

**REPORT OF**

**AN INVESTIGATION INTO THE CIRCUMSTANCES  
THAT REQUIRED JOHN DOE TO RECEIVE EMERGENCY MEDICAL  
TREATMENT WHILE INCARCERATED**

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*Vermont P&A is the Protection & Advocacy System for Vermont*

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## I. INTRODUCTION

This report presents the results of the investigation conducted by Vermont Protection & Advocacy, Inc. (VP&A), into the circumstances that led to the emergency hospitalization of JOHN DOE on January 6, 2004.

In October of 2003, JOHN DOE was re-incarcerated for programming failure and housed at the Marble Valley Regional Correctional Facility (MVRCF) in Rutland. JOHN DOE has a history of treatment for hypertension as well as Bipolar Disorder<sup>1</sup>, and had been treated with Lithium since 1989 according to his Department of Corrections medical records. JOHN DOE was prescribed Vasotec<sup>2</sup>, Prozac<sup>3</sup>, Lithium<sup>4</sup>, and Cardura<sup>5</sup> upon his incarceration. Department of Corrections records demonstrate that on October 17, 2003 a psychiatrist ordered that a Lithium level be done on JOHN DOE, among other lab tests.

On December 19, 2003 JOHN DOE was transferred from MVRCF to the Northwest State Correctional Facility (NWSCF) in St. Albans for mental health reasons. JOHN DOE was actively psychotic at that point as evidenced by notes in his medical record. Once he arrived at NWSCF, another psychiatrist prescribed Zyprexa<sup>6</sup>, and noted that he would discuss the Lithium order with the psychiatric nurse practitioner.

On December 22, 2003, the psychiatric nurse practitioner met with JOHN DOE and noted that even though JOHN DOE had received his Lithium, he had still become manic. This practitioner also noted that there were no laboratory results in JOHN DOE's chart, despite the fact that a Lithium level had been ordered by a psychiatrist in October, 2003. The practitioner noted that he ordered JOHN DOE's Lithium dose increased from 600mg to 750mg. The practitioner also on December 22, 2003, wrote an order for a Lithium level to be performed on JOHN DOE in the physician's orders.

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<sup>1</sup> Bipolar Disorder: Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe. They can result in damaged relationships, poor job or school performance, and even suicide. [National Institute of Mental Health](#) (2001)

<sup>2</sup> Vasotec: Antihypertensive, ACE inhibitor. For the treatment of hypertension alone or in combination with thiazide-type diuretics. [Lippincott's Nursing Drug Guide](#), Ann M. Karch (2002).

<sup>3</sup> Prozac: Antidepressant; selective serotonin reuptake inhibitor. Treatment of depression; most effective in patients with major depressive disorder...treatment of numerous psychiatric disorders. **Clinically important interactions:** Increased toxicity of lithium; avoid this combination. [Lippincott's Nursing Drug Guide](#), Ann M. Karch (2002).

<sup>4</sup> Lithium: Antimanic agent. Treatment of manic episodes of manic-depressive illness; maintenance therapy to prevent or diminish frequency and intensity of subsequent manic episodes. [Lippincott's Nursing Drug Guide](#), Ann M. Karch (2002).

<sup>5</sup> Cardura: Antihypertensive. Treatment of mild to moderate hypertension, alone or as part of a combination therapy. [Lippincott's Nursing Drug Guide](#), Ann M. Karch (2002).

<sup>6</sup> Zyprexa: Antipsychotic. Management of manifestations of psychotic disorders. Treatment of acute manic episodes associated with Bipolar 1 disorder. **Clinically important interactions:** Increased risk of orthostatic hypotension with antihypertensives. [Lippincott's Nursing Drug Guide](#), Ann M. Karch (2002).

On January 1, 2004, a nurse at NWSCF noted in JOHN DOE's medical record that he appeared "*nonsensical, drinks from toilet, appears unable to care for self, per CO's not really eating, needs med eval + increased nursing care for ADL's [activities of daily living].*" On January 2, 2004 a mental health clinician noted that JOHN DOE was "*in cell naked, odd speech.*" There are no DOC records documenting interactions between JOHN DOE and medical or mental health staff from the January 2 interaction until January 5, 2004. On that day JOHN DOE was sent to Northwestern Medical Center in St. Albans for tests because it was noted that he had a large amount of bruising on his body, and that he was "*...nonsensical and unable to do ADL's .*" He was returned from Northwestern Medical Center only to be shipped to the infirmary at the Newport prison. Shortly after his arrival to Newport, he was transferred via ambulance to North Country Hospital, where he was admitted with a diagnosis of renal failure<sup>7</sup> and diabetes insipidus<sup>8</sup>. From the North Country Hospital record: "*The patient was admitted with profound mental status changes and hypotension*<sup>9</sup>. *Sodium on admission was 158 and it was felt that he probably had nephrogenic diabetes insipidus from his Lithium use and had become progressively dehydrated. It was also wondered whether he might have sepsis*<sup>10</sup>."

## II. **Background**

### A. **JOHN DOE**

JOHN DOE is a 56 year-old man with a long history of treatment for bipolar disorder and alcohol dependence. He is diagnosed with hypertension<sup>11</sup> as well. He is currently incarcerated on a sanction for violating conditions of release.

### B. **Marble Valley Regional Correctional Facility**

The MVRCF is a minimum-security jail located in Rutland, Vermont. This facility has no mental health unit. A mixture of employees from the Department of Corrections, Paul Cotton LLC, and Correctional Medical Services provided mental health and medical care during the times relevant to this investigation.

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<sup>7</sup> Renal failure: Acute failure of the kidney to perform its essential functions. May be due to trauma; any condition that impairs the flow of blood to the kidneys..." Taber's Cyclopedic Medical Dictionary, 15<sup>th</sup> Edition, (1985).

