REDACTED

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

JEROME DUVALL, *et al.*,	*	
Plaintiffs,	*	
v.	*	Civil Action No. ELH-94-2541
LAWRENCE HOGAN, *et al.*,	*	
Defendants.	*	

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DECLARATION OF TODD R. WILCOX, M.D.

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I, Todd R. Wilcox, M.D., declare:

I have examined materials provided by Plaintiffs' counsel related to the conditions of health care in the Baltimore City Detention Center (BCDC). This declaration is a summary of my opinions to date in the above referenced matters.

Qualifications

My opinions are based on my 24 years of experience in the design, administration, and delivery of correctional healthcare in various environments as well as the national standards that govern the field. I actively practice in correctional healthcare as the Medical Director of the Salt Lake County Jail System, and I am frequently called upon around the country as a consultant to assist jail and prison facilities in improving their delivery of care, including Maricopa County (Phoenix, AZ); Pima County (Tucson, AZ); Riverside County, CA; Seattle-King County Jail System (Seattle, WA); Arizona Department of Corrections; California Department of Corrections; Mississippi Department of Corrections; the National Commission on Correctional Health Care (Chicago, IL); and the American Jail Association. I have achieved both of the advanced levels of certification in correctional healthcare (CCHP-A and CCHP-P) from the National Commission on Correctional Health Care. Additionally, I have served as the President of the American College of Correctional Physicians and I am a Fellow of that organization. I am board certified by exam in Urgent Care Medicine and HIV medicine. I am licensed to practice medicine in Utah and Arizona. A copy of my curriculum vitae is attached hereto as Exhibit A.

Materials Reviewed

The opinions set forth in this declaration are based on my extensive experience studying and researching correctional systems, my service in the field, and my experience as an expert and monitor in prison and jail conditions cases. In providing this declaration, I have reviewed the medical records and mortality reviews of the following 12 persons who died from March 23, 2018 to September 11, 2020, while detained at BCDC:

- [redacted], died 12/6/18
- [redacted], died 6/27/20
- [redacted], died 11/7/18

- [redacted] died 6/6/18
- [redacted], died 7/6/18
- [redacted] died 1/4/20
- [redacted], died 3/2/20
- [redacted], died 9/11/20
- [redacted], died 9/3/18
- [redacted], died 3/23/18
- [redacted], died 4/11/19
- [redacted], died 7/6/20

The fact that a jail with an average daily population of about 700 detainees experienced 12 deaths in custody in a two-and-a-half-year basis is extremely concerning, and disproportionately high. Many of these deaths were preventable, had there been appropriate systems in place to identify individuals' medical and mental health needs and provide timely care.

Summary of Opinions

In reviewing the records of people who died in BCDC custody, there are a number of systemic problems and common themes that stand out that put BCDC detainees at serious risk of harm and possible death. Defendants have neglected the serious medical and mental health needs of the people in its jail custody by failing to properly manage and administer health care.

A sound health care delivery system for a jail system such as Baltimore's must include, at a minimum, (1) written policies, procedures, and assessment tools that are implemented and followed consistently; (2) qualified and adequate numbers of health care staff; (3) effective intake screening for medical and mental health needs, including identification of people who are intoxicated or withdrawing from drugs; (4) timely access to medical and mental health care; (5) adequate clinical facilities and functional equipment; (6) an effective medication distribution and administration system; (7) a functioning medical records system; (8) a robust emergency response system; and (9) a system for assessing quality and identifying areas for self-improvement, including review of sentinel events such as mortalities, emergencies, and/or acts of self-harm.

In reviewing these cases it appears that there are multiple major systems problems that are evident in health care for detainees in the BCDC. There are clear examples where ordered care is not carried out; there are examples where patients who obviously need physician-level care are not scheduled in a timely manner; there are major clinical processes like intoxication/withdrawal and suicide prevention that are not being handled in accordance with the standard of care; and there are systemic problems with medication administration and continuity of care that are medically significant. Additionally, the mental health screening process to identify people at risk of self-harm or suicide appears to not be working. All of these problems, individually and in combination, put BCDC detainees at serious risk of injury and possible death.

It appears that the major systems of care in this particular jail need to be examined and redesigned to be more reliable, more timely, and to ensure that care is delivered by health care staff with the appropriate level of training and licensure.

