adequately maintained at EMCF; there is no justifiable penologic justification for these gross invasions of privacy.

Section J. Failure to Have or Maintain Necessary Equipment

In my previous review I reported the lack of materials in the CCC required to measure two important parameters of health in patients with diabetes (monofilament to measure nerve damage) and asthma (mouthpieces for peak expiratory flow meter to measure adequacy of breathing). Unsurprisingly, upon review of patient charts, there was little evidence of the tests corresponding to these pieces of equipment being run (e.g. diabetes: Patient 8; documented as having asthma: Patient 25). Thus the critically important care that depends on these pieces of equipment was not being provided. The deficiency is even more troubling given the frequency of these two diseases among EMCF inmates.

Section K. Lack of an Adequate Headquarters-Based System for Monitoring the Quality of Care Delivered by the Vendor

In my last report I criticized the paucity of MDOC’s monitoring of the delivery of health care services by the vendor. MDOC’s current contract with Centurion provides for two monitoring mechanisms. First, it requires Centurion to conduct peer reviews annually and forward those to MDOC. However, there is no provision in the contract for MDOC to verify the results of peer reviews. Without evidence to support what review, if any, MDOC conducts of peer reviews conducted by the vendor, nor any evidence of how, if at all, MDOC responds to any problems thereby identified, I am unable to opine on the usefulness of the peer reviews in assuring patient safety.

Second, according to MDOC’s contract with Centurion, MDOC is supposed to monitor the care provided by the vendor. Failure to meet the compliance level is supposed to result in liquidated damages. However, there are four problems and one unknown with this monitoring:

- Under the agreement, performance is supposed to be measured on only 12 attributes of care delivery (see Attachment 4), such as “A licensed radiologist shall interpret all radiographs [x-rays] the next workday and provide written results within forty eight (48) hours after reading.” Measuring only 12 attributes of care delivery provides an extremely limited view of the totality of key health care delivery activities. For example, there is a measure for the timeliness of written reporting of x-rays, but there are no measures for the timeliness of written reporting of results of any other tests, such as blood tests, urine tests, EKGs, etc. – tests that are much more common than x-rays. As another example, there are two measures of the timeliness of dental visits for routine needs (“All newly admitted inmates shall receive a dental exam within seven (7) days of admission.”; “All inmates shall have routine dental prophylaxis no less than every two (2) years.”). However, there are no measures of the timeliness of dental visits for acute problems or planned treatment – events which are much more common and, arguably, much more clinically important.

- The time limits set for the completion of the 12 activities are quite liberal and in many clinical situations would be dangerous. For example, one measure requires that “Emergency medications are filled and administered within 24 hours of being prescribed.” While certainly no emergency medication should ever be administered more than 24 hours after ordered, most emergency medications should be administered within hours, minutes, or sometimes seconds, after being ordered. Thus the vendor could administer emergency medications dangerously long after they were clinically necessary and still be found in compliance.
- The 12 measures are all limited to the timing of health care delivery. Not a single measure addresses the clinical appropriateness of the care delivered. Thus if dental intake exams are all completed within seven days of admission, but lack important elements of the examination, the vendor would be found in compliance.
- MDOC set the bar very low for determining compliance with the measures. The vendor is considered to be in compliance if 90% of the clinical events measured fall within the time limit for the measure. In other words, health care staff can fail to provide the required care – that is, can provide inappropriate or dangerous care – 1 out of every 10 times, and still be found in compliance.
- Section 7.6 of MDOC’s contract specifies that compliance audits will be performed by MDOC. The specifics of how the audits are to be performed are contained within Exhibit F, which I did not receive. The manner in which an audit is conducted (e.g. how the sample is selected, the size of the sample, etc.) can markedly affect the quality and accuracy of the results. Without knowing these details, therefore, I am unable to opine on the usefulness of these audits in assuring patient safety.

Section L. Inhumane and Unsafe Living Conditions

EMCF is an inhumane, dangerous, and unhealthy place to live. The conditions in which individuals live at EMCF, especially in the isolation cell unit (Unit 5) are horrible. Cells and their surroundings are dirty, smelly, with paint peeling. Shower areas have thick black grime on the floor. Some cells are without lights or mattresses. The ashes of recent (and not-so-recent) fires are everywhere.

I have never visited a dog kennel that wasn’t cleaner than the living conditions I witnessed at EMCF.

In a word, the living conditions at EMCF are inhumane. Living in inhumane conditions for prolonged periods of time cannot be healthy from a mental health perspective, especially for those who are emotionally frail.

EMCF is also a dangerous place to live. Health is, in part, freedom from traumatic and environmental injury, and so EMCF is also an unhealthy place to live.

Having visited well over 100 correctional institutions in my career, I have never encountered one with as many dangers to its residents as EMCF. At every turn I observed conditions conducive to injury.

A seriously impressive threat to safety is the fires in Unit 5. Based on patient reports, and corroborated by my direct observations during this and my previous visits (a fire had just been put out in the cell I was standing next to), there is, on average, a fire a day . . . a fire once every 24 hours in

the part of the institution, which supposedly has the greatest concentration of COs, the highest level of vigilance, and the greatest degree of control. Not only do fires create an obvious threat of thermal injury, but the smoke – ever present in the air the inmates breathe (as did I) – is dangerous for patients with heart and lung conditions.

Another environmental threat I discovered in a shower I inspected was a fluorescent light fixture, mounted on the wall at head-height, with its bare electrical contacts exposed. This poses a clear risk of electrocution due to the exposed wires, a risk heightened by the presence of water and fact that inmates don't wear shoes (which are insulators) in the shower.

Surprisingly, dangers were even present in the Medical Unit. Sharp tools and instruments are dangerous items in a prison. Their presence is necessary in some parts of the prison, though, such as the kitchen, industrial shops, and clinic. However, where such items are present, they should be kept under robust security with careful control of keys to prevent theft, and meticulous inventories to detect it. During my walk through of the Dental Clinic, I discovered scores of sharp instruments (e.g. scissors, probes/picks, etc.) thrown in unlocked drawers (see Attachment 5). Additionally, there was no inventory control log for them.

The use of chemicals is also necessary for the smooth operation of parts of the prison, including the Medical Unit. Like sharp instruments, though, they also need to be maintained under tight control and monitored by careful inventorying. Instead, I observed multiple containers of cleaning and medicinal chemicals either left on countertops (Attachment 6, first panel), or stored in unlocked cabinets (Attachment 6, second panel) where they were easily accessible to inmates. The risk of harm from unsecured chemicals issues results from two mechanisms. First, in any correctional institution, chemicals, in the hands of inmates, can be used to harm other inmates. Second, and more specific to EMCF – an institution focused on care to seriously mentally ill inmates – inmates with poor impulse control or suicidal ideations can use the chemicals for self-harm.

That the risks of harm from traumatic and environmental injury is more than theoretical at EMCF is borne out by data. I reviewed the log of patients sent to the ER. In the eight month period from June 2015 to January 2016, there were 134 trips to the ER. Of these, at least⁷ 89 (64%) were for injury, or more than one injury requiring a trip to the ER every three days. These included such injuries as fractures, stabbings, burns, and rape, among others. This is a very high percentage of injuries (relative to non-trauma events).

I believe that lax custody practices contribute to the health dangers enumerated above. One of the most obvious “windows” on security practices is the manner in which visitors are screened upon entry to a prison: if good security is not practiced here, how secure can it be anywhere in the institution? In a well-run prison, security practices are a) robust, and b) consistent. I observed neither to be true during my personal visitor screenings over a four day period. On two days I was required to remove my shoes and belt; on two days I was not. On three days my briefcase, which contains myriad zippered sections, was allowed in without any visual inspection; on the fourth day every single compartment was opened and meticulously inspected. On three days I brought chewing gum with me (we had not been told it was not allowed); on the 4th day it was discovered and confiscated as contraband. On three days I brought only \$5 with me because we were told that on-person cash was limited to \$20; on one day I forgot that I had my wallet with me containing \$60, and I entered without problem.

⁷ I cite this as the minimum number because I based the count on those diagnoses that were obviously trauma-related, e.g. stab wound. I was unable to determine if any of the trips for other diagnoses, for example, shortness of breath or vomiting, may have been related to environmental factors such as fire, smoke, or chemical ingestion.

I noticed similar lax practices within the walls of the prison when entering the maximum security area (Units 5 and 6). For maximal safety, when one control door of a maximum security area is open, all other doors should be closed. Thus if a prisoner were to break free, there is a limit to the distance he can travel. On two occasions custody staff had two contiguous control doors open.

In sum, EMCF is a dangerous environment with risks of traumatic and environmental injuries to residents (and staff) due, in large part, to the endemic laxity of basic security procedures.

Conclusions

A minimally safe and adequate health care operation in a prison has systems in place to ensure that patients have timely and unimpeded access to health care services and that the health care services they access are clinically appropriate. In my review, I found that a minimally safe and adequate health care system does not exist at EMCF. The health care system at EMCF is simply incapable of meeting the serious medical needs of the inmate population, and it thereby puts the entire inmate population at EMCF at constant substantial risk of serious injury.

In all fairness, there has been some slight improvement in health care delivery since my last visit under the auspices of the new health care vendor. However, this slight movement of the needle is not nearly enough to bring EMCF's health care services into a minimally safe range.

The dysfunction in the medical care delivery system at EMCF permeates every essential aspect of the system; health care operations are broken at every level, and there is massive evidence that the health care system, as it interacts with custody, fundamentally fails to address the systematic health care needs of the prisoner population.

Furthermore, it is apparent that this extreme level of dysfunction within EMCF can exist only if the statewide oversight system is also broken. There is a paucity of oversight of health care at EMCF by MDOC. By contract, MDOC audits the care delivered by the vendor. However, the number and value of the items included in the audit are far too limited, and the performance level required of the vendor sets the bar far too low to ensure safe care. As part of the oversight function, it is the responsibility of central management at the statewide-level to detect and repair systemic problems of this magnitude which put the lives and health of prisoners in State custody at such risk. It is clear to me that MDOC (at least with regard to EMCF) is unable to detect and repair problems, that is, to learn from experience. As stated at the beginning of this report, no correctional health care operation is perfect. However, a keystone of a safe operation is that it can identify its errors and fix them. Based on contrasting the findings in my first report with those of this second report more than two years later, it is clear EMCF is incapable of self-repair.

One important and troubling example of MDOC's disregard of the need to address known failures is its allowance of the EMCF facility physician to work at the facility despite his previous termination. In her 2011 report, Ms. LaMarre described serious problems with the quality of the medical care provided by the then facility medical director, Dr. Abangan. At a certain point, his contract to provide care at EMCF was terminated. Upon return to EMCF this year, I was shocked to find that this physician has been rehired as the facility medical director. Predictably, Ms. LaMarre and I both found that the quality of his medical care continues to be abysmal and dangerous.

MDOC's imperviousness to learning and improvement is captured in a capstone case that transcends my two visits:

- During my visit on April 25, 2014, I reviewed a blood test in the record of Patient 43. The test, a platelet count, had been conducted on February 28, 2013, more than 1 year prior to my visit. The result was abnormally low, at 106,000, with normal being greater than 140,000. As noted above, low platelet counts can be the result of serious health problems that require treatment. Further, the low platelet count by itself is concerning as it can lead to difficult-to-control hemorrhaging. Thus the finding of this abnormal result required a thorough evaluation by a physician, with history questioning, examination, and possible testing focused on finding an explanation for the low platelet count. Instead, in the entire time since the results were received at EMCF – 14 months – they had not been reviewed by the physician, followed up, or investigated.

Upon discovering this unaddressed abnormality, I notified the health care manager at EMCF. Upon my return visit this year, the chart of this patient was one of those that I randomly chose to re-examine. I discovered that, despite my personally bringing this significant abnormality to the attention of the patient's health care providers at EMCF, no action whatsoever was taken on this issue *for nearly one year*: Some five months later, on September 30, 2015, the patient had a visit with the facility physician. Still the platelets were not mentioned, addressed, or the test repeated. On March 15, 2015, some six months later – almost a year after I alerted EMCF staff of the abnormal test – the physician finally ordered a repeat platelet test. It was now 103,000, i.e. still below normal. The physician signed off on the result, but took no further action.

Thus, as of July 13, 2016, almost two years after my alert to staff about a low platelet count, and despite a repeat test a year after my alert that showed the problem continuing, *no one has addressed this issue*. That this happened at all is a reflection of unsafe health care. But that this happened despite the shining of a light by an external agent (me) in an adversarial setting with the threat of litigation, is incredible and emblematic of MDOC's utter paralysis to be able to repair the serious problems it faces in health care delivery at EMCF.

With rare exceptions, the litany of serious and dangerous problems I described in my previous report continue to exist. Little has changed. EMCF health care operation is a system broken that places patients at a substantial risk of serious harm.

These opinions are offered with a reasonable degree of medical certainty, and are based on documents and evidence that are currently available to me. I reserve the right to modify or expand these opinions if additional information becomes available.



Marc F. Stern, MD, MPH

Case Excerpts

In contrast to my last review in July 2014, in which I attempted to review entire patient cases, during this review, I tended to review limited aspects of care within each case. This approach was driven in part by intent and in part by circumstances. The intent was to provide a review that was complimentary, and not necessary duplicative, of my last report, in an effort to survey specific aspects of health care delivery among a larger number of patients at EMCF. The circumstances of this review were different from the last, in that I wanted to limit the scope of review to health care delivered subsequent to my last review. Though any health care delivered after my last review is, technically, relevant to this litigation because it was delivered under the auspices of MDOC, I thought it would be more meaningful to focus on care delivered after June 2015, because that was when MDOC switched to the current health care vendor.

As a result, I do not provide a complete medical summary of the cases below. Instead I provide a focused summary of some key errors. These are indeed summaries; most cases have additional errors in care that appear only in the below sections entitled Interview or Chart Review and are not noted in the summary. There are also errors in care which I observed, but did not capture in every Case Excerpt. This occurred with generic errors which were widespread among patients, such as the failure of the medical record to contain a single, up to date, unambiguous Problem List. I have identified many of these concerns above.

For each patient I indicate a “trigger.” This is an explanation of the reason the patient came to my attention. Where the trigger is one of the logs, rosters or lists provided to me, the reasons I would have selected that patient from among all the patients therein contained is explained in the methodology section of this report. The Chart Reviews show the dates of key events. I recorded the clinical events themselves, as described in the patient’s medical record, in normal-faced type. In italics, I describe the problem or problems with the care delivered during that event along with the reason the care is problematic if it is not obvious. Finally, at the end of each excerpt, I recap the key deficiencies in care and categorize it according to the table at the beginning of this report.

Patient 1

Housing Unit 4

Trigger: Quarterly CCC Lists

Interview

I interviewed this patient on July 13, 2016 due to a recorded refusal of an NP visit for a CCC to address his seizure disorder on August 16, 2015 and September 13, 2015, and then no attempted visit again until December 23, 2015 when he was seen.

According to the patient, he did indeed refuse these appointments because when they call him down, especially if it's later in the day, he may sit in clinic for 2-4 hours waiting to be seen, and he doesn't tolerate that well. No one obtained an informed refusal for these two missed appointments, and they did not attempt to summon him to clinic again until the December 23, 2015 appointment. He asked to stop his medications earlier this year due to the fact that he believes they led to his "dying" six times. After conversation with Dr. Abangan, the doctor stopped them.

He reported that it is difficult to get urgent access to care. When he has had seizures, he cannot get assistance; other inmates have to "beat, beat, beat and kick on the door to try to get the attention of COs."

He also reports difficulty with continuity of medications. When he was on seizure medications, from time to time the nurses ran out of the medication for 2-3 days.

Chart Review

I reviewed Patient 1's chart to verify his report of missed medications. In August 2015, nurses failed to administer his seizure medication on three days. He received all doses in September, October, and December of 2015, but NO doses in all of November, one missed dose in January 2016, and all doses in February until the medication was stopped.

His chart also reveals that he informed the doctor that he had not been taking his medications for a year and his Dilantin levels were undetectable, so, since the patient had not had a seizure in a year (essentially off medications) the doctor discontinued the medication. This may have been a reasonable decision.

Summary of Problems**Section A (Lack of Access to Urgent Care)**

Patients have difficulty accessing urgent care due to the unresponsiveness of custody staff. This patient has seizures, and when he does, other inmates have to beat and kick on doors to try to get attention, which is not immediate.

Section F (Failure to Execute and Follow-up on Medical Orders)

The facility runs out of medications or fails to deliver them. Nurses failed to provide this patient with his seizure medications on numerous occasions, including a stretch of a whole month.

Section H (Failure to Obtain Informed Refusal)

When failing to report for a clinic visit to address a serious health need, medical staff failed to elicit an informed refusal from the patient. Instead, they ignored the patient for three months. Attempting to obtain an informed refusal might have led the staff to understanding the reason for his no-show and given them the opportunity to either remedy the situation or confirm that the patient understood the risks associated with his refusal.

Patient 2

Housing Unit 1

Trigger: CCC Roster

Interview

I interviewed this patient on July 13, 2016 because the visit logs show that he refused a chronic care visit for hypertension on February 25, 2016.

According to the patient, he has never refused going to medical clinic for an appointment.

Summary of Problems

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs); Section C (Lack or Delay of Access to Chronic Care)

The CCC visit log falsely indicates that the patient refused an important clinical appointment.

Instead, he was never notified and was not escorted to the clinic.

Patient 3

Housing Unit 4

Trigger: CCC Roster

Interview

I interviewed this patient on July 13, 2016 because records showed that he refused a CCC appointment on April 25, 2016. He stated he has hypertension, asthma, COPD, and borderline diabetes. According to his records, he refused an appointment on April 25, 2016. According to the patient, he definitely did not refuse to attend clinic on that date; they just didn't call him down.

The patient also stated that he has problems getting his medications. When he reports to the medication nurse, they inform him that he has no medications left. In the past year this has happened twice. Each time it has taken 7-10 days for the medications to appear, during which time he is without medications.

He has a panic button in his cell. However, "half the time it doesn't work." A month ago, a patient had a seizure in the cell next to his. Despite he and others pressing on their panic buttons, but no one responded until the inmates banged on the doors. The response time was about 10 minutes.

Chart Review

I reviewed the chart looking at MARs for August and September of 2015. He received both his medications for hypertension in August. However, in September, he was not given any medications for the first 17 days of the month.

Summary of Problems**Section A (Lack of Access to Urgent Care)**

Patients are unable to communicate urgent medical needs to custody officers in the housing unit. When a fellow inmate had a seizure, the panic buttons did not work, so inmates resorted to banging on doors. It took 10 minutes for staff to respond. This is too long a response time and can result in death. While many seizures resolve on their own, some require prompt medical assistance to prevent or treat complications. Further, some serious conditions, like cardiac arrest, can initially appear to be seizures, and for these conditions, a 10 minute delay in response can be a death sentence.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs); Section C (Lack or Delay of Access to Chronic Care)

The CCC visit log falsely indicates that this patient refused an important clinical appointment. Instead, he was never notified and was not escorted to the clinic.

Section F (Failure to Execute and Follow-up on Medical Orders)

Staff failed to provide this patient's hypertension medications. On one occasion, EMCF ran out of the medication for more than half the month.

Patient 4

Housing Unit 6

Trigger: CCC Roster

Interview

I interviewed this patient on July 13, 2016 because the CCC roster shows that he refused a visit on June 25, 2016.

The patient told me that he is enrolled in clinic for hypertension and did not refuse a visit on June 25, 2016.

Summary of Problems

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs); Section C (Lack or Delay of Access to Chronic Care)

The CCC visit log falsely indicates that the patient refused an important clinical appointment. Instead, he was never notified and was not escorted to the clinic.

Patient 5

Housing Unit: Not Available

Trigger: Patient Reviewed in First Report

Chart Review

This is a 44 year old Native American male with a diabetes, severely damaged liver due to hepatitis C, and depression.

January 2, 2015 Lab report shows platelet count of 74,000 (normal 144,000-400,000)

May 7, 2015 Lab report shows platelet count of 56,000

The preceding events occurred prior to the arrival of the new health care vendor.

July 1-27, 2015 The patient did not receive his insulin at all during this period of time.

August 2, 2015 Lab report shows platelet count of 33,000
 This report shows a rapid and potentially dangerous drop in the patient's platelet count. This critical lab result was not reviewed by a practitioner until October 2, 2015, two months later, so no clinical action was taken at EMCF prior to his transfer.
Platelets are blood cells which are important to help a person's blood clot when they are injured. A number of diseases can cause this, e.g. cancer, so failure to look for and treat the cause can lead to serious health problems. Further, until the underlying cause is found, failure to recognize the bleed risk and take steps to prevent trauma or bleeding can be harmful, if not fatal. Finally, when critically abnormal test results are reported back to the ordering physician, they should be reviewed immediately. Sometimes the laboratory will phone the facility as soon as the results are ready. But as a safety measure in the event they do not, a minimally competent health care system will ensure that all test results are reviewed within a few days of receipt. Clearly this did not happen at EMCF.

August 25, 2015 The patient submitted an SCR for medications and some illegible complaints. He was not seen by a nurse until August 31, 2015, six days later. The nurse referred him to a practitioner. As of September 3, 2015, the date of his transfer out of EMCF, he had not seen a practitioner, and the low platelet count had not yet been addressed.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

Care in response to a written request for medications and other health care by this patient was delayed beyond a safe time period (six days).

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

My previous report highlighted problems with poor clinical judgment applied to this patient's serious medical needs, and resultant poor care. This has continued. Despite seriously to critically low levels of platelets reported on three different occasions, medical staff ignored this problem.

Section F (Failure to Execute and Follow-up on Medical Orders)

Medical staff failed to provide life-sustaining insulin injections to this patient over a half-month period.

Section F (Failure to Execute and Follow-up on Medical Orders)

Medical failed to review a lab report for two months after it was reported back to EMCF. The result was critically abnormal, and failure to act on it might have resulted in hemorrhage, serious harm, and death.

Patient 6

Housing Unit 4

Trigger: Sick Call Request Log

Chart Review

This patient has a history of hypertension, hypercholesterolemia, and bipolar disorder.

- December 22, 2015 The patient submitted an SCR for “motrium.”
- December 23, 2015 RN visit. The nurse noted “both lower leg is [sic] huge and tight.” The patient was referred to a practitioner.
- December 29, 2015 NP visit. His legs were found to have mild edema due to tight socks.
In the absence of a benign explanation for what the nurse thought was marked edema, the patient should have been seen by the NP much sooner than six days hence.
- January 15, 2016 RN visit. The patient was complaining of stomach cramping. The entirety of the clinical history elicited by the nurse was “holding stomach moaning c/o stomach cramping.” His vital signs were normal. The entirety of the nursing examination was “bowel sounds active in all four quadrants and soft to touch c/o been throwing up.” Based on this, her diagnosis was constipation, for which she ordered a single dose of milk of magnesia and increased fluids, without any planned follow-up or education.
This complaint required a careful and comprehensive review of related history, e.g. Where was the cramping? When did it start? Has it ever happened before? What makes it better/worse? Is there any history of perforated or bleeding ulcers? Is the patient able to keep fluids down? etc. The complaint also required further examination, e.g. examination for any masses in the abdomen, evaluation of the patient’s skin color, performance of a special set of vital signs (“orthostatic”) to check for dehydration, etc. The nurse failed to do any of this, which was dangerous and risked delaying discovery and treatment of an accurate diagnosis.
- January 16, 2016 LPN visit. The patient presented to the clinic at 03:00 complaining of stomach pain. His vital signs were normal. The only other clinical history taken by the nurse was “Stated that what was wrong with him could be cured with a good woman. States he has been hurting for three years.” The LPN, acting independently, did nothing further. Later that day he grabbed an officer and attempted to kiss her. When seen by a psychiatric practitioner, it was determined that he was in a manic state. It is likely he was in that state earlier in the day, and it was missed by the LPN.
- January 27, 2016 I reviewed this chart due to a clinic visit on this day which was cancelled due to custody transport issue. According to the chart, the patient was seen by a nurse on January 28, 2016.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

The patient’s referral from a nurse to a practitioner took six days. Given the nature of the problem (marked edema of the legs), this delay in care was potentially dangerous.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

The clinical evaluation of this patient by an RN on January 15, 2016 for stomach cramps was wholly inadequate, below the standard of care, and potentially dangerous.

The clinical evaluation of this patient by an LPN the following day was not only also wholly inadequate, it was also something that was beyond the LPN's legal scope of practice. Further, this failure may have resulted in an assault on a CO later in the day. Indeed, the patient's clinically inappropriate utterings to the LPN earlier in the day may have been a clue to his manic mental state. Had the clinical evaluation been performed by a competent and legally qualified health care professional, that professional may have recognized the behavior as such and arranged for urgent intervention by a mental health expert, possibly averting the officer assault.

Patient 7

Housing Unit 3

Trigger: ER Log; Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 and representatives from SPLC re-interviewed him on July 29, 2016 and September 15, 2016, at my request, to clarify some details. He stated he has a history of heart artery blockages (5 coronary artery bypass grafts). Thus he has very significant heart disease and is also very familiar with his own body's warning symptoms. He reported that on Saturday (according to my medical record review, this was probably Friday, January 22, 2016) he began experiencing chest pressure with pain radiating from his chest into his shoulder and difficulty breathing. The patient immediately attempted to notify a CO by pushing his panic alarm button. No one responded. About 45 minutes later, when a CO was making a scheduled round, he informed this CO who promptly took him (walking) to the clinic. In the clinic he informed two nurses of his symptoms, which he advised them were similar to symptoms he previously had that led to heart surgery. The nurses disagreed with him that the symptoms had anything to do with his heart, told him he was experiencing acid reflux, gave him Maalox, sent him back to his housing unit, and told him to fill out a SCR. On Sunday he was summoned to the clinic and saw a nurse practitioner. She was concerned that his heart was the cause of the pain, and ordered a pain shot, electrocardiogram (EKG), blood tests (including "CPK," a test which measures any leakage from damaged heart tissue), and aspirin. The EKG and CPK are two key initial tests used by medical practitioners to determine whether a patient is having a heart attack. They are simple and quick, and if either or both is positive, a patient then immediately receives the emergency care necessary to treat the heart attack. Aspirin is given to patients as soon as one suspects they are having a heart attack, not for pain relief, but because aspirin has unique chemical qualities that helps thin the blood and restore some of the impaired circulation causing the heart attack; this pharmacological property of aspirin is not shared by other pain medication. The patient did receive the pain shot (which relieved some of the pain). However, the EKG was not performed because the machine was broken, the patient received Tylenol instead of aspirin, and did not receive the blood tests because there are only drawn on weekdays. The following day he was finally sent to the ER where he was admitted and a stent placed in an artery of his heart.

Chart Review

January 22, 2016	The patient had chest pain. Indirect evidence (and the patient's report) indicates he was seen in the clinic and given an antacid, but there is no clinical documentation of the visit in the EHR.
January 23, 2016	The patient submitted an SCR which was triaged on January 24, 2016.
January 24, 2016	11:52 AM. He was seen by an NP. His blood pressure was normal (112/84), but his heart rate was elevated (111). The NP's impression was "atypical chest pain." The order set she wrote was: <ol style="list-style-type: none"> 1. EKG now 2. Aspirin 325 mg by mouth (i.e. swallowed) now <i>This is the wrong dose and wrong route for this situation – the dose is 81 mg. More importantly, because of the need for immediate effect, the aspirin is supposed to be chewed, not swallowed.</i> 3. Nitroglycerin now and every five minutes for pain 4. Cardiac enzymes (blood tests to test for cardiac damage), stat call results to provider 5. Toradol (a pain medication) intramuscularly now

6. Milk of Magnesia now

“Follow up MD in AM, for worsening in condition, please sent to ER”

At 20:46 an RN documented that the EKG had been ordered, but staff were “unable to obtain result,” and the order for nitroglycerin had not been carried out because the medication was “not here at this time.” Also, the order for a stat cardiac enzyme blood test was not carried out. The nurse contacted the health care administrator who informed the nurse to send the patient to the ER if he had any chest pain. No plan was made to monitor the patient or place him in housing closer to the nurses. The patient remained in EMCF and was still alive the following morning.

This entire clinical plan is best described as dysfunctional. First, given this patient’s very significant cardiac history and his familiarity with his own symptoms, “atypical chest pain” (implying that the chest pain was from some benign cause other than heart damage) should be a diagnosis arrived at cautiously after the more serious causes have been reliably ruled out, not initially. Second, given the high likelihood that this patient was having an acute cardiac event, he should have been immediately evacuated to the hospital. However, if he wasn’t, then at a minimum, he required close constant monitoring. This was not provided. Third, if the NP was concerned that the patient might be having an acute cardiac event, she needed to assure that the tests she ordered were performed. She should have been standing at the patient’s bedside, waiting for the results of his EKG to be handed to her, and waiting to see the clinical results of administration of nitroglycerin. Instead, she apparently went on to other activities, effectively abandoning the patient. Third, she made a number of errors in prescribing medications. In addition to the aspirin error described above, an intramuscular injection should be avoided in this situation because the damage it causes to muscles interferes with initial interpretation of the stat blood tests she ordered to measure damage to the muscle of the heart.

January 25, 2016

09:46 AM. MD visit. The patient’s blood pressure was now low (98/79) and his heart was racing more than it had been the day before (124). The doctor ordered blood tests but apparently simultaneously ordered the patient to be sent to the ER. There is no nursing note indicating that the patient was actually sent to the ER, how he was sent, with what information he was sent, what contact was made with the ER doctors and nurses, etc. The transportation log shows that the patient was sent to the ER by van.

This patient was very unstable at this point and at risk for experiencing cardiac arrest at any moment. The decision to transport him to the hospital by van, rather than ambulance was ludicrous and dangerous.

January 25, 2016

In ER at Rush hospital. He was found to have an acute myocardial infarction (heart attack; inferior ST elevation with reciprocal precordial ST depression). He received an emergency PTCA (percutaneous transluminal coronary angioplasty - “roto-rooter” of his coronary arteries) and stent placement due to total blockage of a heart artery (LAD).

The LAD is the largest artery supplying blood to the heart, thus a blockage of this artery has a high likelihood of causing serious damage, including death.

In summary, and as discussed above, this is a patient with an extensive history of serious cardiac disease, who complained of chest pain. When complaining of chest pain, he was walked to the clinic (rather than being transported by wheelchair, or having medical staff respond to his housing unit), which was dangerous (Section E – Failure to Use Sound Judgment). There, a nurse misdiagnosed his condition (Section E – Failure to Use Sound Judgment) and did not document the interaction (Section G - Failure to Maintain an Adequate Medical Record and Accurate Logs). When he was finally seen by an NP, the practitioner, suspecting the patient might be having a heart attack, was grossly incompetent by failing to send the patient to the ER, mis-ordering aspirin, failing to follow up on the patient's condition, and failing to arrange for monitoring of the patient overnight (Section E – Failure to Use Sound Judgment). Nurses failed to follow critically important orders, such as obtaining an EKG, giving nitroglycerin and obtaining blood tests, giving aspirin (instead giving Tylenol which lacks any of the cardio-protective qualities of aspirin), and then failing to notify the prescriber that her orders were not completed (Section E – Failure to Use Sound Judgment, Section F - Failure to Execute and Follow-up on Medical Orders, Section J - Failure to Have or Maintain Necessary Equipment). The health care manager, when informed of staff's inability to complete certain medical orders, failed to notify the ordering practitioner or instruct that the patient be sent to the ER (Section E). Finally, when the physician examined the patient in the morning and found his blood pressure had dropped and his heart was racing, he failed to order the patient transported to the ER emergently by ambulance (rather than van) (Section E).

That the above patient did not die at the hands of EMCF staff over the three day course of what turned out to be an evolving heart attack is truly remarkable.

Patient 8

Housing Unit 4

Trigger: Hospital Admission Log; Death

Chart Review

This patient had a history of bipolar disorder, back pain, Type 2 diabetes, asthma, hypertension, antisocial personality disorder, and “malingering.” He had been housed at EMCF since at least 2009.

November 22, 2015 CCC visit. The NP documented that the patient had his annual diabetic foot screening during this visit, but there is no evidence this was performed and there are no results.

Patients with diabetes have a high risk of developing foot ulcers, which in turn can lead to amputations. Knowledge of the individual patient’s level or risk (by foot screening) can help inform a preventive program.

The NP documented a plan for an annual dilated eye exam, however, that was not performed. In fact, the patient’s last annual dilated eye exam, required in patients with diabetes, was July 25, 2011.

Patients with diabetes also have a high risk of retinal damage leading to blindness, so the standard of care requires that they receive specialized annual eye examinations.

December 2015 During this month, nurses failed to administer the evening dose of one of the patient’s blood pressure medications on eight separate days, the daily dose of one of his other blood pressure medications on two separate days, and 10 doses of his diabetic medications, all without explanation.

January 8, 2016 An MAR is filed as a Medical Segregation form in the EHR.

January 24, 2016 12:25. NP visit. The NP saw this patient at this time at the request of nurses who said he was acting strangely and had acute urinary incontinence. The NP obtained a history and performed a physical examination. The patient’s blood pressure had been elevated (165/110) two hours earlier, but had come down to 160/100. The NP found that he was awake, alert and oriented x 3, but “seems to take focused, concentrated effort, and responses seemed to be delayed at times.” There was bilateral leg weakness. The nurse did not perform any more of a neurologic examination. She concluded the patient had uncontrolled blood pressure and ordered clonidine 0.1 mg and for a repeat in 30 minutes if the blood pressure was still over 150/90. The NP’s documentation is very unclear as to what care/medications were administered when. At some point (I could not determine when) she decided to send the patient to the ER for evaluation of possible stroke or seizure. He was sent by ambulance.

The care the NP provided during this encounter was deficient and dangerous. Simple benign elevation of a person’s blood pressure does not cause them to become incontinent nor have changes in mental status. Thus the NP’s plan to see if control of the patient’s blood pressure resolved the issue was wrong. This patient’s clinical presentation raised the possibility of serious medical conditions (including stroke and seizure, as well as other problems) for which the patient required urgent evaluation. If the patient was having a stroke, for example, every minute between the onset of symptoms and treatment in the ER counts (hence the axiom “time is brain”). Thus if the patient were indeed

having a stroke, the NP's delay to of even 30 minutes would have increased the change of brain tissue damage.

January 24, 2016 20:15. The patient returned from the ER. Nurses failed to contact the facility physician to share the results of the visit and seek any immediate management instructions, and instead planned for the physician to see him the following day.

January 25, 2016 The doctor ordered a change in medication, but there is no evidence the physician actually personally evaluated the patient. The patient was not cooperating with measurement of his blood pressure.
Such evaluation was necessary because the case was not straightforward and a clear diagnosis had not yet been made. Further, the patient's lack of cooperation with vital signs may have been a manifestation of his altered mental status, which made hands-on physician evaluation even more important.

There is also no evidence of further planned follow up. No further blood pressures were measured after the pre-ER measurement on January 24, 2016 until the patient's death on January 29, 2016.

At a minimum, this patient required periodic rechecks by a nurse, including re-measurement of his blood pressure. Indeed an elevated blood pressure was one of the key abnormalities at the outset of this event, so the doctor and nurses needed to make a concerted effort to figure out how this could be measured in the face of the patient's lack of cooperation (up to and including returning the patient to the community hospital).

January 29, 2016 [In randomly conducting interviews on a housing unit, I happen to interview a patient who informed me he had been this patient's roommate and recounted the following events of the night prior to the roommate's death.]

The roommate related that around 01:00 he noticed the patient on the floor, staring into space. He was unable to get the patient to respond to his questions. He had defecated and urinated on himself. The roommate tried, but could not get the attention of COs. Finally, during the 02:00 count when an officer came around, he informed the CO of the situation and the need for medical assistance. That CO brought another (supervising?) officer to the cell who said "those damned drugs" and left. The roommate did not observe the COs to take any other action. At 07:00 the unit supervisor came to the cell, noted the condition of the individual, and instituted an emergency response. The patient was noted by nurses to have a decreased level of consciousness and generalized weakness and was sent to the ER.

At 13:29⁸ he returned from the ER with a possible diagnosis of seizure and a recommendation for observation in the Medical Unit. There is no documentation from the ER, so I was unable to determine from where this diagnosis and recommendation emanated. The patient was placed in the

⁸ The times stated in this paragraph are based on the patient's medical record. They differ from those recorded in an email generated by custody staff (contained in Defendant's document DEF_ESI.0006216), but these differences are not material to my report.

Infirmery. There is no evidence that nurses discussed the case with the doctor nor that the doctor examined the patient at any point. Thus there are no orders for the nurses to conduct any periodic evaluation/monitoring of the patient, nor is there any evidence that nurses did so between his return from the ER in the early afternoon, and his discovery moribund at 17:39. At 17:39 nurses discovered the patient “lying head down toward floor with head between legs at bedside” without a pulse. CPR was begun, and he died later in the hospital.

Summary of Problems

Section A (Lack of Access to Urgent Care)

The lack of a reliable mechanism for inmates to notify custody staff of a medical emergency, coupled with custody staff’s callousness and intentional disregard of this patient’s condition on January 29, 2016 illustrates the lack of access to urgent care at EMCF.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Over the course of more than four years of chronic care for diabetes, including numerous dedicated chronic care visits, staff at EMCF have consistently failed to order one of the basic and routine preventive interventions to prevent blindness in patients with diabetes: an annual dilated eye exam. Such a failure not only reflects on either the poor skill or lack of comprehensiveness of the EMCF clinicians, but also underscores the poor quality of the portion of MDOC’s EHR designed – theoretically – to help clinicians safely manage patients with diabetes.

Each of the medical professionals described above who cared for the patient, from the time he first manifest symptoms on January 25, 2016 until he was found dead in his cell on January 29, 2016, failed to demonstrate a minimally acceptable level of competence. The NP who cared for this patient’s urgent condition on January 24, 2016 and failed to conduct an adequate evaluation of the patient’s incontinence and change in mental status, and delayed evacuation to the ER, failed to use sound clinical judgment. The nurse who received the patient back from the ER on the same day, also used poor judgment in not informing the on-call physician of the patient’s return and seeking instructions for overnight management and monitoring. The doctor failed to clinically evaluate his patient and compose a thoughtful and safe care plan. Most of these errors were repeated by other staff when the patient returned from the ER again on January 29, 2016. ER staff were unable to make a definitive diagnosis (they thought, possibly, he had had a seizure), so made a recommendation that he be monitored by EMCF medical staff. The patient returned without any medical records from the ER, and EMCF nursing staff perpetuated this error by failing to make any attempt to obtain them. Thus they cared for this patient in a relative information vacuum. The nursing staff also failed to contact the prison physician to discuss the patient’s care and obtain instructions. They did place the patient in the Infirmery, but for the four hours from when Patient 8 returned from the ER, until he was found dead on the floor, no monitoring took place. By failing to further monitor this sick patient after his return from the ER, EMCF medical staff went beyond the use of poor judgment – they essentially abandoned their patient.

In the absence of any medical records from the ER, any clinical evaluations from the nurses upon his return, or an autopsy report, I could not determine Patient 8’s cause of death or whether anything medical staff might have done differently could have saved his life. However, the fact set suggests that any chance of his surviving was squandered by EMCF’s medical staff’s failure to obtain critical information about his evaluation in the ER and failure to follow the ER physician’s recommendation to monitor this patient upon his return.

Section F (Failure to Execute and Follow-up on Medical Orders)

Nurses failed to administer numerous doses of this patient's ordered hypertension medications.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

An MAR was electronically filed as another type of document, so would not easily be retrievable if a medical professional had been looking for information it contained.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

The EHR's electronic templates associated with chronic disease management are very poorly designed, making it very difficult to read and interpret what care was provided during a visit. The NP documented that a diabetic foot exam was conducted, but the results are missing. I was unable to determine whether this misinformation was intentional on the part of the NP or a side effect of the ineffective system for documenting chronic disease care.

Patient 9

Housing Unit: Not Available

Trigger: Hospital Admission Log; Death

Chart Review

This patient had a history of depression, diabetes, and hypertension and had been housed at EMCF since at least September 27, 2013.

- May 31, 2015 The patient was seen in CCC for hypertension and diabetes. A diabetic foot exam was conducted and documented. He was not scheduled for required annual diabetic eye examination, nor is there any evidence this was conducted at any time between 2013 and his death. His hemoglobin A1c, a measure of diabetes, was elevated (7.8) and rising (it had been 7.4 in April 2015). *Despite this data, his diabetes control was rated as "improved" and no improvements were made to his insulin regimen, which the lab data indicated was needed.*
- July 2015 During the first 23 days of this month (the time he was at the facility), the patient received 17 of 46 (one dose each of insulin in the morning and evening) scheduled doses of his insulin. On the day prior to his evacuation to the ER, he received no doses of either his morning or evening insulin.
- July 24, 2015 The patient complained of shortness of breath, diarrhea, fever for two days, chest pain, and loss of appetite. The LPN called the NP who ordered the patient sent to the ER. He was transported by ambulance. In the hospital he was found to have had a heart attack with pulmonary edema, and died.

