

Investigation Into the Death of Michael Estabrook While In
the Custody of the Vermont Department of Corrections

Vermont Protection & Advocacy, Inc.
Special Investigations Unit
141 Main Street, Suite 7
Montpelier, Vermont 05602

July 9, 2007 Public Report

www.vtpa.org

VP&A is the Protection & Advocacy System for Vermont.

Table of Contents

I.	Introduction.....	03
II.	Background.....	04
III.	VP&A’s Investigation.....	05
IV.	Sequence of Events.....	05
V.	VP&A’s Findings.....	17
	Medical Furlough Issues.....	17
	Worsening Condition and Symptoms.....	20
	Infirmary.....	21
	Medication Issues.....	22
	Do Not Resuscitate Issues.....	23
VI.	Recommendations.....	25

I. Introduction

This report presents the results of an investigation conducted by Vermont Protection & Advocacy, Inc., (VP&A) into the death of Michael Estabrook on March 7, 2006 at Fletcher Allen Health Care (FAHC) while in the custody of the Vermont Department of Corrections.

In April of 2005 Mr. Estabrook was initially detained at the Chittenden Regional Correctional Facility (CRCF) in South Burlington for failure to appear in court on August 3, 2004 for a contempt hearing for failure to pay a fine. He was also charged with possession of marijuana when he was arrested. During his incarceration Mr. Estabrook was transferred to Northern State Correctional Facility (NSCF), Northwest State Correctional Facility (NWSCF) and Southern State Correctional Facility (SSCF).

Mr. Estabrook was a 37 year-old male, divorced with two children, who suffered from a disabling disease called severe dilated cardiomyopathy.¹ As a result he was also in congestive heart failure.² Mr. Estabrook's medical condition deteriorated during the year he was incarcerated resulting in hospitalization on two occasions. He requested, and was denied, a medical furlough. Mr. Estabrook claimed he was not receiving adequate medical care while incarcerated and that his housing situation caused undue stress and exertion on his body. While in SSCF he requested several times to be transferred back to the jail in South Burlington where, because of the size and layout of the facility, he was able to ambulate with less difficulty. His request to be moved was not granted even though the medical provider at the facility documented that he "...has some effective justification for wanting to be housed at Chittenden..." Beginning in January of 2006 Mr. Estabrook also requested to be housed in the infirmary at the Springfield facility to accommodate his deteriorating physical condition and to make it easier for him to get to areas of the prison. The Department failed to follow up on this request.

¹ Dilated cardiomyopathy (DCM) is a condition in which the heart's ability to pump blood is decreased because the heart's main pumping chamber, the left ventricle, is enlarged and weakened; this causes a decreased ejection fraction (the amount of blood pumped out with each heart beat). In some cases, it prevents the heart from relaxing and filling with blood as it should. Over time, it can affect the other heart chambers as well. www.webmd.com WebMD Medical Reference in collaboration with the Cleveland Clinic.

² Congestive heart failure (CHF), or heart failure, is a condition in which the heart can't pump enough blood to the body's other organs. This can result from *narrowed arteries that supply blood to the heart muscle — coronary artery disease; *past heart attack, or myocardial infarction, with scar tissue that interferes with the heart muscle's normal work; *high blood pressure; *heart valve disease due to past rheumatic fever or other causes; *primary disease of the heart muscle itself, called cardiomyopathy; *heart defects present at birth — congenital heart defects; *infection of the heart valves and/or heart muscle itself — endocarditis and/or myocarditis; *The "failing" heart keeps working but not as efficiently as it should. People with heart failure can't exert themselves because they become short of breath and tired. [American Heart Association Website](http://www.heart.org)

On January 22, 2006, VP&A met with Mr. Estabrook during outreach at SSCF. He requested help with possibly being transferred back to CRCF for the reasons stated above. He expressed concern about being in a single man cell in the Charlie Unit (medical unit) in the event that he suffered another cardiac event. His main concern was that no one would find him in time to save him, therefore he asked for a cell where he could have a roommate. At that time Mr. Estabrook required a wheelchair to move around.

On February 22, 2006, advocates from VP&A had a scheduled meeting with Mr. Estabrook at SSCF to prepare an advance directive for health care³. At this visit Mr. Estabrook was extremely fatigued, had swelling in both of his feet and ankles, and appeared jaundiced. Mr. Estabrook stated that he had not been producing any significant urine output for several days and that no one from the medical staff was taking this seriously. Mr. Estabrook required assistance to return to his unit which was just around the corner. He was not able to open the doors by himself and was very slow and unsteady on his feet. We discussed his condition with medical staff and learned that Mr. Estabrook had an appointment scheduled for that same day with his cardiologist.

Throughout his last 11 months of incarceration Mr. Estabrook had only three visits with his cardiologist. The third visit was on February 22, 2006, where he collapsed entering the office and was subsequently transferred to Fletcher Allen Health Care. It is important to note that in 2004 Mr. Estabrook was also incarcerated for a few months. During that incarceration he went into renal failure and had to be hospitalized. He was subsequently released on medical furlough due to the severity of his illness.

On March 7, 2006, Mr. Estabrook died at Fletcher Allen Health Care from complications of dilated cardiomyopathy.

II. Background

- A. Vermont Protection & Advocacy, Inc., (VP&A) is a federally-funded, not-for-profit organization mandated to investigate abuse, neglect and rights violations effecting people with disabilities.
- B. Chittenden Regional Correctional Facility (CRCF) is a jail located in South Burlington, Vermont.
- C. Southern State Correctional Facility (SSCF) is a prison located in Springfield, Vermont.

³ 18 VSA § 9701 Definitions. (1) "Advance directive" means a written record executed pursuant to section 9703 of this title, which may include appointment of an agent, identification of a preferred primary care clinician, instructions on health care desires or treatment goals, an anatomical gift as defined in subdivision 5238(1) of this title, disposition of remains, and funeral goods and services. The term includes documents designated under prior law as a durable power of attorney for health care or a terminal care document.

- D. Northwest State Correctional Facility (NWSCF) is a prison located in Swanton, Vermont.
- E. Northern State Correctional Facility (NSCF) is a prison located in Newport, Vermont.
- F. At the time of Mr. Estabrook's death, Prison Health Services was the contracted medical provider.
- G. At the time of Mr. Estabrook's death, MHM Services, Inc. was the contracted mental health services provider.