Inadequate documentation

As a threshold matter, I observe that the medical records I reviewed were generally sparse and often lacked critical information. As noted below, many of the records I reviewed lacked a medication administration record – a serious deficiency that makes it extremely difficult for a clinician to follow the course of a patient's care. I found records to be incomplete, inconsistent, and so disorganized that it was difficult to trace the logic of care in the chart. This documentation is an impediment to the delivery of basic health care. Medical records present the most foundational building block for a health care system. If health care staff do not document what they have done in seeing a patient, then anybody seeing the patient in the future will not know what the problem was, what the prior treatment was, in order to evaluate whether the past treatment worked. As every pre-med student learns, health care must be appropriately documented. Multiple death reviews indicated that the recordkeeping in the deceased detainee's files were incomplete.

In addition, the death reviews I saw were generally inadequate. The purpose of a death review is to ascertain errors and omissions that may have contributed to the death, so that corrective action can be taken. However, the death reviews I saw were so vague and general that they were in most cases not useful in ascertaining what corrective action should be taken. For example, the mortality and morbidity review committee meeting minutes for the deaths of Mr. [redacted] and Mr. [redacted] are only a page long. In another case, Mr. [redacted]'s death review documented significant deficiencies in operations and in medical care. Despite those, the corrective action plans to address those are listed only as "potential policy changes." In my opinion, the operational deficiencies in this case were significant enough to warrant major operational changes that would then be studied by a quality assessment process to determine if the identified problems were actually fixed so that they would not happen again.

Intake Screening, Substance abuse/withdrawal/intoxication

Prompt intake screening is essential in a correctional setting to ensure, among other things, that patients receive timely medications for medical and mental health conditions, are screened for communicable and infectious diseases, are identified as having any serious medical or mental health needs or risks of self-harm, the need for specialty consultations, and especially in the context of jails, whether a person is intoxicated or in withdrawal. NCCHC standards indicate that upon admission to a jail, qualified medical staff must use a screening instrument to identify and record observable and non-observable medical and mental health needs, including but not limited to: mental status examination, cognitive assessment, history/charges of violence/sex offense or history of sexual victimization, history of homelessness, recent history of physical trauma, or history of mental illness that may be self-medicated via illicit drugs or alcohol. Critically, if a detainee's reported medication (including self-medication) is discontinued or changed, a qualified provider must ensure that there is continuity of medication within 24 hours of arrival to the jail or sooner as indicated for critical medications (insulin, anticoagulants, anticonvulsants, methadone).

Managing intoxication and withdrawal is a major challenge for all correctional facilities, especially jails. Nevertheless, it is highly unusual that at least three BCDC patients (Mr. [redacted], Mr. [redacted] and Mr. [redacted]) died of fentanyl overdoses. According to the autopsy report of a fourth patient, Mr. [redacted], he died due to a methadone overdose with a contributing factor of fentanyl ingestion. Fentanyl is a potent opiate that is typically used in hospital settings and is frequently found in illicit drugs on the street. It is not a medication that is used commonly in correctional facilities. Staff from BCDC indicated that the most potent opiate that they have in medical inventory is Tylenol #3 (active opiate Codeine) and that they do not have any fentanyl. As a result, the fact that individuals are overdosing on this medication inside of a correctional facility is indicative of security lapses and smuggling of illicit drugs into the jail.

Mr. [redacted] died of a possible drug overdose in June 2018. He died within the holding cell at the sallyport, within six hours of being booked and reporting to nursing staff that he had taken two Percocet (active opiate oxycodone) pills shortly before his booking. He was found unresponsive within six hours of his intake assessment.[1] His cause of death according to the medical examiner was morphine and fentanyl overdose.

As noted in the mortality review of Mr. [redacted], who died in December 2018 at the intake sallyport areas, "this was the third death [at] sallyport this year."

Unfortunately, any corrective action did not appear to happen, because Mr. [redacted] similarly died on June 27, 2020 due to an overdose of fentanyl. According to his mortality review, during an intake exam on June 22 described as a "sally port provider assessment," he "reported using 10 pills of heroin, 100 mg Methadone, oxycodone, taking 2 mg Xanax and drinking 10 cans of beer daily for 5 years on the streets. The last time he used drugs was "32 hr before he was arrested." His Clinical Opiate Withdrawal Scale (COWS) score was 7 and his Clinical Institute Withdrawal Assessment (CIWA) score was 6. These scores indicate that the patient was experiencing clinical signs and symptoms of withdrawal syndrome The provider correctly identified that the patient was in active drug withdrawal, and referred him to an addiction medication provider, who saw him more than 24 hours after his intake. The addiction medication provider therefore saw him at least 56 hours since his last reported ingestion of heroin and/or methadone. The addiction medication provider prescribed methadone treatment, on June 23, 2020, however it does not appear from his medical records that he received any methadone until June 26, 2020, the day before he was found unresponsive due to an overdose of illicit drugs.

