EXPERT REPORT OF STEPHEN TABET, M.D., MPH

Leatherwood v. Campbell

Case No. CV-02-BE-2812-W

In The United States District Court
Northern District of Alabama

Western Division

Dated: August 26, 2003

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QUALIFICATIONS
Stephen Tabet, MD, MPH

See my attached abbreviated *Curriculum Vitae* for additional information regarding my training and qualifications to serve as an expert witness and provide expert commentary on this case.

In 1991, I received my Doctorate in Medicine (M.D.) with high honors (Junior Year Alpha Omega Alpha National Honor Society) from the University of New Mexico (UNM). My doctoral dissertation focused on assessing health care workers' attitudes and fears regarding HIV-infected patients. While in medical school, I started providing medical care for HIV-infected patients at the UNM Hospital AIDS Clinic. During medical school, I undertook independent research projects in the area of HIV/AIDS including a study assessing HIV and hepatitis among street-based prostitutes, presented at the World AIDS Conference and published articles in peer-reviewed journals. I have since published dozens of articles, manuscripts, and abstracts and have presented literally several hundred lectures in the area of HIV/AIDS.

In 1993, I completed my Master of Public Health (MPH) in epidemiology at the University of Washington (UW) School of Public Health and undertook residency training in Preventive Medicine. For my Master's thesis, we were one of the first groups in the world to develop and use molecular epidemiologic methods to track and prevent the spread of tuberculosis among HIV-infected persons. My research resulted in the publication of manuscripts in peer-reviewed medical journals and presentations at national and international medical conferences. I then helped lead public health efforts to decrease the transmission of tuberculosis among HIV-positive persons in Seattle.

In 1994, I completed internship and residency at the UW School of Medicine specializing in Internal Medicine. I went on to further sub-specialize in Infectious Diseases with a concentration in HIV/AIDS at the UW from 1994-97. Upon completion of my Infectious Disease fellowship, I was recruited to become a faculty member at the UW where I am currently Assistant Professor of Medicine in the division of Infectious Diseases. I am double Board Certified in Internal Medicine and Infectious Diseases. I am also Attending Physician in Internal Medicine and Infectious Diseases at the public hospital - Harborview Medical Center (HMC) – in Seattle. One of my main responsibilities at HMC is to provide medical care to patients at Madison AIDS Clinic where we follow over 1200 HIV-infected patients. The majority of these HIV-infected patients suffer from drug and/or alcohol addiction and almost all are homeless, uninsured, mentally ill, or were recently incarcerated. I also serve as one of the main HIV consultants in the community for particularly challenging patients. I teach clinical HIV to medical students, residents, post-doctoral fellows, and practicing physicians. I do a substantial amount of research in the area of HIV/AIDS prevention and treatment both locally and internationally and have been a co-investigator on several National Institutes of Health-funded research grants – the most recent of which is a grant to assess antiretroviral treatment regimens for patients in Lima, Peru – where access to these medications is virtually non-existent. I truly understand the barriers that

exist in providing medical care to HIV-infected patients in resource-poor settings both in the U.S. and abroad.

I hold numerous local and national appointments. I was appointed by former President Clinton and Secretary Shalala to serve as a member of the Department of Health and Human Service's Health Resources and Service Administration's HIV/AIDS Bureau Advisory Committee; the HIV/AIDS Bureau is the largest single provider of care to persons living with AIDS in the US and provides HIV services to the vast majority of our nation's underserved HIV-infected patients. I am currently a member of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment and advise the current administration on these concerns. I also serve as Senior Advisor to Brown University's HIV Education Prison Project, the largest HIV education program for correctional providers in the U.S.

I have over 7 years providing care to incarcerated HIV-infected patients and working in correctional facilities throughout the State of Washington. I lead a group of physicians that has provided medical care to several thousand incarcerated patients. I have worked in prison settings where we were under federal court decrees because of medical problems that occurred in the past. I am Director of the Northwest Correctional Medicine Education Project where I teach other physicians and providers HIV medicine. As part of this project, I operate an electronic mail consultation service and newsletter. This service is provided free of charge to over 450 providers caring for incarcerated patients. I lecture widely both regionally and nationally on the subject.

Basic Science of HIV

It is important to first briefly describe the biology of HIV disease and to define terms I will be using in order to make this report more understandable to the reader. There are literally tens of thousands of medical articles published each year on the subject of HIV/AIDS. It has been said that to understand AIDS is to understand all of medicine.

AIDS and HIV

The Acquired Immune Deficiency Syndrome (AIDS) is the end-result of usually long-term infection with the Human Immunodeficiency Virus (HIV). In 1981, the New England Journal of Medicine published the first articles describing young men with devastating diseases only previously seen in patients with severely suppressed immune systems. Few people were to realize that these men had a disease (eventually termed AIDS) that was already circulating in many parts of the world and that, by year 2001, was to infect 60 million human beings and be the cause of so much suffering and death throughout the world. Only three short years later, in 1984, a virus, later to be called HIV, was found to be the cause of AIDS. What really sets HIV apart from the many viruses that cause illness in humans is that HIV targets and destroys CD4 lymphocytes (or T-cells), a type of white blood cell that is at the center of the immune system. Without T-cells, the immune system defenses cannot work properly thus allowing a number of infectious diseases and cancers to take over the body.

The immune system and T-cells

The immune system is remarkable in that it works intricately to ward off foreign invaders if there is no disruption in this system. The average healthy persons has about 800-1,000 T-cells, but this number is variable. When a person first becomes infected with HIV the T-cells can drop dramatically, but then increase to an average of about 600, but again, as in all of medicine, this is variable. In untreated HIV infection, T-cells decrease by an average of 50 cells per year. Persons with HIV infection and higher T-cells are initially at higher risk for skin infections such as rashes, boils/abscesses caused by bacteria, or herpes infection than persons with normal immune systems. HIV-infected persons with low T-cells are also at risk for these same diseases, but the clinical manifestations are often more severe. It is not until T-cells drop below 200 or even 100 that most clinical illnesses associated with HIV occur.

Opportunistic Infections and other illness affecting HIV-infected patients

Opportunistic infections (OIs) denote infections capable of causing disease only in a person whose immune defenses is lowered. The majority of diseases that affect patients with AIDS are "opportunistic". For instance, *pneumocystis carinii* (PCP) is an organism that can cause a deadly pneumonia in HIV-infected patients, but is harmless to persons with normal immune systems. Some diseases, such as tuberculosis, can manifest in both HIV-infected persons and persons with normal immune systems, but affect HIV-infected persons much more commonly and much more severely and are also sometimes termed "opportunistic". Persons with HIV infection are also at risk for getting cancers, especially cancers caused by viruses, such as Kaposi's sarcoma and cervical cancer.

Treatment and combination therapy

In 1995, the number of persons dying from HIV/AIDS dropped precipitously in the developed world because of the advent of combination antiretroviral therapy (also called "the cocktails" or highly active antiretroviral therapy – HAART). Prior to that time, antiretroviral medications were typically being used one drug at a time which disrupted HIV's life cycle, but then eventually failed because HIV became resistant to the single drug and began replicating again. Currently, a minimum of 3 drugs (and sometimes more) in combination are needed to interrupt life cycle of HIV and the virus becomes "undetectable" (undetectable viral load). Thus, the goal of antiretroviral combination therapy is to suppress viral replication to "undetectable" levels and stop the destruction of T-cells. Because HIV replicates rapidly (billions of time each day), antiretroviral medications must be taken by the patient appropriately and continuously or HIV becomes resistant to the medications, they stop working, and the virus in the blood (or viral load) rebounds and T-cells decrease setting up the patient to contract Opportunistic Infections or other HIV-associated illnesses. Prisons, in particular, have been found to be ideal settings to administer patient's combination therapy. Studies conducted by Dr. Margaret Fischl in Florida and others have clearly shown that nearly 100% compliance can be achieved when treating incarcerated patients.

Years before combination therapy, the use of preventive antibiotics to prevent some infections became the standard of care of therapy when T-cells decreased below certain levels. Preventive antibiotics, with combination therapy, are still the mainstay of therapy. Because these antibiotics are so effective, inexpensive and cost-effective, even many very poor counties in the world have for many years provided these life-saving medications to patients. For example, PCP is nearly 100% preventable when a patient takes one antibiotic once per day. Preventive antibiotics are only a temporizing measure and don't prevent all disease so combination antiretroviral therapy must also be used to decrease the replication of HIV and increase T-cells.

STANDARDS OF CARE

This report draws upon the minimal standards of care utilized in order to adequately care for HIV-infected individuals. These standards include:

The US Department of Health and Human Services and Kaiser Foundation, the Infectious Disease Society of America (IDSA), the Center for Disease Control and Prevention (CDC), and the National Commission on Correctional Health Care (NCCHC) have developed guidelines for the treatment of HIV-infected persons.

The *Mortality Reviews* section of this report draws upon a standard of care that is less than those utilized to adequately treat HIV-infected individuals.

LIMESTONE CORRECTIONAL FACILITY

On February 13 and February 14, 2003, I toured and observed the Limestone Correctional Facility as a medical expert on behalf of the plaintiffs, Antonio Leatherwood, and the plaintiff class. The review of the facility mainly consisted of observing the following:

- Dorm 16 where the majority of HIV-infected inmates are housed (approx 250);
- Substance Abuse Program (SAP) where inmates undergo drug rehabilitation (approx 50);
- The Health Care Unit (HCU) consisting of both an inpatient and outpatient unit;
- Dorm 7, The Isolation Unit [I did not see enough of the Isolation Unit (Solitary Confinement) to be able to provide an informed opinion]

I was not permitted to conduct any formal medical and correctional staff interviews, but did briefly talk to both medical and correctional staff.

I will not go into much detail regarding the Limestone Correctional Facility's history, as this has been previously documented, but what was most striking about this facility is that there is total segregation of the HIV positive and HIV negative inmates - something that has been almost totally abolished around the world. The HIV positive inmates are segregated into an HIV Dorm (Dorm 16) which is severely crowded. The population of HIV-infected inmates in February, 2003 incarcerated in Dorm 16 was 250. Dorm 16 is an old converted warehouse. The warehouse had previously housed the infamous "chain gangs." In addition, the inmates' beds were lined up head-to-toe and very close to each other, as well as side-by-side within a few short feet of each other. The layout of Dorm 16 is documented in photograph 1.

In addition to this severe over-crowding, the facility itself was in poor condition with many of the windows in poor condition, as well as the doors, which clearly allowed cold air to circulate into the facility, creating a health risk to these immunosuppressed individuals. Numerous inmates have reported that Dorm 16 is infested with insects, spiders, and vermin. This is consistent with the condition and physical structure of Dorm 16.

It was reported that the facility had been minimally repaired prior to the February 13-14, 2003 tour. Apparently the Limestone Correctional Facility staff and inmates had painted some of the areas of the unit, as well as had only recently placed screens on the windows. The Department of Corrections had also fumigated the unit given the pest problem.

Of note is that one of the major complaints arising from this unit initially was that of a staphylococcus infection in 2002 where numerous patients had evidence of severe skin infections including pus-filled boils. It is clearly evident that this happened due to overcrowding and the probable influx of stinging and biting insects to the unit. Such conditions would cause infections among HIV-infected patients. An example of this infection is documented in an inmate patient in photograph 2.

There was a lack of adequate facilities or assistance in Dorm 16 and the Health Care Unit for the disabled, as set forth by the Americans with Disabilities Act.

I also toured the Substance Abuse Program housing unit where inmates undergo drug rehabilitation. This unit is also segregated and housed only HIV-infected individuals. Of note again is the lack of facilities for the disabled. This unit, although crowded, was less crowded than the HIV Dorm, and appeared to have slightly better amenities, but still far below standard.

I spent a considerable amount of time observing the Pill Line in Dorm 16. Patients at the Limestone Correctional Facility are administered medications at 3 a.m., 10 a.m., and 3 p.m. The patients are made to wait outside for their medications, often in very severe weather conditions according to many of the patients. The Pill Line I observed did seem to take a very long period of time, making it very difficult for the weaker patients to stand in line for their medications. The nursing staff administers medications directly into the patient's hands. This practice is not hygienic and unacceptable. Patients were given cups that were placed on a very dirty window sill that had mildew and obvious dirt on the surface which obviously contaminates the cups.

The outpatient facility located in the HCU is a considerable walking distance from Dorm 16 and SAP; it takes approximately 20-30 minutes to walk between the units which creates a potential hazard during an emergency. The outpatient unit seemed small for a facility of this size; apparently, the physician and P.A. at one time even had to share examination rooms at the expense of privacy for the patients.

I was also able to observe the Inpatient Unit at the Limestone Correctional Facility. After talking with several of the patients, they reported that the emergency call buttons were repaired just prior to our visit, and had not been working in the past. The inpatients are often too sick to leave their beds and find a nurse, and must use some sort of remote call device that is within reach of their beds. This practice violates accepted minimal standards that govern inpatient units and hospitals.

A compounding problem in the Inpatient Unit is that inmates called “runners” are often used to assist in the Inpatient Unit. This is not a problem in itself, but patients noted that the runners are performing such duties as nourishment administration which is outside of the scope of their training and inappropriate. This practice needs to be stopped immediately - Nourishment should be administered only by professional nursing staff.

PATIENT MEDICAL CHART
REVIEWS AND INTERVIEWS ON-SITE AT LIMESTONE CORRECTIONAL FACILITY

February 13 and 14, 2003

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 1

Patient's medical records were reviewed in detail and patient was interviewed and examined on 2/14/03.

The patient is a 35 year old HIV-infected male also co-infected with chronic hepatitis C. He is on combination therapy (HAART) consisting of nevirapine, saquinavir, and Kaletra. The doses of these medications are correct. The patient has had a good response to HAART in that the CD4+ T-cell count is 700 and HIV RNA (viral load) is undetectable when last assessed October 2, 2002. It is noted in the medication records that the patient has missed some doses of medications; he reported that the HIV medications are sometimes not available. He also had rectal warts which were removed by laser surgery on 12/2/02. Like many other patients, this patient has apparently had outbreaks of skin infections which seem to resolve, but then reoccur. According to the patient, he was treated on 1/28/03 apparently by nurse Hawkins with Amoxicillin prior to her calling the physician. On examination, the patient had evidence of a healing scar from a probable bacterial skin infection. This scar is documented in photograph 3.

IMPRESSIONS:

1. This case demonstrates that medications are apparently not always available. This is potentially very significant for the patient insofar as his viral resistance. If the virus in his body becomes resistant to HIV then the medications will become useless and the patient may become untreatable.

2. This case demonstrates the severe understaffing of medical personnel. There are too many patients with compromised immune systems for one physician and one physician's assistant. This patient is not monitored appropriately especially given his underlying hepatitis C. The last time his liver enzymes were assessed was 3 months previous to the interview and they were elevated and need to be followed more closely. The patient is also overdue for assessment of T-cells and viral load and needs his lipid panel assessed.

3. Patients with chronic hepatitis C are at risk for fulminant liver failure if they acquire hepatitis A or B. This patient apparently has not received a hepatitis A vaccination. This vaccine is the standard of care for patients with Hepatitis C.

4. Nurses are not prescribers of medications; this is illegal and needs to cease.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 2

Chart reviewed and patient interviewed and examined February 13, 2003. His condition is documented in photograph 4.

This patient is a 38 year old male with Class A2 HIV infection (CD4+ T-cells 386/20% and HIV RNA 614 on 7/17/2002). He is not on any medications for HIV (which is appropriate). The patient also has a right leg above the knee amputation and had worn a poorly fitted prosthesis. He is now wheel chair-bound because the prosthesis does not fit; he has been denied an appropriately fitted prosthesis by Naphcare on 3/2/02. Mr. Stephens has reported several falls in which he sustained injury. On 8/23/02, Mr. Stephens was seen by Dr. Simon after having fallen 8/22/02; he was noted to have left ankle swelling and was given analgesics. In her medical note, Dr. Simon wrote: "Needs for handicap accessible shower discussed with Warden Mitchem." He was seen in follow-up on 8/27/02 with mild swelling of the left foot. The patient also apparently fell in March and was not evaluated until 2 days later.

I was informed by this patient and by others that, in preparation for our visit, Limestone Prison officials had handicapped railing installed 2/10/03 – 3 days prior.

IMPRESSIONS:

1. This patient demonstrates delay in evaluation and care of a disabled person. When this disabled patient fell on 8/22/02, he should have been seen on an emergency basis in the clinic – not a day later. The patient fell again in March and this time was not seen by Dr. Simon until two days later. This is not timely and is inappropriate care.

2. This case displays total disregard by Limestone Correctional Facility for the patient and for the Americans with Disabilities Act ("ADA"). Not having a shower that is accessible to a disabled person is a medical issue and violates the ADA. Limestone Prison officials ignore the ADA; this is a problem and Mr. Stephens has suffered because of this violation.

3. Not providing adequately fitted prostheses for amputees is inappropriate on the part of Naphcare. It will result in his becoming wheel chair-bound, fall, and further injure himself.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 3

Chart reviewed and patient interviewed and examined on 2/14/03.

This patient is a 31 year old male with Class C3 AIDS and chronic cryptococcal meningitis, a severe life-threatening fungal brain infection. He has advanced AIDS, but had a very good response to HAART (CD4+ T-cell count went from 54 3/6/01 to 330 8/23/02 despite having missed doses of HAART). It is mentioned in his chart that he has had issues of noncompliance. The patient informed me that he misses doses because he sometimes does not hear the 3 a.m. pill line call or sleeps through it. Patients with chronic meningitis can have decreased hearing and can be quite sleepy and can have altered mental status. Therefore, the patient's medication lapses can be a result of his disease progression. He also states that he is given his protease inhibitor before meals which causes him to have nausea and occasional vomiting. He informed me that he finds it difficult to wait in the pill line (some times up to 45 minutes or an hour) given his chronic illness. The patient is on another medication (ddI – brand name Videx) that must be taken on an empty stomach and 2 hours away from a meal, but it is not being administered in that manner. This is in violation of Food and Drug Administration (FDA) protocol for administering this medication. Apparently in August, 2002, the patient did not receive treatment (Diflucan) for his cryptococcal meningitis for two full weeks. According to Dr. Simon's note dated 8/29/02, "…it was not available". At that time, the patient reports back pain and shows laboratory evidence of a recurrence of worsening cryptococcal disease as evidenced by an elevated serum cryptococcal titer of 1:128. He is placed in the infirmary and administered appropriate medications and then slowly gets better and is discharged. As a result of the meningitis, the patient has developed a seizure disorder and is on an anti-seizure medication (Dilantin). However, Dilantin is a medication that has to be regularly monitored. This patient's Dilantin levels are not being obtained as is the standard of care.

IMPRESSIONS:

1. This patient's case represents many of the severe problems with the administration of medication administration disaster at Limestone and how patients' needlessly suffer as a result of the medication problems. Limestone simply ran out of medication for the patient's life-threatening meningitis. As expected, the patient's condition got worse. This gap in medication could have caused the patient to die. Running out of medication for a serious infection is not acceptable.

2. The patient is not receiving his life-saving combination HIV therapy appropriately. Food requirements and restrictions for these medications are being ignored with total disregard for the FDA. The patient is on an anti-seizure medication yet levels are not being obtained. This represents inappropriate medical care.

3. One of the side effects of the HIV medications is high cholesterol and triglycerides. These levels have never been assessed and should be.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 4

The following information was obtained from an extensive medical record review, interview, and examination of the patient on February 14, 2003.

This patient is a 28 year old male with HIV infection who was admitted to Limestone on a HAART regimen consisting of AZT/3TC (called Combivir) and Viracept. On 5/16/01, this patient had a T-cell count of 563 and viral load <50 (undetectable) indicating good compliance which resulted in an excellent response.
At some point, the patient started getting severely nauseated and was even vomiting the medications. The medications were stopped. In particular, the patient informed me that the HIV medications he was being administered were given prior to meals at 3 a.m. and 3 p.m. (as opposed to with meals or right after meals) and he associates the nausea and vomiting with taking the HIV medications on an empty stomach. This is very common in other HIV-infected patients. He further tells me that he would take the HIV medications if he were allowed to take them with meals. According to medical records, the patient pleads to be given food with his medications. However, this is not done. Instead, the patient becomes noncompliant and the HIV medications are stopped.

On 12/31/01, the patient is seen by Dr. Simon and diagnosed with Shingles (Herpes Zoster infection). Shingles is the reactivation disease of chicken pox (primary varicella) and can spread to others who have not had chicken pox. Seven months later (3/6/02), the patient declined immunologically and his T-cell count dropped precipitously to 260. According to his medical records, no antivirals were prescribed for the shingles. Shingles is a potentially severe viral infection.

IMPRESSIONS:

1. This case demonstrates the recurrent problems at Limestone with food and medication administration at Limestone. Note that Viracept is FDA approved to be taken with food for adequate absorption and taking it on an empty stomach can cause greater gastrointestinal side effects. Some HIV medications, such as Norvir and Mepron, must be taken with a large amount of fat in order to be appropriately absorbed. Many Limestone patients, like this one, are being administered medications on an empty stomach in the middle of the night (3 a.m.) which inappropriately leads to noncompliance. The medications are stopped and the patient is blamed; this practice is inappropriate and needs to cease.

2. This case further demonstrates the problem with inadequate medical care and inadequate infection control practices at Limestone. This patient was diagnosed with Shingles – an infection which results in blistering of the skin and severe pain. The standard treatment

for shingles, especially in an immunocompromised patient, is to use an antiviral agent such as Acyclovir. Acyclovir is often the drug of choice because it is effectual and inexpensive. The standard of care would be for this patient to be prescribed Acyclovir or some similar antiviral and pain medication. Shingles is potentially infectious and could present a problem in a setting (such as Limestone) where immune suppressed individuals are housed in close quarters. The standard of care would be to isolate the patient. An outbreak of any one of a host of potentially serious infectious diseases is possible (and well documented) in an open ward setting and potentially very dangerous. This incident indicates that Limestone does not follow an adequate infection control plan for shingles/chickenpox. I am concerned that they likewise do not have adequate infection control for TB, influenza, and staph infections. (Note that Staph outbreaks have occurred at Limestone in the past.)

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 5

This patient is a 29 year old HIV+ male. His last documented CD4+ T-cell count was 253 with viral load of 15,500 on 12/3/2. He has chosen not to be on HAART. On 1/29/02, the patient reported a rash which progressed into a disseminated pus-filled rash around the hair follicles (called folliculitis) and one large abscess on his thigh. He was given therapy (Keflex and warm compresses) on 5/9/02 by Dr. Simon, but not seen again until 2 months later (7/3/02) after having failed three full courses of Keflex by a physicians' assistant and Dr. Simon. He was then given a month's course of doxycline, which is no better for treating this kind of infection than Keflex in this setting. He was then administered a series of other antibiotics (including additional Keflex, doxycycline, penicillin, and amoxicillin). No cultures of the pus were performed, but eventually – 10 months later – the skin infection seems to resolve itself. This patient reports that the dormitory is infested with flying insects and spiders. The patient also reported to me that he was never informed of his blood test results which were obtained two months prior to the on site visit. Upon examination, this patient has numerous scars and healing ulcerations riddling his body, particularly the lower extremities. At the least, these scars and ulcerations are disfiguring. His condition is documented in photographs 5 and 6.

IMPRESSIONS:

1. This case represents what happens when a health care facility with closely housed patients has an outbreak of an infection and does not have infection control practices in place. This patient suffered the consequences of an outbreak of (most likely) methicillin-resistant staphylococcus aureus (MRSA) infection that went rampant among the closely housed immune suppressed patients. This is one of the problems with housing these types of patients so close together. The medical records do not reflect an outbreak investigation. Numerous other patients had these same severe skin infections leading me to believe this was, indeed, an outbreak of MRSA. When outbreaks such as this are not properly contained, more infections will occur. This will lead to the deterioration of the patients' health. The standard of care to control infections in this setting includes: an investigation of this outbreak, infection control practices, and cultures of the patients' nares to assess for MRSA carriage and attempt to eliminate it.

2. The patient's care was suboptimal. The causative agent of his infections was not assessed.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 6

The patient was interviewed and examined on February 13, 2003 at Limestone Correctional Facility. His medical chart was reviewed.

This is a patient with HIV infection, shingles, and diabetes mellitus. When I saw the patient, he had been complaining of having chronic nausea and vomiting, and he had not been evaluated for quite some time. The patient had a medical order for a diabetic diet, but reports not receiving any diabetic meals. This was confirmed by a Limestone medical staff member who told me that "all the meals were ok for diabetics." The patient reports that his sack lunch consists of one cheese sandwich.

The patient is appropriately on antiretrovirals. However, he informed me that the prison nurses often run out of these antiretroviral medications. The patient often shows up to the early morning or late afternoon pill line, only to discover that his medications are not there.

IMPRESSION:
This patient represents another HIV-infected inmate at Limestone who also has other illnesses and is being denied adequate medical attention through the pill line system. He reports that they run out of his medications, as many of the other patients have concurred. Inconsistent administration of antiretroviral medication can lead to the patient becoming resistant to the medication. Resistant HIV can often become untreatable.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 7

This patient is a 43-year-old male with HIV infection who apparently had a heart attack (myocardial infarction) in the past. The patient was seen on September 17, 2002. At that time, he reported chest pain, left shoulder numbness, shortness of breath, sweatiness, and nausea. Unfortunately, the EKG machine at Limestone was not working. This was documented by a Limestone nurse. The patient was given nitroglycerin and aspirin and was sent back to his unit. Despite the patient being at high risk for having a heart attack, no attempt was made to get the patient to a local facility where a simple test (and EKG) could be done and labs could be obtained. I was unable to find whether the patient was ever evaluated again. According to the patient, he is currently experiencing chest pain at rest, which is characteristic of possible angina.

