



AN INVESTIGATION INTO THE DEATH OF  
ASHLEY ELLIS



DISABILITY RIGHTS VERMONT  
*(formerly Vermont Protection & Advocacy, Inc.)*  
141 Main Street, Suite 7  
Montpelier, Vermont 05602

May 13, 2010

***Tina Wood***  
***Advocate/Paralegal***

***A.J. Ruben***  
***Supervising Attorney***

*DRVT is the Protection & Advocacy System for Vermont*

Table of Contents

I.	Acknowledgement.....	03
II.	Introduction.....	03
III.	Background.....	04
IV.	DRVT’s Investigation.....	04
V.	Sequence of Events.....	05
VI.	DRVT’s Findings.....	12
VII.	PHS Mortality Report.....	20
VIII.	VDH Root Cause Analysis Report.....	20
IX.	DOC Administrative Review of Mortality Report.....	20
X.	AHS Investigations Unit Report.....	21
XI.	Conclusion & Recommendations.....	21

## **I. Acknowledgement**

Disability Rights Vermont (DRVT) would like to acknowledge the cooperation received from Ashley Ellis' family and the Vermont Department of Corrections during the course of our investigation.

## **II. Introduction**

This report presents the results of an investigation conducted by DRVT into the death of Ashley Ellis on August 16, 2009 while incarcerated at the Northwest State Correctional Facility (NWSCF) in Swanton, Vermont.

Ashley Ellis was a 23-year-old woman incarcerated at NWSCF on August 14, 2009 to begin a 30-day sentence for a conviction of misdemeanor negligent operation of a motor vehicle. She had a history of an opiate addiction, depressive disorder and a severe eating disorder. According to Ms. Ellis' family, they knew her as a straight-laced young woman, not a partier. Her family states that her opiate addiction was the result of a back injury and subsequent treatment with opiate pain relievers. She was most recently hospitalized at Rutland Regional Medical Center in June of 2009 for severe hypokalemia (low potassium) secondary to chronic bulimia. She was seeing a licensed psychologist and in April 2009 had received treatment at the Walden Behavioral Care in Massachusetts. She was also being treated for hypocalcemia (lack of calcium).

She entered Department of Corrections (DOC) custody at approximately 12:00 noon on Friday, August 14<sup>th</sup>. She died on Sunday, August 16<sup>th</sup> at 07:33 a.m. at the hospital. During her few days at NWSCF, Ms. Ellis did not receive the potassium as prescribed by both her outside physician and the Prison Health Services' physician. Nor did she receive the Suboxone that she was prescribed to treat her opiate addiction. Prior to Ms. Ellis' arrival the DOC was in possession of medical records detailing the conditions for which she was being treated and the medications that she would require while incarcerated.

The Chief Medical Examiner for the State of Vermont found that Ms. Ellis' cause of death was "Hypokalemic induced cardiac arrhythmia due to anorexia / bulimia nervosa and denial of access to medications."

### **III. Background**

- a. DRVT is a private, independent, not-for-profit agency empowered by federal law to provide advocacy services on behalf of people with disabilities to ensure their rights are protected. Under our federal mandate, DRVT has the duty and authority to investigate allegations of abuse and/or neglect involving people with disabilities if the incident is reported to DRVT or if DRVT determines there is probable cause that an incident of abuse and/or neglect occurred. DRVT is Vermont's designated protection and advocacy system and is a member of the National Disability Rights Network (NDRN).
- b. Northwest State Correctional Facility (NSCF) is a medium-security prison located in Swanton, Vermont which houses female offenders.
- c. Prison Health Services (PHS) was the contracted provider for medical care at the prison at the time of Ms. Ellis' death.
- d. MHM, Inc. was the contracted provider for mental health services at the prison at the time of Ms. Ellis' death.

