King County

King County Ombudsman's Office

FINDINGS AND RECOMMENDATIONS

Respondent: Public Health—Seattle & King County,
Jail Health Services
Ombudsman Case No. 2007-01436
April 15, 2008

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EXECUTIVE SUMMARY

Lynn Dale Iszley was booked into the King County Correctional Facility on July 16, 2007, and soon began exhibiting symptoms consistent with alcohol and heroin withdrawal. Mr. Iszley's symptoms worsened in the early morning of July 18, and his condition deteriorated until his death in the early morning of July 19. The cause of death was acute peritonitis[1] due to a perforated ulcer.

Corrections officers, who are employed by the Department of Adult and Juvenile Detention, appear to have acted appropriately and commendably by responding to Mr. Iszley's condition in a timely and professional manner.

However, based on our independent review of the record and on the opinion of our expert consultants who reviewed Mr. Iszley's medical records, we find that Jail Health Services (JHS), a division of Public Health—Seattle & King County (DPH), failed to provide Mr. Iszley with the medical care he needed. Based on his symptoms, JHS providers should have, but failed to, recognize that Mr. Iszley was suffering from an acute illness other than withdrawal. Mr. Iszley should have received intravenous fluids and been transported to a hospital emergency room on July 18, 2007. Mr. Iszley might have survived had JHS taken these actions.

This Office transmitted its preliminary findings to DPH along with recommendations for improvements. We recommended that JHS review the actions of each JHS employee involved in Mr. Iszley's care, evaluate whether discipline is appropriate, and take steps to ensure that the mistakes made in Mr. Iszley's care are not repeated. We provided DPH with an opportunity to respond to our preliminary findings and recommendations. DPH elected not to respond to our findings, but responded to our recommendations by describing JHS' ongoing efforts to improve its systems of care.

ALLEGATION

At the request of the deceased's next of kin, this Office investigated whether Lynn Dale Iszley received adequate medical care while he was in custody at the King County Correctional Facility.

[1] Peritonitis is an infection of the lining of the inner abdominal wall. http://www.mayoclinic.com/health/peritonitis/DS00990, accessed online, March 13, 2008.

INVESTIGATIVE AUTHORITY

The King County Ombudsman's Office was created by the voters of King County in the County Home Rule Charter of 1968 and operates as an independent office within the legislative branch of King County government. The Office is authorized to investigate the administrative conduct of King County agencies in response to complaints received from the public, or on its own initiative.[2] The Office promotes public confidence in King County government by responding to issues in an impartial, efficient and timely manner.

PROCEDURAL HISTORY

This investigation commenced on July 19, 2007, when this Office received a telephone call from a concerned King County resident regarding an alleged inmate death that morning at the King County Correctional Facility (KCCF).[3] After confirming the death of inmate Lynn Dale Iszley, and the cause of death, this Office sought and obtained relevant investigative records from the Seattle Police Department. Following an internal investigation by the King County Department of Adult & Juvenile Detention (DAJD), this Office obtained and reviewed the complete, unredacted DAJD investigative file, which contains command reviews of the incident, officer reports, deck logs, and other relevant records.

This Office met with Mr. Iszley's mother, who filed a formal complaint seeking an evaluation of the medical care her son received at KCCF. Mr. Iszley's mother also signed a release of information form allowing this Office full access to Mr. Iszley's medical records from Harborview Medical Center (HMC), Jail Health Services (JHS), and the King County Medical Examiner's Office. After reviewing all of the above-noted records, this Office sought expert review of Mr. Iszley's medical records from Dean Dellinger, M.D., and Lori Kohler, M.D. Their reports are attached to this report as Appendices B and C, respectively.

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[2] King County Code (KCC) section 2.52. In addition, the Ombudsman's Office investigates alleged violations of the King County Employee Code of Ethics (KCC 3.04) and the Lobbyist Disclosure code (KCC 1.07), and reports of improper governmental action under the Whistleblower Protection Code (KCC 3.42).

[3] The telephone call was from the mother of a King County Correctional Facility (KCCF) inmate who said her son told her another inmate, whom corrections officers had allegedly assaulted the night before, had died that morning. This Office relayed these allegations to KCCF staff members, the Seattle Police Department (SPD), and the King County Medical Examiner's Office. Later on July 19, 2007, this Office spoke with the pathologist who performed the autopsy on Lynn Dale Iszley. The pathologist stated that Mr. Iszley had died a natural death and that there is no evidence to support the allegation that Mr. Iszley had been assaulted. SPD's investigation supports that conclusion. This Office's independent review of the record in this case, including medical records, inmate witness statements, and corrections officers' reports, also supports that conclusion.

Based on Dr. Dellinger's report, which was completed on February 22, 2008, this Office transmitted preliminary findings to the director of Public Health—Seattle and King County (DPH), on March 14, 2008, and requested a response by April 11, 2008. Dr. Kohler completed her report on March 25, 2008, and this Office transmitted it to DPH that same day. As Dr. Kohler's findings are substantially consistent with Dr. Dellinger's, this Office requested that DPH honor the April 11 reply deadline. This Office received DPH's response to our preliminary findings on April 11, 2008. These final Findings and Recommendations follow.

Senior Deputy Ombudsman Jon Stier led this Office's investigation into Mr. Iszley's death, with assistance and oversight from King County Ombudsman Amy Calderwood, and with assistance from other Ombudsman's Office staff members.

SUMMARY OF KEY FACTS

This Office has produced a chronology of events which is attached to this report as Appendix A. We provide this summary for the reader's convenience.

Mr. Iszley was arrested on the afternoon of July 15, 2007. Before he was booked, a JHS employee conducted a medical screening of Mr. Iszley. The screening noted bleeding on Mr. Iszley's right wrist, and skin sores on his buttocks and legs. Booking was deferred, and Mr. Iszley was taken to HMC, where he was diagnosed with abscesses and prescribed Bactrim, an antibiotic. Mr. Iszley was then transported back to KCCF and booked very early in the morning on July 16, 2007.

Mr. Iszley told JHS staff that he used heroin and alcohol daily. On the evening of July 16, Mr. Iszley appeared to be experiencing opiate withdrawals, and had been vomiting. JHS staff provided him with medication intended to help stop the vomiting.

A JHS physician evaluated Mr. Iszley on the morning of July 17. Mr. Iszley had open and scabbed wounds on his right buttock and calf. The physician diagnosed Mr. Iszley with alcohol and opiate withdrawal, and ordered antibiotics for the open wounds.

In the early morning of July 18, Mr. Iszley pressed the emergency call button in his housing unit. A corrections officer responded, and found Mr. Iszley curled on his bunk. Mr. Iszley said, "I think my liver exploded," and reported "kicking alcohol." A corrections officer made a medical status II call,[4] and a JHS staff member soon arrived. Mr. Iszley complained of abdominal pain "like never before," including pain when lying on his right

[4] A Medical Status II call is appropriate for a "[p]otential life-endangering medical problem and/or inmate unable to be moved". JHS Operating Procedure J-E-08(3).

side. He was sweating and writhing. After examining Mr. Iszley, the responding JHS staff member cleared him to remain in his housing unit.