Review of his medical records does not show that the patient has been seen by a cardiologist, and in fact, has not received a basic cardiac evaluation. He is on multiple medications. However, these medications are treating angina. The patient also has kidney dysfunction as evidenced by a rising creatinine level. His medical record shows that he has not been evaluated for this condition.

IMPRESSION:
This patient is experiencing worrisome symptoms and is clearly at high risk for having a myocardial infarction. The EKG machine at Limestone did not work, and the patient was inappropriately sent back to his room. He may have had a myocardial infarction, and is really not sure whether he did at that time, but fortunately the patient did not die. Yet, he continues to experience chest pain.

A working EKG should be a mandatory minimal component of a health care unit.

Again, this represents a patient who is not being followed in a chronic care clinic and is not being appropriately followed-up on because the medical providers are overwhelmed and Limestone is severely understaffed in terms of medical providers.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 8

The patient was seen and examined on February 13, 2003. His medical records were also reviewed.

This patient is HIV infected. His last T cells were drawn on 12/3/2002, when they were 271. The patient is currently off antiretroviral treatment. The patient reports that he had previously been on HAART at Limestone, but the medications were being given inappropriately, including on an empty stomach. As a result, he experienced severe nausea and some vomiting. Thus, this patient discontinued the medication. In addition, the patient was also given a nonsteroidal anti-inflammatory drug. This medication was also administered on an empty stomach which caused him to experience many symptoms.

According to the patient's medical records, he was last seen in clinic on 8/15/2002.

IMPRESSIONS:

This patient, similar to many of the other patients, is a justified frustration with the prison's medication delivery system. As a result, the patient is unable to take his medications. He was prescribed antiretrovirals on an empty stomach which can cause very severe side effects. Unfortunately the patient has a fairly advanced HIV infection and should be on antiretroviral medications. But, he is unable to take them under these circumstances.

This also represents a patient who is not being seen on a regular basis by the medical staff. Six months is too long for the patient to go without being seen. He should be seen on a regular basis. Unfortunately, like many of the other Limestone patients, this patient is not seen on a regular basis and is not seen in a chronic care clinic.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 9

The patient was seen and examined on February 14, 2003 in the Limestone inpatient unit.

This patient is a paraplegic who has multiple medical problems, including HIV infection, history of a stroke, diabetes mellitus, asthma, hypertension, and hepatitis C. The patient was evaluated in the inpatient unit on 2/14/2003 at the Limestone Prison. The patient informed me that up until this week, he did not have an emergency buzzer in case he needed to contact the nursing staff. Prior to this week, he would have to "holler for a runner" if he had an emergency. The patient also reports that he is not receiving any physical therapy. This was also confirmed in his medical chart.

Additionally, the patient did not appear to be receiving intensive management of his diabetes.

Physical examination:
On examination, the patient clearly has difficulty with movement and has a dense, heavy paralysis. In any kind of an emergency, the patient would have great difficulty moving.

IMPRESSION:
This patient is paraplegic and is not able to get out of bed without assistance. He has no access to staff in an emergency, unless one of the other inmates, who serve as runners, comes to his aid. Fortunately, emergency medical buttons were installed. However, this only occurred one week prior to our visit. The lack of appropriate facilities for immobile or other very ill patients, represents a potential medical disaster for the Limestone Correctional Facility.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 10

This patient is a 36-year-old male who has stable HIV infection. His last T cell count was in October 2002 when it was 358. He should have had a blood test since that time. The acceptable medical standard is for HIV infected patients to have blood drawn every three months. The patient was seen by me because he was complaining of shortness of breath as well as a cough. He has a history of asthma. The patient reports that he has been trying to be seen by a medical provider, but has not been seen. Unfortunately, I did not have access to his medical records.

Physical Examination:
On examination, the patient was clearly having some bronchospasm. This was consistent with an asthma attack.

IMPRESSIONS:

1. This patient, like every other patient I examined, reported having difficulty accessing the prison's medical system. This patient was clearly having an asthma attack. We reported this as an urgent matter to Dr. Simon. She saw the patient and treated him for his asthma attack.

2. The patient also has HIV infection and is not receiving regular chronic care. Overall, Limestone Correctional Facility's care of the chronically ill is poor.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 11

This is a 34-year-old patient with AIDS, toxoplasmosis of the brain, and a seizure disorder. Currently, the patient is taking medications to treat the toxoplasmosis, (clindamycin and Daraprim). In addition, the patient takes antiretroviral therapy. Unfortunately, like the other patients, this patient is given these medications on an empty stomach, and then is told to eat his meal. As a result, he experiences severe nausea associated with these medications.

Also, the patient reports that he often has difficulty standing in line to obtain his medications, especially in the winter. Toxoplasmosis is a parasite which causes abscesses of the brain, as well as inflammation, and can render the patient seriously disabled and quite ill. When not treated appropriately, this is infection often leads to death.

IMPRESSIONS:
Again, like many of the other patients, this is a patient who is frustrated with the medication distribution system, as well as the medical system at Limestone. As a result, he has great difficulty taking his medications which are administered on an empty stomach. Giving these medications in this manner is not medically appropriate and is not recommended by the FDA. Standing in line to receive medications is intolerable for gravely ill patients such as this one. The medical system, as well as the system of pill distribution at Limestone sets the patients up for medication failure.

As so many others, this patient will likely be labeled (or has been labeled) “noncompliant” despite the difficulties and near impossible environment created that do not allow him and others to take their medications appropriately.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 12

This 55 year old patient was examined on February 14, 2003. He has AIDS. He is on an appropriate HAART regimen.

Most remarkable about this patient is that he informed me that he has had a nonhealing ulcer on his right forearm for five years. I examined this and noted that he also has multiple skin actinic keratoses. Upon my review of his record, he was not being treated for these conditions. His condition is documented in photograph 7.

IMPRESSION:
The major issue for this patient is that he has a possible malignancy and is not being followed closely enough. He, like all of the Limestone patients, needs to be followed more closely.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 13

This patient is a 41-year-old male who has AIDS, hypertension, and insulin-dependent diabetes mellitus. The patient is on an appropriate antiretroviral regimen.

This patient had been in prolonged severe pain due to an advanced untreated condition. Since November, 2002, the patient had been reporting anorectal pain to the medical staff. He was seen by a licensed practical nurse (LPN) on November 11, and was given Motrin. On November 20, the patient continued to experience severe anorectal pain and was encouraged by the same LPN, "to stop sexual activity, if he is sexually active." It is medically inappropriate for the nurse to make this statement instead of providing appropriate care.

The patient continued to have very severe anorectal pain, and continued to submit medical requests to the medical providers. The patient was seen on 1/8/2003 by a surgeon. By that time, it was found that he had a large, cauliflower-like anal wart and was given a mild pain reliever - Tylenol No. 3 plus a stool softener.

When I saw the patient, the patient was unable to sit down because of severe pain. He also informed me that he was unable to have a bowel movement.

On examination-- which is documented in photographs 8 and 9, the patient had a huge, fungating, cauliflower-like mass which was the approximate size of a baseball in his anal area. It was eating into the skin of his buttock area. This area was clearly very tender, and was bloody and malodorous due to the probable underlying infection. This mass could be cancerous.

IMPRESSIONS:
This case represents yet another patient at Limestone Correctional Facility whom the medical system has failed to treat. The patient has experienced prolonged severe pain. He is clearly not able to understand the seriousness of his underlying disease. An untreated anal wart could be cancerous. The virus that causes these warts is the leading cause of cancer in women (cervical cancer) and can also cause anal cancer. He is having such severe pain that the patient is unable to sit down or have a bowel movement. This lesion is clearly out of control, and it should have been surgically removed at a much earlier date. However, this did not happen. This situation illustrates an extreme case of negligence and inadequate medical care where the patient's condition is far advanced.

Because this patient's medical condition was so severe, I sent an emergency letter to the medical staff at Limestone Correctional Facility requesting that the patient be seen by a surgeon and have this mass surgically removed.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 14

This patient is an AIDS patient with a T cell count of 86. He is currently not taking antiretroviral medications. He states that he had great difficulty taking his medications because of the early hours the medications are administered. This patient does not understand any of the consequences of not taking the medications or the importance of medication adherence. Medication is especially important in a patient with a T-cell count this low. This indicates that the patient has very advanced AIDS and that he should be on some form of antiretroviral therapy.

The patient has also not been seen by medical staff since August 2002. This delay in medical attention shows that he is someone who has fallen through the cracks. This patient should be seen in a chronic care clinic on a regular basis.

IMPRESSION:
This patient does not understand the consequences of not taking his antiretroviral therapy. From the record, it appears that no one at Limestone Prison has discussed these consequences with him. Therefore, I do not believe that he has made an informed decision to come off of his antiretroviral therapy.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 15

The patient was examined on 2/13/2003, and his chart was reviewed.

This patient is a 36-year-old male who has HIV and hepatitis C co-infection. He reports that he did not learn of his hepatitis C infection until his legs had swollen to the size of watermelons. This indicates he has advanced hepatitis C and cirrhosis which is causing this swelling (edema).

Currently, the patient is on an HIV treatment regimen which is adequately dosed. Similar to other Limestone patients, this patient reports having difficulty standing in line to wait for his medications at 3:00 in the morning.

IMPRESSION:
The patient reports that he has worked in the Limestone Inpatient Unit. He informed me that he has provided medical assistance to other patients in the Inpatient Unit. By all accepted medical standards, it is completely inappropriate medical care for inmates to provide medical assistance to other patients.

Additionally, the patient is not being treated for hepatitis C. Treatment for this virus is not offered to patients at Limestone, although it is becoming more and more available at most correctional institutions around the country. I was unable to locate in this patient's records (as in many of the others) documentation that he had been administered vaccinations against hepatitis A and B. These vaccines must be given to all hepatitis C infected patients.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 16

This patient is a 46-year-old male who has advanced AIDS, chronic hepatitis C and hepatitis B, diabetes mellitus, hypertension, and acute renal failure. When I examined this patient on 2/13/2003, the patient informed me that he is so weak that he is unable to stand in line to obtain his medications. The patient is currently on several medications, including antiretrovirals. Unfortunately, there are no provisions for patients who are too weak to wait approximately one hour for their medication. Photograph 10 documents this patient attempting to wait in line for his medications.

The patient also informed me that he has been experiencing abdominal pain and groin pain. However, he was told by nursing staff that he could not see a physician for two to three weeks.

The patient has acute renal failure. This condition was detected in blood work on 1/29/2003, when the patient had a BUN of 38 and a creatinine of 2.8. Unfortunately, the patient has not had any further evaluation of his acute renal failure.

IMPRESSIONS:

1. This case represents a patient with multiple chronic illnesses and weakness so severe that he is unable to stand for 30 seconds. However, he is forced to stand in line for his medications. This will often result in the patient not being able to obtain his medications. Unfortunately, the long pill line at Limestone is a problem for many patients.

2. A patient who is this ill and who has acute groin and abdominal pain needs to be seen more quickly than two to three weeks. Because of the large number of patients and the low number of medical providers, many Limestone patients are not seen in a timely fashion.

3. This patient also has serious kidney failure. This patient is not being evaluated in a timely fashion-- again demonstrating the lack of sufficient medical providers at this prison.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 17

I examined this patient on February 13, 2003, in the Inpatient Unit at Limestone Correctional Facility. The patient has HIV infection, end-stage renal disease, and has had recent MRSA (resistant Staph) bacteremia.

Most worrisome in this patient's history is that he initially started contacting the clinic in mid-September when he was experiencing some skin infections. At approximately the same time, many other HIV infected inmates at Limestone were experiencing similar infections. The patient was not seen by Dr. Simon or the P.A. Instead, in early September, he was given a prescription for amoxicillin as well as Motrin. The patient continues to experience these skin infections which appear to be Staph folliculitis, as well as pus-filled furuncles and boils.

Most concerning, is that the patient reported urinary problems. In particular, he has had polyuria as well as associated dizziness, nausea, and vomiting, which started in early November. According to the patient's medical records and a written message to the clinic, on November 12 and 15, the patient had urinary symptoms. At that time, the patient said that he was told that he could not see the doctor. In fact, he did not see any medical providers. He saw only the nurses. The patient said he was not offered a urinalysis at that time, but according to the nursing notes, did not return to the clinic to have it performed.

Despite persisting symptoms and medical requests, the patient was not evaluated for another month. Finally, on December 18, 2002, the patient was seen by the Physician Assistant. He was experiencing the same symptoms. Again, the patient was taking Motrin. Not until two weeks later was the patient seen by Dr. Simon. He again complained of polyuria and other associated symptoms.

The next day, on 12/31/2002 (nearly 2 months after his initial symptoms), the patient had a basic evaluation which showed that he had protein in his urine. His BUN was 91, creatinine of 11.4, with a bicarbonate of 14, all signifying that the patient had far advanced, irreversible kidney failure.

Currently, the patient is in the Inpatient Unit, reporting that he has had increasing weakness as well as anorexia and weight loss. He is on antiretrovirals at the appropriate doses, but unfortunately he is hemodialysis-dependent.

Physical Examination:
On examination, the patient appeared very depressed. He did have multiple healing abscesses, as well as healed scars that appeared to be caused by skin infections.

IMPRESSION:

This represents a very severe problem at Limestone Correctional Facility. Patients, such as this one are not seen in a timely manner. It is clearly documented in the patient's chart that he was asking to be seen by a physician or by a physician's assistant, but was not seen and not evaluated by them. He was not evaluated appropriately or in a timely manner. He had some early signs of kidney failure, but again was not seen until at least 1-1/2 months after his initial symptoms. By that time, he was in end-stage renal disease. This is an irreversible medical condition.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 18

The patient was examined on February 13, 2003, and his chart was reviewed on that date.

This is a patient who has class C3 AIDS and toxoplasmosis of the brain. Toxoplasmosis is a parasite which causes abscesses and inflammation of the brain tissue. It is uniformly fatal without treatment. The patient carried this diagnosis for quite some time, but a review of his chart shows that the patient had been missing many of his medications for treating the toxoplasmosis. Upon discussing this with the patient, the patient informed me that he had been quite frustrated with the prison's medical delivery system. On many occasions, the medications had not been available, or he was unable to stand in the pill line. The patient uses a walker because of the neurologic damage and sequela that have been created by the toxoplasmosis of the brain.

The patient had stopped taking his HIV medications (Combivir and Viracept). The patient reports that he had taken these exact medications for many years in the past, but is currently unable to take these medications because of his concern that he may harbor resistant HIV rendering the medications useless. It is not mentioned in the chart whether medication resistance has been discussed with the patient. Resistance testing has not been performed. The patient was also taking Dilantin because toxoplasmosis can cause a seizure disorder, but the patient reports that the dose of the medications is sometimes increased or changed by the nurses. These medication changes are not discussed with him and he does not know if the doctor is consulted about these changes.

Review of the patient's medical records shows that he currently is on a regimen of tenofovir, abacavir, and efavirenz. The patient has a T cell count of 39 which was drawn in January. He is on Bactrim, but the patient reports he does not get azithromycin for Mycobacterium avium complex (MAC) prophylaxis on a regular basis.

IMPRESSION:
This patient is an advanced AIDS patient who has a severe brain infection with neurologic sequela of this infection and is unable to walk or stand for more than a few minutes. He uses a walker. But, the patient is forced to stand in the pill line for his medications. As a result, he becomes tired and frustrated. This is probably what contributes to his not taking his medications. Medications for severe diseases such as toxoplasmosis, need to be available to the patients **every single day.** If a patient is unable or is unwilling to take a medication, this needs to be discussed with the patient in detail. Patients may not understand why they are taking the medication, or there may be some misunderstanding. Therefore, any noncompliance to a life-saving medication needs to be discussed and documented in the patient's chart. This was not done in the case of this patient. This is a huge problem. If the patient continues to not take these medications, it will likely result in the patient's untimely death.

Patient Medical Chart Reviews and Interviews on-site at Limestone Correctional Facility February 13 and 14, 2003

PATIENT REVIEW 19

The patient was examined on February 13, 2003. His medical chart was also reviewed.

This patient has advanced AIDS, hypertension, and psoriasis. I examined him in the Inpatient Unit. The patient had been admitted to the Inpatient Unit approximately one month earlier. He was found to have fever, headaches, and fatigue. According to the patient, he continues to experience these symptoms. A review of the patient's medical record reveals that the patient rarely had a temperature obtained, and I was unable to find any comprehensive nursing notes.

The patient was on Dapsone as a prophylaxis medication for *Pneumocystis carinii* pneumonia (PCP). However, it appears that he was not receiving prophylaxis for Mycobacterium avium complex (MAC). The patient had not received the medically appropriate tests and blood work for all his symptoms. In particular he had not been evaluated for causes of fever, wasting, and MAC. He had also not been evaluated for Cryptococcal meningitis.

Upon examination, the patient appeared rather ill. He looked fatigued. Significant exam findings indicated that the patient had thrush. His condition is documented in photographs 11 and 12.

The patient also told me that some of the other inmates had been administering oral nutritional supplementation to him. In addition, the emergency call system used by the patients to contact a nurse had only recently been fixed. This was confirmed by other patients.

IMPRESSIONS:

1. This patient is an advanced AIDS patient who has not been appropriately evaluated for his symptoms. He should be followed more closely by the physician at Limestone. One physician who treats close to 3,000 patients does not have enough time to give chronically ill patients the medical care they need. In addition, the patient's inpatient notes, including the nursing notes, were inadequate for a patient who is this ill. Nursing is understaffed.

2. Another issue which has come up before is that other inmates are performing duties that should be done by the nursing staff, such as administering nutritional support, as well as possible other physician-prescribed treatments. **This is not acceptable and needs to be stopped immediately.** This represents one of the problems with the lack of adequate nursing care that these inmates are receiving in the inpatient unit.

3. Because of the patient's profound immunosuppression (T cells 31), and because the patient reported fevers, fatigue, diarrhea and headaches, it was felt that the patient needed further evaluation for opportunistic infections. As a result, I put this patient’s condition in writing to the Limestone Correctional Facility medical officials as an emergency order.

SUMMARIES OF HIV INFECTED PATIENTS' DEATHS AT LIMESTONE CORRECTIONAL FACILITY JANUARY, 1999 TO FEBRUARY, 2003

DEATH SUMMARY
Russell Battiste

Russell Battiste is a 46-year-old male with AIDS and presumptive *Pneumocystis carinii* pneumonia who died on 12/29/2002 at the Limestone Correctional Facility.

The patient was initially seen at intake by Dr. Simon on 8/7/2002. The first two notations in the chart are "new man, poor historian." Dr. Simon lists the patient's medical problems as obtained from the patient. Yet, the patient is again listed as being "a poor historian".

After the initial intake, the patient is not seen for approximately one month until 8/7/2002. On 8/7/2002, the patient informs Dr. Simon that he is "legally blind". In her assessment and plan, Dr. Simon did not elaborate further regarding this condition. The patient was found to have highly resistant HIV with a low T cell count of 81 (approximately 1000 T cells is normal). His viral load was greater than 500,000, indicating that he had a large amount of HIV virus. He was placed on antiretroviral therapy.

He developed an allergic reaction. This reaction was managed appropriately and the patient recovered. Yet, on 10/17/2002, approximately three months after his admission to Limestone, the patient was noted to have "AIDS wasting." He was noted to be an "ill-looking male." The patient was diagnosed with pneumonia and started on an antibacterial agent.

On 10/22/2002 the patient worsened and was sent to an outlying hospital. At the outlying hospital (Huntsville Hospital), the patient was quickly diagnosed with blindness in one eye from cytomegalovirus (CMV) retinitis. He was placed on treatment for CMV so that he would not lose the vision in his other eye. The patient was also diagnosed with presumptive *Pneumocystis carinii* pneumonia and started on clindamycin and Primaquine.

The patient was returned to the Limestone Correctional Facility and on 10/27/2002, the focus of his appointment with the physician assistant was the following: "Discharge note that the patient wishes to be DNR, but no signed statement in chart." At that time, Dr. McClain was called and Decadron, which is a corticosteroid, was started. The patient deteriorated as confirmed in multiple notes, and the shortness of breath worsened. On 11/11/2002, the physician noted that the patient was critically ill, and a critically ill referral was filled out to be sent to Naphcare. There is no response in the chart from Naphcare. On 11/18/2002, the patient was visited by the "hospice team." An advanced directive and DNR form were signed by the patient.

The patient continued to progress to worsening respiratory distress, severe respiratory failure, and died at the Limestone Correctional Facility approximately six weeks later on 12/29/2002.

IMPRESSION:

1. The presumptive diagnosis was *Pneumocystis carinii* pneumonia. The patient was only diagnosed presumptively with PCP. When he deteriorated, even though he did not want

to be placed on a ventilator, it is still incumbent upon the medical staff to evaluate the patient for other causes. However, this was not done. The patient was not sent to an outlying hospital to evaluate for other potential diagnoses, including such treatable illnesses as tuberculosis. The patient progressed to worsening respiratory failure and died. This is especially concerning, given that the patient appeared to have a history of tuberculosis.

2. Wasting syndrome. There seems to be a common pattern at the Limestone Correctional Facility. Patients are not receiving adequate nutrition and are wasting. They also are not being evaluated appropriately for causes of wasting, such as infections, and are not given appropriate supplements or medications that can increase the patient's appetite or help the patient put on critical weight gain. This was true in this patient. The external autopsy of this patient indicates that he weighed a mere 89 pounds at a height of 6 feet.

3. Also concerning in these patients is the notation that he was a "poor historian." Yet, there is no indication that any attempts were made to obtain outside medical records for this patient or any of the patients in which charts have been reviewed. This is concerning for some of these patients who are 'poor historians.' This patient had a history of CMV retinitis and blindness. These conditions were missed at his admission.

4. The patient was started on an antiretroviral regimen. Yet, when Dr. Simon asked him whether he had received one of the medications, he reported not even recognizing it. He was not receiving a medication that had been ordered. This is an example of a pattern at Limestone where patients either do not receive their medications, or they receive them only sporadically.

This patient had highly resistant AIDS virus. It was likely that he would not survive a long time. Yet, Limestone's failure to provide adequate medical treatment contributed to his quick demise.

DEATH SUMMARY
Luis Blanco

Luis Blanco is a patient with chronic hepatitis B, HIV infection, and insulin-dependent diabetes mellitus, who died at the age of 44 on 02/22/2001, at the Huntsville Hospital.

The patient unfortunately, suffered from both HIV infection and chronic active hepatitis B and insulin-dependent diabetes mellitus. The patient was treated for his HIV infection with combination therapy consisting of D4T, DDI, and nevirapine. The patient apparently had a good response to these medications. He apparently had done well in managing HIV-related medical issues, as well as from the hepatitis B, but had difficulties with his insulin-dependent diabetes mellitus for quite some time. At one point the patient even refused to take his insulin because the insulin was being administered, according to the patient, at times of the day that did not seem accurate to him.

The start of the patient's demise appears to have begun on 02/11/2001 when he was seen in bed in the Infirmary or inpatient facility. He was found to have remarkable abdominal distention. He was given a bottle of magnesium citrate which is for severe constipation. No further evaluation was done, but the patient was seen the following day when again the patient was noted to have abdominal distention. Even though the patient was in the inpatient unit, he sent a medical request form on 02/13/2001, stating that “my stomach is swollen up. I can’t eat or hold food down. I can’t take any insulin due to me not being able to eat. Please see me as soon as possible.”

Apparently, the patient was not seen in the inpatient unit. Instead, he was scheduled to be examined at the clinic on 02/15/2001. According to Dr. Simon’s notations, the patient was in fact a ‘no show.’ There was no follow-up with the patient that day, until apparently the patient was sent to the emergency room on 02/16/2001 with abdominal distention.

The notes from the emergency room were not made available, but the patient was seen and examined, and was sent back to the Limestone Correctional Facility. At that time, the patient was housed in the inpatient facility when he was returned on 02/16/2001. I can find progress notes that state that this is so. Starting on 02/16/2001, the patient appeared to have continued abdominal distention, abdominal pain and difficulty eating because the pain and distention were so severe. He was even short of breath because of abdominal distention pressing against his diaphragm.

On 02/20/2001, one of the nurses noted that the patient had generalized tenderness of the abdomen. On 02/21/2001, the patient appeared to have severe respiratory distress and labored breathing. He complained of some chest pain at that time. He was placed on oxygen, and actually sent to the emergency room. He apparently died of an infection the following day.
There are no liver function tests present in the patient’s medical chart, even though the patient was on antiretroviral therapy that was potentially toxic to the liver. There was also no assessment for metabolic abnormalities such as lactic acidosis.

IMPRESSION:

The main issue with this patient is that he had chronic active hepatitis B and was not being treated, despite his worsening condition. One could assume that if liver enzymes and other appropriate lab studies had been periodically monitored, that this would have been diagnosed much earlier than it was.

The patient was on medications potentially toxic to the liver, and these should have been monitored more closely.

The lack of any inpatient physician documentation is a serious problem.