<sup>8</sup> Diabetes Insipidus: Diabetes – A general term for diseases characterized by excessive urination. Usually refers to diabetes mellitus. Insipidus – Polyuria and polydipsia caused by inadequate secretion of vasopressin, the antidiuretic hormone, by the neurohypophysis (main portion of the posterior lobe of the pituitary gland). Taber's Cyclopedic Medical Dictionary, 15<sup>th</sup> Edition, (1985).

<sup>9</sup> Hypotension: Decrease of systolic and diastolic blood pressure below normal...Occurs in shock, in hemorrhages, infections, fevers, cancer, anemia, neurasthenia, Addison's disease; in debilitating or wasting diseases; and approaching death. Taber's Cyclopedic Medical Dictionary, 15<sup>th</sup> Edition, (1985).

<sup>10</sup> Sepsis: Pathological state, usually febrile, resulting from the presence of microorganisms or their poisonous products in the bloodstream. Taber's Cyclopedic Medical Dictionary, 15<sup>th</sup> Edition, (1985).

<sup>11</sup> Hypertension: A condition in which the patient has a higher blood pressure than that judged to be normal. Taber's Cyclopedic Medical Dictionary, 15<sup>th</sup> Edition, (1985).

### C. **Northwest State Correctional Facility**

The NWSCF is a medium-security prison located in Swanton, Vermont. This facility has a mental health unit. A mixture of employees from the Department of Corrections, Paul Cotton LLC, and Correctional Medical Services (CMS) provided mental health and medical care during the time relevant to this investigation. At the time of JOHN DOE's incarceration, this prison was under investigation by several outside sources for possible employee misconduct including abuse of inmates, inadequate mental health and medical services, and for inhumane housing conditions that existed in the Delta Unit.

### D. **Northern State Correctional Facility**

The NSCF is a medium security prison located in Newport, Vermont. This facility has no mental health unit but does have an infirmary. A mixture of employees from the Department of Corrections, Paul Cotton LLC, and Correctional Medical Services (CMS) provided mental health and medical care during the time relevant to this investigation.

## III. **CIRCUMSTANCES**

### A. **Sequence of Events at MVRCF**

In October of 2003, JOHN DOE was arrested for programming failure and housed at MVRCF in Rutland. JOHN DOE had a history of treatment for hypertension as well as Bi-polar Disorder, according to his Department of Corrections medical records. JOHN DOE was prescribed Vasotec 5mg p.o. QD PRN, Prozac 20mg p.o. QD PRN, Lithium 600mg p.o. QHS PRN, and Cardura 2mg p.o. QHS PRN upon his incarceration by the facility physician. The psychiatrist verified the order for Lithium and Prozac on that same day. The psychiatrist's initial diagnosis for JOHN DOE on October 17, 2003 was "personality disorder, r/o [rule out] BPAD, ETOH [alcohol] dep., in remission."

On October 17, 2003 the psychiatrist ordered a Lithium level be done on JOHN DOE, among other lab tests. The psychiatrist also noted that JOHN DOE's records from the Vermont State Hospital should be obtained.

On October 21, 2003, JOHN DOE submitted a request form to see someone from mental health.

On October 22, 2003, mental health providers noted in his record that JOHN DOE had a "*deficit in coping skills.*"

On November 12, 2003, JOHN DOE submitted a request form to see someone from mental health.

On November 13, 2003, a mental health intern noted “*I/M slightly manic – seeking support...disorganized thought...distorted thinking, rapid mood swings...seek MH PRN.*”

On November 13, 2003 the registered physician’s assistant wrote an order for weekly blood pressure checks to be performed on JOHN DOE for 12 weeks. The Blood Pressure Record found in JOHN DOE’s medical record reflects that the blood pressure checks were only performed for 4 weeks from this date, then documentation ceased due to his transfer to St. Albans. There is a note written on the top of the Blood Pressure Record form that states it was faxed to St. Albans on December 20, 2003, however, NWSCF did not begin documentation on this form until January 14, 2004.

On November 24, 2003, JOHN DOE submitted a request form to be seen by someone from mental health.

On November 25, 2003, a mental health intern noted “*...normal pressured speech, very tangential, talks almost non-stop...increased anxiety...see PRN.*”

On December 1, 2003, JOHN DOE submitted a request form to be seen by someone from mental health.

On December 4, 2003, a mental health intern noted “*I/M jumps from subject to subject, very angry, disorganized – see MH when ready to address MH issues.*”

On December 18, 2003 at 9:20 am, a correctional officer submitted a Mental Health Referral Form which stated in part “*Continued statements of obvious wrong facts...bizarre coments [sic] unrelated to anything going on currently...his behavior now mirrors Dementia [sic] Can not or will not follow simple directions without cursing at others...roommates complain of his packing belongings & then unpacking them several times at night until 3 A.M....often disassociated with surroundings.*”

On December 18, 2003 at 5:00 pm, a mental health provider noted “*Client presents as somewhat anxious, affect is appropriate. Eye contact is good. Readily conversant, normal speech. No psychomotor disturbances noted...coping effectively at this time.*”

On December 18, 2003 at 10:20pm JOHN DOE was placed on a standard suicide watch as indicated by the Suicide Watch Observation Sheet that is in his medical record.

On December 19, 2003 at 9:00am, a nurse noted in JOHN DOE’s medical record “*...I/M not of his usual demeanor. Appears anxious + confused, not belligerant [sic] or combative. Seen by MH @ 12-18-03.*”

On December 19, 2003 at 11:30 am, there is a note in the Physician’s Orders that states “*Transferred for M/H reasons.*”

On December 19, 2003 at 2:45pm, a mental health provider filled out a Request For Placement in Residential Treatment Program form on which she documented *“Apparently having a psychotic episode. Clearly hearing voices and responding – confused, violent at times, smearing feces, agitated. This is an acute episode – no hx of psychosis.”*

**B. Sequence of Events at NWSCF**

On December 19, 2003 JOHN DOE was transferred from MVRCF to the Northwest State Correctional Facility (NWSCF) in St. Albans for mental health reasons. JOHN DOE was actively psychotic at that point as evidenced by notes in his medical record.