Later on the morning of July 18, a nurse was called to Mr. Iszley's housing unit. The nurse found Mr. Iszley lying on the floor, sweating, with tremors, and complaining of vomiting, nausea, and inability to eat or drink. The nurse notified a JHS physician, who ordered Mr. Iszley transported to the jail clinic. The physician's notes, entered later that morning, record that Mr. Iszley's symptoms were increasing, and that Mr. Iszley was dehydrated. The physician ordered vital signs three times daily, rehydration fluids, and observation in detox housing within the jail infirmary. Mr. Iszley's records show a low blood-oxygen saturation rate in the morning and low blood pressure in the afternoon. His infirmary admission note states that he denied voiding his bladder since the morning of July 15. He was administered 400mg of Motrin.

Mr. Iszley complained of rib pain, chest pain, and pain in general during the night of July 18 and/or early morning of July 19. During medication pass on the early morning of July 19, Mr. Iszley stumbled when he tried to stand. Two other inmates helped him to the floor. Mr. Iszley did not eat his breakfast.

Shortly after 7:00 a.m. on July 19, a corrections officer attempted to wake Mr. Iszley, but he did not respond. The officer called a nurse, who also could not wake Mr. Iszley. The officer made a medical status III call.[5] JHS personnel arrived and attempted to revive Mr. Iszley. Mr. Iszley was declared deceased at 7:50 a.m. An autopsy conducted by the King County Medical Examiner's Office concluded that Mr. Iszley died of acute peritonitis due to perforated duodenal ulcer.[6]

EXPERT REVIEW

This Office obtained review of Mr. Iszley's medical records from two physicians who practice and teach outside of the Seattle area. Each possesses experience and expertise specifically relevant to Mr. Iszley's medical care.

Dean Dellinger, M.D., was certified by the American Board of Internal Medicine in 1995, and serves as an Assistant Professor of Medicine in the Internal Medicine Division of Oregon Health and Science University in Portland, Oregon. Lori S. Kohler, M.D., an expert in correctional health, is Professor of Clinical Family and Community Medicine at

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[5] A Medical Status III call is appropriate for a "[c]ritical, life-threatening emergency." JHS Operating Procedure J-E—8(4).

[6] Mr. Iszley's mother, and a friend of Mr. Iszley's interviewed by this Office, stated that Mr. Iszley knew he was suffering from an ulcer, and had obtained treatment for it from medical providers. However, Mr. Iszley's records do not contain any indication that he told corrections staff or jail health staff about the ulcer.

the University of California, San Francisco, and serves as Director of the Correctional Medicine Consultation Network.[7]

Prior to this case, this Office had no relationship with either Dr. Dellinger or Dr. Kohler, and neither of them knew that the other was reviewing Mr. Iszley's medical records. Dr. Dellinger's report is attached to this report as Appendix B. Dr. Kohler's report is attached as Appendix C.

Overall, Dr. Dellinger identified the following problems with the care that JHS provided to Mr. Iszley:

- JHS staff initially failed to document that they continued Mr. Iszley's antibiotic prescribed by HMC.
- Monitoring vital signs twice per day was not consistent with hospital practice.
- Documentation of patient history was limited.
- Abdominal pain and lack of voiding were not specifically noted as negatives or positives in MD history.
- Chart contains no documentation of evening vital signs.
- More careful evaluation of hydration status would have been appropriate.
- Full orthostatic vital signs were not taken during July 18 medical status II call.
- Low oxygen saturation level noted on the morning of July 18, if accurate, required more urgent evaluation.
- Tachycardia (heart rate above 100 beats per minute) such as that experienced by Mr. Iszley is associated with acute illness as well as dehydration and withdrawal, but JHS did not transport Mr. Iszley to the emergency room.

Dr. Dellinger stated his opinion that "the patient should have been transferred to the emergency room by mid afternoon of 7/18/08 (sic)". In this regard, Dr. Dellinger wrote,

> In Mr. Iszley's case the severity of the pain and the fact that he localized his abdominal pain should have raised concerns earlier for another source of his abdominal pain after his evaluation early 7/18/07. Neither of [the JHS physician's] evaluations on the 18th listed any alternative causes for the abdominal pain, such as gastritis, ulcer, pancreatitis—all of which are more likely in the setting of alcohol abuse.

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[7] The Correctional Medicine Consultation Network (CMCN) is a program of the Department of Family and Community Medicine at the University of California, San Francisco, in collaboration with the California Department of Corrections and Rehabilitation (CDCR). CMCN's mission is to improve the quality of healthcare, the dignity, and the quality of life of inmates in California prisons, through, among other things, peer education and professional development for CDCR clinicians, assessment of care and consultation for high risk patients, and evaluation of medical care delivery systems. http://www.ucsf.edu/cmcn/index.html, accessed online, April 7, 2008.

Regarding Mr. Iszley's apparent worsening dehydration on the morning of July 18, Dr. Dellinger noted that Mr. Iszley's records reflect that full orthostatic vital signs[8] were not taken during the medical status II call. This was not consistent with the relevant standard of care, according to Dr. Dellinger. He further stated that Mr. Iszley's report of not voiding his bladder for three days,

> would suggest severe dehydration and possible renal failure. These signs of dehydration, and especially the lack of voiding in the face of 2 days of antiemetics[9] should have warranted—at the least—IV hydration and closer monitoring. . . . [Mr. Iszley's] low BPs and persistent tachycardia[10] are concerning for worsening dehydration and other more acute illness. . . . the standard of care would have been starting IV fluids at 9am or at the latest 1pm—and had vital signs repeated every 2-3 hours.

While Dr. Dellinger could not identify the exact time when Mr. Iszley's ulcer perforated, "the most likely time would have been early on the morning of the 17th [when he] complained of the most severe abdominal pain." Dr. Dellinger concluded that while Mr. Iszley's substance abuse history would have reduced his chance of survival, "Mr. Iszley's chance of survival would have been significantly improved if he had been diagnosed with perforation within 12-24 hours of the event" and Mr. Iszley "likely would have benefited" from transfer to a hospital emergency room on July 18.

Dr. Kohler's findings are consistent with those of Dr. Dellinger. Dr. Kohler wrote,

> It is obvious from reading the records that his [Mr. Iszley's] was not a case of the usual withdrawal syndromes from etoh [alcohol] and heroin. . . . This patient had an 'acute abdomen' and should have been transferred to an emergency room where prompt surgical evaluation most likely would have saved his life. JHS did not respond appropriately to multiple signs and symptoms that should have prompted immediate transfer to a higher level of care.

Dr. Kohler's report specifically criticized JHS for keeping incomplete patient records, failing to perform various tests indicated by Mr. Iszley's symptoms, and failing to take appropriate action based on the information JHS had.

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[8] Orthostatic vital signs are "serial measurements of blood pressure and pulse taken with the patient in supine, sitting, and standing positions . . . ." http://enw.org/Research-Orthostatic.htm, accessed online, March 12, 2008.

[9] Antiemetics are drugs that prevent vomiting. http://www.britannica.com/eb/topic-27951/antiemetic, accessed online, March 13, 2008.