Mr. [redacted] died in November 2018 due to a methadone overdose, and also had fentanyl in his system at the time of his death. He presented to the intake sallyport unit on November 13, 2018 in the early afternoon after an arrest for intoxication. According to his records, "he reported drinking 5 pints of liquor daily for the past 3 years and snorting 8 pills of heroin daily for 10 years." The intake exam at 1:23 pm by a registered nurse documented that he reported

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[1] The mortality review also notes that other people in the holding cell with Mr. [redacted] alerted custody staff that he was experiencing a medical emergency and not breathing, but that the cell door was stuck and it took multiple attempts after medical staff arrived before the cell door could be opened.

withdrawal symptoms of chills, yawning, nausea, vomiting, body pains, rhinorrhea, tremors, sneezing, abdominal pain, myalgias and drowsiness. Despite all of those complaints he was only assigned a Clinical Opiate Withdrawal Scale (COWS) score of 6 and a Clinical Institute Withdrawal Assessment (CIWA) score of 3. Just by the mere definitions of how COWS and CIWA are scored, the score should have been significantly higher, which would have elevated his care to a medical provider. His stated symptoms suggest that he was experiencing significant signs and symptoms of withdrawal syndrome and it is clear that the staff underscored his clinical presentation significantly. As a result, he was only medicated with Librium six hours after intake, and he was found unresponsive nine hours after the intake assessment. Mr. [redacted] was declared deceased 10 hours after his intake, and according to the autopsy report his cause of death was methadone overdose with contributing factor of fentanyl ingestion. It is likely that his withdrawal symptoms were so severe that he somehow managed to get access to methadone / fentanyl in the jail and ultimately died from an overdose of those medications.

If this is an ongoing issue, there should be improvements in the timeliness of intake screening and effective and humane management of patients reporting that they are detoxing from opioids should be available so that they do not turn to illicit drugs. The availability of fentanyl and methadone within the jail indicates that there is a need for enhancements in security and a wide deployment of naloxone available for emergency use in housing units and intake units. Many jail and prison systems in the country have trained security and health care staff on the use of naloxone, and all staff carry naloxone on their persons. Prompt administration of naloxone could have saved the lives of these patients.

Correlation between clinical documentation and patient medical condition

In some cases that I reviewed, there was a lack of correlation between the medical documentation and the condition of the patient that led to their death. In other words, there were statements in the medical record that were simply not consistent with the patient's clinical presentation. This is especially significant when screening intake reports or nurse's line entries state that a patient's condition is normal or unremarkable, when in reality the physical condition should have been elevated for immediate review by a physician.

As noted above, Mr. [redacted]s COWS and CIWA scores assigned by the nurse did not comport with his symptoms of withdrawal, and he died hours after these scores were assigned.

Mr. [redacted] is another example of this discrepancy. He is a 63-year-old man who died of acute pneumonia and a left lung abscess. He had a 49-year pack-a -day history of smoking and yet his vital signs indicate a pulse oximetry reading of 100% on room air. A person of his age with a significant smoking history and a pneumonia severe enough to cause death would almost certainly not have a reading of 100%. I am highly skeptical that his medical record is an accurate representation of his presenting condition. Had the clinical assessment been performed properly with accurate medical instrumentation, his pulse oximetry reading likely would have been abnormally low which would have prompted the staff that he was in distress and needed a higher level of care.

Mr. [redacted] is third example of this discrepancy. He was incarcerated on 7/2/18 and there are medical notes over the next couple of days, but they are benign, describe his condition as "stable," and do not paint an accurate picture of his condition. His mortality review notes that his medical record included "[c]onflicting documentation of inmate [having] been alert, awake, and lethargic," and that his documented weight fluctuated 60 pounds in three days. Apparently this was because he could not stand up from a wheelchair on the third day, and the weight scales were not calibrated regularly to take into account weighing someone while they were in a wheelchair. When he was sent to the hospital on 7/6/2018, he had New York Heart Association Stage IV decompensated congestive heart failure as well as cellulitis/necrotizing fasciitis, sepsis, acute kidney injury, and acidosis. His legs were completely septic, from his feet to his hips. His hospital admission lactate level was 13 mmol/L. Levels greater than 2.5 mmol/L are considered diagnostic of sepsis.