On December 19, 2003 at 6:05pm, a nurse noted the following in JOHN DOE’s medical record: *“I/M arrived, uncooperative, resistive – placed in Delta, in chains - ✓all 4 limbs – (+) CSMT’s, I/M talking non-sensical, pressured speech. Notified [provider], orders received. I/M took Zyprexa p.o., re-assured I/M. CO’s monitoring I/M frequently. Asst. I/M with water.”*

On December 19, 2003 at 7:30pm, it was noted in his medical record that JOHN DOE was released from the chains.

On December 20, 2003, the psychiatrist met with JOHN DOE and noted the following: *“53 y.o. male tx’d from MVRCF. Bipolar, manic with psychosis. Speaking constantly and nonsensically...manic with psychosis. Begin Zyprexa...Li2 CO3 order to be reviewed with [provider]...”*

On December 22, 2003, the psychiatric nurse practitioner met with JOHN DOE and noted the following: *“...he appears to have gotten manic even though he has (illegible) Li2 Co3. No labs in chart in spite of being ordered by [psychiatrist].. Pt. Is beginning to feel sedation from Zyprexa, he was naked in his cell + somewhat confused but not babbling – agitated, tangential. D/w unit officer app clothing was taken away because he smeared feces on his clothes. (A) Clothing him thought increase normalcy ? Li level adequate (P) will ↑Li2 Co3 to 750mg, Olanzapine 20mg...”*

On December 26, 2003, a psychologist noted on the Secure Residential Treatment Program, Mental Health Rounds Log form that JOHN DOE was “ok.”

On December 27, 2003, a nurse noted on the Segregation Log for the Delta Unit the following: *“I/M in cell, spilled milk food on floor/naked – preoccupied, nonsensical.”*

On December 28, 2003, a nurse noted on the Segregation Log for the Delta Unit the following: *“I/M took meds – continues to appear preoccupied.”*

On December 29, 2003, the facility physician noted in JOHN DOE medical

record the following (note: very hard to read this physician's handwriting, unclear if he actually met with JOHN DOE or was just making a note): "...confused, rambling... ✓ labs..." This physician also noted in the Physician's orders "M.H. consult." He also noted for lab work to be done, CMP, CBC and Lytes.

On December 29, 2003 the psychiatrist met with JOHN DOE and noted: "Examined on D Unit. His Li2 Co3 was increased on 12/22/03 but he continues to have disorganization with some loose associations but appears less agitated than in my 12/20/03 exam. (A) Slow resolution of his bipolar, manic with psychosis. (P) No med (changes), will discuss with MH team."

On December 30, 2003, a nurse attempted to draw blood from JOHN DOE for lab work, but was unsuccessful. The nurse documented that she notified the provider.

On January 1, 2004 at 11:30pm a (nurse) noted the following in JOHN DOE's medical record: "This I/M appears to present as an Alzheimers pt. – nonsensical speech in English however speaks fluent German this eve still non-sensical – I/M strips constantly – shreds his clothes – drinks from toilet – cell a mess with soiled floor – appears unable to care for self – hygiene. Per CO's not really eating – plays with food – needs med-eval & increased nursing care for ADL's."

On January 2, 2004, a mental health clinician noted on the Secure Residential Treatment Program, Mental Health Rounds Log form that JOHN DOE was "in cell naked, odd speech." (Note: This clinician spent about 30 minutes on the Delta Unit doing rounds. There were 10 inmates documented as being in the unit at that time. That equals about 3 minutes per inmate to evaluate their mental health status).

On January 5, 2004 at 10:20 am, a nurse noted the following: "Saw I/M this AM for AM meds – noted lg. Amt. Of bruising on legs, arms, hip areas, buttocks. I/M is non-sensical and unable to do ADL's – he is playing in his food – eating very little, dumping fluids on floor – drinking very little – appears dehydrated. CO's report I/M is falling frequently. I/M is in a camera cell for observation. MH referral done this AM. Discussed I/M with M.D.... and nurse manager. MD to see I/M today."

On January 5, 2004, records indicate that the facility physician ordered a chest x-ray and head CT be done at Northwestern Medical Center. He also ordered labs to be done.

On January 5, 2004 a nurse noted the following in the Physician's Orders per the physician: "1) Send to NWMC for out pt services for CT of head without contrast, chest x-ray PA/lateral, CO AG profile, CMP, electrolytes, CBC. Do now via AmCare. All services STAT."

### C. Sequence of Events at NSCF

On January 5, 2004 JOHN DOE was transferred to NSCF in Newport. The



Infirmery Admission Orders at 3:30pm had a diagnosis of delirium, dementia, dehydration.

On January 5, 2004 a mental health provider met with JOHN DOE upon his transfer to NSCF. The provider noted the following: *“Met with I/M to orient to services. Talkative; confused; labile emotions; no orientation; good eye-contact; poor communication...He could engage in some form of communication for brief periods of time and would then seem to fall off mumbling to himself...see as needed and/or to monitor appropriately.”*

On January 5, 2004 at 4:00pm a nurse noted the following: *“...Alt in mental status...monitor, assess and push fluids. [physician] notified of trans in.”*

On January 5, 2004, a nurse documented approximately 30 bruises on JOHN DOE’s body on a form called Scars, Tattoos, Trauma Marks.