Summary of Problems**Section C (Lack or Delay of Access to Chronic Care)**

Over a period of more than two years, the patient was never provided access to annual eye examinations which are required by national standards to help prevent blindness due to diabetes.

Section D (Failure to Provide Adequate Care in Infirmary)

Practitioners caring for this patient failed to properly manage his diabetes (failed to adjust his therapy when his blood sugar was rising, and failed to arrange for him to have his annual eye exam over a two year before his death).

Section F (Failure to Execute and Follow-up on Medical Orders)

EMCF nurse often failed to administer insulin to the patient as ordered.

The care provided to this patient by EMCF medical staff for his diabetes was below a minimally acceptable standard.

Patient 10

Housing Unit 3

Trigger: Patient Interviewed During Walk Through

Interview

This patient reported that COs sometimes run out of SCR slips for a few days. He gives the SCR to the CO and watches him/her place it in the medical box. He is usually seen the next day after submitting the SCR.

Summary of Problems

Section I (Failure to Maintain Patient Confidentiality)

Though this particular patient's confidentiality is not threatened by the SCR hand-off system, his statement corroborates the description of the hand-off system, a system that for many other patients, does not protect their confidential information.

Patient 11

Housing Unit 3

Trigger: Patient Interviewed During Walk Through

Interview

This patient reported that COs sometimes run out of SCR slips. He gives the SCR to the CO. It takes 2-3 days to be seen.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

The patient's report corroborates the periodic lack of SCR slips, which constitutes a barrier to access to non-urgent episodic care.

Patient 12

Housing Unit 3

Trigger: Patient Interviewed During Walk Through

Interview

This patient reported that he has never had a problem obtaining SCR slips. He leaves them in the crack of the cell block door where they are picked up by COs. There is no delay being seen and no missed medications.

Summary of Problems

Section I (Failure to Maintain Patient Confidentiality)

This patient's statement corroborates the description of the SCR hand-off system, a system that does not protect patients' confidential information.

Patient 13

Housing Unit 3

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016. He informed me that COs run out of SCR's every month for 3-4 days. When submitting an SCR, he hands it to the CO and then watches the CO place it in the medical box. He reported that it usually takes four days to be seen after submitting an SCR.

Emergency responses are rapid.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

The patient's report corroborates the periodic lack of SCR slips, which constitutes a barrier to access to non-urgent episodic care.

Section I (Failure to Maintain Patient Confidentiality)

Though this particular patient's confidentiality is not threatened by the SCR hand-off system, his statement corroborates the description of the hand-off system, a system that for many other patients, does not protect their confidential information.

Patient 14

Housing Unit 3

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016. He has been at EMCF for 1 year. He has hypertension.

When he writes an SCR he leaves it in the crack of the cell block door where they are picked up by a CO who will place it in the medical box. It takes a couple of days to be seen.

Summary of Problems

Section I (Failure to Maintain Patient Confidentiality)

This patient's statement corroborates the description of the SCR hand-off system, a system that does not protect patients' confidential information.

Patient 15

Intake Unit

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. He was currently housed in the Intake Unit. He was on suicide watch, but was placed there because beds in the Infirmary were full.

I noted that he was in a cell without a mattress, blankets, or any way to keep warm.

He was being checked (and custody staff confirmed this) every 15 minutes, exactly.

The standard of care is random intervals of no greater than 15 minutes. Random intervals are used so that the patient cannot predict when staff will check on him, and thus make planning a suicide more difficult.

Further, his cell record showed that he had not been checked by a medical staff member for a welfare check for three days. Such checks are required for patients in these kinds of isolation cells.

Finally, by my observation, the area was devoid of a CO posted there (and the patient reported that this is not unusual). There is a CO who comes through periodically.

As this cell was being used as a de facto medical care bed, patients need to be within sound and sight of staff. This requirement exists so that patients can get the attention of medical staff in an emergency. Clearly patients kept in the Intake Unit cannot do so.

Summary of Problems

Section A (Lack of Access to Urgent Care); Section D (Failure to Provide Adequate Care in Infirmary)

This patient required the level of care that is delivered in an infirmary, but instead was being housed in an area where that level of care cannot be (and was not being) provided, putting the patient at risk.

Section L (Inhumane and Unsafe Living Conditions)

This patient was being housed for an extended period of time (days) in the Intake Unit, which is intended to house inmates short-term (hours). The lack of mattress, blanket, and other typical amenities of medium- to long-term housing unit makes the conditions under which this patient was being housed inhumane.

Patient 16

Housing Unit 5

Trigger: ER Transport Log; Quarterly CCC Lists; Sick Call Log

Interview

I interviewed this patient on July 13, 2016 because, among other triggers, the CCC roster shows that he no-showed for clinic on December 9, 2015 and December 14, 2015. The patient reported to me that he did not refuse to go to clinic during this period of time.

The patient also reported that he had a hand injury and was told by the doctor that he'd be seen again three weeks hence, but had not yet been seen in follow-up.

Chart Review

- December 6, 2015 An LPN noted that the patient submitted an SCR (I could find no such document filed in his chart) that he was concerned about his blood pressure. Without even checking his blood pressure, the LPN, acting independently, ordered him to have his pressure checked daily for 5 days and then see the doctor. Even this illegal order was not followed: he had no blood pressure measured on December 7, 2015 or December 11, 2015.
- December 8, 2015 At 21:36 an RN noted that the patient had "unstable vital signs; dizziness, nausea, diarrhea." There is no record of the nurse conducting any further history or examination or discussing the situation with a practitioner, but sent the patient to the ER by van rather than ambulance, which was dangerous if his vital signs and condition was unstable. Upon return from the ER, the patient was received by an LPN, who, acting independently, failed to conduct any examination, did not receive or seek a report from the ER (beyond patient discharge papers), did not contact a practitioner, and ordered the patient admitted to the Infirmary for examination by the doctor in the morning.
- December 9, 2015 The patient had a scheduled appointment in the CCC. He was, on this day, an inpatient in the Infirmary. Staff marked him as "no show" for his clinic appointment.
- December 27, 2015 The patient was involved in an altercation. He was examined by an LPN, practicing independently, who found his right hand visibly swollen. She treated him with an ice pack and ibuprofen and referred him to the doctor "for placement on the x-ray list." The order for medications was not signed by anyone above her until four days later, yet the patient got the medication. The patient's fracture was not immobilized. An x-ray was done, but there is no evidence of an order from a practitioner, so it appears to be have been done based on the LPN's order. The patient was not seen by Dr. Abangan until December 30, 2015. He noted an angulated fracture of the patient's 3rd metacarpal bone of his right hand. The doctor failed to immobilize it even at this point. Beyond ordering more ice and ibuprofen, the doctor ignored the injury.
- A fracture of a key bone in the middle of a person's right hand has important implications for future function of the hand. The fact that the fracture was angulated means that it required a manipulation (straightening by a surgeon) before casting to ensure proper healing and function. This cannot be easily*

done once the bone has started to heal on its own. Thus this error increased the chance that the patient's hand will not function normally in the future.

June, 2016

The patient submitted an SCR on June 15, 2016 for a problem with his blood pressure. He was seen on June 16, 2016 by the nurse and referred to the doctor for further care. He was seen by Dr. Abangan on June 20, 2016. The doctor's diagnosis was that the patient was not compliant with medication treatment. However, the medication record for June, for example, shows that nurses did not administer his three blood pressure medications on nine of the 30 days for medication 1, 11 of 30 days for medication 2, and 11 of 30 days for medication 3.

Though marked "no show" there was no indication by the nurse that the patient knew that pill line was going on nor any documentation that the nurse spoke with the patient and he made an informed decision to refuse his medications. Further, even if the doctor believed the patient was not compliant, he had a duty to explore the reasons for this and attempt to resolve it. For example, certain medications have side effects which can be relieved by switching to a different agent.

June 14, 2016

At 20:00 the patient's blood sugar was 52. An LPN gave him an injection of glucagon. There is no indication of any further examination or report to an RN. In the absence of symptoms this was unnecessary and harmful, and in the absence of further examination and follow up was dangerous, including independent practice by the LPN. At 14:50 he was brought again to the clinic for a low blood sugar of 59. He was again evaluated by an LPN, independently, who decided to give him insulin, food, and oral glucose. At 23:30 he collapsed in the hallway and was thought to be hypoglycemic by an RN who administered "glucagon gel" (there is no such medication) at 23:30 and a glucagon injection at 23:48. The documentation is very poor, so it is difficult to discern the patient's blood sugars or why oral and then injected medication was necessary.

Glucagon is an "emergency medication" used for patients with critically low blood sugars whose mental status or level of consciousness is so impaired that oral sugar cannot be given. Thus its use defines a medical emergency which must be followed up with highly qualified post-emergency care. No such care was provided. Further, despite these multiple serious problems with his blood sugar, his care was managed by personnel not licensed to do so, and a practitioner was never involved to try to figure out why these dangerous events were happening and what to do to prevent further episodes.

Summary of Problems

Section C (Lack or Delay of Access to Chronic Care)

At the time this patient was scheduled to appear for an appointment in CCC, he was in an Infirmary bed (10 paces away) for an acute problem. That medical staff a) could not or would not figure out that the patient was already in the medical area, and b) blithely documented that the patient elected to no-show for his appointment is emblematic of lack of slip-shot nature of the medical care delivered at EMCF.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

This one case is replete with example after example of EMCF medical personnel making serious errors, some life-threatening, others just potentially disabling. Multiple LPNs made assessments, ordered tests, and provided treatments incompetently and outside of their legal scope of practice. The patient's collapse from low blood sugar (a potentially lethal event) on June 14, 2016 was not wholly unexpected given the problems he was having with maintaining a normal blood sugar earlier in the day, events which were mis-managed by medical staff unlicensed to manage the situation. An RN demonstrated exceedingly poor clinical judgment by sending a patient she described as having unstable vital signs to the ER by van instead of ambulance. Finally, that the doctor did not immobilize the patient's fractured hand and refer him for reduction and casting of the fracture by a qualified physician is reflection of either a level of skill below that of a 3rd year medical student, or a wanton lack of caring.

Section F (Failure to Execute and Follow-up on Medical Orders)

EMCF medical staff clearly demonstrated in this patient's case their inability to provide the most basic of health care needs: medications. In the one month I examined, nurses only managed to administer 66% of the blood pressure pills ordered for this patient; one out of every three pills fell to the wayside.

Patient 17

Housing Unit 4

Trigger: ER log; Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016. The patient reported that on July 11, 2016 he had palpitations. He is aware of his serious heart condition, so asked a CO to notify medical staff immediately. The CO informed him to wait until pill line (which would be a few hours later) and did not notify a medical professional. By the time the pill line nurse arrived, the palpitations had subsided, so the patient did not notify the nurse.

Chart Review

The patient has a history of blockages of the arteries in his heart, having had stents placed in the past.

May 16, 2016 The patient had chest pain starting around 09:00, with radiation to the right and left arms and nausea. Staff did not document how he came to their attention nor how he was transported from his housing unit to the clinic. At 16:20 an RN noted that he had chest pain with radiation to the left neck. His heart rate was 182 and irregular, which in anyone, but especially someone with his cardiac history, constituted a medical emergency. The nurse did not perform any further examination other than vital signs. The nurse contacted Dr. Abangan who ordered the patient sent to the ER by van rather than ambulance, which was inappropriate for this patient.

In the ER he was found to be in atrial fibrillation.

Summary of Problems

Section A (Lack of Access to Urgent Care)

This patient has a known serious medical condition. Failure of custody staff to immediately notify medical staff on July 11, 2016 put this patient's life at extreme risk of harm.

Section E (Failure to Use Sound Clinical Judgment)

Even ignoring this patient's known history of heart disease, the combination of chest pain and a heart rate of 184 constituted a medical emergency. Further, a minimally competent physician would have appreciated that this patient was as clinically unstable as, for example, someone bleeding from a gunshot wound; he was at risk of his heart stopping at any moment. Thus the chilling inappropriateness of the doctor's decision to send this patient to the ER by van cannot be overstated.

Patient 18

Housing Unit 1

Trigger: CCC Roster

Interview

I interviewed this patient on July 13, 2016 because the CCC roster shows that he suffers from HIV and was a no-show for visits on January 5, 2016 and January 25, 2016. The patient adamantly denied that he has HIV, and nothing in the rest of his medical record shows that he has HIV.

He also stated that inmates have difficulty accessing medical help in the middle of the night. If cell door is locked, inmates must wait for COs to come around for count, which is every 1-2 hours, or, if doors open, can bang on the housing unit door. He has submitted SCRs, with the last time being about three months before my visit. It took about three weeks to be called to medical.

Chart Review

August 17, 2015 The patient submitted two SCRs; he was seen the same day for both.

November 23, 2015 The patient submitted an SCR; he was seen the next day.

There is no evidence to support his claim of delayed SCR response.

Summary of problems

Section A (Lack of Access to Urgent Care)

The patient's statement corroborates the difficulty patients have in accessing urgent care.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

One of the clinic management logs erroneously lists this patient as having HIV.

Patient 19

Housing unit 4

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of our walk through the housing units. He reported that, on July 1, 2016, he notified the pill nurse of a developing highly itchy rash. The nurse took him to the clinic, but was told there were no practitioners to see him until July 6, 2016. On July 6, 2016 an NP diagnosed him with “foot fungus” and prescribed a 0.5 oz. tube of antifungal cream. He was instructed to apply it to his whole rash (which encompasses about 80% of his total body surface area) twice a day. The 0.5 oz., which was prescribed as a 30 day supply, was used up after the first application. He was told to return in two weeks if he weren’t better.

During the interview the patient mentioned that he was also experiencing swings in body temperature, which can be a dangerous sign for rashes even if the rash is otherwise of a benign nature. On this basis, and the fact that he no longer had any medication, I was concerned for the patient’s safety and through Defendants’ counsel, informed the health care manager of this, requesting that the patient be seen that day, July 12, 2016, by the doctor. Upon return to the prison on July 13, 2016 I followed up with the patient. He had been seen that morning by a nurse, not a doctor, and in response to an SCR that he submitted, not my request. The nurse informed him he might see the doctor tomorrow. I re-voiced my concerns to health care staff that morning.

Chart Review

The patient was seen later in the day (July 13, 2016) by Dr. Abangan (the doctor diagnosed him with a detergent allergy, gave him a steroid shot, oral steroids, and prescribed a follow-up in one week).

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Management of this patient’s rash was unreasonable. First, it is highly unlikely for a patient to suffer from a sudden, widespread fungal skin rash (and if they did, this would constitute a severe infection for which hospital-level monitoring and care would be indicated). Second, even if this were the case, it is unreasonable to expect a half ounce of cream to suffice. It would require roughly 0.7 ounces to cover his rash...once. Thus the NP did not provide him enough medication for his first application, no less a total of 60 applications for the month. Third, 20% of the rash was on the patient’s back. Even a lay person would have known that it would have been impossible for the patient to apply medication there. Thus overall management of this acute problem fell well below reasonable standards.

Patient 20

Housing unit 3

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. He reported that occasionally inmates are locked in their cells on the housing unit for disciplinary reasons. When this happens, they do not receive their medications from the nurses. Instead, nurses hand the medications to another inmate who slides the medication under the cell door. This has happened to him.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers); Section F (Failure to Execute and Follow-up on Medical Orders)

It is a nurse's responsibility, when administering medications, to assure that he/she is administering the right medication to the right patient, and that the patient is actually taking the medication. The situation described by this patient, wherein nurses give medications to a "runner" inmate to bring to the patient violates this basic tenet of safe medication administration in *any* setting. In a correctional setting, such behavior is even more proscribed because it puts one inmate in a position of power over another (i.e. the "runner" could leverage delivery of the medications to extort something from the patient) or risks the medication being diverted. Thus this delivery method is unheard of in prisons.

Patient 21

Housing unit 3

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016. He reported that mental health and dental care are good, but medical care, especially care delivered by the facility doctor, Dr. Abangan, is not. He relayed the following sequence of events in support of his opinion.

In early 2016, EMCF ran out of the medication he takes to control seizures (divalproex, Depakote). When a nurse was about to take his blood for a scheduled blood level of the drug, he informed the nurse that he wasn't currently taking the medication, so the blood level was not going to be accurate. The nurse drew the test anyway. Later, he had a chronic care visit with Dr. Abangan at which time the doctor reviewed the blood test result. Dr. Abangan knew or should have known from the medication record and the nurse's note, the reason for the medication blood test result (which showed that there was no medication in his blood stream). Either way, the patient also informed him of this fact. Despite this, Dr. Abangan came to the erroneous conclusion that the patient's level was zero because the patient was not adherent to the regimen (i.e. not actually taking the pill), and stopped the medication. Subsequently – and predictably – the patient had another seizure.

With regard to access to care in the housing unit, the patient also reported that it is impossible to get medical attention at night. His and other cell doors are locked, and there are no COs within the living area. He has a panic button in his cell, but he says nothing happens when he presses it (he demonstrated this during our conversation – no one responded).

Chart Review

On the MAR for December, the medication nurse noted that the facility ran out of the patient's evening dose of divalproex on December 30, 2015, so the patient did not receive it on December 30, 2015 or December 31, 2015. There were no further gaps until the latest MAR I reviewed of May 2016.

The rest of the record does not support the patient's report of discontinuation of anti-seizure medications or subsequent seizures.

Summary of Problems

Section A (Lack of Access to Urgent Care)

The patient's statement corroborates the difficulty patients have in accessing urgent care.

Section F (Failure to Execute and Follow-up on Medical Orders)

The patient's statement corroborates EMCF's failure to deliver medications as ordered.

Patient 22

Housing unit 3

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016. He has been at EMCF for 12 years. He is a methamphetamine abuser but states that he is not being provided treatment for this. When he writes an SCR he gives it to a CO who places it in the medical box. It can take up to two weeks to be seen.

Chart Review

- September 22, 2015 The patient submitted an SCR for a headache. He was seen by a nurse on September 25, 2015 and referred to Dr. Abangan who saw him on October 5, 2015. When the doctor saw him, his evaluation was limited to obtaining the following history: "Headache comes and goes." His examination was limited to obtaining vital signs – no other examination was performed. The doctor prescribed ibuprofen.
A minimally competent doctor evaluating a patient for a headache is required to obtain basic information about the history of the problem (e.g. When did it start? Was there any head trauma? What makes it better/worse? etc.) and then actually lay hands on the patient and conduct an examination. None of this happened.
- March 13, 2016 The patient filed an SCR for a runny nose. He was seen the next day by a nurse.
- April 19, 2016 The patient submitted an SCR. He was seen by a nurse on April 22, 2016 and referred to the doctor, who saw him on April 28, 2016. This was a reasonable interval for the complaint.
- April 31[sic], 2016 The patient submitted an SCR bearing this date for headaches. He was seen by a nurse on May 1, 2016. The nurse obtained vital signs (BP 92/60) and noted that he complained of "frequent throbbing frontal headaches. sinus drainage noted. on Claritin. denies dizziness, nausea, and photosensitivity. no neck stiffness." Other than this, the nurse elicited no other history or performed any other examination (in fact, it is difficult to tell from this note which of the problems are based on what the patient said or the nurse examined). The nurse prescribed ibuprofen for five days.
Not only was the evaluation inadequate for the first evaluation of a severe headache, but the expectation that "frequent" headaches would be solved with a one-time 5-day supply of medications is unreasonable.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Technically, Dr. Abangan's "examination" of this patient on October 5, 2015 fits Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers). However the visit was so devoid of even a modicum of data collection and clinical reasoning on the part of the doctor as to be worse than a demonstration of poor judgment; this visit is more accurately classified as lack of access to care. The nurse's "examination" of this patient on May 1, 2016 was not much better.

Patient 23

Housing Unit 3

Trigger: Sick Call Request Log

Chart Review

March 16, 2016

The patient submitted an SCR for a rash and to see the eye doctor. He was seen by a nurse the same day for the rash, but the nurse did not evaluate his eye problem.

March 21, 2016

The patient submitted another request to see the eye doctor for glasses. The request was reviewed by a nurse but no one examined him. He was not seen by an eye doctor until March 30, 2016.

Though not serious in this particular case, a delay of two weeks to initially evaluate an eye complaint is dangerous. One cannot assume that patients have enough medical training to make a diagnosis that their vision problem is due to a lack of glasses and not due to a more serious ocular process, such as uveitis, an inflammation of the eye, which may result in permanent blindness in the absence of prompt diagnosis and treatment.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

The nurses caring for this patient on two occasions failed to function at a minimally acceptable level with regard to the patient's eye complaints. The first nurse ignored the issue, and the second nurse failed to ensure that the problem did not require more urgent care.

Patient 24

Housing Unit 3

Trigger: ER Transport Log

Chart Review

December 24(?), 2015

The patient was housed in the Infirmary for depression. At 00:10 an RN completed a note that the patient stated he had been hoarding medications and “took a lot.” The medications the RN cited were Benadryl, Tylenol, and Zyprexa. Though his vital signs were stable, there is no notation that he was examined or that his level of consciousness was evaluated. The nurse sent the patient to the ER by van.

The documentation is poor and confusing. While according to one note, it appears this incident occurred in the early hours of December 24, 2015, there is another note indicated that this happened at 23:30 on December 24, 2015. It is possible this later note was meant to refer to 23:30 on December 23, 2015.

Incident Notification Email

December 24, 2015

An email was sent from one member of the custody staff to others regarding the patient’s emergency transportation to the hospital. In addition to basic custody information, it included detailed medical information, including the list of specific medications the patient reported ingesting.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

The documentation of this event in the patient’s chart is poor and confusing. More importantly, the nurse failed to conduct even a basic evaluation of the patient’s level of illness. Among the most important missing examinations was an evaluation of the patient’s level of consciousness. Had his level of consciousness been subnormal, he would have required close monitoring of his airway at the prison and by an ambulance crew during transportation to the hospital, to ensure that he did not choke and die.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

The documentation of this clinic event was so poor that I was unable to assess whether the care provided by the nurse was safe. Assuming the time course of this event in the most positive light (i.e. that the events transpired over the course of 40 minutes, not a day plus 40 minutes), the use of a van, rather than an ambulance for this poisoning may have been both too slow and dangerous. Treatment for these ingestions – especially the Tylenol – are very time sensitive. Thus it is necessary to get the patient to the ER as quickly as possible. If the patient’s level of consciousness is impaired, then transportation in a van without paramedics can be dangerous due to the risk of aspiration (vomiting and then inhaling the vomit) or respiratory arrest.

Section I (Failure to Maintain Patient Confidentiality)

The detailed information about the specific medications this patient reported ingesting in excess was apparently shared by a medical staff member with a custody staff member who then shared it with other custody staff members. The criterion for sharing confidential patient information is a “need to know.” I can see no need for at least seven custody staff involved in this email to have known the exact identities of the medications used by this patient, nor, arguably, even the fact that the patient

was suffering from a self-induced overdose. Thus patient confidentiality was unnecessarily breached.

Patient 25

Housing Unit: not available

Trigger: Hospital Admission Log; Death

Chart Review

The patient had a history of stomach reflux, glaucoma, hypertension, and bipolar disorder. He also carried a history of some type of obstructive pulmonary airway disease, described below. He was at EMCF intermittently since the medical record begins in 2012, but seems to have been in residence at EMCF on a more permanent basis after mid-2013.

It is very difficult to determine the nature of the patient's pulmonary disease. His Problem List mentions asthma, but a CCC visit on March 15, 2014 mentions alternatively asthma and chronic obstructive pulmonary disease ("COPD" also referred to as emphysema), though COPD is not mentioned again at other chronic care visits.

Asthma and COPD have some features in common, but they are two very different diseases with different causes and treatments.

A note from a chronic care visit on December 21, 2013 also cites that he has hypertension, but this is not mentioned on his Problem List. His last chronic care visit was on March 21, 2015. At none of the chronic care visits did the practitioner record what the patient reports as his baseline breathing level (peak expiratory flow; "PEF") nor measure and record this important "vital sign" itself for patients with asthma.

- | | |
|----------------|--|
| March 15, 2014 | CCC visit. The practitioner ordered follow up in three months. However, the next appointment and visit was not until December 6, 2014. |
| April 13, 2015 | The patient had an appointment with the eye specialist regarding his glaucoma. The specialist noted that the patient was supposed to be on latanoprost eye drops daily, but the patient was reported to the eye specialist that he has not been getting it. Review of his MARs shows that the medication was listed as something he should be self-administering. However, there is no record that the monthly supply was given to him in February or March of 2015. |
| June 4, 2015 | He was found unresponsive and CPR was administered. |

I cannot find any obvious act or omission of medical care during the period leading up to his death that might be causally related to the death. However, no autopsy report was available. In the absence of the autopsy report, the lack of finding a causal relationship between acts or omissions and the patient's death should be considered tentative.

Summary of Problems**Section C (Lack or Delay of Access to Chronic Care)**

The patient was supposed to be seen in follow-up for pulmonary disease and hypertension in the CCC mid-June 2014. Instead he wasn't seen until December 2014, nearly a half year late.

Section F (Failure to Execute and Follow-up on Medical Orders)

EMCF medical staff failed to provide the patient with medication necessary to control his glaucoma for at least two months. Poorly controlled glaucoma can lead to blindness.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

This patient's chart does not clearly and accurately denote the patient's medical problems (hypertension, asthma vs. COPD) making it difficult for another clinician relying on the chart to gain a true picture of the patient's history and condition.

Section J (Failure to Have or Maintain Necessary Equipment)

The patient's PEF was not recorded at any of the patient's chronic care visits for pulmonary disease. This is likely related to the lack of the proper supplies in the chronic disease clinic to measure it.

Patient 26

Housing Unit 5

Trigger: Sick Call Request Log

Chart Review

January 19, 2016

The patient was the subject of a use-of-force in the Medical Unit. There was also an evaluation by an LPN around the same time, however, due to poor documentation, it is impossible to tell if this evaluation was prior to or following the use-of-force.

If prior to, then staff failed to conduct an examination post use-of-force. If after, then a post-use-of-force evaluation was conducted by an LPN, acting independently, i.e. a non-qualified professional.

January 29, 2016

The patient submitted an SCR for chest pain (“my heart been hurting me real bad”). He was not seen by the nurse until February 2, 2016, four days later. The nurse obtained a history of sharp chest pain for 2-3 weeks and no history of heart disease. She obtained no further basic information about cardiac risk factors nor other key symptoms possibly associated with the pain (e.g. shortness of breath, radiation of the pain, etc.). Moreover, other than obtaining vital signs, she conducted absolutely no physical examination of the patient, and on this basis apparently diagnosed him with a stomach problem (I inferred the diagnosis from her prescription for Mylanta for three days.).

Summary of Problems

Section A (Lack of Access to Urgent Care) or Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Following a use-of-force, an inmate must be evaluated by medical staff to ensure that the use-of-force did not cause any injuries. Following this use-of-force the patient was either not evaluated at all (Section A - Lack of Access to Urgent Care) or evaluated by someone (an LPN) not licensed and qualified to conduct such an evaluation.

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

SCRs are supposed to be triaged on a daily basis. Upon seeing an SCR with a complaint of “my heart been hurting me real bad,” medical staff should have arranged to see the patient immediately, not four days later, which was dangerous.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

When the patient was finally taken to clinic four days later, the evaluation conducted by the RN was so poor as to have been tantamount to no care at all, and was thus dangerous.

Patient 27

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. He reported that he was the subject of a use-of-force early in June which fractured his jaw. He was taken to the Intake Unit and placed in a cell around midnight, but not evacuated to the ER until around 08:00 the following morning. Some time after surgery (when his jaw was wired shut) and he was back in an isolation cell in Unit 5, there was a use-of-force on another inmate nearby. The use of chemical spray made him develop mucous in his mouth, which in turn made it difficult to breath. He reports that he tried, without success, to get the attention of staff to notify them of his problem. When no one responded, he partially removed the wires in his jaw himself.

He reports that a nurse requested that custody staff move him to a different location where he would be less subject to noxious chemicals, but they refused, so he started a fire.

The patient stated that he observes fires on Unit 5 on a daily basis, mostly to get the attention of custody staff. When asked why he (and others) don't use the buzzer (panic button) system to attract attention, he responded that it doesn't work.

He also reported that when he is not on medications, no health care staff stop by his cell to check on him (i.e. no welfare checks).

He is currently not receiving any pain medications for his mouth nor a liquid diet, both of which it would appear are necessary given his current condition (fractured jaw, unable to chew solids).

Chart Review

June 4, 2016 At approximately 22:00 to 23:00, during a use-of-force, the patient was shot in the jaw with a beanbag gun, sustaining injury to jaw. An LPN conducted an evaluation at 23:49. Other than measuring vital signs and noting that he had a large lump to his left cheek and jaw and a bruise on his hip, the nurse conducted no actual examination. Further, there is no indication that the nurse took any further action or notified any medical authority.

Thus the LPN managed this serious condition independently, as well as incompetently.

June 5, 2016 The patient appears to have been moved to a cell in the Intake Unit. There is no evidence he received any pain medication. The patient was not examined by anyone again until 09:42 the following morning, more than 10 hours after the injury, when an RN found his face was swollen and was "drooling bloody sputum" and sent him to the ER at 10:25.

Thus the patient sat in a cell without mattress or supplies, and without medical care, monitoring, or pain control, for 10 hours.

He returned from the ER around 14:00 with a recommendation to be seen by an Ear Nose and Throat surgeon the following day. The EMCF receiving nurse referred him to be seen by Dr. Abangan in the morning.

June 6, 2016 Dr. Abangan saw the patient. Other than measuring vital signs and noting "no distress" there is no evidence that the doctor actually examined the patient. He ignored the ER

doctor's recommendation for the patient to see the specialist that day and provided no clinical justification for ignoring this recommendation.

June 7, 2016 Dr. Abangan finally requested approval to schedule an appointment with the specialist. There is no indication that the doctor indicated that the request was urgent and already overdue. The request was not approved until June 8, 2016.

June 17, 2016 The patient was seen by the specialist, 11 days later than recommended by the ER doctor, and without any documented clinical explanation or justification for the delay. The specialist sent the patient back to EMCF with a written recommendation for surgery, however, at the time this written recommendation had not been received by the facility. The receiving nurse noted that the returned no instructions from the specialist, but made absolutely no effort to obtain those instructions, nor notify the facility doctor that the instructions were missing. She simply placed him back in the Infirmary for continued monitoring.

June 20, 2016 The patient did not cooperate with returning to his cell, so a use-of-force was conducted employing a sprayed chemical. After this, he was transferred out of the Infirmary to an isolation cell in Unit 5. There is no indication that any medical authority clinically discharged him from the Infirmary. Thus, as far as I can tell, this change in medical care level was ordered by custody staff. There is no evidence that the patient received any further monitoring by medical staff until he went for surgery on June 23, 2016.

Discharge from an infirmary is a medical action requiring an order from a practitioner. Thus this discharge was clinically dangerous.

June 24, 2016 He had surgical repair of his jaw, including "wiring shut" of his jaw. He returned to EMCF and was placed in the Infirmary. He was apparently seen by a practitioner, though there is no note from her in the chart.
The standard of care is that every substantive encounter – as was this one – requires documentation in the chart.

After this, there is no evidence that he was seen post-operatively by any practitioners until post-operative day three (June 27, 2016) after which he was not seen again. There is no documentation of any arrangements to have a wire cutter placed near the patient's cell.

Wiring a patient's jaw shut is medically necessary, but potentially dangerous in the event the patient has trouble breathing or vomits. For this reason, the standard of care is that a wire cutter is placed in close proximity to the patient and that staff are instructed in its use in the event of an emergency.

July 1, 2016 The patient apparently started fires and pulled wires out of his mouth. Contrary to the patient's report to me, it appears he was in the Infirmary at this point. The wires had been bothering him (poking at his skin) for a few days, so it is possible that it was this, rather than use of chemicals on another inmate, which led to his removing his wires. In either case, removal of the wires required re-examination by a clinician and probably immediate referral back to the surgeon. This did not happen.

July 5, 2016 The patient was moved to an isolation cell in Unit 5. A nurse noted that "a decision was made" to move him out of the Infirmary for the safety of others, however, there is no evidence of the involvement of a practitioner in this decision.

Discharge from an infirmary is a medical action requiring an order from a practitioner. Thus this discharge was clinically dangerous.

As of my visit and review of the active medical record on July 14, 2016 – three weeks after surgery – there is nothing in the medical record reflecting that the surgeon requested any follow-up, but it is clinically inconceivable that the surgeon would not have wanted this, most likely within a week of surgery. On July 14, 2016 I spoke to Mr. Little and asked him to make sure that the patient has not fallen through the cracks with regard to surgical follow up.

Summary of Problems

Section A (Lack of Access to Urgent Care)

The patient's statement corroborates the difficulty patients have in accessing urgent care.

Section D (Failure to Provide Adequate Care in Infirmary)

On the night this patient's jaw was fractured, medical staff placed him in a bed in the Intake Unit where he received no medical monitoring or treatment for at least five hours.

Later, upon return from surgery, with the exception of 1 day, this patient received no medical care or even monitoring during the entire week he was in the EMCF infirmary following surgery on his jaw. He was also at risk of death due to having his jaw wired shut and staff not being ready to intervene on a moment's notice to release the wires. He was discharged twice from a purported inpatient medical setting in the absence of a practitioner's order to assure that discharge was safe; at least one of those discharges appears to have been ordered by custody staff, despite his medical needs. Thus the "care" this patient received in the EMCF infirmary could be better described as warehousing than medical care, and was therefore dangerous to his health.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Various medical staff failed to provide health care consistent with what is expected of health care providers in the care of this patient. An LPN knew or should have known that she was practicing beyond the legal and safe limits of her license by evaluating this patient for injuries after a use-of-force. Medical staff (I was unable to determine which staff this was) made no provisions for monitoring or treating this patient (including treating him for the pain of a freshly fractured jaw) during 10 hours. I can only imagine how uncomfortable he was when, 10 hours later, a nurse who finally attended to him, found him "drooling bloody sputum." Finally, the facility doctor ignored this patient's serious medical needs three times: the first time when delaying his referral to a surgeon for 11 days; the second time when failing to arrange for a post-operative visit to the surgeon; and the third time when failing to refer him back to the surgeon acutely when the patient removed the wires.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

There is no clinical documentation from the NP who examined this patient upon his return from surgery June 24, 2016. This was dangerous because it makes it impossible for any other clinician assessing the patient subsequently to decide whether or not there has been a change in the patient's condition.

Section N

Custody staff created an unsafe living condition for this patient on June 20, 2016 (and possibly July 5, 2016) by moving him out of a medical care environment to a non-medical environment where, additionally, access to urgent care is seriously impaired.

Patient 28

Housing Unit 2

Trigger: Sick Call Request Log

Chart Review

- January 29, 2016 The patient was seen by a nurse for an upset stomach and diarrhea. Aside from determining that he had had this symptom for three days, and checking his vital signs, the nurse failed to collect any further history or perform any physical examination.
Both of these clinical activities were minimally required to be able to arrive at any rational diagnosis.
- January 30, 2016 The patient submitted an SCR for an acute injury to his face, believing he might have a fractured facial bone. Based on the Sick Call log, the patient was supposed to have a medical examination on this day, but it was cancelled by custody due to transportation issues; he would not be seen by an appropriately licensed professional for another three days.
One might argue that he was seen the next day for this. That rebuttal is insufficient for two reasons. First, an acute injury of this nature required immediate evaluation; if for some reason custody staff had a legitimate transportation challenge, medical staff should have gone to the patient's cell. Second, the evaluation the next day (January 31, 2016) was incompetently performed by someone acting beyond the scope of their legal license.
- January 31, 2016 There is an Injury Report filed by an LPN at 15:12 which notes that he was attacked by another inmate, suffering a bruise to the left eye. Other than obtaining vital signs, the LPN, acting independently, did nothing further.
This history required immediate evaluation – by an appropriately licensed and qualified professional – not only of the face, but also of the eye.
- February 2, 2016 On this day the patient was finally seen by an RN for his injury. Other than obtaining vital signs and eliciting some more symptoms, the nurse failed to conduct any examination of the patient's bones or eye. She referred the patient "to MD for x-ray."
- February 3, 2016 On this day the patient was seen in clinic by an LPN who ordered a "facial x-ray and x-ray of the mandible/jaw" and "notified" the doctor.
This constituted a medical order, outside the clinical scope of license of an LPN. That the LPN "notified" the doctor of this order via the EHR and that the doctor cosigned this order the following day, does nothing to diminish that the x-ray was ordered by, and completed under the sole clinical judgment of, the LPN.
- February 4, 2016 On this day, the patient signed a "Refusal of Treatment." The entire form is blank, save for the patient's signature.
Thus one has no idea what the patient was refusing nor what, if any, information the patient received prior to signing. Thus this is not an informed refusal.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

The cancellation by custody staff of a clinic visit to evaluate this patient's acute injury with possible fractured facial bones, constituted a dangerous lack of access to episodic care. The danger was perpetuated by medical staff who failed to go to the patient if the patient could not be brought to them.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Several nursing staff provided severely deficient care to this patient over the course of the one week I reviewed. An RN evaluating the patient for intestinal symptoms, and another evaluating the patient for the facial injury both failed to obtain a modicum of clinical information (history and physical examination). On two other occasions, LPNs evaluated the patient's facial injury independently, including the ordering of x-rays. If the examinations had been done competently, their actions would only be illegal. However, because they were also not done competently, they also exposed the patient to harm by delaying diagnosis and treatment of a possible facial fracture.

Section H (Failure to Obtain Informed Refusal); Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

The "Refusal of Treatment" form filed in this patient's record is blank, other than the patient's signature. So it is impossible to divine what the patient refused. But assuming he was being offered care that was medically necessary, it is clear that he was not provided any information that he could use to make an informed decision in his own best interest. Thus this refusal was not an informed refusal and was therefore dangerous.

Patient 29

Housing Unit 4

Trigger: Sick Call Request Log

Chart Review and Summary of Problems

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

I reviewed this case because the log indicated a cancelled appointment due to custody problems on January 27, 2016. There is no record of the patient having submitted an SCR during that time period, so the log (or the patient's chart) is in error.

Patient 30

Housing Unit: Not Available

Trigger: Sick Call Request Log

Chart Review

January 27, 2016

The patient submitted an SCR for “bad chest pain.” He was seen the following day by an RN. The entirety of the history she elicited was “c/o having bad chest pain near the mid of chest on L side.” The entirety of the examination, aside from vital signs, was “chest sounds clear no acute resp or cardiac distress noted at this time.” The nurse’s nursing diagnosis was “chest pain” for which she provided an antacid for three days.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

This evaluation was grossly inadequate and exposed the patient to significant risk. The information the nurse collected was grossly insufficient to be able to rule out some serious medical problems. A patient presenting with chest pain – even a 22 year old patient – requires at a minimum questioning about the nature of the pain, personal history and family history of serious conditions which might cause chest pain, examination of the heart and veins of the neck, and possibly an EKG. Failure to perform these (and other) investigations much result in missing such life-threatening problems as a heart attack, ruptured lung, or blood clot in the lung (embolism).

Patient 31

Housing Unit 2

Trigger: Sick Call Request Log

Chart Review

January 19, 2016 The patient submitted an SCR for “excruciating pain...trouble eating along with sleeping.”

January 24, 2016 On this day he was seen by a nurse. The entirety of the nurse’s note was “wants some pain medication. Objective: R[ight] shoulder pain wants pain meds.” Her assessment (i.e. nursing diagnosis) was “Wants some pain meds.” The nurse provided ibuprofen for five days.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

The response time for this SCR (5 days) was unsafely delayed.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

The evaluation conducted by the nurse in this case was so vacuous as to be non-existent and reflect a lack of access to care. There are myriad medical conditions, some less serious, some more serious, which a minimally competent health professional needed to consider in this scenario, such as infection of the bone or muscle, blood clot to the lung (embolism), and ruptured lung, among others. The nurse failed to explore any of these or other possibilities. Thus it was impossible for her to have safely arrived at a diagnosis and treatment plan.

Patient 32

Housing Unit 4

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. He has been at EMCF for three years. He reported that he submitted an SCR for an arm rash six weeks ago. When he finally saw Dr. Abangan, the doctor examined his ear instead of his arm and when the patient told him his problem was his arm, the doctor told him to submit another SCR. With regard to the ear, the doctor initially looked in his ear using a speculum (a disposable plastic cone covering the lighted end of the scope, used to improve the operation of the scope and to prevent spread of infection). When the speculum fell on the floor, the doctor completed the exam without a speculum attached. Finally, the doctor only looked in one ear, but was inexplicably able to opine on the absence of a problem in either ear.

The patient also reported that Dr. Abangan performed a rectal examination on him in his office. The doctor did not use any visual barrier, so multiple other people observed this, including other inmates. During this visit, the doctor also told him his blood pressure was okay, but he understands it was not.

Some time in January he lost consciousness in the gym. He was taken to the Clinic. A nurse kept rechecking his blood pressure until it was higher, which took about 45 minutes, and then finally sent him to see the doctor.

