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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2001-02
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on ... Corrections and Courts (AC-CC)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Mike Barman (LRB) (~~October/2011~~ May-2012)

Department of Corrections

Mortality Review Committee

02/28/2001

Name	Title	Appointment Date
Dr. George Daley	Medical Director (Central Office)	03/01/1993
Kathleen Berkley	Health Services Nursing Coordinator (Central Office)	09/01/1985
Judy Smith	Warden, Oshkosh Correctional Institution	01/24/1982
Courtney Greeley	Nursing Supervisor, Racine Youthful Offender Correctional Facility	07/25/1994
Barbara Powell	Superintendent, Ellsworth Correctional Center	06/28/1971
Grace Treder	Health Services Unit Supervisor, Lincoln Hills School	07/03/1977
Debra Rychlowski	Attorney (Central Office)	06/23/1996
Ann Brewer	Health Services Nursing Coordinator (Central Office)	06/07/1999
Donna Biddle	Employment Relations Specialist	09/21/1999


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Scott McCallum
Governor

Jon E. Litscher
Secretary

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March 14 2001

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State of Wisconsin
Department of Corrections

Executive Directive 58

SUBJECT: Department of Corrections Committee on Inmate/Youth Deaths

I. Policy

The DOC Committee on Inmate/Youth Deaths is to provide the Secretary, Division Administrator, Bureau of Health Services Director and the facilities with an objective review of inmate/youth deaths so as to help the facilities and the Department continually improve the quality of care.

II. Procedure

A. The Committee on Inmate /Youth Deaths may establish an independent investigation team that reports their findings directly to the committee. The committee will:

1. Conduct reviews of inmate/youth deaths at adult correctional facilities, juvenile correctional facilities, correctional centers, and out-of-state contracted facilities housing Wisconsin offenders.

2. Review the causes and circumstances surrounding deaths with particular attention to those considered to be unusual or unexpected.

3. Make recommendations to the Secretary, Division Administrator, Bureau of Health Services Director and the correctional facilities for changes in policies or procedures designed to improve the quality of care given.

4. Ensure that information relating to deaths is properly communicated to the Secretary, Division Administrator, Bureau of Health Care Director, Wardens or Superintendents, and the facility Health Services Managers so that care can be improved.

5. Conduct its reviews in the interest of public safety and the effective health care of inmates/youths.

6. Look at issues relating to the deaths of DOC inmates/youths from a systemic point of view.

B. Committee composition and organization.

1. The DOC Committee on Inmate/Youth Deaths is composed of no more than seven persons, three of which are appointed by the Secretary. The Secretary will appoint a Warden, facility Health Services Manager, and a member of the general public. The Secretary will identify four external agencies and request that each agency select a person to serve on the committee. For example, a physician from the University of Wisconsin Hospital, a physician from a private health care organization such as Marshfield Clinic, a nurse clinician from another state agency such as Division of Care and Treatment Facilities, and a Registered Nurse from a health maintenance organization.

2. The Secretary has designated the Bureau of Health Services Nursing Coordinators in rotation to meet with the committee to act as advisors to the committee.

3. Members are appointed for staggered terms of three years, except the chair who is selected by the full Committee on Inmate/Youth Deaths for a term of two years. Members chosen to fill vacancies created other than by expiration of term shall be appointed for the unexpired term of the member for whom she/he is to succeed.

4. Committee members must be present personally to count for a quorum and to participate in decision-making. Members may not send alternates or designees without the prior approval of the Chair.

5. The committee may authorize the chair to appoint several members to visit a facility to continue a review when the committee deems it appropriate.

6. The committee will require institutions to report actions on recommendations.

7. The committee shall issue a semi-annual report summarizing its work and have this report available to outside agencies as requested.

C. Confidentiality.

1. All information and the proceedings of the committee regarding the cases it reviews, its deliberations and its reports, shall be kept confidential by members in accordance with confidentiality agreements signed by each committee member. Consultants and other individuals with specialized expertise who participate in a review shall be required to sign a confidentiality agreement.

2. The committee may request persons with specialized expertise to participate in a review and members of the committee may visit and inspect any DOC facility and shall have access to all records and data necessary to conduct a review. If the

person having specialized expertise requires compensation that must be pre-approved by the Secretary.

3. The committee may request other persons having relevant information to appear before the committee as part of a review.

D. Procedures of the committee.

1. The committee shall meet at least quarterly unless there were no deaths in the previous quarter. The Secretary or Chair may call additional meetings.

2. Minutes shall be kept at each meeting and shall include:

   a. Records of all death reports reviewed by the committee.

   b. Records of all actions taken by the committee.

   c. The status of all pending reviews.

3. Minutes shall be ratified by the committee and reviewed by the Secretary. Copies of the minutes shall be sent to the Division Administrator and the Bureau of Health Services Director.

4. The Secretary shall designate a member of his/her staff to prepare minutes and provide staff assistance to the committee.

5. A quorum shall consist of two-thirds of the members then in office. While most actions are determined by consensus, a majority of those voting shall be required to adopt motions and approve actions. If a quorum is not present, the committee members present may proceed with the meeting as specified by the agenda and recommend actions to be ratified by the committee, if it has a quorum, at the next meeting. If the chair is absent from a committee meeting, the committee may designate one of its members to be the acting chair during that meeting.

6. The committee shall receive the Investigation Team's report of the cause and circumstances of each death of an inmate/youth in a form and with the information it shall prescribe based on the timelines to be established by the committee.

7. The committee shall receive from each facility a timely report of the cause and circumstances of each death of an inmate/youth in a format and with the information it shall prescribe.

8. The committee shall review how the facility made its clinical and administrative judgments that related to the death, the facility's policies and procedures relating to the death and the Investigation Team's report and the changes a facility may

make as a result of the internal death review. The committee shall review reports, if any, from external agencies. The committee may require additional information from the facility during the course of its review.

9. In its review, the committee may look at the following issues, among others:

   a. The adequacy of care practices.

   b. Whether clinical judgment was exercised properly.

   c. Whether appropriate expertise was utilized.

   d. Whether appropriate internal polices are in place.

   e. Whether internal policies and procedures were followed appropriately.

   f. Whether appropriate family members were kept fully informed.

   g. Whether external agencies were properly notified.

   h. Whether the death was fully reported to the committee.

10. After its review, the committee may make recommendations to the Secretary, Division Administrator, Bureau of Health Services Director and the facility involved, and may determine whether any of the recommendations should be made to some or all of the other facilities.

11. When the committee is satisfied that it can make no recommendations or no further recommendations, it shall consider the review closed and shall communicate the closure to the facility and the Bureau.

E. Procedure for Investigation Team

1. The committee may appoint an Investigation Team(s) composed of no more than three persons to complete an on-site review of an unexpected inmate death.

2. In its review, the Investigation Team may look at the following issues, among others:

   a. The adequacy of care practices.

   b. Whether clinical judgment was exercised properly.

   c. Whether appropriate expertise was utilized.

   d. Whether appropriate internal policies are in place.

e. Whether internal policies and procedures were followed appropriately.

f. Whether appropriate family members were kept fully informed.

g. Whether external agencies were properly notified.

h. Whether the death was fully reported to the investigation team.