DEATH SUMMARY
John Bolton

John Bolton was a 39-year-old HIV positive male who died on 5/22/2000 at 7:47 p.m. at the Limestone Correctional Facility. An external autopsy report from the Alabama Department of Forensic Science stated that the patient died of cachexia (wasting) and was marked emaciated. The patient weighed a mere 74 pounds at the time of his death.

On 4/5/200, the Mr. Bolton's health drastically deteriorated. A Health Service Request form indicates that the patient stated that “have no problem being hungry. It’s after I eat, I have problem keeping my food down.” The nurses noted in his chart that the patient had been vomiting 50% of his food and that he likely had electrolyte imbalances. Despite these observations, there were no laboratory tests obtained and no further evaluation was done other than this cursory examination by the nurses. The patient was not referred to a medical doctor until 4/11/2000.

The patient continued to plea for help. Yet, the medical staff did not provide assistance. The patient submitted another health service request form several days later, reporting that he was thinking of sugar and had no energy. He was seen by a Limestone nurse who administered a cursory evaluation of the patient. She did not provide an adequate evaluation and did not call a medical provider. She wrote down “no discomfort or distress observed and no plan at this time.”

Four weeks later, on 5/7/2000, the patient was admitted to the health care unit with a significant body weight loss of more than 20%. He continued to report not being able to keep food down. By this time, the patient was already end stage and supplementation and Megace (a medication used to increase the appetite) was initiated. At no point was it even discussed with the patient, nor were any medications started, to increase the patient's muscle mass. This treatment -- medications to increase muscle mass -- is the standard of care for patients with wasting. Such medications could include Deca-Durabolin or testosterone.

The patient continued to decline in the inpatient unit. End-of-life issues were never discussed with him, or at least never documented. There was no Do Not Attempt to Resuscitate form. He did not receive any adequate hospice care. He expired from starvation on 5/22/2000 in the inpatient unit.

The patient also had some concomitant illnesses including bipolar affective disorder. He had been seen by Psychiatry on 2/12/2000 because of his refusal of HIV medications. The patient reported that he did not want the HIV medications “until he was back on the streets” which he said would be very soon.

There were numerous instances in the chart where the patient presented earlier in the year, on 1/11/2000, complaining of vomiting and of not being hungry with a poor appetite. He presented on 1/11/2000 to the physician complaining of these symptoms. Nothing was done at that time. On 1/12/2000 he presented with probable *Pneumocystis carinii* pneumonia. On 1/13/2000 he was started on a subtherapeutic dose of Bactrim (double strength two times a day). His Bactrim dose was later increased to three times a day. This was started because the patient had fever, shortness of breath, and a disease process in his lungs. However, the patient never received a diagnosis during this time. According to records, he stabilized on the subtherapeutic dose of Bactrim.

No definitive diagnosis of this patient was ever made.

IMPRESSION:
The focus of this review has been directed to the events that led to the patient's death. The focus has not been diffuse. There are many other issues in this patient's medical records signifying lack of care or inadequate care.

The most concerning part of this patient's care was that he clearly presented early in the year 2000 with difficulty eating and lack of appetite. This was not addressed adequately, even though in February 2000 the patient had a T cell count of 15. It was not until several months later, in May 2000, when the patient was admitted to the inpatient unit and was provided appetite stimulants. By this time, the patient was already dying and had lost such an extreme amount of weight that no course of therapy could reverse his course of wasting.

There have been multiple patients who have died of wasting at the Limestone Correctional Facility. This addresses the issue of inadequate nutrition, inadequate diagnoses, work-up and treatment of wasting at the Limestone Correctional Facility. There are simple medications that can be used to treat wasting and increase the patient's body mass. While it is true that patients still die of wasting in the free world, it is concerning that there are such a large number of patients at Limestone rapidly dying of this ailment.

In addition, the patient's treatment in December, when he presented with a febrile illness and a lung process, is concerning in that the patient was not appropriately evaluated, nor was he treated appropriately. Patients with a low T cell counts presented with a lung process, need a diagnosis. Instead, this patient was presumptively diagnosed with *Pneumocystis carinii* pneumonia. He was started on a subtherapeutic dose of Bactrim. He apparently showed some improvement. But this is inappropriate medical care. This patient’s demise was premature.

Finally, this is another patient whose end-of-life care and DNR issues or Advanced Directive was not addressed.

DEATH SUMMARY
ANTHONY COX

Anthony Cox was a 39-year-old male with AIDS who died at the Huntsville Hospital on 2/4/2001.

The patient had AIDS with a very low T cell count (less than 50), and multiple complications of HIV, including AIDS wasting, esophageal candidiasis, thrush, cytomegalovirus (CMV) retinitis, end-stage renal disease (kidney failure) on hemodialysis, and Staphylococcus bacteremia. The focus of this summary will be on the patient's last few months of care.

As noted by multiple health service request forms, the patient pled for assistance from the health services personnel multiple times. Beginning on 9/13/2000, the patient sent a request to the staff stating "my vision in both eyes are blurry, especially in the left eye and needs to be seen by the doctor." He was evaluated by an LPN and was noted to have 20/20 vision in both eyes. This result is highly suspect given that the patient ultimately was diagnosed with CMV retinitis – a blinding disease of the eye caused by a virus.

Just four days later, on 9/17/2000, the patient continued to have problems and in an additional health services request form the patient stated, "I am having bad blurry vision in both my eyes. I believe it is CMV and I want my medicines changed…" The LPN did not see the patient, but wrote a note to see the prior health services request form. The patient was not even evaluated.

The patient continued to plea for help. On 10/16/2000, the patient again reported, "I've stated I've got CMV which my eyesight is getting worse. I see this as neglect. I must be seen by Dr. Simon about my problem. It's urgent."

On 10/25/2000, the patient again reported, "My eyesight is worser than before. I've been having this problem since early September 2000 and something must be done about it. Needs to see the doctor." The LPN reports that the patient was ready "to see the eye doctor. Doctor unable to see everyone on first visit. To return in November." This statement demonstrates a lack of caring, neglect and a lack of understanding on the part of the nurse of the seriousness of this patient's complaints, who clearly understood that he might have sight-threatening CMV (and who ultimately was diagnosed as having CMV retinitis).

The patient was finally seen by Dr. Simon on 11/25/2000, which was more than three months after his initial request. At that time, he was reporting decreased vision and he reported only being able to see shadows. He was scheduled to be seen by an optometrist, but the optometrist canceled due to "bad weather" as listed in the note. Appropriately, late in the course of the disease, the patient was sent to the hospital. However, the patient was still not diagnosed with CMV retinitis or initiated on therapy until five days later on 12/30/2000, even though the patient clearly had loss of vision and was at risk for losing total vision.

On multiple occasions in this patient's medical record (as in the medical records of other patients), there are notes regarding noncompliance. It is evident that patients had difficulty being compliant at the Limestone Correctional Facility. On 6/28/2000, this patient was counseled about noncompliance. His response was "he can't hear sick call and sleeps through it." The nurse who evaluated him at this time did not address his noncompliance any further. It is very difficult to evaluate the medication administration record forms in this patient's medical chart, but it appears that indeed the patient was not fully adherent to his medication regimens. This is similar to many other patients at Limestone.

On 10/4/2000, the patient complained of diarrhea. He was seen by the physician. As has been indicated, he was not given any work-up, but was instead treated symptomatically. At that time, he had also been complaining of decreased vision. A cursory exam was done by the physician who reported no lesions, even though this was a suboptimal way to diagnose CMV disease. She did not work-up the patient's complaints.

On 1/11/2001, the patient complained of shortness of breath and became ill. He was started empirically on Bactrim, as many of these patients were. He did not receive a diagnosis. Unfortunately, at the Limestone Correctional Facility, IV Bactrim was not available that day so he was put on oral Bactrim. He went on to decompensate and on 1/12/2001, his shortness of breath worsened. He went into respiratory failure and was taken by ambulance to the local hospital where he died on 2/4/2001.

There is no external autopsy and no information available from the patient's hospitalization at Huntsville Hospital.

IMPRESSION:
This patient represents a well established pattern of patients who presented with either critical laboratory values or very serious symptoms such as decreased vision, who were not appropriately evaluated at Limestone Correctional Facility. Unfortunately, the nursing staff and medical staff were unable to recognize the seriousness of an advanced AIDS patient who complained of decreased vision. This was indeed a medical emergency, and these patients needed to be evaluated emergently.

This patient's loss of vision could have been saved had he been treated earlier. However, this did not occur. His pleas for help, written on the health services request forms, were ignored, even though the patient was able to self-diagnose his own CMV retinitis. Unfortunately, the medical staff was incapable of making this diagnosis until late in the course of the disease. This, combined with the lack of an organized health care system, leads to a pattern of deadly diseases being diagnosed late or not at all, being treated inappropriately and ultimately to higher morbidity and mortality in this population.

This patient was noncompliant. This is a common theme at the Limestone Correctional Facility. High instances of patient noncompliance question the therapeutic relationship or lack thereof, that exists between the patient, the medical system and the staff at Limestone Correctional Facility. There was an extraordinary attempt to document noncompliance. Yet, little or no

attempt was made to remedy noncompliance or try to help the patients have access to their medications. Instead, patients are warned against noncompliance, and ultimately medications are withheld and discontinued and the patient is blamed. This, despite the fact that the situation the patients are in makes compliance difficult, if not impossible in the long-term.

In reviewing some of the older notes, this case also brings up the issue of poor medical records and the lack of transcription services at the Limestone Correctional Facility. I have not seen one note transcribed, which causes many difficulties in interpreting the notes. This creates a medical file which is difficult or impossible to read.

In addition, problem lists are not filled out regularly. Medication lists are not regularly filled out or updated. Such basic prevention measures as vaccinations are rarely documented in any of these patients. It is clear from the medical records at the Limestone Correctional Facility that the medical facility is highly disorganized and many patients are falling through the cracks. The patients that are being seen, are not being adequately evaluated because of a substandard and antiquated system.

DEATH SUMMARY
Andy Crawford

Andy Crawford was a 41-year-old male who died on 5/22/2000 from complications of AIDS. He was only at the Limestone Correctional Facility for one night. His history was obtained from scant medical records. It is important to review his medical care prior to arriving at Limestone.

The patient was originally sentenced on 3/13/2000 and held at the Montgomery County Jail until 5/1/2000. He was then transferred to the intake center at the Kilby Correctional Facility. At Kilby, he was held for one week until 5/9/2000. It was clearly documented that he was seen by a physician and noted to have a decreased level of consciousness. It was also noted by the physician that the patient was lethargic prior to his transfer and was urinating on himself (incontinent of urine). However, he was transferred to the Limestone Correctional Facility where he was held overnight. He was then transferred to the Cooper Green Hospital. Mr. Crawford expired two weeks later.

Although there are few medical notes addressing this patient, because of his short stay at Limestone, the notes that can be reviewed are revealing and problematic.

Upon intake, the patient was seen at the Limestone Correctional Facility and was noted to be lethargic and nearly unresponsive. He was also incontinent of urine. Upon reviewing his condition prior to transfer from the Kilby facility, his medical status was similar. At Kilby he was noted to have a decreased level of consciousness. Despite the patient appearing very ill and experiencing decreased levels of consciousness, he was still transferred to Limestone.

The patient received an external autopsy examination. The autopsy noted that the patient had a history of toxoplasmosis of the brain. However, the records do not indicate that he was transferred to Limestone on any anti-toxoplasmosis medications.

Upon being received in this condition at the Limestone Correctional Facility, the patient was sent to the hospital. He died shortly thereafter.

IMPRESSIONS:
This patient's case clearly demonstrates the systemic problems in the Alabama correctional facilities. These two facilities are transferring and accepting patients inappropriately. This patient should not have been transferred from the Kilby facility, and should not have been accepted in transfer by the Limestone Correctional Facility. He was transferred without nursing or any other kind of skilled medical care. He was transferred by correctional officers and it was surprising that this patient did not become even more ill during his transfer and require an emergency stop at a hospital.

DEATH SUMMARY
Ezelle Daniels

Ezelle Daniels was a 60-year-old male who died of AIDS on approximately 11/24/2002. An external autopsy or summary of his death was not available in his medical records.

The patient was received at the Limestone Correctional Facility on 6/19/2002. Although this patient had advanced AIDS with a T cell count of 23, hepatitis C and multiple medical issues and complaints, he was not seen until a full month later on 7/18/2002 by Dr. Simon. On 7/18/2002, it was recorded in Dr. Simon's note that the patient had multiple medical problems. Dr. Simon indicated in her physical examination that he was a thin male and that he was edentulous (he had no teeth).

There was no referral for the patient to be fitted for teeth and no provision made to alter his diet so that he could receive food that he would be able to eat. His extremely thin body habitus was also not addressed.

The patient was not seen again until almost one month later. At that time, the patient had been in the Limestone Correctional Facility for two months. As stated above, his T cell count had been obtained and was found to be quite low at 23 with a viral load of 73,000. The patient was started on *Pneumocystis carinii* pneumonia prophylaxis, *Mycobacterium avium complex* prophylaxis and an antiretroviral regimen.

There is no documentation in the chart that there was any attempt made to obtain the patient's outside laboratory results. In addition, there was no attempt made to determine the patient's prior antiretroviral regimen. The patient spent a full two months at the Limestone Corrections facility without HIV medications and at risk of acquiring deadly, yet preventable, opportunistic infections such as *Pneumocystis carinii* pneumonia or *Mycobacterium avium complex*.

The patient submitted a health service request form on 7/18/2002 requesting double portions of food because of his profound weight loss. However, Dr. Simon did not address this request and did not increase his food portions.

On 8/30/2002, the patient reported fever. Dr. Simon noted "the patient is shaking under his covers...but is in no apparent distress." This is a contradictory statement. A chest x-ray from 10 days earlier reflected what was believed to be a pneumonia. There is no documentation in the chart that the suspected pneumonia was addressed at that time. Therefore, there was a 10-day gap between radiographic documentation and the prescribing of treatment. Despite the 10-day gap, the patient was started on treatment for pneumonia and he subsequently improved.

Finally on 9/05/2002 he was diagnosed with AIDS wasting and started on oral supplementation with Resource. Resource is a protein drink. On 9/13/2002 the patient continued to experience wasting and diarrhea. The diarrhea was not evaluated for parasites or bacterial infection which can cause devastating illness in AIDS patients. Instead, the patient was placed on anti-diarrheal medications which treat the symptom, but not the cause of the diarrhea.

In a physician's note on 10/07/2002, there is a notation that the patient was observed returning his tray with almost all the food still on the tray. The patient was questioned about this. The patient noted that the food was too hard and he could not chew it. It was again noted that he was edentulous and therefore had no teeth with which to chew his food. The patient was referred to a dentist for dentures. This referral for dentures occurred almost three months after the patient was noted to be edentulous on his first physician visit.

On 10/07/2002 there is a request for an Ensure form. According to the records, Ensure is something that needs to be specially requested from Naphcare. This note describes in vivid detail how emaciated and how sick the patient was at this time. It states that the patient was wasting, that he had prominent cheekbones with no visible fat and decreasing muscle. In parentheses it states "wasting." The records indicate "rib cage very visible." He apparently was 5 feet 8 inches and weighed 98 pounds. His ideal weight was 160 pounds. This indicates the patient had lost approximately 30 percent of his ideal body weight. Such weight loss has profound medical complications for an AIDS patient.

The emaciated patient declined in health. He never received his dentures. Consistent with many Limestone patients, he did not receive any end-of-life care. He did not receive any life-saving medications to increase his muscle mass. He expired on 11/24/2002, from AIDS wasting syndrome.

IMPRESSION:
This is a disturbing but common event at the Limestone Correctional Facility where patients are admitted with AIDS and decline rapidly. This is not the norm in the developed world. Patients with AIDS typically do not deteriorate this aggressively and rapidly, at least, not in the United States where modern medications are available.

This patient did indeed have advanced HIV, but he went without treatment for one month at the Limestone Correctional Facility before he was seen by a doctor. He was at the facility for two months without receiving any medications. He was at the facility for almost four months before he was even referred to a dentist for dentures because he was unable to chew the food he was provided.

The patient's Limestone records indicate that his outside medical records were not requested or obtained when he first arrived at Limestone Correctional Facility. Indeed, there is no indication whether there is adequate support at the Limestone Correctional Facility for the physicians and staff to even request outside medical records. If not, that is a serious flaw in a working medical system of care.

As early as July, Dr. Simon did not address this patient's request for double portions of food. Dr. Simon ignored this request. Yet, in her medical records she clearly described the patient as being thin. As the treating physician, it was incumbent upon her, to address this request at the time it was made. Dr. Simon also should have addressed his lack of teeth and made the referral to obtain the patient dentures, especially when Mr. Daniels was seen by her and questioned and was informed by him that he was unable to chew his food. This patient died most likely of AIDS wasting which was exacerbated by the lack of adequate medical and nursing care, lack of treatment, lack of adequate nutrition and the lack of life-saving medications to increase his body mass. In this patient, a lack of teeth made the situation only worse.

DEATH SUMMARY
Larry Davenport

Larry Davenport was a 27-year-old male with AIDS who died of septicemia (commonly called bacteria in the blood or blood poisoning) on 01/24/2000 at the Huntsville Hospital. He had only been incarcerated at Limestone since 12/10/1999.

Mr. Davenport had a history of AIDS and a recent hospitalization for *Pneumocystis carinii* pneumonia. He also had pancytopenia which means that his blood counts were all very low, and a history of hypertension. Upon intake, the patient was seen and only given a cursory evaluation. He had a laboratory blood draw on 12/15/1999. There is no documentation of medical staff or patient follow-up.

None of the medical records show that the patient was placed on medications during this time period. There was also no documented attempt by the Limestone Correctional Facility to obtain medical records from the outside hospital, even though the patient was transferred directly from the hospital into the Limestone Correctional Facility, bypassing the Kilby Correctional Facility.

On 1/12/2000, the patient presented with high fevers. He was put in the inpatient infirmary and was quickly started on an antiretroviral regimen, as well as prophylaxis for *Pneumocystis carinii* pneumonia and *Mycobacterium avium complex*. It is important to note that this antiretroviral regimen was started a full month after his laboratory results were drawn which showed an extremely low T cell count of 24.

Throughout the patient's stay in the infirmary, and in fact on 1/12/2000, Dr. Khouri's notes questioned whether the patient had *Mycobacterium avium complex* (MAC). Given the low T-cell count, the patient could have had MAC. At some point, an additional antibiotic was started.

However, the patient continued to decline. He continued to experience extremely high, spiking fevers, but according to the medical record, the patient had not been given an adequate work-up. In fact, only one blood test was drawn. No additional blood cultures were obtained, which is the standard of care. The single laboratory test was drawn on 01/18/2000 that showed the patient had bacteria in his blood. The patient was transferred to a local hospital where he died of sepsis six days later.

IMPRESSION:
This is an example of another patient at Limestone Correctional Facility who had an incredibly rapid and fatal decline. Despite being transferred directly from a hospital, it is clear that the medical staff at Limestone Correctional Facility did not attempt or did not receive an adequate history regarding this patient's recent hospitalization. In addition, the medical staff was grossly negligent in that the patient was not followed closely, even though he was presented to the infirmary with such high fevers and in such extremis, to die so rapidly. This was a very young patient, only 27 years old, and he died a very rapid death and preventable death.

There is one indication in the medical records of the patient hoarding his medications toward the end, which more than anything, signifies the patient's mistrust in the medical system, given that when he was questioned about this, the patient reports no problems with his medications. The patient was critically ill on 1/21/2000. Yet, the nurse was not making sure that this patient was being administered his medications. The patient died only three days later.

DEATH SUMMARY
Howard Davis

Howard Davis was a 48-year-old male with AIDS who died on 8/9/2000. An external autopsy is not available in the records that have been reviewed.

The patient was HIV positive with a very low T cell count (less than 50), as well as presumptive toxoplasmosis of the brain. The patient also suffered from chronic obstructive pulmonary disease (COPD), significant psychiatric illness and had a long history of noncompliance.

A thorough review of the patient's chart clearly demonstrates that the patient had a long history of noncompliance with medications. In addition, the patient had a rather extensive psychiatric illness which was not well delineated in the medical records. However, at one time in 1996 and 1997, he was on Mellaril and amitriptyline and thioridazine which are administered to patients with significant psychiatric illnesses. The patient had been prescribed medications to prevent *Pneumocystis carinii* pneumonia and medications to prevent *Mycobacterium avium complex*. He had also been on multiple antiretroviral regimens.

A note in the chart on 8/3/1999 is representative of the patient's history. It states “noncompliance with Septra” and states he did not need Septra. This medical advice was made when the patient had a low CD4 and high viral load. Septra was needed to prevent *Pneumocystis carinii* pneumonia. “He stated he understood and he would not take it because he did not need it.” This note was written by an LPN.

This note is concerning because the LPN was not really sure whether the patient understood the ramifications of not taking his medications. In addition, the patient did not undergo psychiatric assessment. At any rate, three months later in 11/1999, a note written by a physician reported a discussion with the patient regarding antiretrovirals. The patient said he understood and will “pass again”. From this note, the physician is unsure of whether the patient understands the medical advice being provided, or whether the patient had confidentiality concerns or other issues.

IMPRESSION:
This is a patient at the Limestone Correctional Facility who has an extensive history of noncompliance with his medication regimen. He had been provided opportunities to take his medications. What is unclear is why the patient was unwilling or unable to take his medications. This patient may have been distrustful of the system and as a result, decided not to take any of his medications throughout his stay at the Limestone Correctional Facility.

Confidentiality could have been another issue caused by pill line. At any rate, these issues were in fact not discussed with the patient. Over the course of several years, medications were initiated and then later discontinued because the patient was noncompliant. The patient is partially responsible for his noncompliance and patients must take their own medications, but this patient clearly had a history of psychiatric disease and ultimately died of a history of toxoplasmosis of the brain which affects neurocognitive functioning, the effects of toxoplasmosis could have compromised his judgment.

DEATH SUMMARY
Andrea Edwards

Andrea Edwards was a 39-year-old male who died at the Limestone Correctional Facility on 10/16/2001.

The patient was HIV positive. He died of AIDS wasting syndrome. The patient's illness was complicated by AIDS dementia, severe thrombocytopenia (which is low platelet count), anemia, and liver dysfunction.

The patient had a rather long previous incarceration. His most recent incarceration started on 3/12/2001, when the patient had a blood draw. At that time the patient was found to have a very low T cell count and a high viral load. The patient was seen in follow-up by the physician on 4/5/2001 and was found to have a urethral infection. His T cell count was 10 and his viral load was over half a million. The patient at that time did not want to start antiretrovirals, agreed to start *Pneumocystis carinii* pneumonia and *Mycobacterium avium complex* prophylaxis. There was no indication as to why the patient did not want to start antiretrovirals.

The patient was seen again in follow-up on 5/31/2001. It was reported that the patient was not coming to the pill line. Again, the physician's note does not discuss why the patient was not coming to the pill line, nor was there a psychiatric assessment for depression or for his mental status. Yet, a licensed practical nurse (LPN) discussed Do Not Resuscitate (DNR) issues, and reports that the patient just wanted to think about it at that point, and specifically did not want to be placed on Do Not Attempt to Resuscitate (DNAR) status. This is problematic because it is not the role of a LPN to discuss such an important issue with a patient.

On 6/3/2001, the patient was seen by the physician and diagnosed with AIDS wasting syndrome. At that time, he had not been receiving any therapy. He was housed in the infirmary until his death. Even though the patient was diagnosed with AIDS wasting until his death, he was not started on any oral supplementation or any medications to increase his lean muscle mass.

On 8/8/2001 he was seen by the physician who described the patient as "an emaciated male, looking pale and weak." He was diagnosed with AIDS wasting and anemia. A few days prior he was started on Ensure which is a protein supplementation. The patient was followed again on the inpatient unit. He continued to decline.

The issue of DNAR was again discussed with the patient. The patient declined DNAR status.

On 10/3/2001 the patient was found to have a critically low platelet count of 11,000. The following day, the patient was started on prednisone to help increase his platelet count. On 10/5/2001, the physician reported that she had ordered some labs that were not sent and that she had to reorder those labs. The patient continued to decline. He received minimal nursing care and no hospice care. He expired on 10/16/2001.

As a final note, the physician noted that considering the clinical picture and prognosis, cardiopulmonary resuscitation (CPR) was not attempted. The patient was pronounced dead.

IMPRESSION:
Mr. Edwards was a very advanced AIDS patient who, like many other patients at Limestone, had a rapidly progressive decline in health. His most bothersome symptom was his AIDS wasting. Many other patients at Limestone have also demonstrated symptoms of AIDS wasting. He was not treated appropriately or aggressively. The patient received some minimal protein supplementation, but no medications were provided to increase his appetite or increase his muscle mass. These medications can be life saving. The patient was clearly noncompliant, yet there was no indication in the medical record of discussing the patient's noncompliance and whether he understood why he was on these medications. In addition, this is a pattern at Limestone Correctional Facility where many patients appeared to be unable to stand in line for their medications, and appeared to not receive their medications as a result.

Medical orders from doctors (such as laboratories) are often missed at Limestone as was the case with this critically ill patient.

As is the pattern at Limestone, while the issue of DNR was discussed with this patient and documented, the patient’s wishes to not be DNAR were not respected.

DEATH SUMMARY
Michael Elliot

Michael Elliot was a 36-year-old male who died at the Huntsville Hospital on 03/27/2001 at 11:00 a.m.