III. VP&A's Investigation

VP&A's investigation of this case included the following:

1. Interviews conducted with Mr. Estabrook before his death
2. Review of medical and mental health records from the Vermont Department of Corrections
3. Review of core file records from the Vermont Department of Corrections
4. Review of medical records from Fletcher Allen Health Care, Rutland Regional Medical Center and Regional Ambulance Service
5. Review of American Heart Association information on dilated cardiomyopathy and congestive heart failure
6. Interview with family member
7. Review of medical examiner's report
8. Discussions with staff and contracted providers for the Vermont Department of Corrections
9. Review of Vermont law on "Do Not Resuscitate" orders
10. Review of Department of Corrections Policies and Directives
11. Review of several online sources of medical information
12. Review of PHS Policies and Procedures

IV. Sequence of Events

Mr. Estabrook was incarcerated in 2004. During that incarceration, he experienced significant medical problems as reflected in the following information contained his Department of Corrections records:

May 17, 2004 "New intake – hx dilated cardiomyopathy...feel pt's needs would best be served at this time by infirmary housing..." [MD]

June 3, 2004 Medical note at NSCF: "...C.O. called to say that IM was having chest pain...EKG done. Returned to unit." [RN]

June 4, 2004 Medical note at NSCF: “Chest pain – in neck L shoulder & upper arm & all sweaty...Diaphoretic + clammy. EKG shows pacer spike on T wave. Alt comfort, alt health maint R/T pacemaker malfunction. Dr... paged 911. Orders rec'd to send to E.R.” [RN]

June 4, 2004 “‘Scared’ – talking non-stop about unrelated topics. Ambulance att present – I/M on stretcher [with] 02 on...”

June 4, 2004 1115 “Returned from NCH. ‘I feel lots better.’ ... Dr... notified of I/M return + need for pm ck today. Orders rec'd.” [RN]

June 4, 2004 2200 “At approx 1500 today we were notified that Mr. Estabrook has been admitted into Fletcher Allen Hospital.” Medical Note.

June 8, 2004 Fletcher Allen Health Care – Nsg [nursing] Note for discharge of PT [with] CHF: “Pt should be weighed daily at the same time each day before breakfast. This is to assure the correct dosage of lasix, that he’s not losing to [sic] much or retaining to [sic] much fluid. Symptoms: He needs to be watched for shortness of breath [with] exercise or difficulty breathing at rest or when lying flat, swollen legs, ankles, or abdomen, dry, hacking cough or wheezing, fatigue, wgt gain, [increase] urination @ night, dizziness or confusion, rapid or irregular heartbeats. Call MD if gain 2lbs in one day or 5 lbs in one week. Make sure a good record of his daily wgt is kept....”

June 8, 2004 Fletcher Allen Health Care Discharge Summary: “Discharge Diagnoses 1. Acute renal failure secondary to over-diuresis⁴. 2. Dilated cardiomyopathy....” [MD]

July 16, 2004 Letter to Director of Clinical Services from Superintendent at NSCF: “I have been informed by Nurse Manager... that Michael Estabrook is suffering from a terminal medical condition and is in need of a medical furlough. Michael Estabrook is a 36 year old offender. Mr. Estabrook is serving a 3 years to 7 years sentence for DWI #6 and DLS #1. His minimum release date is 04/27/07. According to directive 351.08 The Commissioner may place on medical furlough any inmate who is serving a sentence, including any inmate who has not yet served the minimum term of sentence, who is diagnosed as suffering from a terminal or debilitating condition so as to render the inmate unlikely to be physically capable of presenting a danger to society. Due to this current condition Mr. Estabrook is not considered a risk to the public.”

⁴ Diuresis is the secretion of large amounts of urine. – [Medline Plus Website, U.S. National Library of Medicine](#)

Mr. Estabrook was released on medical furlough approximately on July 21, 2004. VP&A could not find an actual release date due to the insufficient records provided. After his release on medical furlough, Mr. Estabrook continued to have serious medical problems. These problems are reflected in the Probation and Parole case notes quoted below:

January 28, 2005 Probation & Parole Case Notes: “Michael is at home...Had surgery on Tuesday to reimplant new pacemaker, has two wounds on chest, states he is already feeling a difference from it...”

February 8, 2005 Probation & Parole Case Notes: “Michael called the machine to advise he had been admitted to the hospital. He said he is on McClure 5...and that he would call when he got discharged.”

February 10, 2005 Probation & Parole Case Notes: “Mike called, left a message that he was released from the hospital...”

April 27, 2005 Probation & Parole Case Notes: “Spoke with [officer] at Burlington PD. He was looking at the updated Furlough lists we were bringing in. He believes that Mike Estabrook has an active warrent [sic] out for his arrest. [officer] calls dispatch and they check and confirm that there is an active warrent [sic] for Mike dating back to November of 04.”

April 27, 2005 Probation & Parole Case Notes: “...At 2115 hours we went over to Estabrook’s home...Estabrook was taken into custody, he was very agitated...”

April 28, 2005 Mr. Estabrook is detained at the Chittenden Regional Correctional Facility.

April 29, 2005 Probation & Parole Case Notes: “...There was an arrest warrant for Mike as he failed to appear on 8/3/04 for a contempt hearing for failure to pay fine. The amount was for \$601. Mike was ordered for arrest until he could satisfy the contempt order by paying the fine in full...”

After he was re-incarcerated in 2005, Mr. Estabrook’s medical condition did not improve as reflected in his DOC records quoted below:

May 10, 2005 PHS Physician’s Order: “Send to ER via 911 per TVO [doctor].” This was due to complaint of chest pain.

May 11, 2005 An Outpatient Referral Request Form completed by Prison Health Services staff read: “To ED [after] CP [chest pain] on 5/10/05. EKG

NSR w/pacer spikes. Defib unit did not fire. ED found [change] in kidney function – probable prerenal azotemia.”⁵

May 11, 2005 Note from Fletcher Allen Health Care “patient should be weighed daily to help manage cardiac condition. He should see [cardiologist] this week for evaluation of the change in kidney function...”

May 18, 2005 Case note “Met with Michael and he asked what was going on. I told him that I am wanting [sic] for some answers from central office on his medical furlough...”

June 1, 2005 Mr. Estabrook had an appointment with [cardiologist] who noted in a letter to Prison Health Services: “...Mr. Estabrook continues to be marginally compensated. He needs continued attention to his underlying congestive heart failure. He needs to watch his sodium and fluid intake...I’ve asked him to see me in the office in six to eight weeks for repeat ICD evaluation. Mr. Estabrook has a significant cardiomyopathy and has a relatively tenuous status...”

June 22, 2005 Email From CWS to DOC Medical Director. “Subject: Michael Estabrook. Do you know anything about this case? He was on a Medical Furlough. His current minimum is 4/27/07 which is about 21 months prior to normal furlough eligibility. An exception can be made for someone on Medical Furlough. Are you involved in re-assessing his Medical condition?”