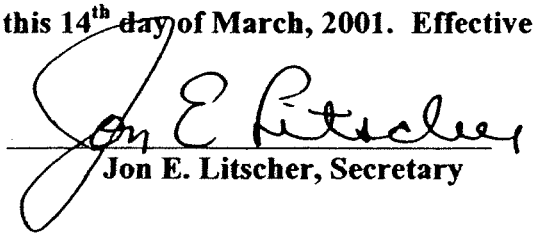
3. After the Investigation Team's review, the Team will report its findings and recommendations directly to the Committee on Inmate/Youth Deaths. The committee will be responsible to ensure that the Investigation Team report is timely and in a form and with the information it shall prescribe.

4. The Committee on Inmate/Youth Deaths has the independent authority to appoint or modify the investigation team to ensure complete and objective fact finding.

5. The Committee on Inmate/Youth Deaths is responsible to ensure the Investigation Team conducts an objective and independent review. The committee may require institutions to provide additional review or assistance as necessary to ensure full cooperation with the Investigation Team. If the committee believes there is an attempt to influence or interfere with the Investigation Team the committee will refer the complaint to the Secretary for immediate review and follow up.

Originated by: Bureau of Health Services

Dated this 14th day of March, 2001. Effective May 1, 2001



Jon E. Litscher, Secretary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COMMITTEE ON INMATE/YOUTH DEATHS

MINUTES OF JULY 24, 2001 - OPEN SESSION

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Members Present: Sherran Dille, Judy Smith, Jeananne Greenwood Hertel, David Titus, Kathleen Bellaire, Dr. John Williams

Members Absent: Dr. Jeff Wells

Invited Participants: Kathleen Berkley, Diane Smerling, Bob Pultz, Diane Reinen

Kathleen Bellaire called the meeting to order at 1:12 PM.

Agenda Item 1 - Review of Minutes

June 5, 2001 minutes were reviewed. A motion was made by Judy Smith and seconded by Sherran Dille to approve the minutes of the June 5, 2001 meeting as written.

Agenda Item 2 - COIYD Review Process

A draft review form developed by the Mortality Review Committee was distributed. Kathleen Berkley explained how the Mortality Review Committee had intended to use the form.

The committee reached concensus on the following processes:

- The committee will use the Mortality Review Committee's draft review form as it's reporting tool.
- Each Institution/Facility will be directed to conduct an internal review of all inmate deaths and document their findings, recommendations and actions taken on the Mortality Review form.
- A review committee will be formed at the time of each death, members will be appointed by the Warden/Superintendent.
- The review committee at the Institution/Facility will include at a minimum the following members:
  - The Warden/Superintendent/Designee
  - A physician or nursing representative
  - Clinical Psychology for suicides (this is mandatory for suicides)

- Others as appointed by the Warden

- An external review will also be conducted for each death by Central Office Staff as follows:
  - The medical director or designee will fill out the medical portion of what is now on Page 8 (Mortality Review form).
  - A nursing coordinator will fill out the nursing portion of what is now on Page 8 (Mortality Review form).
  - The Mental Health Director will review all suicides. K. Berkley will contact TMG and retrieve the evaluation page of the draft form.

- At this time the Divisions will continue to do their immediate review of unexpected deaths. Reports will be forwarded to the COIYD. The COIYD will review the reports and request any additional information/investigation as deemed appropriate.

Agenda Item 3 - Format

- The form will be revised into three separate review documents so that all parties may pull up their section from the Forms Folder and work on the review at the same time.

- The forms will be revised so that each document will include a section for recommendations and actions taken.

Agenda Item 4 - Transition

- The target date for the Committee on Inmate/Youth Deaths to become the primary review body is November, 2001.

Agenda Item 5 - Timelines

The following timelines were established:

- DAI will notify all committee members of all deaths within 24 hours.

- The Institution/Facility must complete the Mortality Review form within 3 working days of an unanticipated death and send the completed form to Diane Reinen in Central Office. Diane will forward the report to all committee members. The committee members will communicate to the other members any concerns they may have.

- The committee will meet in August, November, February and May for quarterly reviews.

Items to be discussed at a later date:

- What evaluation needs to be done for suicides.
- How long does the Institution/Facility have to fill out the form for anticipated deaths.
- How long does the medical director and nursing coordinator have to complete their review.

Misc.

- The confidentiality agreement was signed by Dr. John Williams.

Further discussion on process and timetables was tabled due to time constraints. The open session adjourned at 3:50 PM.

A vote was held and the committee went into closed session at this time for review of inmate deaths.

Agenda Item 6 - Scheduling of Future Meetings

The next meeting will be on Thursday, September 6, 2001 in DOC Central Office in Madison.

Agenda Item 7 - Location of Future Meetings

- David Titus will check into a place in Portage to have future meetings as this may be a more convenient location for the members.


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date?

NATIONAL CONFERENCE *of* STATE LEGISLATURES

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To: Leif Jorgenson

From: Blake Harrison
Criminal Justice Program
blake.harrison@ncsl.org

Message: This is the only report I know of. Here is part of the report ordered by the NE Legislature. Please call if you need the entire report or need more information.
-Blake

Number of pages sent
(including this cover sheet): _____

Date: _____

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OMBUDSMAN'S REPORT

EXAMINATION

OF THE

MEDICAL SERVICES SYSTEM

OF THE

NEBRASKA DEPARTMENT

OF

CORRECTIONAL SERVICES

November 23, 1999

Investigated by:

Oscar Harriott
James Davis III
Carl Eskridge

INTRODUCTION

Background

This Report presents the results of an extraordinary effort of the Nebraska Ombudsman's Office to examine, in scrupulous detail, the operation of the Medical Services division of the Nebraska Department of Correctional Services. Our Report is the product of hundreds of hours of work, involving the efforts of several members of the Ombudsman's staff. In addition to its extensive work in compiling information about policies and procedures particular to the Medical Services division, the Ombudsman's Office also found it necessary to gather facts about specific incidents that were relevant to the issues under review. In the course of its activities on this matter, the Ombudsman's Office also accumulated, reviewed and digested relevant technical information from certain external sources, such as medical texts and medical practitioners in the community. Admittedly, when it comes to medical issues, the technical expertise of the Ombudsman's Office staff is limited. Those of us who work in the Nebraska Ombudsman's Office are not doctors. The Ombudsman's Office does, however, possess a high degree of expertise when it comes to the process of systematically compiling information, a process commonly referred to as "investigation." The Ombudsman's Office also has a significant level of expertise in the area of issues-analysis, particularly with respect to the analysis of issues of administrative policy and practice. That expertise played an important role in producing this Report.

In approaching this matter, the Ombudsman's Office was acutely aware of the fact that problems associated with the delivery of medical services to all segments of our society are of paramount concern to policy-makers at all levels of government. Questions of cost, availability and quality of medical services are issues that have preoccupied our society throughout the last decade. Some of the most difficult of those problems have been concerned with the issue of how we can change the system for the delivery of medical services while still protecting the rights, interests and health of vulnerable consumers and patients. In our pondering over these issues, however, one group that has received far too little attention is inmates.

