SUPPLEMENTAL REPORT
JULIA TUTWILER PRISON FOR WOMEN - ALABAMA
October 4, 1994

I requested the medical records of two inmates who expired while in custody. Dr. John May was provided the two medical records and this report is the result of reviewing his notes and discussing the cases with him on September 27, 1994.

Case Number 1 -- B.J.B No. 152036

BJB was admitted to the facility on 5-13-94 and had admission laboratory work drawn. On 5-19-94 it was noted that she had a new arrival admission.

On 5-21-94 a physician performed a health assessment noting a multitude of medical problems with many treatments. The physician obtained a history of two strokes and one heart attack. In addition, the patient had a past history of suicide attempt. The recorded plan of management -- a SMA-24, lasix, slow K, maxzide, and theodur. The physician did not note that the patient had complained on 5-18-94 of a "tight squeezing in my chest, feels like I'm suffocating and numbness down L arm." She was treated on 5-18-94 with tylenol and advised to sign up for next sick call v/o Dr. Wilson.

On 5-23-94 she registered a complaint of pain in back of my leg. On 5-24-94 she was medically cleared for general population by the physician. On 5-28-94 she was seen at 2:20 a.m. with chest pain and stated, "I been using NTG sublingual". The objective recording in the record is as follows:

- hurting in chest area x 2 days
- is located between breast area
- numbness and tingling in L arm
- nauseated on yesterday p.m. with dry heaves
- takes NTG which relieved symptom briefly but pain returns
- history of heart attack x 1 and strokes x 2

The plan was to refer complaint to M.D.

The physician apparently evaluated this patient some time on 5-28-94 and made the assessment of substernal chest discomfort - SMA-24 as ordered on 5-21-94. Doubt cardiac - 20 min. NTG responded, also speaks against angina. The physician plan was to prescribe quinine for 30 days.

The patient died on 5-30-94. The incident report indicated she was taken to the Almore Hospital at 7:55 p.m. because of "grasping for breath".

FINDINGS AND/OR RECOMMENDATIONS

1. Inadequate medical care. This patient had a history of heart disease that was not adequately evaluated.

2. No chest x-ray, no EKG, no cardiology consultation.

3. The physician either ignored or did not read the medical record regarding the encounter on 5-18-94 when he saw the patient on 5-21-94.

4. This patient exhibited the classical findings of angina and on 5-28-94 had definite symptoms of unstable angina. These symptoms were ignored by both nursing staff and the physician.

5. The physician ordered medications without a diagnosis or justification for the medications.

6. The patient did not receive a health assessment until 8 days after admission.

7. Laboratory studies were not noted by the physician.

8. There is no evidence that this patient was examined by the physician.

9. The physician did not outline a plan of management.

10. There is no death note or death review by a physician on this patient.

CASE NUMBER 2 -- VMP #140630

This patient was on dialysis due to kidney failure secondary to hypertension. In addition, she had asthma with a past history of status asthmaticus on 3-92.

On 12-9-92 the medical record indicates a renewal of 12 medications. There was no evidence of a physician evaluation.

On 1-18-93 she was seen with a complaint, "I can't breathe, I can't lay down". BP = 220/140; P = 128; R = 40. She was sent to the medical unit and given oxygen at 3L/min. On 1-19-94 she was assessed to have difficulty breathing. Plan was to "continue to observe". On 1-20-94 - "inmate in dorm screaming she is having another asthma attack".

- forced to go to HCU, can't feel $O_2$ nasal cannula
- instructed to lay to conserve energy
- leaning forward without respiratory distress

On 1-21-93 Keflex ordered 250mg tid. Death occurred on 1-29-93.

## FINDINGS AND/OR RECOMMENDATIONS

1. Inadequate treatment of asthma and respiratory distress. This is especially noted on 1-18-93.

2. No peak flow measurements.

3. No evidence of use of inhaled steroids.

4. No blood levels of theophyline.

5. No evidence of physician examination.

6. No evidence of a plan of management.

7. No reason for giving an antibiotic on 1-21-93.

8. While the record doesn't indicate the accurate situation regarding the health status of this patient, it is a reasonable certainty that this patient suffered and died without the benefit of contemporary medical practice. She should have been hospitalized.

9. There is no death review or death note by a physician on this patient.

10. There are no medical notes from 1-21-93 until the death on 1-29-93.

Armond H. Start M.D.

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10/4/94

## RECOMMENDATIONS FOR CORRECTION OF DEFICIENCIES THAT RESULT IN INADEQUATE CARE AND TREATMENT

1. The facility must have a full-time physician on-site. The alternative would be a half-time physician and two full-time mid-level practitioners (nurse practitioner or physician assistant).

2. Sick call must be held during the day or evening shift.

3. OB/GYN consultation should be provided on-site.

4. X-ray services must be provided on-site.

5. If nurses are to perform medical triage of sick call requests, there must be a documented, organized training program.

6. Over-the-counter medication must be made available via a system other than the sick call system.

7. Medical record keeping must be supervised and audited by trained and credentialed personnel. The physician especially needs to have his medical record keeping skills upgraded and supervised.

8. The medical care system should follow its own policies and procedures.

9. The dental program needs extensive revolution by a full-time dentist.

10. All inmate deaths must be reviewed by a physician and a clinical death note must be written in the medical record.

11. The medication delivery system should initiate a carry-on-person program for non-abuseable medications.

12. Prepare and implement a TB control program that is consistent with the CDC recommendations.

13. Institute chronic disease clinics or a case management system for continuity of care for patients with diabetes, hypertension, heart disease, seizure disorder, TB, HIV and asthma (COPD).

14. Institute a quality improvement program (CQI) and consider an outside monitor to review defined health care programs.

15. Renovate the medical clinic to provide more space for confidential patient management and create a more therapeutic environment. Repair or replace broken equipment and furniture.

Howard H. Stark M.D. 11-5-94