[10] Tachycardia is a heart rate above 100 beats per minute. http://www.mayoclinic.com/health/tachycardia/DS00929, accessed online, March 13, 2008.

OMBUDSMAN FINDINGS

This office makes findings based on a preponderance of the evidence standard of proof. A preponderance of the evidence means we are persuaded, considering all the available evidence, that the facts at issue are more likely true than not true.

While corrections officers appear to have responded promptly and appropriately to Mr. Iszley's medical condition, based on our review of the complete DAJD investigative file, Mr. Iszley's medical and autopsy records, and the analyses provided by Drs. Dellinger and Kohler, this Office finds that JHS failed to provide Mr. Iszley with the medical care he needed while he was in custody at KCCF. Mr. Iszley was observed suffering from severe localized abdominal pain and other intense symptoms on the morning of July 18, 2007, and yet he was initially cleared to remain in his general population housing unit. He was later transferred to the infirmary, but the anti-vomiting medications and attempts at oral hydration were not working. Moreover, Mr. Iszley's vital signs, including persistent tachycardia, and his overall deteriorating condition, indicated the possibility of acute illness. JHS should have transferred Mr. Iszley to the emergency room on July 18. JHS's failure to do so may have contributed to Mr. Iszley's death.

We note that symptoms of perforated ulcer and peritonitis may overlap with those of opiate and alcohol withdrawal, thereby complicating diagnosis in cases such as Mr. Iszley's. Lay observers might initially assume that withdrawal symptoms would fully mask the symptoms of acute illness present here. However, as Dr. Dellinger's and Dr. Kohler's reviews establish, professionally-trained medical providers should have recognized and acted on Mr. Iszley's symptoms that indicated the presence of illness more acute than withdrawal.

RECOMMENDATIONS AND CONCLUSION

While this Office's investigation focused on determining the appropriateness of the medical care that JHS provided to Mr. Iszley, in our preliminary report to DPH we also recommended that in response to Mr. Iszley's death, JHS should review the actions of each JHS employee involved with Mr. Iszley's care, and evaluate whether to discipline employees found to have violated relevant medical standards of care, or those who otherwise deviated from applicable protocols.

We also recommended that JHS undertake a comprehensive review of how it responds to inmates in severe pain, how it determines whether to transport patients to the emergency room, and how it evaluates patients for acute illness when those patients suffer from complicating symptoms such as those associated with alcohol and heroin withdrawal. We further recommended that JHS assess its basic care protocols, such as documentation of continued dosing of medicines prescribed by HMC providers, and the number of times per day vital signs are checked. Finally, we recommended that JHS

further assess its quality improvement program to ensure adequate continuity of care and that apparent lapses in care are detected before, rather than merely after, catastrophic results.

While DPH's response does not address the specifics of Mr. Iszley's case or this Office's findings, DPH did discuss its ongoing efforts to improve JHS systems of care. (See Appendix D to this report.) It is unclear from DPH's response whether all of the stated improvements were initiated following Mr. Iszley's death. However, Mr. Iszley's death may have been preventable, and this Office therefore urges JHS to ensure that its review of this case is complete and, where necessary, to fully institute reforms that will ensure that future patients receive the medical care they need while in King County custody. We look forward to learning more about DPH's efforts to improve in the future.

Ombudsman Case No. 2007-01436

APPENDIX A

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APPENDIX A

CHRONOLOGY

DATE/TIME	EVENT	SOURCE/NOTES
7/19/07 11:00 am	Autopsy commenced. Cause of death: acute peritonitis due to perforated duodenal ulcer. Manner of death classified as natural.	King County Medical Examiner Autopsy Report, signed 9/10/07 by Associate Medical Examiner; Certificate of Death
7/19/07 8:00 am	JHS personnel conduct debriefing in medication room.	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007
7/19/07 7:50 am	Iszley pronounced deceased.	Jail Incident Report, dated 7/19/07, by Officer G. Vigil; Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/19/07 7:46 am	Life saving measures stopped per direction of Medic One personnel.	Jail Incident Report, dated 7/19/07, by Officer 2; Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/19/07 7:37 am	SFD/Medic One personnel on scene. CPR continues.	Jail Incident Report, dated 7/19/07, by Officer 2; Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/19/07 7:34 – 7:47 am	Other inmates from Iszley infirmary tank interviewed by DAJD: Inmate 1 said Iszley began to fall during breakfast med pass, & Inmate 1 caught Iszley & helped him to the floor; Inmate 2 said he helped lower Iszley to his mattress & that Iszley had been complaining of rib pain; Inmate 3 said Iszley could not get up and had been complaining of chest pain and pain in general; Inmate 4 said Iszley was not eating.	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/19/07 7:27 am	JHS doctors and nurses arrive on scene and assist CPR. Other inmates relocated.	Jail Incident Report, dated 7/19/07, by Officer 2; Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.

7/19/07 7:05-7:26 am	Iszley not responding when name called for detox treatment. Officer attempts to wake Iszley without success. Officer requests assistance of nurse as it appears Iszley not breathing. Nurse responds immediately. Officer calls medical status 3. "On 7/19/07 I (C/O [2]) was assigned to work the Infirmary 1 position. At 0630 I entered J Dorm to perform the initial headcount and security check. All inmates were alive and accounted for at this time. I conducted the next security check at 0700 and again all inmates were alive and accounted for. At 0705, RN Flor asked for the detoxers to come out for their treatments. At 0706, I entered J Dorm again to bring out some of the detoxers. At this time, five came out to see the nurse. The next group would come out when the first five were finished. At 0724, I entered J dorm to bring out the last five detoxers. I/M Iszley, Lynn BA 207030519 was not responding when I called his name. As I approached him, he was on his mattress laying on his right side uncovered by his blanket. I then went to shake him to see if I could get him to wake up and he was still uncooperative. I looked at his chest and I could not tell if he was breathing or not. I exited the tank and asked RN [Nurse 1] to come check him out. We entered the tank and RN [Nurse 1] tried to awaken him but was also unsuccessful. At 0726 I called Central Control via radio and requested a Medical Status 3. . . ."	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007; Deck Log, 7/19/07. NOTE: "Nurse [1] and Provider [] on deck." Jail Incident Report, dated 7/19/07, by Officer 2
7/19/07 5:15 am	Breakfast served in infirmary. Iszley does not eat.	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/19/07 5:00-5:15 am	During morning medication pass, Izsley attempts to stand but stumbles. Two inmates catch & assist Izsley to the floor, where his mattress is. Iszley previously complaining of rib pain according to inmate witness. Inmate said Iszley could not get up and had been complaining of chest pain and pain in general. Inmate said Iszley was not eating.	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/18/07 – 7/19/07 night	". . . none of the subjects [inmates] reported any disturbances or other problems in the cell during the night. There was mention that Mr. Iszley had complained about 'not feeling well'". "On Wednesday night, July 18, 2007, I was assigned to the Infirmary. I do remember inmate Iszley, Lynn – BA 207030519 as being housed in J Dorm. He came to the door of J Dorm as required during medication pass to receive his medication. He was given a shot by the medication nurse. Throughout the night as I was doing my security checks he was awake and asked me	SPD Follow-Up Report, dated 7/25/07, by SPD Homicide Sgt. Officers Report, dated 7/24/07, by Officer 3; Infirmary Security/Surveillance Log, dated 7/19/07