There are few segments of our society that are more vulnerable to flaws and abuses in the system for the delivery of medical services than inmates. As

the United States Supreme Court has so plainly acknowledged, "(a)n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met." *Estelle v. Gamble*, 429 U.S. 97, 103, 97 S.Ct. 285, 290, 50 L.Ed.2d 251, 259 (1976). Thus, while it is arguably true that inmates receive what is, in effect, free medical coverage, it is also true that inmates really have no choice in the matter. When it comes to medical services, inmates simply have no alternative. They are not only confined to penal institutions, but they are also, in a very real sense, literally confined to the medical system that is made available to them by the correctional administrators, good, bad or indifferent though that medical system may be. Even patients who receive their medical services through the most cost-conscious HMO will have, at least, some leverage when it comes to concerns about the quality of the medical care that they receive. Inmates of the Nebraska penal system, on the other hand, when they are confronted by inadequacies in prison medical services, are often unprotected, voiceless, and alone, and are routinely placed in nothing less (or more) than a "take it or leave it" position.

It is in this context that the Ombudsman's Office has witnessed over the last several years a particularly troubling series of events that have aroused increased concerns about the quality of medical care being made available to the inmates of Nebraska's penal system. This is more than simply a matter of receiving an increased number of inmate complaints on medical issues, although that is a phenomenon that has definitely been observed by the staff of the Ombudsman's Office in recent years. The increase in medical-care complaints has, in fact, occurred in conjunction with several other events that deepened concerns about the overall quality of the medical service being provided to inmates in the Nebraska penal system. Those events included:

1. An investigation by the Ombudsman's Office in 1994 of the case of a Department of Correctional Services nurse who complained that she was being retaliated against by the Department for her role in assisting another nurse in articulating various allegations of misconduct among the agency's medical staff to the then Deputy Ombudsman for Corrections and to Department of Health medical licensing authorities. The allegations presented to the Department of Health at that time involved claims of serious misconduct detrimental to the health of inmates. At the conclusion of its investigation of the matter, the Ombudsman's Office found that there were reasonable grounds to believe that the

Department had, in fact, retaliated against the nurse. (Please see Attachment 1)

2. Testimony presented to the Judiciary Committee of the Nebraska Legislature in connection with an interim study conducted by that Committee in 1995. In testimony at a hearing held on December 12, 1995, a number of Penitentiary inmates complained to the Committee about the quality of medical treatment received for a wide range of ailments. Many of the complaints articulated by inmates on that occasion featured a high degree of dissatisfaction with the decisions, actions and inactions of Department of Correctional Services Medical Director Dr. John Cherry, a salient feature which has certainly been characteristic of many of the medical care complaints subsequently received by the Ombudsman's Office.

3. An attempt by the Department of Correctional Services in 1997 to fire a Registered Nurse who was one of the medical staff responsible for providing medical care to inmates at the York Center for Women. The nurse had allegedly refused to provide needed treatment for a child of one of the inmates who was staying with her mother at the Center. The Department of Correctional Services had attempted to fire the nurse, and the Ombudsman's Office, based upon its own knowledge of the case, supported that effort, but in the end a hearing officer ordered that the nurse be reinstated.

4. The results of an investigation conducted by the Ombudsman's Office in 1998 into a case involving the medical treatment provided to an inmate of the Omaha Correctional Center who had been seriously burned in a kitchen accident. The incident had resulted in some third degree burns to the inmate's hand and neck and, after investigating the matter, the Ombudsman's Office concluded that the medical care provided to the inmate, particularly by the Physician Assistant in charge, had been inadequate in several significant respects. The Ombudsman's Office felt that the matter was serious enough to justify the preparation of a critical report, which was completed on April 15, 1998, and presented to the Department of Correctional Services, along with associated recommendations. (Please see Attachment 2)

Troubling though these incidents were, none of them, taken alone, was sufficient to prompt the Ombudsman's Office to take the extraordinary step

of mounting a full scale examination of the Department's medical services system. Finally, however, in September of 1998, a catalyst was added to the mixture, causing the reaction that produced this Report.

Dr. Faisal Ahmed

On September 15, 1998, the Ombudsman's Office received an unexpected visit from Dr. Faisal Ahmed, one of the two medical doctors then employed full time by the Nebraska Department of Correctional Services. Dr. Ahmed had recently been suspended from his job by the Department in connection with an incident involving an inmate/patient by the name of Robert Zolper. (The incident concerning Mr. Zolper will be discussed in detail at later points in this Report.) Because of his suspension, Dr. Ahmed had contacted private legal counsel. His attorneys, after hearing his account of the Zolper incident, had recommended that Dr. Ahmed contact the Ombudsman's Office.

Dr. Ahmed's original visit with the Ombudsman's Office led to an extensive series of interviews that covered a wide range of issues pertaining to the operation of the medical services system of the Department of Correctional Services. The Ombudsman's Office quickly recognized the importance of the information that Dr. Ahmed was providing in terms of the insights that it offered into the workings of the Department's medical services system. The Ombudsman's Office also recognized that, in taking the risks involved in providing this information, Dr. Ahmed was a classic whistleblower, that is, an insider who possesses sensitive information about the weaknesses and/or failures of a system and who is driven primarily by conscience to disclose that information as a way of reforming the system. As is usually the case with whistleblowers, Dr. Ahmed was fearful that his whistleblower activities would lead to retaliation by his supervisors. Dr. Ahmed, in fact, was particularly vulnerable, because of his status as a resident alien. Dr. Ahmed, a Pakistani citizen who received his medical training in this country, is authorized to remain in the United States under a program that allows doctors to continue to reside in the United States when they are working in an area (for example, prisons) where there is a special need for doctors. Thus, for Dr. Ahmed, the possibility of retaliation by his supervisors represented not only the threat that he might lose his job, but also the threat that he might be deported. As it developed, Dr. Ahmed's concerns about retaliation proved to be well-founded.

Given the nature of the information being provided by Dr. Ahmed, and given the seriousness of the allegations that some of that information implied, the Ombudsman's Office determined to move forward with a full scale investigation of the medical services system of the Department of Correctional Services. Shortly after Dr. Ahmed's initial contact with the Ombudsman's Office, and with his express permission, the Ombudsman's Office sent a brief letter to Mr. Harold Clarke, Director of the Nebraska Department of Correctional Services, advising him of the fact that the office had been contacted by Dr. Ahmed, who was providing information relating to alleged wrongdoing within the Department's medical services system. (Please see Attachment 3) As it developed, that letter was the first substantive step in the investigation of Dr. Ahmed's allegations by the Ombudsman's Office.

Investigation

On November 4, 1998, after completing its initial series of interviews of Dr. Ahmed, and after digesting the large amount of information that Dr. Ahmed had provided, the Ombudsman's Office presented the most important issues raised by Dr. Ahmed in a letter addressed to Director Clarke. (Please see Attachment 4) A copy of that November 4 letter was also provided to Dr. Cherry. (Please see Attachment 5) The November 4 letter to Mr. Clarke, consisting of nearly thirty pages, outlined in detail not only the general issues of policy and procedure implicit in the information provided by Dr. Ahmed, but also a number of very specific case-related allegations that pertained to treatment provided by the staff of the medical services system of the Department of Correctional Services. The letter also represented the beginning of a long and comprehensive investigatory process through which the Ombudsman's Office sought information and documentation from the Department that was relevant to the issues raised by Dr. Ahmed.

The Department's response to the issues raised in the November 4, 1998 letter came several weeks later, when the agency provided the Ombudsman's Office with a large volume of the documents that had been requested in connection with the matter. The documentation that was provided by the Department included a copy of a November 9, 1998 letter written by Dr. Cherry and a copy of a November 9, 1998 memorandum written by Associate Health Care Administrator Daniel Danaher, both of which addressed each of the issues raised in the Ombudsman's letter of November 4. (Please see Attachment 6 and Attachment 7) Those two documents were

particularly important, because they, in effect, presented the Department's response to the issues and allegations contained in the information provided by Dr. Ahmed.

