

REPORT OF:

**AN INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF
NEIL PRENTISS ON NOVEMBER 22, 2002**

Tina Wood
Paralegal

A.J. Ruben
Supervising Attorney

Ed Paquin
Executive Director

VERMONT PROTECTION & ADVOCACY, INC.
141 MAIN STREET, SUITE 7
MONTPELIER, VERMONT 05602

Phone: (802) 229-1355

* * *

Fax: (802) 229-1359

FINAL REPORT
May 21, 2004

www.vtpa.org

TABLE OF CONTENTS

I.	Introduction.....	03
II.	Background	
	a. Neil Prentiss.....	04
	b. Chittenden Regional Correctional Facility.....	04
III.	Circumstances Surrounding the Death of Mr. Prentiss	
	a. Sequence of Events at CRCF.....	05
	b. Sequence of Events at FAHC.....	07
	c. Sequence of Events at Lahey Clinic.....	08
IV.	Investigations into the Death of Mr. Prentiss	
	a. Vermont Department of Corrections.....	09
	b. Marks & McLaughlin March 13, 2004.....	09
	c. Vermont Protection & Advocacy.....	10
V.	Findings and Conclusions.....	10
VI.	Recommendations.....	12

I. INTRODUCTION

This report presents the results of the investigation conducted by Vermont Protection & Advocacy, Inc. (VP&A) into the circumstances surrounding the death of Neil Prentiss on November 22, 2002, at the Lahey Clinic in Burlington, Massachusetts.

VP&A is an independent, private, nonprofit agency which protects and advocates for the rights of persons with disabilities. Mr. Prentiss was a VP&A client at the time of his death.

On October 31, 2002, following 18 days of serious medical symptoms, Mr. Prentiss was transported from the Chittenden Regional Correctional Facility (CRCF) in Burlington, Vermont to Fletcher Allen Health Care (FAHC) in Burlington, Vermont. Mr. Prentiss presented to FAHC with an incarcerated umbilical hernia¹. Following surgery he developed progressive respiratory failure and eventually adult respiratory distress syndrome². He was transferred from FAHC to Lahey Clinic in Burlington, Massachusetts on November 20, 2002 for evaluation for a liver transplant. Mr. Prentiss was not considered a good candidate for surgery. Mr. Prentiss passed away on November 22, 2002. Autopsy was declined by family.

¹ Hernia: The protrusion or projection of an organ or a part of an organ through the wall of the cavity that normally contains it. Incarcerated: Hernia completely obstructing the bowels. Umbilical: A hernia in the region of the umbilicus. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

² Adult Respiratory Disease Syndrome (ARDS): A form of restrictive lung disease due to abnormal permeability of either the pulmonary capillaries or the alveolar epithelium. The condition is often found in patients whose lungs were initially normal but who have had some severe or systemic illness. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

II. BACKGROUND

Mr. Prentiss

According to records, Mr. Prentiss was a 47 year-old who had been diagnosed with a variety of disabling conditions that included medical and mental health issues. Mr. Prentiss is survived by his mother, one son, one daughter, three sisters and four brothers.

VP&A initially was in contact with Mr. Prentiss in February of 2002, as he had concerns about difficulties he was having in mandated programming. He was sent to a Virginia prison. He returned to Vermont in the spring of 2002, was sent back to Virginia in the summer of 2002 and returned once again to Vermont in October of 2002, and was lodged at Chittenden Regional Correctional Facility in South Burlington. Mr. Prentiss sustained an injury during one of his transports from Vermont to Virginia when he fell from the bus when trying to descend the stairs. Mr. Prentiss had been approved for parole at the time that he became ill at CRCF.

Chittenden Regional Correctional Facility

The Chittenden Regional Correctional Facility (CRCF) is a jail located at 7 Farrell Street in South Burlington. At the time of Mr. Prentiss' death CRCF housed both male and female inmates.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF MR. PRENTISS

A. Sequence of Events at Chittenden Regional Correctional Facility (CRCF)

On October 14, 2002, Mr. Prentiss submitted a sick slip³ requesting to be seen by medical staff for “severe head and leg pain.”

On October 15, 2002 Mr. Prentiss was seen by a nurse who noted “refer to physician.”