### **IV. DRVT's Investigation**

DRVT's investigation of this case included the following:

- a. Review of Ms. Ellis' DOC medical and mental health records which include some of her community medical records;
- b. Review of unit logs, end of shift reports, incident reports, unit videos, e-mails, handheld videos, facility menu, and core file documents;
- c. Review of medical records from Northwestern Medical Center;
- d. Review of Final Report of Autopsy from the Chief Medical Examiner;
- e. Review of PHS Mortality & Morbidity Peer Review – Confidential;
- f. Review of the Vermont State Police investigation report;
- g. Review of the AHS Investigations Unit investigation report – Confidential;
- h. Review of DOC Administrative Review of Mortality report – Confidential;
- i. Review of VDH Root Cause Analysis - Confidential;
- j. Interview with prisoner(s) at NWSCF;

- k. Review of PHS Policies and Procedures;
- l. Review of DOC Policies and Procedures;
- m. Review of MHM Policies and Procedures;
- n. Online research regarding eating disorders.

DRVT did submit requests to the Department of Corrections, Prison Health Services and MHM Inc. to interview staff involved in Ms. Ellis' case. Our requests for those interviews were declined.

## **V. Sequence of Events**

On August 12, 2009 two days prior to Ms. Ellis reporting to the DOC facility Ms. Ellis' primary care provider in the community faxed 12 pages of medical records on Ms. Ellis to DOC's Health Services Director. There was a note by Ms. Ellis' doctor dated August 6, 2009 which read: *"S-Begins a one month prison sentence on 8/20/09. Continue on Suboxone, 8/2, 2QD. Continue with Potassium...A. - 1. Suboxone use. 2. Bulemia [sic]. 3. Low Potassium due to bulimia [sic]. 4. Social situation. 5. Depression. P - 1. Continue current medications. 2. I wrote a note for her to take that states her dose of Suboxone and encourages her to continue this in prison; otherwise, recheck in two months."* Also included was the discharge summary from Ms. Ellis' stay at RRMC in June of 2009 during which time she was treated with IV potassium, oral potassium and IV calcium.

According to the Vermont State Police Investigation Report based on an October 1, 2009 interview with DOC Health Services Director, she *"...verified she received the medical records by fax from [community physician]...on 08-12-2009. She advised she reviewed the records and faxed them to [PHS LPN # 1]...on 08-12-2009 (the fax date was incorrect...). [DOC Health Services Director]...advised she had two further correspondences whereby she sent 2 e-mails to [PHS LPN # 1]...The first e-mail was sent on 08-11-2009 where she told [PHS LPN # 1] ...that she would be receiving a complicated patient, whose name she... did not have at this time. She also included the patients [sic] diagnosis and medications. The second e-mail was sent the following day when she...learned of Ashley Ellis' identity. She also sent a more detailed diagnosis and medication information."*

There is a fax cover sheet from DOC's Health Services Director addressed to PHS LPN #1 on August 12, 2009 indicating that 12 pages of records from Ms. Ellis' community physician were faxed. However, the fax date stamp indicates the fax was sent and received at 2:34 a.m. on August 13, 2009. These records show that Ms. Ellis was being treated for low potassium as a result of bulimia and for

depression. The records also show that Ms. Ellis was being prescribed Suboxone,<sup>1</sup> Lexapro,<sup>2</sup> and Klor-Con.<sup>3</sup>

According to the Vermont State Police Investigation Report during an interview with PHS LPN #1 on October 1, 2009 they determined “[PHS LPN #1]...was the third person to have been faxed Ashley Ellis’ medical records [on August 12, 2009]. [Community physician]...originally faxed Ellis’ medical records to [DOC Health Services Director]...on 08-12-2009. [DOC Health Services Director]...faxed Ellis’ medical records to [PHS LPN #1]...on 08-12-2009 (the fax date and time are not accurate according to Doctor...as the time on their machine was off. The date handwritten on the actual fax is correct)...”

The Vermont State Police Investigation Report documented that PHS LPN #1 stated “...she worked the day shift on Thursday (08-13-09). She received Ellis’ medical records and reviewed them. In an e-mail sent to [PHS Regional Director] (who is based out of California), she [PHS LPN #1] sent her [PHS Regional Director] a summation of Ellis’ medical records...[PHS LPN #1] stated the medications that Ellis was currently prescribed (from Rutland Regional Medical Center 06-26-09). [PHS Regional Director] sent an e-mail back giving her...orders to order the medications for Ellis’ pending arrival (minus the Suboxone).