After giving careful consideration to the substance and importance of the various issues that were implicit in the statements that Dr. Ahmed had provided, and after examining the Department's initial response to those issues, the Ombudsman's Office was able to narrow the scope of its inquiry into the medical services system of the Department of Correctional Services to ten core issues. Those issues were enumerated in a December 9, 1998 letter addressed to Mr. Clarke. (Please see Attachment 8) The December 9 letter also indicated that the Ombudsman's Office intended to engage in a full examination of the circumstances involved in the death of Mr. Zolper and that the office reserved the right to "expand the boundaries" of its investigation, should new issues arise. A copy of the Ombudsman's December 9, 1998 letter was provided to Dr. Cherry, which prompted him to author a December 14, 1998 memorandum commenting upon the issues enumerated in that letter. (Please see Attachment 9)

In the months that followed, the Ombudsman's Office obtained additional documentation from the Department of Correctional Services and carried out many interviews of Departmental staff in connection with its investigation of the Department's medical services system. The Ombudsman's Office also collected information relevant to its inquiry from other sources. Throughout this period, the Ombudsman's Office remained in contact with Dr. Ahmed, so that he could be asked follow-up questions that occasionally arose. Although the original intent of the Ombudsman's Office was to complete the investigation in the Spring of 1999, events transpired that significantly complicated and prolonged the investigation.

Cooperation by the Department

At the outset of this inquiry, Director of the Department of Correctional Services Harold Clarke essentially pledged that the Department would cooperate in the investigation to be conducted by the Ombudsman's Office. Specifically, in a letter dated September 29, 1998, Mr. Clarke stated that the Department of Correctional Services "welcomes" the investigation and that he was directing Assistant Director Jack Falconer, Mr. Robert Whitson, the Administrator of the Department's medical services division, and Dr. John

"facilitate (the) investigation of this matter." (Please see Attachment 10) In fact, the Ombudsman's Office did enjoy a significant degree of cooperation from the agency, as Mr. Clarke had promised. There were meaningful exceptions to this pattern of cooperation, however, some of which seriously complicated the investigation. Those exceptions included the following:

1. Throughout the investigation conducted by the Ombudsman's Office, there were several attempts by Dr. Ahmed's supervisors to retaliate against him for his cooperation with the Ombudsman's Office. Due to its obligations under **Neb. Rev. Stat.** §§81-2701, *et. seq.*, the Nebraska State Government Effectiveness Act (also known as the "whistleblower protection law"), the Ombudsman's Office was required to expend a great deal of its time and resources investigating the several cases of retaliation against Dr. Ahmed. The Ombudsman's Office ultimately completed two separate retaliation investigations involving Dr. Ahmed and in both instances made findings that a preponderance of the evidence indicated that Dr. Ahmed was retaliated against in violation of the State Government Effectiveness Act. (Please see Attachment 11 and Attachment 12) The fundamental question of retaliation was also an issue before a hearing officer appointed by the Nebraska State Personnel Board to hear Dr. Ahmed's grievances pertaining to the matter. The Department's attempt to secure a summary dismissal of the case was unsuccessful, and the matter went to hearing. After many days of prolonged testimony, a process that produced a transcript that was over 1,000 pages long, the hearing officer found that Dr. Ahmed was a "whistleblower under the State Government Effectiveness Act" and that he had been retaliated against by Mr. Whitson, Mr. Danaher and Dr. Cherry in violation of the Act. (Please see Attachment 13)

2. Efforts by the Ombudsman's Office to obtain copies of nurses' telephone logs for the years 1994 through 1999 were frustrated when the office was advised that the logs for 1994 through 1998 had been destroyed. The logs in question are maintained by the nurses assigned to the various correctional facilities as a routine way of making a record of telephone calls that pertain to the reported medical problems of inmates and/or to the related medical treatment. The Ombudsman's Office wanted to obtain copies of the logs in order to use them as a quick reference on the nature and

frequency of certain health-related complaints that had been voiced by inmates. Although the nurses' telephone logs for 1999 were made available by the Department, the Ombudsman's Office was advised that telephone logs for previous years had been destroyed. When asked for an explanation, the Department asserted that the logs in question were the "personal property" of the nurses. The Ombudsman's Office challenged that rationale and suggested instead that the agency's destruction of the records in question was a probable violation of the State Records Management Act, **Neb. Rev. Stat.** §§84-1201, *et. seq.* (Please see Attachment 14)

3. The Ombudsman's Office was repeatedly frustrated in its efforts to interview Dr. John Cherry. As the Department's Medical Director, Dr. Cherry would obviously be an important source of information relative to virtually all of the issues raised by Dr. Ahmed. The initial attempt to interview Dr. Cherry was made on June 17, 1999. The interview was commenced as scheduled, but was quickly aborted when Dr. Cherry objected to some of the questions asked and stated that the interview was "more than...(he) can handle emotionally." The interview was rescheduled through Department of Correctional Services General Counsel George Green for July 1, 1999. However, that interview was cancelled by Mr. Green at Dr. Cherry's request. On June 30, 1999, Mr. Green wrote to the Ombudsman's Office about the cancelled interview. In that June 30 letter, he indicated that Dr. Cherry had suggested instead that the Ombudsman's Office submit questions to him by in writing as an "accommodation." (Please see Attachment 15)

4. The Ombudsman's Office encountered a great deal of misdirection and difficulty in its repeated efforts to secure documentation from the Department pertaining to Dr. Cherry's professional history. The original request for that material was addressed to Medical Administrator Whitson by the Ombudsman's Office on or about March 3, 1999. While Mr. Whitson did give the Ombudsman's Office copies of Dr. Cherry's state employment application and *Curriculum Vitae*, he also expressed reluctance to provide any of the other documentation in the Department's possession relative to Dr. Cherry's professional history. The issue of Dr. Cherry's professional history was again brought up by the Ombudsman's Office at the June 17 meeting with Dr. Cherry, at which time Dr.

Cherry responded that his full record was in the possession of the Department. General Counsel Green, who was also in attendance at the June 17 meeting, indicated to Ombudsman's Office staff that the record in question could be secured through the Department and suggested that the Ombudsman's Office submit a request for that documentation to the agency in writing. However, when the Ombudsman's Office later did make a specific written request that the Department provide its documentation relative to Dr. Cherry's professional history, the Department informed the Ombudsman's Office that it no longer had that information and that it would have to be secured through direct contact with Dr. Cherry. (Please see Attachment 16) Subsequently, Dr. Cherry offered testimony under oath at Dr. Ahmed's personnel hearing. During that testimony, the following exchange occurred when Dr. Cherry was being cross-examined by Mr. Thom Cope, Dr. Ahmed's attorney:

Q. (By Mr. Cope) You worked at Lincoln General. What did you do there?

A. Private practice general surgery.

Q. So you had your own private practice, but were – had hospital privileges at Lincoln General?

A. Yes.

Q. And at some point you stopped having privileges at Lincoln General, is that right?

A. Yes.

* * *

Q. (By Mr. Cope) Okay. You didn't have privileges for a while, is that right?

A. Correct.

Q. You now have privileges at Lincoln General?

A. No.

Q. And isn't it true that you had to go to some retraining, some classroom training, after losing your privileges at Lincoln General?