On January 6, 2004 at 5:30am a nurse noted the following: *“...Inmate refuses to cooperate – takes clothes off – refuses meds, refuses to drink...Fluid volume deficit RT ↓ intake...cont. to encourage intake, Give verbal cues. Assess & monitor.”*

On January 6, 2004 at 9:00am the facility physician noted the following: *“...gradual change in behavior over the past mo – unable to do ADL’s, falling, (change) in mental status...This AM ↓ responsiveness – opens eyes to verbal + painful stimuli. Basically flaccid, incontinent of urine and stool...CT head without contrast “nl for age”...sent to ER via ambulance @ 0945, ER notified 0920...”*

On January 6, 2004 at 1:00pm the facility physician made the following addendum note: *“Admitted to NCH for Lithium Toxicity 2.0. [doctor] (ER) discussed case with nephrology @ FAHC.”*

On January 6, 2004 a nurse made the following note: *“...I/M not verbal + unable to follow simple commands. Three person transfer from bed to chair. Unable to feed self – fed by staff – fluids only. Very difficult to feed. Transferred back to bed examined by MD...Multiple eccymotic areas noted on extremities...Occasional groaning noted...labs drawn and sent to NCH STAT per order. Unable to do ADL’s – complete care provided...Sent to NCH Hosp ER per MD.”*

#### **D. Sequence of Events at North Country Hospital**

On January 6, 2004 at 9:19am, JOHN DOE was seen in the Emergency Department at North Country Hospital in Newport. The physician noted his impression as: *“Renal failure, diabetes insipidus.”* JOHN DOE was then admitted to North Country Hospital. The Emergency Department Nursing Record noted the following condition of JOHN DOE: *“...Elderly gentleman, unresponsive...bruises seen on legs and arms...moaning – responds to pain only...red patches on body.”*

On January 6, 2004, the History & Physical Report completed by the physician stated the following: “...*Impression: Fifty-five year old male with hypernatremia, dehydration and possible sepsis syndrome...I am making attempts to contact next of kin to explain to them the severity of his illness.*”

On January 7, 2004, a neurology consultation was completed and included the following: “*Assessment: The change in mental status in him is most likely due to metabolic encephalopathy, dehydration, Lithium toxicity and possible sepsis.*”

On January 7, 2004, a psychiatric consultation was completed and included the following: “[*provider*] reveals that [*JOHN DOE*] has a history of experiencing bipolar symptoms, and being maintained on lithium, for over the past several years, at a dose of approximately 750 mg a day...[*provider*] describes the patient being in a manic phase, where he had an elevation of mood, was quite jovial, had a speech disorder with rapid speech, and was quite hyperactive. Due to this, he was also placed on Zyprexa, which was eventually dosed, within a few weeks, up to 20 mg a day. The patient appeared to deteriorate just prior to the Christmas holiday, where he was becoming more disoriented and confused. He was placed in the Newport infirmary, and I believe his lithium dose was reduced. [*provider*] reveals that despite getting blood draws, no one there ever checked on any lithium results over the several weeks he was readmitted to the St. Albans facility. Due to his deteriorating medical status, the infirmary sent the patient to the ER here at North Country Hospital, and he was admitted, as referenced, to the ICU Tuesday. Upon admission, he lithium level was found to be a little over 2 and the next morning after the medication was stopped, the dose had dropped down to 1.33...*Impression: 1. Lithium intoxication. 2. Rule out a possible neuroleptic malignant syndrome. 3. Rule out comorbid sepsis case. 4. Rule out diabetes insipidus secondary to chronic lithium use. 5. Bipolar disorder.*”

On January 9, 2004, JOHN DOE had recovered enough to be returned to the correctional facility. The Discharge Summary Final Report completed by the physician at North Country Hospital included the following: “*Discharge Diagnosis: 1) Nephrogenic diabetes insipidus with associated severe dehydration. 2) Bi-polar disease. 3) Sepsis ruled out. 4) Persistent hypotension now improved. 5) Significant mental status changes now improved...The patient gradually awakened and did better. His electrolytes normalized. On the final hospital day, his intravenous fluids were stopped. His electrolytes remained normal after 12 hours and his mental status remained good. He is drinking to thirst and seems to be doing well. He has ambulated without difficulty. His mental status is back to normal. Discharge Instructions: At this point, it is recommended that he avoid Lithium because of the difficulty he ran into on it...*”

#### **E. Sequence of Events Upon Return to NSCF in Newport**

On January 9, 2004 JOHN DOE was returned to NSCF in Newport from the hospital.

On January 10, 2004 a nurse noted that JOHN DOE had “...*poor fine motor skills,*

*has difficulty with plastic ware – ambulates slow and steady...altered mental status R/T periods of confusion alt in nutrition.”*

On January 11, 2004 a nurse noted the following: “...Able to carry on normal conversation – gait much steadier today – able to ambulate without difficulty – posture better as well...Noted improvement in fine motor skills.”

On January 12, 2004 the facility physician made the following note: “Released from NCH 1/9 – Dx NDH, ARF, Li toxicity, dehydration. Apparently required Dopamine drip to maintain BP until stable. D/c’d in good condition – no Lithium, on prn benzo’s and Zyprexa...Informed of events of past week + that renal fx was improving...d/c from infirmary.”

On January 14, 2004 at 2:30pm the psychiatric nurse practitioner met with JOHN DOE and noted the following: “...He can be transferred to MVRCF or other DOC facility as appropriate.”

#### IV. **INVESTIGATION INTO THE EMERGENCY HOSPITALIZATION OF JOHN DOE**

VP&A’s investigation included the following:

- ➔ Review of JOHN DOE’s medical and mental health records onsite at NWSCF and obtaining a hard copy of his file.
- ➔ Review of Vermont Department of Correction’s Protocols regarding medical and mental health treatment.
- ➔ Review of Correctional Medical Services Policies and Procedures.
- ➔ Review of records from the North Country Hospital.
- ➔ Review of records from Northwestern Medical Center.

#### V. **FINDINGS AND CONCLUSIONS**

VP&A’s investigation found evidence that the Department of Corrections and its contracted agents minimized the seriousness of JOHN DOE’s condition while providing him care. JOHN DOE was in the Vermont Department of Corrections’ custody for approximately 81 days before being transferred to the hospital. During that time his mental status and physical condition deteriorated to the point of psychosis and renal failure.