Chart Review

November 3, 2015	The patient saw Dr. Abangan on this date. This is the only visit with the doctor which conceivably would have resulted in a rectal examination because the patient was complaining of constipation. If the doctor performed a rectal examination, he did not document it. However, he did not document performing any examination of the patient (other than vital signs). <i>So either the doctor did perform a rectal examination, conceivably without providing any privacy, or did not perform any physical examination, neither of which is within the standard of care, and posed risk to the patient.</i>
December 2015	The MAR for this month is erroneously filed as a “Medical Segregation” form – I discovered it by accident.
June 14, 2016	The patient submitted an SCR for an arm rash and drainage from his right ear.
June 15, 2016	He was examined by a nurse who referred him to the doctor for both problems.
June 16, 2016	The patient was examined by Dr. Abangan. The doctor only addressed the ear problem, and only examined his right ear, ignoring the arm rash.

I could not find any documentation in the chart that corresponds to an event involving a loss of consciousness.

I found in the EHR, the following history in multiple visit notes written by practitioners: “Reports dental problems;...reports sores in head that may be MRSA [staphylococcal infection].” This history appeared in the section of the note which practitioners use to document what the patient reports to them contemporaneously, i.e. at that particular visit.

The above passage was documented on May 8, 2013 by NP Ellis, on March 12, 2014 by Dr. Edwards, and on four occasions in 2015 and 2016 by Dr. Abangan.

It is clear that this documentation is not contemporaneous, yet practitioners continue to include it in their notes.

Summary of Problems

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs) and either Section I (Failure to Maintain Patient Confidentiality), or Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Because of less than skeletal documentation (Section G - Failure to Maintain an Adequate Medical Record and Accurate Logs) by Dr. Abangan of his evaluation of this patient on November 3, 2015, I am unable to determine if the doctor performed a rectal exam, possible without providing any visual privacy for the patient from other patients and staff (Section I - Failure to Maintain Patient Confidentiality), or simply failed to conduct any meaningful clinical evaluation at all (Section E - Failure to Provide Health Care Consistent with What is Expected of Health Care Providers).

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

Medical records, in this case the patient's MAR for December 2015, were filed under the wrong document name in the EHR, making them virtually unavailable to another care giver who might need to refer to them to guide safe medical decision-making.

The EHR is either mis-designed or misused in such a way that stale patient information which is no longer accurate, continues to appear (as current information) in clinician progress notes for months or years. If other care givers using the EHR to guide patient care are not aware that the information is old (and no longer correct), they may make erroneous decisions, putting the patient's health at risk.

Patient 33

Housing Unit 4

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. He informed me that one day he reported severe abdominal/rectal pain. Dr. Abangan performed a rectal examination on him in clinic without any privacy screening, allowing several other inmates to see what was going on. Dr. Abangan told him that nothing was wrong. Then about a month later he happened to check with the pill line nurse to check if the antacid he had requested had arrived yet, and was informed that the nurse had a stool softener the doctor ordered for him.

He reported that staff respond quickly to SCR's.

Chart Review

July 24, 2015

The patient submitted an SCR complaining of "sharp blinding pain in my rectum this morning. The pain was bad until I broke out in a cold sweat and I felt nauseous... [The pain is] 20 on a scale from one to 10."

August 4, 2015

On this day the patient was seen by Dr. Abangan. (If there was an intercurrent visit with a triage nurse, it is not documented.)

Thus it took almost two weeks to schedule this patient to be seen for an acute problem.

The doctor performed a rectal and other examination. His diagnosis was "no pathology seen" and his plan was to monitor the patient.

October 20, 2015

Unrelated to the previous visit, the patient submitted an SCR asking for a refill of the antacid tablets he had been receiving in the past. The next day an order was generated, not for the antacid the patient requested, but for a laxative and stool softener. The order was generated by an LPN and cosigned by Dr. Abangan.

Thus the patient did not receive the medication he needed, and instead received a medication a) he did not need and b) that could create a new medical problem such as diarrhea.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

Despite this patient's statement that staff timely respond to SCR's, it took EMCF medical staff two weeks to schedule a patient to be seen after submitting an SCR for severe abdominal pain, a symptom which required immediate attention.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Dr. Abangan saw this patient on August 4, 2015 for rectal pain. He did not propose any explanation for the patient's pain. Then, 2.5 months later, when the patient requested a refill for antacid, used for stomach problems, Dr. Abangan instead wrote a prescription for laxatives. Whether the doctor thought he was treating the rectal pain (from the visit 2.5 months earlier) or had a different thought process is speculative. In either case, the prescription for laxatives on October 21, 2015 was a careless prescribing error on the part of the doctor.

Section I (Failure to Maintain Patient Confidentiality)

Dr. Abangan performed a rectal examination on this patient, essentially in public view, violating a basic health care right to privacy.

Patient 34

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. This patient has been at EMCF for three years. Several days ago he was angry at nurses for poor care and threw feces at one of them. He also intentionally cut himself and required wound care. He reported that the prior evening (July 11, 2016) he had an appointment for that wound care. When taken to the clinic, nurses refused to provide care,⁹ so Sergeant Edwards provided the wound care (peroxide cleanse).

Chart Review

June 7, 2016 The patient submitted an SCR for a “very bad tooth with a whole showing the nerve an it hurting badly it’s needs to be pulled asap.”

June 9, 2016 The patient was seen by an RN. Other than vital signs, the nurse did not examine the patient, but prescribed ibuprofen for five days and referred him to the dentist. On June 15, 2016 there was a scheduled appointment with the dentist that did not take place (“Rescheduled due to escorts.”). As of the date of my review on July 14, 2016, five weeks later, the patient had not yet been seen by a dentist.

June 12, 2016 The patient was seen by an LPN following a cut to his leg. The LPN examined him and treated the wound, independently, without instruction or collaboration with an RN or doctor. Further, the nurse made no arrangements for follow up care.

June 12, 2016 The patient was seen by another LPN later in the day for an injury to his thumb. Again, the nurse evaluated the patient independently.

June 14, 2016 The patient was evaluated by an RN for a boil. The entirety of the nurse’s note was, “Inmate to medical for wound care. Has large non-draining boil on left arm. Needs to see the doctor.”
This is a wholly inadequate examination. Also, as of the date of my review on July 14, 2016, four weeks later, the patient had not yet been seen by the doctor for this infection nor received treatment for it.

On July 7, 2016, July 8, 2016, July 10, 2016, July 11, 2016, July 12, 2016, July 13, 2016, and July 14, 2016 the patient had appointments scheduled to see the nurse, but all were marked as “Rescheduled due to escorts.” I was unable to determine the clinical purpose of these missed visits.

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

This patient did not have access to dental care for an acute problem. Despite triage by a nurse who determined the need for the patient to see a dentist, five weeks later (the day of my review) no such visit had yet taken place.

⁹ While the nurses’ unwillingness to treat the patient may seem understandable, prisons house patients who can sometimes be challenging, but these patients are nonetheless entitled to adequate health care, a responsibility that health care professionals accept when they agree to work in this environment. I do not expect nurses faced with such threats to their own safety to place themselves unnecessarily in harm’s way. However, having experienced a threat, there are custody systems in place to assure the nurses’ safety in such situations while still providing clinically ordered care.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

On four separate occasions nurse failed to provide a minimally acceptable level of care to this patient. On June 9, 2016 the RN evaluating him for dental pain failed to conduct even the most rudimentary of clinical exams to determine the nature of the patient's problem. Further, her provision of only five days of pain medication was not medically sound: If she expected the patient's pain to be resolved by day 6, why did she refer the patient to the dentist? And if she didn't expect the problem to be resolved, why didn't she provide more medication (or arrange for a dental examination before day 6). The RN caring for the patient's boil on June 14, 2016 was equally incompetent and ineffective, conducting almost no examination. Two LPNs, one evaluating the patient for a cut to his leg, the other for an injury to his thumb, both practiced nursing outside their legal scopes of practice.

Section F (Failure to Execute and Follow-up on Medical Orders)

At the conclusion of the patient's visit with an RN on June 14, 2016, the nurse's stated intent was that the patient needed to see the doctor. Despite this follow-up plan, the doctor visit has not yet happened. I could not determine if this error is the fault of the nurse or some other EMCF staff member, but in either case this failure to follow-up with the doctor is an error in patient care with potentially serious health repercussions for the patient.

This patient related the unwillingness of nurses to care for his leg wound. Based on my review of his chart, his report is either accurate or for a full week custody escort staff were not able to bring a patient to the clinic for required care. In either case, the patient does not have access to medical care (other than, perhaps, by a CO).

Patient 35

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this inmate on July 12, 2016 as part of my walk through. At that time, he had been in isolation for three days. He complained of not having a mattress or blanket.

He also reported having been in a fight three days ago during which he was kicked, but was not taken to the Clinic for evaluation.

Summary of Problems

Section L (Inhumane and Unsafe Living Conditions)

I did not see a mattress or blanket in this inmate's cell.

Patient 36

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. This patient has been at EMCF for six months, and in isolation for three months.

He hurt his leg playing basketball and was satisfied with the medical care he received.

He reported that COs only come to the unit every 1-2 hours during the night. There is no call button, so there is no way to summon help other than waiting for the COs rounds.

Summary of Problems

Section A (Lack of Access to Urgent Care)

The patient's statement corroborates the difficulty patients have in accessing urgent care.

Patient 37

Housing Unit 4

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. The patient reported that he has had a rash since May 13, 2016. He received an antifungal cream, but he still has the rash and it still itches. He was last seen on June 23, 2016.

He reported that medical staff do not respond if someone has a medical need at night.

Summary of Problems

Section A (Lack of Access to Urgent Care)

The patient's statement corroborates the difficulty patients have in accessing urgent care.

Patient 38

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. This patient has been at EMCF for three months. During that time he has experienced a 30 pound weight loss. He stated that he has a confirmed history of hepatitis C from tests done prior to incarceration. Two to three months ago he submitted his first SCR, complaining of throwing up blood. He was seen within two to three days. Staff took blood and gave him antacids, but they told him that he did not have hepatitis C, and the symptom continued. He was later seen again, at which time he informed nurses that he had blood in his urine, but believed nothing was done about it. He continued to send SCRs on a weekly basis.

Chart Review

The patient's EHR has conflicting information about critically important information in the Problem List. The Problem List in the "Summary" tab of the EHR for this patient lists his medical problems as:

- Leg pain, right
- Hip pain
- Back pain
- Bipolar disorder
- Hypertension
- Routine General Medical Exam

However, under the "History" tab, the patient's medical problems are:

- Cancer
- Heart Condition
- Hypertension
- Surgeries
- Other

It is thus impossible for someone using on this patient's chart to guide medical decision-making to rely on the information therein contained. Further, neither "Routing General Medical Exam" or "Other" are recognized medical diagnoses, thus in addition to erroneous information, the patient's EHR contains non-sense information.

January 4, 2016	The patient's intake health assessment was performed at MDOC's intake facility. (It was performed by an LPN, independently without any evidence of oversight.) One of the patient's conditions noted by the LPN was "liver cancer." Another condition the LPN noted was "Other," which is utterly useless.
February 11, 2016	Upon transfer to EMCF on this date, no one at EMCF noted that the patient carried a diagnosis of liver cancer. EMCF staff also did not inquire about the "Other" diagnosis. Instead, they continued to blindly roll this unknown diagnosis forward. The patient reported currently taking Norvasc 10 mg daily and Benazepril 20 mg daily, both for hypertension.

- February 24, 2016 The patient's chart shows that he was scheduled for a CCC visit for which he "no showed." However, there is a progress note for this non-existent visit showing that the nurse was able to measure his height, and that the patient gave a medical and family history.
These two entries are mutually exclusive: either the patient did not report for the visit, or he reported to the visit and provided history; both situations cannot exist simultaneously. Thus the medical record is false and unreliable.
- February 25, 2016 The patient was seen by an NP in CCC. The NP ignored the patient's history of "cancer" and "liver cancer." The NP's plan was to continue the patient's pain medication, but not his hypertension medications. The patient's weight was 172 pounds.
- March 5, 2016 The patient submitted an SCR because he thought his foot might be broken.
- March 7, 2016 The patient was seen by Dr. Abangan who ordered an x-ray that showed a displaced fracture of his ankle. The doctor requested a specialist appointment. However he did not immobilize the fracture nor provide the patient with crutches or any way to avoid weight bearing.
Failing to avoid weight bearing would not only cause pain but also could cause the fracture to become more severe.
- March 10, 2016 The patient was scheduled to go to the orthopedist, but refused. An RN spoke with the patient about this and had him sign a refusal form.
While it is good that the nurse spoke with him and tried to encourage him to go, it is clear that the nurse failed to provide the patient with adequate information to make an informed refusal. The nurse's note shows that she did not inform the patient that he had a fracture, that the fracture was complicated, might not heal by itself, and, if not handled correctly, might result in lifelong disability.
- May 21, 2016 The patient was listed as "no show" for a CCC appointment.
- May 24, 2016 The patient was seen by an NP in CCC. His weight was 166. Despite an explicit plan at the last visit to assess the patient's weight, this loss of weight was ignored.
In light of a history of cancer, this loss of weight is worrisome, and ignoring of it is potentially dangerous.
- May 24, 2016 The patient submitted an SCR requesting liver treatment and saying that his kidney was bothering him. An RN responded to this on paper stating that he had seen the NP for this, so declined to see him.
Not only was the patient denied access to care for a potentially serious medical condition, but it is doubtful the RN actually reviewed the NP's note because it is clear that these specific complaints were in fact not directly addressed.
- May 25, 2016 Lab tests show normal liver enzymes.
This does not necessarily mean that the patient does not have hepatitis C.
- July 13-14, 2016 Scheduled clinic visits were cancelled due to unavailability of custody escorts.

July 15, 2016 The patient was seen by an RN for reports of vomiting with bleeding and blood in his urine. His weight was now 158. An urgent referral was made to the doctor.

Medication Administration

Nurses failed to provide the patient one of his hypertension medications on nine of the 31 days of March 2016. The reason given for six of these is that the patient “no showed.” For one of them, the reason was that the medication was out of stock, and for the remaining missed doses, no reason was given. In the month of April, nurses failed to provide the patient both of his hypertension medications on five days. For four of those days, the nurses documented again that the patient “no showed.” On the fifth day, the nurses didn’t bother to offer it (at least, the MAR is blank).

In correctional health care “no-show” is not an acceptable reason for not administering a scheduled medication.

Post-Script

During my interview with this patient he was adamant that he has hepatitis C, based on tests done prior to incarceration, but that EMCF staff insisted that he did not. He said his mother had medical records that would support his claim. Plaintiffs’ attorneys accompanying me at the interview obtained the patient’s mother’s contact information and the patient’s permission to contact her. On July 18, 2016 Plaintiffs’ attorneys received and forwarded to me 19 pages of medical records from the patient’s mother. The records contain lab tests from 2013 clearly showing that the patient has hepatitis C (hepatitis C antibody positive; AST 181 [normal 4-40]; ALT 327 [normal 4-40]).

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

This patient was denied access to medical care pursuant to his SCR of May 24, 2016 complaining of problems with his liver and kidney. This denial was manifest by the nurse responding to his SCR stating that the issue was already addressed by the NP at a visit. Even if a problem was addressed at a previous visit, a problem may continue (or worsen), and thus a repeat request cannot be ignored without re-evaluating the patient in person. Further, there is little evidence to support that the nurse’s statement that the NP addressed his complaints of liver and kidney problems at the previous visit, thus this was a new problem (demanding of a face-to-face clinical visit).

Section C (Lack or Delay of Access to Chronic Care)

The patient was not evaluated in clinic for two scheduled clinic visits due to the unavailability of custody staff to escort the patient.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

Fractured bones need to be immobilized and relieved of pressure, after which efforts need to be made to assure that they heal correctly. The extreme load borne by foot bones, coupled with the importance of the feet for normal functioning make this even more important for foot fractures. The doctor’s failure to immobilize this patient’s broken foot, instruct the patient to avoid weight bearing, and provide the patient with a means to perform basic activities of daily living without weight bearing (crutches, wheel chair, or admission to an infirmary bed) all fell well below the standard of care and put the patient at risk for unnecessary pain and future disability.

The NP examining the patient in CCC failed to use reasonable care by not addressing the patient’s loss of weight, despite her own previous plan to do so. At the time of this visit, the patient’s weight had dropped from 172 to 166. While this is not necessarily a remarkable drop, by failing to make a

plan to monitor his weight, it does not appear that anyone has noticed that as of July 15, 2016, 7.5 weeks later, his weight is down to 158.

This loss of weight is especially worrisome in light of the patient's history (according to one of his Problem Lists) of cancer. As of July 15, 2016, a full five months after arriving at EMCF, no one who has been involved in the patient's care, not the doctor, not the NP, not any of the RNs or LPN, have questioned this diagnosis or attempted to obtain any further information. Certainly, if treatment of the cancer is needed, no one had provided it.

Finally, each of the several EMCF health care staff caring for this patient failed to use good clinical judgment in failing to do one of the most basic medical tasks that all doctors and nurses are taught: obtain the patient's previous medical records. I obtained these records in six days; it was not difficult. These records clearly corroborated what the patient had been saying all along: that he has hepatitis C. Safe medical care cannot be provided to this patient without taking into account his hepatitis C diagnosis. Thus the persistent ignoring of this issue by EMCF health care staff put this patient's health at further risk.

Section F (Failure to Execute and Follow-up on Medical Orders)

Within the only two months of medication administration histories that I examined, nurses failed to administer this patient multiple doses of his hypertension medications.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

An accurate medical record is essential to the safe management of a patient. This patient's EHR is not accurate. There is no unambiguous list of the patient's basic medical diagnoses.

The documentation surrounding a scheduled clinic visit on February 24, 2016 contains the patient's height and his updated report of his medical and family history...except that he apparently did not show for the appointment.

Section H (Failure to Obtain Informed Refusal)

EMCF staff failed to provide this patient with sufficient information to make his decision to decline to visit an orthopedist after injuring his foot. Among other omissions, the patient was not even informed his foot was broken. Thus his refusal was not an informed refusal and this error may lead to further pain and permanent disability.

Patient 39

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. This patient has been at EMCF for eight years, and in isolation in Unit 5 for the past two months. He claims to have a history of asthma and PTSD. He had been using a steroid inhaler for asthma prior to his arrival at EMCF, but for some reason it was stopped upon his arrival. A couple of weeks prior to my visit, however, a practitioner reinstated the steroid inhaler and planned follow-up in one month. The patient said that he now uses the steroid inhaler as directed, but still had to use his rescue inhaler 10-12 times per day. *Such frequent use is an indication that his asthma is under very poor control. Patients in this state are much more likely to experience an asthmatic emergency requiring hospitalization.*

He stated that he is supposed to be able to get nebulizer treatments (emergency asthmatic breathing treatments administered by a nurse) as needed, but when he tries to request these when having trouble breathing, it either takes hours to receive it, or he simply doesn't get it at all. For example, in the two weeks prior to our interview, he requested the nebulizer treatment 8-9 times, but only received it twice.

On July 9, 2016 he was having trouble breathing and notified a CO. Instead of having a nurse come to check him, the CO returned with a device for checking the amount of oxygen in his blood. *A CO is not trained, qualified, or licensed to deliver health care. This patient required much more than a check of his oxygen level to rule out serious causes of his breathing difficulty, such as heart or lung problems.*

Chart Review

This patient's EHR has conflicting information about critically important information in the Problem List. The Problem List in the "Summary" tab of the EHR for this patient lists his medical problems as:

- Bipolar disorder
- PTSD
- Ringworm
- Conjunctivitis
- Asthma

However, under the "History" tab, the patient's sole medical problem is:

Heart condition

June 29, 2016 The patient was seen by an NP in CCC. The NP documented in one part of her chart note that he has not used any canisters of his asthma inhaler, but in another part of her note she documented that his canister is almost empty. *These two entries are mutually exclusive, and given that the main reason for this visit was for control of asthma, this misinformation is dangerous.*

Further the NP notes that the "appropriate labs" were reviewed with the patient. However, one of the key labs to review is the patient's peak expiratory flow (PEF), a key test that helps assess the status of a patient's asthma condition, but this test was not performed.

June 30, 2016 The patient submitted an SCR for something in his ear. He was not seen for this complaint until July 6, 2016.

This is too long an interval.

I could not verify the patient's claim that he had not received nebulizer treatments in the previous two weeks because that MAR was active and therefore not yet filed in the patient's chart. However, there is no record of his having received these treatments at any time in the previous month of June 2016. (During our interview we only discussed his failed requests for this treatment in the previous two weeks, i.e. the first two weeks of July, thus I did not ascertain if the lack of treatments during June reflects failure to provide urgent care or that the patient did not request them.)

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

EMCF staff's response to this patient's SCR for an ear problem was six days, which is too long an interval.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

An accurate medical record is essential to the safe management of a patient. This patient's EHR is not accurate. There is no unambiguous list of the patient's basic medical diagnoses.

Patient 40

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. This patient reported that he has a history of asthma. He was supposed to get Tylenol that day, but the nurse didn't come because, he believes, she was afraid that someone would throw feces.

He often does not get his evening medications.

Chart Review

There is a mismatch between this patient's Problem List in the "Summary" and "History" tabs of his medical record, so his actual medical history is not clear.

Over the past three months of MARs I reviewed, the patient did not get his evening medications on four occasions.

Summary of Problems

Section F (Failure to Execute and Follow-up on Medical Orders)

EMCF medical staff fail to provide this patient with all the medications he is ordered to take.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

An accurate medical record is essential to the safe management of a patient. This patient's EHR is not accurate. There is no unambiguous list of the patient's basic medical diagnoses.

Patient 41

Housing Unit 5

Trigger: Patient Interviewed During Walk Through

Interview

I interviewed this patient on July 12, 2016 as part of my walk through. This patient has been at EMCF for two years; he has been in an isolation cell the whole time.

He reported having a toothache about three months prior to my visit. He was examined by a nurse who gave him ibuprofen. Not having received further care, he submitted 4-5 SCRs without response.

Then, about a month prior to my visit, he had another toothache. He was examined by a nurse who provided him with aspirin for five days and said he would be seen by the dentist, but as of the day of my interview, this had not yet happened.

Chart Review

He was seen in CCC in his previous facility in May 2014 for hypertension, hepatitis C, hyperlipidemia, and seizures. (He also has "Other" as a listed problem in his Problem List.) At that time, the practitioner ordered for him to be seen again in six months. At the 6-month mark he was at EMCF (he was transferred on July 29, 2014), but no such follow-up appointment took place, despite the fact that on April 3, 2016 Dr. Abangan noted that the patient has hypertension, and on July 9, 2016 he noted that the patient has a seizure disorder. Thus, as of my chart review on July 15, 2016, almost two years after having been transferred to EMCF, and after clear recognition by Dr. Abangan that the patient has chronic disease, the patient has not yet been seen in chronic disease clinic at EMCF.

- | | |
|----------------|---|
| March 26, 2016 | The patient submitted an SCR for a toothache. There is no evidence the SCR was immediately triaged, and he was not seen by the dentist until April 19, 2016. The dentist found and filled a cavity which was "close to the pulp."
<i>This is an unacceptably long delay to see the patient for a toothache.</i> |
| March 31, 2016 | The patient was seen by a nurse for chest pain. He has a history of hypertension and cocaine abuse as well as a family history of a heart condition, all risk factors for heart disease. He is 44 years old. The nurse performed an examination and referred the patient to the doctor. As of the date of this review on July 15, 2016, 3.5 months later, the patient has not yet been seen by the doctor. |
| May 9, 2016 | The patient submitted an SCR for a toothache. He was seen the next day by a nurse who scheduled him to see the dentist on May 12, 2016. However the appointment was cancelled due to "lockdown" and the reappointment on May 13, 2016 was cancelled due to lack of custody escort. As of the date of this review, July 15, 2016, more than a month after his request, the patient has still not been seen by the dentist. |

Summary of Problems

Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)

After submitting an SCR for a toothache, it took almost a month for the patient to receive treatment from the dentist. This is an unacceptably delay for access to episodic care.

Section C (Lack or Delay of Access to Chronic Care); Section F (Failure to Execute and Follow-up on Medical Orders)

This patient has four chronic diseases: hypertension, hepatitis C, hyperlipidemia, and seizures. Upon transfer from his previous facility to EMCF two years ago, an order for the patient to be seen in follow-up in CCC six months hence (November 2014) went ignored by medical staff at EMCF. Despite at least two visits with Dr. Abangan at EMCF during which the error should have been caught and corrected, EMCF continued to ignore his need for chronic disease follow-up. Thus two years after his last chronic disease visit (at which time follow-up was ordered for six months hence), this patient still has not had access to comprehensive chronic disease management.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers); Section F (Failure to Execute and Follow-up on Medical Orders)

This patient presented to an EMCF nurse with chest pain. Given his history of a number of significant risk factors for cardiac disease (hypertension, cocaine abuse, family history of a heart condition, 44 years of age, high cholesterol), there is a very real chance that the patient's chest pain is a symptom of (ischemic) heart disease which might require urgent, if not emergent evaluation and treatment to prevent a heart attack and sudden death. Thus I believe the nurse who initially evaluated him used poor clinical judgment in not arranging immediate evaluation by a practitioner on March 31, 2016. Failing that, he still needed to be evaluated within a short few days. Yet the nurse's order for follow-up by a doctor never materialized; as of the date of this review on July 15, 2016, 3.5 months later, the patient has not yet been seen by the doctor. This delay in follow-up for what is very possibly a life-threatening disease is outrageous.

Patient 42

Housing Unit 3

Trigger: Patient Reviewed in First Report

In my previous report, I noted that this is a 53 year old black male with a history of seizures, high blood pressure, acid reflux, and schizophrenia. At the time, I noted numerous problems with the quality of his care, some of the most serious of which were failure of nurses to follow the physician's order to administer prednisone (cortisone) for five days, instead continuing it for 12 days and then possible injudicious reordering of the medication a second time. Prednisone is a powerful medication which can cause serious medical problems if continued longer than necessary. In this patient's case, the patient developed a ruptured organ, which may have been the result of his prednisone treatment. After developing this rupture – a life-threatening emergency – the physician sent the patient to the hospital by passenger van without medical escort.

Chart Review

Medication Administration:

On March 7, 2016 the patient's nurses failed to administer any of his hypertension medications, without explanation. On March 8, 2016 they failed to administer the medications again, this time noting "no show." The prescription for these medications expired on March 8, 2016, i.e. that was the last day they could legally be administered. Despite this, nurses continued to administer the medications on March 9, 2016, March 10, 2016, and March 11, 2016. March 12, 2016 and March 13, 2016 they did in fact hold the medications, but on March 14, 2016 they started administering one of the medications again (still illegally). Finally, on March 16, 2016 both medications were stopped, with a note that there was a new prescription as of that date. The new prescription was for the same medications. However, the nurses did not start giving the medications again until March 18, 2016. Thus, in sum, in the first 18 days of March, the patient failed to receive 12 of 36 possible doses of medications for his hypertension. Of the doses he did receive, eight of these were administered by nurses illegally, i.e. in the absence of a valid doctor's order.

In the month of May 2016, nurse failed to administer the patient's medications for 24 of 60 possible doses. For 19 of those doses there is some indication that the nurse knew the medication needed to be administered, but failed to do so. The way the nurses indicated this on the MAR, however, varied from nurse to nurse, and does not always adhere to the required method of documentation. For the other five doses, the nurses simply ignored the scheduled administration.

- | | |
|------------------|---|
| February 1, 2016 | The patient submitted an SCR for a runny nose. He was seen on February 3, 2016 by an RN. The entirety of the nurse's examination, other than vital signs, was "c/o sinus drainage chest sounds clear resp reg and unlabored already on sinus medication." The nurse failed to examine the body parts of which the patient was complaining.
<i>Due to this omission, the nurse could not safely arrive at a diagnosis and treatment plan.</i> |
| March 8, 2016 | The patient had a chronic care visit for hypertension with an NP. The patient appears to have been on two medications for hypertension at that time (though medications are not noted in the progress note, according to the MAR the medications were amlodipine 10 daily, hydrochlorothiazide 25 daily) and the plan was to continue them, though no order was written. |
| May 4, 2016 | The patient was seen by Dr. Abangan pursuant to a referral by the sick call nurse after the patient requested vitamins "to improve his health." Other than |

checking the patient's vital signs, including his weight (BMI=25), the doctor failed to elicit any other history from the patient or conduct any examination. *While the request for vitamins can be a benign request from an unformed patient, such a request can be a proxy for an evolving medical symptom, especially in a patient in a mental health institution or poor health literacy. Thus this request required at least a minimal exploration by the doctor of the reasons for the request and the presence of any new symptoms. This did not happen.*

June 26, 2016

The patient had a chronic disease clinic appointment with an NP to address his hypertension, gastric reflux, and seizure disorder. As with most chronic disease clinic notes, the format of the note can best be described as disjointed. *As a result, it is very difficult for a subsequent clinician who needs to rely on this information to actually appreciate how the patient is doing, what the patient's examination revealed, and what the plan of care is going forward.*

In this visit, the NP noted that the patient had had a seizure a few days before the clinic visit, but failed to discuss this or formulate any plan of care.

June 28, 2016

On this date a Dilantin (seizure medication) blood level appeared in the patient's chart. It was 25.4 which is considered to be a high level (though there are no strict cut-off values for this medication). Dr. Abangan and the NP both signed off review of the results, and the NP decreased his Dilantin from 300 mg at night to 200 mg at night.

Receipt of this information required an evaluation of the patient for possible toxicity from Dilantin, and again, a thoughtful consideration of how to handle his seizures. Indeed, if the patient had a recent seizure and the dose of his medication were lowered, it is reasonable to expect that his seizures would get worse, putting him at risk. It should also be noted that a level of 25.4 while high, is not necessarily toxic nor requiring of a dose reduction.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

The review of this patient's care during the last 12 months reveals four examples of poor medical decision-making on the part of the patient's care providers. Dr. Abangan failed to use good clinical judgment in his evaluation of the patient when he requested vitamins by failing to make at least some inquiry into what symptoms or changes were prompting this request. An NP caring for the patient in CCC, with the specific goal of managing his seizure disorder, failed to take into account that the patient reported having had a seizure just a few days before the visit. A nurse, evaluating the patient for sinus congestion failed to examine the patient's nose, sinuses, ears or any other part of his head, i.e. the part of the patient's body where the problem was. Finally, Dr. Abangan and an NP failed to manage the results of a seizure medication blood test in a logical and safe manner.

It is important to note that in my previous report, this same patient was the subject of poor decision-making on the part of the medical practitioners. Even though some of the medical staff have changed, the problems I originally cited have not.

Section F (Failure to Execute and Follow-up on Medical Orders)

Nurses failed to execute medication orders for this patient. Nurses made both errors of commission and omission. Depending on the time period examined, nurses failed to administer between 33 and

40% of the patient's needed doses. Conversely, nurses continued to administer medications even when a valid order no longer existed.

It is important to note that in my previous report, this same patient was the subject of one of the identical errors cited here: nurses continuing to administer a medication when a valid order no longer existed.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

The EHR's electronic templates associated with chronic disease management are very poorly designed, making it very difficult to read and interpret what care was provided during a visit.

Patient 43

Housing Unit 2

Trigger: Patient Reviewed in First Report

Chart Review

In the EHR, neither the Problem List in the “Summary” tab or “History” tab reflect that this patient is being treated for macular degeneration, depression, and a chronic stomach problem.

Medication Administration

I reviewed the most recent MAR in the EHR (June, 2016). Of 30 possible doses of Tegretol, nurses only administered 16 doses. Of the other 14 doses, nurses indicated that the patient “no showed” for five doses. For the remaining nine doses, the nurses ignored the patient.

- February 28, 2013 The following excerpt is from my previous report:
 The patient had a blood test done on this day. His platelet count was 106 (normal 140-415).
 As of the date of my visit, April 25, 2014, the lab result was never reviewed by the physician and has not been repeated since. On April 25, 2014, I notified Mr. Little of the abnormal blood test result.
Platelets are blood cells which are important to help a person’s blood clot when they are injured. A number of diseases can cause this, e.g. cancer, so failure to look for and treat the cause can lead to serious health problems. Further, until the underlying cause is found, failure to recognize the bleed risk and take steps to prevent trauma or bleeding can be harmful, if not fatal.
- July 3, 2014 The patient submitted an SCR for a headache. He wrote that he is under the care of an off-site eye doctor who told him that if his head started hurting, to notify medical staff as soon as possible. He was not seen for this SCR until July 17, 2014, but even then there is no evidence of any examination or evaluation.
A delay of two weeks to first evaluate a patient with a headache is dangerous.
- September 30, 2014 There were no doctor visits or notes after my alert to EMCF health care staff on April 25, 2014 (during my last visit) until this date when the patient had a physical exam with Dr. Abangan. The doctor made no mention of the platelets.
- March 15, 2015 Almost a year after I alerted EMCF medical staff about the patient’s abnormal platelet count, the patient finally had a repeat platelet count. It was 103,000, i.e. still below normal. Dr. Abangan signed off on this result, but took no action.
Thus, as of almost two years after my alert to staff about a low platelet count, and despite a repeat test a year after my alert that showed the problem continuing, no one has addressed this issue.

Summary of Problems**Section B (Lack or Delay of Access to Non-Urgent (Episodic) Care)**

EMCF failed to provide this patient with timely access to care for an episodic problem. It took two weeks from the time the patient submitted an SCR to be seen for a headache, despite instructions from a specialist that the patient should be seen as soon as possible if he experienced a headache. And even when seen after waiting two weeks, the quality of the encounter was very poor, lacking any evidence that the patient was actually examined or evaluated.

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

EMCF medical staff demonstrated on-going poor judgment in managing this patient. On February 28, 2013 a blood test ordered by EMCF medical staff showed that the patient's platelet count was low. Medical staff ignored this result. I noticed it during my last on-site review 10 months later and personally brought it to the attention of the medical staff on April 25, 2014. Despite this, no further action was taken until March 15, 2015 – almost a year later – when Dr. Abangan repeated the test. The result was the same: still low. However, Dr. Abangan did not address the issue and did nothing. Now, as of my current review on July 13, 2016, some three years later, the issue had still not been addressed.

Section G (Failure to Maintain an Adequate Medical Record and Accurate Logs)

An accurate medical record is essential to the safe management of a patient. This patient's EHR is not accurate: important diagnoses are missing from the patient's Problem List.

Patient 44

Housing Unit: Not Available

Trigger: Referred by Ms. LaMarre

Chart Review:

This is a complicated patient with mutism and a disorganized schizophrenia. He also has hypertension. It is very difficult to follow what his current care plan is. The MAR for April 2016 is missing. There is an order for Lasix for June, but the patient does not appear to have been offered it in the first part of the month, and refused it later on. He has indicated to staff that he doesn't want medications for blood pressure. During the CCC visit of January 16, 2015 (the last one he has had!) with an NP, he indicated that he wouldn't take medications, yet the NP's care plan was a prescription for medications. He refused the CCC visit in May 2015, and none have been offered in the year since. In a progress note from Dr. Abangan during one visit, the doctor writes that the patient told him his leg is swollen, and in then later reports that the patient is mute.

This patient is clearly difficult to manage. However, he clearly is in need of interdisciplinary collaborative management among nursing, medical, and mental health. There is little evidence that is happening.

Patient 45

Housing Unit 3

Trigger: Records Received from MDOC in Response to Request for Production by Plaintiffs
(document DEF-031440)

Document Review

January 2, 2016

The patient was the subject of an assault by another inmate. He was taken to the Clinic where he received a post-injury examination by an LPN.

The examination was wholly inadequate, failing to elucidate the where and how the patient was injured, and failing to examine important elements such as neurologic function, given that the patient was injured in the head. Also, the assessment was conducted by an LPN without collaboration with an appropriately licensed professional.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

An LPN, practicing beyond the scope of his/her license, independently conducted a post-injury assessment. Further, the assessment was incomplete. The deficiencies could have led to missing such serious complications as a concussion or hemorrhage into the brain.

Patient 46

Housing Unit 3

Trigger: Records Received from MDOC in Response to Request for Production by Plaintiffs
(document DEF-031462)

Document Review

January 14, 2016

The patient was the subject of an assault by another inmate. He was taken to the Clinic where he received a post-injury examination by an LPN.
The examination was wholly inadequate, failing to elucidate the where and how the patient was injured. Also, the assessment was conducted by an LPN without collaboration with an appropriately licensed professional.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

An LPN, practicing beyond the scope of his/her license, independently conducted a post-injury assessment. Further, the assessment was incomplete.

Patient 47

Housing Unit 3

Trigger: Records Received from MDOC in Response to Request for Production by Plaintiffs
(document DEF-031503)**Document Review**

January 7, 2016

The patient cut his throat. He was taken to the Clinic where an LPN attempted to conduct a post-injury evaluation. While being treated, custody staff recovered a substance in his cell believed to be an illicit drug (“spice”). The patient refused examination or treatment. The LPN documented this and then apparently released the patient back to custody staff. After refusing treatment, while being escorted back to his cell, he threatened to harm staff and property and was taken to an isolation cell.

The encounter with the LPN – even if competently conducted – was beyond the legal scope of practice of an LPN. The encounter was not competently conducted. The fact that the patient had harmed himself (and in a possible suicide attempt), on its face indicates that the patient probably did not have the capacity to refuse examination. Beyond any immediate medical needs (which were not met), the patient was at on-going risk of self-harm and death. Thus the medical professional taking care of him at that point should have immediately placed him in a protected environment (i.e. suicide watch cell) and notified a mental health professional. Instead the nurse allowed him to be placed back in general population.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

An LPN, practicing beyond the scope of his/her license, independently attempted to conduct a post-injury assessment. When the patient “refused” examination, the nurse failed to recognize that the patient might be mentally impaired, failed to immediately place the patient in a safe environment and failed to summon a mental health professional. All this resulted in placing this patient in mortal danger.

Patient 48

Housing Unit 3

Trigger: Records Received from MDOC in Response to Request for Production by Plaintiffs
(document DEF-031588)

Document Review

February 16, 2016

The patient was involved in a fight with another inmate. He was taken to the Clinic where an LPN attempted to conduct a post-injury examination. The patient refused and he was released by the LPN.

Conducting a post-injury assessment is beyond the scope of practice of an LPN as is executing an informed refusal. Given the lack of information about possible injuries, the LPN should have contacted an RN or practitioner to discuss this with the patient and obtain an informed refusal.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

An LPN, practicing beyond the scope of his/her license, independently attempted to conduct a post-injury assessment and independently obtained a refusal. Such a “refusal” is not an informed refusal (because an LPN would typically not have the knowledge, skills, and training to provide all the patient with all the necessary information), meaning the patient may have refused due to lack of sufficient information about the risks and alternatives. Thus the LPN placed the patient at risk for adverse consequences of an untreated injury.

Patient 49

Housing Unit 1

Trigger: Records Received from MDOC in Response to Request for Production by Plaintiffs
(document DEF-031630)**Document Review**

February 17, 2016

According to custody documents, the patient was sent to the Clinic for a screening examination prior to being placed in an isolation cell due to a rule violation. (This does not match with the history obtained by the nurse, which indicates that the patient was assaulted by other inmates.) He was examined by an LPN whose examination indicates trauma to the patient's head.

The examination was wholly inadequate, failing to elucidate the where and how the patient was injured, and failing to examine important elements such as neurologic function, given that the patient was injured in the head. Also, the assessment was conducted by an LPN without collaboration with an appropriately licensed professional.

Summary of Problems

Section E (Failure to Provide Health Care Consistent with What is Expected of Health Care Providers)

An LPN, practicing beyond the scope of his/her license, independently conducted a post-injury assessment. Further, the assessment was incomplete. The deficiencies could have led to missing such serious complications as a concussion or hemorrhage into the brain.

Patients 50-60

Patients 50-60 have been purposefully omitted and are addressed below.

Patient 61

Housing Unit 3

Trigger: Patient Interviewed during Walk Through

I interviewed this patient on July 12, 2016. He had been at EMCF for seven years. He seeks health care for hypertension and mental health issues. He believes medical services are good. He complains about the food, which he says has too much starch.

Patient 62

Housing Unit 5

Trigger: Patient Interviewed during Walk Through

I interviewed this patient on July 12, 2016 as part of my walk through.

This patient was satisfied with medical care at EMCF.

Patient 63

Housing Unit 3

Trigger: Patient Interviewed during Walk Through

I interviewed this patient on July 12, 2016. He reported that health care delivery is okay. He receives a monthly injection of haloperidol and sees an NP about every three months.

Patient 64

Housing Unit 3

Trigger: Patient Interviewed during Walk Through

I interviewed this patient on July 12, 2016. He had been at EMCF for three years. He hadn't used medical services much and has not had any problems with it. He believes medical services have been more responsive in the past year.

Patient 65

Housing Unit 3

Trigger: Patient Interviewed during Walk Through

I interviewed this patient on July 12, 2016. He reported that medical care is good. It takes a couple of days to be seen after submitting an SCR.

Patient 66

Housing Unit 5

Trigger: Records Received from MDOC in Response to Request for Production by Plaintiffs
(document 20150819_DEF-029702)

Document Review

August 25, 2015

This document includes an incident report and email shared among 17 custody staff regarding the transportation of this patient to the ER. It includes medical details about the patient's condition including "increased lethargy, no appetite for 2-3 days and possible diabetic ketoacidosis."