June 23, 2005 Email from DOC Medical Director to CWS: “Hi... Sorry I don’t recognize your...name. What is your connection to the offender?”

June 23, 2005 Email from CWS to DOC Medical Director: “I am the CWS at Chittenden. I need to determine what to do with Mr. Estabrook. Should he be reviewed for a return to a Medical Furlough? Does his current physical condition warrant being placed on furlough? If the decision is that he remain incarcerated should he be placed at a facility with more extensive medical facilities? I suspect that [name removed] was involved in the original decision which is why I E-Mailed you. I had also heard that you were involved in a review of the case however that may not be true.”

June 23, 2005 Email from DOC Medical Director to CWS. “Thanks...I did review his case about a month ago. At that time, I recommended against a

⁵Definition: Prerenal azotemia is an abnormally high level of nitrogen-type wastes in the bloodstream. It is caused by conditions that reduce blood flow to the kidneys. Prerenal azotemia is reversible if the cause can be identified and corrected within 24 hours. However, if the cause is not corrected quickly, damage may occur to the internal structures of the kidney ([acute tubular necrosis](#)). MedLine Plus, Service of the U.S. National Library of Medicine

medical furlough based on my understanding of the criteria for granting furloughs. I am happy to review it again if there has been a change in his condition. Essentially, he has a serious medical condition that is chronic and stable. At the time of my review, he was not in need of special housing. He was scheduled for a follow-up with his cardiologist this month which may shed additional light. His cardiologist did inform us that Mr. Estabrook did not keep hi [sic] appointments while residing in the community. If you think this should be reconsidered, please advise as to your rationale and I will ask the medical staff to re-examine his situation.”

June 23, 2005 Email from CWS to DOC Medical Director: “No. There isn’t anyone pushing for another review, we didn’t know the results of the original assessment. I’ll check with medical regarding the date of his next apt. If there hasn’t been a dramatic change or an on-going need for treatment in this area, we will consider placement at another facility.”

July 18, 2005 Case note written by CWS “...was placed on a medical furlough when he was originally sentenced. He was returned to this facility in April on a warrant. The issue has been resolved however the basis for the Medical furlough was reviewed by Central Office. A decision has been made that it is not warranted at this time...”

July 18, 2005 Transferred from CRCF to SSCF.

July 19, 2005 Transferred from SSCF to NSCF for “population management.” “d/c to medical hsg unit.” PHS Note.

July 29, 2005 Physician at NSCF wrote the following note: “...will consider transfer to facility [with] higher level nursing care, closer to cardiologist in FAHC...”

August 9, 2005 Prison Health Services fax sheet to [doctor] from Physician at NSCF: “...Michael’s care basically remains a guessing game as to how to adjust his diuretics. During his last incarceration he wound up in acute renal failure. Thanks...”

August 16, 2005 Physician at NSCF wrote the following note: “...stood + argued for several minutes that he wanted me to call [cardiologist] about getting him medical furlough (I told him this had already been d/w Dr.’s...”

September 13, 2005 VT Dept of Corrections Grievance #1 filed by Mr. Estabrook while at NSCF. “Every night on third shift this unit and [illegible] are left unattended for extended periods of time. There are chronically ill individuals (including myself having been described w/a tenuous condition by my cardiologist I have these docs.) that could not summon help if and when needed...As w/any other grievance in this system I do so w/great reluctance

for fear of retaliation. However, I know my safety and my life are in jeopardy so I don't care. Do what you need to do. If DOC or PHS is going to keep chronically and seriously ill patients in this facility they should be able to summons [sic] immediate help at all times. What should be [sic] the outcome be? I believe I will [sic] may my atty. Aware of this situation who will also make the presiding Superior Court Judge aware of the problem. He will be unimpressed. This should really help my suit against DOC. The facility is understaffed and misconduct rampant.”

September 16, 2005 DOC Case Notes: “Michael has left the facility and was transferred to Southern State.”

September 20, 2005 Mr. Estabrook saw [cardiologist] who noted a 30 pound increase since June, but that client was reasonably stable.

September 28, 2005 Case note written by [caseworker]: “Met with Michael Estabrook today. He is here from Newport due to medical issues. From the casenotes, it seems that Michael has to serve his minimum. It appears that he is asking me the same questions that he asked of his other CSS in Newport, for medical furlough...When talking to the Nurse manager here at SSCF...I was under the impression that Michael quite possibly may not make it to his minimum with the heart condition that he has...”

September 28, 2005 Licensed Nursing Assistant note about Mr. Estabrook stating he was a “DNR” and that he wanted to enter into a discussion about his right to choose.

October 18, 2005 DOC Case Note by case worker: “Met with Michael in the Infirmary Ward where he remains until a lower room becomes available in the Charlie Unit. Explained to Michael that he will not be eligible for release to the community on furlough due to his medical needs have not become more severe according to medical staff. Informed him that I had reviewed the casenotes and that at which time that his medical needs become more than the facility can handle he may be eligible for medical furlough...I spoke to Nurse Manager...and he stated that there was no reason that Michael could not get up and around more than what he was doing in the infirmary...”

October 20, 2005 VT Dept of Corrections Grievance Form #2, NSCF Response to Mr. Estabrook's Grievance #1. “I/M grieving the fact that there is only one nurse on at night. *Investigative Action Taken:* None. *Summary of Facts:* Contract between DOC + PHS for this facility only requires one LPN on night shift. *Recommendation:* Dismiss. *Superintendent's Decision:* Facility has 24 hour medical coverage. No further action is required.”

October 29, 2005 Mr. Estabrook was admitted to the Springfield Hospital for chest pain. There was a discussion about putting him back in the medical

infirmary at prison so he would not have to walk long distances. Physician wrote: "I recommend the patient be returned to the correctional facility and be placed in the infirmary...This plan was discussed with the patient's escort who confirmed that these requirements could be fulfilled."

October 31, 2005 DOC Case Note by caseworker: "...Will email...regarding what it would take for him to be reconsidered for this furlough."

November 2, 2005 DOC Case Note by caseworker: "...Spoke with [LUS] yesterday about possible medical furlough for Michael. She informed me that as long as he can be treated by the facility that a medical furlough would not be an option for Michael at this time..."

November 3, 2005 Mr. Estabrook was transferred from SSCF to CRCF.

November 4, 2005 Mr. Estabrook was transferred from CRCF to NWSCF.

November 8, 2005 Mr. Estabrook was transferred from NWSCF to SSCF.

