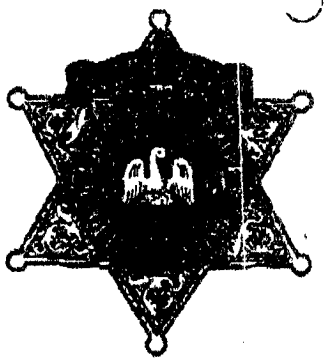

Office of the Criminal Sheriff
Parish Of Orleans • State Of Louisiana

Marlin N. Gusman
Sheriff

For Immediate Release:
May 13, 2005

Contact: Renee Lapeyrolerie
826-7034

SHERIFF GUSMAN REQUESTED INDEPENDENT REVIEW OF MEDICAL OPERATIONS AT ORLEANS PARISH PRISON
Sheriff Releases Results

New Orleans – The Orleans Parish Criminal Sheriff's Office reports the findings of an independent review of the medical operations at the Orleans Parish Prison (OPP). Recently, there have been three deaths at the jail and media inquiries have been made as to the specifics of the health care programs at the Orleans Parish Criminal Sheriff's Office.

The Orleans Parish Criminal Sheriff's Office has a large, comprehensive Medical Department which provides primary care and emergency medicine services to inmates. The department is staffed by 125 heath care personnel, including 13 full-time physicians. The OPP Medical Department is fully accredited with both the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). In August of 2004, the OPP Medical Department was recognized by the NCCHC for outstanding medical care to inmates.

Several weeks ago, an OPP inmate, Mr. John Scott, died as a result of complications from an active tuberculosis infection. A few weeks later, a Deputy Sheriff died from a rapidly progressive pneumonia. Due to the serious nature of these matters and out of concern for the safety of OPP inmates and staff, Sheriff Marlin Gusman invited three independent medical professionals, unaffiliated with the jail, to examine the recent deaths and the jail's infection control program. Tuberculosis experts from LSU Health Sciences Center, Tulane University School of Medicine, and the Louisiana Office of Public Health (OPH) were asked to provide an impartial evaluation of inmate medical care and to specifically examine the case of each person who died.

Mr. Scott was arrested 09/02/04. At the time of booking, he underwent a routine health screening which was unremarkable. Two days later, he had a full history and physical examination which was again unremarkable. On 9/08/05, Mr. Scott was tested for tuberculosis (part of the routine screening performed on all new arrestees). The test was *negative*.

Mr. Scott did well until 02/02/05 when he submitted a routine request to see the doctor. He was seen by an internist on 02/04/05 where he reported a "bad cough." The physician examined Mr. Scott, ordered lab work and a chest x-ray, and prescribed antibiotics for a possible pneumonia. A follow-up evaluation was scheduled as well. A second tuberculosis test was also performed to assess for tuberculosis infection. This repeat test was again *negative*.

Mr. Scott had a follow-up appointment with the physician on 2/18/05. He reported significant improvement in his symptoms. Likewise, his physical examination had also improved after the antibiotics. The physician scheduled another follow-up appointment (in one week) to assess his progress. On 02/24/05, the day prior to his scheduled follow up, Mr. Scott became acutely ill, complaining of shortness of breath. He was immediately transferred to the Medical Center of Louisiana for further care. Unfortunately, despite aggressive medical efforts, Mr. Scott died in the hospital. (Of note, Mr. Scott did not report any medical problems between his appointment on 02/18/05 and 02/24/05 despite the fact that a nurse visited him daily.)

The second death involved an OPP Deputy Sheriff. The deputy died from a severe pneumonia that was completely unrelated to tuberculosis. However, given the seriousness of both events and their temporal proximity, Sheriff Gusman felt compelled to request an independent, impartial review of medical services. The tuberculosis experts were asked to address four specific questions: (1) Did Mr. Scott receive appropriate medical treatment at the jail? (2) Was the Deputy's death related in any way to the death of Mr. Scott? (3) Did the jail's tuberculosis (TB) screening and prevention policies comply with nationally accepted guidelines and recommendations set forth by the Centers for Disease Control and Prevention (CDC)? and (4) Did OPP take appropriate action to protect inmates and staff once an active case of TB was identified?