7/18/07 – 7/19/07 night (continued)	questions. He said I looked familiar and what high school did I go to. He asked if there was a temporary release for him in the computer, everytime I got to J Dorm he would ask me a question. During the morning medication pass he got up to ask for medication, he stumbled and was helped back to his bunk. The medical nurse alerted the R.N. who at that time went to J-Dorm and checked to see if he was alright. I gave him a breakfast tray at his bed and he looked up at me and said thank you. The last I saw of inmate Iszley was at my last security check at 0600hrs."	
7/18/07 3:35 pm	Diagnosis/Problem: Polysub abuse, dehyd P[ulse?] 126/142 BP 103/80 102/79 Temp 98' A/O c/o n/v/d ped IL 0 trembling	Multiple Treatment Form – Infirmary, signed by [?] 2547E
7/18/07 2:12 pm	Started meds: Motrin 400 mg tabs: 1 tab oral(po) QID, KOP T.O. [JHS physician]	Infirmary Admission Note 7/18/07 13:16
7/18/07 1:16 pm	BP 81/63 (standing) 99/69 (sitting) Pulse 135 (standing) 135 (sitting) Temp 97.8 (oral) Appearance: "brought from med. Status II 9th floor, weak, shaky, demanding, with several c/o's, sitting on the floor c/o back pain." Heart: tachycardic Abdomen: cramping, tender on palpation Back: Most LBP with inc tenderness to light palpation Genitourinary: denies voiding since sund. 07/15/07 on AM	Infirmary Admission Note 7/18/07 13:16
7/18/07 10:03 am	"Dehydration first observed"	Infirmary Admission Note 7/18/07 13:16, signed by [Nurse 1], RN
7/18/07 9:50-9:55 am	Iszley transferred to Infirmary Housing Unit "Detox" tank	DAJD Deck Log for 7/18/07; Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/18/07 9:44 am	BP 133/69 (supine) 105/69 (sitting) Pulse 95 (supine) 86 (sitting) Temp 95.8 (L ear) SO2 86% Medicatons: Pepto-Bismol 262 mg, 2 tabs oral(po) QID OTC as need Phenergan 25 mg, 2 tabs oral(po) TID SD only Promethazine HCL 25mg/ml, intra-musc Septra DS 800-160mg, 1 tab oral(po) BID <u>Subjective</u>: "severe cramping, aching, dizziness and weakness, continued N/V/D w/o relief with meds since yesterday." <u>Objective</u>: Pale, weak, in W/C, writhing. Abdomen soft,	Medical Provider Progress Note 7/18/07 9:44 am, signed by JHS physician. Meds ordered by [Nurse 2], ARNP.

7/18/07 9:44 am (continued)	diffuse tenderness, ? active BS. Neurologic: + - tremor. Skin: cool, sticky, no change from 7/17/07. Assessment and Plan: Opiate W/D – Increased Sxs without relief, now dehydrated. Will move to 7W Obs for [incr.] management. r/o EtOH W/D – Doubt dominate contributor to current presentation and last drink 4 days ago per pt. Procedures ordered: Rehydration fluid Q shift: dehydration Procedures ordered: EM – 99213 – EST – 15 minutes – EPF, EPF, L: rule out opiate withdrawal, dehydration, alcohol withdrawal, etoh, detox, TRANSFER TO 7W NON-INFIRMARY STATUS: Dehydration VITAL SIGNS – BID X3 Days: Dehydration, rule out opiate withdrawal	
7/18/07 9:10 am	BP 110/90 (sitting) Pulse 108 (sitting) Temp 96.7 (L ear) Resp 18/min	Nursing Progress Note, 7/18/07 9:10 am, signed by [Nurse 3], RN
7/18/07 8:50 am	Triage [Nurse 3] "called to pts cell, to find pt laying on the floor and extremely diaphoretic and tremulous Was not able to sit up without assistance, pt c/o not being able to drink or eat, and emisis and nausea Vs at this time were taken, and med notified Dr. [JHS physician], gave vo; TO BRING PT VIA WHEEL CHAIR TO BE SEEN NOW IN CLINIC, pt was transferred by officer and RN 571 WAS FILLED OUT" "On 7/18/07, I was assigned as the second Triage Officer conducting my duties on the ninth floor, when C.O. 4, who was assigned to South 9, requested the triage team presence, to please come to his wing and see a very sick Inmate, who was named Iszley. The assigned ninth floor nurse was [Nurse 3] and she took Inmate Iszley vitals, did a medical assessment, called the clinic and talked to the medical provider. [Nurse 3] then requested me to go, retrieve a wheelchair and transport this Inmate to the clinic per Dr. [JHS physician]. I complied, the nurse and myself escorted Inmate Iszley to the clinic, where he was admitted into the infirmary for medical observation on that day."	Medical Provider Progress Note 7/18/07 9:44 am. Nursing Progress Note, 7/18/07 9:10 am, signed by [Nurse 3], RN Officer Report, dated 7/19/07, by Officer 5
7/18/07 6:28 am	BP 120/80 (supine) Pulse 60 Resp 18/min S: Seen on Med Stat II. c/o abdominal pain "like never before." Admits withdrawing from heroin. Hurts to lie on R side. O: I/M sweating, doubled over lying in bed. Abdomen soft, nondistended. RLQ tenderness and RCVA tenderness. See vs. Pupils 4-5 mm. Receiving meds for heroin w/d and abx. A: Abdominal pain probably due to heroin w/d P: report to day shift RN to follow-up in triage.	Nursing Progress Note, signed by [Nurse 4], RN