November 18, 2005 VT Dept of Correction's Grievance Form #1 filed by Mr. Estabrook at SSCF: "Nursing staff (not nurse manager) trying to convince me to come to main bldg. for meds. I thought this issue had been decided. I am not going to get better. This will cause additional stress on my heart unnecessarily. Distribute meds in unit bldgs as before."

November 25, 2005 PHS Progress Note: "I/M complaining of increased swelling, weakness, shortness of breath...I/M has minimal swelling in lower legs...Will continue to monitor." [RN]

November 29, 2005 DOC Case Note caseworker: "Met with inmate * in my office this pm. He stated to me in regards to his recent medical condition in which accdng [sic] to him he has severe heart problem. He also requested to this CSS if he could go back to Chittenden which his regional area and a smaller facililty [sic] in terms of everyday mobility. I stated to him that I will get in contact with our movement."

December 6, 2005 Mr. Estabrook submitted written request to be transferred to CRCF.

December 7, 2005 VT Dept of Correction's Grievance Form #2, SSCF Response to Mr. Estabrook's Grievance #1 filed 11/18/05. "I/M complains that nursing staff are trying to have him come to main med for med. pass. I/M has been receiving his meds in the Charlie Unit due to a chronic heart condition as he become short of breath walking to main med. Cont. to distribute his meds in Charlie unless there is a significant improvement. Only

the nurse mgr will make this decision. No further action – inmate is taking his meds in the unit.”

December 7, 2005 Sick Call Request slip submitted by Mr. Estabrook: “This sustained tachachardia [sic] continues to be a problem. I have seen no action taken in this matter. This has ocured [sic] approx. 10x in 6 wks. I want to meet w/the Doc. To discuss this matter.”

December 12, 2005 PHS Progress Note by physician “...thinks he may have a flu-like illness now...Notes that he hasn’t gotten Lisinopril in recent days...”

January 3, 2006 PHS Progress Note “...Today’s weight of 172 ½ is stable...”

January 6, 2006 DOC Case Note by caseworker: “Met with inmate Estabrook last night and again explained to him his request to be transferred out of SSCF. I explained to him that according [sic] to the Med team that he is to be remained here at SSCF and such request is denied. Please note that this CSS did request this transfer to the medical team and was told that inmate * will reside here at SSCF since this is the medical unit now.”

January 6, 2006 Prison Health Services Memo stating that Mr. Estabrook had an appointment with his cardiologist on January 25, 2006. There is a handwritten note on this typed memo that reads: “Canceled. DOC did not take him. New appt. 2/22 @ 3:30.”

January 9, 2006 Mr. Estabrook submitted a written request to be returned to CRCF. “I would like DOC + medical to consider transferring me back to my regional (CRCF) with the provision that I sign a notarized release of liability absolving DOC + medical of legal liability (that’s what this is really about after all) in the event of a catastrophic or fatal cardiac.”

A PHS physician met with him and noted: “Discussed above with IM. As previously, I think he has some effective justification for wanting to be housed at Chittenden. Will discuss with [doctor]...weight 168#...”

January 17, 2006 Mental Health Progress Note by [clinician name]: “...’I feel frustrated and powerless and hopelessness.’ Feelings are related to his efforts to return to Chittenden facility. He is currently on Charlie Unit, is fearful of the potential difficulty of calling attention to himself if he needs help (no roommates, door locked) and also feels cut off by his cardiac condition as he does not have the strength to use a wheelchair and the distances involved at SSCF are dangerous for him to walk. After discussing the situation we identified some steps he could take including writing to [DOC physician] again, talking with LUS...and moving to the infirmary (which he

had previously rejected because it was associated with death and dying in his mind...)...Spoke with LUS...regarding possible transfer to Infirmary. MH staff will remain available for clinical supports PRN.”

January 22, 2006 VP&A met with Mr. Estabrook for the first time at SSCF during outreach. Mr. Estabrook was concerned about his placement in the Charlie Unit in a single man cell. His concern was that if something happened to him that no one would find him in time to help him. He wanted to be where he would have someone close by and also wanted to go to CRCF.

February 9, 2006 Mental Health note by [clinician name]: “Mr. Estabrook seen in response to sick slip request. Today he speaks more openly about the possibility that he may die before he gets out of prison...He reiterates that he feels that CSS...is deliberately blocking his transfer to any other facility or his release...Mr. Estabrook scheduled for medication review 3/1/06 and it is unlikely that a physician will be able to see him before that date. He is not experiencing self-harming or suicidal ideation; on the contrary, he is angry that he is dying.”

February 10, 2006 PHS note “...respond to Charlie Unit. I/M c/o pressure pain in diaphragm [sic] area causing SOB [shortness of breath]...Order obtained per [DOC physician] by charge nurse to send to infirmary for 24 [hour] observation and juice.”

February 10, 2006 Physician’s Order by [DOC physician]: “Admit to infirmary for 24 hour observation. Encourage real fruit juice.”

February 10, 2006 PHS note “...WT 171...”

February 11, 2006 PHS note “I/M complaining of feeling faint. Vital signs 92/60 P70, R20, 98% RA. States could not palpate pulse. Radial pulse palpable upon assessment...”

February 12, 2006 PHS note “80/48, P-45 irregular (radial)...color pale – continue to monitor present condition.”

February 13, 2006 Discharged from infirmary, placed in Charlie Unit.

February 14, 2006 DOC Case Note by [LUS]: “I met with Michael Estabrook. He reported that he is concerned about his heart condition and he thinks that his pace maker / defibrillator needs to be checked. I told Michael that I would check into this issue for him.”

February 16, 2006 DOC Case Note by [LUS]: “I received a message from... in medical. She informed me that the request for outside referral for

Michael to see the cardiologist has been approved by [doctor] and he is scheduled to see a cardiologist on 02-22-06.”

February 16, 2006 PHS note “I’m cold. I know I see the cardiologist soon. I’d rather be in the infirmary because if something was to really go down.’ ... Enc. I/M to return to bed and elevate feet. Notified charge nurse...Orders came from MD via charge nurse...enc. Fluids of juice...I/M reports [increase] SOB when lying flat on back. And [increase] dizziness [sic] when ambulating to bathroom. Other wise comfortable and taking in significant amt. of fluids. [decrease] cardiac output R/T hx heart failure. Cont. to monitor per MD orders.”

February 16, 2006 DOC Case Note by LUS: “I met with Michael this afternoon. He reports that he is very low on energy and has difficulty breathing. I told him that he will see the cardiologist soon. He would like to move back to the infirmary. I told him that I would consult with medical staff about this request. I am also asking for him to be reevaluated and considered for another medical furlough.”