Although medical records are not available from the patient's hospital stay, a review of the patient's external autopsy report shows that he died of *Pneumocystis carinii* pneumonia and that he suffered from AIDS, Cryptococcal meningitis, AIDS dementia, and depression. This is one of the few patients reviewed who signed a Living Will. The Living Will was signed on 3/7/2000.

A review of this patient's extensive medical history shows that he was on multiple antiretroviral therapies and other treatment regimens. He was seen repeatedly by the nursing staff and occasionally by the medical staff addressing noncompliance of his medication regimens.

The patient was not capable of taking a one medication a day regimen to prevent *Pneumocystis carinii* pneumonia or to treat his Cryptococcal meningitis. Indeed, he was not capable of taking a complicated regimen to treat HIV. Most of the regimens to treat HIV involve medications which must be taken at least three times a day, with special attention to food intake.

This patient had great difficulty adhering to medication regimens which is reflected throughout the patient's chart. There is only one instance in the medical records where the patient received any counseling to help increase his adherence or to discuss what some of the issues were addressing his adherence. Most medical providers recognize these steps as necessary for noncompliant patients.

On 4/4/2000, a note in the chart by an LPN states, “noncompliance with antiretroviral medications and Septra,” [which is *Pneumocystis carinii* pneumonia prophylaxis]. “Inmate signed release of responsibility. Antiretroviral medications DC’d. Septra DC’d due to noncompliance.” It is very concerning that the patient's medications were completely discontinued despite his not being counseled on this issue. Discontinuing a patient’s medications are not within the scope of responsibility of a licensed practical nurse. This should have been addressed by the physician, or at least by a pharmacist.

Several instances are also documented in the patient's chart referring to a “counseling report.” In the counseling reports, there are warnings called “first warning” or “second warning” or “third warning.” These warnings are filled out by LPN’s. However, all the LPN does is fill out the form. The LPN does not counsel the patient addressing noncompliance. Then the LPN reports that the patient needs to be more compliant with medication treatment or be subject to discontinuation of medications. It is clear from the records that warnings are used as threats to the patient, and are not utilized to increase the patient's understanding or cooperation of noncompliance with their medication.

While the patients need to be adherent, need to take their medications and need to recognize that it is necessary to take their medication on a regular basis, these types of warning tools used by the Limestone LPN's are clearly not helpful to the patient.

On 3/7/2000, the patient presented to the physician with a differential diagnosis of pneumonia versus tuberculosis. The following day, the physician ordered an antibiotic which apparently was not available at the Limestone pharmacy. However, even though the drug was not available, the doctor was not informed about the unavailability. Thus, the patient was never given the antibiotic. The patient was administered medication for presumptive *Pneumocystis carinii* pneumonia, although he was not diagnosed with that date. The diagnosis of PCP is typically made by induced sputum or an invasive procedure called a bronchoscopy. PCP is not diagnosed according to symptoms.

Without a diagnosis, the patient declines fairly rapidly over the next few days. On 3/11/2000 his oxygen saturation was 71% on five liters. At this time, he was appropriately sent to the local hospital for treatment. However, his presumptive pneumonia was so severe that he eventually died on 3/27/2000.

IMPRESSION:
This 36 year old patient presents a classic example of a noncompliant patient at Limestone Correctional Facility where the patient's reasons for noncompliance were never determined. Throughout the patient's medical record, it is clear that he was unable to take his medications -- even a simple pill once a day. Yet, no medical or nursing staff ever discussed with him the importance of taking this medication, or such discussions were not documented in the chart.

This calls into question the effectiveness of the system that currently exists at Limestone Correctional Facility where all patients must stand in line for their medications, regardless of their medical condition or ability to comply. Many correctional institutions in the United States have adopted a system of treatment where patients are allowed to keep their own medications and are allowed to administer their own medications. In many ways, this increases the patient's feeling of responsibility and increases the patient's adherence, given that it makes it much easier for the patient to take their medications, especially such simple medications as an antibiotic once a day to prevent pneumonia. This patient likely died of a pneumonia which was 100% preventable -- *Pneumocystis carinii* pneumonia.

This could have been prevented, yet it was not because the patient was not capable of taking his *Pneumocystis carinii* pneumonia prophylaxis. Despite the patient's responsibility, it is also the responsibility of the correctional institution to assist patients in taking their medications and to create a healthy therapeutic environment to allow patients to take their medications, especially the patient who is more vulnerable or who may have underlying psychiatric illness such as this patient who was depressed and who had AIDS dementia, or who might not understand the consequences of his actions.

DEATH SUMMARY
Terrell Grey

Terrell Grey a 41-year old HIV-infected patient who died at an outlying hospital on 1/25/2003 at 12:40 p.m.

The significant part of this patient's medical history started in November 2002 when the patient was discovered to have cotton-ball lesions on both lung fields. This condition was discovered during a routine chest x-ray. The initial belief was that the patient may have metastatic cancer to the lungs. However, the patient never had an adequate evaluation which would have included a tissue diagnosis. Approximately one month later, the patient had a chest CT scan which revealed that the patient had some large lesions that might have been consistent with metastatic lung cancer.

The patient was seen by Dr. Simon on 1/25/2003 at 6:00 a.m. He was experiencing shortness of breath after being exposed to a large amount of dust caused by a piece of the ceiling that fell in his housing unit. The patient was placed on oxygen and was given albuterol. He improved somewhat. However, he was placed on a large amount of oxygen at 4 liters per minute. In Dr. Simon's chart note from that day, it is noted that he had an oxygen saturation of 85% and a blood pressure of 100/60. A normal oxygen saturation is above 95%. 100% is an optimal normal level.

Dr. Simon then left the prison and instructed the nurses that if the patient's oxygen saturation became less than 80%, he was to be sent out to the emergency room. It is unclear from the medical records how this number -- 80% -- was decided. At 8:30 a.m., as set forth in the nurse's note in the chart, the patient was sitting on the side of his bed with shortness of breath. He was using his intercostals (rib) muscles to breathe, meaning that he was having great difficulty breathing. This is something that is often seen in patients who have very severe emphysema. The patient's oxygen saturation was 88% while on four liters of oxygen. 88% is a low saturation number. Also, the patient's skin color was ashen, signifying severe respiratory distress.

According to the notes in the chart, even though the patient was clearly in respiratory distress, the nurses observe "no respiratory distress noted at this time." The vital signs were obtained. The patient's pulse was 120 and respirations were 26. Normal respirations are usually about 1/2 of this amount.

One-half hour later, at 9:00 a.m., the nurses noted that the patient was anxious and was breathing through his mouth. Oxygen saturation was extremely low at 74% with a very high pulse rate of 144. It was then decided that the patient would be transferred to the hospital. The patient's oxygen saturation dropped even lower to 69% when the patient was being transferred from the concentrated oxygen to portable oxygen. His respirations increased to 38 with a low blood pressure of 98/50.

At 10:20 a.m., the nurse's note in the chart states that the patient tolerated his transfer from the wheelchair to the Department of Corrections van quite well. However, this observation is not supported in their other notes in the chart. The portable oxygen tank was placed in the van. Officer Timothy Howard was concerned about the instability of the patient and actually makes a statement to the nurses, and there is a signed statement on 2/1/2003. In fact, the officer noted that "I saw the patient get out of bed one time to utilize the toilet. He appeared to be weak with labored breathing at that time. Inmate Gray had an oxygen SAT monitor on his index finger and it read 79, down to 72, and stayed between the two every time I looked at him."

The officer continues, "I stated to Nurse Smith, if Inmate Gray is that bad, shouldn't he be transported in an ambulance." Officer Howard, in his signed statement, states that Nurse Smith told him that "He'll be fine!" Office Howard then stated "I stated to Nurse Smith that the two officers transporting Inmate Gray do not have medical training to be able to transport an inmate with the problem that Inmate Gray was having. Nurse Smith stated, 'He'll be fine. I'll put some oxygen in the vehicle with him and **let him roll**. He will be fine.'"

The two officers started transporting the patient. Instead of taking him to the nearby Athens Limestone Hospital, the officers were instructed to take him to Birmingham-- two hours away. Soon after the patient was en route, Officer Kossi and Newman who were transporting the patient, noted that the patient appeared quite ill. They noted that his eyes rolled behind his head. The officers were in a quandary about what to do. The officers decided to stop at a store to ask for the location of the nearest hospital. The patient was in respiratory arrest and in need of cardiopulmonary resuscitation. The officers stopped at the nearest hospital, which was the Woodland Medical Center.

The patient was removed by the Woodland Medical Center nurses approximately 30 minutes after going into cardiopulmonary arrest. The nurses attempted CPR. No CPR was attempted prior to the patient's arrival at the hospital. Even though the staff at the Woodland Medical Center made a valiant effort, the patient died soon thereafter.

A review of the chart reveals a signed statement by Mary Jones, LPN. The nurse states that she was asked by Ms. Elizabeth Smith to look at Inmate Terrel Gray. She reports that when she entered his cell, she observed a solemn facial expression with an ashen gray skin color. Nurse Jones further states that the patient's oxygen saturation was between 74% and 79% with a high pulse between 133 and 144. The patient's blood pressure was very low at 98/50. The nurse's assessment is "no respiratory distress or cardiac distress was observed, but I do suggest we go ahead and send him to the hospital."

Then the nurse states "The inmate was sent to the hospital via Department of Corrections van for follow-up care. No indications were present for need of ambulance or emergency van."

IMPRESSIONS:
This is another example of a patient at Limestone Correctional Facility who was permitted to suffocate without receiving appropriate therapy. An oxygen saturation in the 80's -- much less in the 70's or 60's -- on four liters of oxygen is very low. At this time, the patient was critically ill.

However, the patient was allowed by the nurses and by Dr. Simon to stay at the Limestone Correctional Facility until his oxygen saturation was lower than 80%.

There are signed statements in this patient's medical records by medically untrained officers. These statements indicate that the officers were uncomfortable transporting the patient in extremis. The officers were medically untrained. However, the officers were still able to recognize that he was critically ill. The nurses at Limestone did not recognize that this patient was critically ill or the nurses did not care and neglectfully chose to send the patient in the van despite the officers' verbal concerns. Instead, the patient was transported in the van by the two officers and went into cardiac arrest and died with no medical personal present.

This is a clear example of the grossest neglect and inappropriate care provided to this patient. The nursing staff should have recognized that the patient should be transferred emergently in an ambulance with trained paramedics to the nearest hospital. He should not have been transported to a hospital as distant as one in Birmingham.

This death could have been avoided. The patient's diagnosis is unclear from the medical records. A diagnosis of metastatic carcinoma was made by CT scan; not from a biopsy. This patient may have had a very treatable infection, such as a fungal infection of the lungs, or even tuberculosis. At any rate, Terrell Gray was permitted to die. This case demonstrates the lack of even a minimal level of medical care and the substandard nursing care at the Limestone Correctional Facility.

DEATH SUMMARY
Chelsea Hammac

Chelsea Hammac was a 34-year-old male who died at the Limestone Correctional Facility on 11/14/2002 at 3:25 a.m.

This patient had advanced AIDS, as well as multiple complications, including CMV, retinitis, wasting syndrome, herpes and candidal mouth infections, and chronic renal failure. Ultimately, he most likely died from *Pneumocystis carinii* pneumonia (PCP).

Of note, the patient did have a rather extensive history of noncompliance. His antiretroviral medications were reviewed multiple times by Dr. Simon, and the patient appeared to not want to go back on therapy, although he had been on antiretrovirals in past. In fact, the patient had done rather well in the past, but had been changed to a different regimen which caused nausea. It is assumed, but not delineated in the medical records, that the patient ceased his medication regimen because of their side effects. In none of the notes was the reason for the patient's refusal to take the antiretroviral therapy discussed with the patient. This was in spite of the patient having very advanced AIDS and severe HIV complications.

In the end, the patient did decide to start antiretroviral therapy.

Of note, it appears that the patient also did not take his PCP or MAC prophylaxis. Again, the reasons were not included in the medical record.

IMPRESSION:
The major issue in the patient's case was that he appeared to be followed appropriately, but was unable to take his medications. In particular, the medication to prevent the illness that ultimately caused his demise (PCP), involved taking one tablet once a day or as little as three times weekly. It is suspected that as the patient became more and more ill, as his energy level decreased, he was unable or unwilling to stand in line for his medications. Medications at the Limestone facility are dispensed to HIV-infected prisoners in a pill line. The prisoners stand in line outside of Dorm 16 -- in the heat of the summer or the cold of the winter -- to receive their medication sometimes up to three times per day. A prisoner can wait up to one hour for their medication, which is difficult or impossible for someone who is ill. There is not an attempt at Limestone to assist patients and help them become more compliant.

DEATH SUMMARY
Eddie Harris

Eddie Harris was a 44-year-old male who was admitted to the Limestone Correctional Facility on 05/23/2000 and died one day later, 05/24/2000.

Mr. Harris had a history of AIDS. He had also been diagnosed with pulmonary *Mycobacterium kansasii*, dementia, and AIDS wasting. His last T cell count had been 50. The patient had previously been at the Montgomery County Jail where he had a rather extensive evaluation and inpatient stay at the Baptist Medical Center. At that time he had been started on extensive medications and treatments including INH, rifampin, ethambutol, AZT, 3TC, efavirenz and Megace. All of these medications are appropriate.

Given that the patient was at the Limestone Correctional Facility for only one short day, there are very few medical records available. The few records indicate that on 05/23/2000, the patient had a fever of 102. He reported experiencing chills and shortness of breath. He expired the next day.

There is no further documentation addressing this patient.

IMPRESSION:
Given the short stay of this patient at the Limestone Correctional Facility, there are few medical records. This was a very end-stage patient who appears to have been transferred on the appropriate medications and who expired incredibly rapidly. It is unclear from the records why the patient expired so rapidly at the Limestone Correctional Facility. This is concerning because it is a pattern at Limestone Correctional Facility for HIV infected patients to expire rapidly.

Another concern is that there are no medication administration records in this patient's medical record. Therefore, the patient may have never received his medication regimen as was intended.

DEATH SUMMARY
Kelvin Harris

Kelvin Harris was a 44-year-old male who died on 9/12/2001.

Conspicuously there is no information noted from the patient's chart from the year 2001, and absolutely no information available surrounding the months prior to his death. As a result, this review will focus on several other aspects of his chart and will not be able to focus on his death.

This is an AIDS patient who had a history of *Pneumocystis carinii* pneumonia and peripheral neuropathy who had been on HIV therapies. The patient noted in 3/1998 that he was not being given all three of his HIV medications. During that same month, in a physician note, the patient was labeled as noncompliant. Approximately one month later, on 4/1/1998 a note by Ms. Riggs (who was a nurse) stated "compliance of AZT and 3TC was only 50%."

Guidelines were followed. It is difficult to read Dr. Moore's notes because they are largely ineligible which is typical of his notes, but the notes suggest that "by guidelines compliance is less than 95% and the plan is to discontinue antiretroviral medications." There was no discussion of why the patient was unable to take his medications if he indeed was noncompliant, or if the medications were not being supplied to him appropriately.

A health services request form from Mr. Harris pleads that he be restarted on his antiretroviral medications. This demonstrates that the patient was motivated to restart his medications.

There is also a letter from the patient dated 3/5/1999. The letter is addressed to Mr. H. Dobbs of the Health Care Unit. Mr. Harris writes:

> "Mr Dobbs, I am having problems with the medication that I am presently taking, which is D4T, DDI, and Crixivan. The problem that I am having is my feet and hands are numb all the time and stay in pain. I am also throwing my food up; can't keep it down in my stomach. I am bringing this to your attention because I don't want to take myself off the medications. Maybe there is something that can be done to help these side effects or possibly change the medications. Your attention to this matter will be highly appreciated. Thank you. - Kelvin Harris"

At that time, it appeared that the patient was on a regimen that is very difficult to take consisting of D4T, DDI, and Crixivan. Specifically, Crixivan needs to be taken on an empty stomach. Crixivan causes a lot of side effects including abdominal pain and gastrointestinal ("GI") upset. D4T and DDI classically cause neuropathy. The patient described these side effects which we see in patients on the same regimen.

At the bottom of this note, Dr. Moore callously writes: "Discontinue HIV treatment." There is actually discussion about trying to help the patient take these medications or treat his side effects.

The patient is seen several days later on 3/5/1999. He is complaining of nausea and vomiting with pain in his feet. He was experiencing vomiting for several days. Dr. Moore did not perform a neurologic examination, even though the patient was complaining of neuropathy. The assessment is HIV positive since 1985. “Side effects: Neuropathy, nausea and vomiting.” The treatment plan was to discontinue treatment for “drug holiday” (at patient's request). However, in the note, the patient did not want to be taken off the medications. This note demonstrates that the patient was not informed that the side effects could be treated and there were other medication options for this patient.

Other notes in the chart describe the patient’s problems with these medications and not being treated for side effects. The patient was eventually (six months later) started on a different regimen. Again, the regimen was d4T, abacavir, and nelfinavir. Of note, nelfinavir causes severe, horrible, watery diarrhea. Typically, treating physicians will immediately provide patients medication to stop the diarrhea, including such simple things as Tums or antidiarrheal agents. However, in this case, the patient was not administered any of antidiarrheal medication. In addition, this patient had a history of neuropathy and was inappropriately started on a full-dose of a medication (d4T) that appeared to cause his neuropathy in the past. This set the patient up for failure.

IMPRESSION:
Although the cause of this patient’s death is unclear, and the medical records which would provide information concerning the cause of death are absent, since no medical records at the time of his death or for the year prior to his death were provided for review from the Department of Corrections, this chart provides another important focus addressing the medical treatment at Limestone.

The pattern that occurs over and over again at the Limestone Correctional Facility is one of patients being started on therapies which might be appropriate, but they are set up for failure. Patients at Limestone fail because they are not treated concurrently for known side effects, or are given regimens that are nearly impossible to adhere too given the environment of the Limestone Correctional Facility. In this case, it appears that this patient was started on a very difficult-to-adhere-to regimen. In addition, the regimen caused rather significant and severe side effects. Yet, even though these side effects can often be treated very easily by decreasing the dose of the D4T for instance, or giving him medication for his GI upset from the Crixivan, instead Dr. Moore chose to discontinue the medication and place the patient on a “drug holiday” which is not only contraindicated in patients, but has been proven to lead to rapid deterioration.

DEATH SUMMARY
Michael Headon

Michael Headon was a 29 year old patient with class C3 AIDS who appears to have died on 09/18/2002, although I am unable to confirm because he died outside of the Limestone Correctional Facility.

It appears that the patient was originally diagnosed with *Pneumocystis carinii* pneumonia at the Huntsville Hospital. He was placed on antibiotics appropriately and was returned to the Limestone prison system, and accepted for transfer on 09/13/2002.

The patient was admitted to the Health Care Unit and the initial nursing notes from 09/14/2002, stated that the patient had "dyspnea" (shortness of breath) with an oxygen saturation of 81% while on five liters of oxygen. This is critically low. The assessment was "altered respiratory decreased oxygen saturation". Despite the patient's respiratory distress, the plan was to monitor the patient's condition and administer antibiotics as ordered. Despite the patient's grave condition, Dr. Simon was not contacted, and the patient was only observed and continued to have a low oxygen saturation.

Over the next few days, the patient continued to deteriorate. At one point, there was an oxygen saturation recorded of 70% on 09/17/2002, while the patient was on large amounts of oxygen supplementation. This is impending respiratory failure.

Mr. Headon was finally seen by Dr. Simon on 09/16/2002, and was prescribed an additional antibiotic (Levaquin), given the concern that the patient most likely had a bilateral lobar pneumonia or had acquired pneumonia while he was hospitalized. Unfortunately, this antibiotic was not administered to the patient as ordered by the doctor. Consequently, his condition on 09/16/2002 was worse. He was breathing at 40 per minute while he was oxygen and IV Bactrim. (Normal breathing rate is 12 times per minute.)

Most concerning was that the patient's oxygen saturation continued to deteriorate until and on 09/18/2002 at 12:00 p.m., one of the nurses wrote that "the patient is respiratory distress." The patient had *been* in respiratory distress for the past several days. "**The patient has difficulty breathing and his oxygenation is at 55%." This is an extremely low oxygenation, and not compatible with life.**

IMPRESSION:
This patient essentially suffocated to death. His patient's death demonstrates gross neglect of a patient at Limestone Correctional Facility. This patient clearly deteriorated in front of the nursing and medical staff at Limestone. His oxygenation was so poor that were he to have been in a medical facility where appropriate care was administered, he would have been given emergency ventilatory support (i.e. placed on a "breathing machine").

Earlier on, it was discussed with the patient whether he wanted to have additional support (such as being placed on a “breathing machine”), and Dr. Simon did write on 09/16/2002 that the patient did NOT wish to sign a DNR (Do Not Resuscitate) form, which meant that the patient did wish to have more invasive treatment. The patient’s wishes were not followed! The patient was allowed to become ill beyond treatment, and he was admitted to Huntsville Hospital and expired soon thereafter.

This patient was deathly ill and medications that were ordered were not administered. This is a failing of the nursing and/or pharmacy system at Limestone. Medications written for must be delivered to critically ill patients.

This case represents extremely negligent care of this patient. It is almost unbelievable that he was allowed to basically suffocate to death.

DEATH SUMMARY
Dennis Hearns

Dennis Hearns was a 32-year-old male with C3 AIDS, cryptococcal meningitis, and AIDS wasting. He expired at Limestone Correctional Facility on 06/04/1999 at 9:40 p.m.

A thorough review of the patient's medical records revealed that the patient had been HIV infected for over one decade. The patient had been treated with multiple antiretroviral medications in the past, and prior to his death, he had been on an antiretroviral regimen. The review will focus on the patient's end-of-life care.

The patient was admitted into the inpatient unit at the Limestone Correctional Facility in approximately February 1999. At that time, it was noted that the patient had AIDS wasting syndrome. Wasting syndrome appears to be the cause of the patient's death. In reviewing the patient's inpatient medical records at Limestone, it does not appear that the patient ever received a thorough work-up for AIDS wasting syndrome. In addition, it is not clear from his chart whether he received any appetite stimulants, which would have been an appropriate treatment for his wasting syndrome.

In April, the patient was described as comatose. Yet, the medical staff decided that no further treatment interventions would be administered; that the patient would be “kept comfortable”; and that antiretroviral medications would be discontinued. For the next couple of months, the medical record notes and the nursing notes indicate that the patient continued to decline. At one point, the patient develops blindness. Again, the condition was merely accepted by the medical staff. The patient’s blindness was not evaluated by the medical staff.

A review of the patient's laboratory results indicates that he did not receive any laboratory testing after 3/30/1999 through his demise on 6/4/1999. No additional medical testing is evidenced in his medical records.

The patient also reported hearing voices. On 5/17/1999, it was recorded that the patient did have a history of psychiatric disease and had been on Mellaril (an antipsychotic). At that time, the patient requested that he be put back on Mellaril, but apparently he was not put back on any antipsychotic medications.

The nurses performed daily documentation of the patient's general status and occasionally documented the vital signs. However, there is no indication of the patient’s weight or any nutritional assessments of the patient that appears in the medical records.

IMPRESSIONS:
Mr. Hearns was a young 32-year-old AIDS patient who clearly had advanced AIDS. His advanced AIDS condition was evidenced by a very low T-cell count as well as Cryptococcal meningitis. In addition, he had quite severe wasting syndrome. Problematic in Mr. Hearns' medical care is that he did not receive an appropriate or adequate work-up or treatment for AIDS wasting syndrome. Simple medications can assist in stimulating a patient's appetite or help this patient gain life saving body mass. Due to this lack of treatment, the patient progressed to advanced disease and died from AIDS and wasting syndrome.

An additional concern is that the patient became blind. Again, this condition was not evaluated by the medical staff. There are many diseases, including cytomegalovirus (CMV), which can cause blindness and are indeed treatable in AIDS patients.

As with other HIV infected patients at Limestone, Mr. Hearns did not receive adequate end-of-life care, much less adequate Hospice Care. There is no indication in the medical documents that this patient requested such minimalist measures, or that he did not desire more aggressive types of treatment for his disease. This is most worrisome. It appears that this Limestone medical staff decided that the patient should not receive more aggressive treatment.

DEATH SUMMARY
Cletis Johnson

Cletis Johnson expired at the age of 36 on 05/24/2002 at 2:20 pm at Limestone Correctional Facility.

To understand this patient's clinical course, one must briefly review the records from Kilby Correctional Facility (the receiving center for incarcerated men into the Alabama Department of Corrections), where the patient was initially incarcerated in the Alabama DOC. This patient clearly had ongoing medical issues, including nausea and vomiting and malaise (just generally not feeling well). While at Kilby, the patient received only minimal care.

Prior to the patient's transfer to Limestone, he was evaluated at Kilby by a registered nurse on 04/24/2002. At that time the patient was only on minimal medications. The intersystem transfer form documents that the patient was stable and the nurse failed to check past chronic clinics, specialty referrals, or significant medical history. In fact, in the medical records, after the notation of significant medical history, there is a zero with a line through it, which signifies that the patient had no significant medical history, notwithstanding that the patient indeed had advanced AIDS.

The patient was transferred into the Limestone Correctional Facility with minimal history, as well as inaccurately designated as having no significant medical history. When he arrived on 4/25/2002 at 2 p.m., the patient was not evaluated by the Limestone healthcare staff. Rather, he was inappropriately evaluated by a correctional officer who designated in the medical records that the patient appeared stable, which is hard to believe because only five days later the patient filled out a health service request form, on 04/30/2003, and wrote in this form “feet have swollen real bad and lots of thrush in mouth.” At any rate, correctional officers are not adequately trained to make these types of decisions.