A. After losing my privileges at Lincoln General, I was told that, in order to regain my privileges at Lincoln General, I would have to take further training; which I did.

Q. All right. So in fact you did take further classroom training, is that right?

A. Not classroom, it was a surgical critical care fellowship.

Q. So it would have been a practical training?

A. Correct.

Q. On site in a medical facility?

A. Yes.

Q. And why is it that you lost your privileges at Lincoln General?

A. There was concern over four patients of mine that died.

Q. All right. And the next job that you had after your private practice was at Department of Corrections, is that right?

A. Correct.

Q. And when you lost your privileges at Lincoln General, did you cease your private practice?

A. Yes.

(Please see Attachment 17) Although some of this information was not included in Dr. Cherry's state employment application and *Cur-*

riculum Vitae, the testimony did correlate with the basic chronology reflected in those documents.

While it would certainly be correct to say that the various impediments to the progress of this investigation were, in differing degrees, sources of difficulties that generally delayed and compounded the complexity of the investigation of this matter by the Ombudsman's Office, in the end none of these instances of non-cooperation presented an insurmountable hurdle to the completion of the investigation. On the contrary, some of those instances, particularly those involving the destruction (inadvertent or not) of records and the rather crude and clumsy attempts at retaliation against Dr. Ahmed, offered important in-sights into the quality of the leadership of the Department's medical services system. Ultimately, the investigation was not compromised and, as the balance of this Report will clearly demonstrate, the Ombudsman's Office was able to uncover, record and analyze an extensive volume of relevant information.

SUMMARY

This Report is the result of a detailed and conscientious examination of the medical services system of the Nebraska Department of Correctional Services. The Ombudsman's Office undertook this project, because it was something that, in a very real sense, demanded to be done. Indeed, it was the product of an opportunity that could not be ignored. The truth is that, in many cases, our bureaucratic systems are machines enveloped in a dense fog that obscures their real workings from the prying eyes of outsiders. The obscure minutia of their particular areas of specialty, the complex twist and turns of their policies and procedures, and sometimes even the protective reflexes of the bureaucrats who lead them, all conspire to make administrative systems into things that are very difficult to penetrate, not to mention understand. This was particularly true here, where so many of the issues involved the highly technical and specialized area of the practice of medicine. In this case, however, the Ombudsman's Office had an unusual advantage, because Dr. Ahmed's unqualified cooperation offered a unique opportunity to see through the fog and find the truth. When voicing a response to the many complaints about the agency's medical services system expressed by inmates at the hearing of the Legislature's Judiciary Committee in 1995, Director of Corrections Harold Clarke, in effect, indicated that he was not surprised by the inmates' reaction. They were inmates and inmates complain. (Please see Attachment 59) It is much more difficult, however, to minimize the complaints of Dr. Ahmed, a man who is not only an insider insofar as the system is concerned, but who is also a medical professional who presumably understands the intricacies of the medical issues thoroughly and well.

In fact, Dr. Ahmed was not the first insider within the Department's medical services system who had raised significant issues about the quality of care in that system. In 1994, Nurse Arlene Trainor (RN), an employee of the Department, had presented a long list of allegations of improper and unprofessional conduct within the Department's medical system to the medical licensing authorities of the Nebraska Department of Health. (Those allegations came into possession of the Ombudsman's Office in connection with its investigation in 1994 of an allegation that another Department of Correctional Services nurse had been retaliated against by the Department for cooperating with Nurse Trainor.) Many of Nurse Trainor's 1994 allegations

were, in effect, distant and troubling echoes of similar allegations being made by Dr. Ahmed in 1998. (Please see Attachment 60) In fact, Nurse Trainor's complaints included allegations:

1. That there had been cases of failure to properly manage patients who complained of chest pain, including instances of two patients who subsequently died;

2. That there had been cases of mishandling of patients with upper gastrointestinal tract bleeding;

3. That there had been a refusal to provide treatment to a Hepatitis patient, because it was "too expensive;"

4. That the decisions of doctors were out voted and "overruled" by physician assistants at medical staffing (Medical Review Board) meetings;

5. That a secretary formerly working for Mr. Whitson had left the Department's employ, because "she was unwilling to type up minutes to meetings required by the DOH (Department of Health) when she knew that (Mr. Whitson) 'made up the minutes'";

6. That physician assistants were not properly supervised by the Department's doctors, were allowed to "overrule" the doctors, and to "dictate prescription policy" to a doctor;

7. That there were cases where patients were denied proper medication for the relief of pain;

8. That needed surgery was denied for an inmate who was soon to be released from incarceration in order to "save money;"

9. That there had been a failure by medical staff to manage a sexually active inmate who was infected with HIV;

10. That there was an instance of a refusal to refer a patient to an outside specialist;

11. That there had been a case where a diabetic inmate had developed

severe infection due to a failure to take proper steps to follow-up a surgical procedure; and

12. That Physician Assistant Danaher had made a statement that an ailing inmate should be made a "Do Not Resuscitate" case to "save money for the state."

Not only were Nurse Trainor's 1994 allegations startling as a distant reflection of the allegations being made by Dr. Ahmed in 1998, but the two cases had the additional commonality of retaliation, in 1998 against Dr. Ahmed and in 1994 against one of the nurses who cooperated with Nurse Trainor. (Please see Attachment 1)

It is quite clear that this project addressed one of the most crucial areas in the Nebraska penal system. For some, it might be more convenient to pretend that inmates are not really human beings – that they are creatures from another planet. In fact, however, they are our sons and brothers, our daughters and sisters. Potentially, they are us, or they are someone dear to us. Inmates are human beings, and they need to be treated humanely. What are we to do with these men and these women when they become ill, or injured, or old and infirm? Are we to provide them with basic shelter, but not with basic medical care? Are we to feed their stomachs, but not heal their wounds? And when they grow old, are we to allow them to languish, the infirmities of their old age untreated or inadequately treated, until they are robbed of the last faded rags of their humanity? The answers are that when we take away the liberty of inmates, our society necessarily assumes the responsibility of meeting their basic needs; to shelter them from the elements, to feed them when they are hungry and, of course, to provide them with medical treatment when they are ill. Any penal system that fails to meet this latter obligation is fundamentally flawed and in need of reform.

The work of the Ombudsman's Office in preparing this Report has been carried out in the spirit of optimism that systems can be reformed. To that end, the Report has presented the findings of the Ombudsman's Office on a number of the salient issues that were raised by Dr. Ahmed and/or that were unearthed in the process of our investigation. Not only has each of those issues have been discussed individually and in detail, but also, in most cases, appropriate recommendations have been made. Those recommendations include the following specific proposals:

1. With regard to the diagnosis of chest pain patients, the Ombudsman's Office recommends that, unless it is absolutely clear that the source of chest pain is not cardiac in nature (e.g., the result of trauma, esophageal reflux, etc.), it should be the standard and protocol of the Department of Correctional Services medical system to immediately transport all patients complaining of chest pain that has not been previously diagnosed to the emergency room of a local hospital. In order to carry out this standard, it should be a standing order at all of the correctional institutions that the nurses and/or physician assistants shall immediately contact the medical officer of the day in any instance where an inmate presents himself or herself to the medical staff with chest pain, unless a cardiac source can be immediately ruled out as the cause of that pain. The medical officer of the day should respond to such calls by directing that the inmate be immediately transferred to the emergency room of a local hospital, unless he or she can rule out a cardiac cause as a source of that pain.