February 17, 2006 PHS Physician’s Order: “DNR”⁶ written, signed by physician (unable to read name).

February 17, 2006 PHS Physician’s Order: “Encourage juice / Gatorade. Vital signs every 2 hours x3. Then every 4 hours. T.O. [DOC physician].”

February 19, 2006 PHS note “I drank 60oz and my output was only 15oz stunk up my room + was the color of the apple juice here...f/u [with] MD [with] regards to above matter.”

February 19, 2006 PHS note “IM request v/s [vital signs] to be taken c/o pain – sternum + up to shoulders...”

February 22, 2006 VP&A met with Mr. Estabrook and discussed physician’s order dated 2/17/06 which read “DNR” and signed by PHS physician. Mr. Estabrook was unaware that the physician had written this order and stated that he was not consulted prior to this order being written. Mr. Estabrook further stated he did not wish to be a DNR until he made up his mind that he is ready to do that. Mr. Estabrook wrote a statement rescinding the physician’s DNR order on this date and VP&A assisted him in completing an Advance Directive document. Both the Advance Directive document and the statement rescinding the DNR order were hand delivered to the nurse manager. During discussion with the nurse manager about Mr. Estabrook’s desire to be moved to the infirmary she stated that she did not feel he needed to be in the

⁶ 18 VSA § 9701 Definitions (6) “Do-not-resuscitate order” or “DNR order” means a written order of the principal’s clinician directing health care providers not to attempt resuscitation.

infirmary as the infirmary was for sick people. But if his condition were deteriorating she would reconsider moving him there.

At this visit Mr. Estabrook was extremely fatigued, had swelling in both of his feet and ankles, and appeared jaundiced. Mr. Estabrook stated that he had not been producing any significant urine output for several days and that no one from the medical staff was taking this seriously. Mr. Estabrook required assistance in returning to his unit that was just around the corner. He was not able to open the doors by himself and was very slow and unsteady on his feet. We questioned his condition with medical staff who indicated that Mr. Estabrook had an appointment scheduled for that same day with his cardiologist.

February 22, 2006 PHS Physician's Order: "Patient is now a full code per directive written on 2-22-06. T/O [physician name]"

February 22, 2006 PHS note "Spoke [with] [cardiologist] @ Rutland ER...[cardiologist] state I/M collapsed in office. [Cardiologist] stated class 4 CHF, kidney failure, renal insufficient...[Cardiologist] stated that they would be transferring him to Fletcher Allen Hospital..."

February 22, 2006 PHS note "[Physician] informed of situation...informed [physician] of code [change]." Then noted "Late entry. [Cardiologist] informed of I/M [change] of code status from DNR to full code."

February 22, 2006 Regional Ambulance Service Run Form" "While walking into the doctors office the patient became lightheaded and had a near syncopal episode, falling to the floor. Also had chest pain that he described as 10/10 crushing pain in the left side of his chest. Since sitting and relaxing the pain decreased to 6/10. Placed patient on the stretcher and loaded into the ambulance. Patient stated that he has been feeling poorly during exertion lately and has had hypotensive episodes...Patient stated that he did not get his Amiodarone a couple of times during the past week. Patient transported to RRMC ED and turned over with a verbal report."

February 22, 2006 Rutland Regional Medical Center Emergency Department Report: "Patient is a 37-year-old who was inadvertently in [doctor's] office when he had sudden unexpected syncope, that he was actually on his way for an outpatient cardiology appointment with [cardiologist] when this occurred. Mr. Estabrook states that he has constant left anterior chest discomfort, this is more of a pressure and is not acutely worsened at present. This is nonradiating. There is no jaw, neck or shoulder pain. Mr. Estabrook notes that his health has been deteriorating for several years...Mr. Estabrook notes that he has gained some 20-30 pounds during the last 3 weeks. He has begun having increasing pedal edema and notes that he has never had swelling of his ankles to this degree. He also notes that he has

not been urinating very much in the last 2 weeks...Patient is an inmate in the correctional system and when he began to pass out the guard was able to catch him and gently lower him to the floor. By the time EMS had arrived Mr. Estabrook had come back to consciousness...[Cardiologist] has actually arrived to see patient and has assumed his care. I am relinquishing care. Preliminary diagnosis of acute syncope and hypotension. Must rule out renal failure..." [MD]

February 22, 2006 Regional Ambulance Service Run Form: "Patient was transferred to FAHC due to renal failure/CHF. Patient was on the cardiac monitor for the transport showing a paced rhythm in the 70's...Patient is in custody and is accompanied by a guard. TOT FAHC staff with a verbal report."

February 22, 2006 FAHC History and Physical Examination completed by [cardiologist]: "This is one of several Fletcher Allen Health Care hospitalizations for Michael Estabrook, an unfortunate 37-year-old gentleman who is transferred emergently from Rutland Regional Medical Center emergency room with worsening congestive heart failure and renal insufficiency...He has dilated cardiomyopathy complicated by multiple heart rhythm abnormalities and arrhythmias. The patient has been hospitalized multiple times in Burlington. Mr. Estabrook has been in and out of difficulty with the law and is presently incarcerated. The patient reports a two to three month history of worsening shortness of breath, fatigue, lightheadness [sic] and edema. I last saw the patient in September of 2005...Over the last few months, Mr. Estabrook has had multiple symptoms of worsening shortness of breath, orthopnea⁷, and worsening edema...Medications at this time include amiodarone 200 mg twice daily, Lasix 80 daily, carvedilol 12.5 twice daily, warfarin as directed, Klonopin 3 mg twice daily, lisinopril 10 mg daily, nitro patch...Assessment/Plan:...4. Hypothyroidism: This is likely drug-induced and related to amiodarone...5. LFT abnormalities: The patient has elevated bilirubin, which undoubtedly is related to his amiodarone. Amiodarone will be held for the time-being. Overall, the patient is in very poor health and may well need a cardiac transplant in the near future if that is possible."

February 22, 2006 FAHC Admitting History & Physical "...Over last 2 weeks he had [increased] SOB and wt gain around 15 lbs has also noticed [increased] fatigue and leg edema. He thinks this started when his prison ran out of lisinopril..."

February 23, 2006 FAHC Nursing Acute Care Flow Sheet "...weight 83.1 kg..." [Note: 83.1 x 2.2 = 182.8 weight in pounds]

⁷ **Orthopnea:** The inability to breathe easily unless one is sitting up straight or standing erect. [Medicine.Net](http://www.Medicine.Net), Owned and Operated by WebMD.