Mr. [redacted] was a profoundly sick man with conditions that worsened over four days in the jail. Based on his medical history and his presenting diagnostic test results and vital signs including alarmingly elevated blood pressure, he should have been seen immediately by a physician and likely would have sent him to the infirmary or hospital immediately. The postmortem death review admits that this should have happened. That did not happen, and he was not seen by a physician until three days after his admission date of July 2, 2018, on July 5, 2018.[2] The physician's note on 7/5/18 suggests that he saw the patient at 10:17 pm but the patient was not taken to the emergency room until 7/6/18 at 1:13 am. It is not clear why there was such a delay in getting a critically ill patient to the hospital, and that time delay for him was medically significant. He died on July 6, 2018, a few hours after arrival at the hospital due to cardiopulmonary arrest due to septic shock and acidosis. This was a preventable death.

The death review of Mr. [redacted] who died of acute chronic lung disease and pneumonia in September 2018, noted that "[t]here were many discrepancies with the documentation." The review found that his blood pressure readings were inaccurate, and that his reports of problems breathing in the weeks before his death were not addressed in a timely manner by the physician. The death review noted that he was seen on 8/22/18 by a provider in response to his reported symptoms of shortness of breath, and dry cough, and ordered for a follow up visit two days later, but that did not happen and he was not evaluated until September 3, 2018, the date of his death when he was found unresponsive and not breathing. This 14-day delay in seeing a provider again may have contributed to the death.[3]

Failure to address critical diagnostic test results

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[2] It is unclear if the delay was due to the July 4 holiday, and no physician being available sooner. However, if this were the case, the jail should have a plan to ensure that there are on-site, or at a minimum on-call providers, during holidays.

[3] The report also noted that the patient had repeatedly reported chronic lower back pain, was diagnosed with spinal stenosis and degenerative disc disease, and had problems ambulating that required the use of crutches or a walker, but that staff repeatedly wrote that he had not pain, swelling, or complaints of tenderness or deformity.

There was an unusual pattern of critically low blood glucose values in several of the patients whose records I reviewed. This is a highly unusual finding in patients who are not diabetic and on medication to lower their blood sugars. Levels below 70 mg/dL are considered low, and levels below 54 mg/dL are critical. Mr. [redacted] had a very low documented blood glucose of 34 mg/dL at the time of his man down (that is, when an emergency was called because he had collapsed). This was unexplained and highly unusual.

Similarly, Mr. [redacted] was a gentleman who had bipolar disorder but no history of diabetes mellitus. At his man down they were unable to get a reading of his finger stick blood glucose on two separate occasions because it was so low. These findings are possibly suggestive that the point of care testing equipment is either inaccurate, or patients somehow have access to medications that lower their blood glucose within the institution. The presence of multiple unexplained critically low blood glucose readings is so unusual medically that it indicates a deficiency that is putting patients at risk of harm and really needs to be investigated.

Continuity of medication administration

There are multiple problems with continuity of medication administration in this institution. Many of the records lack a medication administration record (MAR) – a foundational deficiency -- so it is difficult to determine precisely what the problem was as well as the magnitude of that problem. MARs are a critical component of patient care because that is how you determine what medications a patient received, what dose they received, and when it was administered. However, in several patients, medication inconsistencies and failure to administer medications were noted in the death reviews.

One significant case is that of Mr. [redacted] He was a complicated 28-year-old patient on dialysis due to renal disease who had a history of coagulation issues and he was discharged from the hospital on 6/27/20 on the medication Apixaban (blood thinner). In the institution Apixaban is non-formulary and so it had to be ordered through a nonformulary request process that delayed the medication by two days. It appears on his MAR that he first received his dose of Apixaban on 6/29/20. Unfortunately, if Apixaban is stopped suddenly it puts the patient at extreme risk for development of a clot, which unfortunately it appears may have contributed to his death. It also is unclear if he received dialysis between 6/28/20 and 7/6/20. Mr. [redacted] died on July 6, 2020, several hours after receiving dialysis. The cause of death was cardiopulmonary arrest secondary to possible pulmonary embolism or possible complication of delayed dialysis. The jail should have a system in place to immediately obtain critical nonformulary medications beyond the typical ordering process, this could include a policy as simple as going to a local Walgreen's or CVS to get the medication as a "bridge" during the time period of ordering through the regular process. This is a significant systems problem that needs to be addressed.