The DOC failed to evaluate on its own the problems that resulted in this near fatal circumstance, failed to notify JOHN DOE of its findings, even though JOHN DOE

questioned both mental health and medical staff about what happened to him. On April 8, 2004, JOHN DOE submitted a Health Services Request Form to mental health asking for help in piecing together what happened last December and January. The response provided to JOHN DOE by the mental health provider was to “*go through DOC and medical to gain factual information.*” On April 12, 2004 JOHN DOE submitted a Health Services Request Form to medical staff writing, “*I’d like to know the dates of my stay in the infirmary here and when I was out to the hospitals if known and when I was sent down to Echo Delta Unit.*” The response by a registered nurse on this form was: “*Refer to DOC for info. Per [nurse].*” DOC also failed to discipline those involved in failing to provide reasonable medical and mental health care to him.

## ***MENTAL HEALTH CARE:***

### **A. Failure to Properly Evaluate Records**

The psychiatrist requested that medical staff obtain JOHN DOE’s records from the Vermont State Hospital (VSH) by writing this in the Physician’s Orders on October 17, 2003. MVRCF did receive some of JOHN DOE’s records in October 2003. One part of the VSH record from 1989 documented the following critical information: “*[JOHN DOE] had been becoming increasingly psychotic, agitated. His father says that [JOHN DOE] had been unable to work and obviously not functioning in a very high level since prior to Thanksgiving, but the week or so prior to his admission here he became much more agitated, becoming more delusional. Apparently he was found sitting naked on the kitchen floor with a pair of scissors contemplating circumcising himself. Because of his extremely bizarre and delusional behavior, [JOHN DOE] was sent to the Vermont State Hospital on an emergency exam.*”

JOHN DOE had a history of eating very little prior to the July 1989 admission to VSH. Had the psychiatrist, and the other mental health providers actually reviewed JOHN DOE’s records from VSH, they would have known that his behavior in December of 2003 resembled his prior psychotic episode in July of 1989, and therefore should have treated JOHN DOE accordingly. An admission to VSH may have been in order at that time instead of continued segregation. There is nothing documented in JOHN DOE’s mental health record to suggest that any mental health provider actually reviewed the records received from VSH. Another indication these records were not reviewed was the documented note by a mental health provider at MVRCF on December 19, 2003 which read: “*... no hx of psychosis.*” This statement is not accurate.

Department of Corrections, Continuity of Care for Medical/Mental Health Services, Protocol 361.01.07, V. B.1.c. “*Obtaining private mental health records. (1) If an inmate has been receiving mental health care prior to incarceration or if the inmate appears to have a significant past history of mental health problems, the inmate will be asked to sign the Release of Information form if he or she has not already done so. (2) The mental health staff member shall submit the form to the administrative staff who will then send for the requested information by mail, fax, etc. (3) Upon receipt of the information, administrative staff shall forward it to mental health staff for review... (5) Documentation of these actions will be noted in the inmate’s mental health chart.*”

## **B. Residential Treatment Programs Failure**

On December 19, 2003, a mental health provider at MVRCF completed a Request For Placement in Residential Treatment Program form for JOHN DOE stating that *“Apparently having psychotic episode, clearly hearing voices and responding – confused, violent at times, smearing feces, agitated.”* The form fails to document which program they are recommending placement in, as there are two choices. There is the Secure Residential Treatment Program (SRTP)<sup>12</sup> or the Intermediate Residential Treatment Program (IRTP)<sup>13</sup>. The SRTP is located in the Delta Unit, while the IRTP was the A Unit, both at NWSCF. While not specifically documented, it can be assumed from JOHN DOE’s condition at the time he was transferred and his subsequent placement in the Delta Unit that he was admitted to the SRTP. The form in JOHN DOE’s record is also incomplete in that neither the Chief Psychologist nor the Superintendent at NWSCF signed the form approving placement and for which program.

Department of Corrections, Residential Treatment Program, Protocol 361.01.09, V. Secure Residential Treatment Program, A. *Referral to the SRTP*, 2. *“If the mental health professional concludes that the needs of the inmate would be best served in the SRTP at NWSCF, he/she shall forward this recommendation in writing (see RTP Referral form) to the Superintendent of the sending facility who shall review and approve/disapprove the request. If approved, the request shall be forwarded to the Chief Psychologist at NWSCF for consideration and approval.”*

## **C. Failure to Add to Mental Health Roster**

There is no documentation in JOHN DOE’s mental health records to indicate that he was placed on the Mental Health Roster per DOC protocol.

Department of Corrections, Mental Health Roster: Admission/Discharge Criteria, Protocol 361.01.12, V.A.,#4 *“An inmate may be included on the mental health roster if it appears that active mental health treatment is needed on an ongoing basis. This would include individuals with acute or chronic mental illness, those undergoing continued psychopharmacotherapy, and those with significant psychiatric symptoms related to their incarceration.”*

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<sup>12</sup> Department of Corrections Protocol 361.01.09, Residential Treatment Programs, IV. Definitions, *Secure Residential Treatment Program (SRTP)*: the secure residential mental health unit at Northwest State Correctional Facility. The purpose of the RTP-Max is to provide psychiatric treatment and intervention for inmates with close custody needs. It has ten single-man cells, two group rooms, private offices and a satellite health service area. It is designated to facilitate the clinical management and treatment of inmates with mental health needs who pose an immediate security risk.

<sup>13</sup> Department of Corrections Protocol 361.01.09, Residential Treatment Programs, IV. Definitions, *Intermediate Residential Treatment Program (IRTP)*: the residential mental health unit at Northwest State Correctional Facility. The purpose of this unit is to provide transitional mental health care to designated inmates and to prepare them for successful reintegration into the general inmate population. This unit has single and double-man cells, 1 group room, a day room, and a mental health staff office.