On October 17, 2002, Mr. Prentiss submitted another sick slip that read: “Head leg pain severe. Hernia in stomach stick out need to be seen – no medical treatment since I left VA 10-9-02. No meds with me. Thank you.” He had not been seen by a physician as of this date. This form was marked received October 18, 2002.

On October 18, 2002, Mr. Prentiss submitted another sick slip. He still had not been seen by a physician as of this date. “Severe head leg pain, hernia in stomach. Second request to be seen. Came from VA and have none of my meds. Must see doctor. Thank you.”

This form was marked received October 21, 2002. Mr. Prentiss’ record shows that he was seen in the medical office on October 21, 2002. The nurse reported that he had no complaints. His case was referred for a chart review.

³ “Sick slip” is the process by which inmates with medical needs write down their complaint on a request form and submit it to the medical department.

On October 21, 2002, Mr. Prentiss submitted another sick slip.
“Severe head leg pain. Hernia in stomach. None of my meds came with me from Virginia. Must be seen. Third request. Thank you.”
This form was marked received October 23, 2002.

On October 22, 2002, Mr. Prentiss submitted another sick slip that read:
“Been in jail over 7 years strait [sic] those are not made up illnesses in fact have got more need to be seen by doctor. Please this is my fourth request.”

This form was marked received October 26, 2002.

On October 28, 2002, Mr. Prentiss submitted another sick slip that read:
“Head leg hernia cronic [sic] illness been in 7 1/2 years strait [sic] Am I going to be seen by the doctor. Thank you.”

This form was marked received October 31, 2002.

Mr. Prentiss was seen in the medical department on October 30, 2002, but only after 2 calls from a correctional officer to the medical department were made. The officer reported that Mr. Prentiss had been in bed for two straight days and “appears ill.” The nurse then called Mr. Prentiss to the health center at 2040 and noted, “...abd. Firm and distended with positive guarding with palpation of mid supra umbilical region, positive hypoactive BS x 4 quads, color dusky...I/M [inmate] appears week and does appear to be ill...advise nothing by mouth except water tonight and to see practitioner in AM, I/M returned to unit. Advised CO and I/M to call for worsening symptoms.” The nurse’s signature is illegible.

On October 31, 2002, Mr. Prentiss gave a hand written note to the nurse practitioner. “Need something done today...”

On October 31, 2002, Mr. Prentiss was seen by the physician's assistant at 1524 who noted, "...c/o abdominal pain, swollen tense abdomen, increase past few days...unable to speak in complete sentences...(P) discussed with [doctor]...will send to E.R....via ambulance."

B. Sequence of Events at Fletcher Allen Health Care

On October 31, 2002, Mr. Prentiss was brought to the Emergency Department at Fletcher Allen Health Care by Shelburne Rescue. He was evaluated in the emergency room where he was noted to have tachycardia⁴ and positive orthostatics⁵, and General Surgery was consulted. On physical exam he had a diffusely⁶ tender abdomen with guarding and no bowel sounds. He was acidotic⁷ and showing signs of early shock⁸. He was taken urgently to the operating room for an exploratory laparotomy⁹ with possible bowel resection.¹⁰

⁴ Tachycardia : Abnormal rapidity of heart action, usually defined as a heart rate over 100 beats per minute. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

⁵ Orthostatic Hypotension : Postural hypotension; decrease in blood pressure upon assuming erect posture. This is normal, but may be of such degree as to cause fainting, esp. in persons who first stand up after having been flat in bed for several days. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

⁶ Diffuse: Spreading, scattered, spread. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

⁷ Acidotic: Pert. To acidosis. Acidosis: Excessive acidity of body fluids, due to an accumulation of acids (as in diabetic acidosis or renal disease) or an excessive loss of bicarbonate (as in renal disease). The hydrogen ion concentration, q.v., is increased and thus the pH is decreased. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

⁸ Shock: A clinical syndrome in which the peripheral blood flow is inadequate to return sufficient blood to the heart for normal function, particularly transport of oxygen to all organs and tissues. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

⁹ Laparotomy: The surgical opening of the abdomen; an abdominal operation. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

¹⁰ Resection: Partial excision of a bone or other structure. Taber's Cyclopedic Medical Dictionary (15th ed. 1985).