7/18/07 4:39 – 4:49 am	"Inmate Iszley, Lynn (B/A# 207030519) pushed the Lower-D dayroom button. I looked down to see him curled up on his bunk by the door. I asked him what was wrong. He moaned and said 'I think my liver exploded.' I called floor control with that information and a medical status II was called at 0440 hours. Officers [7] and [8] arrived immediately, followed by Sergeant [3] and Officers [9] and [10]. Nurse Cynthia arrived at 0443 hours. Inmate Iszley was evaluated and cleared to stay in Lower-D. The medical status II was cleared at 0448 hours." ". . . I found I/M Iszley laying on his bunk writhing in pain and moaning loudly. I asked him what was happening and his (sic) said it 'felt like his liver exploded' (sic) and wanted to go to the hospital. When JHS arrived, they examined him and took vital signs. All tests were within acceptable ranges. JHS [Nurse 9] said he remembered I/M Iszley from ITR and said he was withdrawing from heroin and alcohol. The inmate confirmed that he was still 'kicking alcohol', but that he was over his heroin withdrawal. JHS determined to refer I/M Iszley to the clinic for further testing but allowed him to remain in his current housing. The code was cleared at 0449 hours." "0442....Medical Status 2, 9 South LD. I/M Iszley, Lynn (07-30519) says he felt like his "liver exploded". I/M Iszley is kicking alcohol and heroin. JHS examined I/M Iszley and cleared him to remain in his current location. IT# 07-1093. Sgt. [2]." ". . . When I asked what was wrong he was moaning and said "I think my liver exploded." . . . At 0442 hours Sergeant [3] arrived along with Officers [9], [10] and [Nurse 10] and [Nurse 9]. [Nurse 4] arrived at 0443 hours. Inmate Iszley was evaluated and cleared to remain in lower-d."	DAJD Deck Log for 7/18/07, 9 South. DAJD Supervisors Incident Report, 7/18/07, by Sgt. 2. DAJD Roster Notes for 7/17/07 Jail Incident Report, dated 7/18/07, by Officer 6
7/17/07 1:30- 4:00 pm	Izsley in court re criminal charges.	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/17/07 10:57 am	BP 128/70 (sitting) Pulse 72 Temp 98 (oral) Resp 16/min Meds: Phenergan 25 mg, 2 tabs oral(po) TID single dos Promethazine HCL 25mg intramusc as dir SUBJECTIVE:Chief Complaint: 47 year-old male with complaint of abscesses, N/V/D 2' heroin w/d. History: R buttock, B calves abscesses x 1 mo, not in shooting sites per pt. Also 3 gm/d IVDU, last hit – yesterday. States drinking 1 qt/d vodka until yesterday. Active problems: open wounds on R buttock, Bilat Les. Heroin	Medical Provider Progress Note, 7/17/07 10:57 am, signed by [JHS physician], MD

7/17/07 10:57 am (continued)	w/d. OBJECTIVE: appearance WD/WN, in NAD. Alert, aware, cooperative, irritable. Nose + sniffles. Lungs clear. Abdomen soft, uncomfortable, Active BS. Musculoskeletal FROM, w/o CCE, pulses equal. Skin: Open, moist, tender, mildly flared wound along dimpled and distorted scar R buttock, with thick brown D/C. Small open, moist wounds Bilat posterolateral upper calves, with crusting but no active D/C. Healed ? wound L posterolateral calf. Closed, scabbed, small linear wound R upper lateral calf. ASSESSMENT & PLAN: Opiate w/d – with symptoms. Will [incr.] management. R/O EtOH w/d – no obvious acute findings, has V/S checks ordered. R buttock wound – With ?purulent D/C noted, minimal flare, located in old scarring. OK empiric Rx awaiting ROI review. B cald wounds – Healing w/o complication. Procedures ordered: EM – 99213 – EST – 15 minutes – EPF, EPF, L: alcohol withdrawal, etoh, detox, rule out opiate withdrawal, wound open buttock. Started meds: Septra DS 800-160mg, 1 tabs oral(po) BID; Pepto Bismol 262 mg tabs, 2 tabs oral(po) QID OTC Wounds redressed. Continue current management plan	
7/17/07 10:25 am	BP 128/70 Pulse 72 Temp 98 (oral) Resp 16/min <eds: Phenergan 25 mg; Promethazine HCL 25 mg S: States, "I am in withdrawals from heroin and I have nausea and I can't keep anything down." Requesting above previous meds-states they helped a lot. O: Slight hand tremors bilat hands, VSS. Given nutria boost packet A: Poss heroin withdrawal P: Ref to provider for new orders. VS BID to continue x3 days. Advised to report or re-kite if s/s worsen. Instruction given for increasing fluids, slowly.	Nurse Note: Triage, signed by [Nurse 5], RN.
7/17/07 8:45 am	BP 128/70 Pulse 72 T 98 R 16	Medical Kite – JHS response by [Nurse 5], RN
7/17/07 8:00 am	Pt complained of "withdrawals – still can't keep water down"	Medical Kite submitted by pt

7/17/07 12:58 am	BP 110/72 (sitting) Pulse 86 (sitting) Resp 18/min Meds: Phenergan 25 mg, 2 tabs oral(po) TID single d. Promethazine HCL 25 mg intra-musc as directed, vo from [Nurse 6], ARNP S: at 12:15 am, 7/17, inmate c/o vomiting, saying he is detoxing. O: v/s 142/70, p81. dry heaves. a/ox3 A: Heroin withdrawal, not ETOH w/d. P: instructed to KITE in AM. Increase fluids.	Nursing Progress Note, signed by [Nurse 7], RN
7/16/07 9:27 pm	BP 110/72 (sitting) Pulse 86 (sitting) Resp 18 S: Seen in treatment room. IM reports "kicking heroin" vomiting all day O: VS – see above. IM actively vomiting. A: Opiate WD P: VO from [Nurse 6], ARNP for Phenergan 25 mg IM x1 then 50 mg PO x 3 days. Started Meds: Phenergan 25 mg tabs 2 tabs oral(po) TID single dose Promethazine HCL 25 mg intra-musc as directed x 1Sd now	Nursing Treatment Sheet, signed by [Nurse 8], RN
7/16/07 5:26 am	BP 121/83 Pulse 74 Temp 96.4 (L ear) Resp 16 SO2 99% Initial observation: bleeding, injury, sores, observable pain. Medical History: Skin sores or infection-mult abscesses; hepatitis. Substance abuse: daily alcohol, seizures, hallucinations when stops drinking or using; currently using; daily drug use: heroin 3 grms qd, last used 12-14 hours. Prescrip meds: Soma. ETOH Eval: Vodka 32-48 oz qd, time since last drink: 12-14 hrs; history of w/drawal symptoms: seizures, shakes. Cooperative, alert. Housing Recommendation: Gen Pop	JHS Receiving Screening Form, signed by [Nurse 9], RN
7/16/07 4:56-5:05 am	Iszley moved to receiving area (S09LD) of jail	Memorandum from Sgt. 1 (SIU/CIU) to KCCF Commander, dated August 22, 2007.
7/16/07 12:25 am	Booked at King County Jail (VUCSA, Disord Cond, Obstructing)	JILS printout 7/20/07

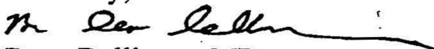
7/15/07 7:00 pm – 7/16/07 12:00 am	Transported by: SPD BP 109/67 Pulse 78 Resp 16 History & Findings: multiple abcesses + chills/sweats. 0 N/V. + D. Diagnosis: Abscesses Discharge Meds: Bactrim	Harborview Medical Center – Emergency Notes
7/15/07 6:30 pm	Cleansed abscesses, referred to Harborview for eval.	DAJD Arrestee Medical Clearance Report
7/15/07 5:44 pm	Izsley declined at jail: Bleeding R wrist, diabetes, skin sores, seizures, daily alcohol, heroin today.	DAJD Deferral Screening,
7/15/07 unknown	EMT contact Meds: Bactrim S: 47 yr old male call to SPD north to cut of handcuff. O: Pt states he has MRSA. Ulcers on rt buttocks both legs. Pt states he has drug resistant MRSA, not compliant w/ meds or med/care A: Pt needs no further med assist. No exam. P: Leave w/ SPD to trans to jail.	Seattle Fire Department Medical Incident Report, signed by SFD ID# 1240
7/15/07 3:05 pm	Iszley arrested next to Cowen Park in Seattle.	DAJD Superform

Ombudsman Case No. 2007-01436

APPENDIX B

APPENDIX B

Review of Medical Records in Ombudsman Case No. 2007-01436
Completed 2/22/08

Dear Mr. Stier,
I have reviewed the records you have sent me regarding the death of King County inmate Lynn Dale Iszley. These records included your offices data review and summary, the Harborview ED records, and the Jail Health Services records including RN and MD progress notes, vital signs and med administration records. I also reviewed the autopsy report. I have done a narrative summary of the records, followed by a summary. If you have any questions about my review please contact me.
Sincerely,

Dean Dellinger, MD
Assistant Professor of Medicine
OHSU
Portland, OR

Narrative Review:

Mr. Iszley was admitted to Jail Health Services after an eval in the Harborview ER for small lower extremity and buttock abscesses on 7/15/07. There he appears to have been appropriately treated and started on TMP/SMZ, a good antibiotic choice for a patient at risk for MRSA.