February 23, 2006 FAHC Clinical Record – General Progress Notes:
“...1500 cc fluid restriction, strict I/O’s, daily wghts...”

February 24, 2006 PHS note “Called Fletcher Allen – spoke with inmate’s nurse...She stated that he would be in at least a week for tests and [decreased] BP, diuresing...”

February 24, 2006 VP&A spoke with Living Unit Supervisor at SSCF, on the telephone. We were informed of Mr. Estabrook’s status. VP&A inquired if his Advance Directive document went with him to the hospital. LUS said she would check with medical and let VP&A know. She called back later this same day and informed us that the nurse manager stated that his Advance Directive did go with him to the hospital.

March 6, 2006 FAHC Records: “‘Still don’t feel well.’ Tired, feels ‘out of it’, funny dreams. Shortness of breath unchanged...”

March 7, 2006 FAHC Records: “...Feeling poorly...abdomen distended...twitching.”

March 7, 2006 DOC Case Note by Assistant Superintendent at CRCF:
“Received a phone call from CO...at 1811 hours reporting that Mr. Estabrook passed away at 1808 hours. On 2/23/06 Mr. Estabrook was transferred from the Rutland hospital to FAHC due to his medical needs exceeding their ability to meet them. He had a heart condition that was deteriorating. I spoke with Nurse...at FAHC who said they expected him to pass away given his deteriorating [sic] health condition. [Nurse] also reported that the attending Doctor was on the phone as we spoke notifying his 2 sisters that were listed for family contact in MA. His cause of death was heart failure...”

May 2, 2006 Final Report of Autopsy, Office of the Chief Medical Examiner:
“Cause of Death: Multiple complications of dilated cardiomyopathy.”

V. VP&A’s Findings

VP&A found several areas of concern with regard to Mr. Estabrook’s medical care while incarcerated. Those areas of concern, which are detailed further in this section, include – but are not limited to - medical furlough status, his worsening condition and symptoms which went unaddressed, his housing assignment, medication problems and end-of-life decisions.

Medical Furlough Issues

Mr. Estabrook should have been granted a medical furlough by the Department of Corrections during his last incarceration based on his deteriorating state and need for strict and careful medical monitoring. He

would have been able to receive this quality/level of care in a community setting. Instead the medical providers at SSCF apparently ignored his worsening condition and serious symptoms for weeks leading up to his acute episode and hospitalization on February 22, 2006. The fact that, in 2004, Mr. Estabrook was granted a medical furlough because, at that time, he had experienced renal failure while incarcerated should have been considered in favor of granting the medical furlough he requested earlier in 2005. A DOC physician in July of 2005 wrote a medical note stating that she would "...consider transfer to facility [with] higher level nursing care, closer to cardiologist in FAHC..." This physician also noted on a fax coversheet she sent to another DOC physician in August of 2005 that "Michael's care basically remains a guessing game as to how to adjust his diuretics. During his last incarceration he wound up in acute renal failure..."

The Department of Corrections and its contracted providers should have realized that they could not manage his complicated medical condition and should have furloughed him soon after his incarceration again in 2005.

Mr. Estabrook was clearly a candidate for medical furlough. It was discussed during his 2005-2006 incarceration at various times but, in the end, no one took responsibility to insure the appropriate consideration was given to his request.

In June of 2005 DOC Medical Director noted in an email that she had reviewed Mr. Estabrook's case "about a month ago" and at that time she recommended against medical furlough based on her understanding of the criteria for granting furloughs⁸. She stated that he had a serious medical condition that is "chronic and stable". According to the cardiologist's medical note of June 1, 2005 "...Mr. Estabrook has a significant cardiomyopathy and has a relatively tenuous status." VP&A identifies that the DOC Medical Director's statement was based on outdated, inaccurate or erroneous information and did not accurately reflect the severity of Mr. Estabrook's medical situation.

The DOC Medical Director did say that she would ask medical staff to re-examine his situation if staff felt she should. At that time the case work supervisor indicated there was no one "pushing for another review, we didn't know the results of the original assessment."

⁸ Department of Corrections, Medical Furlough Directive #351.08 effective date 5/01/01: "Authority for this directive is derived from VSA Title 28, Chapter 11, §808(f). The Commissioner may place on medical furlough any inmate who is serving a sentence, including any inmate who has not yet served the minimum term of the sentence, who is diagnosed as suffering from a terminal or debilitating condition so as to render the inmate unlikely to be physically capable of presenting a danger to society."

According to the Medical Furlough Directive, if an inmate is considered for medical furlough such as what the DOC Medical Director described above, the following process will take place:

“7. After receipt of the furlough investigation report from the CCSC, the facility superintendent shall gather the medical, caseworker and furlough investigation materials and submit them with a cover letter concerning the proposed medical furlough to the clinical director and the director of security and operations. They shall review the plan and recommendations and either approve or disapprove same.”

VP&A could find no evidence in the records provided that this process took place even though the DOC Medical Director stated she reviewed Mr. Estabrook’s case.

In August of 2005 Mr. Estabrook discussed his request that the physician discuss with his cardiologist a medical furlough. The physician told Mr. Estabrook that that decision had already been made by the DOC Medical Director. It appears there was insufficient effort made by the contracted medical providers to assure that accurate and complete information was provided to the DOC Medical Director.

On September 28, 2005 a case worker at SSCF noted that Mr. Estabrook was asking her about medical furlough. She wrote that she “...will need to look into this a little more.” She also noted that when she spoke to...the PHS nurse manager at that time, he indicated Mr. Estabrook would probably not make it to his minimum because of his heart condition. VP&A found no evidence in Mr. Estabrook’s records that the case worker followed up on this request.

According to the Department’s Medical Furlough Directive, *“The Responsible Health Authority and Regional Health Authority will determine that an inmate’s medical condition is either terminal or debilitated to the point of needing a higher level of care than can be realistically provided within the confines of a correctional facility.”* The nurse manager is defined as the person who is typically the Responsible Health Authority. The PHS nurse manager made no notes or recommendations regarding Mr. Estabrook’s continued incarceration or medical furlough request as is required by this directive.

On October 18, 2005 a case worker also noted that she “met with Michael in the Infirmary Ward...Explained to Michael that he will not be eligible for release to the community on furlough due to his medical needs have not become more severe according to medical staff...at which time his medical needs become more than the facility can handle he may be eligible for medical furlough...”

Then on October 31, 2005 a case worker made a case note that she would email [redacted name] regarding what it would take for him to be reconsidered for this furlough. VP&A found no evidence in Mr. Estabrook's records that this communication took place.