The patient’s medical request form was unfortunately not responded to until six days later, when on 05/06/2002, Jay Cook, LPN, responded “will wait to see MD per patient.”

Mr. Johnson was not seen in the health care unit until 05/09/2002 at which time an attempt was made to draw blood. He was not seen by a physician until 05/17/2002. At that time, Dr. Simon documented that “the patient looks pale and ashy, has oral thrush, his skin is dry.” The patient was immediately transferred to Huntsville Hospital.

On admission to the hospital, even though Dr. Simon indicated that the patient had no complaints, the patient reported to the staff “can’t keep anything down. Weak and dizzy.” Dr. Chassay, at Huntsville Hospital, performed a thorough evaluation and assessed the patient as having nausea, vomiting a likely opportunistic infection, and esophagitis. It is clear from Dr. Chassay’s evaluation that the patient, at the time of his transfer from Limestone, was very ill.

Significantly, Dr. Chassay did elicit from the patient that he also had a 75-pound weight loss, and in fact, he had not been on antiretroviral medications because he was told that they were not available to him.

The patient was admitted to the Huntsville Hospital and was evaluated and was found to have abscesses of the brain, which were most likely cerebral toxoplasmosis, a severe parasitic infection. The patient also had severe esophageal candidiasis (yeast in the throat), metabolic disturbances, as well as seizures from the severe brain infection that was thought to be toxoplasmosis. After several days and hydration and some therapy, the patient continued to be quite ill. Indeed, he required a large amount of oxygen because his oxygenation was so poor.

A call was made to Dr. Simon and the patient, despite being critically ill, was transferred back to the Limestone Correctional Facility. At the Limestone Correctional Facility, the patient was not treated for toxoplasmosis of the brain. He was admitted to the inpatient unit and was only continued on treatment for his thrush as well as given IV fluids. He was also given oxygen. At no time were antiretroviral medications initiated, despite the patient having only two T cells.

The nurses did evaluate the patient at least approximately every two hours until about 2:30 a.m. on 05/24/2002. There is no documentation indicating that the patient was seen by any medical personnel after 2:30 a.m. on 5/24/2002. The nurses note that the patient was rather ill, his skin was dry and cool, and that the patient had "copious amounts of yellowish-white discharge coming from his mouth and nares."

The patient had an opportunistic infection (toxoplasmosis of the brain), as well as severe respiratory distress. He expired on 05/24/2002 at 2:20 p.m. It bears mention that, it was Officer Danny Albertson who found the patient dead and notified the medical staff. There is no indication that any medical staff had treated or assessed the patient during the 12 hour period from 2:30 a.m. through 2:20 p.m.

Mr. Johnson died one day after being discharged from the Huntsville Hospital, and the patient died of a very treatable illness for which he was not being treated.

IMPRESSION:
This patient was an advanced patient with AIDS whose substandard care displays the profound problems that occur when a patient is not evaluated and treated in a timely fashion and not treated appropriate manner. Clearly this patient's situation was advanced in both his AIDS diagnosis, as well as the toxoplasmosis of the brain. However, toxoplasmosis is treatable, and the patient was not treated for this illness. It is my opinion, within a reasonable degree of medical certainty that the patient died unnecessarily and from a treatable illness. Contributing to this patient's death was clearly the slow response of the medical staff to evaluate this very ill patient, as well as the acceptance of a patient from a hospital facility back to a prison that was not able to take proper care of a patient in an extremis condition.

DEATH SUMMARY
Leslie Johnson

Leslie Johnson was 45-years old when he died in the Limestone Healthcare Unit, cell #153, on 12/04/1999 at 3:05 a.m.

The patient was HIV positive with a T-cell count of approximately 100. It was also noted that he had liver disease. The medical records do not indicate whether the cause of the liver disease was ever determined. The patient ultimately died on 12/04/1999 when he was found to have a weak pulse and exhibited Cheyne-Stokes breathing.

The patient had an extensive discussion about end-of-life care issues with Dr. Khouri on 11/11/1999. According to this entry, the patient did not want any unnecessary prolonging of his life. The note in his chart outlines the future disease process that the patient might expect. The patient agreed and signed a "do not resuscitate" ("DNR") order. This order was signed on 11/11/1999.

Soon after this patient signed this DNR order, the patient continued to decline in health. On 11/27/1999, the patient was noted to have a hematocrit of 15 (less than ½ normal), a prothrombin time of greater than 15 (indicating severe 'thinning of the blood'), and an extremely low platelet count of 22,000. The question was raised about whether he needed a blood transfer; although apparently the Athens Hospital does not release blood. It was believed that the patient should receive blood from another hospital in Birmingham.

During the time, it was noted that the patient was not in distress, he was out in the yard, and that a blood transfusion was not to be administered.

A review of the patient's additional laboratory tests on that day revealed that the patient had a bicarbonate of 11, indicating that he was in rather severe acidosis (possibly an underlying infection), as well as a glucose of 49 (normal glucose levels are greater than 100).

IMPRESSIONS:
Mr. Johnson was a 45-year old HIV positive patient with probable underlying chronic hepatitis C. His chart does not clearly document the condition. This is inappropriate. Any patient with underlying hepatitis or liver disease should have a diagnosis, or at least an attempt at making a diagnosis recorded in their chart.

On 11/27/1999, the patient had some laboratory tests drawn indicating that the patient was very severely ill. In fact, regardless of his symptoms, he was gravely ill. A bicarbonate of 11 demonstrates that the patient had a severe underlying acidosis and likely a severe infection. His laboratory tests indicated that he had profound anemia and thrombocytopenia (low platelets) and

a severe coagulopathy (thinning of the blood). Such a condition may very well result in a patient bleeding internally.

The patient was not provided any treatment intervention. In fact, no attempt was made to reverse his severe blood thinning (coagulopathy) or anemia. The patient died soon after these laboratory tests were drawn.

While it was clear the patient had fairly advanced liver disease and agreed not to have life extending measures, such as intubation or cardiopulmonary resuscitation (CPR), the lack of adequate medical care was inappropriate and led to this death.

DEATH SUMMARY
Morris Johnson

Morris Johnson was a 30-year-old male who died on 7/25/1999 at the Limestone Correctional Facility. The incident report incorrectly dated the patient's death as 7/24/1999.

The patient carried a diagnosis of AIDS, chronic obstructive pulmonary disease, chronic bronchitis, asthma and renal insufficiency (kidney dysfunction).

This review will focus on the events that led to this patient's death.

Beginning in 5/1999, the patient was seen in clinic by Dr. Khouri. The patient was complaining of difficulty breathing. In fact, Dr. Khouri quoted the patient as stating, “Couldn’t breathe.” The patient was placed on Corticosteroids (Prednisone), but returned approximately three weeks later, on 6/14/1999, stating that he “can’t handle it in the dorm.” Dr. Khouri noted that the patient was having great difficulty breathing. Dr. Khouri also noted that the patient had a high viral load of 108,000.

At this time, the plan was to continue the patient on his current therapy and start him on the antibiotic erythromycin. During the next several days, the notes in the chart, including on 06/15/1999 and 06/16/1999, clearly show that the patient was not doing well. In fact, on 06/15/1999, Dr. Khouri wrote that the “patient is HIV positive with end-stage AIDS and? PCP” (abbreviation for *Pneumocystis carinii* pneumonia). The patient was on erythromycin which is not effective against *Pneumocystis carinii* pneumonia.

On 6/22/1999, the patient continued to have shortness of breath and was desaturating. This means that the patient was unable to breathe enough oxygen and was suffocating to death. Previous patient records at Limestone Correctional Facility have indicated a similar desaturating condition. The patient was taking clindamycin and erythromycin. These are two antibiotics which do not specifically treat *Pneumocystis carinii* pneumonia.

The patient was still short of breath. On 6/24/1999, he reported that “the oxygen helps a little.” On 6/25/1999, the patient was started on a subtherapeutic dose of Bactrim (even in the setting of renal insufficiency), which was one double strength tablet b.i.d. times 10 days.

The notes in the chart for the next several days report that the patient continued to worsen. The patient had a sulfa allergy and he had another allergic reaction to the Bactrim.

Chest x-rays were obtained on 6/15/1999. These X-rays clearly demonstrated that the results were consistent with *Pneumocystis carinii* pneumonia. Another chest x-ray on 7/1/1999 showed results that were again consistent with *Pneumocystis carinii* pneumonia. A repeat chest x-ray on 7/15/1999 showed the same results. Given his initials on the reports, these chest x-rays were viewed by Dr. Khouri. However, no action was taken by the Limestone medical staff.

On 7/21/1999, a pulmonary culture was obtained which showed the growth of a very resistant and deadly organism called *Pseudomonas aeruginosa*. The patient was not initiated on an antibiotic to fight this organism and on 7/23/1999 the culture results from blood obtained on 7/21/1999 confirmed the same results. Mr. Johnson died 4 days later on July 25, 1999.

IMPRESSIONS:
Morris Johnson likely died from PCP and a secondary deadly bacterial pneumonia which could have been prevented if he had received appropriate therapy. This an example of another patient at Limestone Correctional Facility who presented with a life threatening illness, was not appropriately evaluated, was treated with a subtherapeutic dose of a medication and then died. In addition, this patient became infected with a secondary bacterial pneumonia -- Pseudomonas aeruginosa. Despite his rapid deterioration, he was not started on a life-saving antibiotic.

The treatment mismanagement of this AIDS patient demonstrates Limestone's medical staff's lack of knowledge in even basic HIV management. Dosages of antibiotics are easily found in simple texts, online, or can be obtained by calling the pharmacist.

DEATH SUMMARY
Stanley Lillie

Stanley Lillie was a 47-year-old male who died on Christmas Eve, 12/24/2001 at 7 p.m. at the Huntsville Hospital.

There is no Huntsville Hospital report and no autopsy available.

The patient had a diagnosis of AIDS with a T cell count of less than 20 and a viral load of 98,000 obtained on 11/1/2001. The patient was also diagnosed with hypertension and a lupus anticoagulant which caused him to experience recurrent deep venous thrombosis as well as a history of pulmonary emboli. As a result of this condition, the patient had a filter placed and had been on chronic high-dose Coumadin.

The patient was transferred from the Kilby Correctional Facility to the Limestone Correctional Facility on 10/03/2001. At the time of his transfer from Kilby, the patient was on Bactrim, azithromycin, low-dose Coumadin at 2.5 mg, and Maxzide.

On 10/08/2001, the patient sent a health care request form to the medical staff requesting a bottom bunk. He stated that he had a blood clot in his lower extremity. This was answered by LPN Kirk who responded that the patient would see the physician in "a couple of weeks." The LPN did not understand that this patient, who was on Coumadin, should have been seen by the physician much earlier.

According to the medical records, the patient was not seen until at least 11/13/2001, six weeks after his transfer to the Limestone Correctional Facility where he was admitted into the infirmary with a swollen lower extremity. The concern was that he might have a clot in the lower extremity. In response, he was administered a higher dose of Coumadin in addition to subcutaneous heparin. However, he was not started on intravenous heparin. Because the physician was ruling out deep venous thrombosis in the setting of Coumadin treatment, intravenous heparin would have been the standard of care. Also, at this time he was not evaluated for a lower extremity deep venous thrombosis.

The patient was seen on 11/18/2001 and was found to have "difficult veins." It appears that a blood draw was not done. In fact, the first blood draw that can be found the patient's medical chart is on 11/20/2001. On 11/19/2001 an attempt at a blood draw was also unsuccessful. On 11/21/2001 the PA-C wrote that the patient "needs a blood draw as soon as possible." Multiple attempts were made, but none were successful. The patient was not sent to the local hospital. There was no attempt to obtain blood through a large vessel, which is the standard procedure.

On 11/26/2001, the patient reported bleeding from his rectum. His anticoagulants were then held. The patient finally had a blood draw and the anticoagulation factor called PT-INR was normal.

On 11/27/2001, the heparin was resumed. On 12/28/2001, the patient complained of fever and chills with a temperature of 101.8. For some reason he was diagnosed with a viral syndrome by the physician's assistant. No blood cultures were drawn. The patient was not seen until 12/10/2001 when he was in acute renal failure. At one point, his creatinine increased to 3.9 (which is more than three times normal). He was sent to the Huntsville Hospital where he was placed on intravenous antibiotics and then returned to the Limestone Correctional Facility.

The patient returned to the Limestone Correctional Facility and on 12/11/2001 he continued to have a fever of 104 degrees. The physician notes that "the patient is an apparently healthy male in no respiratory distress." No medications were started. On 12/13/2001 the patient continued to have fever of 103 degrees. Empiric antibiotics were appropriately started.

The patient's blood draw from 12/12/2001 showed that he had a blood stream infection with coagulase negative Staphylococcus. On 12/17/2001 the physician noted that the patient received his vancomycin on 12/15/2001 and then **they ran out**. Because they ran out of vancomycin, the patient was placed on a different antibiotic on 12/16/2001 which in fact was not appropriate for treating coagulase negative Staphylococcus. The vancomycin was resumed on 12/17/2001 because "a supply came in today." The patient was also started on empiric antibiotics for another infection.

The patient continued to experience fevers and he continued to decline. A blood draw from 12/20/2001 showed that he was neutropenic with a neutrophil count of 576, INR quite high at 6.4, a very high glucose of 542. In particular, the low neutrophil count was not addressed. The patient was not put on G-CSF. He continued to decline.

The results of a blood draw on Christmas Eve, 12/24/2001, are present in the medical records. The patient had a PT of 72.8 (extremely high) indicating a severe coagulopathy (thinning of the blood). He was sent out to the Huntsville Hospital and died that night.

IMPRESSION:
This patient rapidly succumbed under the care of the nursing staff at Huntsville Hospital. The patient had a long history of lupus anticoagulant, deep venous thrombosis and clotting which caused him to have clotting factors abnormalities. It is apparent from the management of this patient that he was not receiving appropriate or close enough monitoring of his anticoagulant medications.

The patient developed an infection, probably of his blood, although the type of infection is not known. He did have a severe coagulopathy (thinning of the blood) as evidenced by a very high PT prior to his death. The patient was sent to the Huntsville Hospital and died quite rapidly. It is not clear why the patient's low neutrophil count was not addressed nor why this patient was not given closer monitoring of his anticoagulation medications.

In addition, there was absolutely no discussion of antiretroviral therapy or starting this patient on a regimen to help increase his CD4 count or his viral load. This patient could have benefited from antiretroviral therapy.

The patient should have been evaluated much sooner. He appears to be yet another patient who slipped through the cracks at the Limestone Correctional Facility because the medical staff was overwhelmed.

DEATH SUMMARY
Wilford Lockett

On 3/15/2000 at 2:15 p.m. Wilford Lockett was pronounced dead at the health care unit at the Limestone Correctional Facility after having collapsed on the prison field while umpiring a softball game.

Mr. Lockett was a 68-year-old male with HIV infection, questionable seizure disorder, hypercholesterolemia, and hypertension. The patient received an external autopsy -- as did all HIV infected patients -- which is uninformative. In fact, the autopsy lists the patient's illnesses incorrectly. He is listed as having human diabetes (human diabetes is not a known medical term) and hypocholesterolemia (low cholesterol) as opposed to hypercholesterolemia (high cholesterol).

The patient was originally seen at the Kilby Correctional Facility and complained of left-sided pain. At that time, he was given Motrin and was found as having a high blood pressure at 144/102 (normal is less than 120/80). He was also found to have a high blood sugar of 375 (four times the normal range).

A review of the patient's medical records at Kilby also indicate that he had an extremely high glucose of 698. Nothing was done to address this condition because the patient arrived at the Limestone Correctional Facility on 2/19/2000 and the transfer form from Kilby did not list the patient on any medications and listed his only medical illness as being HIV infection. Specifically diabetes, hypertension, hypercholesterolemia, and seizure disorder were not listed as medical illnesses.

At the Limestone Correctional Facility, a third serum glucose was obtained and measured 232. This is more than twice the normal range. The patient also had a high cholesterol of 214. He was seen almost three weeks later by Dr. Khouri who reported that the patient had “high blood pressure. Rx Norvasc - 3 years.” The next line states “diabetes - no meds.” Dr. Khouri’s assessment was “ ? diabetic, ? hypertension” This demonstrates that Dr. Khouri had not reviewed this patient’s chart, much less obtained an adequate medical history.

Despite the fact that the patient had three high blood glucose results, no medications were initiated. These tests clearly indicated that the patient was a diabetic and hypertensive. The patient was not seen again until he collapsed out in the yard. An unsuccessful attempt was made to resuscitate the patient. However, it appears that he died of cardiac arrest.

IMPRESSIONS:
Wilford Lockett was an elderly patient with multiple medical problems. He was at a very high risk for cardiac disease. The medical staff at Limestone Correctional Facility and Kilby, did not heed this patient's symptoms or his laboratory values and did not treat his underlying diabetes, hypertension or hypercholesterolemia. This patient clearly died of a cardiac arrest which could have been thwarted had he been treated appropriately.

It is unclear why these very obvious laboratory values were not treated, and why the patient's underlying illnesses were not treated. This is an example of a pattern at Limestone and Kilby where laboratory tests are drawn and the patients suffers because they are not treated.

This HIV-infected patient appears to have died from a cause unrelated to HIV, concerns about care at Limestone for patients with other serious diseases such as diabetes, coronary artery disease and hypertension must be brought into question.

DEATH SUMMARY
Joseph McClure

Joseph McClure was a 71-year-old male who died on 05/06/2002. The patient's medical records are incomplete. There are no medical records after 03/30/2002. This is a full five weeks prior to the patient's death.

Mr. McClure had the diagnosis of AIDS with a low T cell count of 28; he was originally diagnosed at the Kilby Correctional Facility. The patient also had diabetes mellitus and hypertension, renal failure, and benign prostatic hypertrophy. Additionally, the patient also suffered from severe anemia.

It is important to review the patient's medical records from Kilby Correctional Facility which showed the patient had a T cell count of 32, a viral load of 75,300 and a creatinine of 3.7 (a normal creatinine level is less than 1.4). The blood test was obtained on 08/03/2001.

While at Kilby, this patient's renal failure was never evaluated. The patient was placed on medication to treat his hypertension and diabetes. However, the patient went into a hypoglycemic coma. Soon thereafter the patient was transferred to the Limestone Correctional Facility on 10/03/2001.

On 10/08/2001, the patient was seen by Dr. Simon. Dr. Simon started the patient on an antiretroviral regimen. Yet, at Kilby, the patient had inappropriately not been placed on MAC prophylaxis. So, MAC prophylaxis was started. He was continued on *Pneumocystis carinii* pneumonia prophylaxis, as well as his other multiple medications.

The patient complained of difficulty urinating as evidenced by a health services request form as early as 10/28/2001 which stated "I'm having problems urinating; at times I can't urinate." The nursing staff's response to this is that the patient "seen MD on 10/18/2001." The nurse did not even address the patient's' problems of urinary retention.

Despite the patient's complaints and evidence of renal failure, he did not get an initial evaluation for his renal failure until February 2002. At that time, the patient was seen in consultation by a urologist who obtained a renal ultrasound which showed that the renal pelvises and ureters of the kidneys were very large. The condition is concerning because it can cause obstruction from his enlarged prostate. The Limestone Correctional Facility obtained a laboratory test on 03/27/2002 indicating a BUN of 91 (which is approximately four times the normal level) and a creatinine of 8.3, which demonstrated that the patient was in almost total renal shutdown. His potassium was also critically high at 6.4. His hematocrit was 13 which was about one-third of normal. His bicarbonate was 10, also demonstrating that the patient had very severely impaired renal function. Attempts were made to lower the patient's potassium.

At the point, there are no further medical records. This absence of medical records is very concerning.

IMPRESSION:
This patient was an elderly and fragile gentleman who clearly had evidence of an obstruction in his urinary tract secondary to an enlarged prostate. As early as August 2001, the patient had very severe kidney function problems. It was not until a full six months later, when the patient was at the Limestone Correctional Facility, that he received an evaluation for this kidney failure. By that time, it was too late. The patient's kidneys shut-down.

There are also missing records from this patient's chart. It is unclear what caused this patient's death. Yet, it is most likely that Mr. McClure died from the renal failure with complications caused by the HIV infection, diabetes mellitus and hypertension.

There is a pattern that occurs over and over again at the Limestone Correctional Facility where patients who are extremely ill, are examined, evaluated and laboratory tests are sometimes obtained with no follow-up, no work-up, and no further evaluation when warranted. Sometimes these results, such as a creatinine of 3.7, as was the case in this patient, which demonstrates that the patient needed an evaluation of his kidney function, are not evaluated, and the patient progresses to a severe worsening of his disease.

Additionally, this patient had a very low T cell count and should have been transferred to Limestone on *Mycobacterium avium complex* prophylaxis which consisted of azithromycin.

DEATH SUMMARY
George McHeard

George McHeard was a 48 year old patient who died on 11/12/2001 at 12:15 a.m. at the Limestone Correctional Facility. This patient was HIV positive and had noninsulin-dependent diabetes mellitus which was poorly controlled. He also had hypertension and hypercholesterolemia, as well as a seizure disorder.

On 11/11/2001, the patient presented to the Health Care Unit complaining of abdominal pain, vomiting, and headache, but no fever or diarrhea or other symptoms suggestive of a viral illness. The patient was also complaining of chest pain, as this was documented in the nursing notes of 11/11/2001 at around 10 p.m. When the patient reported that "my chest and stomach is hurting; I feel weak and trembling and am throwing up," the patient was given some IV fluids and medication. The patient continued to be ill throughout the evening. He continued to have abdominal pain and appeared to be rather sick.

At 10:30 p.m., the patient was moaning and groaning, moving from side to side, with labored respirations. He was breathing at 24 per minute, which is fairly rapid. Obviously the patient was in a significant degree of pain. Again, he continued to have increased pain at 11 p.m. By 11:30 p.m., the patient had no complaints and appeared sleepy. He was assessed at least a couple of times by the nurses. He was then found, at least initially, by the inmates to be pulseless and dead.

IMPRESSIONS:
This is a diabetic who had multiple risk factors for having a heart attack, yet he was not evaluated for this condition. His medical records contain no reference to an EKG. Nurses as Limestone are unaware of different presentations of heart attacks and patients die needlessly.

This patient most likely died of a myocardial infarction (a heart attack), but that cannot be ascertained with any degree of certainty. After the inmates placed the patient's body in a body bag, which is standard procedure at Limestone Correctional Facility, the inmate did undergo an autopsy which really consisted of a visual autopsy. There was no organ inspection or evaluation of the patient's coronary arteries. Of note, only VISUAL autopsies are performed in the Alabama correctional system.

This inmate, who had diabetes, presented with almost classic angina or chest pain for a diabetic; yet the patient was not evaluated for this condition. It is assumed that he had an ongoing heart attack and died as a result. The patient was not properly evaluated.

DEATH SUMMARY
James Pryor

James Pryor was a 36-year-old male who died on 10/13/2001 from cryptococcal meningitis secondary to AIDS. The patient had only recently been diagnosed as HIV positive at the Kilby Intake Correctional Facility. He was diagnosed as HIV positive on 9/26/2001. The patient was transferred to the Limestone Correctional Facility on 10/4/2001.

Upon being received by the Limestone Correctional Facility, the patient complained of fever, chills, dizzy spells and headache. He stated that "I'm not feeling good." He was noted to have a very high pulse and to be ill. He was immediately sent to the Athens Hospital and given a presumptive diagnosis of bacterial pneumonia versus *Pneumocystis carinii* pneumonia.

The patient was transferred back to the Limestone Correctional Facility on 10/7/2001 and seen by Dr. Simon. Dr. Simon appropriately administered tests for toxoplasmosis and cryptococcal meningitis titers. The cryptococcal meningitis titer returned extremely high at 1:4096 which indicated that he had very severe cryptococcal meningitis.

Dr. Simon immediately sent the patient back to the hospital for further management of his severe cryptococcal meningitis and also ventilatory support because he had such severe respiratory symptoms. Unfortunately, the patient died soon thereafter on 10/13/2001, after it had been decided by his family, given his advanced cryptococcal meningitis, that they would not pursue any further life-saving measures.

It was also noted that he had a T cell count of 35 and his viral load was 26,000 at the time of his death.

IMPRESSIONS:
This is an example of another patient in the Alabama correctional system who was very unstable and was inappropriately transported from the Kilby Intake Facility to Limestone. This clearly demonstrates that there is little or no communication between the Kilby Correctional Facility and the Limestone Correctional Facility because it is doubtful that any reasonable medical personnel would have accepted this patient given that he was recently diagnosed HIV positive and had such severe complaints. Instead, the patient should have been immediately sent to a hospital.

DEATH SUMMARY
Willie Robinson

Willie Robinson was a 48-year-old male with AIDS and a T cell count of 20 in 9/2000. He died on 11/5/2002 in the health care unit at the Limestone Correctional Facility, although there is little documentation. The patient has a history of HIV infection, but no confirmed opportunistic infections.

On 8/29/2002, the physician noted in the chart that "the officer reported that patient has been looking disoriented lately." The patient reported that he had experienced fever for two days and was feeling lazy and tired. The physician reported that the patient was on Bactrim, which "he does not take regularly." The note further indicates that the patient is a chronically ill-looking male. There was no mention of discussion with the patient addressing why he was not taking his medications, nor was there a neurologic exam documented. Minimal labs were done. On 9/3/2002, a toxoplasmosis titer was negative and a Cryptococcal antigen was also negative.