The jail staff didn't document that they continued this antibiotic, intially. Otherwise, his initial evaluation by jail staff the morning of 7/16/07 was reasonable. His vital signs were stable. He reported past ETOH withdrawal associated seizures. His self reported last use of ETOH and heroin were noted as 12-14 hours prior to admission. His ER blood alcohol level of .13 was consistent with this. Need for wound dressing changes and vital signs BID were noted. He was reevaluated by RN at 21:26 complaining of vomiting all day. Vital signs were stable and antiemetic given.

On 7/17/07 he was reevaluated by RN at 1am. Vital signs were stable. He was still complaining of vomiting, dry heaving in office. Told to increase fluids. RN and Dr. [redacted] eval at 10:25am – vital signs stable. Patient complaining of nausea and stated antiemetic was helping but stated "I can't keep anything down".

Tremors and sniffling were noted, typical withdrawal symptoms. Patient was showing signs of opiate withdrawal more than ETOH withdrawal, but his history of ETOH withdrawal seizure would suggest potential for more serious ETOH withdrawal. In the hospital we monitor patients in ETOH withdrawal with more frequent vitals than twice daily, and monitoring tools that include other symptoms of withdrawal are available and may be used for both types of withdrawal.

Dr. [redacted] examined wounds and restarted the antibiotic recommended by ER 7/15/07. Patient history documented was limited. Abdominal pain and lack of voiding were not specifically noted as negatives or positives in MD hx. Abdominal exam was "uncomfortable" but active bowel sounds and lack of rigidity reassuring. Twice daily vital signs continued but I couldn't find documentation of evening vitals. More careful evaluation of hydration status would have been appropriate, such as documenting fluid intake, voiding, and physical findings such as looking at oral mucosa and performing orthostatics to assess for dehydration. If patient was showing signs of dehydration he should have been observed more closely and IV fluid hydration considered if unable to adequate hydrate orally.

Next patient contact RN eval 7/18/08 4:43am when RN, [redacted], was called to patient's cell by corrections officer to assess abdominal pain. (The deck log states 5 officers saw the patient and a medical status II was called and that the RN saw patient briefly and cleared to stay in cell. RN note entered 6:28am but deck log states RN arrived at 4:43am. Patient described pain "like never before" and worse with lying on right side. Patient was lying in bed doubled over and diaphoretic. Blood pressure and heart rate were taken supine and sitting, but not standing so not full orthostatics. Patient was afebrile. RN exam noted abdomen soft, but with RLQ and RCVA tenderness. Assessment was abdominal pain due to heroin withdrawal. Plan was for patient to follow up in triage with report to day shift RN.

Triage RN, [redacted] was then called by corrections officer to patient's cell at 8:50am to assess patient for severe abdominal pain. Patient found lying on floor of cell, diaphoretic and unable to sit up without assistance. Vital signs were repeated supine and sitting and HR(heart rate) 108 sitting vs. 60 supine. BP(blood pressure) dropped from 120 to 110 with sitting. MD was notified and he gave verbal order for patient to be taken by wheelchair to infirmary immediately.

Dr. [redacted] evaluated patient at 9:44am. Repeat vitals were 105/69 HR 86 sitting and 133/69 HR 95 supine. Oxygen saturation low at 86%, normal respiration reported. History was copied from RN assessment. Dr. [redacted] noted patient "writhing" with diffuse abdominal tenderness and "?active bowel sounds". Assessment was opiate withdrawal. The oxygen saturation of 86% is concerning but it was commented on in the note. If this oxygen saturation was accurate, it would be evidence of severe illness, and would require urgent evaluation. (It is somewhat puzzling, b/c the next two readings taken 4 and 6 hours after were both normal.)

Dr. [redacted] reevaluated patient at 1:16pm and noted c/o of abdominal pain, n/v x2 days, diarrhea, feeling "very dehydrated". Also c/o of "mid and low back pain 10/10 secondary to slip on wet floor." MD noted "denies voiding since Sunday 7/15/07 am". Sitting BP 99/69 HR 135, standing 81/63 HR 135. Oxygen saturation 100%. On exam noted abdominal tenderness and low back tenderness. Assessment was polysubstance withdrawals. Twice daily vitals were continued and antiemetics and presumably oral rehydratoin. Ibuprofen for pain.

Medical record ends with vital signs at 3:35pm: oxygen saturation 97%, sitting BP 103/80 HR 126, standing BP 103/80 HR 142. Patient HR was high and increased with standing. Both are concerning findings. HR>100 is tachycardia and associated with dehydration and acute illness as well as withdrawal. HR increases >10-20 and/or BP drops of 10-20 suggest orthostasis – consistent with dehydration.

Corrections officers' notes report patient was asking questions and was able to stand for medication pass and that he was given a shot by RN. In the morning at 5am he stumbled during med pass and was helped back to bunk. RN was alerted and reportedly checked on patient. Patient was reporting pain to fellow inmates. CO reported last seeing patient at 6am. Next CO reported on his security checks at 6:30am and 7:00am all inmates were "alive and accounted for". At 7:24am patient, Iszley, did not respond to name call and was found unresponsive on exam. Medical team called and unsuccessful resuscitation attempts begun.

Summary:

Medical treatment of patients in opiate (and etoh) withdrawal is complicated by the symptoms and signs of withdrawal which include elevated HR, abdominal pain, diaphoresis, nausea/vomiting, diarrhea, shakiness, and mental status changes. Nonetheless, in Mr. Iszley's case the severity of the pain and the fact that he localized his abdominal pain should have raised concerns earlier for another source of his abdominal pain after his evaluation early 7/18/07. Neither of Dr. ’ evaluations on the 18th listed any alternative causes for the abdominal pain, such as gastritis, ulcer, pancreatitis – all of which are more likely in the setting of alcohol abuse.

