Marc F. Stern, MD, MPH
Consultant in Correctional Health Care
Tumwater, Washington 98501
(360) 701-6520
marcstern@live.com

June 16, 2014

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 1[2]) 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 tired 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 practitioners[4] 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 a pose 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 infection[7]. 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 Infirmary

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 infirmary within the prison. In the infirmary, 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 infirmary (Medical Observation or OBS) that can house 10 patients. Nurses are available around the clock. Unfortunately, as with other clinical operations at EMCF, the infirmary 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 later[12].

[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 ot [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 interested; 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 tired 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.
A*t 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 - Dec 2013 MARs for this period time are missing from the patient's medical record. *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):

Date	*AM dose*	*PM dose*
11/19	*x*	*x*
11/20	*x*	*x*
11/21		*x*
11/22	*x*	*x*
11/23		*x*
11/24	*x*	*x*
11/25		*x*
11/26	*x*	*x*

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] *The follow-up did not take place until over 1.5 years later on 11/1/13.*
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. *As of the date of my visit, 4/22/14, almost 6 months later, he had still not had the ordered follow-up.*
4/15/14	*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*

[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 trigged 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 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 - Apr 2014 Over this period of time, the patient had regular visits to CCC for 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