Summary of Problems

Section I (Failure to Maintain Patient Confidentiality)

The detailed information about the specific symptoms and diseases (diabetes) this patient suffered from was apparently shared by a medical staff member with a custody staff member who then shared it with more than a dozen other custody staff members. The criterion for sharing confidential patient information is a "need to know." I can see no need for custody staff to have known the exact symptoms or disease (diabetes) suffered by this patient. Thus patient confidentiality was unnecessarily breached.

Other Individuals

In the course of my review, I interacted with another 11 inmates. One inmate expressed fear of retaliation for speaking with me. The information I obtained from them did not contribute to this report for the following reasons:

- the individual offered no opinion about healthcare at the time of the interview (Patients 52, 53, 54, 55, 59, 60);
- the individual was not at EMCF during the relevant time period (Patients 50, 51); or
- the individual refused an interview, (Patients 56, 57, 58).

Attachment 1

Documents reviewed

- List of Off-Site Specialist Visits
- CCC Roster
- Quarterly CCC List for Quarters 3 and 4 of 2015
- Health Care Policies and Procedures
- Roster of Health Care Staff
- Sick Call Logs (two)
- Hospitalization Log
- ER Trip Log
- Sheltered Housing (Infirmary) Log
- Centurion – MDOC Contract
- External Medical Records for Patient 38
- DEF-031440
- DEF-031462
- DEF-031503
- DEF-031588
- DEF-031630
- 20150819_DEF-029702
- Expert Report of Ms. LaMarre, 2011
- Expert Report of Ms. LaMarre, 2014
- Expert Report of Dr. Stern, 2014

Attachment 3



Attachment 4

Contractual compliance standards, violation of which is supposed to result in liquidated damages

- Emergent medications are filled and administered within 24 hours of being prescribed.
- Newly admitted inmates shall receive a comprehensive health assessment and history within seven (7) days of intake
- Non-emergent health care (sick call) requests shall be triaged (face-to-face encounter by a RN) within twenty-four (24) hours of receipt (date stamp)
- Sick call referrals by a triage nurse to a medical provider for non-emergent issues shall be evaluated by a physician or mid-level practitioner within seven (7) calendar days of receipt of the original complaint
- All newly admitted inmates shall receive a dental exam within seven (7) days of admission
- All inmates shall have routine dental prophylaxis no less than every two (2) years
- Inmates referred for routine psychiatric evaluation upon intake shall be seen by a psychiatrist within five (5) calendar days for initial urgent mental health screenings
- Inmates referred for psychiatric evaluation in all cases except upon intake shall be seen by a psychiatrist within fourteen (14) calendar days of referral
- Inmates who are on psychotropic medications shall be seen by a psychiatrist at least every ninety (90) calendar days (or more frequently if deemed necessary by the prescribing psychiatrist), to include telemedicine evaluations where appropriate
- Inmates referred by a physician or nurse shall be seen by an optometrist within thirty (30) calendar days of the referral
- A licensed radiologist shall interpret all radiographs the next workday and provide written results within forty eight (48) hours after reading

Attachment 5



Attachment 6



Attachment 7

Expert Report of Dr. Stern, 2014

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Task

I was asked by the National Prison Project of the American Civil Liberties Union and the Southern Poverty Law Center to opine on the adequacy of the system for delivering medical care to the prisoner population housed at the Eastern Mississippi Correctional Facility (EMCF) in Meridian, Mississippi.

Summary of Opinions

A minimally safe and adequate health care operation in a prison has systems in place that ensure that patients have timely and unimpeded access to health care services and that the health care services they access are clinically appropriate. To be clinically appropriate, a number of conditions must be met, including, but not limited to: care must be delivered by appropriately licensed professionals operating within the limits of their licensure, training, and ability, who use sound judgment in making clinical decisions; appropriate care resulting from those decisions must be executed as ordered and followed up as needed; and all care delivered must be memorialized in a permanent medical record such that subsequent care takers have full knowledge of previous care that was planned and delivered.

I found that these components of a minimally safe and adequate health care system are missing at EMCF. The health care system at EMCF is simply incapable of meeting the serious medical needs of the inmate population, and it thereby puts the entire inmate population at EMCF at constant substantial risk of serious injury.

The dysfunction in the medical care delivery system at EMCF permeates every essential aspect of the system; health care operations are broken at every level, and there is massive evidence of deliberate indifference on the part of medical and security staff at the facility as well as their supervisors.

Furthermore, it is apparent that this extreme level of dysfunction within EMCF can exist only if the statewide oversight system is also broken. It is the responsibility of central management at the statewide-level to detect and repair systemic problems of this magnitude, which put the lives and health of prisoners in State custody at such risk. However, such oversight is practically non-existent at EMCF, since MDOC chose to enter into a health-services contract that practically guarantees there will be no meaningful oversight. First, the contract limits MDOC's monitoring of the vendor's health care delivery to eight standards. In my extensive experience monitoring correctional health care systems, it is impossible to effectively monitor a complex system with only eight standards. Further, of these eight, some are wrong (that is, compliance

with the standard would result in poor health care), most relate to low priority/low risk activities, and many are not being followed. Finally, MDOC does not even fully audit this anemic set of standards. For example, in one MDOC quarterly monitoring report I reviewed, four of the eight standards were simply not measured.¹

I preface my analysis of this system with an example from a case (Patient 1²) I review in this report: That of a 43 year old black male with a very severe cardiac condition, damaged heart tissue, congestive heart failure, asthma, high blood pressure, anemia, and schizophrenia, who recently died in an isolation cell confinement in EMCF. His heart condition was very severe, and his symptoms and related events clearly indicated the danger that his heart function was deteriorating. Medical and security staff at EMCF rarely took any of these repeated symptoms or events seriously. The patient spent several months in the medical observation unit at EMCF and then, incredibly, he was discharged back to an isolation cell in Unit 5—where he died, a month later.

Fifteen days before his death, a Mental Health Counselor saw him and noted that he was having hallucinations and said he had “nothing to live for.” The counselor observed that he “was trying to cut himself with a small dull object and he had a long rope tied around his neck” and was asking for medical and mental health assistance. The counselor’s conclusion was that the patient “did not appear to be in any distress” after which the counselor simply walked away. Despite his history of severe mental illness and the fact that he was supposedly under close monitoring by the mental health team due to his very high risk of deterioration, and after this searing encounter, he was not to be seen by any mental health professional again for nine more days. This event went beyond any deliberate indifference I have seen in my entire career; it is the definition of intentional patient abandonment.

Two days before his death, he set fire to his cell, apparently in a desperate effort to get medical attention. Later, a registered nurse noted in his medical chart that the patient’s vital signs were stable and he was in no acute distress: At that point in time, however, the patient had been dead for ten hours.

I cannot state with certainty that the blatant and callous lack of care that this 43 year old man received during his last months at EMCF caused his death. However, I can state that it deprived him of any chance he had for continued survival.

This case illustrates not only most of the categories of systematic deficiencies in the medical care system that are identified in this report, but also the tragic, callous, and outrageous neglect of basic human needs to which prisoners in solitary confinement are subjected by medical staff and security staff at EMCF, and the profound lack of oversight

¹ The report (Quarterly Performance Review, April 1 through June 30, 2013) cites the absence of a computer program as the reason for not monitoring these standards. Based on my experience as a monitor, measurements can be made in the absence of a computer program – lack of a computer program is rarely an adequate excuse. Further, the monitoring report I reviewed was issued nearly two years after implementation of the contract it was meant to monitor. If there was a technical barrier to effective monitoring, that barrier should have been addressed and resolved two years earlier.

² See Attachment 2 for a list of patient numbers and names.

and abdication of responsibility by Department of Corrections (DOC) leadership and by the corporate vendors at EMCF.

Errors occasionally happen in any health care system. In properly functioning health care systems, the leadership understands that it has a non-delegable duty to recognize and address these errors to prevent recurrences. Based on my review of this case, EMCF is incapable of doing so. On 12/23/13 medical staff, supervisors, and Health Assurance Corporate managers conducted a mortality review of this patient's death, and did not identify a single one of the plethora of problems identified in my current report, satisfied that there was "nothing additional that could have been done" and that the patient's treatment "appears to have been appropriate." Thus, it is clear that the system of care at EMCF is broken, and that at every level staff are unable or unwilling to fix it.

Qualifications and Disclosures

I am a board certified internist specializing in correctional health care. I have managed health care operations and practiced health care in multiple correctional settings. Most recently, I served as the Assistant Secretary of Health Care for the Washington State Department of Corrections.

On a regular basis I investigate, evaluate, and monitor the adequacy of health care delivery systems in correctional institutions on behalf of a variety of parties including federal courts; the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security; the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice; and state departments of corrections and county jails.

On behalf of the National Commission on Correctional Health Care (NCCHC) until 2013 I taught the Commission's correctional health care standards semi-annually to correctional health care administrators at NCCHC's national conferences. I authored a week-long curriculum commissioned by the National Institute of Corrections of the U.S. Department of Justice to train jail and prison wardens and health care administrators in the principles and practice of operating safe and effective correctional health care operations, and am currently the principle instructor for this course. Additional details of my education, teaching and work experience, and publications, are contained in my Curriculum Vitae, which is attached.

I am being compensated for my work in this matter at a rate of \$225 per hour.

The facts or data I considered in forming my opinions below are contained within this report. A list of the documents I reviewed and upon which I relied appears in Attachment 3.

Methodology

I visited EMCF from 4/22/14 to 4/25/14. I was accompanied by Madeleine LaMarre, APRN, another medical expert with whom I coordinated review of the delivery of medical and dental care at the prison. I was also accompanied by two mental health experts, Dr. Terry Kupers, MD, and Dr. Bart Abplanalp, PhD. During the course of the

visit I met with, among others, the facility's custody supervisors and officers, EMCF's Health Services Administrator (HSA) Mr. Ollie Little, the phlebotomist, and numerous patients.

I visited all non-isolation housing units (Units 1 through 4 and Unit 7), all isolation housing units (Units 5 and 6), the recreation areas for Units 5 and 6, the intake area, and the Medical Unit.

I observed the van used for transportation to the hospital.

I reviewed 22 patient records on site and another single record after the tour. I chose records for review from a sampling from a number of different sources, including the following:

- a) logs of patients sent to the emergency room
- b) logs of patients admitted to the community hospital
- c) logs of patients housed in the Medical Unit
- d) logs of patients who have submitted Sick Call Requests (SCR)
- e) the register of patients enrolled in the facility's Chronic Care Clinic (CCC)
- f) grievance logs
- g) cases referred to me by the mental health subject matter experts based on their own reviews
- h) cases referred to me from the Plaintiffs' attorneys
- i) randomly chosen patients with whom I spoke in Unit 7 (the least restrictive housing unit at EMCF) randomly chosen patients with whom I spoke in Unit 5 (the most restrictive housing unit at EMCF)

I chose cases from the logs and register a) through e) because these logs point to inmates who actually use health services and/or point to care which is more substantive and has the potential for harm if mismanaged. Eight of the 23 cases were chosen because a problem was already suspected (including one death); the remaining fifteen cases were drawn from the generic logs cited earlier. I coordinated my work with my colleague, Ms. LaMarre. We discussed elements of cases as we worked on site and used those discussions to help ensure that our individual findings were accurate. Ms. LaMarre reviewed an additional 19 cases. Thus, between us we reviewed a total of 42 cases. I have reviewed Ms. LaMarre's findings and conclusions and find them to be entirely consistent with mine.

Based on my experience operating, auditing, and investigating correctional health care operations, I conclude with a high degree of certainty that the problems I identify in this report are systemic. No health care operation – even the best – is perfect. I would not be surprised to identify an occasional problem here and there in even the best-managed prison health care system. However, each and every case that I examined at EMCF was rife with evidence of dangerously deficient care. There is no question in my mind that these dangerous deficiencies permeate the health care operation at EMCF.

Background

EMCF houses inmates at the entire spectrum of custody levels (i.e. from minimum to close custody) and specializes in care for the mentally ill. On the day of my visit, the population was approximately 1,200. The facility is part of the Mississippi DOC system, and is currently operated by MTC, a private prison operator. Health care is contracted to a private health care vendor, Health Assurance LLC (“HALLC” or “Health Assurance”). Health Assurance provides all medical, dental, and psychiatric care to the prisoner population at EMCF. Health Assurance also provides psychological care except for care associated with programs, such as chemical dependency treatment and behavior change, which is provided by MTC.

The health care operation is managed centrally in the Medical Unit by a single leadership team, and all direct health care is provided by the same clinical staff. An electronic health record system is used for all patients.

Inmates transferring to EMCF are received only during business hours. The intake area is located across the hall from the Medical Unit; inmates are taken there shortly after arrival for health screening.

Patients are expected to request non-urgent health care by submitting a SCR. The forms are either placed by the patients or officers in locked boxes which are accessed by health care staff. Patients are expected to request urgent/emergent care by notifying an officer. Sick call is provided primarily by one registered nurse (RN) who schedules sick call approximately two days per week for each living unit. Sick call is generally conducted in rooms near the living units: a room near Units 3 and 4 for inmates in those units; a classroom for inmates in Unit 2; a room in the hallway leading to isolation for inmates in Units 1, 5, and 6.³ Most care is recorded in an electronic health record (EHR).

There is an Observation Unit (OBS) which is used for short term observation. It has a 10-bed capacity and was full during our tour. It is used primarily to house patients with acute psychiatric needs, though it is occasionally used to house patients with acute medical needs.

Almost all medications are administered directly by the nurses. My colleague Ms. LaMarre describes the medication administration process more thoroughly in her report.

Findings and Opinions

A. Lack of Access to Urgent Care

An essential element of a safe health care system is that inmates need to be able to access it, especially when their need is urgent. “Access” means receiving attention for a medical need in a timely manner. Inmates at EMCF generally access urgent health care by

³ Typically, a classroom is not a clinically appropriate venue for delivery of health care due to the lack of proper medical equipment, hand washing facilities, and confidentiality. I did not visit the classroom during my tour.

making an oral request to an officer who should then notify a nurse, who in turn should evaluate the patient's health care need. I found ample evidence that inmates at EMCF do not have timely access to urgent care.

Inmates with whom I spoke told me of the difficulty they have accessing care for urgent needs. First, if they are locked in their cell – as are inmates housed in isolation cells, or as are other inmates at night – they often have difficulty getting the attention of an officer. There are emergency buzzer buttons located in each cell but this emergency notification system is unreliable. Ms. LaMarre and I tested the emergency buzzer buttons in isolation and non-isolation cells. I triggered the buzzers while Ms. LaMarre, located in the picket (officer observation booth), observed the response board. The results of these tests were as follows:

- Unit 3, first living unit: three out of three operated properly.
- Unit 3, second living unit: one out of three operated properly.
- Unit 5: one buzzer operated, one buzzer was already alarming in the picket prior to the test and the officer could not shut it off, one buzzer button was missing (there was a hole in the wall where the button should be).

EMCF staff contend that if the emergency buzzers don't function, the inmates can attract staff's attention by yelling or banging on their doors. However, this method is of little use in the isolation living units when it is so noisy (as it was during part of my visit) that the inmate in distress will not be heard.

If and when inmates are able to get the officer's attention, inmates reported difficulty in convincing the officer that they need medical attention. One patient told me the only way one can get to see a nurse is if "they see blood." If they do get the officer's attention, and the officer does communicate the request to a nurse, the officer is often told by the nurse "tell them to drop a slip" (i.e. submit an SCR; SCRs are not processed on an urgent basis), thus guaranteeing that the patient will not receive an evaluation or any urgent care. Finally, if the inmate is able to leap the hurdles of getting an officer's attention, convincing the officer to contact a nurse, and motivating the nurse to evaluate him, that evaluation sometimes takes place only after a delay of hours.

The following cases illustrate some examples of barriers to access to urgent care:

- Patient 4 is housed in an isolation cell. He told me that if he has an urgent problem, he notifies an officer, but it can take a while to be seen. Three days prior to my visit he suffered from chest pain and a headache at around 21:00. He was able to get the attention of an officer who notified a nurse. The nurse instructed the officer to have the patient fill out an SCR. Chest pain (and at times, even headaches) can be symptoms of serious medical problems and require immediate evaluation, and thus having the patient fill out a form instead of conducting an immediate evaluation is dangerous.

- Patient 5, also housed in an isolation cell, told me that if he notifies an officer of an urgent problem, the officer usually tells him to fill out an SCR. Response to those SCRs can take “a couple of weeks” and sometimes he has to submit multiple SCRs.
- Patient 8 related the statement above, that if a patient has an urgent need, the only way to be seen is “if they see blood.”

Thus, there is a high risk that inmates at EMCF who have an urgent health need will either not be able to make their need known to staff, or, even if they do make their needs known, will not receive timely – or any – care. As a result, there is a high risk they will suffer harm.

B. Lack of Access to Non-Urgent (Episodic) Care

It is also essential that inmates be able to access care for non-urgent medical needs in a timely manner. Non-urgent routine health care at EMCF is generally accessed by submitting a written sick call request (“SCR”). I found as a systemic matter that inmates at EMCF do not have reliable access to non-urgent care.

Some patients told me that often they receive no response to their SCRs and that they have to submit multiple SCRs until they receive attention. Some patients receive written responses without any actual examination or evaluation, which amounts to no care. Some receive care, but only after an unacceptably long delay, which can range from several days to weeks.

EMCF Medical Unit staff’s failure to take any action on SCRs is sometimes caused by custody-related impediments, such as lock-downs or lack of custody escorts to take patients to the Medical Unit. According to the log of patients who submitted SCRs during just the first three weeks of October 2013 (the most recent month on the log provided by EMCF prior to my tour), 19 patients were denied access to care for custody-related reasons. While, it is understandable that custody emergencies might sometimes have to take precedence over patient access to non-urgent care, this should happen only on very rare occasions; the frequency of this occurrence at EMCF is unacceptable and dangerous.

A review of the same log during the same three-week period revealed an additional 24 instances in which patients were denied (for reasons unrelated to custody) any meaningful examination or evaluation, and received only a written response. While a few of these written responses were replying to requests for refills of medications (for which a written response is acceptable), most were for actual health needs, such as rash, pain, and cough. Attempting to deliver care in this manner – “health care by correspondence” – is dangerous and unacceptable.

During my review of medical records, I found example after example supporting patient claims of impaired access to care. A few of these examples are below; more are detailed in Case Extracts on proceeding pages:

- Patient 9 submitted an SCR on 10/27/13 for chest pain and shortness of breath. The SCR was not reviewed until 11/11/13. This is an exorbitant delay given the nature of the complaint; the patient should have been seen as soon as the SCR was received in the Medical Unit, typically the same day. The same patient submitted an SCR on 12/5/13 with similar complaints. Once again, there was a dangerously long delay until he was finally seen on 12/12/13.
- Patient 11 submitted an SCR on 3/14/14 for pain in his left foot and stomach. He did not receive any evaluation. Instead a nurse wrote back, “Have you hurt your foot?” In a patient such as this one, with diabetes, foot pain can be a serious – even life-threatening – symptom, and requires immediate face-to-face evaluation.
- Patient 14 submitted an SCR on 12/21/13 for a cough. The problem was managed by correspondence. A cough can be a symptom of something as benign as a mild cold or as serious as pneumonia, tuberculosis, or a pulmonary embolism, and thus requires evaluation.
- Patient 15 submitted an SCR on 10/21/13 for “body pain.” The problem was managed by correspondence.

Barriers to access to care were also seen for dental-related complaints, as the following examples illustrate:

- On 1/10/14, Patient 2 submitted an SCR for a toothache, writing “it hurts so bad.” No action was taken on this request until 2/2/14 (including any pain relief), at which time his condition was serious enough to require an extraction.
- Patient 3 submitted an SCR on 7/22/13 for “gums are bleeding and 31, 32 lower left [two molars] are killing me.” The SCR was not reviewed until 12/1/13 – more than four months later.

C. Failure to Use Sound Clinical Judgment and Care

It is not enough for a patient to simply gain access to health care. Once health care is accessed, care must be delivered by appropriately licensed professionals operating within the limits of their licensure, training, and ability, who use sound judgment and a reasonable degree of competency in making clinical decisions and delivering care. At EMCF, care, sound clinical judgment and competency are often lacking; and some care is provided by clinical staff practicing beyond the scope of their license or without a license.

(1) At EMCF, Defendants employ an optometry technician (a discipline which is not licensed in Mississippi) to practice as an optometrist, optometry being a profession that does require a license. This is discussed in greater detail by Ms. LaMarre in her report.

2) At EMCF, LPNs practice beyond the scope of their licenses. According to Mississippi state law (and consistent with LPN education and most states' laws throughout the nation), LPNs do not have the "substantial skill, judgment, and knowledge required of a registered nurse,"(Mississippi Nursing Practice Law, Section 73-15-5 (5)). Therefore LPNs should only collect data to be used by RNs or practitioners⁴ to make clinical decisions, and should only implement care plans developed by RNs or practitioners; LPNs should not make clinical decisions (nursing assessments) or design care plans independently. Unfortunately, at EMCF, LPNs do just that, denying patients the benefit of competent medical decisions as the following examples illustrate:

- An LPN caring for Patient 14 on 9/2/13 measured his blood sugar and discovered it was so high, it could not be registered on the unit she was using. The LPN, acting independently, apparently made the clinical decision that no further action was needed and did not report this life-threatening abnormality to an RN or practitioner. On 9/6/13, four days later, several hours after nurses responded to an emergency for this patient due to apparent loss of consciousness ("man down"), another LPN made a similar observation and again decided to take no action. This medical mismanagement eventually led to the patient becoming disoriented and needing evacuation to the ER later that night.

3) At EMCF, RNs practice beyond the scope of their licenses. RNs may not independently order x-rays or prescribe medications. According to Mississippi state law (and consistent with RN education and most states' laws throughout the nation) these acts are reserved for practitioners.⁵ At EMCF, RNs order x-rays and prescribe medications independently, denying patients of the benefit of competent medical decisions as illustrated in the following examples:

- An RN examined Patient 9 on 11/19/13 for chest pain with breathing and a cough. In the absence of a legal order from a practitioner, the nurse ordered a chest x-ray.
- Another nurse also ordered a chest x-ray on Patient 9 on 12/12/13.
- An RN prescribed a powerful steroid (cortisone) medication for Patient 5 on 3/19/14 in the absence of a legal order from a practitioner. (Further, there is no evidence the nurse ever examined the patient prior to prescribing the medication.)

⁴ In this report, "practitioners" are professionals licensed to independently order medical tests and prescribe treatments. At EMCF they include physicians and nurse practitioners.

⁵ "Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation and supervision of nursing, and execution of the medical regimen, including the administration of medications and treatments prescribed by any licensed or legally authorized physician or dentist. The foregoing shall not be deemed to include acts of medical diagnosis or prescriptions of medical, therapeutic or corrective measures, except as may be set forth by rules and regulations promulgated and implemented by the Mississippi Board of Nursing." Mississippi Nursing Practice Law, Section 73-15-5 (2)

Even when professionals act within the scope of their licensure, patient records abound with examples of failure to exercise reasonable professional judgment when making clinical decisions. Such failure is demonstrated by all clinical disciplines at EMCF, including physicians, nurse practitioners, nurses, and dentists. In fact, in some cases professionals provided such a paucity of actual hands-on care, that it was doubtful that these events should be classified as clinical encounters at all; they might more properly be classified as examples of complete lack of access to care.

The most common example among nurses is the deficient level of care delivered in sick call in response to SCRs, as illustrated in the following examples:

- Patient 7 was seen by a nurse on 4/21/12 for pain of his left side and shoulder. Evaluation of such a complaint requires eliciting a history of symptoms and conditions from the patient and then performing a physical examination; without this one cannot rule out serious medical problems. There is no evidence of any such evaluation by the nurse.
- In response to an SCR for “bad” chest pain sent by Patient 9 on 12/5/13, a nurse finally evaluated him on 12/12/13. The nurse did no examination other than obtaining vital signs.
- In response to an SCR for chest congestion sent by Patient 4, he was seen by a nurse on 10/19/11. Other than measuring vital signs, the nurse failed to conduct any examination. The patient had a similar encounter with a nurse on 4/10/14 when he complained of sinus congestion, except this time the nurse did not even measure any vital signs before prescribing medications.

I found that one of the most common examples of failure to exercise sound clinical judgment by physicians is the decision to send unstable, acutely ill patients to the ER by passenger van. For most evacuations of patients from the prison to the ER, EMCF uses a passenger van rather than summoning an ambulance. The van is a 12-passenger vehicle in which the patient rides in a seated position, without any medical equipment or the presence or monitoring by any medical personnel. EMCF is billed for ambulance use while the passenger van is owned and operated by the prison. Transportation by van can be appropriate in situations where the patient has a minor ailment that does not require medical monitoring, or an ailment where transport in an upright position will not pose a risk to the patient. In all other situations, transportation by an ambulance is the only safe choice. The following are examples of dangerous substitution of a van for an ambulance:

- Patient 21 submitted an SCR for chest pain, sweats, and a “speeding heart” on 1/13/14. He was seen by a mental health counselor (not a medical professional) on that day and referred to a nurse, but was not seen until the following evening. At that time his blood pressure was dangerously high (146/110). This set of facts defined a medical emergency and demanded transportation under medical

monitoring and care in an ambulance. The nurse contacted a physician who ordered the patient sent to the ER by passenger van.

- On 9/4/13, Patient 2 was found on the floor with slurred speech and dilated pupils. His heart rate was dangerously high (144) and his blood lacked the normal amount of oxygen. Staff documented that he had taken someone else's medication. In the face of this patient's symptoms, vital signs, and the possibility of an adverse reaction to medications, the patient's health was in a precarious state requiring emergency evacuation to a hospital with close medical monitoring. Instead, he was sent to the hospital by van.
- On 9/6/13, Patient 16 was found disoriented and unable to answer questions. He had diabetes and was found to have an extremely high blood sugar level (near 500). The physician was called and ordered him transferred to the hospital by van. Sending the patient to the ER in a van was dangerous. First, the reason for his change in mental status was not known and could be due to a serious and unstable problem that might get worse during transportation, requiring medical intervention. Second, since his mental status was unstable, transportation by van accompanied only by security staff placed him and staff at additional risk if he became unruly.

In the first 10 months of 2013, EMCF used the passenger van for 125 of the 168 patient evacuations to the ER. Based on the cases I reviewed, many of these transportations by van were dangerous and placed the inmates at risk. This practice of transporting patients to the ER by passenger van puts inmates at EMCF at substantial risk of serious injury.

D. Failure to Execute and Follow-up on Medical Orders

Once a patient accesses health care and a medical professional orders care, that order must be carried out. "Orders" are specific instructions or prescriptions for medical care. Examples include orders to monitor patients' vital signs, obtain blood tests or x-rays, and begin medications. In the absence of a specified time frame, orders are expected to be carried out in a clinically appropriate time frame. Orders may be issued only by duly licensed practitioners; as explained earlier, nurses may not independently issue medical orders.

At EMCF, critical orders for care are systematically delayed for significant periods, or simply ignored altogether. These failures manifest themselves in a number of ways. Sometimes the order is not carried out by custody staff.⁶ Sometimes a plan from a transferring facility is ignored, usually an order for a patient to receive monitoring for a chronic disease in the CCC within a set period of time. Sometimes an internal order – for a blood test, for an x-ray, for a follow up appointment – is simply lost.

⁶ See the example provided below in the "A Capstone Case" section of this report.

- Patient 8 has a history of severe hypertension (high blood pressure). On 5/24/13 his blood pressure was 150/105, which is significantly elevated. The physician ordered that his blood pressure be re-checked in four weeks. However, the recheck did not occur. His blood pressure was not checked again for nearly a year.
- Patient 6 has asthma. On 4/5/12 an order was written for a follow-up visit for care of his asthma in two to three months. The visit did not occur until 18 months later.
- Patient 9 uses an inhaler for a breathing problem and had screened positive for tuberculosis infection⁷. On 12/5/13 he submitted an SCR for chest pain and shortness of breath. A nurse ordered a chest x-ray. As an initial matter, a nurse cannot and should not order an x-ray without a practitioner's order. The order was never executed and the chest x-ray never performed for this patient at risk for developing active tuberculosis.

Another serious type of failure to execute orders is the failure of nursing staff to administer medications as ordered by a practitioner. Every dose of medication that is administered should be documented on a paper grid, which is called the Medication Administration Record, or MAR. When a patient refuses a dose of medication, the nurse should make some notation. Unfortunately, this is not what happens at EMCF. There are so many holes on the MAR grids of patients at EMCF that they can sooner be likened to Swiss cheese than medical records. This problem is so pervasive that I was unable to open a patient MAR without finding an example. Most medications are prescribed to treat serious medical conditions, thus it follows that failure to provide medications puts patients at serious risk of harm as the following examples illustrate:

- Patient 22 has a cardiac condition that requires him to take Coumadin (a blood thinner). Coumadin is a powerful medication that requires frequent monitoring and adjustment to keep the medication level from being too high or too low; failure to do so places the patient at risk of developing dangerous blood clots or bleeding. On 5/29/13, the patient's blood was too thick. The doctor ordered that his dose of Coumadin be increased to avoid a clot. However, nurses failed to carry out this order until more than a week later. During this period, the patient was in danger of developing a potentially lethal blood clot.
- Patient 18 who was supposed to be receiving Tegretol and phenobarbital to prevent seizures. During the month of April 2012, nurses failed to administer 23 doses of Tegretol and 22 doses of phenobarbital. The level of these drugs in the patient's blood dropped and as a result on 5/1/12 he had a seizure.

⁷ The test indicated that he had tuberculosis in the past and had overcome it. However, the tuberculosis organism remains dormant in the body, so he was at risk for the tuberculosis infection recurring in the future.

- Patient 8 had severe hypertension (high blood pressure) requiring multiple different medications to control it. During the month of October, 2013 (chosen at random) nurses failed to administer 40 doses among the patient's six different blood pressure medications.

These failures to execute orders and follow up on care plans are systemic and place patients at EMCF at significant risk of serious harm.

E. Failure to Provide Adequate Care in Infirmiry

In prisons, some patients are too sick to live in general housing, but are not so sick that they require hospitalization. These patients are placed in the infirmiry within the prison. In the infirmiry, they are supposed to receive closer monitoring and/or more frequent care by doctors and nurses. If their condition becomes graver, they are transferred to a hospital.

At EMCF there is an infirmiry (Medical Observation or OBS) that can house 10 patients. Nurses are available around the clock. Unfortunately, as with other clinical operations at EMCF, the infirmiry operation does not work as it should. Health care staff do not have a reasonable degree of competency and do not exercise sound clinical judgment (see Section C) and health care staff fail to execute or follow up on medical orders (see Section D). These failures subject these sicker patients, who are placed in OBS, at significant risk of serious harm, as illustrated by the following examples.

- Patient 10 was admitted to OBS on 7/6/13 upon return from a community ER for treatment of a large boil in his abdomen. A physician saw him in OBS. He ordered antibiotics and for results of wound cultures (tests of pus from the boil, results of which help guide proper antibiotic therapy) obtained in the ER to be checked in a few days. Based on the patient's overall condition plus his loss of weight, the physician was concerned that the patient might suffer from a more serious underlying medical condition (e.g. cancer), and also ordered an x-ray and blood tests. The blood tests were obtained and antibiotics were given. The patient was monitored by nurses until around 7/12/13. The blood test results were markedly abnormal, indicating that the patient was chronically ill and had a seriously low blood count (anemia). However, clinical attention for the patient seems to end on or about 7/12/13 without explanation. The x-ray was never obtained; the results of the wound cultures were never checked; there were no further visits by nurses or the physician; and as of my departure from the facility on 4/25/14, the blood tests results were never reviewed or addressed by the physician (despite the fact that they supported the physician's concern that the patient might have a serious underlying disease).
- Patient 16 was very ill from his diabetes and was sent emergently to the ER on 9/6/13. Upon return from the ER, nurses admitted him to OBS. In OBS he was still quite ill: he was confused and unable to walk safely on his own. At this point, nurses should have sought the input of the physician. Instead, they simply

put him to bed. The following morning he was still disoriented and unable to follow commands. Given a biscuit to eat, he placed it first on his nose. Finally a nurse practitioner was contacted who ordered the patient returned to the ER. Thus the patient was managed improperly overnight without the necessary involvement of a practitioner, and as a result remained at EMCF's OBS in a highly unstable and dangerous clinical condition when he should have been in the ER.

- Patient 19 was seen by a nurse at around 10 A.M. on 7/11/13 because officers were concerned that the patient was ill. The patient had been vomiting for two days. On the nurse's examination he appeared "hollow eyed," had cool and clammy skin, and his abdomen was swollen. His vital signs were not normal: his heart rate (114) and breathing rate (22) were both abnormally elevated, and due to his poor blood circulation, the nurse was unable to measure the oxygen level in his blood. Despite evidence to the contrary (including some of the physician's own actions, such as ordering a stat x-ray), the physician diagnosed the patient with constipation and placed him in OBS. However, once in OBS, no observation took place. Over the ensuing five or more hours, no nurse checked on the patient nor were his vital signs rechecked. Finally, later that evening, the radiologist called the facility due to concern about the results of the x-ray. Sometime after 5 P.M. the patient was sent to the ER. He was found to have had a ruptured ulcer resulting in stomach contents spilling into his abdomen. After a complicated course, he was released from the hospital 17 days later. Valuable time was lost during the patient's stay in OBS from 10 A.M. to 5 P.M. due to both misdiagnosis and lack of monitoring. That delay in getting to the operating room may have resulted in the rupture becoming much more serious; it certainly did not help.

Thus the systems of care present in EMCF's OBS are dysfunctional and place some of the facility's sickest and most unstable patients at significant risk of serious harm.

F. Failure to Maintain an Adequate Medical Record

Health professionals must record all significant health care information about a patient in a medical record. The medical record is the primary tool for the multitude of health professionals caring for a patient to communicate with one another. The record must be complete and clear so that each user of the record can easily and accurately determine what is already known about the patient and what care has already been delivered to the patient. To be complete, all care givers must document all significant information, and all this documentation must actually be in the record. These are fundamental and universal principles for the provision of health care. If the medical records is not complete and clear, health care providers make decisions and provide care in a vacuum, resulting in errors. This requirement is so fundamental to adequate care that there is an axiom, "If it isn't documented in the medical record, it didn't happen."

EMCF uses an electronic medical records system (the proprietary name of the system EMCF uses is Centricity). All patient care information is supposed to be contained in the Electronic Health Record (EHR). When providers record care on a paper document, that

document is supposed to be scanned electronically and filed in the EHR as soon as its use has ended (for example a monthly paper record is supposed to be scanned into the EHR at the end of the month).

There are serious deficiencies in the medical record maintained at EMCF, both in the way the record is designed as well as in the way it is used.

The design of the EHR used at EMCF makes it difficult if not impossible to find and retrieve useful information for safe care for the following reasons:

- The process for determining when a patient has been transferred from one facility to another is extraordinarily convoluted. It must be divined by a combination of looking at the EHR folder called Transfers (which is not complete) and another folder called Lab Reports which, for some reason, is the repository of both actual lab test reports, and reports of patient transfers from one facility to another.
- It is exceedingly difficult to figure out what medications a patient was ordered to take at any particular moment in time, further clouded by the fact that refills (i.e. continuation of existing orders) appear as new orders replacing old orders. Thus if a practitioner needs to figure out what medications a patient with diabetes was taking at a particular moment in time, to correlate those medications with his blood sugar measurements and make necessary adjustments, it is prohibitively time-consuming.
- When scanning a paper document into the EHR, it appears that the EHR only allows one paper page to be stored per file for certain document types. Thus when reading a multiple page document, like a hospital discharge summary, the reader must open each page separately. This is very time consuming and also makes moving back and forth among the pages difficult. To make the process even more difficult, the various files each bear the same name and are not always scanned and stored in sequential order. Patient 16, for example, has a scanned copy of ER records from a 9/6/13 trip in his EHR. The report is 29 pages long. Each page is in its own file, which must be opened separately... and the pages are out of order and some of them are upside down.
- The results of blood tests are found in the Lab Test Results section of the EHR. This is where someone searching for blood test results would normally look. However, if a blood test has not yet been reviewed by the physician, the computer automatically files the results elsewhere in an obscure part of the EHR. Thus someone looking for a patient's blood test results will likely miss those results if they have not yet been reviewed by the physician. Patient 11, for example, has four diabetes blood tests results (9/23/13, 8/1/13, 3/8/13, and 12/20/12) which are not posted in the Lab Test Results section of the EHR, but rather reside in an obscure part of the EHR. I happened to discover them

by accident. This important clinical information can be easily missed, resulting in patient harm.

In addition to the mass of errors introduced into the records by these profound design flaws in the EHR system, the records are rife with careless errors introduced by staff, who do not compose or file documents as they should:

- Documents are labelled and filed under the wrong category, so they cannot be found when searched. For example, Patient 7 had an injury evaluation filed under chronic care visits. Patient 17 had an MAR filed as a chronic care visit (...sideways).
- Scanning of paper MARs into the EHR is about 6 months behind. So it is impossible for a practitioner to determine a patient's medication dosing history within the past 6 months without doing a manual search of paper records (kept in another part of the prison outside the Medical Unit), which is time consuming. For example, for all patients I reviewed, the MARs for November, 2013 through to March 2014 have not yet been scanned and filed in the EHR. If a patient is transferred to another facility before his paper MARs have been scanned, the paper MARs remain at EMCF, creating an additional barrier for a practitioner at the new facility.
- For expediency, practitioners cut and paste passages from previous clinical notes into the current one, meaning that the current notes are not records of the current encounter. In other words, the EHR is not a reliable record. For example, Patient 11's chart shows the following information during a visit on 11/04/11: "Bronchitis, c/o swollen R foot; hemorrhoids, c/o dental problems on bottom L side; accucheck [blood sugar] 169 @ 3:50pm." The identical information also appears on the patient's visits on 2/23/12, 2/15/13, 4/16/13, 4/20/13, 7/28/13, and 2/1/14. Clearly the patient's blood sugar was not 169 at 3:50 P.M. on seven different occasions. However, a health care provider reading this patient's EHR would not likely notice this error. If s/he then relied on this misinformation to make a treatment decision, the treatment would likely be wrong.
- Practitioners do not keep patient problem lists up to date. The problem list is a list of all a patient's diagnoses. It is an essential tool in a medical record that assists all users of the record to quickly know what health problems a patient currently suffers from. Most patient records I reviewed were missing serious health problems from the problem list.
- Documents are scanned and filed helter-skelter. Many documents are scanned sideways or upside down. The user can rotate the image, but this is time consuming. Other documents are mislabeled. Patient 10 had blood tests done in the ER on 7/6/13. The report is two pages long. Page one was scanned and filed (correctly) as an outside document on 7/6/13. I could not find the second page until I accidentally opened the scan of an outside document labeled 6/6/13.

- Physicians do not always review and sign off on blood test results (see above). An EHR should have a mechanism by which such delinquent reviews are flagged and communicated to a supervisor. At EMCF those notifications either do not occur or no action is taken on them. (It is also possible that the EHR in use at EMCF does not have such a flagging/communication function. If that is the case, there is still a serious flaw, but it is in the design, not usage, of the EHR.) In the example above for Patient 11, there were four diabetic blood tests which had not yet been reviewed by the physician, and were therefore still filed in an obscure section of the EHR. These four tests had been performed on 12/20/12, 3/8/13, 8/1/13, and 9/23/13; as of my visit on 4/22/14, the physician had still not reviewed them.
- Perhaps the most scandalous entry I discovered was a progress note created by a nurse describing the stable condition of Patient 1...who had been dead for 10 hours.

In the absence of a complete and clear medical record there cannot be safe patient care. The medical records in use at EMCF are atrocious. They cannot be relied upon as being a true and reliable record of patient care. They are missing important information. Information that is not missing is not easily usable because it is: out of order; misfiled; stored sideways or upside down; or mislabeled. Worst of all, some content is intentionally or carelessly fabricated. For all practical purposes it is impossible for a provider who is responsible for patient care to review, digest, and rely upon information in patient charts. Thus there exists a systematic problem in record keeping at EMCF that puts patients at risk of harm.

G. Failure to Have or Maintain Necessary Equipment

Clinicians must use certain medical equipment to care for patients. Every clinical operation must have this equipment to test or treat patients. If this equipment is missing or non-functioning, patients cannot be safe. During my visit, I found problems with the availability of three types of equipment: equipment for assessing breathing in patients with asthma, equipment for testing nerve function in patients with diabetes, and emergency response equipment.