The other concerning issue was the patient's apparent worsening dehydration despite antiemetics and oral rehydration. He was orthostatic the morning of 7/18 with a >40 point increase in HR with sitting. Though the HR didn't rise when these were repeated at 9am, the blood pressure dropped almost 30 points – again suggestive of dehydration. Some argue the reliability of orthostatic vital signs in the assessment of fluid status, but they are still the standard of care. The patient also reported not voiding in 3 days would suggest severe dehydration and possible renal failure. These signs of dehydration, and especially the lack of voiding in the face of 2 days of antiemetics should have warranted – at the least - IV hydration and closer monitoring.

Repeated vital signs at 1 pm showed tachycardia to 135 and hypotension with BP<100 sitting. At 3pm the HR was 126 sitting and 142 standing with BPs just over 100. These low BPs and persistent tachycardia are concerning for worsening dehydration or other more acute illness. If related to heroin withdrawal this tachycardia should have appeared earlier probably after 24hours from last use, not at >72 hours, and neither heroin or etoh withdrawal present with hypotension unless the patient is dehydrated or otherwise ill. With his vital signs and his report of not voiding >48hours, the standard of care would have been starting IV fluids at 9am or at the latest 1pm - and had vital signs repeated every 2-3 hours.

Based on the character of his abdominal pain, the issue of dehydration, and persistent tachycardia, it is my opinion that the patient should have been transferred to the emergency room by mid afternoon of 7/18/08. The jail infirmary could have started IV fluids and monitored him more closely at 1pm, and if he didn't improve significantly within a few hours they could have transferred him to the ER. It is likely that he would have benefitted from a transfer during the afternoon of the the 18th.

I read a historical review of perforated peptic ulcers in a surgical journal from 2000. They reported a range of 5-18% mortality for patients under the age of 50. Non-lethal complications ranged from 10% to just over 40% for wound infections, other intraabdominal and extra-abdominal complications. Morbidity and mortality increased with time after perforation, particularly at >12 hours. At >24 hours mortality increased 7-8 fold and complication rate 3 fold. I would estimate >=50% chance of survival if he had been evaluated in the ER within 12-24 hours of the event.

One confounding factor is Mr. Iszley's substance abuse history. Substance abuse and withdrawal alter vital signs increasing heart rate and increasing blood pressure, and alcohol withdrawal increases morbidity and in some cases mortality of comorbid conditions. The confusion associated with withdrawal also makes it more difficult to evaluate patient's medically. Mr. Iszley reported alcohol and heroin abuse, but his autopsy toxin screen also showed benzodiazepines and cocaine as well. If anything, his substance abuse history would reduce his chance of survival. Nonetheless, Mr. Iszley's chance of survival would have been significantly improved if he had been diagnosed with perforation within 12-24 hours of the event.

I don't think it is possible to know when Mr. Iszley's perforation occurred, but the most likely time would have been early on the morning of the 17th. This is when he complained of the most severe abdominal pain, and soon after complained of severe back pain which is associated with perforated ulcers and in some cases peritonitis – inflammation of the abdominal lining. The autopsy report detailed a anterior ulcer with perforation, though posterior ulcers are more likely associated with back pain. The 2500ml of feculent material was probably not present when the staff at the jail examined his abdomen the morning and early afternoon of 7/18/07. That would have been associated with a likely rigid, distended abdomen and other signs of peritonitis. It most likely leaked out over a period of some hours, during the early hours of 7/19 and some after Mr. Iszley expired.

Ombudsman Case No. 2007-01436

APPENDIX C

APPENDIX C

Stier, Jon

From: Kohler, Lori [LKohler@fcm.ucsf.edu]

Sent: Monday, March 24, 2008 11:21 PM

To: Stier, Jon

Subject: RE: Review of Deceased Inmate Med Recs

Hello- my general impressions are not good. There are a number of issues, not the least of which is the charting and the missing data. It is obvious from reading the records that his was not a case of the usual withdrawal syndromes from etoh and heroin. This patient was in extreme pain and he was repeatedly ignored. I see no record of an exam by a physician, no repeat labs-a total bilirubin of 6.5 needs to be addressed, especially in the case of severe abdominal pain- there was no assessment for a GI bleed-no questions, no rectal or stool guaiac test, no cbc, there are multiple notes that indicate this patient was suffering from extreme pain, multiple abnormal vital signs were ignored, there is a question on 7/18 of whether bowel sounds are present- this should have triggered further work up. On the same note, the postural vital signs indicate orthostatic hypotension that was ignored, skin was noted to be cool – all of these signs suggest a potentially serious and grave condition but the plan was to move to 7W for observation and hydration and give Imodium. Upon admission to the infirmary the patient was given ibuprofen- in the setting of severe abdominal pain this is clearly inappropriate.

This patient had an 'acute abdomen' and should have been transferred to an emergency room where prompt surgical evaluation most likely would have saved his life. JHS did not respond appropriately to multiple signs and symptoms that should have prompted immediate transfer to a higher level of care. the treatments given were meant to stop his diarrhea but given that he had feculent material in his peritoneum, he must have suffered from a rupture of his gut and the use of Imodium and Pepto-Bismol may have exacerbated his condition.

From an outside observer perspective is appears to me that they let this man suffer and did nothing. It is unlikely that they would tolerate this kind of agony in a friend or family member and his misery is quite obvious. I am happy to discuss any further details with you. I hope this helps and I apologize for taking so long. Lori

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Patient Appointments
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Ombudsman Case No. 2007-01436

APPENDIX D

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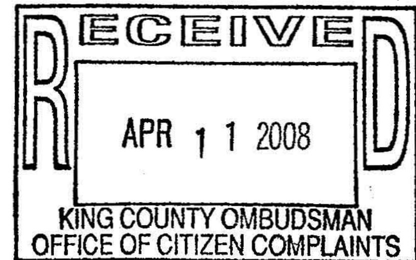
Public Health
Seattle & King County



April 11, 2008

TO: Amy Calderwood, Ombudsman-Director
Jon Stier, Senior Deputy Ombudsman

FROM: David Fleming, M.D., Director & Health Officer
Via: Benjamin Leifer, Chief Administrative Officer

RE: Response to Ombudsman Case No. 2007-01436

This letter responds to your memorandum of March 14, 2008, regarding Lynn Dale Iszley, Ombudsman Case No. 2007-01436. Thank you for requesting our comments regarding an investigation conducted by your office in the death of Mr. Iszley.

While no health care system can completely eliminate the risk of adverse outcomes, we are committed to providing the best quality system of care in Jail Health Services. Health care organizations recognize that sad outcomes do occur, and health care providers regret the loss of any patient. Jail Health Services takes very seriously its responsibility for ensuring that systems of care are appropriate to treat illness and to systematically decrease the risk of adverse outcomes for the patients they serve.

While recognizing the tragic nature of Mr. Iszley's death, it is also important to recognize ongoing efforts to improve systems of care in Jail Health Services. A key method of improving systems of medical care, which includes preventing risks of errors, is the Jail Health Services Quality Improvement (QI) Program. While specific QI reviews cannot be disclosed here (the information is protected and confidential under RCW 43.70.510 and Chapter 246-50 WAC), Jail Health Services is committed to providing the best quality system of care and actively uses its QI program as one means of monitoring quality of care.