2. With regard to providing emergency treatment in cases of cardiac arrest, the Ombudsman's Office recommends that automatic external defibrillators (AED's) be added to the equipment of all of the medical facilities of the Department of Correctional Services and that it be made clear to the medical staff that, as a standard of practice, they are expected to use those devices in all appropriate circumstances. The Ombudsman's Office further recommends that the Department train all of its medical personnel in the use of the AED and that the Department institute a procedure for the periodic retraining of the medical staff in the use of that device. The Ombudsman's Office also recommends that the Department train all of its physician assistants in the techniques of advanced cardiac life support (ACLS) and that the Department make it clear to those so trained that, as a standard of practice, they are expected to use those techniques in all appropriate circumstances. The Ombudsman's Office further recommends that the Department institute a procedure for the periodic retraining of the agency's physician assistants in the use of ACLS techniques.

3. **With regard to cases of acute upper gastrointestinal bleeding, the Ombudsman's Office recommends that the Department of Correctional Services transfer all such cases to local general care hospitals where the patients can be examined by a gastro-enterologist and where, if deemed advisable, an upper GI endoscopy can be performed.**

4. **With regard to the treatment of Hepatitis C cases among the Nebraska prison population, the Ombudsman's Office recommends that the medical staff of the Department of Correctional Services act as swiftly as possible to develop and implement a treatment protocol for Hepatitis C cases identified within the inmate population of the Nebraska penal system.**

5. **With regard to the prescription of medication to treat inmate pain and illnesses, the Ombudsman's Office recommends that the Department of Correctional Services conduct a detailed review of the approach of its medical staff to the prescription of medication to patients and that the Department take steps that will make certain the prescription of medication to the system's patients, particularly medication to control pain, will not be influenced by non-medical factors.**

6. **With regard to the management of inmates infected with HIV, the Ombudsman's Office recommends that the Nebraska Department of Correctional Services adopt regulations on the subject of the isolation of those HIV positive inmates whose conduct presents a health risk to other inmates substantially the same as the regulations on that subject formulated by the U. S. Bureau of Prisons.**

7. **With regard to restoring discipline within the lines of authority of the agency's medical system, the Ombudsman's Office recommends:**

    a. **That all subordinate medical staff should be admonished to respect and implement the directives of the Department's doctors. It should be made clear to subordinate**

staff that the primary responsibility for making ultimate medical decisions resides in the hands of the doctors, who are the personnel best trained to make those decisions. With the obvious exception of those rare situations where following a doctor's directives might seriously jeopardize the health or life of a patient, the Department of Correctional Services should insist that its subordinate medical staff follow the doctors' orders;

b. That if, in the future, any subordinate medical staff person should neglect or fail to follow the directives of one of the agency's doctors, then the Department should impose swift discipline and, if necessary, terminate the offending staff person; and

c. That, insofar as medical treatment decisions are concerned, it should be emphasized that the Department's physician assistants are subordinate to, and subject to the supervision of, the agency's doctors. The Department should take immediate action to clearly delineate the levels of authority of its doctors and its physician assistants.

8. With regard to the interference of security staff with the activities of the Department's medical staff, the Ombudsman's Office recommends that the Department of Correctional Services immediately implement a policy statement that will: (a) direct that security staff avoid any unnecessary disruption of the agency's medical staff when the medical staff is providing treatment to injured or ill inmates; and (b) provide guidelines for those limited situations where security concerns might be deemed to take precedence over medical concerns. The Ombudsman's Office further recommends that this policy statement be reinforced through relevant training of administrators and staff.

9. With regard to insuring that inmate care is not unduly influenced by cost concerns, the Ombudsman's Office recommends that the Department of Correctional Services promulgate specific standards, based substantially upon Nebraska

Department of Health and Human Services Medicaid rules and regulations, stating, in detail, how various inmate diseases and disabilities should be addressed by the Department's medical staff.

The background of each of these recommendations is discussed in full in Part 1 through Part 11 of this Report.

Certain general observations are also called for under the circumstances. As a general observation, it is the opinion of the Ombudsman's Office that the medical services system of the Nebraska Department of Correctional Services is woefully inadequate, so much so that in many instances it fails to meet the agency's fundamental obligation to provide for the medical needs of its inmate population. In summary, we have found the agency's medical department to be understaffed, inadequately trained, poorly organized and badly led. So long as the medical services system remains in this condition, there is the very real chance that the courts may intervene in the operation of the State's medical services system, as has apparently happened in the State of Kansas, where a court order led to the privatization of the prison medical system. (Please see Attachment 61) There is even the possibility, in the most extreme scenario, that the medical services system could be subjected to investigation by the federal Justice Department (Please see Attachment 62), as has occurred in response to human rights issues raised by allegations of inmates being brutalized by employees in the Florida prisons. (Please see Attachment 63) The medical services system in Nebraska's prisons is not, however, beyond redemption and can, in our opinion, be restored to an acceptable level of performance, if the leadership of the agency understands the pressing need for, and has the initiative to implement, certain fundamental changes. Those changes should include, but not be limited to:

1. **A fundamental reorganization of the agency's medical department. That reorganization should, at a minimum, include:**

    a. **Removal of the Department's health care system from the supervision of the agency's Assistant Director for Administrative Services, thereby making the head health care position into an assistant-level position that would be directly answerable to the Director of the Department of Correctional Services;**

b. Elimination of the Medical Director position;

c. Requirement that the person holding the Assistant Director for Health Care position be an MD;

d. Requirement that the individual holding the agency's Associate Health Care Administrator position possess a background of education, training and experience in management and administration (Under no circumstances should the Associate Health Care Administrator be either a nurse or physician assistant.); and

e. Elimination of the agency's Medical Review Board and replacement of that body with an advisory panel that is designed solely to address general issues of medical policies and procedures.

2. A thorough review of the staffing patterns of the Department's medical system to determine where the needs for additional staff are most acute. At a minimum, the Department should secure a doctor (who may be either on staff or under contract) to work at the Omaha Correctional Center and supervise the medical staff at that institution.

3. The establishment of a meaningful peer review process within the Department's medical services system. Ideally, that peer review process should be designed to identify, critique and correct errors in medical practice and procedure that occur in the agency's ongoing provision of medical services to its inmate population.

4. A thorough review of the training provided to the medical staff of the Department, with particular emphasis on the need for improved training of staff in the area of emergency response, including use of the automatic external defibrillator and advanced cardiac life support techniques.

5. The reestablishment of the tele-medicine program (a program using telecommunications systems to transmit images and

read-outs to remote sites) to provide for timely examination and evaluation of inmates with conditions that require the expertise of a specialist. This program should include procedures which allow any of the Department's doctors to unilaterally refer inmates to the tele-medicine services.

6. The immediate discontinuance of all surgical procedures performed by Departmental staff. In the future, all surgical procedures on inmates should be performed by practitioners in the community and in the appropriate surgical settings.

7. Selection of an Assistant Director for Health Care who is both an MD and who has demonstrated that he or she can be an effective advocate for the medical needs of all the inmates served by the Department's medical services system.