After a thorough examination of Medical Department policies and a review of pertinent medical records, all three investigators reached the same conclusions. First, Mr. John Scott was provided with appropriate medical care at the jail, care which met accepted standards of good medical practice. Moreover, the experts commented that Mr. Scott had, "adequate access to medical care and medical complaints were promptly triaged and appropriately attended to by the medical staff." Second, the experts concluded that the Deputy's death was not related in any way to the death of Mr. Scott or to tuberculosis infection. Next, they commented that, "TB screening, prevention, and control policies are in accordance with current CDC and national guidelines," ... "screening and prevention policies in place at OPP are completely in accord with the recommendations of experts in the field of tuberculosis control." Finally, the experts universally agreed that the Medical Department's response to an active, contagious case of TB was appropriate. Every effort was made to protect inmates and staff and to limit the spread of infection. In fact, OPH commented that the jail's response, "even exceeded recognized standards for contact investigation, disease detection, and appropriateness of treatment."

Sheriff Gusman remains committed to providing inmates with quality health care, care which equals community standards in terms of quality and timeliness.

Evaluation of the TB Prevention and Control Program for Orleans Parish Criminal Sheriff's Office

March 24, 2005

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1. Introduction

On February 28, 2005, an inmate (JS) was transferred from Orleans Parish Criminal Sheriff's Office (OPCSO) and later died at Medical Center of Louisiana, New Orleans (MCLNO). Also, around the same time, a Deputy of the OPCSO (CB) died at MCLNO after she reported with acute respiratory symptoms to the Emergency Department. At the request of the Criminal Sheriff's Office, we have been asked by the Chancellor's office of the Louisiana State University Health Sciences Center (LSUHSC) and the Departments of Medicine at LSUHSC and Tulane University Health Sciences Center to review these cases and to specifically address the questions outlined below in section 2. We present our report based on the methodology outlined in section 4.

2. Specific questions to be addressed by this review

a. Based on the information available to the Medical Staff of the OPCSO was standard of care provided for inmate JS? Did inmate JS have adequate access to medical care?

b. Is there an adequate Tuberculosis (TB) Surveillance program at OPCSO Medical Division?

c. Was there a failure of TB screening at OPCSO?

d. Is there any correlation between the case of Deputy CB and inmate JS?

3. Background

TB is an individual medical and a societal medico-social public health problem. In the United States, TB remains a major hazard in correctional facilities and constitutes a large reservoir of cases and potential transmission of disease. The transmission of Mycobacterium tuberculosis in this high risk, high prevalence setting is an enormous public health concern for not only the inmates of these facilities but also for the employees of these correctional facilities and eventually for the communities to which these inmates are released. An effective TB control and prevention program for correctional facilities requires not only close surveillance and screening at the entry level but cohesive coordination and collaboration with the Office of Public Health in the region and the affected community medical services.

The Centers for Disease Control and Prevention (CDC) Advisory Council for the Elimination of Tuberculosis advises that all correctional facilities have a TB Infection Control Program that includes three essential components of TB control activities:

(a) Screening-Identifying person who are infected with Mycobacterium tuberculosis (Latent TB Infection) or who have active TB disease; (b) Containment- Prevention of transmission of Mycobacterium in the correctional facility by adequately treating persons with latent infection or active TB disease (c) Assessment- monitoring and evaluating screening and containment activities.[1]

Contacts of persons with active tuberculosis are at risk for developing latent TB infection or active disease. An untreated active TB case can spread the disease to 15-20 persons per year. A contact investigation, therefore, must be initiated promptly after detection of an active TB case in order to identify and medically evaluate contacts at risk for active TB disease or infection[2].