A peak expiratory flow (PEF) meter measures a patient's breathing strength. Its use is an integral part of chronic care for patients with asthma. Thus safe, effective care for patients with asthma can only be delivered if PEFs are measured, recorded, and tracked. To measure a PEF, the clinic must have a PEF meter and a matching (i.e. manufactured by the same company) disposable mouthpiece, which is discarded after each use. At EMCF there is a PEF meter in the CCC – but there are no mouthpieces. There are mouthpieces in the nursing station, but they are not the ones that fit the PEF meter in the CCC. During my tour, I asked the clinic staff twice to produce the equipment (PEF plus compatible mouthpieces) that they use in the CCC to measure PEFs. They could not produce this equipment. During my review of medical records of patients with asthma, I

did not find a single measurement of PEF among the five patients with asthma. Thus medical staff do not appear to be able to provide a basic element of safe care for patients with asthma.

Patients with diabetes have a high risk of developing nerve damage in the feet. When they do, they then have a high risk of developing ulcers which can lead to infections and amputation. An effective way of preventing these adverse outcomes is by early detection of nerve damage. The way to test for nerve damage is with a monofilament. This is a standard tool used in the care of patients with diabetes; patients are tested periodically during routine care for their diabetes. During my review of charts at EMCF I did not see any nerve testing with a monofilament. When I inquired about this, I was informed that if EMCF had and used such a tool, it would be in the exam room in which I was working; no monofilaments were found in that room. Thus EMCF is not appropriately equipped to provide one element of safe care for patients with diabetes.

Prison health care staff are expected to respond to medical emergencies in the prison outside the Medical Unit. They must therefore have equipment and supplies to take with them to these emergencies. At EMCF there is an emergency bag used when responding to emergencies. Its contents are listed on an inventory sheet (see photo, Attachment 1). Upon my inspection, the bag had all these contents except a glucometer, which, I was told, had broken a few days earlier; staff were awaiting a replacement. But a glucometer is a basic and important tool for measuring a patient's blood sugar during an emergency; without it, a diabetic's critically high or low blood sugar can be misdiagnosed, with lethal results. There is no justification for the failure to immediately replace the glucometer, as they are very inexpensive and available in any local pharmacy.

The emergency bag at EMCF does not include oxygen, bag mask breather, airways, and oxygen mask, or medications for treating emergencies such as aspirin and nitroglycerin for heart attacks, inhalers for asthma attacks, and glucose or glucagon for low blood sugar. If the responding nurse needs any of these supplies or equipment, an officer calls back to the clinic and someone brings it after someone gathered each item separately. Each of these are important tools for emergency care, when minutes – even seconds – count, and thus EMCF's failure to keep them in the emergency bag is dangerous. I also found that the oxygen tank which would be used for an emergency had been used earlier in the day (at least four hours earlier), was half empty, and had not yet been replaced. Thus medical staff at EMCF are not appropriately equipped to respond to medical emergencies outside the Medical Unit.

H. A Capstone Case

The body of this report describes specific problems within the systems of health care at EMCF, and provides examples of each. While that is the best analytical way to describe the failure of so many critical systems, sometimes it is also helpful to see the failure of these components in the context of a whole case affecting a single human being. Many of the case extracts below contain such stories. Some of these cases can only be described as calamities. In these cases, there is such a vacuum of care that I had

difficulty even discerning which part of the health care system was broken. The following case is worth highlighting here.

Patient 8 told me that he had severe high blood pressure requiring a number of medications, but had not had his blood pressure measured in a year. I expected he was exaggerating. He was not. He was admitted to EMCF on or around 2/3/12. He had had a CCC visit at his previous facility. His blood pressure was determined to be under good control and the plan was to have a follow up in CCC in three months.

Shortly thereafter he was transferred to EMCF. As of the time of my tour, 4/22/14, he had still not had the three month follow-up. He did have his blood pressure measured on 5/24/13. It was very high (150/105). A physician ordered medications and a return to the clinic in four weeks. That never happened.

The patient is currently on six medications for his blood pressure. A review of his MAR for October 2013 (the most recent one filed in his EHR) showed that nurses failed to administer 40 doses of his medications during that month. Early this year, he was scheduled to have some blood tests done for his blood pressure. He was scheduled to have the blood tests drawn on 3/4/14, but that did not happen because, as documented by a medical staff member in his medical record, "Security failed to bring him to the medical room...Stated short on staff. This is an ongoing issue with security." The lab tests were rescheduled for 3/11/14, but again were not done; a similar note was again placed in his medical record, "Security did not bring inmate...On going problem with unit 5." Finally, on 4/22/14, almost a year after his last blood pressure measurement – and the day I arrived for my tour - the patient had his blood checked. Not surprisingly, it was now higher.

He began to get a little more health care. A nurse notified the physician and the physician ordered the blood pressure checked the next day, when it was 198/138 in one arm and 201/125 in the other. These levels can be actively life-threatening. Appropriately, the physician ordered stat medications and to have the patient's blood pressure rechecked in two hours. However, that order was not carried out: according to a nursing note in his EHR, custody failed to bring the patient as requested. When his blood pressure finally was re-measured, almost four hours later, it was lower, but still high, but the nurse never notified the physician. Finally, when a patient has such elevated blood pressures sustained over such a long period of time, one must entertain the diagnosis of a secondary (i.e. treatable) cause of his high blood pressure. There is no evidence that over the entire time this patient was at EMCF a physician ever evaluated this patient for such a disease.

I. Case Extracts

Each medical record I reviewed was so rife with problematic care that at a certain point in most reviews, I concluded that I had adequately assessed the pattern of care for that patient, and made the decision to move on to the next case. Thus, although these extracts

are not exhaustive reviews of each patient's case, they are representative of the totality of care delivered to the patient.

Except for the shorter cases, for each case I provide a Case Summary. These are indeed summaries; most cases have additional errors in care which appear only in the Chart Review and are not noted in the summary. Finally, the Chart Reviews show the dates of key events. I recorded the clinical events themselves, as described in the patient's medical record, in normal-faced type. In italics, I describe the problem or problems with the care delivered during that event along with the reason the care is problematic if it is not obvious.

Patient 1

Case Summary

This is a 43 year old black male with a history of damaged heart tissue (non-ischemic cardiomyopathy), congestive heart failure (CHF), with the heart operating at 10%⁸, substance abuse, obesity, asthma, high blood pressure, anemia (hemoglobin = 11.8, hematocrit = 35.3) and schizophrenia, who died while under the care of EMCF. His heart condition was very severe, and thus symptoms and events which would be worrisome in any patient (e.g. chest pain, shortness of breath, high blood pressure, rapid pulse), were especially worrisome in him; these symptoms and events could both be a) tipping points to cause his heart to deteriorate (e.g. acute heart failure) as well as b) the result of deterioration of his heart function. Unfortunately, as the Chart Review below demonstrates, medical and security staff at EMCF rarely took any of these repeated symptoms or events seriously.

The patient spent several months in OBS at EMCF and then about a month before he died, he was discharged back to an Isolation cell. There are so many errors in his medical management that it is impossible to accurately capture the magnitude of the problem in a case summary. Most of the categories of systematic problems identified elsewhere in this report are illustrated in just the 5-month period leading to his death that I examined:

- Security knowingly barred his access to care for emergent problems (chest pain) on at least 2 occasions. Nurses knew of the emergent need, yet did nothing, such as notifying medical or custody supervisors or calling an ambulance.
- Time after time, practitioners failed to use sound clinical judgment. For example, when the patient had markedly to dangerously high blood pressure readings, practitioners did little...or nothing. On one occasion when a practitioner finally realized the gravity of the situation (the patient had chest pain, shortness of breath, left arm numbness, sweating, a blood pressure of 210/140 (extremely and dangerously high) and a pulse of 124 (very high)), he ordered the patient to be sent to the ER by passenger van rather than ambulance.
- Similarly, nurses failed to use sound clinical judgment in serious or gravely serious situations.
- LPNs were allowed to make independent assessments of the patient's condition, beyond the scope of their training and licensure. For example, after the patient set fire to his cell to get medical attention, an LPN decided to simply check the patient's vital signs, failing to assure the patient was evaluated for smoke inhalation or burns. Further, the vital signs she obtained were not normal (requiring attention), but she told no one, concluding that no further action was necessary.
- Despite being housed in OBS, where presumably he would receive closer observation and monitoring (such as monitoring of vital signs, including blood pressure, pulse, breathing rate, temperature, and blood oxygen levels), he spent

⁸ The normal ejection fraction is approximately between 55 and 70%. Thus when someone's heart's ejection fraction is 10% that means their heart is working no better than a car traveling at 10 miles per hour on a highway where the speed limit is 55 miles per hour.

long stretches in OBS when little or no medical monitoring took place. Periods of 3 to 13 days passed when not a single vital sign was measured, even though medical staff knew that his vital signs were dangerously abnormal and required close monitoring. Nor was this the forgetful human error of a single person: multiple nurses failed to do their job and multiple practitioners (who should have been reading the nurses' notes) failed to notice. Similarly, over this 5 month period, a medical practitioner only saw the patient 4 or 5 times. Given his degree of illness, especially during the almost 4 months he was in OBS, a practitioner should have been seeing him 2 to 3 times per week.

- Approximately 12 hours before his death, the patient complained of chest pain and other "red flag" symptoms. Security staff markedly delayed medical access to the patient. When access was granted, only an LPN saw the patient. Despite abnormal vital signs (elevated blood pressure, pulse, and breathing rate), nurses failed to do anything. They conducted no further monitoring until, 12 hours later, when they went to his cell to give him scheduled medications and they found him lifeless. Given his condition and symptoms, more monitoring was required.

This patient suffered from serious heart disease. His heart was pumping at a small fraction of the level it should have been pumping. High blood pressure puts additional work load on the heart, and any additional work load on this damaged pump increases the likelihood the pump will fail. He therefore required intensive management of his disease, including careful attention to and treatment of his high blood. He received just the opposite in the 5 months leading to his death from heart disease. I cannot state with certainty that the blatant and callous lack of care he received during these 5 months caused his death. However, I can state that it deprived him of any chance he had for continued survival.

Finally, errors occasionally happen in any health care system. Healthy health care systems must be able to recognize and address these errors to prevent recurrences. Based on my review of this case, EMCF is incapable of doing so. On 12/23/13 medical staff, supervisors, and Health Assurance Corporate managers conducted a mortality review of this patient's death, the purpose of which was to determine if there was any room for improvement in the systems of care. They did not identify a single one of the plethora of problems identified in my current report, satisfied that there was "nothing additional that could have been done" and that the patient's treatment "appears to have been appropriate." Thus, it is clear not only that the system of care at EMCF is broken, but also that the staff in place are unable to fix it.

Chart Review^{9,10}

10/12/10 An officer notified an RN that the patient thought he was having an asthma attack. The nurse asked the officer a number of questions, and

⁹ Most of this review was conducted using a scanned version of the a printout from the patient's EHR and a death review assembled by EMCF clinical staff, both provided by Plaintiffs' attorney.

¹⁰ Other than the first event below on 10/12/10 which I noticed accidentally because at first I thought it was in 2013, I only reviewed medical records from July 2013 onward.

based on this advised the officer to observe the patient for a while and have the patient submit an SCR for asthma medications.

Officers are not trained medical personnel, and thus it was dangerous to use an officer as a medical observer. Moreover, the patient's complaint of an asthma attack demanded a physical evaluation by the nurse. It might be reasonable to use the officer's information to help the nurse to triage whether she needed to run, walk, or could see the patient in a few minutes after completing another task. However, it was unreasonable and dangerous to use the officer's information as a basis to deny access to care that evening.

- 7/26/13 Readmitted to EMCF and placed in Medical Unit.
- 8/7/13 The patient was sent to Rush ER. On 8/8/13 an echocardiogram showed a 15-25% heart ejection fraction.
- 8/9/13 The patient was discharged back to EMCF for "lack of cooperation and disruptive behavior."
- 8/13/13 Admitted to Rush Hospital for chest pain at rest and a known history of CHF.
- 8/15/13 A cardiac catheterization was performed (80% obstruction of the sino-atrial nodal branch – a small vessel, not amenable to PCI: minimal coronary artery obstruction, ejection fraction of the heart = 10%¹¹) and he was returned to EMCF.
- 8/29/13 The patient was seen in OBS by the physician. His blood pressure was abnormally elevated (174/106) and he was complaining of chest pain. The physician diagnosed him with uncontrolled spasm of his breathing tubes (bronchospasm) and irritation of the joints of his chest causing chest pain. He ordered Tylenol and to "check [blood pressure] daily until controlled – may need to adjust medications."
The patient's blood pressure was abnormally elevated, and in a patient with such severe heart disease, it was even more dangerous. Thus failing to intervene immediately put the patient at some risk of a heart attack over the next few days.
- 8/29/13 - 9/11/13 *Aside from a blood pressure recorded later that night (130/80) no nurse checked the patient's blood pressure or other vitals signs. The physician had ordered nurses to check his blood pressure daily; nurses ignored this order. Even in the absence of an order from the physician, basic medical practice would dictate that a patient who is placed in a medical observation unit for observation, should have a set of vital signs measured each day, if not each shift. And, if the physician's order and basic medical*

¹¹ See footnote 1.

practice were not enough of a trigger for nurses to check vital signs, the EHR form nurses filled out each shift prompt the writer to fill in vital signs. Thus despite 3 compelling reasons to check the patient's blood pressure, no one checked it and the patient remained at risk of worsening of his heart condition due to possible uncontrolled high blood pressure.

When the physician saw the patient again in OBS on 9/2/13, he should have, but failed to review the results of the blood pressure readings he had ordered. Had he done so, he would have noted, and corrected, the nurses' lapse in care. Instead, he ignored his own order and nurses continued to not check the patient's blood pressure.

On 9/9/13 the patient had chest pain. When a patient with a serious heart condition suffers chest pain and a nurse has to intervene, it is mandatory to check the patient's blood pressure and other vital signs. Yet a nurse administered nitroglycerin, but did not check any vital signs. If the preceding 4 compelling reasons to check the patient's blood pressure were not sufficient, the nurse now had a 5th reason to check it: nitroglycerin almost always causes the blood pressure to drop, so nurses must check the blood pressure to be sure it is safe to administer the nitroglycerin.

Finally, at 23:06 on 9/11/13 a nurse finally checked the patient's vital signs. It is inconceivable and unconscionable to imagine that a patient with severe heart failure was placed in a medical observation area where he could be clinically monitored, and yet despite 5 compelling reasons to do so, over 13 days and 39 shifts, not a single nurse or physician checked his vital signs and not a single nurse or physician noticed or cared.

9/12/13

The physician (Dr. Faulks) saw the patient on this date. His blood pressure was 192/121, dangerously higher than it had been on 8/29/13. The physician finally made adjustments to the patient's blood pressure medications. As the day progressed, the blood pressure continued to rise (212/114, 199/127). At 20:37 it was briefly normal, but by 03:30 on the morning of 9/13/13, it was dangerously high again (164/120).

The nurse should have, but failed to notify the physician of this blood pressure to get orders for treatment, leaving the patient at continuing risk of serious complications.

These dangerously high blood pressures required much better control and close monitoring over the days to come. Instead, he was left with a dangerously high blood pressure untreated and unmonitored by EMCF staff; his blood pressure was not checked again by EMCF staff until 3 days later¹².

¹² A doctor at Jackson Heart Clinic did check the patient's blood pressure on 9/13/13, but EMCF staff did not review this measurement until 9/15/13.

An incident report notes that the patient was observed “forcing himself to vomit to get the nurses attention...I just want to see Dr. Faulks...[he was] yelling about his chest pain.”

9/13/13 He was seen at the Jackson Heart Clinic.

9/18/13 *At 18:40 on 9/18/13, after 3 days without any care for his blood pressure, a nurse finally checked the patient’s blood pressure. However, after finding a reading of 81/57, which is dangerously low, the nurse did not evaluate the patient or call the physician or send the patient to the ER by ambulance. Instead, the nurse simply notified the nurse who took over the next shift a few hours later. This inaction placed the patient at risk of death.*

9/23/13 An MAR shows the patient receiving clonidine for an “[increased] high blood” pressure twice, and then nitroglycerin 3 times. *Both of these drugs are very potent and require a measuring of the patient’s blood pressure, a clinical evaluation, and contact with a practitioner for orders. None of this is in the medical record. Thus it appears that, among other things, an RN prescribed medications, without the authority to do so. Further, assuming the patient’s blood pressure were increased, it was necessary to prove that the medications were effective in bringing it down. This also did not happen.*

9/24/14 Twenty-four hours after the last blood pressure emergency, the patient’s blood pressure was measured for the first time. It was 220/130 – higher than it had ever been before. The patient was having chest pain and nausea. The nurse contacted the physician who ordered a dose of medication and for the blood pressure to be rechecked in 2 hours. *The patient’s symptoms, along with his history of heart failure, constituted an emergency. In addition to receiving a dose of medication, at the very minimum, he needed an examination of his heart and breathing and an EKG. In the absence of these, he needed evacuation to the ER.*

The nurse rechecked the patient’s blood pressure in 2 hours. It was now higher yet (230/130).

When contacted by the nurse, the physician again failed to use sound clinical judgment and instead just ordered more of the same medication (without any orders to recheck the patient’s blood pressure).

A nurse administered the medications, but failed to check the patient’s blood pressure, which sound nursing judgment would dictate, even in the absence of a physician’s order to do so. Thus a patient with a weak heart, in whom a blood pressure of 230/130 constituted a medical emergency

was simply left without further blood pressure checks for another 24 hours.

9/25/14 At 04:37 a nurse finally checked the patient's blood pressure for the first time since the day before when it was 230/130. It was now 180/120 – better but still dangerously high. The physician, when contacted, advised the nurse to give him nitroglycerin every night “if needed.”
In so many ways, this is a bizarre and irresponsible way to address high blood pressure. For example, nitroglycerin lasts for a brief few minutes. Thus it is impossible to anticipate that a dose of nitroglycerin once in the evening would control the patient's blood pressure for the next 24 hours (and it didn't). Nitroglycerin is only an emergency medication for blood pressure control. More permanent, long lasting medications need to be used after the emergency is over.

Once again, the patient underwent a long lapse in any checking of his vital signs in OBS. No one checked his vital signs again until 10/10/13 – 15 days and 45 shifts later.

10/12/13 For the first time in a while, medical staff started to notice the patient acting strangely. He was loud, “super agitated,” refusing to cooperate, throwing pills, refusing vital signs, with “rapid pressured speech,” and not sleeping. A mental health counselor thought his behavior was manic.
These were clear indications of a devolving mental status of a manic nature, which not only might indicate a developing mental or physiologic crisis, but also, regardless of the cause, had a high likelihood of making his high blood pressure (and heart condition) worse. Though the medical and psychiatric practitioners were both made aware of this, nothing more was done to diagnose and treat his deteriorating condition.

10/14/13 The medical physician went to see the patient. He reported that the patient is “emotionally unstable today...is unable to eat and is throwing up blood today,” but did not examine him because he was “emotionally upset at this time, so will not examine.”
Despite the serious developments in his health over the previous weeks and the fact that due to his unstable condition he was placed in OBS (where a practitioner should have been making rounds on him on a regular basis, i.e. at least 2 to 3 times per week), no medical practitioner had actually talked to or laid hands on the patient since 9/12/13 – more than a month earlier. And the encounter today did nothing to end that streak.

10/15/13 A mental health practitioner examined the patient in depth. She wrote:
[History] of HTN and [history] of CHF - is likely to medically decompensate if he continues to refuse medical medications...
recent severe exacerbation of [symptoms] of CHF - requiring

hospitalization to stabilize CHF - to allow him to continue to refused [sic] his medical meds places the offender at a high risk of danger to himself - risks of heart attacks - risk of stroke - risk of sudden death due to multiple medication issues - he is not able to weigh the risks/consequences of his actions/thoughts/behaviors - he is a danger of [sic] self at this time with allowing the offender to refuse medical medications - as well as to allow him to continue to refuse psychiatric medications - an extensive hx of severe mental illness - hx of paranoid schizophrenia.

Orders 1. Thorazine 100 mg IM Tonight - refusing mental health and medical medications - has refused meds for last 2 days - exhibiting [symptoms] of decompensation - in need of stabilization of [symptoms] of severe mental illness - DX of paranoid schizophrenia - exhibiting [symptoms] of severe paranoia - a danger to self - unable to weigh the risks/consequences of his actions/thoughts/behaviors at this time.

This was a pivotal moment in this patient's care. The mental health practitioner recognized the urgency of the situation and appeared to be ordering involuntary medications to stabilize the patient's mental health, and through that, his physical health. Yet the medical record is devoid of any indication that these orders were followed.

10/17/13 At 23:35 the mental health practitioner saw the patient again and reiterated her high level of concern for the patient's safety. She again ordered a number of shots of psychotropic medications, adding the instruction "NOW."

A nurse wrote a note on the morning of 10/19/13 that she injected medications. In the absence of any MARs from this period of time, I am unable to determine if the orders were executed in the prior 36 hours.

10/20/13 A nurse checked the patient's vital signs.
This event ends another long streak (9 days) in which no vital signs were taken while the patient was in a medical observation status. Given the patient's highly unstable mental and physical condition, it was impossible

to safely manage his condition and medications in the absence of vital signs.¹³

The nurse recorded the blood pressure as “1304/80” which is an implausible value. Thus the first blood pressure in 9 days is useless. While it is only human to make a typographical error, had other nurses and practitioners been reading the patient’s chart, as would be expected in a safe health care setting, someone would have brought this error to the writer’s attention and it could have been corrected.

- 10/22/13 The patient complained of chest pain. His blood pressure was measured at 160/110.
Despite his unstable heart condition and existing orders to give nitroglycerin for chest pain, the nurse did not contact a practitioner and did not administer nitroglycerin until 2 hours later. This was a dangerous delay. After giving the medication, it was absolutely incumbent on the nurse to ascertain whether or not the medication had been effective. She did not. The nurse administered another nitroglycerin 30 minutes later, again without any assessment, after which the patient was ignored by medical staff for another 12 hours.
- 11/02/13 A nurse measured the patient’s blood pressure.
This is the first time it was rechecked in the past 11 days, despite it having been extremely high the last time it was checked; the only reason it was checked was because the patient asked.
- 11/5/13 At 17:45 an LPN saw the patient because he reported swallowing several pills. She took his vital signs: blood pressure 160/98, pulse 90 (irregular) and called a practitioner. While waiting for a call back, the nurse offered him activated charcoal, which he refused.
The nurse failed to ask the patient what kinds of pills he took or how many. The practitioner never called back and there is no evidence that nurses tried to reach him again. The current situation constituted a medical emergency. When the practitioner did not call back after a couple of minutes, the nurse should have either contacted an alternative practitioner or supervising nurse, or if none of these were available, should have evacuated the patient to the ER by ambulance. Instead, the nurse did nothing – the patient was not monitored nor were his vital signs taken. Incredibly, no further vital signs were taken again until 11/14/13.

¹³ On 10/12/13 and 10/13/13 nurses attempted to take his blood pressure and noted that he refused. These facts do not change my conclusion. There is ample evidence that the patient was suffering from serious mental illness and thus there was reason to suspect that he may have lacked the capacity to make health care decisions in his own best interest. If that were the case, his “refusals” were meaningless and did not absolve EMCF medical staff of responsibility for proper care of his serious condition. If that was not the case, and the patient indeed retained decision making capacity at that point, then there is no evidence that EMCF staff provided him with the information he needed to make an informed decision in his own best interest; in other words, staff failed to obtain an informed refusal.

At around 19:00 the patient decided to take the activated charcoal. By that time the nurses learned from mental health staff that the patient reported having taken heart/blood pressure pills.

At 03:30 the morning of 11/6/13 the patient asked the nurse for more charcoal and the nurse gave it to him.
Activated charcoal is only likely to be effective within an hour or so of ingestion of a substance. It was now more than 9 hours later. Thus there was no benefit, but there was the risk of giving the nurses and patient a false sense of security.

11/14/13 A nurse finally took the patient's blood pressure (162/104), but no other vital signs. The nurse notified a physician.
This blood pressure is high and requires treatment. Instead, the physician did nothing other than discharge the patient from OBS back to regular housing.

11/20/13 The patient developed chest pain, left arm numbness, and shortness of breath. He was examined by a physician at EMCF. His heart rate was 124 (very high) and his blood pressure was 210/140 (extremely high). He was sweating. After a 30 minute delay to see if he responded to emergency medications, the physician ordered him sent to the ER by passenger van.
It is likely this patient's emergency was due to his elevated blood pressure. It is also likely that his blood pressure had been elevated in the days prior to the event. However, the last time it had been checked was a week earlier. At that time it was high, but was ignored. The care this patient received (or rather did not receive) was outrageous and is the likely cause of the preventable emergency this day.

The physician's decision to send a seriously ill unstable patient to the ER by passenger van was irresponsible and dangerous.

When the patient returned later that night from the ER, his blood pressure was 182/138. Even if his blood pressure had been normal, nurses should have contacted a practitioner to inform him/her of the patient's arrival, to share the results of the ER visit, and to obtain orders for continuing care. Given the dangerously high blood pressure, such contact was even more critical. However, nurses notified no one.

Still, no treatment was provided for his elevated blood pressure. At 05:30 the following morning his blood pressure was better, but still abnormally elevated (170/102). Again, it went untreated. At 12:21 the patient's blood pressure was rising again (165/115). The nurse notified a practitioner who did nothing.

12/3/13 (?) On 12/5/13, a Mental Health Counselor filed the following report that supposedly took place on 12/3/13:

Offender was seen on assigned housing unit by this provider. Offender reported SI and A/V hallucinations. Offender reported that he is heart was hurting and he has nothing to live for. Offender was trying to cut himself with a small dull object and he had a long rope tied around his neck. Offender stated he wanted to go to medical and to be place on suicide watch. Offender did not appear to be in any distress. MHC will continue to monitor offender for psychiatric needs.

No further action was taken.

The patient complained about chest pain, which is clearly a medical, not mental health, symptom. Further, in a patient with severe heart disease, it requires immediate attention. The counselor failed to notify any medical personnel placing the patient at grave risk.

Recordings made in a medical record must be made contemporaneously. On the rare occasion one has to make a late entry, it must be clearly marked as such, preferably accompanied by the reason for its lateness. This entry appears to be have been made on 12/5/13 about an event on 12/3/13. Given the critical nature of the event along with a lack of identification of it as a later entry and the reason why, the entry is highly irregular and undermines the reliability of this patient's EHR as a true record of events.

Though my review focused on medical care, this mental health event is of such monumental importance that I cannot ignore it. In short, a patient who has a history of severe mental illness and is supposedly under close monitoring by mental health professionals due to his heightened risk of mental deterioration, told a mental health professional that "he has nothing to live for," has a rope around his neck, and is in the midst of cutting himself, from which the mental health professional concluded that the patient "did not appear to be in any distress," and left. This event goes beyond deliberate indifference; it is the definition of intentional patient abandonment.

The counselor's plan to "continue to monitor offender for psychiatric needs" never materialized. The abandonment

continued for 9 more days at which time he was next seen by someone on behalf of the mental health team.¹⁴

12/17/13 19:10 An LPN reported that the patient set fire to his cell to get medical attention. She recorded vital signs as: blood pressure 140/98 (high), pulse 88, respirations 18, oxygen saturation and temperature not measured. *These vital signs (which are not complete) were not normal and required an assessment by an RN or higher level person. But the LPN notified no one.*

The patient also required evaluation for possible burns and smoke inhalation. No such evaluation was done.

12/18/13 (?) (Time not documented) An RN noted that on this date the patient had chest pain and that security staff had been instructed to bring the patient to the medical unit 45 minutes earlier, but had still not done so. So the RN sent an LPN to measure vital signs. *This entry in the EHR was made on 12/19/13 at 08:25, a day after the nurse alleges the event took place, and 11 hours after discovering that the patient had died. The entry is therefore of dubious authenticity and puts into question the accuracy of the EHR as a valid record of events, especially with events surrounding the patient's death.*

The patient was complaining of chest pain. He therefore required a full evaluation for this, not just a set of vital signs, as the RN requested. Further, and more importantly, an evaluation for chest pain in a patient with severe heart disease could NOT be competently and safely conducted by an LPN. Thus the RN should not have dispatched an LPN to do this.

The failure of security staff to transport a patient with a critically important complaint upon the request of medical staff is evidence of lack of access to care for an urgent medical need and placed the patient's health at grave risk.

When security staff refused to provide access to care for this critically important complaint, the nurse should immediately have escalated the issue to the next person in her, or the officer's, chain of command. Instead, she did nothing. In light of other facts I have cited in my report, the nurse's passive acceptance of the unacceptable indicates to me that security-related barriers to care were a custom and practice at EMCF.

12/18/13 (?) 08:50 (?) An LPN noted that at this date and time she had been instructed to measure the patient's vital signs. When she arrived at the patient's cell,

¹⁴ The signatory of the note failed to write his credential, as is required. Thus, I was unable to determine if he was a psychiatrist, psychiatric nurse practitioner, RN, LPN, mental health counselor, or an unlicensed person.

security would not let her access the patient until 09:28, 38 minutes later. Vital signs: blood pressure 146/92, pulse 102 (elevated), breathing rate 22 (elevated), oxygen saturation and temperature not measured.

This entry in the EHR was made on 12/19/13 at 07:34, a day after the nurse alleges the event took place, and 10 hours after discovering that the patient had died. The entry is therefore of dubious authenticity and puts into question the accuracy of the EHR as a valid record of events, especially with events surrounding the patient's death.

Once again, the failure of security staff to make the patient accessible to the nurse for a critically important complaint is evidence of lack of access to care for an urgent medical need and placed the patient's health at grave risk, and the nurse's failure to immediately escalate the issue to the next person in her, or the officer's, chain of command, indicates that this was the norm.

12/18/13 21:25 An RN noted that upon arriving at the patient's cell he was not moving and was found to be unresponsive. She started CPR. The patient was pronounced dead in the ER shortly thereafter.

Final autopsy results were not provided. A preliminary autopsy finding was "Death due to natural causes related to known heart disease processes."

12/19/13 08:35 An RN noted that according to the LPN, the patient's vital signs were stable and he was in no acute distress.
At this point in time he had been dead for 10 hours; thus this entry is simply false. (In a sense, the patient's vital signs were "stable": his vital signs (all zero) had not changed in 10 hours.) Once again, the EHR is not an accurate record of events.

If, in fact, this note was in reference to the above LPN note regarding 12/18/13 08:50 (written on 12/19/13 at 07:34), when the vital signs were: blood pressure 146/92, pulse 102 (elevated), breathing rate 22 (elevated), oxygen saturation and temperature not measured, the nurse's conclusion that these vital signs were "stable" was wrong: the vital signs were not normal or stable and required attention.

Oct 2013 - MARs for this period time are missing from the patient's medical record.
Dec 2013 *The EHRs at EMCF are incomplete and therefore an unreliable source of information about patient care at EMCF.*

Patient 2

Case Summary: This is a 31 year old Hispanic male with a history of high blood pressure, chemical dependency, high cholesterol, depression, and psychosis. Limited review of his chart revealed numerous serious problems with his health care, some of which are highlighted here.

- He received inadequate care for a serious medical problem – high blood pressure – on many occasions and for a number of different reasons, including: failure to renew medications; failure to administer medications; and decreasing medications on which his blood pressure was stable for no reason and then failing to monitor him on the new regimen to assure that his blood pressure did not go back up.
- After an apparent drug reaction he became very ill (hemodynamically unstable), yet was sent to the ER by van instead of by ambulance.
- Symptoms suggesting possible colon cancer were either not appreciated or ignored.
- Nurses prescribed medications, which is beyond their legal scope of practice.
- Severe tooth pain was ignored for three weeks and his treatment consisted of extraction, which may not have been necessary.

Thus this patient was exposed to numerous episodes of poor care which placed him at serious, and at times grave, risk of risk to his health. The entire record was not reviewed.

Chart Review

- 5/14/13 Admitted to EMCF. BP 121/96. Weight 200. He had been on medications for high blood pressure (HCTZ 12.5 daily, Norvasc 10 mg daily) and high cholesterol (Zocor 10 mg. daily), upon admission. *Only the first two medications were reordered upon admission. High cholesterol is not on the problem list and the medication for this was not reordered.*
- A number of times medications were not given (blank spaces on the MAR) with no explanation. For example, for the month of June 2013, there are 19 missed doses of 248 possible doses.*
- 6/9/13 Seen in CCC by the nurse practitioner. High blood pressure and high cholesterol noted as problems, but missing from the problem list. *Cholesterol (LDL) is listed as being in good control (100-129); however, the most recent LDL in the record at this point is from 4/29/13 and is 140, i.e. not in good control. The patient was not placed back on his medications for cholesterol until 6/30/13 – he suffered a gap of 1.5 months off medication for no reason.*
- 9/2/13 The patient submitted a sick call slip for depression, sleeplessness, paranoia, distressing dreams, and hearing voices. He was seen by an MHC who referred him to a practitioner.

- 9/4/13 12:19. Urgent sick call. The nurse was called to the living unit for this patient. He was on the floor, speech slurred, pupils dilated. He was brought to the Medical Unit where he was seen by the doctor. Vital signs were 110/60, pulse 144, Oxygen saturation 93%. An LPN's note on the same day indicates that the patient "took someone else's medicine." *He was sent to the hospital by van, not ambulance, which was dangerous, given his condition.*
- 9/5/13 The patient returned from the hospital and was placed in OBS. *The chart contains some papers from the hospital, but is missing any clinical report or diagnosis.*
- The patient was seen by an RN upon return, but there were no vital signs taken. No further vital signs were taken until 9/10/13; this is a dangerously long time.*
- 10/26/13 Seen in CCC by the nurse practitioner. BP 111/83 on high blood pressure medications (Norvasc and HCTZ). Thus the blood pressure was under good control. *Despite this, on or around this date, the Norvasc and HCTZ were stopped and replaced with a different (single) high blood pressure medication (Prazocin 2 mg. daily). This switch was apparently made by the psychiatrist. This change of medications had a high likelihood of destabilizing the patient's good blood pressure control, yet no plan was made to monitor the patient's blood pressures until 3/24/14, five months later. This was dangerous.*
- The patient reported that he has a history of colon cancer, and is now having constipation. *This history demanded attention, yet none was given. In a patient with a history of colon cancer, constipation may be a sign of recurrence. The patient required further history taking (e.g. the date and findings of last colonoscopy), examination (possibly rectal examination), and based on these findings, follow up to rule out recurrent cancer. None of this was done.*
- 10/27/13 Visit with a psychiatrist. *There was never any recognition in any MH notes of the patient's medication event of 9/4/13 (when he allegedly took someone else's medications and required emergency evacuation to the ER). After return from the hospital he was seen on MH rounds, but not seen by a psychiatrist until today, almost 2 months later.*
- 11/27/13 The patient submitted an SCR for migraine headaches for which he was taking Excedrin in the past and needed to get back on it.

- 12/4/13 The RN responded to his SCR indicating that she had ordered Excedrin migraine for him for three months. The EMR shows the order was “authorized by Dr. Edwards.”
A nurse should not be ordering medications. There is no indication that the physician reviewed the medical records (there is no cosignature); thus the nurse prescribed medications independently. More importantly, there is no medical information to review. The patient could not be safely evaluated at a distance – he needed an examination. Finally, 8 days (from 11/27/13 to 12/4/13) is dangerously long to respond to a health concern.
- 1/7/14 The Prazocin was discontinued by the psychiatrist today because the patient was no longer having sleep disturbances.
However, again, no plan was made for blood pressure management, i.e. he has high blood pressure, all his blood pressure medications were stopped, and there was no plan for following up on his blood pressure again until 3/24/14, which is dangerously long.
- 1/10/14 The patient submitted an SCR for a tooth ache: “it hurts so bad.” The SCR response says “Ext#31” and is dated 2/2/14. The dental note says: Tooth 31 requires extraction. Periodontal involvement. Anesthetic: 2 carpules 2% lidocaine. Extracted tooth no difficulty.”
There is no evidence that any action was taken on this urgent request for almost one month.

There does not appear to be adequate dental examination to establish the need to remove this tooth – it appears a salvageable (and possibly healthy) tooth was extracted.
- 4/2/14 There is a sick call report in the record. The subjective part of the encounter says “was getting labs drawn and also has a cold.” For the objective part, it says, “see EMR.” Guaifenesin, Claritin, and Tylenol were ordered, with “authorization” by a physician.
There are no objective data anywhere, including any vital signs or examination.

There is no indication the physician actually authorized any medications. Thus treatment was prescribed without history, examination, or involvement of the physician.

Patient 3

Case Summary

This is a 29 year old male with seizures, asthma, and depression. A limited review of his medical record revealed numerous serious problems with most of the essential elements of health care described in the body of this report, such as:

- Medical staff ignored plans for him to have regular follow-up care for his chronic medical problems. For example, upon transfer to EMCF he was supposed to be seen in CCC in 3 months; instead it took 8 months. When he was finally seen in CCC, an order was given for him to be seen in another 3 months; instead it took a year. All of his medical problems are potentially life threatening, so failure to manage them properly on a regular basis, placed the patient at significant risk of short- and long-term damage.
- Examinations, when they are conducted, are wholly inadequate. For example, he had a serious reaction to an unknown drug resulting in a fall and head injury. Staff failed to evaluate him for a concussion and failed to determine if the drugs were taken intentionally (i.e. as a suicide attempt in a patient with a history of major depression). On another visit for management of seizures, medical staff failed to ask basic questions about the patient's seizures as well as ignored an abnormally elevated blood pressure.
- Serious acute problems are ignored. For example, he had dental bleeding and severe pain; it took over 4 months for him to be seen and treated.
- Blood test results are mismanaged. For example, the patient's blood level of a medication used to treat his seizures was so high, it was immeasurable, i.e. it was at a toxic level. Laboratory staff immediately called EMCF staff to notify them of this "critical result." EMCF staff ignored it. The patient was not re-examined or re-tested. On another occasion, the blood level was again very high – though now measurable – and again required intervention by a physician. Instead the blood test result was signed off by an unlicensed office assistant and no further action was taken.
- Orders to administer (or stop) medications are not followed by nurses. During a random 4-month period, nurses failed to administer 40 doses of medications for serious medical problems. On a different occasion, when the physician ordered for a medication to be held because it had reached a dangerous level in the patient's blood, nurses just kept on giving it.

The chart review below contains additional examples. Overall, this case revealed numerous serious problems with several essential parts of the health care operation at EMCF reflecting systematic deficiencies. The entire record was not reviewed.

Chart Review

3/23/12 Admitted to EMCF. Active medications: Dilantin 300 mg hs (for seizures), Albuterol inhaler 2 puffs 4 times a day as needed (for asthma), bupropion 75 mg daily (for depression). The most recent CCC prior to

transfer was on 3/19/12. At that time the plan was to be seen again in CCC in 3 months.

This 3-month follow-up in CCC did not happen upon transfer to EMCF – the next time he was seen was 11/30/12 – 8 months later.

11/30/12 The patient was seen for the first time at EMCF for CCC. The plan was to see him again in 3-4 months.

His asthma was addressed, but his seizure disorder was ignored.

The order to see him again in 3-4 months was not followed – he was not seen again in CCC until 10/26/13, almost a year later.

7/22/13 The patient submitted an SCR for “gums are bleeding and 31, 32 lower left are killing me.”

This SCR was not reviewed and addressed until 12/1/13, some 4 months later, an inhumanely long time to leave a patient in pain.

10/10/13 The patient reported taking an overdose of 5 Dilantin pills “because the guard was coming and he did not want to be locked down.” Afterwards he fell and injured right eye. Vital signs: 137/95, pulse 85, temperature 98. The patient was examined by the physician who Steri-Stripped the laceration (closed it using special tape), ordered the Dilantin held for 2 days, and ordered a Dilantin level to be drawn at that time.

The examination was wholly inadequate. The patient needed to have a neurologic examination, including an assessment of mental status.

Further, without knowing the timing of the overdose, he needed continual monitoring. Finally, the story does not make sense – patients do not keep their own medications – they are kept and administered by nurses. So how could the patient have taken extra? Thus the history required further investigation and possibly involvement of psychiatric staff, or at a minimum confirmation that this overdose was not psychiatrically driven, especially in light of the patient’s history of depression.

10/11/13 The Dilantin level was reported back at greater than 60.8. Because this was considered a “critical value,” the laboratory called to report it to the lab technician at EMCF.

This result is well within the range that can be toxic (the desirable level is roughly between 10 and 20). There is no record that the lab technician notified anyone, which was required. At this high toxic level, the holding of the Dilantin for 2 days (which had been ordered the previous day) was probably not adequate. The patient required re-evaluation at this point, and retesting. None of this was done. This was dangerous.

10/26/13 Visit for CCC.

His asthma and seizures were addressed, however, the practitioner failed to do basic elements of the review. Specifically the practitioner failed to

assess the current status of his seizure disorder (e.g. any seizures since the last visit?), and failed to address an abnormally elevated blood pressure of 145/93 that required, at a minimum, a planned recheck.

Follow up was planned for 2-3 months with a Dilantin level to be drawn in 3 months, i.e. some time around 1/26/14.

As of the date of my visit, 4/23/14, the repeat Dilantin level had not been done.

The CCC follow up appointment was not conducted until 4/4/14, more than 5 months later.

11/12/13 The Dilantin level was reported back on 11/11/13, was 33.6, which is high and potentially dangerous. It was signed off by Patricia Parrott, the doctor's assistant.