The findings from surgery were an incarcerated¹¹ umbilical hernia with necrotic preperitoneal fat¹² and an abscess¹³ present. There was no evidence of incarcerated bowel. The abdominal cavity contained approximately 12,000 cc of purulent ascites.¹⁴ Final diagnosis was strangulated¹⁵ umbilical hernia.

After surgery Mr. Prentiss was taken to the intensive care unit, intubated, placed on a respirator and in critical condition. Mr. Prentiss had been put on the transplant list for a liver. On November 1, 2002, it was noted that he was in liver failure.¹⁶ Mr. Prentiss was noted to have an active infection that was contraindicated for a transplant, however, he remained on the list. The Lahey Clinic did not have a bed available at this time for Mr. Prentiss. On or around November 12, 2002, Mr. Prentiss developed adult respiratory distress syndrome (ARDS). He was transferred from FAHC to Lahey Clinic on November 20, 2002 for evaluation for a liver transplant.

C. Sequence of Events at Lahey Clinic

Mr. Prentiss was admitted to the Lahey Clinic on November 20, 2002. Consultation notes by the physician dated November 21, 2002, give the following assessment and plan: *“...The prognosis of this patient is extremely poor. This has been discussed with the patient’s mother and his ex-wife. He is currently*

¹¹ Incarcerated: Hernia completely obstructing the bowels. Taber’s Cyclopedic Medical Dictionary (15th ed. 1985).

¹² Necrotic: Rel. to death of a portion of tissue. Preperitoneal: Located in front of the peritoneum. Taber’s Cyclopedic Medical Dictionary (15th ed. 1985).

¹³ Abscess: A localized collection of pus in any part of the body. Taber’s Cyclopedic Medical Dictionary (15th ed. 1985).

¹⁴ Purulent: Suppurative; forming or containing pus. Ascites: The accumulation of serous fluid in the peritoneal cavity. Taber’s Cyclopedic Medical Dictionary (15th ed. 1985).

¹⁵ Strangulated: So tightly constricted that gangrene results if surgery does not relieve it. Not reducible by ordinary means. Taber’s Cyclopedic Medical Dictionary (15th ed. 1985).

¹⁶ Liver Failure: Inability of the liver to function because of a disease process within the liver or because of demands beyond its capability. Taber’s Cyclopedic Medical Dictionary (15th ed. 1985).

not a candidate for liver transplantation. This has also been discussed with the family.” On November 22, 2002, artificial life support was terminated after all hope of recovery had passed. Hours later Mr. Prentiss passed away with his family by his side.

IV. INVESTIGATIONS INTO THE DEATH OF MR. PRENTISS

A. Department of Corrections

No investigation completed that VP&A is aware of.

B. Michael Marks, Esq. and Philip McLaughlin, Esq.

On March 13, 2004, Mr. Marks and Mr. McLaughlin released the results of their independent report entitled “Investigative Report into the Deaths of Seven Vermont Inmates and Related Issues.” They were contracted by the Governor to perform this investigation. Their conclusion in Mr. Prentiss’ case was as follows:

“Mr. Prentiss made repeated requests for health care. He expressed urgency. He provided detail to support urgency...Setting aside the potential causal connection between the care rendered to Mr. Prentiss and his death, we conclude that Chittenden [Regional Correctional Facility] did not adequately respond to Mr. Prentiss’ requests...We have found no written report from any governmental authority regarding Mr. Prentiss’ death.”

It was also noted in this report that the Assistant Superintendent and the Superintendent at Chittenden Regional Correctional Facility had conveyed concerns during a meeting on April 23, 2003, of senior departmental staff. *“...[T]here was inadequate medical staff to properly run the health center; they expressed a concern that inadequate staff would lead to significant medical problems and errors in medication administration. Following that meeting, [the clinical director] sent a formal letter, based upon the consensus of senior staff, to Correctional Medical Services. [The clinical director] commented that CMS should declare a staffing emergency at Chittenden.”*

The report further details that “[O]n October 23, 2002, [the assistant superintendent] *had occasion...to walk through the facility to check on conditions and talk with offenders...[He] went to the infirmary...and... learned that the infirmary was ‘...70, some 70 intakes behind, which at that time happened.’ [He] reported his findings and his concerns to the Regional Director of CMS and to DOC Clinical Director...”.*