On November 2, 2005 a case worker made another case note that she had talked with the LUS about the possible medical furlough for Michael. "[LUS] informed me that as long as he can be treated by the facility that a medical furlough would not be an option..."

Then on February 16, 2006 the Living Unit Supervisor made a case note which stated that she was going to ask for Mr. Estabrook to be re-evaluated and considered for another medical furlough. VP&A could find no evidence in Mr. Estabrook's records provided that this request was ever made.

Worsening Condition and Symptoms

Mr. Estabrook was displaying serious symptoms that were not acted upon by the medical staff or the correctional staff at SSCF. The June 2004 Fletcher Allen Health Care nursing note outlined conditions for the DOC providers that, if displayed by Mr. Estabrook, would need medical follow up. Those conditions were: shortness of breath, swollen legs, ankles or abdomen, dry hacking cough, wheezing, fatigue, weight gain, increased urination at night, dizziness or confusion, rapid or irregular heartbeats.

There were at least 8 notes found in Mr. Estabrook's records starting in November of 2005 indicating that his condition was starting to deteriorate and the warning signs listed above were clearly noted. There was no appropriate medical response to these worsening signs that were identified in Mr. Estabrook's records.

November 25, 2005 minimal swelling was noted in Mr. Estabrook's lower legs. On January 13, 2006 Mr. Estabrook submitted a sick call request reporting that he has filed sick call slips that have gone unanswered and even filed a grievance about his shortness of breath. On February 10, 2006 Mr. Estabrook was admitted to the infirmary at SSCF for 24-hour observation as he was having chest pain and shortness of breath. On February 11, 2006 Mr. Estabrook was complaining of feeling faint. On February 12, 2006 a nurse noted that Mr. Estabrook's pulse was irregular, his color pale. On February 16, 2006 a PHS progress note indicates Mr. Estabrook was complaining of shortness of breath and an increase in dizziness. Also on February 16, 2006 the Living Unit Supervisor made a note that she met with Mr. Estabrook and he complained of being low on energy and having difficulty breathing. On February 19, 2006 a PHS progress note recorded that Mr. Estabrook stated he drank 60 oz and his urine output was only 15 oz and it was foul smelling and colored. Later that same day he was complaining of chest pain.

On February 22, 2006 VP&A advocates met with Mr. Estabrook and witnessed the swelling in both of his lower legs, his fatigue, jaundice appearance and inability to go from one unit to another without assistance. Staff was made aware of these observations and we were told that Mr. Estabrook had an appointment scheduled for that very day with his cardiologist.

On November 12, 2005 the physician wrote an order that Mr. Estabrook's weight be checked every other day. That weight check did occur every other day until January 1, 2006. After that it ended even though there was no new physician's order rescinding the order. After January 1, 2006 Mr. Estabrook's weight was checked only occasionally: January 3, 2006 -172.5 lbs; January 9, 2006 – 168 lbs; February 11, 2006 – 171 lbs. Part of the treatment recommended for patients with dilated cardiomyopathy is “Daily monitoring of body weight may be advised. Weight gain of 3 of 4 pounds or more over 1 or 2 days may indicate fluid accumulation.”⁹

On February 22, 2006 when Mr. Estabrook was taken to the Emergency Department at Rutland Regional Medical Center, part of that record reflected that he told the physician that “...he has gained some 20-30 pounds during the last 3 weeks. He has begun having increasing pedal edema and notes that he has never had swelling of his ankles to this degree...”

Mr. Estabrook's hospital records reflect that on February 23, 2006, one day after being admitted to FAHC, his weight was 182.8 lbs. That is an approximate 11 lb gain in the same number of days. Had the medical staff been following the physician's written order this symptomatic weight gain would have been recognized and Mr. Estabrook could have potentially received adequate medical care before his condition deteriorated.

In addition, medical orders on February 16, 2006 indicated that Mr. Estabrook was encouraged to take in a lot of fluids. This order was given without any documented check of Mr. Estabrook's current weight. Had his weight been monitored carefully, as is the standard of care for his illness, the course of treatment for Mr. Estabrook could have been corrected. Upon his admission to FAHC Mr. Estabrook was actually placed on fluid intake restrictions.

Infirmery

On January 17, 2006 Mr. Estabrook discussed with a mental health clinician the possibility of moving to the infirmary. On this same date this clinician spoke with the Living Unit Supervisor about the possibility of transferring him to the infirmary. A month later on February 16, 2006 the Living Unit Supervisor noted that she met with Mr. Estabrook and he once again asked to

⁹ American Heart Association's website www.americanheart.org 9/22/06 “Cardiomyopathy”

be moved to the infirmary due to his worsening symptoms. She noted that she would “consult with the medical staff about his request.”

VP&A could find no evidence in Mr. Estabrook’s records that any actions were taken by either the mental health clinician or the LUS in response to Mr. Estabrook’s request.

Prison Health Services, Health Services Policy and Procedures Manual, Title: Infirmary Care, No. P-G-03: Policy. 1. The scope of care provided in the infirmary may include, but is not limited to such illnesses/diagnosis/conditions as: ... b. Long-term care for inmates with chronic medical conditions that occasionally need medical services that cannot be supplied in general population...”

Mr. Estabrook should have been moved to the infirmary when he made this request in January of 2006. He had a chronic medical condition which required a higher level of care when his symptoms worsened. The fact that various staff kept saying they would follow up and never did is very disturbing in what is supposed to be the medical prison for Vermont.

Medication Issues

On February 22, 2006, the day Mr. Estabrook collapsed, he mentioned to the ambulance personnel that he had not received one of his medications a few times that week. Upon reviewing the Medication Administration Records (MAR) for Mr. Estabrook, VP&A discovered that PHS ran out of a few of Mr. Estabrook's critical medications for a few days in February.

Mr. Estabrook was prescribed Amiodarone 200mg once per day. Amiodarone is only used for treatment of the following documented life-threatening recurrent ventricular arrhythmias that do not respond to other antiarrhythmics or when alternative agents are not tolerated; recurrent ventricular fibrillation, recurrent hemodynamically unstable ventricular tachycardia.¹⁰

According to DOC and PHS records Mr. Estabrook did not receive this medication on December 23, 2005 and February 18 & 19, 2006. The MAR reflects that the medication was out of stock on those dates.

Mr. Estabrook was also prescribed Lisinopril, an antihypertensive and ACE inhibitor drug used for the treatment of hypertension alone or in combination with thiazide-type diuretics. It is also used for adjunctive therapy in CHF for patients unresponsive to diuretics and digitalis alone.¹¹

¹⁰ 2002 Lippincott’s Nursing Drug Guide

¹¹ 2002 Lippincott’s Nursing Drug Guide

According to DOC and PHS records Mr. Estabrook did not receive this medication on November 6, 7, 8, 9, 10, 2005; December 10, 11, 12, 13, 14, 15, & 16, 2006; February 18 & 19, 2006. The MAR reflects that the medication was out of stock on these dates.