4. Methodology

For the purposes of this evaluation and in preparing the report, we adopted the following methodology

a. Reviewed OPCSO medical record, Mortality Review, and Chest X-Ray (CXR) for inmate JS.
b. Reviewed MCLNO medical record, CXR, and CT scan for inmate JS and Deputy CB for public health review purposes.
c. Reviewed Prevention and Control of Tuberculosis for the OPCSO Manual[3]
d. Reviewed TB Prevention and Control protocol at OPCSO with Dr. Richard Inglese, Medical Director of OPCSO, whose cooperation we acknowledge and appreciate.
e. Review of current medical literature relating to tuberculosis control guidelines for correctional facilities.[1]

5. Summary of review

a. Case JS.
   i. JS is a 24 year old African American male booked at OPCSO on 9/2/04. As per protocol of the facility, an initial health assessment was conducted by a nurse, and the inmate reported no medical problems. A tuberculin skin test was placed on 9/8/04 and was read as negative on 9/10/04.
   ii. On 10/13/04, a "Sick Call" request was placed by the inmate for a rash/hives witnessed by a nurse. The inmate was triaged and sent to the medical unit for evaluation. He was observed overnight and treated with prednisone 40mg daily for three days in addition to Benadryl and Zantac and released on 10/14/04. A follow-up visit on 10/25/04 showed no additional lesions. On 11/15/04, a second "Sick Call" request was made by the inmate for a toothache and he was seen by the dentist on 11/21/04.
   iii. On 12/29/04, inmate JS asked for a "Sick Call" request for a cold with a nonproductive cough. He was triaged by a nurse and a medical appointment was scheduled for 1/4/05. He was seen by a physician and diagnosed with viral upper respiratory infection and prescribed medications for symptomatic relief.
   iv. On 2/2/05, another "Sick Call" request was placed for cough, decreased appetite, and weight loss. He was triaged by a nurse and scheduled for clinic

on 2/4/05. His vitals signs were: temperature of 98.6, pulse of 88, and weight of 128lbs. Physical examination was significant for decreased breath sounds diffuse, rhonchi and wheezes bilaterally, and crackles at the right base. Inmate JS was prescribed Doxycycline 100mg twice day for a 10 day course. In addition, the physician also ordered a CXR and laboratory evaluation consisting of a complete blood count, complete metabolic panel, and thyroid function studies. He was scheduled for a follow-up appointment on 2/18/05.

v. A CXR was taken on 2/5/05. A faxed report of the CXR reading was sent to Infection Control on 2/7/05 with the "Abnormal" box checked off and written statement of "Bilateral upper lobe parenchymal disease. Right greater than left. ?chronic versus acute". Upon review of the CXR report, the Infection Control physician ordered a repeat tuberculin skin test (PPD) and a HIV test. A rapid HIV test was performed on 2/12/05 which was negative and a repeat PPD was placed on 2/12/05 and read on 2/15/05 as negative.

vi. On 2/18/05, inmate JS was seen in the clinic for his two week follow-up by the same physician who had seen him earlier. The clinic note stated inmate's "dry cough persist" but "...feels better". The physician was unaware of the CXR report. Physician noted the abnormal laboratory results from 2/11/05: WBC of 11.9, Hemoglobin 9.2, Platelet 518, Sodium of 129 and Albumin of 2.6. . The physician ordered iron supplement, dietary and fluid supplements, an anemia work up, routine bacterial sputum culture, and additional labs including an HIV test. Blood was drawn on 2/22/05 but the complete metabolic panel was unable to be performed by reference lab due to improper labeling (no name on the specimen.)

vii. On 2/24/05, inmate JS complained of shortness of breath, worsening over 2 weeks, with bloody sputum noted by nurse. He was triaged by the physician on-call and was noted to be in distress and unable to complete full sentences. Vital Signs at Medical Unit were temperature of 102.1, pulse of 153, blood pressure of 94/68, respiratory rate of 24, and pulse ox of 91%. The inmate was then transported via ambulance to MCLNO.