By this time, the patient had been in the health care unit for four days. He was then released from the health care unit. He was seen on 9/11/2002, by the physician. At that time, he was complaining of poor appetite. The physician noted in the chart that the patient was a wasted looking male. The physician's diagnosis was wasting. Antiretroviral therapy was started. There was no mention of even a discussion of starting the patient on any type of appetite stimulant or any kind of medications to increase his critical body mass.

On 10/16/2002, the patient was complaining of being fairly sick and of throwing up. He reported that he thought he needed more food to take with his medications. The patient was not offered any more food. However, he was given some oral supplementation. On 10/22/2002, the patient complained of an upset stomach with his medications.

On 10/31/2002, the patient was seen by the physician and reported that he had been becoming confused. There were multiple nurse's notes that the patient had been in fact getting confused. The diagnosis at this time was HIV dementia, although no head CT was done -- only a minimal work-up consisting of toxoplasmosis and Cryptococcal antigen tests.

On 11/01/2002, the patient had an unsteady gait. Before the patient's death, the toxoplasmosis titer came back positive. He was started on medications for toxoplasmosis, and he died the next day of an unknown cause.

IMPRESSIONS:
Mr. Robinson's case represents another instance of a Limestone patient who had advanced AIDS and proceeds to a rapid death from most likely a preventable, opportunistic infection. This patient was clearly lost in the medical system and a follow-up should have addressed prevention for opportunistic infections. While it is clear that any patient can refuse a medication, it is incumbent upon the medical staff to make medications easily available to patients and to explain to the patients in a thorough manner why it is important for them to take these medications.

There were multiple times when this patient missed his medications and it can be assumed that this may have been because he was unable to stand in the long pill line, as evidenced by the reports of the patient looking wasted, disoriented, and confused, and even unable to walk or having an unsteady gait. He was unable to take his medications and was not monitored.

A review of the medical records are of further concern because the patient clearly had a mental process (a neurologic defect) occurring for quite a while. Yet, no imaging studies were conducted of his brain. It is very important for the medical staff to at least have done a scan of the patient's brain to evaluate for a central nervous system process.

As is the case with many patients who have died, this patient also had severe AIDS wasting. It is concerning that these patients are not getting enough calories. This patient reported not getting enough food to eat. Although he was not supplemented with any more food, he was given oral supplementation. It is clear that patients who are very, very ill and have AIDS, have high caloric needs (sometimes twice the normal level) and if their needs are not met, they ultimately die of starvation. It is concerning that these patients at Limestone are in fact dying of starvation given that they are not receiving adequate nutrition, much less do not have access to a nutritionist.

DEATH SUMMARY
Tony Rowland

Tony Rowland was a 30 year-old male who died on 01/22/1999 at 7:00 a.m. at the Limestone Correctional Facility health care unit.

Mr. Rowland had end-stage AIDS, polyarteritis nodosa, end-stage renal failure, AIDS wasting, and cardiac arrhythmias. Again, I will focus mainly on the patient's lack of end-of-life care on this summary. The patient was admitted to the inpatient infirmary on 12/28/1998 after it had been noticed at least a week prior that he had had fevers up to 104 degrees F. At that time, it was noted that the patient had a bacterial pneumonia and he was placed on oral antibiotics. Throughout the inpatient stay, however, the patient's course was one of continued decline. The documentation of his treatment was extremely poor. Very few notes were written by the physician. The notes that were written by him are extremely difficult to read or are not informative.

It is clear from the medical record that the patient was admitted to the inpatient infirmary and he continued to have fevers. However, his fevers were not evaluated appropriately. The patient died in the inpatient unit.

Of note, on review of the patient's medication administration record, he was not on any *Pneumocystis carinii* pneumonia prophylaxis and was not on any prophylaxis for Mycobacterium avium complex. These medications would be indicated given his low T cell count (on 08/1998) of 25 and a high viral load of 295,000. It is clearly the standard of care to place patients on prophylaxis for these infections, especially if they are on an inpatient unit.

On 04/16/1998, there was a very worrisome note by a licensed practical nurse (LPN) who advised the patient of his “poor compliance with antiretroviral therapy.” This LPN “advised the patient that therapy would be discontinued secondary to his poor compliance.” The LPN goes on to list that two of medications he is “34% compliant with” and one of his medications he is “52% compliant with.” Unfortunately, there was no discussion with the patient as to why he was not being compliant. He was not asked if he was having any side effects. He was not educated on the importance of adherence. Given the patient's advanced illness, it was unclear whether the patient was even capable of standing in the pill line to obtain his medications. The patient became upset during this medical visit.

I was unable to find any DNR (Do Not Resuscitate) orders, no advanced directive, and no discussion of how aggressive the patient wished therapy to be undertaken. It appears that this was decided by the medical staff at the facility.

IMPRESSIONS:
This is yet another example of a patient at the Limestone Correctional Facility who had a rapid decline in his HIV status. His condition was extremely advanced and he had complications that

included kidney failure. There was very little documentation provided, but I was unable to find any evaluation of his kidney failure, much less any treatment for this. Unsurprisingly, the patient died rather rapidly of infection.

Also, it is concerning that there was no discussion regarding end-of-life care, advanced directive, or DNR status of this patient.

The staff at the Limestone Correctional Facility seemed very quick to take medications away from patients if there were "noncompliant." It should be the role of the physician, not an LPN, to assess patients and decide if a prescription should be discontinued. The medical staff does not seem to understand the importance of a good therapeutic relationship or the value of discussing compliance issues with patients. The appropriate questions were not asked: was he able to obtain his medications, was he able to stand in line, was he having any side effects, or were other therapies necessary? These questions should have been asked by an physician. LPN's at Limestone are routinely practicing outside the scope of their licenses.

Another issue of concern when treating a patient with such advanced AIDS, is whether the patient was depressed. Depression was never discussed with this patient. This further shows the lack of care that is provided to the patients at the Limestone Correctional Facility.

Inexpensive and easy to offer medications, such as prophylaxis for *Pneumocystis carinii* pneumonia and *Mycobacterium avium complex*, were not offered to this patient. He might have died from one of these easily prevented infections.

This patient, as were many others, was labeled with end-stage AIDS. This term became a death sentence for patients so labeled at Limestone Correctional Facility. It appears that the nursing and medical staff at the facility do not perform any further interventions or evaluations on these patients.

DEATH SUMMARY
Dionicio Salazar

Dionicio Salazar was a 41 year old HIV positive male who died on 9/16/1999 at 3:42 p.m. at the Limestone Correctional Facility health care unit.

This review will focus on the patient's last few days prior to his death. The patient had no prior opportunistic infections, even though he was HIV infected and had a relatively low T cell count earlier in the year of 159. These results were obtained in 1/1999.

In 11/1998, the patient had "refused HIV treatment" per Dr. Moore's note despite treatment being indicated. It is unclear whether the patient understood English well enough to comprehend this refusal of HIV treatment. Just prior to Dr. Moore's note, there is a nursing note that states the following on 7/29/1998: "The inmate has a problem with communication, understanding English language and speaking English language. This nurse tried to advise inmate of increased viral load and decreased CD4 count and treatment with antiretrovirals …." There was absolutely no attempt at obtaining interpretive services.

The patient was not placed on any treatment for his HIV infection. The patient was transferred from the Kilby Correctional Facility on Haldol and trazodone for an unspecified psychiatric illness. These medications were for treating either depression and/or schizophrenia. It is noteworthy that the patient did not have any clear evidence of uncontrolled psychiatric disease and took all of his psychiatric medications while incarcerated at the Limestone Correctional Facility and was quite compliant in that respect.

There are several handwritten notes by other inmates for the patient. He probably relayed information regarding different complaints. It is clear from his record that he was unable to write in English. It is evident that these were not his notes because the handwriting of the signature is different from the handwriting which completed the health services request notes.

The patient's severe decline in health appears to have started several days prior to his death as evidenced on 9/7/1999 when he had a very large increase in his liver enzymes with a SGOT of 1248 (30 times normal) which signified that he had liver failure. He also had a creatinine at that time of 2.7 (normal is less than 1.3) which signified that he had a loss of kidney function. He also had abnormalities in his electrolytes.

The patient's liver abnormalities remained severe and his kidney function declined. The patient was in the inpatient unit at the Limestone Correctional Facility. He was followed and subsequently died of what appeared to be fulminant liver failure and kidney failure with a bacterial pneumonia, possibly *Pneumocystis carinii* pneumonia. It was recognized that the patient might have pneumonia. A chest x-ray had been obtained on 9/10/1999, six days prior to his death. The patient was started on medication for presumptive *Pneumocystis carinii* pneumonia and bacterial pneumonia at that time.

The patient died after a rather rapid downhill course.

IMPRESSION:
This patient most likely died of liver disease in addition to kidney disease which was complicated by HIV infection. There was actually no underlying cause of his liver disease. He never received a thorough evaluation of his liver disease. The patient should have had an evaluation by a liver specialist. However, this evaluation never occurred. This demonstrates a pattern at the Limestone Correctional Facility where patients are not seen by specialists and are instead evaluated by generalists or by others who are not adequately trained to deal with such specialized fields of medicine.

In addition, this patient appears to have acquired possible *Pneumocystis carinii* pneumonia. Although he refused HIV medications, it is unclear whether he refused any prophylaxis or whether he understood the ramifications of refusing prophylaxis. In the end, he did not refuse any of his other medications. This questions whether he understood the ramifications of his decision.

Also, the patient had language barriers. There was no attempt at the Limestone Correctional Facility to provide an interpreter for this patient to try to assist him in obtaining better medical care.

DEATH SUMMARY
Milton Smiley

Milton Smiley was a 43-year-old male who died on 2/12/2003 from complications of cirrhosis. The patient had carried the diagnosis of AIDS with a T cell count of 118, hepatitis C with secondary cirrhosis, low platelet count, AIDS wasting, osteonecrosis of his hips bilaterally, chronic bleeding hemorrhoids, chronic nausea and vomiting.

Mr. Smiley's medical records are extensive in that they demonstrate that he had multiple major medical problems which resulted in his being seen in the infirmary on frequent occasions. The most significant visits were for excessive bleeding. He had bleeding from his nose which needed packing and also bleeding from a hemorrhoid in the rectal area. The rectal hemorrhoid bleeding was exacerbated by the patient's difficult clotting secondary to cirrhosis and his low platelet count. There is no documentation in the chart demonstrating that the patient was ever surgically evaluated to stop the rectal bleeding, although it was a significant medical problem.

Another major issue for this patient involved chronic nausea and vomiting. These symptoms of the patient's illness were not investigated. On 10/25/2002, one of the nurses accused the patient of self-inducing his vomiting.

There are multiple entries in the chart where the patient experienced decreased mental status in which he was "too groggy, too sedated, as well as unable to walk." In all of these entries, there was no further evaluation of this patient. In many of these instances, the patient was unable to take his medications. When the patient was not in the health care unit, he was often unable to stand in the pill line to obtain his medications. When he did not stand in the pill line, the nursing staff did not administer the patient his medication.

On 10/1/2002, the nurse responded to a call that "Smiley fell." It is not documented in the chart that the nurse rendered assistance to the patient. No physician was called even though it is the standard of care that a physician must be contacted and an evaluation conducted when a patient in an inpatient unit falls.

The medical chart does not contain a death certificate or an autopsy. As with all of these patients, the actual cause of death must be ascertained by review of all available medical records since no post mortem autopsies are performed. Only external autopsies are performed on HIV infected individuals. There is no "Do Not Resuscitate" order and no Advanced Directive for this patient. There was also no discussion addressing end-of-life care for this patient. Mr. Smiley was pronounced dead at 5:45 a.m. on 02/12/2003.

IMPRESSIONS:

1. This is a patient with advanced cirrhosis from hepatitis C. The major manifestation of this disease in this patient is rectal bleeding. The patient was never evaluated by a surgeon or a gastroenterologist in an attempt to stop the bleeding. Yet, the bleeding created great problems for the patient.

2. There were also numerous documentations that the patient experienced decreased mental status when he was almost unable to stay awake. He was highly sedated and unable to take his medications. A review of the patient's medical records clearly demonstrates the lack of care that he received by the nursing staff. For example, when the patient was not in the inpatient unit, he would not be administered his medications by the nursing staff.

3. The patient also experienced chronic nausea and vomiting which was not evaluated. This condition was treated, but should have been further evaluated. Chronic nausea and vomiting in an advanced AIDS patient must be taken seriously and such treatable and deadly illnesses as lactic acidosis and pancreatitis must be part of an initial evaluation. They can both be easily evaluated by a blood draw.

4. In addition, as with most patients reviewed, there is no discussion of end-of-life care, although it is reasonable that in a patient who is this ill, a "Do Not Resuscitate" order should be instituted. It is an accepted medical standard that patients have this discussion rather than the medical staff making these decisions for the patient.

DEATH SUMMARY
Lamar Smith

Lamar Smith was a 49-year-old patient at the Limestone Correctional Facility who died on 01/21/2002.

The patient suffered from AIDS co-infected with hepatitis C and was on appropriate antiretroviral therapy which consisted of Viracept, Zerit, and Ziagen. He was fairly stable, although he did suffer from chronic anal herpes infections and rectal prolapse, until he was seen initially on 01/15/2002 by the physician's assistant, Ms. Ebbe. At that time, the patient had some facial swelling as well as was noted to be jaundiced. At that time liver enzymes were obtained which showed that the patient clearly had a severe hepatitis (inflammation of the liver) in that his liver enzymes were very high. His AST was 542, ALT was 508, bilirubin was 7.5. Carbon dioxide was 21.

The patient was seen the next day on 01/16/2002 and admitted to the health care unit. At that time, it was noted that the right side of his face had further swelling, that his right eye was in fact swollen shut, and that he had a distended abdomen. The patient was seen on 01/17/2002 by Dr. Simon, and at that time, the patient was noted to be complaining of "tightness of the throat," as well as "difficulty swallowing." The patient was given Benadryl without any improvement. He continued to have throat tightness and difficulty swallowing.

The patient had some mild abdominal distention and a rash, and some mild desquamation – a process where the outer layer of the skin falls off. It was thought that the patient had acute hepatitis secondary to an allergic reaction to medications. He was followed in the Inpatient Unit, but did not improve. According to the nurses' notes, in fact, the patient not only did not improve, but he continued to deteriorate and was having bouts of increasing confusion and difficulty arousing him. In fact, on 01/20/2002, one day before the patient died, it was noted that the patient at 6 p.m., was not moving and did not respond to command, only reflexes. He apparently did not respond to painful stimuli. The patient was very ill at this time and very severely, profoundly neurologically depressed. Suppression of the neurologic system was determined to be the assessment.

Unfortunately, at that time no one was called, and the patient was assessed 3:30 a.m. on the following day, January 21, 2002 and was found dead.

IMPRESSION:
It is my opinion within a reasonable degree of medical certainty, that this patient should have been followed very closely in a hospitalized setting. Six days prior to his death, on January 15, 2002, this patient's HIV was under fairly good control with a T-cell count of 439. He potentially had a fairly long life span. It appears that this patient had a toxic hepatitis secondary to his medications. He died of fulminant hepatic failure most likely as a result of his medications. More attentive medical surveillance could have resulted in saving his life.

Of note, in this patient (as with other patients), it appears as if inmates were asked to help prepare the patient's body, as well as to place the patient in a body bag. This practice is inappropriate.

DEATH SUMMARY
Timothy Summers

Timothy Summers was a 32-year-old male with a history of AIDS, but no known opportunistic infections. He had a low T cell count (less than 50) and he died at the Limestone Correctional Facility on 3/11/2002.

The patient's medical records, as is the case with many of the other medical records, demonstrate multiple times that the patient was labeled as noncompliant with his medication regimens, and multiple times in which the patient's medications were discontinued. However, nowhere in the chart is there a discussion as to why the patient was unable to take his medications and no efforts were made to help this patient become more compliant.

The patients at Limestone Correctional Facility are made to stand in a long pill line to take their medications. Many of these patients are unable to stand in line or unable to understand the importance of taking their medications.

This patient suffered from a chronic severe skin rash as evidenced by his multiple pleas for assistance to the medical staff. There are many health service request forms from the patient stating that he had a severe rash. At times the rash appeared to be even ulcerating and causing a secondary bacterial infection.

The patient was initially received on 7/15/2001. By 7/25/2001 he was using health service request forms to contact the staff that he was having blisters. On 11/27/2001, he reported that he had bumps that "itches like mad, sores on face that hurt and don't want to heal." The nurse states that the patient remains noncompliant with all medications. Yet, she does not attempt to discuss noncompliance with the patient. The patient is concerned about noncompliance. He is also concerned about another medical disorder that he is experiencing.

On 12/16/2001, the patient stated that he "needs for his records to be sent from the Kirkland Clinic" and he requests an MRI given that he might have an aneurysm, although he does not spell aneurysm correctly. It was clear from his note that he is referring to a brain aneurysm. He spells it "anarivem of brain." On 12/18/2001, in a health services request form, the patient complains of chronic skin rash. He was seen by the physician who diagnosed the patient with HIV dermatitis. The patient was not seen by a dermatologist. No biopsy was done. Although there was no attempt to document a noncompliance discussion with the patient, the physician reported that the patient was noncompliant and the patient "still does not want antiretrovirals."

In the patient's chart, records arrive at some time from the outside hospital and these are available for review. There is a clinic visit that states that the patient has a history of an aneurysm. The source of this information is unclear, but the information is dated 7/16/1999. There is also a brain CT result from 7/19/1999 which describes the following. Impression: 13-mm left and 9 to 10-mm right prominently hyperdense masses just anterior-superior to the internal carotid artery, supraclinoid segment bifurcations. It states "aneurysms are expected."

This patient’s condition is showing aneurysm, Dr. Simon writes “aneurysms” on the CT result and initials it on 11/09/2001. Despite this result, the patient has no further work-up at the Limestone Correctional Facility.

On the day of the patient's death, 3/11/2002 at 2 a.m., a nurse is called to the room by the inmate stating, “he was having a seizure.” The nurse writes that upon entering the patient's room, the patient is having severe tremors. His eyes rolled back into his head. He had no verbal response to his questions. The nurse turned the patient’s head so that he will not aspirate. She took some vital signs. The patient started to respond. Soon thereafter, the nurse left the room. At 2:25 a.m. the nurse was called back to the room. The patient was seizing again. The patient was described as being restless, moaning, rolling back and forth in the bed when his head rolled back and the patient went rigid.

At that point Dr. Simon was notified and gave the patient Valium 10 mg IM at 2:33 a.m. At 3:15 a.m., the nurse left the room. The patient was having difficulty breathing. Respirations were labored. He had Kussmaul breathing noted which was very worrisome. Respirations were between 9 and 12 with periods of apnea lasting up to 30 seconds. Dr. Simon was notified at 3:25 a.m. and IV normal saline was started and the patient was given an antiepileptic drug called Dilantin. During the procedure, the patient became cyanotic, cold and gray. Apparently his color improved slightly. The patient remained unconscious without any verbal response. Prior to 4:45 a.m., the nurse again left the patient alone in the room.

At 4:45 a.m. the nurse returned to the patient's room. The patient’s respirations were uneven and labored; they were 4 to 6 times per minute. Again, this patient was barely breathing. The patient was moved to a private room and oxygen was administered. Upon moving, the patient stopped breathing. Apparently cardiopulmonary resuscitation (CPR) was started at 5:15 a.m., but only after a mere 10 minutes, CPR was stopped. There was absolutely no documentation as to what was done as far as the CPR went; there was no advanced cardiac life support. At 5:30 a.m. on 3/11/2002, the inmate is pronounced dead by Dr. Simon. However, the note was signed by L. Robertson, RN.

IMPRESSIONS:
This note, dated 3/11/2002, displays the almost incredible lack of insight by the medical and nursing staff at the Limestone Correctional Facility into the seriousness of severe illness and how these types of illnesses need to be handled. This patient had a grand mal seizure. He initially showed signs of being quite ill. He had a history of having had aneurysms which were ignored previous to this disastrous medical event. With the exception of one outside medical record, this was not even documented in the patient's chart. The nurse was unaware of this medical history. The nurse tended the patient, then left the room. She did care for him appropriately. This was a patient who was severely ill and who should have received one-on-one patient care in a highly skilled medical facility (hospital). The care provided to this patient was unprofessional, showed poor judgment and was highly negligent. This patient should have been sent immediately via emergency medical services to a hospital where he would have received an emergent CAT scan of the head, supportive respiratory care, and aggressive therapy for his grand malignancy

seizures. The medical records demonstrate how this patient was poorly managed and how quickly he deteriorated and died.
There was no adequate postmortem on this patient. The reason for death is unclear, but it is concerning that he might have had an aneurysm that ruptured, especially given his history. The patient pleaded for an evaluation of his aneurysms but this was not addressed by the medical staff at Limestone Correctional Facility.

Additionally, the patient had a low T cell count. He could have had an infectious process of the brain, especially in light of the fact that the patient had difficulty taking his medications. It is an established pattern at the Limestone Correctional Facility that, despite indications of an ongoing disease process, rather than evaluate the patient for a definitive diagnosis, the minimum of care is provided until a medical crisis presents itself. And in the case of Timothy Summers, the crisis could not be overcome and the patient died as a result.

DEATH SUMMARY
Rickey Thompson

Rickey Thompson was a 30-year-old male with AIDS who died on 9/2/2002 at the Limestone Correctional Facility.

Mr. Thompson apparently died suddenly after being administered magnesium citrate for constipation and then vomited a bright red material. Unfortunately, the documentation from a week prior to his death was not available from the chart. The only exception is a note on 9/2/2002 by Dr. Simon which lists the patient's problems. Dr. Simon also reports that the patient had signed release of responsibility forms and a DNR. (Do Not Resuscitate)

The patient also had cirrhosis, but review of the records showed that he was hepatitis B and hepatitis C negative. I was unable to find any further evaluation for his cirrhosis, including no hepatitis C viral load. Many patients who are co-infected with HIV and hepatitis C can be hepatitis C antibody negative, yet have hepatitis C virus detectable in their blood. The patient also had depression of his bone marrow cells as well as a history of clinical depression.

On review of the patient's chart, there were multiple occasions when the patient apparently did not go through the pill line to receive his antiretroviral therapy or his medications for prophylaxis against opportunistic infections. He was counseled to go through the pill line, but there was no attempt to understand why the patient was not going through the pill lines or why he was not able to take the medications.

On 08/09/2002, the patient was seen by the physician and diagnosed with probable pneumonia. He was written for a prescription of Levaquin. Interestingly, this medication was withheld by a nurse claiming that the patient might have had a possible allergy. Unfortunately, the nurse did not call the physician, but instead decided to withhold the medication permanently. The nurse's withholding of a prescribed medication is only with precedent for one dose; she should have called the physician to verify her suspicions.

IMPRESSIONS:
There are clear patterns of lack of care and inadequate care at this facility.

This is another patient from the Limestone Correctional Facility who had AIDS and chronic hepatitis and cirrhosis with no known cause. In a standard system of medical care, any patient with cirrhosis should have an appropriate diagnosis. Any patient who is infected with hepatitis C can show no antibodies, yet have the virus present in the blood. However, these tests were not obtained in this patient. The patient did have very advanced cirrhosis and did die from his disease at the Limestone Correctional Facility.

The patient had a history of depression. A review of the records shows his frustration with the system. It is uncertain whether he had a good understanding of why it was important for him to take his medications. There are many notes in the chart that document that he did not show up in the pill lines to take his medications. However, there was no documentation of discussions with the patient why it was important for him to take his medications. There was no recent psychiatric or psychological assessment in his record.

DEATH SUMMARY
Henry Turner

Henry Turner was 35-years-old and died of AIDS on 8/3/2002 at the Limestone Correctional Facility at 4:06 p.m.

Mr. Turner carried the diagnosis of AIDS with a low T cell count of less than 20 and a viral load of greater than 500,000. He was also diagnosed with AIDS wasting, Mycobacterium avium complex, and bed sores. The patient was on a complicated antiretroviral regimen consisting of Bactrim, Mycobutin, ethambutol, clarithromycin, HAART. The patient was also receiving oral supplementation for AIDS wasting.

The patient was initially housed at Kilby Correctional Facility. On 5/15/2002, he was seen by a nurse on intake. On 6/27/2002, the patient was found by one of the officers and noted to have "five old trays" in his room, "three bags of old garbage, and in filthy clothes. The officer sends for a runner." On 6/28/2002, the patient was transferred to Limestone Correctional Facility health care unit. While on the inpatient unit, the patient had 100% compliance with his medications. 100% compliance would be expected because the nurses brought his medications to him. He continued to take all of his medication every day until 8/1/2002. Two days before his death, the physician made the decision not to treat the patient with any more medications because she felt that it would not make any difference.

There was no team consultation or consultation with other physicians or medical ethicist before the patient's treatment was stopped. The patient deteriorated rapidly after his medications were discontinued. He continued to have fevers and severe wasting.

IMPRESSIONS:
This patient was an end-stage AIDS patient who deteriorated rapidly at the Limestone Correctional Facility. He appeared to have a severe infection which did not appear to be responding to treatment. Unfortunately, no other possible infections were investigated in this patient, so it is uncertain whether he died of the Mycobacterium avium complex or of some other infection. Regardless, the patient passed away from a febrile illness.