8. The identification of an outside agency with a high degree of medical expertise to be retained to assist the Department in monitoring the ongoing provision of medical services to its inmate population. At a minimum, this outside agency should be charged with the responsibility of:

   a. Following-up on inmate complaints of a medical nature;

   b. Examining the cause of and the medical response to all inmate deaths;

   c. Conducting annual reviews of the job performance of all of the Department's medical staff (including those under contract with the Department);

   d. Advising the Department on the selection and hiring of the Department's Assistant Director for Health Care; and

   e. Conducting semiannual reviews to examine and evaluate (1) the adequacy of medical staffing patterns within the agency; (2) the adequacy of the training being received by the agency's medical staff; (3) the timeliness of the agency's responses to inmate medical needs, including

follow-up for chronic conditions; (4) the needs of the agency to secure additional or replacement medical equipment; (5) the adequacy of medical record-keeping by the agency; and (6) the effectiveness of the agency's medical peer review process.

COMMENTS

The Ombudsman's Office offers the following commentary to these recommendations:

1. **Reorganize the medical department** – The organization of the medical department has a direct and profound influence upon the nature and quality of medical decision-making occurring within the Department of Correctional Services. The Ombudsman's Office has found that, under the medical system's current organization, the responsibility for medical decisions is dispersed, rather than concentrated, and too many of those decisions are made by staff other than doctors. Too often, fundamental medical decisions are made by nurses, physician assistants and even administrators, rather than by the attending physician. To ensure that medical decisions are made by the right professionals with the best background, and also to ensure that those decisions will be guided primarily by genuine medical considerations, a fundamental reorganization of the agency's medical department is necessary.

   The Health Care Administrator, specifically, and the agency's medical department, in general, are currently under the direct supervision of the Department's Assistant Director Administrative Services. Since the Assistant Director Administrative Services is also the Department's chief budget officer, this arrangement, in effect, places the medical services system under the immediate control of the same person in the agency who is responsible for the Department's budget-making and fiscal management. Such a manner of organization brings worries about cost too close to the medical realm and makes it almost inevitable that the agency's medical decision-making process will, at some point, be unduly influenced by cost considerations. While it is certainly appropriate for the department to be cost conscious to the point of avoiding


FORWARD

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AB 170 folder

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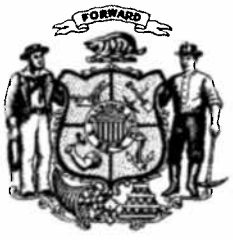
WISCONSIN STATE LEGISLATURE



DEPARTMENT OF CORRECTIONS
DOC- 3356 (09/`01)

AB 170 folder

DRAFT#2 9/`01

MORTALITY REVIEW

INSTRUCTIONS: Attach all applicable institutional Policies / Procedures, Incident Reports, video tapes, Law Enforcement Reports, Investigative Team Reports, Communications, external agency reports, etc.

Inmate / Youth Name: _____ DOC ID #: _____ Gender: M F

Date of Death: _____ Time of Death: _____ Birth date: _____

Assigned facility at death: _____ Date assigned to facility / infirmary: _____

Date of Current Incarceration: _____ Hospital admission date (if applicable) _____

LOCATION OF INMATE / YOUTH AT TIME OF DEATH:

_____ Within Facility: ( ) Health Services Unit / Infirmary ( ) General Housing Unit
( ) Segregation ( ) Other Location: _____

_____ Outside Facility: ( ) Hospital: _____
( ) Emergency Department
( ) Within 24 hours of admission
( ) After 24 hours of admission
( ) In transit

Contracted Facility: _____ Other: _____

Prepared by: _____ Date: _____

CATEGORY OF DEATH: (CHECK ALL THAT APPLY)

_____ CHRONIC ILLNESS
( ) Natural progression of disease process
( ) Acute exacerbation

_____ ACUTE ILLNESS: Death occurred:
( ) Less than 24 hrs. from onset of symptoms
( ) More than 24 hrs. from onset of symptoms

_____ ACCIDENTAL

_____ HOMICIDE

_____ SUICIDE *
* Complete Suicide Review Section

PRIMARY MEDICAL FINDINGS:

A. Preliminary cause of Death: _____

B. Contributory Diagnoses: _____

_____

C. Cause of death listed above based on: _____ Clinical evaluation findings
_____ Preliminary autopsy findings
_____ Death Certificate

Preparer's Signature: _____ Title: _____ Date Completed: _____

MORTALITY REVIEW

Inmate / youth Name: _____ County of Commitment: _____

Current Offense: _____

Sentence Structure: _____

Mandatory Release Date: _____ Discharge Date: _____ Parole Eligibility Date: _____

Latest Parole Action: _____

Description of events leading up to death (chronology – Add a blank page if more space is needed):

Found by whom: _____ Response: _____

_____

Time HSU Called: _____ HSU arrived on scene: _____

Ambulance called: _____ Ambulance at Sally Port: _____ Ambulance at Scene: _____

Names of staff who responded, including HSU: _____

_____

_____

IM/Youth ID#:_____Preparer's Signature:_____Title:_____Date completed:_____

MORTALITY REVIEW

Was family notified of illness / injury? ❒ Yes ❒ No ❒ N/A

If yes, Date / Time: _____

Comments: _____

Was family notified of death? ❒ Yes ❒ No ❒ N/A

If yes, Date / Time: _____

Comments: _____

Recommendations: _____

_____

_____

Actions Taken: _____

_____

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MORTALITY REVIEW

Complete 1-5 for all deaths.

1) Chronology leading up to and including the death. Please include **significant** health issues including Health Service Requests, Sick Call, Scheduled Appointments, Scheduled labs or consults and indicate if they were completed or not completed:

Completed by Health Services

2) Significant medical conditions (contributing to death):

3) Inmate's / youth's current medications:

4) Were there any changes (additions, discontinuations or changes in medication, dose or frequency) in the 3 months before death? ❑ Yes ❑ No
(If "Yes" please detail below.)

5) Was the inmate / youth evaluated and / or followed by specialty consultation? ❑ Yes ❑ No
If "Yes", who?

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MORTALITY REVIEW

Completed by Health Services

6) Did the inmate / youth refuse any medically recommended evaluation or treatment? ❑ Yes ❑ No
Please check all that were refused and provide details to the right:
- ❑ Specialty Consultation
- ❑ Surgical Procedures
- ❑ Medications
- ❑ Dietary Recommendations
- ❑ Other

Is this refusal a potential contributing factor to the inmate's / youth's death? ❑ Yes ❑ No

7) Was this inmate / youth known to have a Terminal Diagnosis? ❑ Yes ❑ No
Is the Cause of Death related to this terminal diagnosis? ❑ Yes ❑ No
If "Yes" please answer the following:
Advanced Directive:

a) Inmate / youth had a Durable Power of Attorney for Healthcare ❑ Yes ❑ No
Inmate / youth had a Declaration to Physicians (Living Will) ❑ Yes ❑ No

b) Does the documentation for the Advanced Directive meet standard? ❑ Yes ❑ No
If "No" please comment:

c) Did this inmate / youth have a Do Not Resuscitate (DNR) order? ❑ Yes ❑ No
If "Yes" does DNR documentation meet standard? ❑ Yes ❑ No
If "No" please comment:

8) Did deceased become pulseless or non-breathing (PNB) in the institution? ❑ Yes ❑ No
If "Yes" please answer the following:

Date / time medical emergency was identified: Date: _____ Time: _____

Was inmate / youth pulseless or non-breathing when discovered? ❑ Yes ❑ No

If no, time of PNB: Time: _____
Was CPR started? ❑ Yes ❑ No Time: _____
Was AED initiated? ❑ Yes ❑ No Time: _____
If CPR was not initiated, was the reason documented in the Medical Record? ❑ Yes ❑ No

Reason: _____

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MORTALITY REVIEW

COMPLETE THE FOLLOWING QUESTIONS IF THE DEATH WAS UNEXPECTED, BUT DID NOT INVOLVE HOMICIDE, SUICIDE OR ACCIDENT:

Completed by Health Services

9) Date last seen in Health Service Unit, prior to death? _____

10) Why was inmate / youth seen? _____

_____

11) Who did inmate / youth see? ❑ MD ❑ NP ❑ PA ❑ RN

12) Last date seen by MD / NP / PA: _____

If not documented in #11 above, why was inmate / youth seen? _____

_____

Recommendations: _____

_____

_____

Actions Taken: _____

_____

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MORTALITY REVIEW

SUICIDE / SUSPECTED SUICIDE INQUIRY

The following information is obtained by review of the Medical Record, Psychological Services File, Incident Reports and interviews with providers, health services unit personnel and appropriate correctional staff in the event of a suspected or known suicide.