viii. At MCLNO, the admitting CXR was abnormal with evidence of multi-focal pneumonia ("Patchy air-space disease in upper and middle lung zones, predominantly on the right...but also noted in left superior lung zone. Cannot exclude right paratracheal widening from lymphadenopathy. The hilar regions are not well visualized".) He was initially placed on broad spectrum antibiotics and admitted to the medical service. Later, he required intubation and transfer to the medical intensive care unit for respiratory failure. Anti-tuberculosis treatment was started and the sputum smear sent on 2/25/05 was later reported positive for acid fast bacilli. Patient "coded" on 2/28/05 and was pronounced dead at 2/28/05 8:59 A.M.

ix. At the time of this report, the final autopsy report of JS is still pending.

b. Case CB.

i. Deputy CB is a 42 year old African American female seen at the MCLNO on 3/9/05 with complaints of shortness of breath, inability to speak, and lethargy. Her admitting CXR was abnormal and significant for patchy opacities noted in the right hemithorax more prominent in the mid and lower lung zones with air-bronchograms. She was intubated in the emergency department due to respiratory failure and placed on broad spectrum antibiotics. Sputum and blood cultures were positive for *methicillin resistant staphylococcus aureus* (MRSA). No acid fast bacilli were identified to date. Patient "coded" twice during the hospitalization and subsequently died on 3/11/05.

ii. At the time of this report, the final autopsy report of CB is still pending.

6. Answers to specific questions

a. Based on the information available to the Medical Staff of the OPCSO was standard of care provided for inmate JS? Did inmate JS have adequate access to medical care?

Yes. Standard of care was provided for inmate JS by the Medical Staff at OPCSO based on the information available to them at various visits. In addition, Inmate JS did have adequate access to medical care and his medical complaints were promptly triaged and appropriately attended to by the medical staff.

b. Is there an adequate Tuberculosis (TB) Surveillance program at OPCSO Medical Division?

Yes. The Contact Investigation at OPCSO subsequent to the detection of the active case of TB (JS) was adequate and has been conducted appropriately. Further details of this contact investigation are on record with the medical staff at OPCSO. The reported conversion rate of approximately 35% (29 tuberculin skin test conversions from 83 who previously had negative skin tests) is to be expected in this epidemiological setting.

c. Was there a failure of TB screening at OPCSO?

This can best be answered in two parts:

- The current TB screening protocol at OPCSO provides adequate screening of its employees and inmates. The Prevention and Control of Tuberculosis for the OPCSO Manual from February 2003[3] contains outlines of the protocol for OPCSO; the protocol is in accordance with the current recommendations of CDCP and national guidelines.
- As stated above, we would like to re-emphasize that the current TB screening, prevention, and control procedures adopted by the OPCSO are in accordance with current CDC and national guidelines for correctional facilities. However,

we have noted that there are some aspects of coordination and communication at various clinical/medical/radiological levels in the system at OPCSO that can be further improved.

d. Is there any correlation between the case of Deputy CB and inmate JS?

No. At this time, as far as we know, and based on the data available, there is no evidence to suggest any correlation between the deaths of inmate JS and Deputy CB. The final autopsy reports of both cases are pending and we are not aware of the findings. It can be reasonably assumed that Deputy CB's death may be due to post viral/influenza pneumonia infection. However, the final autopsy report of the case is still pending.

7. Recommendations

Our recommendations are based on the above findings and supported by referenced evidence based data. The recommendations focus on three components outlined and specified below.

a. Improvement in TB Prevention Program
b. Improvement in Inmate/Patient Care
c. Update of TB Prevention and Control Manual

a. Improvement in TB Prevention Program

1. Follow-up Screening of inmates and employees of correctional facility[4].
    a. Data regarding skin test conversions of inmates and employees of correctional facility should be analyzed periodically to estimate the risk for acquiring new TB infection in the correctional facility.
    b. Additionally more frequent testing every 6 months in this high prevalence high risk populations, may be needed. If this requires more Health Care Worker manpower, it is worthwhile to consider expanding such a program at OPCSO