Patricia Parrott is an unlicensed assistant. There is no indication that any licensed professional was notified of this potentially dangerous test result.

11/19/13 On this date the physician finally signed off on the high Dilantin level. He ordered the nurses to hold the Dilantin for 7 days, restart it on 11/26/13, and then check the Dilantin level again on 12/01/13.

The patient required examination for toxicity from Dilantin. There was no such examination. Also the plan makes no sense: previously, when the patient's Dilantin level was unmeasurably greater than 60, the doctor's plan was to hold it for 2 days. Now that the level is less than half that, the plan is to hold it for 7 days.

Regardless of whether or not the order to hold the Dilantin was consistent with the previous one or makes sense, this critical order to hold all Dilantin from 11/19/13 to 11/26/13 was not followed by nurses: nurses ignored the order and continued to administer Dilantin during that time frame as follows ("x" indicates the Dilantin was given):

<i>Date</i>	<i>AM dose</i>	<i>PM dose</i>
<i>11/19</i>	<i>x</i>	<i>x</i>
<i>11/20</i>	<i>x</i>	<i>x</i>
<i>11/21</i>		<i>x</i>
<i>11/22</i>	<i>x</i>	<i>x</i>
<i>11/23</i>		<i>x</i>
<i>11/24</i>	<i>x</i>	<i>x</i>
<i>11/25</i>		<i>x</i>
<i>11/26</i>	<i>x</i>	<i>x</i>

The Dilantin level ordered for 12/1/13 was never done (the next level was checked on 12/13/13, almost 2 weeks later). This care is dangerous.

Dec 2013 – *A review of the MARs for these 4 months reveals that nurses failed to*

Mar 2014 *administer 40 of 248 doses of medication.*

Patient 4

This patient, whom I met during a random cell-side interview, reported to me that he has a history of hypertension on multiple medications. If he has an urgent problem he tells an officer, but it can take a while to be seen. Nurses check-in with inmates in isolation on a daily basis and in a meaningful manner. He can give an SCR directly to a nurse.

It usually takes about a week to be seen. Three days ago he had chest pain and a head ache at around 21:00. He notified an officer who called the Medical Unit who instructed the officer to tell him to fill out an SCR.

Case Summary

This is a 22 year old black male with high blood pressure and depression. Review of his case reveals numerous serious problems with his health care, such as:

- Inmates have inadequate access to care for urgent medical problems. For example, the patient had chest pain. Rather than responding to his cell emergently, a nurse instructed him (through an officer) to submit an SCR, thus brushing off a potentially life-threatening problem. On another occasion, the patient was left to suffer with severe tooth pain for almost 2 weeks before he was given any care.
- Orders to administer medications are not followed by nurses. During a random 1-month period, nurses failed to administer 52 doses of medications for serious medical problems.
- The medical record is not a reliable source of information about patient care and/or practitioners do not use due care when reading it. In one note, the practitioner stated the patient was on a certain medication for high blood pressure, but the MAR showed that nurses were administering a different medication for high blood pressure.
- Orders for follow-up care are not followed, resulting in inadequate care for chronic conditions. For example, after discovering an abnormally high blood pressure, the practitioner ordered nurses to recheck his blood pressure twice weekly for 4 weeks and then to have a follow-up appointment. None of this was ever done. A year later he was finally given an appointment, but this also failed to take place. Two months later, someone measured his blood pressure. It was still abnormally elevated and required medical intervention. Instead the physician just signed off on it and took no further action.
- Health care is managed by correspondence instead of interview and examination, which essentially deprives patients of access to care and is highly dangerous.

The chart review below contains additional examples. Overall, this case revealed numerous serious deficiencies in key parts of the health care operation, and indicated systemic problems which place inmates at significant risk. The entire record was not reviewed.

Chart review

- 9/23/11 Admitted to EMCF. At that time his blood pressure was normal and he was not on any blood pressure medications. His weight was 185.
- 10/19/11 The patient submitted an SCR for congestion. He was seen by an RN. He complained of chest congestion. The only examination was vital signs (weight=175) and "I/M [inmate] exhibiting cold symptoms, congestion symptoms noted."
- 12/21/11 The patient submitted an SCR for "a lot of pain" from a tooth.
The SCR was not reviewed until 1/2/12, when he was finally seen and given antibiotics. This is too long a time to be seen for what was felt to be an infection.

February, 2013

The MAR for this month shows that nurses failed to administer 32 out of 124 possible doses of blood pressure and psychiatric medications. For an additional 20 doses, there is a vertical line drawn through the dosage. This does not correspond to any official notation, and I must assume it means that, again, no dose was administered. I asked the Health Services Administrator (HSA) if he had a different explanation for these vertical lines. He thought they might represent the initials of a nurse and was going to check the dates of the marks against the staff roster for those days. As of the time of publication of my report, I have received no new information on this issue and thus maintain my original assumption that it denotes no medication given.

- 2/16/13 The patient was seen in CCC. Blood pressure = 132/96. His blood pressure was felt to be in fair control. His medications were listed as Norvasc 5 mg. twice daily and Lopressor 50 mg. twice daily (both for high blood pressure) but the plan was to discontinue Norvasc when the Lopressor was available.
The practitioner's indication of the medications the patient is taking is not consistent with what he was actually taking: according to the MAR, on this day he was on Norvasc 5 mg. twice daily and lisinopril/HCTZ 10/12.5 mg. once daily (a totally different medication than Lopressor). Thus one part or another of the EHR is not an accurate record of care.

The nurse was to check his blood pressure twice weekly for 4 weeks and patient is to have a follow up appointment with the practitioner in 4 weeks. No blood pressure follow up was done. His blood pressure was not checked again until 4/9/13 when it was now up to 146/101, which is abnormally high.

The follow-up visit with the practitioner was also never conducted. There was no follow up of the blood pressure in CCC at all.

On 2/2/14, a year later, he finally had a follow up CCC visit scheduled, but is listed as a “no show.” There was no notation about why he was a no show or what efforts were made to contact him. He was in Isolation at this point (Unit 5) so he would not have had the ability to show/no show on his own. There is no indication that he was refusing to come. Thus health care staff failed to provide follow up care for a serious medical condition for at least a whole year.

- 4/10/14 *The patient was seen by an RN for sinus problems (there is no corresponding SCR).
No further history taking or examination of ANY kind took place, including basic measurement of vital signs. However, operating in this vacuum of information, the nurse nonetheless ordered a medication for allergies (Claritin). Thus essentially no medical judgment was provided for what could be a serious medical need.*
- 4/21/14 *This date corresponds to the day the patient reported to me that he told officers he had chest pain, but there is no notation in the medical record of any health care activity.*
- 4/22/14 *He has still not been seen by a practitioner for his high blood pressure, but a blood pressure obtained by an LPN today is 152/105, higher than the last time. The physician signed off on this result on 4/22, but failed to address it clinically.*

On 4/25/14 I notified Mr. Little of the patient’s blood pressure.

Patient 5

This patient, whom I met during a random cell-side interview, reported to me that he has asthma and was last seen for this in CCC about 3 months ago. If there is an urgent problem, they tell the officer who usually tells them to fill out an SCR. Response to the SCR can take a couple of weeks and sometimes they have to put in multiple SCRs until they're seen.

Case Summary

This is a 33 year old black male with a history of asthma, manic-depressive disorder, and schizophrenia. A limited review of his medical record revealed numerous serious problems with many of the essential elements of health care described in the body of this report, such as:

- Orders or plans of care are not followed. For example, this patient was supposed to be seen in CCC for his asthma in the early summer of 2013. However, as of almost a year later, he had not been seen, so his asthma is not being managed. An x-ray ordered because the patient was short of breath and had a nodule in his lung (which could be cancer) was never done. In a random month, nurses failed to administer 51 doses of medication.
- Access to care is impaired. For example, on two separate occasions the patient informed staff he needed to be seen for a tender knot and chest pain. Either of these symptoms demanded immediate care, yet he was not seen for almost a week. When he finally was seen, the nurse failed to address his chest pain. On a third occasion he had to submit a complaint form after numerous previous SCRs went unanswered.
- Staff practice outside their legal scope of practice by prescribing medicine.

These deficiencies reflect system-level problems in health care delivery at EMCF and each poses a risk to patient safety. The entire record was not reviewed.

Chart Review

- 3/24/13 The patient was seen in CCC with a plan to be seen again in follow up in 2-3 months.
As of my visit on 4/22/14, he had not yet been seen in CCC. (He had an appointment on 8/30/13, but custody officers failed to bring the patient from his isolation cell in Unit 5, and when that happened, medical staff did nothing.
- 7/19/13 Admitted to EMCF on albuterol and inhaled steroids (for asthma).
- 11/12/13 The patient submitted an SCR for a refill of both his inhalers. A nurse responded that they were requested and would be delivered when they came in.

11/30/13 The patient submitted an SCR for a tender knot on the left side of his face and chest pain for a few days.
He was not seen for this until 12/5/13, which is dangerously long for this complaint. The entirety of the history and examination for this encounter on 12/5/13 is “No knot found on inmate face. Concerns about his diet.” This encounter demanded more of an examination, especially regarding his chest pain. Thus essentially no medical judgment was provided for what was a serious medical need.

1/4/14 The patient submitted an SCR for a “cough, sore throat, chest hurting.” He was seen for this on 1/8/14. At that time he was seen at the cell door (due to lock down) but reported no current complaints except need for shampoo.
There was a 4 day delay from the time of his complaint until he was seen. Given the nature of his complaint – especially chest pain, which is a serious medical need – the delay was dangerous.

2/7/14 *The patient submitted a generic Inmate Request Form, complaining that despite multiple SCRs for a cold, he had not yet been seen.*

Most of the SCRs the patient submitted are missing from the chart; the only one present is the one from 1/4/14.

3/19/14 There is an order on this date for Lotrisone cream (a combination of an anti-fungal and cortisone) for a “sore on upper body.”
The medication was ordered by an RN, but there is no co-signature by a physician. Further, there are no clinical notes related to this encounter. Thus, it appears that an RN ordered a powerful steroid cream a) without an order from a practitioner, beyond the scope of his/her license, and b) without any encounter with the patient; the nurse’s action was illegal and dangerous. Further, the prescription does not indicate the strength or amount of the cream, and the instruction (“Use as directed”) has no meaning, because the patient was given no directions.

3/27/14 There is an order for a “repeat” chest x-ray in 2 weeks regarding “SOB [shortness of breath] with Right lower lobe nodule.”
There is absolutely no clinical note related to this x-ray! There is also no previous x-ray (i.e. for which this is the repeat) and as of the day of my visit, 4/22/14, more than 3 weeks later, no repeat x-ray had been done.

March 2014 *A review of the MAR for this month reveals that nurses failed to administer 51 of a possible 279 doses of medications.*

On 4/25/14, I notified Mr. Little of the chest x-ray which has not been done or reported.

Patient 6

The patient, whom I met during a random cell-side interview, reported to me that he had a history of asthma. Last week around Tuesday (4/15) he had chest pain and emesis around 07:00. He informed an officer who called the Medical Unit and was told to have him fill out an SCR. He was taken to the Medical Unit around 09:30 where a nurse put her hand on his chest, said he was okay, and sent him back to his cell. When making rounds in the Isolation Unit to check in on inmates, the nurses don't always stop at his cell***. He has not been to the CCC for his asthma since last summer (about a year earlier).

Case Summary

This patient is a 27 year old black male with asthma and depression. A limited review of his medical record revealed numerous serious problems with two essential elements of health care described in the body of this report:

- Orders or plans of care are not followed. This patient was supposed to be seen in CCC for his asthma in the late summer of 2013, however, he was not seen until more than a year later, depriving him of ongoing regular care for his asthma. At that visit, once again a plan was made for him to be seen again in 3-4 months, and once again, as of 6 months later, that appointment has not yet materialized. Thus the patient has been deprived of adequate planned care of his serious chronic disease, increasing his chances of short-and long-term complications of his disease.
- Professionals do not use sound judgment when assessing serious acute problems. When assessing the patient for acute chest pain, a nurse failed to do almost any examination or refer the patient to a practitioner, putting the patient's life at risk.

These errors help define systemic problems with the quality of health care at EMCF.

Chart Review

4/5/12	The patient had a CCC for asthma. A follow-up was ordered for 2-3 months. ¹⁵ <i>The follow-up did not take place until over 1.5 years later on 11/1/13.</i>
4/18/12	Admitted to EMCF
11/1/13	The patient was seen in CCC for asthma. There was a reasonable evaluation with an order to follow up in 3-4 months. <i>As of the date of my visit, 4/22/14, almost 6 months later, he had still not had the ordered follow-up.</i>
4/15/14	<i>This is the date (approximately) on which the patient states he was seen in the Medical Unit for chest pain. There is no record of any medical</i>

¹⁵ There is a conflicting order in the chart for a follow-up in 6 months. In either case, follow-up did not take place until over 1.5 years later.

encounter. During my tour, I requested the custody log for this period to see if and when this patient was transported to the Medical Unit. Those logs were never provided to me. Based on the patient's description of his evaluation by the nurse (put a hand on his chest and said he was okay), the nurse failed to use sound clinical judgment in evaluating a potentially serious medical condition.

Patient 7

Case Summary

This is a 53 year old male with diabetes and depression. His case demonstrates how multiple system-level problems ultimately contributed to mismanagement of his diabetes over the mid-range.

- When he arrived at EMCF from another facility his diabetes under excellent control (HbA1c test 6.2). From that point onward over the next 3 years, control of his diabetes deteriorated, such that the last time it was checked, his test result was over 8 (high), putting him at increased risk of the complications of diabetes, such as blindness, kidney failure, and amputations. Due to the disorganization of the medical record, it is difficult to determine the exact cause(s) of this deterioration, but I was able to identify factors which contributed. For example, staff at EMCF failed to schedule him for regular visits to manage his diabetes. While these should happen on a regular basis, typically every 3 or so months, at one point a full year passed between visits. When that visit finally took place and a return visit was ordered for 3 months hence, it took place in 5 months instead. And when the patient was finally brought to the doctor for that visit after a 5 month delay, his blood tests – which the doctor needed in order to plan future care – had not been obtained. Two weeks after the visit, the blood tests were finally done and showed that the patient’s diabetes was getting worse, meaning his treatment needed to be changed. However, the doctor failed to review this test result until yet another 3 months had passed, and when he finally did review it, he ignored it, leaving the patient’s worsening diabetes unaddressed.
- Nurses failed to administer medications, including a medication helping to control diseases complicating the diabetes. During a random month, nurses failed to administer 14 doses of necessary medications. A water pill (usually used to reduce risks from diabetes by reducing blood pressure) was abruptly stopped because the order ran out. An order for a chronic medication should not just run out, and if it does, nurses immediately notify a practitioner to get it restarted. They did not (the patient did not get the medication again for over 2 weeks).

This case illustrates how different systemic dysfunctions of the health care system at EMCF converged on one patient to negatively impact management of an important chronic disease: diabetes. We know that poor control of diabetes leads to worse patient outcomes, including loss of limb and life. The chart review contains other examples of system-based errors that put this patient’s health at risk; I did not review the patient’s entire medical record.

Chart Review

12/27/11 Admitted to EMCF

3/13/12 The patient was seen for his first CCC at EMCF. The physician ordered fasting labs and for the patient to return in 4 weeks for follow-up. The labs were done on 3/16/12 and included a HbA1c=6.2 (a test for blood

sugar levels). The physician reviewed the labs on 3/19/12 and ordered a 24 hour urine for creatinine clearance and protein.

Microfilament testing was not done due to unavailability of a filament. When I asked the clinic manager about filaments, he said he did not believe they had any. He said if they did, they would be in the CCC room I was working in; there were no filaments in that room. Microfilaments are used to test for nerve damage in diabetic patients and are an essential tool in the care of patients with diabetes to help prevent amputations.

This test value reflects good diabetic control. However, from this point onward, his HbA1c results began rising. They reached a maximum of 10 (reflecting very poor control of diabetes) around February, 2013. They have come down somewhat to over 8, which is still high, in February 2014.

- 4/21/12 The patient submitted an SCR for left side and left shoulder pain. He was seen by a nurse the same day.
There is no evidence of any further questioning or examination by the nurse, including measuring any vital signs. The entire encounter written by the nurse amounts to "Deep Heat ointment applied given to patient." Pain in the left side and could reflect a serious medical problem, but essentially the patient did not get the benefit of a professional medical judgment for this problem.
- 3/9/13 The patient attended a CCC visit. The practitioner noted that control is worse and the patient has significant callouses on the feet, and appropriately orders cream and special shoes. She also ordered follow up in 3 months.
This is the first CCC visit in about 1 year!

The 3-month follow up did not happen for 5 months.
- 8/2/13 The patient attended a CCC visit. His blood pressure was elevated at 172/94.
His HbA1c was not measured in preparation for this visit (it had last been measured 4/17/13), so it was impossible to come up with a treatment plan during that visit.

When it was later measured on 8/13/13, it was high (9.3), which was higher than in April. That abnormal result was not reviewed by the physician until almost 3 months later, on 10/22/13!

When the physician finally checked it on 10/22/13, he made no change in the patient's treatment plan, which was required at that point.

August, 2013 *An MAR for this month shows that nurses failed to administer 14 doses of medications of 73 possible doses. Further, an important medication, furosemide (a water pill), was abruptly stopped on 8/12/13 with a notation that there was no active order for it. There is no documentation of nurses attempting to get an active order at that time. It was not started again until 8/27/14. Thus, the patient suffered a lapse of an important medication for 15 days for no reason.*

Overall, this patient's diabetes deteriorated at EMCF. His test results (HbA1c) rose from a normal level upon admission, to over 8 (high). This appears to be due to lack of management of the diabetes, i.e. not due to any apparent intercurrent medical problems which would result in a valid clinical reason for poorer control or any recorded change in the patient's self-management.

Patient 8

This patient, whom I met during a random cell-side interview, reported to me that he has a history of hypertension. He stated he gets his medications without problem. He's been in the Isolation unit for 2 years. Staff were checking his blood pressure about weekly initially, but then stopped about a year ago and did not check it again until last week. It takes about 2 weeks to receive responses to SCRs. If there is an urgent need, the only way you can see a nurse is if "they see blood." He's not sure if it is a problem with the officers or the nurses, but thinks it may be both.

Case Summary

This is a 33 year old male with a history of high blood pressure. Review of his case shows how systemic health care problems impacted care of this patient's serious chronic disease: high blood pressure.

- The patient was being followed for his high blood pressure in the CCC at his previous facility where it was determined at his last visit there that he needed follow-up in CCC 3 months hence. Shortly after that visit he was transferred to EMCF. As of the time of my visit, over 2 years later, that CCC visit at EMCF for management of high blood pressure had still not taken place.
- When seen for another reason, his blood pressure was found to be too high and a doctor ordered medications and for the patient to be followed up in 4 weeks. However, that follow-up did not happen for almost a year. When it was finally checked, it was even higher. The physician then asked for nurses to check the patient's blood pressure daily for 3 days. During one of those checks, his blood pressure was even higher (193/138 and then 201/125), levels at which there is an imminent threat of heart, brain, or kidney damage, and which constitute clinical urgencies. The physician ordered medications and for the patient to be checked in 2 hours. The 2-hour check was not done, however, because, according to a nurse's note, custody staff failed to follow the order to bring the patient to the medical unit. When custody staff finally brought the patient to the medical unit and nurses finally measured it, his blood pressure was still very high (190/100) and required attention. Instead, it was ignored.
- Custody practices have interfered with delivery of needed medical care for this patient in other ways. On two occasions practitioners ordered blood tests to help guide management of the patient's serious problem, and the tests were not done. Nurses documented, "*Security failed to bring him to the medical room on hallway 5-6. Stated short on staff. This is an ongoing issue with security.*"
- This patient's high blood pressure is so high and difficult to control that at times it has required 6 different medications to control it. Yet nurses fail to administer medications as ordered. In a random month, nurses failed to give the patient 40 doses of one or another of his medications.
- A significant portion of the patient's blood pressure are simply missing from the patient's medical records: MARs for November and December 2013, and January, February, and March 2014 are presumably in a pile somewhere awaiting scanning and filing into the EHR. They are not readily available to the patient's

practitioner if he/she wants to evaluate the patient's history and response to blood pressure medications to properly plan his care.

The chart review below contains other examples of problems with health care. As a whole, these examples demonstrate pervasive on-going system-wide problems which put this patient's health at risk. This case was not reviewed in its entirety.

Chart Review

2/3/12(?) Admitted to EMCF. His previous CCC appointment at his last facility was on 3/12/12 at which time his blood pressure was described as being in good control; the plan was for him to be seen again in 3 months.
This plan was not executed at EMCF: as of my visit on 4/22/14, over 2 years later, he had never been seen in CCC at EMCF.

5/24/13 The patient had a clinic visit on this day with the physician. It was not a CCC visit.
His blood pressure was 150/105 (significantly elevated). The physician ordered medications and for the patient to return to him in 4 weeks for a recheck.
Other than vital signs, the physician did not ask the patient any questions about important symptoms that might be related to his specific medical history of high blood pressure, such as questions about chest pain, head ache, or shortness of breath.

The only part of the patient he examined was his legs (which revealed mild edema or fluid swelling).

The recheck never happened. The patient's blood pressure was not checked again for almost 1 year.

Oct. 2013 A review of the MARs for this month show that nurses failed to administer 40 doses of 310 possible doses of his 6 blood pressure medications.

On the day of my visit in April 2014, this was the most recent MAR entered into the patient's medical record; those from November 2013 through March, 2014 were missing.

3/4/14 Chronic disease labs were ordered for today.
The labs were not done. According to records, "Security failed to bring him to the medical room on hallway 5-6. Stated short on staff. This is an ongoing issue with security." According to these records, staff have knowledge of a serious impediment to safe patient care: medical orders are not carried out.

3/11/14 Rescheduled lab drawing.

The labs were not done again. According to records, "Security did not bring inmate to medical room on units 5-6 or chronic care lab. Will reschedule again. On going problem with unit 5." The labs were finally done one month later, on 4/3/14.

4/22/14

Vitals signs were measured today: Blood pressure 178/108, pulse 82, breathing rate 132 [sic].

This is the first time the patient's blood pressure has been checked in close to 1 year. The patient is on 6 different blood pressure medications which ordinarily reflects a severe blood pressure problem, and which a) requires close monitoring, and b) requires a search for a secondary (i.e. potentially curable) cause. Given the severity of his blood pressure and complex/intensive medication regimen (which the physician continues to reorder and the nurses continue to deliver), this failure to monitor and treat reflects lack of sound professional medical judgment.

After reviewing this blood pressure reading, the physician asked for the patient to have blood pressures measured daily for 3 days. In the evening of 4/23, a nurse checked his blood pressure again. It was now 193/138 and 201/125. At 16:00 the doctor ordered urgent medications and for the patient to have his blood pressure rechecked in 2 hours.

This was not done. Instead he was not rechecked until almost 4 hours later, because, according to a nursing note, custody failed to bring him to the Medical unit as requested. That custody did not follow a physician's order is unacceptable. However, it is equally unacceptable that the nurse did not adjust to this situation and simply go to the patient's cell to check his pressure there. Given the stress of being transported from an isolation cell (i.e. 2 officers, handcuffs), the validity of a blood pressure taken in the patient's cell would also have been greater.

When finally measured, the patient's blood pressure was lower, but still high: 190/100.

There is no evidence this blood pressure was reported to the physician or that the physician made any changes to the patient's blood pressure regimen, both of which were necessary to keep the patient safe.

On 4/25/14 I notified Mr. Little of the need for the physician to be informed of the most recent blood pressure result and for the need for the patient to be evaluated by the physician for possible secondary causes of hypertension.

Patient 9

Case Summary

This is a 25 year old black male with a history of asthma and depression who reported to Plaintiffs' attorney that he was scheduled to get a chest x-ray but has not had it done in over a week. His case shows failure of staff to address basic health care needs to protect him from harm due to his chronic and acute conditions.

- Access to care for this patient was seriously impaired, and even when he accessed care, what he received at EMCF can barely be called "care." On a number of occasions this patient complained of symptoms (chest pain, cough, shortness of breath) which would be serious in any patient, but are especially so in a patient with a history of asthma. His appeals for care were either ignored for 1 to 2 weeks, acknowledged, but did not result in a visit with any medical professional (on one occasion where an explanation was provided, nurses blamed the failed visit on custody), or resulted in a visit, but there was little or no examination during the visit. Visits that did occur were with nurses; nurses are not qualified to handle this issue independently.
- Even when some modicum of care was delivered, if it resulted in orders for further testing or treatment, the orders did not get executed. Thus the EKG and – on two separate occasions – the chest x-ray described above, once ordered, were never obtained. The patient complained of the serious symptoms above again and was seen once by a physician. The physician ordered a chest x-ray, and for a third time, no chest x-ray was done; as of the date of my visit on 4/22/14, none of the three chest x-rays – first ordered 11/19/13 – had been done.
- Care, in the form of medication administration, is also woefully incomplete. For a random month, nurses failed to administer 13 doses of necessary medication. I could not evaluate the completeness of medication administration for the months of November and December 2013, and January, February, and March 2014 because MARs for these months are missing from the medical record.

This patient suffered extreme neglect for serious medical problems at EMCF. His case illustrates the system problems at EMCF that prevent a patient from getting to a health care provider, getting minimally competent diagnosis and treatment from an appropriate level of care provider, and having the tests and treatments issued from those decisions actually executed. I did not review this case in its entirety.

Chart Review

9/20/13

The patient saw a nurse in sick call for coughing and chest pain. His pulse was 100, but his vital signs were otherwise normal. He reported coughing for about a month and that his abdomen and ribs were now sore. He reported greenish sputum.

The nurse did not conduct any examination. Given his history of a positive tuberculosis test and a cough for a month, this required attention for a serious medical problem, possibly including tuberculosis, which presents a risk to others. Instead the nurse informed him that he probably

has sinus problems due to “exposure to smoke due to fires on the unit” and treated him with cold remedies. No physician was involved and no follow up was arranged.

10/27/13 The patient submitted an SCR for chest pain and shortness of breath. *The SCR was not triaged until 11/11/13. On 11/11/13 the only notation of any kind in the EMR was a notation on the SCR form indicating he was scheduled to have an EKG on 11/13/13. The two week delay to address this pair of symptoms is unacceptably long and dangerous.*

It was also unacceptable not to physically see and examine the patient, especially since the staff thought the patient might have a heart problem (as is evidenced by their plan to perform an EKG).

The EKG was never done, i.e. the plan of care was not carried out.

11/19/13 The patient was seen by an RN in sick call for complaints of his chest hurting when he breathes, and his cough becoming non-productive. *The nurse did not do any further assessment of symptoms or conduct an examination. She wrote, “Chest x-ray ordered and will notify doctor in a.m.” This complaint demanded an evaluation.*

A nurse cannot and should not order an x-ray without a practitioner’s order. Clearly she ordered it without that.

The chest x-ray was never done, i.e. the plan of care was not carried out.

12/5/13 The patient submitted an SCR for shortness of breath and “bad” chest pain and cold sweats. He was seen by an RN for this complaint on 12/12/13. She ordered a chest x-ray. *He was not seen for this complaint until 12/12/13 which is dangerously long.*

The vital signs that were measured were normal. However, the nurse did not check one of his vital signs – his oxygen saturation – which she should have measured given his respiratory symptoms.

The nurse did not examine him. An examination was absolutely required. Further, in the absence of an examination, obtaining an x-ray is wrong – other tests may be indicated.

The nurse cannot and should not order an x-ray without a physician’s order.

The chest x-ray was never done.

3/5/14 The patient submitted an SCR stating this was his 4th request for problems with his heart, breathing, stomach, and chest pain.
The SCR was not reviewed until 3/20/14 which is unacceptably and dangerously long for this set of symptoms.

At that time the nurse called for the patient to be brought from Unit 5, but the officers informed her that the inmate threatened staff, so they were unable to bring him due to security issues. The nurse did not go to see the patient, which was necessary, nor did she even make arrangements for a rescheduling.

3/27/14 The patient was seen by the physician for his cough, shortness of breath, and chest pain. He ordered a chest x-ray.
Other than vital signs (from which oxygen saturation, an important vital sign in this situation, was missing) the physician only examined his lungs.

This was the third time in 4 months that a chest x-ray had been ordered, but not yet done. As of the date of my visit, 4/22/14, the chest x-ray had not yet been done.

Oct. 2013 *A review of the MARs for this month show nurses failed to administer 13 doses of 31 possible doses of his antidepressant medication.*

On the day of my visit in April 2014, this was the most recent MAR entered into the patient's medical record; those from November 2013 through March, 2014 were missing.

At 16:40 on 4/23/14, I notified Mr. Ollie Little of this case and asked that the physician be notified and follow up on the patient's chest pain and x-rays.

Patient 10 (Living Unit 3)

Case Summary

This patient is a 54 year old black male with schizophrenia and anemia (low blood count). He developed a complex ailment which included a large abscess and low blood count. My review of his chart revealed multiple serious systemic problems in his care that have subjected him, and continue to subject him, to risk of serious harm to his health. I did not review this case in its entirety.

- The patient complained of vomiting. Instead of being evaluated by a medical nurse, he was evaluated by a mental health counselor who would not have the skills to do an appropriate evaluation.
- Orders were not executed. After the above “evaluation” the mental health counselor referred the patient to see a physician. But that evaluation never took place. A week later the patient had developed a large abscess and required emergency evacuation to the hospital. Appropriate evaluation and treatment a week earlier may have avoided this emergency.
- Even when orders are executed, the follow-up system fails. After returning from the hospital, the EMCF physician noted that the patient was losing weight. He was concerned the patient might have a more serious “underlying problem.” He placed him in OBS to receive wound care for his opened abscess and to be monitored by nurses. He also asked nurses to check the results of tests (cultures) on the patient’s abscess, and he ordered blood tests and an x-ray. Nurses monitored him for a few days. Then, for no apparent reason, they simply stopped. The blood tests the doctor ordered were performed on 7/9/13 and the results were returned shortly thereafter showing marked abnormalities, including a low blood count. As of the date of my visit, 4/24/14 – more than 9 months later – the physician had still not reviewed these abnormal results. The culture test results were never checked. The x-ray was never done. The physician never noticed. Thus the physician’s appropriate and rational concern that this patient may have a serious underlying problem – such as cancer – has still not been addressed.

Chart Review

- 5/27/09 Earliest record of him in EMCF
- 6/28/13 The patient submitted an SCR for “acid reflux and have been throwing up all my food.” On the same day he was seen by an MHC (Mental Health Counselor) who took a brief medical history (“Offender reports stomach pain and vomiting”) and referred him to the medical physician.
An MHC does not have the skill, and I assume the licensure to assess medical problems. Thus this SCR was not triaged by a qualified medical professional.
- He was never seen by the physician.*
- 7/6/13 On this day the patient again complained of abdominal pain. He was seen by an RN who found a “large baseball size red area noted to mid abd with

outer areas extra hard and firm. Entire area hot to touch. 146/80, 84, 20, 101.7.” The nurse called the physician. The physician examined the patient, and noted that the patient weighed 114 pounds representing a 26 pound weight loss, and had a large (10 cm on the surface, larger deeper down), tender (pain level 10/10), red epigastric mass which the patient stated had been growing for 2.5 months. He had been having chills, fever, dizziness, and near loss of consciousness twice. The doctor ordered a pain shot (Toradol) which resulted in pain relief. The doctor sent him to the ER in Jackson, about 1.5 hours away, by van. Parts of an ER record in the chart indicate that the patient was treated for a boil. A lab result from St. Dominic Jackson Hospital indicates the patient had significant anemia (hemoglobin 8.9, hematocrit 26.9, MCV 77.7, platelets 454K) and low calcium and albumin levels in his blood.

This patient requested care for abdominal pain on 6/28/13, was ignored, and by a week later had developed a severe infection which required evacuation to an emergency room. This emergency may very well have been avoidable.

Nursing notes indicate the patient returned from the hospital. His vital signs were stable. He was placed in OBS and Dr. Faulk was contacted. He ordered the clindamycin (and antibiotic) recommended by the ER physician changed to Bactrim DS (a different antibiotic) 1 twice daily x 7 days and Rocephin (another antibiotic) 1 g IM daily x 7 d, and ordered blood tests (CBC, comprehensive metabolic panel, urinalysis), and a chest x-ray for the following week. The only order for wound care was for the packing to remain in place for 2 days and the gauze changed.

7/7/13 The physician saw the patient in OBS. He noted that based on the patient’s loss of weight “must consider some underlying problem with this IM.” He ordered to stop the Bactrim he had previously ordered and add clindamycin 300 mg. every 6 hours, and for the results of wound cultures from the ER to be checked in 4 days. He ordered for the patient to be seen by him in follow-up the next day.

7/9/13 The patient had a CBC performed. The results were hemoglobin 9.4 (12.6-17.7), hematocrit 10 (37.5 – 51), with a normal MCV and RDW, Platelets= 620 (140-415). The patient’s albumin was 2.7 (3.5-5.5). LFTs were normal. The patient’s cholesterol was low (84). TSH was normal.

7/7-7/12/13 There is evidence the patient was seen and treated on a regular basis by nurses in OBS.
*Nursing care appears to end on 7/12/13. After this point, there is no evidence of any care for his abdominal wound by medical staff.
There were no further visits by the physician.*

A mental health note indicates that he was being discharged from OBS, but there is no indication if it is safe to do so based on his abdominal abscess.

The blood tests the doctor ordered were obtained on 7/9/13. There were markedly abnormal, indicating that the patient had a severe anemia. The test results were never reviewed by the doctor.

The x-ray was never done.

The doctor's concern about the patient's loss of weight was dropped, unaddressed.

The results of the wound cultures were never checked.

Lastly there is no record of any of the antibiotics ordered for this patient actually being administered – any records of medication administration from the month of July 2013 are missing, presumed lost. (I asked Mr. Little for the July MARs, if they exist. As of the time of publication of my report, I have not received any MARs for this patient for July, 2013.)

As of the date of my visit, 4/24/14, the open clinical issues above had not been addressed.

August 2013 *A review of the MAR for this month shows that nurses failed to administer 19 of 124 possible doses of essential medications.*

In addition, on 34 other occasions, the nurse failed to administer medications, indicating "NS" in the cell. NS does not correspond to any approved form of documentation allowed by MDOC. I made the inference that "NS" meant that the patient no-showed for medication administration. There should be, but is not, any documentation on the MAR for the reason for the no-show nor was there any attempt to find the patient or communicate the missed medication doses to the prescriber. It is unacceptable to abide no-show as a reason for not administering medications. The reason it is unacceptable is that in a prison there are reasons a patient might not show for medications other than the patient's informed and free-will choice to forego his medications. Those reasons might include: he doesn't understand the need for the medication; he's too ill to report for his medications; he has been intimidated by other inmates; or officers failed to provide his access to the nurse.

On 4/25/14 I discussed the dropped evaluation for loss of weight and anemia with Mr. Little and asked that he convey these concerns to the physician.

Patient 11 (Living Unit 7)

The patient, whom I met in a random cell-side interview, informed me he has diabetes but staff won't check his blood sugar.

Case Summary

This is 50 year old black male who has diabetes, high blood pressure, high cholesterol, and schizophrenia. These chronic diseases and his age and race place him at increased risk of cardiovascular problems, such as heart attack and stroke. Mismanagement of his condition at EMCF has increased that risk as the following examples illustrate.

- Due to errors in the way the EHR is constructed, this patient's chart contains what appears to be imaginary (and therefore misleading) information. Blood sugar results from 2011 ("169 @ 3:50pm") have appeared repeatedly in chart notes from 2012, 2013, and 2014. Unless a practitioner did a careful review of the whole medical record (which is not usual practice) and discovered this erroneous information, he or she might have made, and may indeed have actually made, prescribing errors after relying upon it.
- Medical professionals fail to conduct proper evaluations or follow-up. During a CCC visit, this patient complained of intervals of chest pain. Chest pain, in a patient with multiple risk factors for heart disease, is an important symptom that must be pursued. The practitioner failed to pursue it by asking important questions, such as when the pain started and whether or not it was related to exercise. The practitioner did order an EKG on 2/1/14, which might have been helpful. However, as of my visit on 4/24/14, almost three months later, the EKG had never been done and the practitioner did nothing about it. On other occasions a physician ordered other blood tests related the patient's chronic diseases, but on 4 of these occasions, the physician never bothered to review the results of those tests.

This patient remains at ongoing risk of mismanagement of chronic medical conditions with the attendant risk of complications of those diseases. The review below contains additional examples; I did not conduct a review of the patient's full record.

Chart Review

11/14/11 Admitted to EMCF

2/1/14 The patient had a CCC visit for diabetes, hypertension, and high cholesterol. He reported having short intervals of chest pain without shortness of breath.

Chest pain, in a patient with multiple risk factors for heart disease, is an important symptom that must be pursued. The practitioner failed to pursue it by asking other important questions, such as when the pain started and whether or not it was related to exercise.

The practitioner did order an EKG. However, as of the date of my review, 4/24/13, almost 3 months later, there is no evidence in the medical record that the EKG was done or its results reviewed by a practitioner.

The content of the CCC notes contains misleading nonsense: documentation that the patient's blood sugar was "169 @ 3:50pm" has appeared on every CCC progress note since 2012. Clearly the patient's blood sugar was not 169 at 3:50 P.M. on seven different occasions. However, a health care provider reading isolated parts of this patient's EHR would not likely notice this error. If s/he then relied on this misinformation to make a treatment decision, the treatment would likely be wrong.

3/30/14 The patient submitted an SCR for pain in his left foot and stomach. (This is not in the EHR – the patient showed me a copy of his SCR.) An RN responded to his SCR: "Have you hurt your foot? You are on Zantac for your stomach."
According to the patient, he was not seen by the nurse, which was borne out by his medical record. Thus this patient's care was delivered by correspondence. Failing to see the patient for these symptoms amounts to lack of access to care. It is especially dangerous in a patient with diabetes in whom foot pain can be the first symptom of an infection, which can be limb- or life-threatening.

2012 – 2014 This patient has had HbA1cs (an indication of blood sugar levels) measured on the following dates and at the intervals indicated:
9/20/12 (7.2)
6/25/13 (7.0) (9 month interval)
12/19/13 (6.5) (6 month interval)
2/21/14 (6.4) (2 month interval)
There are 4 more sets of blood test results which the physician ordered, but never reviewed, which are, therefore, excluded from the lab results section of the EHR. They are from: 9/23/13, 8/1/13, 3/8/13, and 12/20/12.

Despite the unusually long intervals between blood tests, the HbA1c was initially good and it has gotten better.

Medical staff have never tested nerve sensation in his feet, as is part of basic ongoing diabetic care.

He has had annual ophthalmic exams as is required for basic ongoing diabetic care to prevent blindness. The examination of 10/11/12 was adequate, though it was not a dilated exam. However, the exam of 8/30/13 was not. At that time he only had his lens and vision checked. There is no evidence of examination of the retinas, which is essential in the annual check of a diabetic's eyes. More importantly, according to the staffing roster, the "optometrist" is actually an optometry technician, who

appears to be treating patients independently. His examination is not adequate for the purposes of an annual diabetes examination. Ms. LaMarre discusses this further in her report.

The patient has only had finger-stick blood sugar checks during a few days in February 2014. However, given his other blood test results, this is reasonable.

Patient 12 (Living Unit 7 - Camp Support)

Case Summary

This is a 58 year old black male with non-insulin dependent diabetes, high cholesterol, high blood pressure, and depression. He has a nerve condition where his eyelids will not stay open without him manually holding them open. ACLU provided me a copy of an Administrative Remedy Program (Grievance) report to the patient dated 9/16/13 which indicates that the physician planned to send the patient to a specialist (Dr. Jones.), but doubts he has myasthenia gravis (a neurologic disorder).

I briefly scanned this chart. It appears the patient saw an outside ophthalmologist at least as early as 2011 or 2012, who ruled out myasthenia gravis. It is not clear to me that further workup is essential. I did not extract the chart thoroughly.

Chart Review

7/27/09	Admitted to EMCF
11/6/12	There is a handwritten note from the physician stating that the patient may have myasthenia gravis, and should see a medical or neurologic specialist.

Patient 13 (Living Unit 1)

Case Summary

This is a 46 year old black male with schizophrenia who developed an infection in his knee. Multiple parts of the health care system at EMCF failed him as illustrated below:

- The patient was denied access to care. He submitted an SCR due to “body pain.” This required a face-to-face encounter to obtain more information and to conduct an appropriate examination to determine if this was a serious medical need. Instead, as happened in numerous other case, medical staff did not bother to do this, and simply responded to him by correspondence.
- When medical professionals actually conducted evaluations, they did not use sound clinical judgment. Pursuant to an SCR for “great” pain in his knee, the patient was seen by a nurse who found that he had drainage (pus) coming from his knee. This required additional inquiry and examination to determine the severity and extent of the infection, e.g. was the infection spreading elsewhere, in which case the patient may have required evacuation to a hospital and possibly surgery. The nurse did not take these additional steps.
- The nurse also practiced beyond her legal and safe scope of practice by ordering antibiotics without the approval of a physician. She also failed to order the antibiotic to begin in a timely manner: instead of ordering it to start immediately, it was not ordered to start until 3 days after the infection was discovered. Once a serious infection is discovered every day – sometimes every hour – that is lost increases the chances that the infection will spread.