#### **D. Failure to Develop an Adequate Mental Health Treatment Plan**

JOHN DOE was not provided an adequate mental health treatment plan, nor was the initial plan that was created adjusted to meet his mental health needs once his mental illness escalated. The treatment plan that was developed on November 17, 2003 for JOHN DOE includes the following: *“Problem: mood instability. Goal: Stable mood. Target Date: 5/17/04. Interventions: Medication, counseling. Evidence of Progress: Observation, self report”* JOHN DOE’s mental health began deteriorating rapidly after this plan was developed, yet no new plan was instituted to address this deterioration which proved almost fatal.

Department of Corrections, Individualized Treatment Planning, Protocol 361.01.06, Mental Health Treatment Plan definition, page 2: *“specifies the particular course of therapy and the roles of medical and non-medical personnel in carrying out the current course of therapy. It is individualized and based on assessment of the individual patient’s needs, and includes a statement of the short and long-term goals and the methods by which the goals will be pursued.”* V. B. #4: *“Treatment planning is an ongoing assessment process carried out by the mental health treatment team in cooperation with the inmate and with all appropriate staff. The treatment plan is updated and revised as necessary to document changes in the inmate’s condition or needs, and in the mental health services and interventions provided.”* 4.a. (3) *“As new problems arise, these should be identified and the corresponding intervention(s) indicated. The status of ongoing problems must also be documented.”*

#### **MEDICAL CARE:**

##### **A. Failure to Ensure Adequate Testing**

On October 17, 2003, a psychiatrist wrote an order for a Lithium level to be performed on JOHN DOE. According to JOHN DOE’s medical records, this lab report did not appear in his record until January 26, 2004, the date that a copy of the lab results from October 2003 was faxed to MVRCF. There is no documentation in JOHN DOE’s record that these lab results were received before this date. The ordering psychiatrist as well as the CMS employees placed JOHN DOE at considerable medical risk by not ensuring that these laboratory results were received and reviewed.

On December 22, 2003, the psychiatric nurse practitioner ordered a Lithium level and other lab work be done on JOHN DOE. There is nothing in JOHN DOE’s medical record that indicates this lab work was ever done. The psychiatric nurse practitioner and CMS employees placed JOHN DOE at considerable medical risk by not ensuring that this laboratory work was performed.

Correctional Medical Services, Inc. Healthcare Services Policy and Procedures Manual, Medical Record Format and Contents, Policy No. 60.00, #7. *Physician or designated practitioner will review all laboratory, radiology, EKG, consultations, etc. This will be ensured by physician dating and initializing report. Consultations should be*

*further addressed in progress notes.*

Correctional Medical Services, Inc. Healthcare Services Policy and Procedures Manual, Diagnostic Services, Policy No. 29.00, #6. *Diagnostic test results are reviewed by physician, dated, & initialed.*

Department of Corrections, Psychotropic Medication, Protocol 361.01.14, E. 1. *Psychiatrist documentation, e. laboratory tests requested shall be recorded on the Physician Order form and the results of said tests shall be initialed by the ordering psychiatrist and subsequently filed in the inmate's mental health file.*

There is no documentation in JOHN DOE's medical record to indicate that either the medical provider or the psychiatrist received and reviewed the ordered lab tests.

According to DOC protocol, there is a specific outline of how often Lithium testing should be completed for individuals receiving that medication. Even though JOHN DOE was receiving Lithium in the community, there is no indication that the psychiatrist, the psychiatric nurse practitioner, or CMS employees were aware of what JOHN DOE's prior Lithium levels had been, nor did they follow the DOC protocol in the number of Lithium levels ordered. The psychiatrist initially ordered a Lithium level on October 17, 2003. There is no indication the psychiatrist ever followed up on the results of this test. The next Lithium level was ordered by the psychiatric nurse practitioner on December 22, 2003. There is no indication blood work for this test was ever drawn by the nurses, nor is there any record that the psychiatric nurse practitioner followed up on the results of this ordered test.

Department of Corrections, Psychotropic Medications Protocol 361.01.14, Protocol D. #4. *The physician or psychiatric nurse practitioner initially prescribing and/or continuing to prescribe psychotropic medication must review the inmate's condition and response to medication at clinically appropriate intervals to document said response, untoward symptoms and side effects and to adjust the medication as appropriate. (a) During the initial stage of outpatient medication administration, progress notes and follow-up visits will be made by the physician or psychiatric nurse practitioner as often as necessary and clinically indicated, but not less frequently than: (1) bi-weekly for the first 30 days of medication administration; (2) monthly for the next 60 days of medication administration; (3) every 60 to 90 days thereafter.*

Department of Corrections, Psychotropic Medications Protocol 361.01.14, Appendix A, Psychotropic Medication Use Protocols, Laboratory Testing, IV. Requires Tests for Lithium...C. 2. *Required frequency of assessment (a) Determine Lithium serum levels once weekly during the acute phase and until the serum level and clinical condition of the inmate have been stabilized. (b) After serum level and clinical condition of the inmate have been stabilized, determine serum levels as follows: (I) Once a week for two weeks; (II) Then once per month for three months...(III) Thereafter, determine serum level in uncomplicated cases receiving maintenance therapy during remission every two to three months or as clinically indicated. Monitor the elderly on maintenance therapy*

more frequently.

## **B. Failure to Respond to Deteriorating Condition**

On December 27, 2003, a nurse noted on the Segregation Log for the Delta Unit “*I/M in cell, spilled milk food on floor / naked –preoccupied, nonsensical.*” There is no documentation of this encounter in the Interdisciplinary Progress Notes, nor is there any documentation that this nurse referred JOHN DOE to mental health for evaluation.

On January 1, 2004, a nurse noted that JOHN DOE was “*nonsensical, drinks from toilet, appears unable to care for self, per COs not really eating, needs med eval+ increased nursing care for ADL’s.*” Despite this documentation that JOHN DOE was in need of assistance with his activities of daily living, there is no documentation that this nurse discussed these problems with any other provider, nor did the nurse notify mental health.