2. Routine analysis of status of inmates with active and latent infection to evaluate completion rates for Latent and Active TB treatment.
    a. CDC Advisory Committee on TB Elimination advises that at least 95% of inmates who begin active or latent TB treatment should complete the prescribed regimen.[5]. In case of treatment of active cases post release, the Office of Public Health (OPH) has the infrastructure for follow up to ensure compliance and adherence to treatment. However, they must be plugged into this in a seamless consistent manner. The use of specific case managers at the OPCSO level will enhance this coordination and ensure continuity of care.
    b. In case of treatment of latent TB infection (which is non-mandatory from the public health point of view), as long as the inmate is

incarcerated, Directly Observed Preventive Treatment (DOPT) is prescribed and ensured by the OPCSO. The continuation of this therapy once the inmate is released is not mandated and lacks a consistent approach. It relies upon the follow-up by the ex-inmate and his/her contact with the public health system. As a general trend, these ex-inmates approach the public health system only when they require medical attention for other purposes, or screening and or clearance for homeless shelter and transitional stay facilities. Also, they may not come into public health preview until they are either seen in shelters or come through the OPCSO system again. This exposes this "revolving door" format to wide gaps in public health enforcement and follow-up. Therefore, it can be justified that such cases that come through this "revolving door" mechanism or are in the OPCSO system for a short period should have a CXR as a screening tool rather than on just relying on reports of a PPD skin test. This approach has been described and proposed in the medical literature especially for inmates who stay in the OPCSO like system for less than 10 days. Again, case managers at the OPCSO level may play an important role in this regard in conjunction with the Louisiana Office of Public Health.

c. We further stress that the issues mentioned in this subsection are the weakest link in the overall control of TB in Orleans Parish and the Greater New Orleans metropolitan area vis a vis TB in the inmates and in the sub group of "transient"/mobile populations.

d. Improve follow up of inmates to referral TB or community clinics of inmates who are released by specifically

   i. Update referral information to Region I Wetmore TB Clinic with new location address and through appointed contact /designated personnel..

   ii. For inmates with active TB: Provide TB-9 forms with TB medication regimen to the Region I, Office of Public Health. Upon release of inmate from correctional facility provide updated medical information regarding their TB treatment to Office of Public Health through designated contact personnel

   iii. Provide names of inmates who were on latent TB treatment to Office of Public Health Regional Clinic such as Wetmore TB Clinic upon their release in order for Clinic to contact and facilitate follow-up appointment.

   iii. Adopting innovative measures to encourage released inmates to complete treatment for TB.[6]

3. **Improvement in Patient Care**

   a. **Reportable CXR ("RED FLAG X-RAY")**

      i. In conjunction with the consensus to be adopted by the OPCSO clinicians and contracted radiologists while keeping in mind the logistics and limitations of the system, we recommend that a list of "Reportable" CXR findings be created which mandates the

radiologists to notify the physicians of such findings by telephonic or pager system immediately. For example: CXR suggestive of TB, multi-lobar pneumonia, or obvious malignancy should be notified to the clinician promptly and not left up to the channel of written notes through the infection control triage .

ii. Improve filing of CXR results into medical record and establish a back- up method of recalling a CXR result in case of delayed or misfiling of results at follow-up appointments.

iii. Ensure that abnormal CXRs are reviewed by the physician caring for the inmate in order to enable them to correlate their clinical impression/ status with CXR findings.

iv. For symptom screening, inmate's CXR interpretation should be available within 24 hours.[7]

b. Improve communications between medical staff.

a. Medical Charting:
Although in this setting, the clinical symptoms, history and physical signs data play a secondary role, the importance of the documentation of such findings as elaborate as possible cannot be overemphasized. Some of the physician findings were excellent in our review. However at certain other points, some findings were missing and may have helped in attracting closer clinical scrutiny.

b. Laboratory Tests and labeling
Sputum should be submitted for AFB smears and culture examination from persons who are diagnosed with initially with other respiratory disease but whose symptoms do not improve after initiation of treatment.[8] For inmates with document weight loss, chronic cough for greater than 3 weeks and at risk for tuberculosis should have sputum smear and culture evaluation for TB. Proper labeling of specimens for laboratory analysis will ensure timely retrieval of testing results.