The frequency and length of time that critical medications were not available in the facility is unconscionable. PHS and DOC are required to have a system in place to assure that inmates are not suffering because prescribed medications are not effectively monitored to assure availability. If an inmate is prescribed a medication for daily use, DOC and PHS are required to provide those medications daily or move the inmate to an adequate treatment environment. DOC does have the option of using a local pharmacy to obtain critical medications if they run out. It does not appear that anyone did this for Mr. Estabrook during the dates outlined above. The lack of prescribed medications just prior to Mr. Estabrook's collapse and eventual death cannot be overlooked as a potential contributing factor in the series of medical and administrative failures identified leading up to his death.

DNR Issues

The unethical issuance of a written DNR by a Prison Health Services physician for Mr. Estabrook is shocking. While not contributing to Mr. Estabrook's death it is an example of overall questionable medical practices by DOC and its contracted providers. According to Vermont law¹², a physician must document that they consulted with, or made an effort to consult with, their patient. There is no evidence that anyone within the medical system took time to discuss what a DNR is and how it is carried out with Mr. Estabrook, even at the point when he wrote what he thought was a DNR order for himself on November 30, 2005 and asked that it be placed in his medical record. The document he wrote did not conform to legal requirements, yet PHS staff placed it on the front page of his chart and there is no evidence of any discussions with Mr. Estabrook about this. On February 17, 2006 the PHS physician wrote a physician's order that read "DNR" and there is no evidence that he discussed this order with Mr. Estabrook before he wrote it. There is also no evidence in Mr. Estabrook's records that any mental health clinician took the time to discuss this DNR order or Mr. Estabrook's own handwritten document with him.

The PHS physician's written DNR did not meet either the requirements of Vermont law or PHS policy.

¹² 18 VSA § 9709 Authority and obligations of health care providers, health care facilities, and residential care facilities regarding do-not-resuscitate orders. (a) A do-not-resuscitate ("DNR") order must: (1) be signed by the patient's clinician; (2) certify that the clinician has consulted, or made an effort to consult, with the patient, and the patient's agent or guardian, if there is an appointed agent or guardian.

- 18 VSA § 9708 (3) include either: (A) the name of the patient, agent, or other individual giving informed consent for the DNR and the individual's relationship to the patient; or (B) certification that the patient's clinician and one other named clinician have determined that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.

Prison Health Services, Health Services, Policy & Procedures Manual, Title: Care of the Terminally Ill. Do Not Resuscitate (DNR) Orders, No. P-G-12.01 Effective Date February 1, 2005:

Purpose: To allow the terminally ill inmate to participate in the medical care decisions during the terminal stages.

Policy:

1. Inmates will be provided the treatment options available in the community, including "Do Not Resuscitate Request".
2. Mental Health Staff and Clergy will be requested to discuss the decision with the inmate to evaluate the inmate's understanding of the decision.
3. The Responsible Physician will document in the progress notes the desire of the terminally ill inmate not to have cardio-pulmonary resuscitation performed. The progress note will contain the issues discussed with the inmate and will be signed by the Physician and the inmate.
4. If the inmate has completed a Living Will in the state, the inmate will be required to provide a copy for placement in the Medical Record.
5. If the inmate has not completed a Living Will, or if a copy cannot be obtained, a representative providing inmate legal services will be requested to meet with the inmate to discuss this option.
6. The Institutional Authority will be notified of any terminally ill inmate who has requested a "no cardio-pulmonary resuscitation order".
7. Orders for "DO NOT RESUSCITATE" do not preclude other indicated medical and nursing care. "DO NOT RESUSCITATE" orders can be rescinded by the inmate at any time.
8. "DO NOT RESUSCITATE" orders will be discussed with the inmate monthly and renewed or changed to reflect the desires of the inmate.

The medical progress notes are very clear that the physician made no attempts to have a discussion with Mr. Estabrook about his DNR status at any time. And the one note made by a Licensed Nursing Assistant in September of 2005 demonstrates that Mr. Estabrook wanted to engage in a discussion with medical staff about being a DNR. No effort was made by anyone to have this discussion with Mr. Estabrook, even when he went as far as to write his own DNR statement.

Prison Health Services, Health Services, Policy & Procedures Manual. Title: End of Life Decision Making No. P-I-04 Effective Date: February 1, 2005.

Purpose: To ensure that inmates approaching the end of life are permitted to execute advance directives including living wills, health care proxies, and “do not resuscitate” (DNR) orders. These directives are signed only after the patient receives appropriate information regarding the meaning and consequences of such decisions.

4. DNR orders are reviewed by a medical professional who is not directly involved in the patient’s treatment.
5. Mental Health Staff and Clergy will be requested to discuss the decision with the inmate to evaluate the inmate’s understanding of the decision.

Again, there is no documentation in the records provided to VP&A that the physician or any other medical or mental health provider made any effort to discuss this issue with Mr. Estabrook. In fact, it wasn’t until VP&A met with Mr. Estabrook and explained to him what a DNR order meant that he seemed to fully understand the difference between a DNR order and what he actually wanted. What Mr. Estabrook wanted directly conflicted with having a DNR order in place. Without VP&A’s intervention it is likely this unwanted DNR would have remained in place.

VI. Recommendations

Due to the number of policy violations in this case, VP&A recommends the following actions be taken by the Department of Corrections and its contracted providers immediately:

1. The rights of terminally ill inmates must be clearly discussed with the inmate and accurately documented in the medical record.
2. Contracted staff must be trained in Vermont law and their own policies and procedures about end of life decisions and what is required of them as medical providers.

3. Contracted staff who violate Vermont law and policies and procedures shall be disciplined accordingly.
4. Reassess all recent requests for medical furlough to assure the decision to refuse medical furlough was arrived at with sufficiently current and accurate medical information.
5. Implement independent review and quality assurance for medical furlough decisions.
6. Develop a system to ensure that medications are stocked and are available each day they are prescribed for an inmate.
7. Develop a system for access to infirmary or other correctional facilities that are appropriate for the medical condition.
8. Develop a system whereby inmates with serious and/or terminal illnesses are able to access their outside specialist in a timely fashion consistent with the medical necessity identified by the specialist for their patient.
9. Develop and implement a system for documentation and peer review of untimely deaths in corrections and assure that a review is done on every death, even when the inmate dies in a hospital.