The chart review below contains more examples of problems in the care of this patient; I did not review the entire record. Overall, the case reinforces the existence of multiple system-level problems in the health care operation at EMCF that put this patient’s health at grave risk.

Chart Review

4/20/12 Admitted to EMCF

8/28/13 The patient submitted an SCR for “great” pain in his knee; he thought he might have an infection. He was seen by an RN on 8/29/13. The nurse checked his vital signs, which were normal. He had a Band-Aid on the area and there was drainage. At the completion of the visit, there was an order for Bactrim DS (an antibiotic) 1 twice daily x 10 days.
The nurse’s did not obtain additional history, such as any symptoms of systemic infection. The only examination she performed was “the area on his knee is red swollen and sore to him. Unable to express much drainage out of the knee but does need to be on antibiotics.” The history taking and examination were wholly inadequate, lacking any indication of how extensive the infection was, whether or not it was spreading elsewhere, whether or not it involved the joint space itself.

No education was given to the patient on wound management and avoidance of spreading it to others, which is especially important in a congregate environment such as prison.

No arrangements were made for follow-up.

There appears to be a treatment plan for nurses to clean the knee with saline daily, however, a) the plan is for treatment from 9/1/13 until healed (why did it not begin immediately?), and b) there is only documentation of it being done on 9/3/13 (on 9/6 there was instruction for the patient to do it himself). Thus the patient did not appear to get the care that was planned.

There is no evidence that the antibiotic was prescribed by a physician, i.e. it appears to have been ordered by the nurse independently, beyond the legal scope of license of a nurse.

The order for Bactrim – whoever wrote it – was not written to begin until 9/1/13, 3 days after the infection was discovered. Once a serious infection is discovered every day – sometimes every hour – that is lost increases the chances that the infection will spread. Failure to prescribe the antibiotics immediately reflects a severe lack of sound professional judgment.

Even after prescribing the antibiotic, the first dose was not actually administered until the evening of 9/2/13, now 4 days after the infection was identified.

Finally, on 9/6/13, 9/7/13, and 9/8/13, there is conflicting documentation as to whether or not the medicine was actually administered.

10/21/13

According to the contemporaneously maintained Sick Call Log, this patient submitted an SCR for “body pain” on 10/21/13.

According to this same log, the patient was not seen by any medical staff, and only a written response was provided. Attempting to deliver care in this manner – “health care by correspondence” – is dangerous and unacceptable.

I was unable to find an SCR in the patient’s medical record corresponding to this date +/- 2 months. Thus the patient’s medical record is not a reliable record of care which was provided.

Patient 14

Case Summary

This is a 38 year old black male with a history of high blood pressure. His chart contains examples of failures of each of the key components of a safe health care system:

- Delayed access to care. This patient submitted an SCR for a “sore big toe.” He was not seen until 6 days later which, had this been an infection, would have been much too long a delay. On another occasion, when the patient submitted an SCR for a cough, the patient never received an evaluation.
- Nurses practice beyond the scope of their license. A nurse ordered a chest x-ray without consultation and an order from a physician. Further, the nurse did not provide any explanation to the radiologist of why the x-ray was being ordered, something that decreases the accuracy of the x-ray reading and something upon which the radiologist commented in his report.
- The medical record is not reliable. We know the patient submitted the two aforementioned SCRs only because nurses made references to one in a later note and to the other in a log book. The SCRs should have been, but were not, in the patient’s medical record.
- EMCF staff fail to take the simplest of steps to follow up on tests or care plans. For example, the aforementioned x-ray was reported back to the facility. It showed marked abnormalities that required immediate action (further evaluation and possible treatment). No one reviewed it, though, until almost 3 months later. Follow-up for CCC visits for hypertension also did not happen. After one CCC visit, the practitioner ordered the patient to be scheduled back to the clinic for evaluation in 3 months; that visit was not scheduled until 7 months. That visit did not take place, however. There is no explanation of why it did not take place except for the fact that that appointment is filed in an electronic file entitled “ChronCare: refuse.” There is no other documentation (which would be necessary when a patient refuses) to indicate that the patient was actually notified of the appointment, that a qualified health professional met with him and explained the need for the visit and the risks of refusing, and that the patient then gave informed refusal. The appointment was rescheduled for 2 months later. At that appointment – which was now a half year after it was supposed to take place – the patient’s blood pressure was abnormally elevated. Control of high blood pressure is important to prevent damage, such as heart attacks and strokes. It is noteworthy that this patient’s blood pressure was likely not well controlled for the 6 months during which EMCF failed to provide follow-up care. About 2 weeks after this last appointment, the patient suffered a heart attack.

The chart review below contains other examples of poor care; I did not review this patient’s entire record. The examples cited in this case underscore the dangers inherent in the health care system at EMCF. Further, if the heart attack suffered by this patient was caused by his poorly controlled high blood pressure, the poor care did not just put this patient at risk of harm - it caused harm.

Chart Review

- 3/16/13 The patient had a CCC visit for high blood pressure. The plan was to follow up in 3 months.
The 3-month follow up did not happen. The patient was not scheduled until 7 months later. At that time, he apparently refused (see below), and did not end up having an appointment until 12/27/13, 9 months later, at which time his blood pressure was high (132/100). Thus lack of appropriate follow-up resulted in worsening of his blood pressure, increasing his risk of a heart attack or stroke.
- 9/06/13 The patient submitted an SCR for a sore big toe.
The sick call request is not in the patient's EHR – it is only referred to by the nurse during the following visit. Thus the patient's medical record is not a reliable record of the care the patient received.
- The nurse saw him on 9/12/13 for and did not provide a diagnosis, but decided to refer him to a podiatric specialist.
There was a 6 day delay until the patient was seen for this SCR, which is too long.
- 9/18/13 The patient was seen by the podiatrist who performed a partial nail avulsion.
- 10/18/13 The patient was scheduled for a CCC visit.
It did not take place. The only indication of the reason for it not taking place is the title of the electronic file in which the note is filed: "ChronCare: refuse." There is no indication as to who obtained this refusal, whether it was, indeed, a true patient refusal (vs. failure to notify or bring the patient), nor was there any evidence of a medical professional having obtained informed refusal. Thus, the evidence supports failure to provide access to care.
- 10/21/13 According to the contemporaneously maintained Sick Call Log, this patient submitted an SCR for a cough on this date.
According to this same log, the patient was not seen by any medical staff, and only a written response was provided. Attempting to deliver care in this manner – "health care by correspondence" – is dangerous and unacceptable.
- I was unable to find an SCR for cough in the patient's medical record on or around 10/21/13. (The nearest related symptom recorded on an SCR was for a cough on 11/25/13.) Thus the patient's medical record is not a reliable record of care which was provided.*
- 11/23/13 The patient submitted an SCR for a cough and "sick, very sick." He was seen by a nurse on 11/25/13.

There is no evidence that the nurse solicited any history at all (for example any history of fever, sputum, shortness of breath), and the entire examination was limited to measuring his temperature and observing "some coughing noted." Based on this, the nurse administered throat lozenges. The encounter was so empty as to constitute lack of a professional medical judgment.

On 12/27/13 a chest x-ray was done and reported to EMCF. The chest x-ray report indicates that no ordering physician's name was provided nor any information about the reason for the exam. Since there were no clinical encounters prior to the x-ray, other than this visit on 11/25/13, I concluded that this x-ray was ordered by an RN at the 11/25/13 visit, independently (and beyond the scope of her license), without the collaboration of a physician, and with inadequate medical information.

The report, which described marked abnormalities (peribronchial cuffing, compatible with asthma and bronchitis) was not reviewed by the physician until 2/17/14, almost a quarter of a year later!

12/27/13 The patient finally had his CCC visit for high blood pressure. At this visit his blood pressure was elevated (132/100); it had been elevated at least once in the interim since his missed CCC in June 2013. His elevated blood pressure was treated on this date. He was transferred to another facility around 1/1/14. On or around 1/7/14 he began experiencing chest pain, and on 1/11/14 he was admitted to the hospital with a heart attack. *Uncontrolled high blood pressure is a risk factor for (i.e. contributes to the development of) heart disease. EMCF failed to provide adequate monitoring and care of this patient's high blood pressure. While this mismanagement was below the standard of care and contributed to risk of having a heart attack, I cannot state with certainty that it was causal.*

Patient 15

Chart Review

10/15/13

According to the contemporaneously maintained Sick Call Log, this patient submitted an SCR for “shoes and pain” on this date.

According to this same log, the patient was not seen by any medical staff, and only a written response was provided. Attempting to deliver care in this manner – “health care by correspondence” – is dangerous and unacceptable.

I was unable to find an SCR for anything related to shoes or pain in the patient’s medical record on or around 10/15/13. (The nearest related symptom recorded on an SCR was for foot pain on 11/11/13.) Thus the patient’s medical record is not a reliable record of care which was provided.

Patient 16

Case Summary

This is a 44 year old Native American male with a diabetes, severely damaged liver due to hepatitis C, and depression. This case is most illustrative of the dangers at EMCF due to health care professionals failing to make sound clinical judgments because they are operating outside the bounds of their abilities and/or licenses, as the following examples demonstrate:

- The culture and practice at EMCF allow LPNs to make decisions well beyond their safe limit. During a routine measurement of this patient's blood sugar by an LPN, the machine gave a result of "hi" indicating that the patient's blood sugar was so high, it was beyond the limits of the machine (usually 500 or 600). Blood sugars in this range define a medical urgency or possibly emergency. The LPN should have immediately notified an RN or practitioner. Instead, the LPN chose to do nothing. A few days later, an emergency call was triggered to the nurses for a "man down." Given the patient's history of diabetes, his previous high blood sugar, and the fact that the most likely cause of a "man down" in a diabetic is due to an abnormal blood sugar level, the responding nurses should have but failed to measure the patient's blood sugar. Later that day, on two separate occasions, LPNs measured the patient's blood sugar at close to 500...and again, they did nothing. As events later that day unfolded, these repeated failures of LPNs to practice safely put the patient at grave risk and resulted in what was probably a preventable emergency evacuation to the hospital.
- Physician decision making was also flawed in the management of this patient's emergency. Two hours later the patient became disoriented and unable to answer questions. A nurse contact the physician who ordered the patient sent to the ER. Due to the patient's unstable condition (that could deteriorate at any moment), the physician should have sent the patient to the ER by ambulance. Instead he sent him by passenger van (and without any medical personnel in attendance). The following day, when presented with an almost identical scenario, the physician again elected the more dangerous mode of transportation for this patient.
- Bad clinical judgment compounds poor policies at EMCF. When this patient returned from the ER after his first trip, he was still disoriented and unable to follow simple commands (for example, given a biscuit to eat, he placed it first on his nose). In a minimally safe prison health care system, nurses should call the physician when a patient returns from the hospital to communicate the patient's condition and diagnosis, and receive further orders. At EMCF nurses do not have to call the physician, and in this case did not. Instead, they placed the patient in OBS. In a minimally safe prison health care system, nurses should call the physician when placing a patient in OBS. At EMCF nurses do not have to call the physician, and in this case did not. Thus the physician was unaware that the patient returned from the ER still ill, and was unaware that he was so ill that he required placement in the OBS. When the physician was finally informed of his condition the next morning, he ordered the patient returned to the ER. Thus an unstable patient remained in an unsafe (non-hospital) environment overnight.

Thus at EMCF, poor professional judgment and poor policies create a “perfect storm” for dangerous patient care.

Chart Review

7/25/13 Admitted to EMCF

9/2/13 An LPN measured the patient’s blood sugar as “hi.”
A reading of “hi” means the blood sugar was too high to register on the testing machine, typically meaning it is over 500 or 600, and typically constituting a medical urgency, requiring immediate treatment of the high blood sugar and assessment for possible causes, including infection and heart attack. There is no evidence the nurse notified anyone of this result or that any action was taken to assess or treat this potentially life-threatening situation.

9/6/13 At 07:20 a nurse documented that an emergency was called for this patient (“man down”). No problem was found after 1.5 hours of observation and the patient was sent back to his living unit.
Despite his history of high blood sugar (which would be one of the most likely causes of a change in mental status or a fall in this patient), the nurse failed to check his blood sugar.

Later that day, at approximately 16:40 and again at 17:00, an LPN measured his blood sugar at close to 500.
In light of the earlier “man down,” this high reading should now have been more worrisome, and, until proven otherwise constituted an emergency, but there is no record that the LPN notified anyone or that any treatment was provided. The LPN, by making an assessment that no further action was necessary, failed to use sound clinical judgment and was practicing beyond the scope of his/her license. His/her inaction put the patient at grave risk.

Finally, at 19:30 the patient was found to be disoriented, again with a blood sugar close to 500. He was now given insulin and brought to the Medical Unit. His vital signs were stable. He remained disoriented and unable to answer questions properly. The physician was called and the patient was sent to the emergency room by van.
Sending the patient to the ER in a van was dangerous. First, the reason for his change in mental status was not known and could have been due to a serious and unstable problem that might get worse during transportation, requiring medical intervention. Such intervention could not be provided in a van. Second, since his mental status was unstable, transportation by van (only officers in attendance) placed him (and staff) at additional risk if he became unruly due to his altered mental state.

Upon return from the ER, he was unable to walk safely on his own and was still confused. He was placed in OBS pending evaluation by the physician in the morning.

After any patient returns from the ER, the physician should be notified, but especially so if the patient is still unstable. Yet the physician was not notified.

There should be, but are not, any meaningful medical records from the ER visit in the patient's medical record, nor is there any evidence that EMCF requested them. In the absence of ER medical records, it is difficult, if not impossible, for EMCF medical staff to provide appropriate follow up care.

9/7/13

The patient was still disoriented and unable to follow commands. He was unable to hold his spoon correctly to eat. Given a biscuit to eat, he placed it on his nose and then to his mouth. His vital signs were stable but his pupil response was sluggish. He was assessed by the nurse practitioner who contacted the physician, and the patient was sent back to the ER by van.

For the same reasons as above, it was dangerous to send the patient by van with only officers.

It does not appear that the patient's condition had changed since the night before when he returned from the ER. In other words, if his condition on the morning of 9/7/13 was unstable enough to warrant being in the ER, he warranted being in the ER on the evening of 9/6/13; failure to notify the physician upon the patient's return on 9/6/13 led to this delay in getting him back to emergency care.

Patient 17

Chart Review

2/7/11 Admitted to EMCF

6/21/13 The patient submitted an SCR for “chest pain, coughing/spitting up blood, and headaches continuously, I do have bronchysis [sic].”
The SCR was not reviewed until 6/25/13 at which time the nurse wrote back that the patient saw the nurse practitioner on 6/22/13. In a minimally safe system, this SCR would have been discovered within 24 to 48 hours of its writing and medical staff would have immediately requested this patient to be brought to the Medical Unit. Instead care for an urgent medical problem was delayed for 4 days.

6/22/13 During the Warden’s rounds, the patient had the same symptoms. Medical staff was notified and he was sent to the Medical Unit. There, a nurse notified the nurse practitioner of his symptoms. The nurse practitioner ordered him sent to the ER at 12:55. He was sent by van.
There is no evidence the patient had any clinical evaluation in the Medical Unit by the nurse or nurse practitioner, including any history taking or vital signs. Given his symptoms and the fact that staff thought he was sick enough to need transport to the ER, his condition MANDATED an evaluation first by staff, at the very least to see if he required transportation by ambulance. In the absence of such evaluation, transportation by van was dangerous.

There is a note from the ER indicating a chest x-ray, EKG, and CBC were all normal, and asking if he has had a skin test for tuberculosis.
This note was not reviewed by a physician until 6/25/13, when he referred the patient to a nurse to answer the ER’s question. If the current problem were active tuberculosis, addressing it 3 days later would be dangerous for anyone with whom the patient came in contact with during the ensuing 72 hours. There is no note related to checking of the skin test. The last time the patient was tested for tuberculosis was 1/12/11, 2.5 years earlier. The fact that it was checked at that time and was negative was meaningless; the ER physician’s concern was for current/new infection, for which a negative test 2.5 years ago was irrelevant. Thus the doctor’s order to check if it was done, needed to be more specific and/or he needed to follow up to learn the results; he either did check and ignored the results, or did not check. Thus the concern that this patient might have active tuberculosis (that might be spreading to other inmates, staff, and their families) went unaddressed, and remained unaddressed as of my visit in April of 2014.

9/4/13(approximately) Transferred out of EMCF

On 4/25/14 I alerted Mr. Little of the ER physician's unaddressed concern about tuberculosis.

Patient 18

Case Summary

This patient has seizures, asthma, high blood pressure, and schizophrenia. I found numerous problems with his care, including themes mentioned earlier in my report, such as:

- Staff fail to follow through with important care plans. At his previous facility, medical staff determined that he needed follow-up in CCC for his seizures and high blood pressure in 6 months. He was then transferred to EMCF where the follow-up took place more than a year later.
- Nurses do not execute physician orders. The patient has a seizure disorder and is prescribed seizure medications, but nurses do not consistently give them. During key months in this patient's case, nurses failed to administer between 1 and 23 doses of individual seizure medications.

However, this case is most noteworthy for the repetitive poor decision making by the practitioners. The chart review below contains examples of this during management of the patient's asthma. In this case summary, I will concentrate on management of the patient's seizure disorder. Seizure disorders are managed mainly by seizure medications. Seizure medications are managed mainly by measuring the blood levels of the seizure medications and then making appropriate dosing adjustments (also taking into account the frequency of seizures). At EMCF, practitioners ordered blood levels for this patient, but responded to these tests in illogical ways. Sometimes the blood levels were undetectable, but the physicians did nothing, leaving the patient unprotected from seizures. Sometimes physicians made dosage changes in the absence of any blood level information, i.e. made the changes blindly. Sometimes physicians ignored the seizure disorder completely, not making dosage changes nor measuring blood levels at all for long periods of time. Once, the physician decided (without any discernable discussion with the patient or other evidence) that the patient's low blood level was the result of the patient hoarding his medications, and promptly stopped them. However, 3 months later, with no more information than the physician had when he stopped the medications, he started them again. In sum, the management of this patient's seizure disorder is best described as seizure-like. It is spasmodic, without apparent logic, with large gaps of time between addressing issues, with some issues simply not-addressed, and with plans not carried out. In my opinion, the patient suffered at least one seizure as a result of these patterns of care.

Chart Review

- 3/31/11 At the last CCC visit at the previous facility, the patient was ordered to have follow up in 6 months.
This follow up should have occurred at EMCF around 10/1/11. Instead, it did not take place until 1/5/13, nearly 2 years later.
- 6/9/11 Admitted to EMCF

- 1/5/13 The patient attended a CCC visit for asthma, hypertension, and seizures. *The practitioner failed to collect any history of the status of the patient's seizure disorder or of his asthma (other than use of his inhaler).*
- 2011-2013 I sampled MARs during this period:
I was unable to analyze the MAR of July 2011 because the signature page was missing from the EHR.
- For the month of August 2011, nurses failed to administer 10 of 38 possible doses of Tegretol.*
- For the month of February 2012, nurses failed to administer 6 of 25 possible doses of Tegretol.*
- For the month of September 2013, nurses failed to administer only 1 of 15 possible doses of Tegretol.*
- Jan 2013 - Over this period of time, the patient had regular visits to CCC for
Apr 2014 management of his seizures.
However, due to lack of sound clinical judgment and follow up, care for his seizure disorder was poor:
- The patient was on Tegretol for control of his seizures. When he arrived at EMCF, his blood level was 6.1 (therapeutic level 8-12). When it was checked again on 1/25/12 (not actually reviewed by anyone at EMCF until 2/3/13), it was 4.4. By 2/7/12, it was so low it was undetectable. This test result required immediate action (increase in medication dosage) in order to protect the patient from having another seizure. Instead, the facility physician signed off on this test result but did nothing about this medication.*
- At some point a physician added another anti-seizure medication (phenobarbital).
A review of the MAR for the month of April 2012 shows that nurses failed to administer 22 of 60 possible doses of phenobarbital, and 23 of 60 possible doses of Tegretol.
- The level of Tegretol in the patient's blood was measured on 4/26/12 and was still undetectable.
As before, this test result required immediate action (increase in medication dosage) in order to protect the patient from having another seizure. Once again, a physician signed off on it, but did nothing. Then, on 5/1/12 the patient had a seizure. Another level checked on 5/26/12 was also undetectable. Though this critical test result was available to EMCF staff to review on the day the laboratory completed it – 5/26/12 – the physician failed to review it until 6/18/12 – 3 weeks later. Thus it can be

concluded that this patient had a seizure due to the absence of anti-seizure medication in his blood stream, a medication which was given to him by doctors at EMCF because he has a known seizure disorder to prevent seizures. Despite the fact that doctors knew he did not have enough (if any) Tegretol in his blood stream to prevent a seizure, they did nothing. That the patient had a seizure was predictable and preventable.

In response to the undetectable level on 5/26/12, staff finally ordered a change in the Tegretol dose (the exact dosage change is not clear in the medical record). On 8/23/12, the dosage was changed again (200 mg. AM, 300 mg. PM).

After making a change in the Tegretol dosing, it is necessary to recheck the blood level to make sure the change was successful (i.e. that the blood level is high enough to prevent a seizure but not too high to cause toxicity). Yet EMCF practitioners did not measure the Tegretol blood level again until nearly a year later, on 3/13/13, at which time it was still undetectable. This means that for period of time, possibly a year, the patient's dosage of medication was dangerously low, placing him at constant risk of seizures, and that during this time, health care staff simply ignored it.

On 3/17/13 (4 days after the last blood test was done), the patient had a CCC visit.

Despite yet another opportunity to revisit and properly manage the patient's seizure disorder during a visit specifically for that purpose, doctors did nothing. The blood test result from 3/13/13 showing that Tegretol was undetectable in the patient's blood and that therefore he was in imminent danger, was noted and ignored. During the CCC visit itself, the patient's chronic disease – seizure disorder – was ignored.

Over the next few months, practitioners made changes to the patient's seizure medications (on 5/6/13, phenobarbital 32.4 mg AM, 64.8 mg PM was ordered; on 8/30/13, Tegretol 300 daily was ordered; on 9/15/13, Tegretol was discontinued, as was phenobarbital). Briefly, on 5/17/13, the Tegretol blood level was high enough to be measurable (4.9), but by 9/13/13, it was undetectable again. On 9/15/13 the physician wrote a note addressing this in which he stated that the patient is not taking his Tegretol and his plan is to discontinue it and also discontinue his phenobarbital, to prevent hoarding.

The physician did not actually meet with the patient on 9/15/13, so I cannot determine how the physician came to the conclusion that the patient was not taking his medications and was hoarding them. He asked to meet with the patient the next day. No such direct meeting ever took place. Both seizure medications were then abruptly halted.

Discontinuation of all medications used to treat a serious medical condition is a sentinel event. It must be undertaken with the utmost of

care and deliberation because it knowingly and predictably subjects the patient to great risk. It requires careful discussion with the patient, examination, and discussion with others on the team. There are reasons a patient's blood level may be low, other than hoarding. And even if a patient is hoarding, the reason must be determined and addressed (e.g. the patient may be having an untoward side effect, he may be the subject of extortion, etc.) Thus this patient's seizure medications were aborted in a deliberate and careless manner, placing the patient at great risk of another seizure and bodily harm.

The patient's Tegretol was restarted on 12/13/13 (200 mg. twice daily). On 3/10/14, it was changed to 400 mg. twice daily. Clearly, practitioners at EMCF felt it was appropriate to stop the patient's seizure medications on 9/15/13. Whether that action was justified or not, the rational practice of medicine requires that a practitioner have a logical reason for making a change to a treatment regimen (e.g. discovery that the patient was not hoarding, a promise by the patient that he would stop hoarding, etc.). However, I was unable to find a scintilla of rationale explaining this sudden reversal in treatment regimen. In other words, restarting of Tegretol appears to be a random event without clinical justification and is therefore unacceptable medical practice.

Whether the decision to restart Tegretol was justified or not, once started, it was incumbent on practitioners to monitor blood levels within the first couple of weeks and make appropriate dosage adjustments. Yet it was not measured again until 2/5/14, almost 2 months later, at which time it was too low (4.4). Thus the patient remained without adequate protection from the medication for an unnecessarily extended period of time.

Jan 2013 -
Apr 2014

Over this period of time, the patient had regular visits to CCC for management of his asthma. However, due to lack of equipment and sound clinical judgment, care for his asthma was poor:

I was unable to find a single measurement of the patient's peak expiratory flow rate (PEF) in CCC, which is an essential "vital sign" for patients with asthma.

The conclusions reached during visits are sometimes completely contrary to the data collected and are therefore unsafe. For example, during the 11/30/13 CCC visit, the practitioner noted that the patient is using 1 to 1.5 canisters of beta-agonist inhalers per month for asthma, but then concludes that the patient's asthma control is "good" based on the following definition printed on the progress note itself: "No more than one beta-agonist MDI [canister] used per month." The patient is clearly using more than 1 canister a month. Thus the conclusion that his asthma

control is “good” is wrong. That wrong conclusion led the practitioner to the wrong treatment, putting the patient at risk.

At the 4/4/14 CCC visit, the patient gave a history of shortness of breath, chest pain, chronic cough with sputum production, yet no action was taken to address these potentially serious problems.

Patient 19

Case Summary

This is a 53 year old black male with a history of seizures, high blood pressure, acid reflux, and schizophrenia. A limited review of his case revealed several problems with care. The two main ones are as follows (the others are described in the chart review):

- Medical staff do not execute orders or follow-up on care plans. After seeing this patient for hip pain, the doctor ordered prednisone (cortisone) for 5 days and for the patient to follow-up in 3 weeks. *Prednisone is a powerful medication with potential serious side effects. Nurses ignored the order and gave it to him for 12 days, putting the patient at risk.* The follow-up never happened. Despite the lack of follow-up, and therefore not armed with any information about whether the prednisone was working or causing any side effects, someone renewed the prednisone order 3 weeks later.
- Practitioners do not exercise sound clinical judgment as evidenced by the prescribing decisions just described and the following subsequent events. One of the potential serious side effects of prednisone is ulceration of the stomach/intestines. Within a few days of the above renewal of prednisone, the patient was hospitalized with internal rupture of an ulcer of the intestines. The incident started with the patient complaining of nausea and vomiting. He appeared quite ill to a nurse, who had him seen by a physician. The physician diagnosed the patient with simple constipation and gave him medications to increase the forcefulness of intestinal contractions, but at the same time, ordered a stat x-ray to make sure he did not have a different problem. These actions are illogical, contradictory, and dangerous. If the patient were suffering from something other than constipation (which the physician suspected he might), then giving him laxatives had a risk of making his condition worse, e.g. causing an internal rupture. Several hours later when the x-ray was done, the radiologist immediately called EMCF to notify staff of an abnormality. Despite the fact that there was now very good reason to believe the patient had suffered a catastrophic intra-abdominal event, the EMCF physician sent this patient to the ER in a passenger van (i.e. sitting up, with no medical personnel). The patient underwent surgery and remained in the hospital for 17 days.

It is very possible this patient suffered a ruptured intestines from injudicious prescribing of strong medications. Once he developed serious symptoms, additional dubious clinical decisions were made; I did not review the patient's entire record. The errors made were consistent with patterns of care seen for other patients at EMCF and define systemic flaws in health care at the facility.

Chart Review

5/27/09 Admitted to EMCF on or before this date

5/16/13

The patient was seen in clinic for hip pain. The practitioner gave him prednisone (cortisone) 20 mg daily for five days, with an order to return in 3 weeks.

The patient did not begin receiving this medication until 5/20/13. Despite a clear order for him to receive the medication for 5 days, the time limit was ignored and nurses gave it to him for 12 days (nurses failed to administer it on one of those days). Prednisone is a powerful medication with potential serious side effects, including stomach/duodenal ulcers. Thus ignoring the prescribed time limit put the patient at risk.

The ordered follow-up in 3 weeks never occurred.

Despite the lack of any follow-up, the prescription for prednisone was re-ordered on 6/30/13, i.e. without any clinical evaluation of either the effectiveness of the medication or search for side effects.

I was not able to verify administration of this medication pursuant to the 6/30/13 re-order because the July MAR is missing from the patient's medical record; I cannot therefore tell if the medication was administered as ordered.

7/11/13

At approximately 10:00 an RN saw the patient after being called by the officers because the patient was ill. The nurse documented that the patient had been sick for a week and had nausea and vomiting for 2 days. On examination he looked "hollow eyed," had cool and clammy skin, and his abdomen looked distended (swollen). His bowel sounds were hypoactive (abnormal), and due to poor circulation, the nurse was unable to measure the oxygen level in his blood. His other vital signs were normal except his respiratory rate was elevated at 22, and his pulse was elevated at 114. The nurse referred him to the physician. The physician saw the patient at 12:13. The patient's pulse was now slightly higher (116) (his respiratory rate and oxygen levels were not measured). The physician also documented a history of nausea but he wrote that there was no vomiting, which was inconsistent with the history obtained beforehand by the nurse and afterwards by the ER physician. His exam also confirmed lack of normal bowel sounds.

The physician's evaluation was incomplete. He failed to palpate and percuss the patient's abdomen, basic steps in a physical examination of the abdomen. Palpation determines if the patient's abdomen is tender. Percussion determines if the distension is due to air or fluids/solid material. This information is of major importance and is a routine part of such an examination. The physician also failed to take note of the patient's history of recent (or possibly current) prednisone usage, which is a known risk for causing ulcers.

At this point – and with an incomplete evaluation of the patient – the physician took two actions. First, he diagnosed the patient with constipation, and ordered medications to increase bowel pressure and movement. Second, he ordered a stat abdominal x-ray and had the patient admitted to OBS for observation.

These two actions were in logical conflict with each other. The fact that he ordered an abdominal x-ray (and especially the fact that he ordered it stat) indicates that he was not sure the patient was constipated and was concerned that the patient might have something more serious. On the other hand, if the patient did have another, more serious, diagnosis, the prescription for constipation medications had a real chance of making the patient's condition worse. Thus the physician did not use sound clinical judgment and put the patient at grave risk.

Despite the patient's unstable vital signs and that he was admitted to OBS for observation, no observation took place. Over the ensuing 5 or more hours, no nurse checked on the patient nor were his abnormal vital signs rechecked. In effect, the patient was abandoned in plain sight; any deterioration in his condition would go unnoticed.

The stat abdominal x-ray was performed. The radiologist reading the results discovered that the x-ray was abnormal (possible ruptured internal organs), and immediately called the facility. Sometime after 17:00, the patient was sent back to the ER by van.

Despite abnormal vital signs (when last checked some 5 hours earlier) and now serious concern about having a catastrophic intra-abdominal event, the physician ordered the patient sent to the ER in a van instead of an ambulance. This was an incorrect and dangerous choice.

The patient was admitted to the hospital. The hospital admission note indicates that he had a 3-day history of nausea, vomiting, and abdominal pain. A CT scan showed that his small bowel was obstructed, that it had ruptured, and air (and intestinal contents) was now free inside his abdomen. At surgery he was found to have a ruptured duodenal ulcer. Fluid from his stomach/intestines had spilled into his peritoneum. The patient was released from the hospital 17 days later.

Patient 20

Chart Review

- 5/2/11 Admitted to EMCF on or about this date
- 4/30/13 The patient submitted an SCR for severe tooth pain. According to the record it was “triaged” on 4/30/13.
Though triaged (on paper) on 4/30/13, the patient was not actually seen and evaluated for this problem until 5/25/13, at which time a tooth was extracted. The patient was thus left in pain without evaluation or pain treatment for almost a month.
- 6/18/13 On 6/10/14 the physician had ordered a drug screen. On this date the physician wrote, “Urine drug screen was positive for THS and low tramadol level. Positive urine drug screen. Nurse Inge will write RVR [Rule Violation Report] for this problem.”
There was no clinical evaluation indicating a clinical need for a urine drug screening. This fact, coupled with the fact that the physician instructed staff to punish the patient (Rule Violation Report) demonstrates that the physician has breached his ethical and professional boundaries as the patient’s physician and was no longer acting in a clinical capacity, but rather a custody capacity; who then was functioning as the patient’s physician at this point?
- 11/19/13 Transferred out of EMCF

Patient 21

Case Summary

This is a 40 year old white male with manic/depression. After submitting an SCR for a severe headache, it took 7 days for him to be evaluated, which is dangerously long. When he finally was evaluated, the evaluation was wholly inadequate and narrowly more than useless; any serious problem, such as meningitis or brain cancer could have been easily missed. Care was also dangerously delayed when he complained of chest pain and a “speeding heart” and was evaluated for this by a Mental Health Counselor who referred him to a medical person, but not until later the next day at which time his blood pressure was found to be dangerously high and he was evacuated to the ER. Despite his serious condition, the physician ordered him sent by passenger van. The care this patient received was emblematic of EMCF system problems and placed his health in grave danger.

Chart Review

6/4/13 Admitted to EMCF

9/17/13 The patient submitted an SCR for severe headaches for 4 days. He was evaluated by an RN for this complaint on 9/25/13.
A gap of 7 days between SCR and examination is too long a delay for this complaint.

In her note, the nurse reported that she attempted to see the patient on 9/18/13, but he was in class.

This is not a legitimate excuse in a prison environment for failing to provide access to care. Classes and clinic are not spontaneous, unpredictable events.

The RN took his vital signs, which were normal.

Other than this, however, the nurse failed to obtain any further history about the headache and failed to conduct a scintilla of an examination. In the absence of these steps it is impossible to arrive at a diagnosis and rational treatment plan. Nonetheless, the nurse arrived at a treatment plan: pain pills. If this patient had a serious cause for his headache, such as a brain tumor or meningitis, it would have been missed.

1/13/14 The patient submitted an SCR for chest pain, “speeding heart,” and sweats. He was seen on the same day by a Mental Health Counselor and referred to medical staff. The patient was not seen by a nurse until the following day around 18:00. At that point his blood pressure was 146/110, which is markedly elevated.
This complaint constituted an emergency. The patient should have been referred to and seen by medical staff immediately. Instead he was not seen until the following day, at which time he was quite ill.

Other than the pulse, no other vital signs were measured. Given his unstable blood pressure and symptoms, it was necessary to measure other basic vital signs immediately.

The nurse contacted the physician who ordered the patient sent to the ER. The physician ordered him sent to the ER by van.

This episode constituted a medical emergency. The risks of the patient decompensating during transportation were high. Sending the patient by van instead of ambulance was dangerous.

Patient 22

Case Summary

This is a 33 year old white male with a history of an artificial heart valve, high blood pressure, Marfan's Syndrome, and depression.

- Medical staff failed to arrange routine follow-up in CCC in this patient with serious chronic conditions upon arrival at EMCF. The doctors at the previous facility ordered CCC follow-up for 3 months, but this did not happen at EMCF for 10 months.
- Failure of nurses to follow practitioner medication orders coupled with sub-standard clinical decision making by practitioners resulted in numerous errors in care and great risk. The patient was on a blood thinner (Coumadin) to prevent him from developing clots (which can then cause strokes) due to his damaged heart valve. Coumadin doses must be carefully monitored (with blood tests) and adjusted to keep the blood appropriately thinned; too much thinning causes bleeding and too little allows clots to develop. During his entire first 15 months at EMCF, practitioners failed to keep this patient's blood thinned enough (i.e. at risk for clots). This was due, at least in part, to nurses' failure to administer his blood thinner. For example, during one month, nurses failed to administer 30 (of 31 possible) doses of Coumadin. On another occasion, when a practitioner ordered an increase in the dose, it took several days for nurses to note the order, and several more to actually increase it. At some point the patient's blood became too thin and he started bleeding internally. He told nurses who contacted the physician. Rather than treating the patient as the emergency case he was, the physician placed him in the prison's OBS for observation. Once there, he did not get all the intense monitoring he needed. But even when he did get monitored, and the results showed his blood pressure was dropping (indicated that his bleeding had reached critical levels), nurses did nothing. It was only when his blood pressure dropped even further (81/50), his heart was racing (104) and he was spitting up blood, that a nurse contacted a physician who ordered him evacuated to the ER. And even at this point, when medical urgency had turned to a medical emergency, medical staff failed to fully comprehend the seriousness of the situation: the physician ordered the patient sent to the ER by passenger van.

Beginning with sloppiness in losing track of CCC appointments at EMCF, and ending with outrageous irresponsibility when sending him in critical condition with internal bleeding and failing life signs to the ER by passenger van, this case, once again, demonstrates the deep systematic problems in health care at EMCF.

Chart Review

2/13/12 The patient's last CCC visit at the previous facility determined he needed follow-up in 3 months. Among his other problems, the practitioners at the previous facility noted that the patient also suffers from Marfan's Syndrome (a complex condition affecting the body's connective tissue that

can result in abnormalities to joints, the heart valves, the lens in the eye, etc.).

The ordered 3-month follow-up did not happen at EMCF until 10 months later, on 12/9/12.

4/3/12 Admitted to EMCF

Apr 2012 - Jul 2013 The patient is on a blood thinner (Coumadin) to prevent him from developing blood clots due to a damaged heart valve. When a blood clot develops in the heart, it can then travel to other parts of the body where it will block blood flow. If the clot lands in the brain, for example, it usually causes a stroke.

Based on his blood test results, he spent the entire time, from his admission to EMCF in 2012, until his hospitalization on 7/11/13, with his blood not adequately thinned and thus at constant risk of developing blood clots.

I viewed his MARs for the months of May and June 2013 (the 2 months prior to his hospitalization). His MAR for May 2013 reveals that nurses failed to administer 30 of 31 possible doses of Coumadin.

On 5/29/13 his blood was found to be too thick. The doctor ordered his dose of Coumadin be increased.

The nurses failed to note the changed dose until a week later, which is too long – during this period of time he was in danger of blood clots. Even once the nurses noted the order, they did not start giving it until 6/7/13 and then on the two following days, failed to administer it at all. Nurses failed to administer another 5 out of the next 14 doses. (In July, the patient received all doses of his medication from 7/1/13 until hospitalized on 7/13/13.)

7/12/13 The patient presented to a nurse complaining of blood in his stool (“a large tarry stool earlier today”) with complaints of nausea and “feeling bad since early am.” The nurse contacted the physician who, at approximately 17:30, ordered him placed in OBS for observation with vital signs to be taken every hour, and to send him to the ER if there were any changes. He also ordered routine blood counts.

This fact set defined a medical urgency (or, possibly, emergency). It required, among other things, direct examination by a physician, measurement of orthostatic vital signs (vital signs measured lying and standing to assess for blood loss), and stat blood tests for blood count and blood thinning. To have left the patient in a medical observation unit was dangerous.

A blood pressure measured 12 hours later, at 05:30 the following morning, was dangerously low (94/68).

According to the doctor's orders ("send the patient to the ER if there were any changes"), the patient should have been sent to the ER at that moment. He was not, and the doctor was not notified. Thus the plan of care was not followed and/or nurses failed to use sound clinical judgment, placing the patient in grave danger of death from internal blood loss.

An hour later, at 06:50, the patient's blood pressure dropped even more (81/50), and his heart began racing (104). He now reported spitting up blood. The nurse contacted the physician who ordered the patient sent to the ER by van.

At this point, a medical urgency had turned to a medical emergency. Sending this unstable patient with internal bleeding to the hospital by van was outrageously irresponsible.

In the hospital it was discovered that the patient's blood was now overly thinned in the dangerous level (INR=9.17). He had internal bleeding. The patient survived the event and was eventually discharged back to the prison.

Patient 23

50 year old black male

2/28/13 The patient had a blood test done on this day. His platelet count was 106 (normal 140-415).
As of the date of my visit, 4/25/14, the lab result was never reviewed by the physician and has not been repeated since.

On 4/25/14 I notified Mr. Little of the abnormal blood test result.

Conclusions

There are serious deficiencies in the health care system and resultant health care delivered at EMCF. Patients do not have adequate access to urgent and routine care. Even when they are able to access care, they are treated by professionals who practice outside the scopes of their licenses and practice without using minimally acceptable sound clinical judgment. When plans for monitoring or treatment are made, such as the plan to do an x-ray or administer a medication, the plans are not carried out. Key components that exist to support the health care operation are inadequate or do not function, such as the infirmary (OBS) for sicker patients, availability of equipment for diagnosis or emergency response, and the utterly dysfunctional electronic medical record system.

There was not a single medical chart I opened, regardless of the sampling source, that did not immediately reveal multiple serious examples of dangerous to life-threatening defects in health care. Every aspect and dimension of health care delivery at EMCF is dysfunctional. These deficiencies are systematic; they permeate the health care operation; and they subject all inmates at EMCF to a substantial risk of serious injury. These deficiencies create “equal opportunity dangers”: they can affect any inmate at any time without regard to age, race, crime, housing unit, or medical condition.