In this connection, a suggested mechanism of charting is the development of a single standardized form in a check list so that findings and labs (be they be ordered, awaited or missing) by treating MDs. are all clearly available.

4. **Update of TB Prevention and Control Manual for OPCSO**
We recommend periodic review and updating of the TB Prevention and Control Manual for OPCSO. This would serve a dual purpose of better clinical and public health collaboration between the two arms of TB control in this population base i.e. Inmates while at OPCSO and when released to the community at the OPH level.

8. References:

[1] MMWR Prevention and Control of TB in Correctional Facilities. Recommendations of the Advisory Council for Elimination of TB. June 7, 1996. Vol 45/NO. RR-8.

[2] MMWR Essential Components of Tuberculosis Prevention and Control Program. Screening Tuberculosis and Tuberculosis Infection in High Risk Populations. September 8, 1995/Vol 44/ No. RR-11

[3] Inglese, R. Prevention and Control of Tuberculosis for the Orleans Parish Criminal Sheriff's Office. February 2003

[4] MMWR Prevention and Control of TB in Correctional Facilities. Recommendations of the Advisory Council for Elimination of TB. June 7, 1996. Vol 45/NO. RR-8. page 13.

[5] MMWR Prevention and Control of TB in Correctional Facilities. Recommendations of the Advisory Council for Elimination of TB. June 7, 1996. Vol 45/NO. RR-8 page 22.

[6] MMWR Prevention and Control of TB in Correctional Facilities. Recommendations of the Advisory Council for Elimination of TB. June 7, 1996. Vol 45/NO. RR-8 page 19.

[7] MMWR Prevention and Control of TB in Correctional Facilities. Recommendations of the Advisory Council for Elimination of TB. June 7, 1996. Vol 45/NO. RR-8 page 7.

[8] MMWR Prevention and Control of TB in Correctional Facilities. Recommendations of the Advisory Council for Elimination of TB. June 7, 1996. Vol 45/NO. RR-8 page 15 .

[10] MMWR Treatment of Tuberculosis. American Thoracic Society, CDC and Infectious Diseases Society of America. June 20,2003. Vol 52/RR-11

[11] MMWR Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection. June 9, 2000. Vol 49/RR-6.

Signed:
Juzar Ali M.D.
Shu-Hua Wang M.D.

March 24, 2005

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

April 20, 2005

Orleans Parish Criminal Sheriff's Office
Att'n: Richard D. Inglese, M.D.
Medical Administration
2800 Gravier Street
New Orleans, Louisiana 70119

Dear Dr. Inglese:

Please find enclosed a copy of the report, which I wrote following our meeting. Please feel free to share this report with anyone you feel may be interested in it, and thank you for the opportunity you gave me to meet with you about these matters.

Sincerely,

Louis Trachtman, M.D.

Louis Trachtman, M.D., M.P.H.
Medical Director

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REPORT

On Wednesday, April 6, 2005 I met with Dr. Richard D. Inglese, medical director at Orleans Parish Criminal Sheriff's Office (OPCSO) and discussed at length the Tuberculosis Control Program at Orleans Parish Prison (OPP), including the following major points:

(1) The screening program
(2) The medical disposition of incarcerated persons with disease, both active and latent
(3) The surveillance program, including contact tracing
(4) The details of the medical course of illness of the patient J.S., a person incarcerated recently at OPP, who died of tuberculosis

In our discussion, Dr. Inglese showed me the Tuberculosis Control Manual used at OPP, which he wrote in 2003, and which contains all of the latest recommended procedures published by recognized experts in the control of tuberculosis in the United States, in general, as well as in correctional facilities, in particular. Additionally, Dr. Inglese shared with me the detailed patient record of J.S. from the medical clinic at OPP and the files kept at OPP regarding follow-up of those persons who had contact with J.S. and were exposed or were even possibly exposed to J.S.'s active tuberculous disease. I was also provided with a report addressing many of these same points written by Dr. Juzar Ali of Louisiana State University Medical School and Dr. Shu-Hua Wang of Tulane University Medical School.