It is noteworthy that the patient was 100% compliant to all his medications. Patients who are in the inpatient health care unit take more of their medications because it is much easier for them to be compliant. Non-compliance is often a function of the design of the pill line in Dorm 16.

I was unable to find any discussions regarding end-of-life care, DNR orders, or advanced directives in this patient's record.

As in many of the other patients' charts, poor care at Kilby is a common problem. This advanced- AIDS patient had been found after three weeks of living in a dirty room without having bathed. The condition of the room described is unacceptable.

DEATH SUMMARY
Freddie White

Freddie White was a 51-year-old male with AIDS who died on approximately 6/9/1999. His entire medical records have been reviewed which do not contain an autopsy or the documentation from the last day of his life. Therefore, it is unclear to tell exactly which day he died.

The patient had a rather extensive inpatient hospitalization when he was diagnosed with Cryptococcal meningitis and was appropriately started on an antifungal agent. He was also diagnosed with pancreatitis and *C. difficile* colitis. The patient was put on medications and had multiple complications from these medications which required rather intensive therapy while he was an inpatient. The discharge summary indicates that he was admitted for at least a one-month period and possibly longer. The patient was transferred back to the Limestone Correctional Facility on 6/3/1999.

When the patient was discharged from the hospital, his electrolytes were stable. At Limestone Correctional Facility, the patient's electrolytes soon became dangerously unstable. He was given Potassium supplementation. On 6/6/1999, he had a high potassium level of 5.1 which increased to 6.9 on 6/9/1999. He was then given medication -- Kayexelate -- to decrease his potassium level. It appears that he also went into acute renal failure and his creatinine on 6/6/1999 increased to about 2.4, which means he lost about half of his kidney function.

The labs from 6/6/1999 indicate that he went into rapid liver failure. The patient continued to be managed at Limestone Correctional Facility by Dr. Khouri, who documented the patient's condition very poorly and illegibly. On 6/8/1999, the patient had critical lab values of bicarbonate of 7 (meaning profound metabolic acidosis), potassium of 7.3 (nearly twice the normal level), and a creatinine of 3.3 (a loss of more than ½ of the kidney function). He had multiple EKG's with abnormalities.

The patient rapidly expired on 6/9/1999 of an unknown cause. There was no indication that the patient signed any Do Not Attempt Resuscitation orders or had any Advanced Directive.

IMPRESSION:
This is a poorly documented series of medical records. This patient had a treatable illness. He had a prolonged hospital stay and was stable on his discharge from the hospital and died within six days of his discharge to the Limestone Correctional Facility.

It is evident that given his electrolyte fluctuations, that he was not being managed appropriately. It is likely he died as a result of his very rapid liver and kidney failure. The records are unclear as to why this patient was not readmitted to the Intensive Care Unit given his severity of illness soon after his discharge.

Mr. White is another AIDS patient at the Limestone Correctional Facility who was poorly managed, neglected, rapidly declined and died after a prolonged hospital stay where he had been stabilized.

DEATH SUMMARY
Dewayne Wilder

Dewayne Wilder was a 37-year-old HIV positive patient who died of presumptive *Pneumocystis carinii* pneumonia at the Limestone Correctional Facility on 4/17/1999.

This review will focus on the medical records immediately prior to the death of the patient. These records are the most revealing addressing inadequate medical treatment.

On several occasions, the patient presented to the clinic at the Limestone Correctional Facility complaining of shortness of breath. An emergency treatment record dated 3/13/1999 noted that the patient was experiencing problems breathing. He was provided Tylenol and observed for a short period. He was then sent back to his dorm.

Another emergency treatment record dated 3/15/1999, documented that the patient was experiencing problems breathing. It was also noted that he had been ill for seven days with fever and weakness. On these two occasions, his condition was listed as "satisfactory on discharge." This appears to be a pattern throughout his stay at Limestone.

A chest x-ray obtained on 3/17/1999 showed that the patient had worsening *Pneumocystis carinii* pneumonia. The patient was seen by a physician on 3/16/1999 and diagnosed with bronchitis. He was also diagnosed with wasting syndrome with profound weight loss. However, this diagnosis was not evaluated further, even though there are many potential causes for wasting in HIV infected patients.

Because the patient continued to experience severe respiratory difficulty, he was seen again on 3/29/1999 by a physician and started on treatment for *Pneumocystis carinii* pneumonia. The physician started the patient on oral therapy for mild *Pneumocystis carinii* pneumonia, even though he clearly had severe *Pneumocystis carinii* pneumonia. On 4/5/1999, the patient declined and his oxygen saturation was noted by the physician to be 70%. This was his oxygen saturation on 5-1/2 liters of oxygen, indicating severe respiratory distress. In fact, the physician's assessment reported "respiratory failure secondary to *Pneumocystis carinii* pneumonia." Yet, no further treatment was initiated. The patient was kept on his current therapy and no further evaluation was conducted.

On 4/12/1999, the patient experienced some improvement. However, the patient continued to have fevers. On 4/14/1999, the physician reported that the patient was "slowly resolving, but still in respiratory distress." Meanwhile, nursing notes in the chart documented that on 4/10/1999, the patient stated "I am afraid to go to sleep. Please stay and talk to me and watch me." The nurses noted that his oxygen saturation was low at 81% on five liters and the patient was in respiratory distress with rapid respirations.

On 4/12/1999, the patient's oxygen saturation recorded by the nurse was 76% on 4-1/2 liters. On 4/13/1999, the patient was observed to be “weak, groggy, very dyspneic” (short of breath). He was complaining of “great difficulty breathing.” **Despite no clear reasoning, the nurses encourage this suffocating patient to attempt to ambulate.** On 4/14/1999, the nurses reported that the patient was restless and panicky. “His anxiety is high.” Again, the nurses noted that the **“patient refuses to try to ambulate.”** On 4/14/1999, the patient had a visit from his family. At that time, he was started on prednisone which was indicated for treating worsening *Pneumocystis carinii* pneumonia. Yet, it was too late.

On 4/15/1999, the patient was placed on “high oxygen” at 10 liters per minute. As expected, given that the patient had severe *Pneumocystis carinii* pneumonia or some other diagnosis, that he was on sub-optimal therapy and that he was started on prednisone too late in the course of his disease, he expired two days later on 4/17/1999 from respiratory failure.

IMPRESSIONS:
There is a pattern addressing the care at the Limestone Correctional Facility that even the minimal standards of acceptable care are not being followed. Numerous patients are permitted to drown in their own respiratory secretions and suffocate while under the care of the medical and nursing staff. It is improper that this patient had such severe respiratory difficulties and that his condition was permitted to worsen without being treated or worked-up appropriately for some other possible illness.

The treatment this patient received was sub-optimal and inappropriate.

In addition, the patient had a high viral load. The patient was not appropriately treated with antiretroviral therapy. A review of his medical records demonstrates that he expressed some complaints addressing side effects. These side effects were most likely secondary caused by the medications not being administered with food. His side effects were secondary to taking the medications on an empty stomach.

DEATH SUMMARY
Iverson Williams

Iverson Williams was a 36-year-old HIV positive patient who died at the Huntsville Hospital on 11/15/2000 at 11:07 p.m.

The patient apparently died of *Pneumocystis carinii* pneumonia with possible secondary bacterial pneumonia, although medical records from the Huntsville Hospital are unavailable. The patient went into respiratory distress approximately five days prior to his death and was transferred to the hospital. He had a very low T cell count on 11/08/2000 of 15. The patient's chart is riddled with notes of his refusing blood draws and refusing medications throughout almost his entire incarceration.

Most significant in this patient's medical record is the volume -- pages upon pages -- addressing the patient's severe psychological problems. The patient spent a large amount of time in administrative segregation for behavioral problems. There is many years of documentation that the patient was threatening to harm himself. At one point, he even set some fires or threatened to set some fires. Thus, as documented in the medical record describing his behavior, the patient had severe behavioral problems.

There were also notes documenting that the patient had a depressed affect and was on suicide watch multiple times. His depression was also evidenced by his multiple complaints and possible somatization from his multiple health service request forms for complaints such as headaches, dizziness, nausea and vomiting throughout the course of his incarceration.

The patient's chart is filled with disciplinary segregation -- medical type diaries -- which exist soon up to his dying days when he was transferred to the hospital on 11/10/2000. I was unable to find any detailed psychiatric or psychological evaluations in the medical records, although there were some present. On 6/13/2000, there is a cursory psychological evaluation which states that the patient has a personality disorder. There is a note in his chart on 8/19/2000, apparently from a psychiatrist, which states that the patient was seen in the inpatient unit. In the note, it was discussed that the patient was coherent, calm and refusing to take his medications. His diagnosis was personality disorder and continued psychiatric evaluation.

IMPRESSION:
Mr. Iverson’s biggest problem was that he was unable to comply with his HIV medications due to his psychological and psychiatric problems. Psychological and psychiatric issues are not my area of specialty. However, one can review these medical records and not find any in depth psychiatric or psychological assessment. This is appalling. The patient spent most of his entire period of incarceration in administrative segregation, and experienced severe psychological and psychiatric problems. It would seem appropriate that a patient with this many problems would have had a thorough evaluation. Yet, such an evaluation was not indicated in the medical records.

In addition, this patient may not have been competent to make the decisions refusing his own medical care, which he was permitted to do. His chart contains his own handwritten notes documenting his own paranoia and delusions.

DEATH SUMMARY
John Willis

John Willis died at the age of 35 on 03/28/2002 at the Huntsville Hospital Critical Care Unit.

The patient was a previously fairly healthy HIV positive gentleman who, at least prior to his death had a fairly high T cell count of 373 (24%) and a moderately low viral load at 9,900. As a result, he was appropriately not on any antiretrovirals.

The patient died of kidney failure.

In December 2000, the patient had a normal creatinine of 1.3. This was reassessed on 07/27/2001 when his creatinine had increased to 2.3. This represented a loss of approximately ½ of his kidney function at that time. Apparently the patient was seen one month later. During that month, there was no workup (not even a simple analysis of urine much less a biopsy) concerning why this otherwise relatively healthy patient should have such an acute change in his kidney function with a potential life-threatening shut-down of his kidneys.

Unfortunately, the patient was not seen again for more than four months until 12/06/2001. At that time, it is noteworthy, his kidney failure was not even mentioned as a problem by Dr. Simon. The patient returned to clinic almost three months later, on 02/28/2002. At that time, the patient was found to be in total kidney failure. He had a BUN of 68, a creatinine of 7.9, and a high potassium of 5.5.

The patient, at this point, did have an evaluation and was seen by a kidney specialist, who recommended that the patient go on hemodialysis (artificial “kidney machine”).

The patient continued to be followed. On 03/20/2002, the patient was scheduled to have a urine collection, which was not properly collected. By 03/25/2002, the patient's renal function had deteriorated further as evidenced by a rising BUN and creatinine. It was assumed at that time that the patient was oliguria (i.e., had low renal output), or was totally anuric (i.e., no renal output), although the patient was not followed. On 03/25/2002, he was showing evidence of fluid overload as evidenced by his swollen face. On 03/25/2002, the patient was scheduled to have a chemistry panel and electrolytes. Patients in renal failure have disturbed electrolytes and can die of cardiac arrhythmias.

The blood test was not picked up that day; it was not picked up, according to Dr. Simon’s notation, until the following day, 03/26/2002. Two days later, on 03/27/2002, the BUN was exceedingly high at 165 with a creatinine also incredibly high at 25. These laboratory values are as high as I have previously ever seen. The patient's potassium was 6.5, approximately twice the norm. On 3/27/02, Dr. Simon prescribed magnesium citrate, which would induce diarrhea. Magnesium citrate was not a reasonable treatment for elevated potassium; there are more aggressive and better measures. The patient was sent for emergency dialysis to the Huntsville Hospital. Unfortunately, the patient died the next day on 3/18/2002.

IMPRESSIONS:
This patient’s case highlights the problems that occur repeatedly at the Limestone Correctional Facility. A patient with a potentially very serious illness is not thoroughly evaluated, or the patient is not followed regularly or closely because of a lack of access to care or a lack of chronic care clinics. As a result, the patient will present in extremis and has past the stage for any medical treatment.

This patient had very high T cells, and no complicating illnesses. His kidney dysfunction initially could have been evaluated and treated appropriately. In fact, his renal failure could have been supported by hemodialysis. There was no reason that this patient could not have lived for several years at least after this diagnosis.

Unfortunately, his kidney disease was allowed to progress to such a severe degree and so rapidly that the patient again was admitted to the hospital. In all probability, this patient died either of cardiac arrhythmia, or from an infection. His listed cause of death is sepsis. The major cause of the patient's death is simply that his kidneys shut down and the patient was not supported appropriately. The patient’s high potassium was not managed appropriately.

DEATH SUMMARY
Earnest Wynn

Earnest Wynn was a 39-year-old male with AIDS who died at the Limestone Correctional Facility on 02/16/2002.

The patient had advanced AIDS with a T cell count of 20. He had a history of *Pneumocystis carinii* pneumonia, a history of treated tuberculosis, and a history of AIDS wasting. Wasting was ultimately the cause of his death.

The patient's most recent incarceration began in 06/2001. He had a fairly rapid decline thereafter. The patient was seen regularly in the health care unit complaining of diarrhea and vomiting. He reported an inability to take his antiretroviral medications because of nausea. Patients at Limestone Correctional Facility do not receive their antiretroviral therapy with food. This causes many Limestone patients to have severe nausea. Antiretroviral medication would have been vital to this patient because his T cell count was only 20.

The patient continued to have chronic gastritis. Because he was experiencing such severe weight loss, he was seen by Dr. Simon. She prescribed extra meals and extra bread for the patient. It appears in the medical record that the patient did not receive this extra food. He continued to complain of being hungry.

The patient was seen on 12/26/2001 by the physician assistant. She reported that the patient was not able to take his medications secondary to nausea. He was then seen by Dr. Simon on 12/29/2001. This is a very disturbing note. The quote is "**begging for sandwiches** because he can't eat solid food. Burst into tears during evaluation. Emaciated looking." At that visit, the physician did little intervention. At that time the patient was given some intravenous fluids. He was also given medication to decrease his diarrhea, but no medications are given to increase his appetite or to decrease the HIV wasting syndrome. The patient continued to decline.

He was seen three days before his death on 02/13/2002, again by the physician. Again, he was diagnosed with AIDS wasting and chronic diarrhea. No proper evaluation and intervention was done at that time. The patient expired on 02/16/2002 of HIV wasting.

A review of the patient's medical administration records indicate that eventually he was given anti-diarrheal agents. However, there is no notation in any of the medical records indicating that the patient was administered any extra food or any medication for the AIDS wasting.

IMPRESSIONS:
This was a patient with advanced AIDS. Like many of the patients at the Limestone Correctional Facility, he had extreme difficulty taking his medications because the medications are administered without coordination with meals. He also had AIDS wasting exacerbated by the lack of proper nutrition at the Limestone Correctional Facility. The patient was prescribed extra food, but it did not appear to be administered. He continued to complain of needing food. At one point, the patient was put in the inhumane position of begging the doctor for food. This patient

was literally starving to death. In fact, the patient was feeling so poor that he burst into tears. He appeared emaciated, yet the medical staff did nothing to try to increase the patient's critical mass or alleviate his suffering. After reviewing dozens of volumes of medical records, I have seen a pattern of the medical staff at Limestone doing little to help their patients' misery and suffering.

For many years, it has been the standard of care to give patients life-saving medications to increase their critical mass when they have severe wasting. However, none of these medications have been prescribed at the Limestone Correctional Facility. There have been a large number of patients who have died of AIDS wasting over the past several years. In my review of all of their medical records, I have not witnessed one patient treated with the proper medications to treat AIDS wasting syndrome.

DEATH SUMMARY
Marvin Youngblood

Marvin Youngblood was a 39-year-old male with an HIV infection who died on 9/5/2000 at the Limestone Correctional Facility.

The patient died of multiple myeloma, a cancer of the bone marrow cells. The patient develops secondary problems from this condition. These problems include kidney failure, wasting and decreased mental status.

On 12/22/1999, the patient presented for a laboratory draw. It was discovered that he had a protein of 9.9 and an albumin of 3.0. This laboratory report was signed by the attending physician, Dr. Khouri. However, no further work-up was administered. These laboratory values were very abnormal, and the elevated protein should have had further evaluation, especially for multiple myeloma which the patient ultimately was diagnosed with and died from 9 months later.

The patient was lost in the medical system and a follow-up was not conducted, or he received no further evaluation for this problem. In fact, the next blood draw was not until approximately five months later on 2/3/2000. The patient's blood draw showed critical laboratory values with a calcium of 14.5, among other abnormal laboratory values. 14.5 is an extremely high calcium level that should have been addressed immediately. But the laboratory values were not co-signed until four days later by the attending physician, Dr. Khouri. There were no immediate responses by the medical staff to this critical laboratory value or several others until the patient was admitted to Huntsville Hospital four days later, on 2/7/2003.

During his stay at the Huntsville Hospital, the patient was diagnosed with very advanced multiple myeloma. Multiple myeloma is a cancer involving bone marrow tissues. He also had severe secondary complications, which included renal failure. The Huntsville Hospital staff appropriately documented that "after discussing the situation with the family and the patient on at least three different occasions, the family decided to defer aggressive treatment." Thus, the patient was placed on Do Not Resuscitate status and Do Not Attempt Aggressive Therapy.

The patient was transferred back to the Limestone Correctional Facility where he remained in the inpatient facility until his demise several months later. On 2/10/2000, during re-intake to the Limestone Correctional Facility, Dr. Khouri recommended "hospice care" and then followed this recommendation with "by fellow inmate and friend." This recommendation demonstrates that Dr. Khouri did not understand hospice care and that it is inappropriate for fellow inmates and friends to provide this kind of care.

The patient was placed in the inpatient unit at Limestone. He was placed on minimal comfort care. Given the lack of adequate nursing at Limestone, the patient developed a severe bed sore on his back side. Chelsea Hammac died on 9/5/2000.

IMPRESSIONS:
This patient presented with clearly abnormal laboratory values. He had a protein of 9.9 which was above the normal level and an albumin of 3.0. These levels indicate that there was an obvious medical problem, including multiple myeloma. The Limestone Correctional Facility physician did not work-up these abnormal laboratory values. Instead, he waited until the patient presented several months later, looking very ill and having advanced cancer. Once the patient presented in extremis, his laboratory values indicated that he needed to be treated urgently. However, the physician and medical staff did not initiate treatment. A calcium of 14.5 is very high and will cause a patient to have decreased mental status with cardiac arrhythmias.

The patient was then sent to Huntsville Hospital. Given his advanced disease, the Huntsville Hospital staff discussed the prognosis with the family and the patient who decided on no further aggressive therapy. Yet, the patient was sent back to the Limestone Correctional Facility where he was provided minimal care by the nursing staff. The care was so minimal, he developed a severe bed sore.

Another concern is that Dr. Khouri writes in his note in the medical chart that the patient should receive hospice care by fellow inmates and friends. Hospice care is a multidisciplinary approach to caring for patients who have terminal illnesses. Clearly the Limestone Correctional Facility does not have a medically acceptable hospice care program.

This case is another example of a patient whose health care was below any acceptable standard of care. In fact, this patient was grossly neglected by the medical and nursing staff at the Limestone Correctional Facility.

SUMMARY

Stephen Tabet, MD, MPH

SUMMARY OF THE CARE AT LIMESTONE CORRECTIONAL FACILITY

The most egregious medical failure at Limestone is the number of preventable deaths. I reviewed the medical records of 38 HIV-infected patients who died at Limestone since 1999. In almost all instances the death was preceded by a failure to provide proper medical care or treatment. Consistently, patients died of preventable illnesses. Patients with serious diseases experienced serious delays in medical care or were not treated at all. Chronic care clinics are unheard of at Limestone. Life-threatening laboratory results were treated routinely instead of urgently. Other tests such as radiographs showing pneumonia were commonly not assessed until many days later. At least one patient had such severe pneumonia that he suffocated in front of the medical staff – despite the patient's requests for treatment, he was not sent to a hospital until his condition was irreversible. CPR was rarely attempted in any critically ill patient that I reviewed.

The deaths of HIV infected inmates at Limestone are not reviewed internally. The coroner provides only a physical description of the patients' bodies. The medical staff's documentation of the events leading up to the deaths of inmates is deplorable. There are no internal or external mortality reviews or quality improvement reviews of deaths. Without the medical staff assessing why so many patients are dying, they cannot identify and solve the problems within their system.

The current medical system does not appreciate the cost-effectiveness of ensuring patients receive preventative care. For instance, assuring that a patient receives life-saving Bactrim (one pill only three times per week) costs merely pennies per day yet prevents a deadly, expensive-to-treat infection called *Pneumocystis carinii pneumonia* (PCP) – a disease that many patients at Limestone seemed to have needlessly died from. Patients, who clearly do not understand the consequences of not taking these life-saving antibiotics, are allowed to stop taking them without being counseled by the medical staff. Patients in such closely observed settings should at least receive preventive therapy. Such a simple measure as allowing the patient to take the medication back to his unit (often called "keep on person") is not even an option for patients at Limestone. It is unclear why.

Patients at Limestone are treated like they are nuisances. They are forced to interrupt their much-needed sleep at 3:00 a.m. each early morning to stand in a pill line outside, often in cold, wet weather or sweltering heat, for up to forty-five minutes to receive their life-saving medications. Many of these AIDS patients are too sick or unable to stand long enough to wait in line. Thus, they can not obtain their medications, and sometimes the medications are not available. This leads to lapses in medical care, increases the potential for resistant forms of HIV, and results in further mistrust by the patients in the medical system.

HIV-infected patients at Limestone Correctional Facility are totally segregated from other inmates. This presents a serious problem in terms of medical emergencies. Limestone administration apparently require that the prison facility be "shut down" when moving HIV-infected patients. "Shutting down" an entire prison takes a considerable amount of time; if an HIV-infected patient has a medical emergency and needs to be transferred off the facility, the critical time period is quickly lost and many patients have needlessly died.

Medically necessary dietary requirements for diabetics or undernourished patients are virtually non-existent. Staff indicates that they are strongly discouraged from writing (by the Department of Corrections) for special diets for patients, even when indicated. It must be acknowledged that certain patients have specific dietary needs that must be adhered to. Specific dietary requirements for diabetic patients, patients in renal failure, or under-weight patients is a medical issue that requires attention. A large proportion of patient who died at Limestone were severely malnourished and not receiving adequate nutrition or vitamin/mineral supplementation.

The physically handicapped and disabled suffer disproportionately. They are denied access to baths. The only way of cleaning their bodies in Dorm 16 or Dorm 7 is by showering - an often impossible task for patients who are unable to get out of their wheelchairs and step over a high ledge to access the shower. There are numerous areas I toured in the facility where accessibility for the handicapped is disregarded and neglected. For example, there are not adequate railings or ramps for wheelchair access**.** The medical understaffing also leads to the inappropriate use if inmates caring for disabled patients.

The open warehouse where approximately 250[1] HIV-infected patients live is overcrowded. Side-by-side and head-to-toe bunk arrangements place these immune compromised patients and the staff at an undue risk of acquiring contagious diseases. This is evidenced by the recent widespread outbreak of a staphylococcal bacteria infection. I examined many patients who had clear evidence of staphylococcal skin infections – both new infections and scars. Reports from other facilities underscore the need for clean and separate living facilities particularly for patients who are immune compromised and more likely to spread diseases. I suspect the patients will continue to keep getting and spreading boils and abscesses that spread like wild-fire given the over-crowded sleeping and living conditions at Limestone. I have been told that Summer, 2003 has heralded additional skin infections as evidenced by increased complaints from patients to their attorneys.

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[1]NaphCare's inmate population statistics for Limestone are as follows:

December 2002 - 309 HIV infected inmates and 57 AIDS infected inmates;
January 2003 - 307 HIV infected inmates and 55 AIDS infected inmates;
February 2003 - 310 HIV infected inmates and 54 AIDS infected inmates;
March 2003 - 288 HIV infected inmates and 52 AIDS infected inmates.

Without adequate infection control practices, the possibility of an outbreak of drug-resistant tuberculosis and the subsequent deaths is acute. Some patients request to be transferred to the lock-down units where they will at least be afforded some privacy and physical barriers to potentially deadly infectious diseases.

Because of a broken, severely stressed or often non-existent medical system, patients are needlessly dying and suffering from AIDS-related complications and other illnesses that could be prevented. The conditions at Limestone Prison are unsafe for both the incarcerated and for the staff. There is a sense of hopelessness and helplessness among the patients at Limestone -- to a degree that I have not witnessed prior.

INITIAL RECOMMENDATIONS

Stephen Tabet, MD, MPH

Limestone Correctional Facility has a vast array of significant medical problems. Moreover, the standard of medical care rendered at Limestone falls far below the standards in the community or those standards set by organized bodies described in the introduction to this report. For this report, I will make only recommendations that I feel need to be addressed urgently. In addition to these minimal recommendations, there are many changes that could be put into place to develop a sound system of medical care that are not currently being addressed at Limestone. The following recommendations address what I see to be the most serious problems at the prison

1. **Deaths.** The number of deaths and the manner in which HIV-infected patients are dying at Limestone is a huge concern and present issues of potentially serious medical liability. All deaths need to be thoroughly evaluated by a medical doctor with expertise in the area. Full autopsies should be performed on all patients dying at Limestone until this disturbing trend is reversed.