On January 2, 2004, a mental health clinician noted on a Mental Health Rounds Log that JOHN DOE was “*in cell naked, odd speech,*” yet did not document that this was of concern or that he needed close observation to continue to evaluate his condition at the time. From the records that VP&A was provided, it appears JOHN DOE was not seen again, except to be given medications, until January 5, 2004.

On January 5, 2004, a nurse noted that “*CO reports I/M is falling freq.*” There is no documentation in JOHN DOE’s record to indicate that correctional officers documented JOHN DOE’s declining health or the fact that he was falling frequently, which is a violation of Department of Correction policy.

Department of Corrections, Referral for Mental Health Services, Protocol 361.01.02, B. Mental health referrals by staff members, 1. Any staff member who believes that an inmate may be in need of mental health services shall complete a Mental Health Referral Form. This form includes the following: a. observations of the inmate’s behavior.

Correctional Medical Services, Health Services Division Policy & Procedures Manual, Referral to Mental Health Services Policy No. 37.01, Procedure 2. b. Referral by correctional staff – The officer will call the H.S.U. and the nurse will determine if the request is emergent, and if so the inmate will be brought to the H.S.U. and seen as soon as possible by the mental health staff. If it is a routine referral the nurse will fill out a written mental health referral form and/or place the inmate’s name on the list for the mental health staff to see at their next visit.

A CMS medical provider noted on January 1, 2004 that JOHN DOE was not eating, that he needed assistance with his activities of daily living and that he appeared to be unable to take care of himself. Despite these observations, no plan was developed to immediately address JOHN DOE’s deteriorating condition. There is no reference that the physician would be consulted regarding JOHN DOE’s serious declining health. There is



no indication that consideration was given to housing JOHN DOE in the infirmary until he could be evaluated by a physician or psychiatrist. Instead, JOHN DOE was left unattended and allowed to deteriorate for four days before anyone sought medical help. This lack of documentation regarding JOHN DOE's deterioration during this time is hard to understand, as JOHN DOE had to have been observed by a nurse while being given his daily medications, as indicated by the Medication Administration Record for this time period.

Correctional Medical Services, Health Services Division Policy & Procedures Manual, Referral to Mental Health Services, Policy No. 37.01, Procedure 2. c. *Referral from medical staff – If a nurse or practitioner feels an inmate needs to be seen by mental health the inmate's name will be placed on the list to be seen as soon as possible by the mental health staff. If an emergency situation the inmate will be kept in the H.S.U. and mental health notified so the inmate can be seen and evaluated as soon as possible.*

### **C. Use of Restraints**

On December 19, 2003, one of the correctional officers assisting in escorting JOHN DOE from booking to a cell in the D Unit noted the following in a Facility Report Form: "...[JOHN DOE] was transported to this facility, and was uncooperative getting out of the van. Once inside the 121 door, he was asked to stand in the corner but laid on the floor instead. At this time [correctional officer] ordered that [JOHN DOE] to be carried to delta and placed in hard restraints. [JOHN DOE] was placed face down on his bunk in cell 48. [JOHN DOE] was uncooperative as the transport hardware was removed and the hard restraints place on him. This officer was holding his left arm to the bunk during this time..." It is a violation of DOC protocol, and also a significant safety risk to restrain an inmate face down.

Department of Corrections, Mental Health Restraints, Protocol 361.01.15, Protocol H. "At no time is an inmate to be restrained for mental health purposes in an unnatural position (e.g., hog-tied, face-down or spread-eagle)."

On December 19, 2003 at 6:05pm upon his arrival at NWSCF, JOHN DOE was "placed in Delta, in chains...Notified [psychiatric nurse practitioner], orders received." The Physician's Order sheet only references an order by the psychiatric nurse practitioner to give Zyprexa to JOHN DOE. There is no indication that restraints were discussed with, or approved by, mental health. The medical record reflects that JOHN DOE was released from the chains at 7:30pm. There is nothing in JOHN DOE's medical record to indicate that other less restrictive approaches were used to calm JOHN DOE's behavior before restraining him.

Correctional Medical Services, Health Services Policy & Procedures, Use of Therapeutic Restraints, No: 66.01, #2. Restraints will be used to prevent substantial bodily injury to inmate or others when inmate is "out of control," but only if all other approaches to inmate's disruptive behavior have failed. #3. Restraints will not be used as punishment or for the convenience of staff but only when less restrictive means are not

effective or appropriate clinically.

Department of Corrections, The Use of Administrative and Disciplinary Segregation for Inmates with Serious Mental Illness, Policy 370, Page 5, Restraints, *The use of physical restraints shall be instituted only when other attempts to calm or safely manage the inmate have failed and when, in the judgment of a physician or psychiatrist, the threat of serious injury to self or others warrants such a response...Restraints will be used for inmates with serious mental illness only with the approval of a psychiatrist, physician or QMHP...*”

There is no documentation or restraint log in JOHN DOE’s record that would show 15-minute checks were performed while he was restrained, as required by DOC protocol.

Department of Corrections, Mental Health Restraints, Protocol 361.01.15, V. Protocol, E. *When an inmate is placed in restraints for mental health or medical reasons, correctional or medical staff will perform 15 minute checks and document these checks on the restraint log.*”

#### **D. Informed Consent**

VP&A could find no signed Informed Consent for the Administration of Psychotropic Medication form in the records provided by the DOC for JOHN DOE in 2003. While there is a general Informed Consent form that was signed by JOHN DOE in November 2003, this does not specifically address the medication issues as outlined in the Administration of Psychotropic Medication form. JOHN DOE did not sign the medication consent form until January 2004, and this form erroneously lists EMSA Correctional Care as the contracted medical provider. Correctional Medical Services was the contracted medical provider at the time of this signing. JOHN DOE was lodged within DOC in October 2003, and subsequently prescribed psychotropic medication, yet was not asked to sign a release form nor apparently informed of the potential side effects and risks of the medications he was taking.