C. Vermont Protection and Advocacy, Inc.

VP&A first learned of Mr. Prentiss’ medical issue on November 12, 2002, when his mother called to inform VP&A that he had been taken to the hospital. VP&A then learned of Mr. Prentiss’ death on November 22, 2002. VP&A opened its own investigation, which included the following:

- Reviewing Mr. Prentiss’ medical and mental health records from CRCF.
- Reviewing Department of Correction’s Protocols regarding medical care.
- Reviewing Mr. Prentiss’ medical records from Fletcher Allen Health Care.
- Reviewing Mr. Prentiss’ medical records from Lahey Clinic.
- Telephone discussions with Mr. Prentiss’ mother and administratrix of his estate.
- Review of Standards for Health Services in Prisons, National Commission on Correctional Care, 2003.

V. FINDINGS AND CONCLUSIONS

VP&A’s investigation found evidence that the Department of Corrections, and its contracted agent, Correctional Medical Services, showed deliberate indifference when providing for the medical needs of Mr. Prentiss. He had a documented history of prior surgery for an umbilical hernia, he presented over an 18-day period of time with severe symptoms of that condition, was referred to a physician for follow up, but was never evaluated by a physician until reaching the emergency department. Mr. Prentiss was not receiving

the standard of care that would be available in the community.¹⁷

There is no evidence that a physician at CRCF actually met with or evaluated Mr. Prentiss during the time he submitted seven requests to be seen over an 18-day period of time that he suffered with serious medical symptoms.¹⁸

On October 15, 2002, when Mr. Prentiss was seen by a nurse after putting in his first sick slip, the nurse documented, “refer to physician.” He was never seen by a physician until he was admitted to Fletcher Allen Health Care on October 31, 2002.¹⁹ Comparing these facts as to what one would expect in the community, it seems clear that Mr. Prentiss was not evaluated by a physician in a timely fashion. Had Mr. Prentiss been properly evaluated and treated, the serious nature of his condition could have been detected earlier for a more favorable outcome.

There has been no explanation provided by DOC for the failure to assure adequate medical care to Mr. Prentiss, nor has there been any apology to Mr. Prentiss’ family by DOC or its medical contractor for this tragic event.

¹⁷ Vermont Department of Corrections, Policy and Operating Procedures, Health Care Services (481), I. Introduction, “...*Proper medical care for inmates should be viewed not only as a basic right, but also an integral component of any correctional program.*” V. Standards of Medical Care, “*The Vermont Department of Corrections requires its contracted medical service providers and its medical service employees to provide to inmates the same professional minimum standards of care that would be found to be provided to any citizen of the community at large.*”

¹⁸ 28 VSA §801 Medical Care of Inmates (c) *When there is reason to believe an inmate is in need of medical care, the officers and employees shall render emergency first aid and immediately secure additional medical care for the inmate in accordance with the above standards.*”

¹⁹ Standards for Health Services in Prisons, National Commission on Correctional Health Care, 2003, **P-E-12 Continuity of Care During Incarceration**. “*Timeliness of the response to sick-call requests is an important indicator of quality of care and should be tracked through the continuous quality improvement (CQI) process. A high number of inmate grievances or a high number of hospital emergency room visits may point to the need for increased physician time.*”

VI. RECOMMENDATIONS

Vermont Protection & Advocacy offers the following recommendations to the Department of Corrections:

1. Staff training in recognizing and reporting behaviors that are potentially life threatening for the individual experiencing them.
2. Assure that policies, directives, and procedures are taught to all staff and contracted employees, including the physicians, and that these rules are followed consistently.
3. Consistently and adequately staff the medical department at all times.
4. Any inmate who continues to complain of the same ailment during a short period of time, with or without the presence of life-threatening symptoms, be evaluated at the local emergency department when a contracted physician is not available to immediately evaluate the inmate.
5. Disciplinary actions to be taken against the contracted health providers for failing to provide the standard of care in this case.
6. The Department should review and reconsider its current contract with Correctional Medical Services to ensure that the State is being provided with the absolute best level of services possible that at least satisfies our community standard of care.

Cc: Dorothy Prentiss
Dawn Seibert, Esq.
Steve Gold, Commissioner, DOC
Janice Ryan, Deputy Commissioner, DOC
Charles Smith, Agency of Human Services
Honorable Governor James Douglas