2. **Physician and mid-level staffing.** Limestone is dangerously understaffed in terms of medical personnel according to accepted guidelines for incarcerated medical settings. Dr. Simon has an overwhelming task to perform with only one Physician's Assistant. One medical doctor serving as Medical Director and providing care to over 2800 patients--including 300 with the HIV or AIDS-- is overwhelming and dangerous. At least another full-time physician and two other mid-level practitioners (physician's assistants or nurse practitioners) are needed to adequately provide care for the large number of sick patients at Limestone. Limestone staffing levels are far below what is normally accepted for provider staffing in a facility of this size with this level of acuity in terms of patient load.

3. **Inmates providing care.** Because of the shortage of nurses, inmates are called upon to provide nursing care -- especially in the inpatient unit. Inmates can provide comfort and company to other inmates, but must not provide nursing care.

4. **Nursing.** Nursing is very understaffed and many nurses are poorly trained at Limestone. Nurses need training in CPR as well as ongoing continuing education. Nurses at Limestone have made serious errors and patients have died or suffered needlessly. The numerous unfilled nursing positions need to be staffed. The National Commission on Correctional Health Care (NCCHC) guidelines need to be followed in terms of adequate nursing levels and training.

5. **Infection Control.** Infection control practices and guidelines are not being adhered to. Inmates with contagious diseases should be treated and isolated from the population especially given an HIV-infected person's extreme vulnerability to these diseases. Outbreaks of infections need to be investigated and treated accordingly. National

resources such as the Centers for Disease Control and Prevention need to be called upon for assistance when necessary. Staphylococcus bacterial infections, in particular, are a problem and need to be eradicated as one would in any closed setting. Prevention, with respect to infectious diseases, is severely deficient at Limestone and needs to be integrated as a part of a patient's medical care to decrease morbidity, mortality, and unnecessary costs.

6. **Pharmacy and Medication Supply.** Multiple patients disclosed that Limestone did not provide adequate medications because the nursing staff often ran out. Patients need to be provided medications on a regular and consistent basis. Running out of medications is unacceptable. The pharmacy needs to be adequately stocked and the inventory properly managed. HIV-infected patients need to take their antiretroviral medications consistently or they will develop drug-resistant HIV, fail medication therapy, and die. Additionally, inmates should not provide medical care, distribute medication, or provide emergency transport for other inmates.

7. **Patients not taking essential medications.** Too many patients are not taking appropriate medications. It is unclear whether some patients comprehend the dire consequences of not taking antiretroviral medications or preventive antibiotics. There needs to be appropriate education and documentation that the patient understands the consequences of not taking medications or antibiotics. Patients who are not taking simple medication regimens such as Bactrim (one pill is taken three times per week) or Dapsone (one small pill taken once daily) to prevent deadly *Pneumocystis carinii pneumonia* should be counseled, encouraged, and supported so they can easily take these inexpensive, life-saving medications. Opportunistic infections are deadly and very expensive to treat. Food (a sandwich or even crackers) needs to be provided to patients so they can take their medications without unnecessary side effects. For medications that need to be taken on an empty stomach, then patients need to be counseled regarding this.

8. **Pill Line.** Making patients stand in line outside, often in the cold or extreme heat, to receive any and all medications is counter-productive for a good therapeutic relationship. Patients should be taken their medication on a pill cart into their dorm and/or allowed "keep-on-person" medications when appropriate. "Keep on person" medications is a common practice in correctional settings which allows patients to keep a few weeks or one month of medication in their possession. They can take their medications at the correct times and with the correct food requirements. A "keep-on-person" program excludes any medications that are potentially dangerous and may be bartered such as psychotropics, narcotic pain medications, and sleeping medications. Pill line at 3:00 a.m., or even 3:30 a.m., and then breakfast in the early morning is inappropriate. Patients should be administered medications that do not interrupt their normal sleep patterns. For example, medication could be provided at 7:30 a.m. after eating breakfast. Many of the medications are Food and Drug Administration (FDA) approved to be taken with food, so all patients on medications that need to be given with food must have access to food. This will decrease the amount of side effects like nausea and vomiting, and increase

medication compliance, as well as potentially decrease the number of illnesses.

9. **Dietary requirements.** **N**utritional supplementation and diets are currently not satisfying the needs of patients with illnesses that require special diets. In particular, malnourished AIDS patients need evaluation for supplementation and mediations to increase lead body mass. Many chronically ill patients, such as patients on dialysis and patients with diabetes mellitus have special dietary needs. The dietary options provided at Limestone require an assessment by a nutritionist. AIDS patients need to be given vitamin/mineral supplementation especially given that the combination HIV therapies toxicities.

10. **Medical Emergencies.** Emergency response by medical staff at Limestone is either non-existent or dangerously slow. Patients are needlessly dying of medical emergencies. The current rule of "locking down" the prison before providing care to a patient with a medical emergency needs to stop. This needless delay in treatment during the first few "golden" minutes of a medical emergency has undoubtedly hastened the death of patients at Limestone. Patients who declare an emergency need to be either attended to immediately by trained medical staff or transported to the infirmary for immediate evaluation and treatment. Correctional officers should not be making medical decisions and deciding what is a medical emergency as they are presently doing**.** The issues of Do Not Resuscitate (DNR) and advanced directives needs to be consistently and compassionately discussed with patients and the patient's wishes need to be respected. The current standard of the Limestone medical staff deciding for the patient how much to do for the patient needs to cease.

11. **Americans with Disabilities Act.** This is an area that is so replete with deficiencies that to adequately catalog them would require an extensive report, separate and apart from this report. I highly recommend an extensive evaluation of these problems before a disabled patient endures serious injury.

12. **Crowded conditions and the housing unit.** Patients at Limestone live in an open warehouse with extremes in temperatures. Overcrowded conditions and the close proximity of the beds fosters transmission of serious infections from one patient to another. HIV-infected persons at Limestone should not be housed in such crowded, dangerous, and inhumane conditions.

13. **Monitoring.** Developing an appropriate system of medical care at Limestone is going to take time, resources and a serious commitment by the medical providers. I recommend that health care delivery at the prison be monitored closely by an outside HIV specialist until the program has been brought up to acceptable standards.

Curriculum Vitae
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August 2003

Personal Data

Date of Birth	November 21, 1961
Birthplace	Belen, New Mexico
Citizenship	United States
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Street Address	HIV Vaccine Trials Network (HVTN) 1100 Fairview Avenue N. J3-100 PO Box 19024 Seattle, Washington 98109-1024
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Education

1987 Biology and Business Administration (Presidential Scholar)
University of New Mexico, Albuquerque, NM
1987-91 Doctor of Medicine
University of New Mexico School of Medicine, Albuquerque, NM
1991-93 Master of Public Health, Epidemiology
University of Washington School of Public Health, Seattle, WA

Postgraduate Training

1991-1992 Intern in Internal Medicine
University of Washington School of Medicine, Seattle, WA
1992-1993 Resident in Public Health and Preventive Medicine
University of Washington School of Public Health and Community Medicine, Seattle, WA
1993-1994 Resident in Internal Medicine
University of Washington School of Medicine, Seattle, WA
1994-1997 Senior Fellow in Infectious Diseases
Division of Allergy and Infectious Diseases, University of Washington School of Medicine, Seattle, WA

Faculty Positions Held

1997- 1999 Acting Instructor, Division of Infectious Diseases, UW School of Medicine
1998 –present Faculty Educator, Northwest AIDS Education and Training Center
1999– present Assistant Professor of Medicine, Division of Allergy and Infectious Diseases, UW School of Medicine
2002 – present Faculty Member, Fogarty International AIDS Research Training Program
2003 – present Senior Clinical Trials Physician - Antiretrovirals, HIV Vaccine Trials Network (HVTN)
2003 – present Affiliated Assistant Member, Fred Hutchinson Cancer Research Center (FHCRC)

2003 – present Associate Professor of Medicine (proposed) Division of Allergy and Infectious Diseases, UW School of Medicine

Hospital Positions

1994- 2003 Attending physician
Sexually Transmitted Disease Clinic, Harborview Medical Center, Seattle, WA

1997- 2003 Attending physician
Infectious Disease Clinic, Harborview Medical Center, Seattle, WA

1997- present Attending physician (Primary provider 1992 - 2003)
Madison (HIV/AIDS) Clinic, Harborview Medical Center, Seattle, WA

Other Positions

1995 – present Medical Director, Pacific Professional Medical Services (Supervise physician services to Washington Department of Corrections and Department of Social and Health Services)

Honors and Awards

1991 Alpha Omega Alpha, University of New Mexico School of Medicine, Albuquerque, NM

1991 University of New Mexico School of Medicine Faculty Award for Excellence Albuquerque, NM

1996-98 American Social Health Association (ASHA) Research Fellowship in STDs

Board Certification

1997 Diplomate, American Board of Internal Medicine

1998 Diplomate, Infectious Diseases

Medical Licensure

1991- present State of Washington, Physician and Surgeon #MD00031074

Professional Societies

American College of Physicians, Member
Infectious Disease Society of America, Member

Teaching Responsibilities and Mentoring

Daniel Corey, UW School of Medicine MS 1 – Project assessing costs associated with OI treatment and ARV use in Lima, Peru

Nina Kim, MD, Senior Fellow in Infectious Diseases – Issues Associated with Antiretroviral Therapy in the Context of Phase III Vaccine Trials

Raul Salazar, MD, Almenara Hospital (Peru Social Security System) – UW AIDS Clinical Trials Unit

Regular Lecturer

Northwest AIDS Education and Training Center
Seattle Sexually Transmitted Diseases Prevention Training Center

Courses

UW Center for Health Education and Research CME May 2003
Regional Conference on HIV in the Correctional Setting
(Course Director)

CME/Invited Lectures

UW Emergency Medicine Grand Rounds July 2002
"HIV Issues of Particular Importance in the Emergency Room"

UW School of Nursing – 10th Annual Clinical Update for Nurses

"Update on HIV Disease" July 2002
Country Doctor Community Health Center September 2002
"Toxicities Associated with use of Antiretrovirals"
Seattle HPTU/HVTU Community Forum September 2002
"What's going on in the area of HIV prevention?"
University of Nevada School of Medicine – Networking for HIV Care
"Correctional Medicine: Maximal Adherence / Minimal Resistance in the Setting of Intermittent Patient Contact" October 2002
National Conference on Correctional Health Care October 2002
"Real Life Examples: Managing Infectious Disease in Corrections" October 2002
UW Hospital Clinical Pathology Conference October 2002
Northwest AETC and Seattle STD Training Center Provider's Update February 2003
"Care of the HIV-infected Incarcerated Patient"
"STDs in the Correctional Facility"
Pacific AETC HIV, OIs, and Hepatitis C Conference
Honolulu, Hawaii April 2003
"The Special Case of Working with Corrections"
Northwest AETC and STD Training Center Training for Washington May 2003
Corrections Center for Women, Gig Harbor
International Adult Clinical Trial Group Latin American / Caribbean Course on HIV
(Multiple lectures) May 2003
Peruvian Conference on HIV, Pathogenesis and Treatment May 2003
"New Antiretrovirals"
"Update on Occupational Exposure to HIV, HBV, and HCV"
"Management of Treatment Failure"
"Metabolic Complications of Antiretrovirals and HIV"
Northwest AETC Montana Corrections Training Programs June 2003
Billings and Butte, Montana (Course Director)
Seattle AIDS Education and Treatment Program (STEP)
Community Forum on Antiretrovirals – Focus on QD regimens August 2003
Northwest Nevada Correctional Facility Training Program and Preceptorship, Reno, Nevada September 2003

Editorial Responsibilities

1998 – present Reviewer, Journal of Infectious Diseases
2000 – present Reviewer, Journal of the American Public Health Association

Special National/International Responsibilities

1999 – present Deputy Editor, HIV and Hepatitis Education Prison Project, Brown University, Providence, RI
1999 – 2003 Member, US Dept. of Health and Human Services HIV/AIDS Bureau Advisory Committee
2003 – present Member, US Dept. of Health and Human Services CDC/HRSA Advisory Committee
1999 – 2003 Chair, US Dept. of Health and Human Services HIV/AIDS Bureau Treatment and Access to Care Committee
2000 – present Member, Advisory Committee to the National Clinician's Consultation Center, San Francisco
2003 – present Medical Editor, HIV and Hepatitis Education Prison Project Case Study Section, Brown University, Providence, RI
2002 – present Liaison, UW International Clinical Trials Unit – Lima, Peru Site

2003 World Health Organization/UNAIDS consultation on modalities for access and standard of treatment for participants with intecurrent HIV infections during vaccine, microbicide and other prevention research trials. Geneva, Switzerland

Special Local and Regional Responsibilities

2000 – present Member, UW Sexually Transmitted Diseases Prevention Training Center Advisory Committee
2000 – present Editor, NW AIDS Education Center Correctional Medicine Update
2001 – present Director, Northwest Correctional Medicine Education Program

Research Funding, Current

9/01/02 – 8/31/05	NIH/NIAID AACTG International Therapeutic Clinical Trials Initiative (P.I. Ann Collier)	Co-Investigator (10%)

Publications

1. Tabet S, Weise W. Medications obtained in Mexico by patients in southern New Mexico, Southern Medical Journal 1990;83:271-73.

2. Tabet S, Voltura A, Wallerstein N, Koster F. Fear of AIDS: An assessment of knowledge and attitudes of medical, nursing, and medical technology students. Teaching and Learning in Medicine 1992;4:156-61.

3. Tabet S, Palmer D, Wiese W, Voorhees R, Pathak D. Seroprevalence of HIV-1 and hepatitis B and C in prostitutes in Albuquerque, New Mexico. American Journal of Public Health 1992; 82:1151-54.

4. Tabet S, Goldbaum G, Hooton M, Eisenach K, Cave M, Nolan C. Restriction fragment length polymorphism analysis detecting a community based tuberculosis outbreak among persons infected with HIV. Journal of Infectious Diseases 1994;169:189-92.

5. Tabet S, De Moya E, Holmes K, et al. Sexual behaviors and risk factors for HIV infection among men who have sex with men in the Dominican Republic. AIDS 1996; 10:201-6.

6. Tabet S, Krone M, Hooton T, Koutsky L, Holmes K. Bacterial infections in adult patients hospitalized with AIDS: Case-control study of prophylactic efficacy of trimethoprim-sulfamethoxazole vs. aerosolized pentamidine. International Journal of STD and AIDS 1997;8:563-9.

7. Tabet S, Krone M, Paradise M, Corey L, Stamm W, Celum C. Incidence of HIV and sexually transmitted diseases (STDs) in a cohort of HIV-negative men who have sex with men. AIDS 1998;12:2041-8.

8. Krone M, Tabet S, Paradise M, Wald A, Corey L, Celum C. Herpes simplex virus shedding among HIV-negative, men who have sex with men (MSM): Site and frequency of herpes shedding. JID 1998;178:978-82.

9. Tabet S, Surawicz C, Horton S, Paradise M, Coletti A, Gross M, et al. Safety and toxicity of Nonoxynol-9 gel as a rectal microbicide. Sex Transm Dis 1999;26:564-71.

10. Gross M, Celum C, Tabet S, Kelly C, Coletti A, Chesney M. Acceptability of a bioadhesive nonoxynol-9 gel delivered by an applicator as a rectal microbicide. Sex Transm Dis 1999;26:572-78.

11. Krone M, Wald A, Tabet S, Corey L, Celum C. Herpes Simplex Virus Type 2 shedding in HIV-negative men who have sex with men: Frequency, patterns, and risk factors. Clin Inf Dis 2000;30:261-7.

12. Casper C, Wald A, Pauk J, Tabet S, Corey L, Celum C. Correlates of prevalent and incident Kaposi's Sarcoma-associated Herpesvirus infection in men who have sex with men. J Infect Dis 2002;185:990-3.

13. Tabet S, Sanchez J, Courtois B, Lama J, Goicochea P, Campos P, et al. HIV, syphilis and heterosexual bridging among Peruvian men who have sex with men. AIDS 2002;16:1-7.

14. Schwartz M, Tabet S, Collier A, Wallis C, Carlson L, Nguyen T, Kattar M, Coyle M. Central venous catheter-related bacteremia due to *Tsukamurella* species in the immunocompromised host: A case series and review of the literature. CID 2002;35:72-76.

15. Renzi C, Tabet S, Stucky, Eaton N, Coletti A, Surawicz C, et al. Acceptability and safety of the Reality condom for anal sex among men who have sex with men. AIDS 2003; 17:727-31.

16. Tabet S, Callahan M, Mauck C, Gai F, Coletti A, Profy A, Moench T, Poindexter A, Frezieres R, Walsh T, Kelly C, Richardson B, van Damme L, Celum C. Safety and acceptability of penile application of 2 candidate topical microbicides: BufferGel and PRO 2000 Gel: 3 randomized trials in healthy low-risk and HIV-positive men. J Acquir Immune Defic Syndr 2003; 33:476-83.

Books and Chapters

1. Tabet S, Celum C. Nongonococcal urethritis, Conn's Current Therapy. Philadelphia: W.B. Saunders Co., 1995.

2. Tabet S, Berg A. Screening for Cerebrovascular Disease (Chapter 4). Guide to Clinical Preventive Services: An assessment of the effectiveness of 169 interventions. Baltimore, Maryland: Williams and Wilkins, 1996.

3. Tabet S, Berg A. Screening for Peripheral Vascular Disease (Chapter 5), Guide to Clinical Preventive Services: An assessment of the effectiveness of 169 interventions. Baltimore, Maryland: Williams and Wilkins, 1996.

4. Tabet S, Root P. Continuous quality improvement in AIDS care. (USPHS publications 1999).

Electronic Publications

Tabet S. Northwest AIDS Education Training Center Correctional Medicine Update (Monthly publication focusing on HIV, HCV, and HBV and related issues for providers working in correctional settings.)

Videos

1. Tabet S. Washington Department of Public Health and Northwest AIDS Education and Training Center.
   Taking control: Adherence and HIV/AIDS Medication. 1998.

2. Tabet S. Northwest AIDS Education and Training Center. Positive in prison: Women on combination therapy. 1998.

3. Tabet S. Northwest AIDS Education and Training Center. Caring inside the wall: HIV treatment in the correctional setting. 2001.

4. Tabet S, Shuhart M. Northwest AIDS Education and Training Center. Diagnosis and treatment of HIV and
Hepatitis C co-infected patients. 2002.

Selected Presentations/Published Abstracts

Tabet S, Voltura A, Wallerstein N, Koster F. Fear of AIDS: An assessment of knowledge and attitudes of medical, nursing, and medical technology students. (Clinical research, Vol. 39, p. 7A); Western Regional Meetings, Carmel, California, February 1991.

Tabet S, Palmer D, Voorhees R, Wiese W, Pathak D. Prostitution, drug use and HIV/AIDS on the streets of Albuquerque, New Mexico, USA. Seventh International Conference on AIDS, Florence, Italy, June 1991.

Tabet S, Goldbaum G, Hooton T, Eisenach K, Cave M, Nolan C. DNA fingerprinting analysis detecting a community-based tuberculosis outbreak among HIV-infected persons. (Abstract no. B07-1121); Ninth International Conference on AIDS, Berlin, Germany, June 1993.

Tabet S. Tuberculosis in high risk populations. University of Washington School of Public Health Grand Rounds, Seattle, November 1993.

Tabet S, Goldbaum G, Hooton T, Eisenach K, Cave M, Nolan C. Restriction fragment length polymorphism analysis detecting a community-based tuberculosis outbreak among HIV-infected persons. (Abstract no. 010); American College of Physicians Annual Session, Miami Beach, April 1994.

Tabet S, Hooton T, Koutsky L, Krone M, Holmes K. Bacterial pneumonia in adult HIV-infected patients. American College of Physicians Annual Session, Miami Beach, April 1994.

Tabet S, Krone M, Paradise M, Stamm W, Corey L, Celum C. Herpes, the most common STD in a cohort of high-risk HIV-negative men who have sex with men. (Abstract no. Mo.C.1634); Eleventh International Conference on AIDS, Vancouver, July 1996.

Tabet S, Root P. The role of Continuous Quality Improvement (CQI) in federally-funded HIV/AIDS clinics. US Department of Health and Human Services Health Resources and Services Administration AIDS Conference, Bethesda, Maryland, April 1997.

Celum C, Tabet S, Dondero D, et al. HIV viral load in rectal mucosa and plasma: Implications for pathogenesis studies and transmission. 35th Annual Meeting of the Infectious Diseases Society of America, San Francisco, September 1997.

Tabet S, Krone M, Paradise M, Corey L, Stamm W, Celum C. Prevalence and incidence of HIV and STDs in a cohort of HIV-negative men who have sex with men (MSM) (Abstract no. O-138). International Congress of Sexually Transmitted Diseases. Seville, Spain, October 1997.

Krone M, Tabet S, Paradise M, Wald A, Corey L, Celum C. Herpes simplex virus shedding among HIV-negative, HSV-2 seropositive patients (Abstract no. O-189). International Congress of Sexually Transmitted Diseases. Seville, Spain, October 1997.

Celum C, Tabet S, Paradise M, et al. Safety, acceptability, and biologic effects of nonoxynol-9 as a rectal microbicide (Abstract no.O-258). International Congress of Sexually Transmitted Diseases. Seville, Spain, October 1997.

Lama J, Goicochea P, Chion M, Alva J, Ueda L, Cairo J, Watts D, Campos P, Sanchez J, Tabet S, Holmes K. Comportamiento sexual y factores de riesgo para ETS e infeccion VIH entre hombres que tienen sexo con otros hombres de Lima, Peru. XI Latin American Conference on STDs and Panamerican Conference on AIDS, Lima, Peru, December 1997.

Tabet S, Celum C, Surawicz C, et al. Rectal sno-strips and biopsies: A simple method to assess rectal viral load and lymphoid architecture. 12th World AIDS Conference, Geneva, June 1998.

Tabet S, Collier A, Deeks S. Post-Geneva update on antiretrovirals. Harborview Medical Center AIDS Clinical Conference. Seattle, September 1998.

Tabet S. Adherence issues of HIV-infected incarcerated persons. Current Strategies for the Management of HIV in Corrections. Brown University School of Medicine. New York City, October 1998.

Tabet S. Current issues in the medical management of HIV-infected patients. UCSF – Fresno Grand Rounds. Fresno, California, October 1998.

Tabet S. Update on STD diagnoses and treatments. AIDS Healthcare Foundation, Los Angeles, California, November 1998.

Tabet S. Antiretroviral adherence issues. Alaska Native Health Association and AIDS Education Project, Anchorage, Alaska, January 1999.

Tabet S. A case-based approach to the advances in the treatment of HIV Disease. University of Hawaii Grand Rounds. Honolulu, HA, October 2000.

Tabet S. Update on viral load, CD4 count, and antiretroviral resistance testing and salvage therapy. NW AIDS Education and Training Center Training on HIV/AIDS in the African American Community. Seattle, WA, November 2000.

Tabet S., Celum C, Dondero D, Haggitt R, Huang M, Kelly C, Brodie S. HIV-1 localization, shedding, and CD4+ T-cell depletion in rectal mucosa. 8th Conference on Retroviruses and Opportunistic Infections. Chicago, IL, February 2001.

Tabet S., Brodie S, Dondero D, Haggitt R, Huang M, Kelly C, Celum C. The rectal mucosa is a site of HIV-1 replication and shedding and CD4+ T-cell depletion in men with chronic HIV-1 infection. Abstract 22. 1st International Conference on HIV Pathogenesis and Treatment. Buenos Aires, Argentina, July 2001.

Brodie S, Tabet S, Krieger J, et al. Intestinal mucosal macrophages are a principle reservoir of HIV replication and sustain high levels of infectious virus in persons with chronic-progressive HIV infection. Abstract 27. 9th Conference on Retroviruses and Opportunistic Infections. Seattle, WA, February 2002.

Celum C, Tabet S. Penile safety studies on PRO-2000 and BufferGel. Microbicides 2002. Antwerp, Belgium,
May 2002.

Bartholow B, Royal S, Niedig J, Buchbinder S, Mayer K, Dyslin K, Tabet S, Goli V; The VISION Study Team. HIV vaccine efficacy trial site characterstics associated with the enrollment of trial participants at increased risk of HIV infection. XIV International AIDS Conference. Barcelona, Spain, July 2002.

Bartholow B, Royal S, Niedig J, Buchbinder S, Mayer K, Dyslin K, Tabet S, Goli V; The VISION Study Team. HIV vaccine efficacy trial site communications practices associated with enrollment of trial participants at increased risk of HIV infection. XIV International AIDS Conference. Barcelona, Spain, July 2002.

Ackers ML, Buchbinder S, McKirnan D, Mayer KH, Novak R, Popovic V, Heywood W, Para M, Fuchs J, Tabet S, Vax004-Vision Study Team. Post-exposure prophylaxis among HIV-uninfected participants in a phase III HIV vaccine efficacy trial. XIV International AIDS Conference, Barcelona, Spain, July 2002.

Bartholow B, Royal S, Niedig J, Buchbinder S, Mayer K, Dyslin K, Tabet S, Goli V; The VISION Study Team. Enrolling high-risk HIV vaccine efficacy trial participants: Media coverage, advertising, and opinion leader endorsement. XIV International AIDS Conference. Barcelona, Spain, July 2002.