Correctional Medical Services, Health Services Policy & Procedures Manual, Psychotropic Medication, Policy No. 27.10, #9, *“When an inmate is prescribed a psychotropic medication, the psychiatrist will inform the inmate of the reasons for the medication, the anticipated benefits, the probable consequences if medication is not accepted, and the possible major side-effects of the medication. Informed consent for medication will be documented by completion of Informed Consent: Psychotropic Medication form. This form will be retained in the Medical Record.”*

#### **E. Other Findings**

Aside from Department protocols already noted as having been violated in this case, VP&A also finds the following were violated as well:

- DOC Directive 361.01 Mental Health Directive II. Purpose, *The mission of the Vermont Department of Corrections' (VDOC) mental health services is three-fold: (1) to provide comprehensive clinical services to alleviate symptoms and reduce suffering; (2) to enhance the safety of the correctional facility environment for inmates, staff and visitors; and (3) To ready inmates with mental illness for participation in risk reducing programs through direct services, case coordination, and research evaluations."*

This directive was violated as evidenced by the fact that JOHN DOE did not receive adequate mental health treatment even though it is documented by medical and mental health staff that his mental and medical condition consistently deteriorated during his incarceration.

- It was evident from JOHN DOE's records that the medical providers and the mental health providers were not communicating regularly in trying to treat JOHN DOE. Part of the Department's contract with Paul Cotton L.L.C. states that this type of partnership will exist so as to provide continuity of care for the inmate.

- It was evident from JOHN DOE's records that there was no oversight of nursing and mental health staff by any of their superiors. Had there been oversight, some of these omissions in care could have been caught and dealt with and potentially could have saved JOHN DOE from this traumatic event.

- It is important to note the different medications that JOHN DOE was taking at this time had contraindications noted in the Nursing Drug Guide. It is recommended not to prescribe Prozac and Lithium together as doing so may result in Lithium toxicity. JOHN DOE was receiving these two medications simultaneously. Some of the other medications can cause symptoms such as dehydration and high sodium levels, which also creates the environment for Lithium toxicity to occur. As JOHN DOE was not drinking nor eating well during this time, all of these different variables together may have contributed to the medical crisis that he suffered.

## VI. SUMMARY

From review of JOHN DOE's case the Department of Corrections and its contracted providers failed to provide adequate mental health and medical care in his case which ultimately led to very serious medical complications and mental health deterioration that could have permanently disabled him or caused his death. One of the issues that weighs heavily in this case is that the mental health providers never documented a detailed treatment plan to address JOHN DOE's underlying serious mental illness. The only plan apparent from reviewing the records, especially during his psychotic episode, was to keep medicating him until his psychosis dissipated. There was no discussion documented in the mental health notes by the psychiatrist or the psychiatric nurse practitioner around providing any type of intensive mental health therapy or perhaps considering a transfer to the Vermont State Hospital for closer observation and treatment.

Records are not clear as to why JOHN DOE was not admitted to Northwestern Medical Center in St. Albans on January 5, 2004, as he was sent there for laboratory tests and a CT scan. Instead, he was returned to the prison in Swanton, transferred that same day to the infirmary at the prison in Newport. From there he was sent via ambulance to North Country Hospital on January 6, 2004. It appears as though the severity of his condition was not adequately assessed until he reached the infirmary in Newport.

## VII. RECOMMENDATIONS

Based on its findings and conclusions, VP&A recommends that the following actions be undertaken by staff and all contracted providers at all the correctional facilities in Vermont:

1. **Verifiable and ongoing staff training in recognizing and reporting behaviors that are potentially life threatening for the individual experiencing them.**
2. **Requiring psychiatrists to spend enough time in facilities to adequately assess the mental health needs of inmates.** Psychiatrists have the ultimate duty to provide mental health treatment to inmates when those inmates are referred to them. The psychiatrist must ensure that when an inmate has been referred for psychiatric evaluation and that inmate is transferred before the psychiatrist has had a chance to evaluate that inmate, that the receiving facility be aware of the need for an immediate psychiatric evaluation. A system to verify the actual amount of time psychiatrists spend with individual inmate/patients is strongly recommended.
3. **Assure that outside records are obtained and reviewed by the ordering physician when an inmate is lodged who has a history of mental illness or is experiencing symptoms of a mental illness.**
4. **Assure continuity of care.** No one took responsibility for following up on the laboratory work for Lithium levels that was repeatedly ordered, and no results were found in JOHN DOE's record until January 2004. JOHN DOE was admitted to the hospital with a partial diagnosis of Lithium toxicity. The psychiatric nurse practitioner should not have increased JOHN DOE's Lithium level while he was experiencing increased psychosis, as he was not aware of what JOHN DOE's current Lithium level was. The supervising psychiatrist should have also questioned the increase in Lithium without any laboratory work supporting the medical safety for doing so.
5. **Assure through repeated testing that policies, directives, and procedures are taught to all staff and contracted employees, including the psychiatrists, and that these rules are followed consistently.**
6. **Staff, contracted providers and state employees who violated policies or standards of care should be disciplined or terminated depending on the severity of**

**violation.**

**7. The Department of Corrections should re-evaluate whether to consider Correctional Medical Services and Paul Cotton LLC as potential providers in future contract bids due to continued documented neglect of inmates.**

**8. Assure that all medical and mental health clinical staff are properly educated on the use of and prescribing of medications.**

**9. In the future the Department of Corrections should conduct internal investigations whenever an inmate is admitted to a hospital for emergency care. In this case, the Department should have conducted an internal investigation as soon as they were aware that JOHN DOE's condition was life-threatening upon admission to the hospital. This would have ensured that the Department was monitoring the care that inmates were receiving by the contracted providers, and to assure that future incidents such as this did not occur.**

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