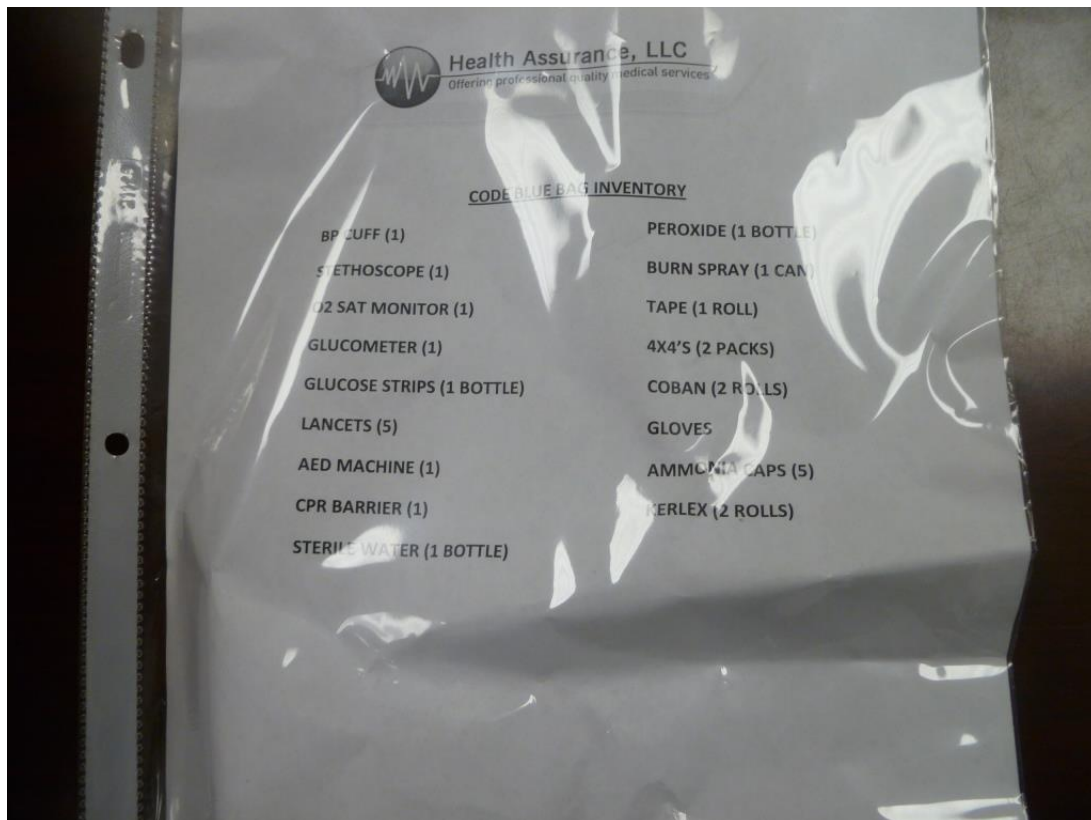
These opinions are offered with a reasonable degree of medical certainty. I reserve the right to modify or expand these opinions if additional information becomes available.



Marc F. Stern, MD, MPH

Attachment 1

Emergency Response Bag Inventory



Attachment 3

Documents reviewed

- Class Action Complaint filed 5/30/13
- Medical records (electronic) of Patients 2 through 23
- Medication Administration Records (MAR, paper) for Patients 3, 4, 5, and 8 for select months
- Medical record (PDF) of Patient 1 (four files, 2,484 pages)
- Mortality Review of Patient 1 (4 pages)
- Register of patients enrolled in the facility's Chronic Care Clinic (CCC) (63 pages)
- Logs of patients admitted to the community hospital (6 pages)
- Medical Audit/Comprehensive Quality Improvement Committee Meeting, 4th Quarter 2013 (16 pages)
- Logs of patients housed in the Medical Observation Unit (OBS) (31 pages)
- Logs of patients sent to the emergency room (16 pages)
- Logs of patients who have submitted Sick Call Requests (SCRs) (291 pages)
- Grievance logs (28 pages)
- Health Assurance Staffing List (2 pages)
- Contract for Medical Services, July 19, 2012 (15 pages)
- Quarterly Performance Review, April 1 through June 30, 2013 (11 pages)

Attachment 8

Curriculum Vitae, Dr. Stern

MARC F. STERN, M.D., M.P.H., F.A.C.P.

December, 2016

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SUMMARY OF EXPERIENCE

CORRECTIONAL HEALTH CARE CONSULTANT

2009 – PRESENT

Consultant in the design, management, and operation of health services in a correctional setting to assist in evaluating, monitoring, or providing evidence-based, cost-effective care consistent with constitutional mandates of quality.

Current activities include:

- Consultant on “Drug-related Death after Prison Release,” a research grant continuing work with Dr. Ingrid Binswanger, University of Colorado, Denver, examining the causes of, and methods of reducing deaths after release from prison to the community. National Institutes of Health Grant R21 DA031041-01. (2011 -)
- Patient safety/health systems advisor to various jails in Washington State and the Nassau County (New York) (2014 -)
- Consultant to Human Rights Watch to evaluate medical care of immigrants in Homeland Security detention (2016 -)
- Consultant to the US Department of Justice, Civil Rights Division, Special Litigation Section. Providing investigative support and expert medical services pursuant to complaints regarding care delivered in any US jail, prison, or detention facility. (2010 -) (no current open cases)

Previous activities include:

- Member of monitoring team (medical expert) pursuant to Consent Agreement between US Department of Justice and Miami-Dade County (Unites States of America v Miami-Dade County, *et al.*) regarding, *entre outre*, unconstitutional medical care. (2013 - 2016)
- Jointly appointed Consultant to the parties in Flynn v Walker (formerly Flynn v Doyle), a class action lawsuit before the US Federal District Court (Eastern District of Wisconsin) regarding Eighth Amendment violations of the health care provided to women at the Taycheedah Correctional Institute. Responsible for monitoring compliance with the medical component of the settlement. (2010 - 2015)
- Consultant to the US Department of Homeland Security, Office for Civil Rights and Civil Liberties. Providing investigative support and expert medical services pursuant to complaints regarding care received by immigration detainees in the custody of U.S. Immigration and Customs Enforcement. (2009 - 2014)
- Special Master for the US Federal District Court (District of Idaho) in Balla v Idaho State Board of Correction, *et al.*, a class action lawsuit alleging Eighth Amendment violations in provision of health care at the Idaho State Correctional Institution. (2011 - 2012)
- Facilitator/Consultant to the US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, providing assistance and input for the development of the first National Survey of Prisoner Health. (2010-2011)
- Project lead and primary author of National Institute of Corrections’ project entitled “Correctional Health Care Executive Curriculum Development,” in collaboration with National Commission on Correctional Health Care. NIC commissioned this curriculum for its use to train executive leaders from jails and prisons across the nation to better manage the health care missions of their facilities. Cooperative Agreement 11AD11GK18, US Department of Justice, National Institute of Corrections. (2011 - 2015)
- Co-teacher, with Jaye Anno, Ph.D., for the National Commission on Correctional Health Care, of the Commission’s standing course, *An In-Depth Look at NCHC’s 2008 Standards for Health Services in Prisons and Jails* taught at its national meetings. (2010 - 2013)
- Contributor to 2014 Editions of Standards for Health Services in Jails and Standards for Health Services in Prisons, National Commission on Correctional Health Care. (2013)
- Consultant to the California Department of Corrections and Rehabilitation court-appointed Receiver for medical operations. Projects included:
 - Assessing the Receiver’s progress in completing its goal of bringing medical care delivered in the Department to a constitutionally mandated level. (2009)
 - Providing physician leadership to the Telemedicine Program Manager tasked with improving and expanding the statewide use of telemedicine. (2009)

- Conceived, co-designed, led, and instructed in American College of Correctional Physicians and National Commission on Correctional Health Care's Medical Directors Boot Camp (now called Leadership Institute), a national training program for new (Track "101") and more experienced (Track "201") prison and jail medical directors. (2009 - 2012)
- Participated as a member of a nine-person Delphi expert consensus panel convened by Rand Corporation to create a set of correctional health care quality standards. (2009)
- Convened a coalition of jails, Federally Qualified Health Centers, and community mental health centers in ten counties in Washington State to apply for a federal grant to create an electronic network among the participants that will share prescription information for the correctional population as they move among these three venues. (2009 - 2010)
- Participated as a clinical expert in comprehensive assessment of Michigan Department of Corrections as part of a team from the National Commission on Correctional Health Care. (2007)
- Provided consultation to Correctional Medical Services, Inc., St. Louis (now Corizon), on issues related to development of an electronic health record. (2001)
- Reviewed cases of possible professional misconduct for the Office of Professional Medical Conduct of the New York State Department of Health. (1999 – 2001)
- Advised Deputy Commissioner, Indiana State Board of Health, on developing plan to reduce morbidity from chronic diseases using available databases. (1992)
- Provided consultation to Division of General Medicine, University of Nevada at Reno, to help develop a new clinical practice site combining a faculty practice and a supervised resident clinic. (1991)

OLYMPIA UGM FREE CLINIC, OLYMPIA, WASHINGTON

2009 – 2014

Volunteer practitioner providing primary care at a neighborhood clinic which provides free care to individuals without health insurance until they can find a permanent medical home; my own patient panel within the practice focuses on individuals recently released jail and prison.

WASHINGTON STATE DEPARTMENT OF CORRECTIONS

2002 – 2008

Assistant Secretary for Health Services/Health Services Director, 2005 – 2008

Associate Deputy Secretary for Health Care, 2002 – 2005

Responsible for the medical, mental health, chemical dependency (transiently), and dental care of 15,000 offenders in total confinement. Oversaw an annual operating budget of \$110 million and 700 health care staff.

- As the first incumbent ever in this position, ushered the health services division from an operation of 12 staff in headquarters, providing only consultative services to the Department, to an operation with direct authority and responsibility for all departmental health care staff and budget. As part of new organizational structure, created and filled statewide positions of Directors of Nursing, Medicine, Dental, Behavioral Health, Mental Health, Psychiatry, Pharmacy, Operations, and Utilization Management.
- Significantly changed the culture of the practice of correctional health care and the morale of staff by a variety of structural and functional changes, including: ensuring that high ethical standards and excellence in clinical practice were of primordial importance during hiring of professional and supervisory staff; supporting disciplining or career counseling of existing staff where appropriate; implementing an organizational structure such that patient care decisions were under the final direct authority of a clinician and were designed to ensure that patient needs were met, while respecting and operating within the confines of a custodial system.
- Improved quality of care by centralizing and standardizing health care operations, including: authoring a new Offender Health Plan defining patient benefits based on the Eighth Amendment, case law, and evidence-based medicine; implementing a novel system of utilization management in medical, dental, and mental health, using the medical staffs as real-time peer reviewers; developing a pharmacy procedures manual and creating a Pharmacy and Therapeutics Committee; achieving initial American Correctional Association accreditation for 13 facilities (all with almost perfect scores on first audit); migrating the eight individual pharmacy databases to a single central database.
- Blunted the growth in health care spending without compromising quality of care by a number of interventions, including: better coordination and centralization of contracting with external vendors, including new statewide contracts for hospitalization, laboratory, drug purchasing, radiology, physician recruitment, and agency nursing; implementing a statewide formulary; issuing quarterly operational reports at the state and facility levels.

- Piloted the following projects: direct issuance of over-the-counter medications on demand through inmates stores (commissary), obviating the need for a practitioner visit and prescription; computerized practitioner order entry (CPOE); pill splitting; ER telemedicine.
- Oversaw the health services team that participated variously in pre-design, design, or build phases of five capital projects to build complete new health units.

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES

2001 – 2002

Regional Medical Director, Northeast Region, 2001 – 2002

Responsible for clinical oversight of medical services for 14,000 offenders in 14 prisons, including one (already) under court monitoring.

- Oversaw contract with vendor to manage 60-bed regional infirmary and hospice.
- Coordinated activities among the Regional Medical Unit outpatient clinic, the Albany Medical College, and the 13 feeder prisons to provide most of the specialty care for the region.
- Worked with contracting specialists and Emergency Departments to improve access and decrease medical out-trips by increasing the proportion of scheduled and emergency services provided by telemedicine.
- Provided training, advice, and counseling to practitioners and facility health administrators in the region to improve the quality of care delivered.

CORRECTIONAL MEDICAL SERVICES, INC. (now CORIZON)

2000 – 2001

Regional Medical Director, New York Region, 2000 – 2001

Responsible for clinical management of managed care contract with New York State Department of Correctional Services to provide utilization management services for the northeast and northern regions of New York State and supervision of the 60-bed regional infirmary and hospice.

- Migrated the utilization approval function from one of an anonymous rule-based “black box” to a collaborative evidence-based decision making process between the vendor and front-line clinicians.

MERCY INTERNAL MEDICINE, ALBANY, NEW YORK

1999 – 2000

Neighborhood three-physician internal medicine group practice.

Primary Care Physician, 1999 – 2000 (6 months)

Provided direct primary care to a panel of community patients during a period of staff shortage.

ALBANY COUNTY CORRECTIONAL FACILITY, ALBANY, NEW YORK

1998 – 1999

Acting Facility Medical Director, 1998 – 1999

Directed the medical staff of an 800 bed jail and provided direct patient care following the sudden loss of the Medical Director, pending hiring of a permanent replacement. Coordinated care of jail patients in local hospitals. Provided consultation to the Superintendent on improvements to operation and staffing of medical unit and need for privatization.

VETERANS ADMINISTRATION MEDICAL CENTER, ALBANY, NY

1992 – 1998

Assistant Chief, Medical Service, 1995 – 1998

Chief, Section of General Internal Medicine and Emergency Services, 1992 – 1998

Responsible for operation of the general internal medicine clinics and the Emergency Department.

- Designed and implemented an organizational and physical plant makeover of the general medicine ambulatory care clinic from an episodic-care driven model with practitioners functioning independently supported by minimal nursing involvement, to a continuity-of-care model with integrated physician/mid-level practitioner/registered nurse/licensed practice nurse/practice manager teams.
- Led the design and opening of a new Emergency Department.
- As the VA Section Chief of Albany Medical College’s Division of General Internal Medicine, coordinated academic activities of the Division at the VA, including oversight of, and direct teaching in, ambulatory care and inpatient internal medicine rotations for medical students, residents, and fellows. Incorporated medical residents as part of the general internal medicine clinics. Awarded \$786,000 Veterans Administration grant (“PRIME I”) over four years for

development and operation of educational programs for medicine residents and students in allied health professions (management, pharmacy, social work, physician extenders) wishing to study primary care delivery.

ERIE COUNTY HEALTH DEPARTMENT, BUFFALO, NY

1988 – 1990

Director of Sexually Transmitted Diseases (STD) Services, 1989 – 1990

Staff Physician, STD Clinic, 1988 – 1989

Staff Physician, Lackawanna Community Health Center, 1988 – 1990

Provided leadership and patient care services in the evaluation and treatment of STDs. Successfully reorganized the county's STD services which were suffering from mismanagement and were under public scrutiny. Provided direct patient care services in primary care clinic for underserved neighborhood.

UNION OCCUPATIONAL HEALTH CENTER, BUFFALO, NY

1988 – 1990

Staff Physician, 1988 – 1990

Provided direct patient care for the evaluation of occupationally-related health disorders.

VETERANS ADMINISTRATION MEDICAL CENTER, BUFFALO, NY

1985 – 1990

Chief Outpatient Medical Section and Primary Care Clinic, 1986 – 1988

VA Section Head, Division of General Internal Medicine, University of Buffalo, 1986 – 1988

- Developed and implemented a major restructuring of the general medicine ambulatory care clinic to reduce fragmentation of care by introduction of a continuity-of-care model with a physician/nurse team approach.

Medical Director, Anticoagulation Clinic 1986 – 1990

Staff Physician, Emergency Department, 1985 – 1986

FACULTY APPOINTMENTS

2007 – present	Affiliate Assistant Professor, Department of Health Services, School of Public Health, University of Washington
1999 – present	Clinical Professor, Fellowship in Applied Public Health (previously Volunteer Faculty, Preventive Medicine Residency), University at Albany School of Public Health
1996 – 2002	Volunteer Faculty, Office of the Dean of Students, University at Albany
1992 – 2002	Associate Clinical/Associate/Assistant Professor of Medicine, Albany Medical College
1993 – 1997	Clinical Associate Faculty, Graduate Program in Nursing, Sage Graduate School
1990 – 1992	Instructor of Medicine, Indiana University
1985 – 1990	Clinical Assistant Professor of Medicine, University of Buffalo
1982 – 1985	Clinical Assistant Instructor of Medicine, University of Buffalo

OTHER PROFESSIONAL ACTIVITIES

2016 – present	Chair, Education Committee, Academic Consortium on Criminal Justice Health
2016 – present	Member (Prisoner Advocate), Washington State Institutional Review Board
2015 – present	Founding Editorial Board Member, Journal for Evidence-based Practice in Correctional Health, Center for Correctional Health Networks, University of Connecticut
2013 – present	Course Faculty, “Health in Prisons” course, Bloomberg School of Public Health, Johns Hopkins University/International Committee of the Red Cross
2013 – present	Member (Prisoner Advocate), Institutional Review Board, University of Washington
2011 – 2012	Member, Education Committee, National Commission on Correctional Health Care
2010	Recipient, Armond Start Award of Excellence, American College of Correctional Physicians
2010	Recipient, (First) Annual Preventive Medicine Faculty Excellence Award, New York State Preventive Medicine Residency Program, University at Albany School of Public Health/New York State Department of Health

2010 – present Member, International Advisory Board, International Journal of Prison Health

2009 – present Member, Editorial Board, Journal of Correctional Health Care

2007 – present Member, National Advisory Committee, COCHS (Community–Oriented Correctional Health Services)

2007 – present Member, Planning Committee, Annual Academic and Health Policy Conference on Correctional Health, University of Massachusetts Medical School and Commonwealth Medicine Correctional Health Program

2005 – present Member, American Correctional Association/Washington Correctional Association

2004 – 2006 Member, Board of Directors, American College of Correctional Physicians

2004 – 2006 Member, Fellow’s Advisory Committee, University of Washington Robert Wood Johnson Clinical Scholar Program

2004 Member, External Expert Panel to the Surgeon General on the “Call to Action on Correctional Health Care”

2004 Recipient, Excellence in Education Award for excellence in clinical teaching, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington

2003 – present Faculty Instructor, Critical Appraisal of the Literature Course, Family Practice Residency Program, Providence St. Peter Hospital, Olympia, Washington

2001 – present Chair/Co-Chair/Member, Education Committee, American College of Correctional Physicians

2000 – present Member, American College of Correctional Physicians

1999 – present Faculty Instructor, Critical Appraisal of the Literature Course, Preventive Medicine Residency Program, New York State Department of Health/University at Albany School of Public Health

1999 Co–Chairperson, Education Subcommittee, Workshop Submission Review Committee, Annual Meeting, Society of General Internal Medicine

1997 – 1998 Northeast US Representative, National Association of VA Ambulatory Managers

1996 – 2002 Faculty Mentor, Journal Club, Internal Medicine Residency Program, Albany Medical College

1996 – 2002 Faculty Advisor and Medical Control, 5 Quad Volunteer Ambulance Service, University at Albany

1996 Recipient, Special Recognition for High Quality Workshop Presentation at Annual Meeting, Society of General Internal Medicine

1995 – 1998 Preceptor, MBA Internship, Union College

1995 Member, Quality Assurance/Patient Satisfaction Subcommittee, VA National Curriculum Development Committee for Implementation of Primary Care Practices, Veterans Administration

1994 – 1998 Member, Residency Advisory Committee, Preventive Medicine Residency, New York State Department of Health/School of Public Health, University at Albany

1993 Chairperson, Dean’s Task Force on Primary Care, Albany Medical College

1993 Member, Task Group to develop curriculum for Comprehensive Care Case Study Course for Years 1 through 4, Albany Medical College

1988 – 1989 Instructor, Teaching Effectiveness Program for New Housestaff, Graduate Medical Dental Education Consortium of Buffalo

1987 – 1990 Member, Human Studies Review Committee, School of Allied Health Professions, University of Buffalo

1987 – 1989 Chairman, Subcommittee on Hospital Management Issues and Member, Subcommittee on Teaching of Ad Hoc Committee to Plan Incoming Residents Training Week, Graduate Medical Dental Education Consortium of Buffalo

1987 – 1988 Member, Dean’s Ad Hoc Committee to Reorganize “Introduction to Clinical Medicine” Course

1987 Preceptor, Nurse Practitioner Training Program, School of Nursing, University of Buffalo

1986 – 1988 Course Coordinator, Simulation Models Section of Physical Diagnosis Course, University of Buffalo

1986 – 1988 Chairman, Service Chiefs’ Continuity of Care Task Force, Veterans Administration Medical Center, Buffalo, New York

1986 Recipient, Letter of Commendation, House Staff Teaching, University of Buffalo

1979 – 1980 Laboratory Teaching Assistant in Gross Anatomy, Université Libre de Bruxelles, Brussels, Belgium

1973 – 1975 Instructor and Instructor Trainer of First Aid, American National Red Cross

- 1972 – 1975 Chief of Service or Assistant Chief of Operations, 5 Quad Volunteer Ambulance Service, University at Albany.
- 1972 – 1975 Emergency Medical Technician Instructor and Course Coordinator, New York State Department of Health, Bureau of Emergency Medical Services

EDUCATION

- University at Albany, College of Arts and Sciences, Albany; B.S., 1975 (Biology)
- University at Albany, School of Education, Albany; AMST (Albany Math and Science Teachers) Teacher Education Program, 1975
- Université Libre de Bruxelles, Faculté de Medecine, Brussels, Belgium; Candidature en Sciences Medicales, 1980
- University at Buffalo, School of Medicine, Buffalo; M.D., 1982
- University at Buffalo Affiliated Hospitals, Buffalo; Residency in Internal Medicine, 1985
- Regenstrief Institute of Indiana University, and Richard L. Roudebush Veterans Administration Medical Center; VA/NIH Fellowship in Primary Care Medicine and Health Services Research, 1992
- Indiana University, School of Health, Physical Education, and Recreation, Bloomington; M.P.H., 1992
- New York Academy of Medicine, New York; Mini-fellowship Teaching Evidence-Based Medicine, 1999

CERTIFICATION

- Provisional Teaching Certification for Biology, Chemistry, Physics, Grades 7–12, New York State Department of Education (expired), 1975
- Diplomate, National Board of Medical Examiners, 1983
- Diplomate, American Board of Internal Medicine, 1985
- Fellow, American College of Physicians, 1991
- License: Washington (#MD00041843, active); New York (#158327, inactive); Indiana (#01038490, inactive)
- Certified Correctional Health Professional, 2010

REVIEWER

- 2015 – present Journal for Evidence-based Practice in Correctional Health
- 2015 – present PLOS ONE
- 2001 – present Journal of Correctional Health Care
- 2011 – present American Journal of Public Health
- 2010 – present Langeloth Foundation (grants)
- 2001 – 2004 Journal of General Internal Medicine
- 1996 Abstract Committee, Health Services Research Subcommittee, Annual Meeting, Society of General Internal Medicine
- 1990 – 1992 Medical Care

WORKSHOPS and PRESENTATIONS

- Stern, MF.** *Why it Matters: Advocacy and Policies to Support Health Communities after Incarceration.* At the Nexus of Correctional Health and Public Health: Policies and Practice session. American Public Health Association Annual Meeting. Chicago, Illinois. 2015
- Stern MF.,** Kern D. *Hot Topics in Correctional Health Care.* American Jail Association Annual Meeting. Charlotte, North Carolina. 2015.
- Stern MF.** *Contracting for Health Services: Should I, and if so, how?* American Jail Association Annual Meeting. Dallas, Texas. 2014
- Stern MF, Allen S, May J, Ritter S.** *Hunger Strikes: What should the Society of Correctional Physician's position be?* American College of Correctional Physicians (Formerly Society of Correctional Physicians) Annual Meeting. Nashville, Tennessee. 2013

Stern MF. *Addressing Conflict between Medical and Security: an Ethics Perspective.* International Corrections and Prison Association Annual Meeting. Colorado Springs, Colorado. 2013

Stern MF, Barboza S. *Patient Safety: Raising the Bar in Correctional Health Care.* National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee, 2010

Stern MF. *Patient Safety: Raising the Bar in Correctional Health Care.* American Correctional Health Services Association, Annual Meeting, Portland, Oregon, March, 2010

Stern MF. *Evidence Based Decision Making for Non-Clinical Correctional Administrators.* American Correctional Association 139th Congress, Nashville, Tennessee, August 2009

Wright L, Kendig N, Hearn P, **Stern M.** *Managing the Geriatric Population.* Panel Discussion, State Medical Directors' Meeting, American Corrections Association, Alexandria, Virginia, November 2007

Stern MF, Hohmann LK. *Evidence Based Medicine.* The Empire State Advantage, Annual Excellence at Work Conference: Leading and Managing for Organizational Excellence, Albany, New York, May 2002

Stern MF. *Diagnosis and Management of Male Erectile Dysfunction – A Goal-Oriented Approach.* Society of General Internal Medicine National Meeting, San Francisco, California, May 1999

Turner C, Charleston VA Staff, **Stern MF.** *Models For Measuring Physician Productivity.* National Association of VA Ambulatory Managers National Meeting, Memphis, Tennessee, August, 1997

Stern MF. *Evaluation and Treatment of the Patient with Impotence: A Practical Primer for General Internists.* Society of General Internal Medicine National Meeting, Washington D.C., May 1996

Stern MF. *Patient Motivation: A Key to Success.* Tuberculosis and HIV: A Time for Teamwork. AIDS Program, Bureau of Tuberculosis Control – New York State Department of Health and Albany Medical College. Albany, 1994

Stern MF. *Impotence: A Rational and Practical Approach to Diagnosis and Treatment for the General Internist.* Society of General Internal Medicine National Meeting, Washington D.C., May 1991

Stern MF, Lubitz RM. *Nirvana and Audio-Visual Aids.* Society of General Internal Medicine, Midwest Regional Meeting, Chicago, October 1991

INVITED LECTURES

Prison Health Leadership Conference. 2-Day workshop. International Corrections and Prisons Association/African Correctional Services Association/Namibian Corrections Service. Omaruru, Namibia, 2016.

What Would YOU Do? Navigating Medical Ethical Dilemmas. Spring Conference. National Commission on Correctional Health Care. Nashville, Tennessee, 2016.

Improving Patient Safety. Spring Provider Meeting. Oregon Department of Corrections. Salem, Oregon, 2016.

A View from the Inside: The Challenges and Opportunities Conducting Cardiovascular Research in Jails and Prisons. Workshop on Cardiovascular Diseases in the Inmate and Released Prison Population. The National Heart, Lung, and Blood Institute. Bethesda, Maryland, 2016.

January 5-6, 2016 *Medical Ethics in Corrections.* Recurring seminar. Criminal Justice 441 – Professionalism and Ethical Issues in Criminal Justice. University of Washington, Tacoma, 2012 – present.

Turning Sick Call Upside Down. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas, 2015.

Diagnostic Maneuvers You May Have Missed in Nursing School. Annual Conference. National Commission on Correctional Health Care. Dallas, Texas, 2015.

The Challenges of Hunger Strikes: What Should We Do? What Shouldn't We Do? Annual Conference. National Commission on Correctional Health Care. Dallas, Texas, 2015.

Practical and Ethical Approaches to Managing Hunger Strikes. Annual Practitioners' Conference. Washington Department of Corrections. Tacoma, Washington 2015.

Patient Safety and 'Right Using' Nurses. Keynote address. Annual Conference. American Correctional Health Services Association. Philadelphia, Pennsylvania, 2013.

Patient Safety: Overuse, underuse, and misuse...of nurses. Keynote address. Essentials of Correctional Health Care conference. Salt Lake City, Utah, 2012

The ethics of providing healthcare to prisoners-An International Perspective. Global Health Seminar Series. Department of Global Health, University of Washington, Seattle, Washington, 2012

Recovery, Not Recidivism: Strategies for Helping People Who are Incarcerated. NAMI Annual Meeting, Seattle, Washington, 2012 (Co-presented with Sue Rahr, Washington State Criminal Justice Training Commission and Ari Kohn, Post-Prison Education Program)

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center, Salem, Oregon, 2011

Ethics and HIV Workshop. HIV/AIDS Care in the Correctional Setting Conference, Northwest AIDS Education and Training Center, Spokane, Washington, 2011

Achieving Quality Care in a Tough Economy. National Commission on Correctional Health Care Mid-Year Meeting, Nashville, Tennessee, 2010 (Co-presented with Rick Morse and Helena Kim, PharmD.)

Involuntary Psychotropic Administration: The Harper Solution. American Correctional Health Services Association, Annual Meeting, Portland, Oregon, 2010 (Co-presented with Bruce Gage, MD, Director of Psychiatry, Washington State Department of Corrections)

Death Penalty Debate. Panelist. Seattle University School of Law, Seattle, Washington, 2009

The Patient Handoff – From Custody to the Community. Washington Free Clinic Association, Annual Meeting, Olympia, Washington. Lacey, Washington, 2009

Balancing Patient Advocacy with Fiscal Restraint and Patient Litigation. National Commission on Correctional Health Care and American College of Correctional Physicians “Medical Directors Boot Camp,” Seattle, Washington, 2009

Staff Management. National Commission on Correctional Health Care and American College of Correctional Physicians “Medical Directors Boot Camp,” Seattle, Washington, 2009

Management Dilemmas in Corrections: Boots and Bottom Bunks. 2008 Annual Meeting, American College of Correctional Physicians, Chicago, Illinois

Public Health and Correctional Health Care. Guest Lecturer: Masters Program in community-based population focused management – Populations at risk, Washington State University, Spokane, Washington, 2008

I Want to do my own Skin Biopsies. 2005 Annual Meeting, American College of Correctional Physicians, New Orleans, Louisiana

Corrections Quick Topics. 2003 Annual Meeting, American College of Correctional Physicians,

Evidence Based Medicine in Correctional Health Care. 2003 Annual Meeting, National Commission on Correctional Health Care, Austin, Texas

Evidence Based Medicine. 2002 Excellence at Work Conference, Empire State Advantage. Albany, New York

Evidence Based Medicine, Outcomes Research, and Health Care Organizations. National Clinical Advisory Group, Integrail, Inc., Albany, New York, 2002

Taking the Mystery out of Evidence Based Medicine: Providing Useful Answers for Clinicians and Patients. Breakfast Series, Institute for the Advancement of Health Care Management, School of Business, University at Albany, Albany, New York, 2001

Study Design and Critical Appraisal of the Literature. Graduate Medical Education Lecture Series for all housestaff, Albany Medical College, Albany, New York, 1999

Male Impotence: Its Diagnosis and Treatment in the Era of Sildenafil. 4th Annual CME Day, Alumni Association of the Albany-Hudson Valley Physician Assistant Program, Albany, New York, 1998

Introduction to Male Erectile Dysfunction and the Role of Sildenafil in Treatment. Northeast Regional Meeting Pfizer Sales Representatives, Equinox Hotel, Vermont, 1997

Male Erectile Dysfunction. Topics in Urology, A Seminar for Primary Healthcare Providers, Bassett Healthcare, Cooperstown, New York, 1997

Impotence: An Update. Department of Medicine Grand Rounds, Albany Medical College, 1996

Diabetes for the EMT First-Responder. Five Quad Volunteer Ambulance, University at Albany, 1996

Impotence: An Approach for Internists. Medicine Grand Rounds, St. Mary's Hospital, Rochester, New York, 1994

Male Impotence. Common Problems in Primary Care Precourse. American College of Physicians National Meeting, Miami, Florida, 1994

Recognizing and Treating Impotence. Department of Medicine Grand Rounds, Albany Medical College, 1992

Medical Decision Making: A Primer on Decision Analysis. Faculty Research Seminar, Department of Family Practice, Indiana University, 1992

Effective Presentation of Public Health Data. Bureau of Communicable Diseases, Indiana State Board of Health, 1991

Impotence: An Approach for Internists. Housestaff Conference, Department of Medicine, Indiana University, 1991

Using Electronic Databases to Search the Medical Literature. NIH/VA Fellows Program, Indiana University, 1991

Study Designs Used in Epidemiology. Ambulatory Care Block Rotation. Department of Medicine, Indiana University, 1991

Effective Use of Slides in a Short Scientific Presentation. Housestaff Conference, Department of Medicine, Indiana University, 1991

New Perspectives in the Management of Hypercholesterolemia. Medical Staff, West Seneca Developmental Center, West Seneca, New York, 1989

Effective Use of Audio-Visual Aids. Nurse Educators, American Diabetes Association, Western New York Chapter, 1989

Management of Diabetics in the Custodial Care Setting. Medical Staff, West Seneca Developmental Center, West Seneca, New York, 1989

Effective Use of Audio-Visuals in Diabetes Peer and Patient Education. American Association of Diabetic Educators, Western New York Chapter, 1989

Pathophysiology, Diagnosis and Care of Diabetes. Nurse Practitioner Training Program, School of Nursing, University of Buffalo, 1989

Techniques of Large Group Presentations to Medical Audiences – Use of Audio-Visuals. New Housestaff Training Program, Graduate Medical Dental Education Consortium of Buffalo, 1988

PUBLICATIONS/ABSTRACTS

Stern MF. *Patient Safety (White Paper).* Guidelines, Management Tools, White Papers, National Commission on Correctional Health Care. <http://www.ncchc.org/filebin/Resources/Patient-Safety-2016.pdf>. June, 2016

Binswanger IA, **Stern MF**, Yamashita TE, Mueller SR, Baggett TP, Blatchford PJ. *Clinical risk factors for death after release from prison in Washington State: a nested case control study.* *Addiction* 2015 Oct 17

Stern MF. Op-Ed on Lethal Injections. *The Guardian* 2014 Aug 6

Stern MF. *American College of Correctional Physicians Calls for Caution Placing Mentally Ill in Segregation: An Important Band-Aid.* Guest Editorial. *Journal of Correctional Health Care* 2014 Apr; 20(2):92-94

Binswanger I, Blatchford PJ, Mueller SR, **Stern MF.** *Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009.* *Annals of Internal Medicine* 2013 Nov; 159(9):592-600

Williams B, **Stern MF**, Mellow J, Safer M, Greifinger RB. *Aging in Correctional Custody: Setting a policy agenda for older prisoner health care.* *American Journal of Public Health* 2012 Aug; 102(8):1475-1481

Binswanger I, Blatchford PJ, Yamashita TE, **Stern MF.** *Drug-Related Risk Factors for Death after Release from Prison: A Nested Case Control Study.* Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Blatchford PJ, Forsyth S, **Stern MF**, Kinner SA. *Death Related to Infectious Disease in Ex-Prisoners: An International Comparative Study.* Oral Presentation, University of Massachusetts 4th Annual Academic and Health Policy Conference on Correctional Healthcare, Boston, Massachusetts, March, 2011

Binswanger I, Lindsay R, **Stern MF**, Blatchford P. *Risk Factors for All-Cause, Overdose and Early Deaths after Release from Prison in Washington State Drug and Alcohol Dependence.* *Drug and Alcohol Dependence* Aug 1 2011;117(1):1-6

Stern MF, Greifinger RB, Mellow J. *Patient Safety: Moving the Bar in Prison Health Care Standards.* *American Journal of Public Health* November 2010;100(11):2103-2110

Strick LB, Saucerman G, Schlatter C, Newsom L, **Stern MF**. *Implementation of Opt-Out HIV testing in the Washington State Department of Corrections*. Poster Presentation, National Commission on Correctional Health Care Annual Meeting, Orlando, Florida, October, 2009

Binswanger IA, Blatchford P, **Stern MF**. *Risk Factors for Death After Release from Prison*. Society for General Internal Medicine 32nd Annual Meeting; Miami: Journal of General Internal Medicine; April 2009. p. S164-S95

Stern MF. Force Feeding for Hunger Strikes – One More Step. *CorrDocs* Winter 2009;12(1):2

Binswanger I, **Stern MF**, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. *Release from Prison – A High Risk of Death for Former Inmates*. *New England Journal of Medicine* 2007 Jan 11;356(2):157–165

Stern MF, Hilliard T, Kelm C, Anderson E. *Epidemiology of Hepatitis C Infection in the Washington State Department of Corrections*. Poster Presentation, CDC/NIH *ad hoc* Conference on Management of Hepatitis C in Prisons, San Antonio, Texas, January, 2003

Phelps KR, **Stern M**, Slingerland A, Heravi M, Strogatz DS, Haqqie SS. *Metabolic and skeletal effects of low and high doses of calcium acetate in patients with preterminal chronic renal failure*. *Am J Nephrol* 2002 Sep–Dec;22(5–6):445–54

Goldberg L, **Stern MF**, Posner DS. *Comparative Epidemiology of Erectile Dysfunction in Gay Men*. Oral Presentation, International Society for Impotence Research Meeting, Amsterdam, The Netherlands, August 1998. *Int J Impot Res*. 1998;10(S3):S41 [also presented as oral abstract Annual Meeting, Society for the Study of Impotence, Boston, Massachusetts, October, 1999. *Int J Impot Res*. 1999;10(S1):S65]

Stern MF. *Erectile Dysfunction in Older Men*. *Topics in Geriatric Rehab* 12(4):40–52, 1997. [republished in *Geriatric Patient Education Resource Manual, Supplement*. Aspen Reference Group, Eds. Aspen Publishers, Inc., 1998]

Stern MF, Wulfert E, Barada J, Mulchahy JJ, Korenman SG. *An Outcomes–Oriented Approach to the Primary Care Evaluation and Management of Erectile Dysfunction*. *J Clin Outcomes Management* 5(2):36–56, 1998

Fihn SD, Callahan CM, Martin D, et al.; for the **National Consortium of Anticoagulation Clinics**.* *The Risk for and Severity of Bleeding Complications in Elderly Patients Treated with Warfarin*. *Ann Int Med*. 1996;124:970–979

Fihn SD, McDonnell M, Martin D, et al.; for the **Warfarin Optimized Outpatient Follow–up Study Group**.* *Risk Factors for Complications of Chronic Anticoagulation*. *Ann Int Med*. 1993;118:511–520. (*While involved in the original proposal development and project execution, I was no longer part of the group at the time of this publication)

Stern MF, Dittus RS, Birkhead G, Huber R, Schwartz J, Morse D. *Cost–Effectiveness of Hepatitis B Immunization Strategies for High Risk People*. Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. *Clin Res* 1992

Fihn SD, McDonnell MB, Vermes D, Martin D, Kent DL, Henikoff JG, and the **Warfarin Outpatient Follow–up Study Group**. *Optimal Scheduling of Patients Taking Warfarin. A Multicenter Randomized Trial*. Oral Presentation, Society of General Internal Medicine National Meeting, Washington, D.C., May 1992. *Clin Res* 1992

Fihn SD, McDonnell MB, Vermes D, Kent DL, Henikoff JG, and the **Warfarin Anticoagulation Study Group**. *Risk Factors for Complications During Chronic Anticoagulation*. Poster Presentation, Society of General Internal Medicine National Meeting, Seattle, May 1991

Pristach CA, Donoghue GD, Sarkin R, Wargula C, Doerr R, Opila D, **Stern M**, Single G. *A Multidisciplinary Program to Improve the Teaching Skills of Incoming Housestaff*. *Acad Med*. 1991;66(3):172–174

Stern MF. *Diagnosing Chlamydia trachomatis and Neisseria gonorrhoea Infections*. (letter) *J Gen Intern Med*. 1991;6:183

Stern MF, Fitzgerald JF, Dittus RS, Tierney WM, Overhage JM. *Office Visits and Outcomes of Care: Does Frequency Matter?* Poster Presentation, Society of General Internal Medicine Annual Meeting, Seattle, May 1991. *Clin Res* 1991;39:610A

Stern MF. *Cobalamin Deficiency and Red Blood Cell Volume Distribution Width*. (letter) *Arch Intern Med*. 1990;150:910

Stern M, Steinbach B. *Hypodermic Needle Embolization to the Heart*. *NY State J Med*. 1990;90(7):368–371

Stern MF, Birkhead G, Huber R, Schwartz J, Morse D. *Feasibility of Hepatitis B Immunization in an STD Clinic*. Oral Presentation, American Public Health Association Annual Meeting, Atlanta, November 1990

EXPERT TESTIMONY

Winkler v. Madison County, Kentucky, et al. US District Court, Eastern District of Kentucky, Central Division at Lexington, 2016 (deposition)

US v. Miami-Dade County *et al.* US District Court, Southern District of Florida, periodically 2014 - 2016

Rosemary Saffioti v. Snohomish County *et al.* US District Court Western District of Washington at Seattle, 2015 (deposition)

Christopher Alsobrook v. Sergeant Alvarado, *et al.*, US District Court, Southern District of Florida, Miami Division, 2014 (deposition)

Stefan Woodson v. City of Richmond, Virginia, *et al.*, US District Court, Eastern District of Virginia, Richmond Division, 2013 and 2014 (deposition)

Robert Mitchell, *et al.* v. Matthew Cate *et al.*, US District Court, Eastern District of California, 2013 (deposition)