After our discussion and review, Dr. Inglese posed the following questions to me:
(1) At the Orleans Parish Criminal Sheriff's Office (OPCSO) correctional facility, also known as Orleans Parish Prison (OPP), are screening and prevention policies in place?
(2) Was the care of J.S. at OPCSO (OPP) demonstrative of adequate access to competent medical care as well as demonstrative of acceptable medical care by the physician(s) at OPCSO (OPP)?
(3) Was the response of the medical and allied health staff at OPCSO (OPP) to the presence of an active case of tuberculosis at the facility appropriate?

In response to these questions, I have the following comments:

(1) The screening and prevention policies in place at OPCSO (OPP) are completely in accord with the recommendation of experts in the field of tuberculosis control as published by the United States Public Health Service, Centers for Disease Control and Prevention (CDC) – Core Curriculum on Tuberculosis, 4th edition, 2000, and Prevention and Control of Tuberculosis in Correctional Facilities, 1999.
(2) In my opinion, the medical care of J.S. at OPCSO (OPP) was acceptable by all medical standards regarding access and appropriateness.
(3) In my opinion, the response of the medical and allied health staff at OPCSO (OPP) to the presence of an active case of tuberculosis (J.S.) at the facility was

appropriate and even exceeded recognized standards for contact investigation, disease detection and appropriateness of treatment of those persons needing such treatment.

(4) Recognizing that the current system in place at OPCSO (OPP) follows the recommended guidelines of CDC mentioned in (1) above, certain additions and/or modifications to the system in place at OPCSO (OPP) are recommended. These are:

(a) The environmental conditions of the correctional facility should be inspected now and deficiencies, if found, should be corrected. By environmental conditions, I refer specifically to the heating, ventilation and air conditioning systems, which, if not kept meticulously clean and in good working order, can facilitate spread of infectious disease, like tuberculosis, from one infected person to others within a short time.

(b) Incarcerated persons at OPCSO (OPP) diagnosed with pneumonia, being at high risk for having active tuberculosis, should have sputum samples examined for causative micro-organisms of tuberculosis, the acid-fast bacilli of tuberculosis, at the earliest possible opportunity. The Louisiana Office of Public Health (OPH) through its public health laboratory in New Orleans would be able to accept and examine the sputum samples submitted from OPCSO (OPP) for the causative micro-organisms of tuberculosis.

(c) The radiologist's interpretation of any abnormal findings in the x-ray films taken at OPCSO (OPP) should be communicated immediately by telephone to a member of the medical staff at OPCSO (OPP).

(d) Upon release from OPCSO (OPP) the names and addresses of (formerly) incarcerated persons on treatment for tuberculosis should be made known to the Louisiana OPH's regional office in New Orleans, where disease investigation specialists can follow-up with the formerly incarcerated persons to make sure they have appropriate medical follow-up care and medicines at either the public clinic for tuberculosis in New Orleans (Wetmore Clinic) or through private medical care.

(e) A permanent liaison staff person at OPCSO (OPP) and a permanent liaison staff person at OPH's regional office in New Orleans should both be named to meet regularly, e.g. once weekly, to discuss matters of mutual concern related to the control of tuberculosis. OPH would be able to name such a person at this time.

(f) The possibility of establishing a respiratory isolation unit at OPCSO (OPP) should be explored.

I appreciate the opportunity to have met with Dr. Inglese about these important matters. I would also welcome any questions, the reader may have about this document.