Another patient was Mr. [redacted] who prior to his death in 2018, experienced "multiple incidents of missed medication administration doses" according to the death review. The corrective action plan was to schedule a meeting with nursing staff to discuss the importance of medication administration.

Similarly, Mr. [redacted], who had a history of bipolar disorder and multiple hospitalizations who died in March 2020, had documented in his death review that he inexplicably had missed nine consecutive days of his mental health medications, and that the prescriptions changed multiple times within a month. He was reported as having an altered mental status, and exhibiting bizarre behavior in the jail. He died of apparently unrelated causes (hypertensive cardiovascular disease), but the failure to properly provide medication and to document refusals were identified as problems in the postmortem review.

Suicide prevention

There are two patients whose records I reviewed who died from suicide. It appears in this institution that the intake screening tool for suicidality and the subsequent management of patients who flag positive on that tool needs to be recalibrated.

Mr. [redacted] was a 49-year-old male who was in jail for the first time. He had been arrested on charges of sexual assault of a minor, who happened to be his daughter. During his intake mental health assessment on 3/20/18 he rated his depression as 8/10 and his anxiety as 8.5/10; he also had a history of post-traumatic stress disorder (PTSD). The mental health staff documented that he was talking strangely and reported a history of prior suicide attempts and substance abuse. The combination of depression and anxiety is known to be a very high risk for attempting suicide. Persons who have never been incarcerated before are at higher risk of self-harm when first jailed, and Mr. [redacted] also was facing very serious criminal charges. During his clinical encounter he cried multiple times. Despite all of these red flag findings indicating a very high risk of suicide, he was ultimately placed in a single cell and not placed on suicide watch. He died on 3/23/18 by hanging. It is difficult to understand how these clinical decisions were made, given that all of his red flags were known and on display. This was a preventable death.

Mr. [redacted] was a 35-year-old gentleman who also died from suicide. He was assaulted on his unit and accused of being a snitch, and had to go to the emergency department on 4/8/19 for repair of his wounds. When he came back to the jail he requested protective custody; the disposition of that was unclear in the medical records. He was seen by mental health staff in the infirmary on April 10, 2019, at the request of custody staff, but they concluded that he was not at risk of self-harm. Staff also documented that he had last taken his prescribed Percocet and Xanax on April 2, 2019, the day prior to his booking in the jail. He was placed in the medical unit but not on any sort of suicide watch and he ultimately hanged himself – while still housed in the medical unit -- on 4/11/19. Threats and intimidation from other prisoners and requests for protective custody are a significant predictor of suicide, and they must be investigated promptly and extensively as part of a successful suicide reduction program. It does not appear that occurred in this case. In addition, this patient was likely withdrawing from opiates and benzodiazepines which greatly elevated his risk of suicide. It appears that this was unaddressed. This was a preventable death.

Functional Clinical Space and Equipment

Several of the deaths reviewed call into question whether BCDC has the appropriate diagnostic equipment necessary to provide care and to monitor treatment. As noted above, several patients

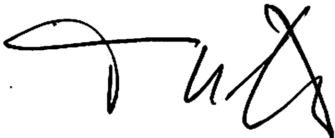
who were not diabetic had extremely low blood glucose levels prior to their deaths, which may be indicative of them being on inappropriate medications, or that the diagnostic equipment is not properly calibrated. If the later, this implicates the ability to monitor the blood glucose levels of people with diabetes. Also noted above, a long-term smoker who was describing breathing problems (and who ultimately died due to pneumonia) had a recorded blood oxygen level of 100%, which does not seem possible given his other conditions. The death review for another patient noted that the weight scales needed to be regularly calibrated. In the mortality review of Mr. [redacted] one of the detainees who died of a fentanyl overdose, there was concern regarding the AED machine, which did not indicate that the staff needed to use the "shock" function when it was applied.

Accurate medical equipment is a basic requirement for practicing healthcare. Medical staff make many critical decisions based on the diagnostic data is collected and if the instrumentation is not accurate then there is no way to apply the science of medicine to the patient's situation. Most institutions have rigorous and regular calibration programs for their equipment. It would be important to ascertain whether the medical equipment in this jail has ever been inspected and calibrated.

Conclusion

The opinions in this report, based upon the materials reviewed, and my education, experience, and knowledge, are presented with a reasonable degree of scientific and medical certainty. These opinions are based on the assessment of work accomplished to date, and I reserve the right to change any opinions expressed upon production of additional materials.

I declare under penalty of perjury that the foregoing is true and correct. Signed the 20th day of November, 2020, in Salt Lake City, Utah.



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