1. Was the inmate / youth screened upon arrival at the institution? ❑ Yes ❑ No
   If yes, screening was completed by: ❑ Security Staff ❑ PSU ❑ HSU

2. Is there a history of past attempts at suicide? ❑ Yes ❑ No

3. Did the inmate / youth have a history of Mental Illness? ❑ Yes ❑ No
   If yes, please list diagnostic history: _____

Completed by Psychological Services

4. Crime: _____ Sentence: _____

When was the inmate / youth last seen by Psychological Services? _____

5. Intervention: ❑ Crisis ❑ Individual ❑ Group ❑ Psych. Monitoring

4. When did a Psychiatrist last see the inmate / youth? _____

5. Was the inmate / youth in special status? ❑ Yes ❑ No
   If yes, status was: ❑ non-medical single cell ❑ excused from program ❑ security checks
   ❑ Special Management Unit ❑ Observation Status ❑ Other (Please specify)

8. Did DOC personnel have knowledge of inmate / youth's current suicidal ideation, threats and/or gestures? ❑ Yes ❑ No

If yes, what DOC staff member knew about the threat first? ❑ Security Staff ❑HSU
❑ Psychologist ❑ Psychiatrist ❑ Other List: _____

9. How did they find out?
❑ self-report notes ❑ family contact ❑ collateral reports ❑ behavioral observation
❑ other: _____

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

Completed by Psychological Services

10. Were the following individuals advised of the suicidal ideation, threat or gesture?

Security Staff ❑ Yes ❑ No Date and Time notified: _____
Psychologist ❑ Yes ❑ No Date and Time notified: _____
Psychiatrist ❑ Yes ❑ No Date and Time notified: _____
HSU personnel ❑ Yes ❑ No Date and Time notified: _____
Other: _____ Date and Time notified: _____

11. How was the ideation, threat or gesture handled? ❑ Property restriction ❑ Safety Contract
❑ "On-unit" watch ❑ Multiple Psych. Contacts / wk. (brief) ❑ Observation
Regularly scheduled psychotherapy: ❑ Individual ❑ Group
❑ Control Status ❑ Restraints

12. Rationale for choice of treatment options:

Recommendations: _____

_____

_____

Actions Taken: _____

_____

_____

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MORTALITY REVIEW

NURSING REVIEW

In the month prior to death, were there any HSU visits? ❑ Yes ❑ No

If "Yes" complete the following:

Completed by Nursing Coordinator

Please indicate level of agreement with the following statements using the following scale:
1 = Strongly Disagree 2 = Disagree 3 = Somewhat disagree 4 = Somewhat agree
5 = Agree 6 = Strongly agree N/A = Not Applicable

N1)	Nursing assessments were complete.	1	2	3	4	5	6	N/A
N2)	Appropriate referrals to advanced practitioners were made.	1	2	3	4	5	6	N/A
N3)	An appropriate plan of care was developed.	1	2	3	4	5	6	N/A
N4)	Order transcription was timely.	1	2	3	4	5	6	N/A
N5)	Communication of diagnostic test results was timely.	1	2	3	4	5	6	N/A

N6) Comments or concerns related to nursing care:

Recommendations: _____

_____

_____

Actions Taken: _____

_____

_____

Check here if review needs to be expedited. ❑

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MEDICAL REVIEW

Completed by Medical Director

Please indicate level of agreement with the following statements using the following scale:
1 = Strongly Disagree 2 = Disagree 3 = Somewhat disagree 4 = Somewhat agree 5 = Agree
6 = Strongly agree N/A = Not Applicable

M1)	The assessment was complete and appropriate to the complaint.	1	2	3	4	5	6	N/A
M2)	Appropriate diagnostic tests were ordered.	1	2	3	4	5	6	N/A
M3)	Appropriate actions were taken based on diagnostic results.	1	2	3	4	5	6	N/A
M4)	Appropriate consultations were requested.	1	2	3	4	5	6	N/A

M5) Comments or concerns related to medical care:

Recommendations: _____

_____

_____

Actions Taken: _____

_____

_____

Check here if review needs to be expedited. ☐

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____

MENTAL HEALTH REVIEW

Completed by Mental Health Director

Please indicate level of agreement with the following statements using the following scale:
1 = Strongly Disagree 2 = Disagree 3 = Somewhat disagree 4 = Somewhat agree 5 = Agree
6 = Strongly agree N/A = Not Applicable

MH1) The assessment was complete and appropriate to the complaint. 1 2 3 4 5 6 N/A

MH2) Appropriate diagnostic tests / drug levels were ordered. 1 2 3 4 5 6 N/A

MH3) Appropriate actions were taken based on diagnostic results. 1 2 3 4 5 6 N/A

MH4) Recommendations, comments or concerns related to mental health care:

Recommendations: _____

_____

_____

Actions Taken: _____

_____

Check here if review needs to be expedited. ☐

IM/Youth ID #: _____ Preparer's Signature: _____ Title: _____ Date completed: _____


FORWARD

5/10/01

Meet w/ Charlie Haslett & Jeff Grossman

AB 170

support underlying intent

UW could modify its current process
to review deaths, report findings

internalize process in UW (or alternate w/ MCW)

possibility of sending all deaths to UW
then possible negligence cases to mortality board

Dr. Jeff Wells, liaison to DOC
(familiar w/ security background

DOC undergoing change in medical directorship

create blue ribbon task force to
evaluate health care in DOC
(limited-term, not permanent committee)

price of accreditation = $5,000

adoption of standards

mortality review by medical College?
coroner or medical examiner from
County w/o correctional facility?

at least one board certified forensic pathologist?

10 ~~members~~ 11 members

4+4+2 who ~~appoints~~ - deans of medical schools?
Sec'y appoints ~~two~~ three

dept. report deaths w/in 72 hrs.?
parallel info: a ~~federal~~ requirement

committee has privileged access to records

act as peer review
meet quarterly - Send final reports to Sen. Pres., Assembly Speaker
committee act as reporting agency
recommend changes to dept.

2 co-chairs (one from MCW, one from CLW)

send report to DOC & family
require electronic medical record - check w/ corrections, Leg Council
require screening for STDs

AB 170 folder

date?

page #4

Budge Request book

Info Technology & Systems

≠ 9 million

use for pilot program to transmit medical records

set up meeting w/ DOC & LFB