Components of the QI Program include Critical Incident Reviews (which evaluate actions of each employee involved in the care of a given patient, as well as review of applicable policies/procedures, training, and equipment) and a Morbidity and Mortality review (this is typically referred to as "M&M" in health care organizations.) At M&M reviews, providers discuss in a step-by-step method each critical decision point in the clinical process of care.

The Pharmacy also has a Quality Improvement Committee, which is a subcommittee of the JHS QI program. Its general process includes reviews of medication-related incidents, including those involving documentation issues and documentation quality at the multiple levels in the pharmacy/medication administration system. Revisions to medication procedures may result from discussions at the Pharmacy Quality Improvement Committee meetings.

The following comments are provided in response to the preliminary recommendations included in your memorandum.

Ombudsman Comment: **"JHS should review the actions of each JHS employee involved with Mr. Iszley's care, and evaluate whether to discipline employees found to have violated relevant medical standards of care, or those who otherwise deviated from applicable protocols."**

Jail Health Services conducted reviews of Mr. Iszlely's case within its QI Program. Due to the confidential nature of these reviews, as referenced above, specifics are not described in this memorandum.

Ombudsman Comment: **"This incident should also prompt JHS to undertake a comprehensive review of how it responds to inmates in severe pain..."**

Jail Health Services already has an ongoing process in place to review and update written guidelines for the care of a number of conditions. This work is performed by the JHS Provider Group, which includes all medical, psychiatric, nursing, and dental providers. The Jail All Staff References folder, located on a shared computer drive and accessible from any computer workstation in JHS, provides immediate access to care guidelines for any line staff member at the point of care.

These guidelines, which are organized by organ/body system, include topics such as: treatment of withdrawal (withdrawal syndromes from various substances are covered separately); pain management (there are separate guidelines for acute pain, chronic non-cancer pain, and pain related to cancer and terminal illness); high blood pressure; high cholesterol; diabetes; schizophrenia; depression; and many others. For example, the guideline on Epilepsy/Seizure Disorders was recently updated and approved by the JHS Provider Group. In another example of ongoing work, the JHS Provider Group has been updating protocols for managing pain, which were initially developed in 2006. This has included a discussion of agreed-upon drugs for use to balance efficacy and safety in a setting where most inmates suffer from medical and mental health or chemical dependency conditions and the potential for diversion is high.

The Nursing Office also has a process to update JHS Nursing Protocols for triage and general nursing practice, and specific protocols have been redesigned to reflect best practice considerations, offering structured guidance to nurses regarding appropriate assessment and referral of the chosen conditions. These protocols take into account the principles of evidence-based medicine, algorithms and practice standards developed by the JHS Provider Group and current referral processes. Each protocol prompts appropriate medical history review, symptom analysis, and referral for further care. Protocols developed to date include those for nursing assessment of abdominal pain, chest pain, headache, substance withdrawal, diabetes, upper respiratory infection, suicidality, and others.

Ombudsman Comment: **"...JHS should review] how it determines whether to transport patients to the emergency room..."**

Both JHS and the Department of Adult and Juvenile Detention are interested in maximizing safety and security for all inmates and staff in King County Jail facilities. JHS conducts regular reviews of random samples of inmates transported from the facility for emergency department evaluation. JHS has developed a clear decision tree for staff to use in determining when to transport for outside medical care of any kind, and this tool has been shared with DAJD.

Ombudsman Comment: **"...[JHS should review] how it evaluates patients for acute illness when those patients suffer from complicating symptoms such as those associated with alcohol and heroin withdrawal..."**

This has long been recognized as an important diagnostic area in JHS. Large numbers of inmates show signs and symptoms of withdrawal to alcohol or opiates while incarcerated. Many of these persons are also suffering from acute or chronic medical problems. The evaluation of these cases is not necessarily different in the initial stages of assessment. A thorough medical history and examination, with the generation of an appropriate differential diagnosis supported by diagnostic testing or emergency room evaluation, is the basis to develop an appropriate treatment plan.

Ombudsman Comment: **"JHS should also assess its basic care protocols, such as documentation of continued dosing of medicines prescribed by HMC providers ...."**

In addition to the provider guidelines referenced above, the JHS Medication Administration Manual (MAM) describes in detail procedures of nearly every aspect of medication administration in Jail Health Services. Updates to the MAM are shared with all staff as they occur, both in writing and in meetings of the various staff disciplines, with major revisions accompanied by all staff face-to-face training sessions and a required post-test on the updated MAM content. New staff are also oriented to the MAM, since so much of the practice involves medication management. The most recent revision to the MAM was completed in May 2007. With the implementation of the Electronic Health Record and 24-Hour Medication Cart Fill in late 2007, another major revision is pending for 2008.

Ombudsman Comment: **"... [JHS should review] the number of times per day vital signs are checked."**

Medical providers may order vital sign checks outside of the Infirmary as needed for specific conditions. If these checks are ordered, then the nurses comply with the specific directions outlined in the order, such as "twice a day for three days."

Vital sign checking also occurs in the Infirmary. Providers may order patients to be admitted to the Infirmary when they need care requiring constant nurse availability. However, if a patient's medical condition or vital signs are unstable, this may indicate a patient who may be considered sufficiently ill to warrant a hospital transfer.

Ombudsman Comment: **"JHS should further assess its quality improvement program to ensure adequate continuity of care and that apparent lapses in care are detected before, rather than merely after, catastrophic results."**

Consistent with QI systems commonly used in health care organizations, the JHS Quality Improvement Program includes regular reviews of documentation of clinical care to ensure that care provided is not only congruent with established guidelines, but overall reflects quality clinical decision-making. Such reviews can help to detect issues with a clinician's care that could lead to a problem, and thus are an important part of error prevention and quality improvement.

Also, review of care provided by JHS staff according to provider guidelines is further reviewed as an essential standard (J-E-12 Continuity of Care During Incarceration) by the National Commission on Correctional Health Care (NCCHC).

Prevention of medical errors is also facilitated by redundancy of systems and improved access to information. When multiple JHS staff (clinical and non-clinical) can access information in the health record at once from varied locations, questions regarding care can be readily answered without having to "look for the chart" or "route the chart to the next location." Likewise, greater involvement of multiple disciplines (providers, nurses, social workers, pharmacy staff, etc.) with access to the same information reduces the chance of "something being missed." This difficult-to-quantify quality improvement gain is one of the greatest potential benefits of the electronic health record, and one that Jail Health Services will try to leverage as staff become more experienced with the product and its features.

Finally, training and education of JHS staff, while always challenging in a two-facility, 24/7/365 operation, can help to raise awareness of high-risk areas of the practice, decreasing the potential for medical errors. The 2008 training calendar already includes Suicide Prevention, Alcohol and other Drug Dependency and Withdrawal, and Wound Assessment and Management.

In summary, it is an unfortunate aspect in health care organizations that adverse outcomes occur, even in the absence of medical errors. While we know that complete elimination of adverse outcomes is impossible in any health care system, we will continue to focus our efforts at JHS on reducing to a minimum the risk of adverse outcomes, while providing the highest quality health care possible to the inmate-patient population.

Thank you again for giving us an opportunity to respond.