[PHS LPN #1] went on to state that she then transposed [PHS Regional Director’s] orders to their medical order form and she...put it on her desk to continue on Friday (08-14-2009).

[PHS LPN #1] came in to work Friday morning (0700-0730hrs). One of the two nurses on this shift did not show up. [PHS LPN #1] bypassed her responsibilities so she could assist the lone nurse by verifying medications for the 7-8 intakes they had. [PHS LPN #1] stated she was also scheduled for a meeting in Waterbury with [DOC Health Services Director]. She called her boss to request postponing this meeting so she could help the nurse that was at NSCC by herself. [PHS LPN #1] was contacted by her boss and told to attend the meeting. [PHS LPN #1]

---

<sup>1</sup> Suboxone is used to treat opiate addiction. Generic name: buprenorphine and naloxone. Suboxone can cause drug dependence. This means that withdrawal symptoms may occur if a patient stops using this medication too quickly, patients are warned to not stop taking Suboxone without first talking to their doctor. [www.drugs.com](http://www.drugs.com)

<sup>2</sup> Lexapro is a selective serotonin reuptake inhibitor, or SSRI. Lexapro has been proven to be an effective treatment for depression. [www.lexapro.com](http://www.lexapro.com)

<sup>3</sup> Klor-Con, Generic name: potassium chloride. Potassium is a mineral that is found in many foods and is needed for several bodily functions, especially the beating of your heart. Potassium chloride is used to prevent or to treat low blood levels of potassium (hypokalemia). Patients are warned to not stop taking this medication without first talking to their doctor as sudden discontinued use may case the patient’s condition to become worse. [www.drugs.com](http://www.drugs.com)

*stated she left the facility around 1045hrs, never having a chance to follow up on Ashley Ellis' medication order from the day before."*

Ms. Ellis reported to the correctional facility on August 14, 2009 and at 1:00 p.m. an officer in the Booking Unit completed a Special Observation Monitoring Sheet for Ms. Ellis.

On August 14, 2009 at 1:28 p.m. a licensed psychologist who treated Ms. Ellis in the community, faxed a letter and 13 pages of records to DOC's Health Services Director in the DOC Central Office. The letter recommended that Ms. Ellis be housed *"on a medical unit and that any refeeding efforts be directed by protocols appropriate to refeeding a severely malnourished individual. She also is quite depressed at this point in time..."*

There is a handwritten note on the original cover sheet of the licensed psychologist's fax that states *"Fax to...8/14/09."* The fax time stamp on the document shows that the documents were faxed to NWSCF on August 18, 2009 at 7:42 p.m. from DOC Health Services. The fax cover sheet from the DOC Health Services Director to the above individuals is dated August 18, 2009.

On August 14, 2009 at 2:20 p.m. a MHM mental health clinician met with Ms. Ellis in the Booking Unit. Her note reads in part: *"...Ashley said she was under the care of a physician, that she was taking Lexapro + that she had an eating disorder – she is a self-admit and will be here for 30 days. Inmate is prepared to go to Delta – f/u w/inmate to complete an evaluation / intake after med + security have completed intakes."*

On August 14, 2009 at 5:30 p.m. an Initial Needs Survey form was completed. Ms. Ellis was placed on 15-minute checks.

On August 14, 2009 at 9:00 p.m. a Mental Health Intake form was completed by a correctional officer in Booking.

On August 14, 2009 an Offender / Inmate Orientation to ADA form was signed by Ms. Ellis. Boxes on the form obtained from Ms. Ellis' DOC medical records are checked for "I do request a reasonable accommodation" and "I have been given a Request Form to complete." Upon reviewing this same form that was provided from her DOC Core File (not the copy from the medical records), the box indicating that she had been provided a request form was **not** checked off. Both copies appear to be of the same form and it is unclear at what point the box was checked on the version in the medical record.

On August 14, 2009 at 9:03 p.m. the PHS Intake Receiving and Screening form was completed by PHS LPN #2. This form states “*HX: recent medical hospitalizations – yes, low potassium. Pre-Admission Medications: Suboxone...last dose 8/14/09, Lexapro...last dose 8/1/09, Klor-Con...last dose 8/13/09, Folic Acid...last dose 8/8/09.*” It is noteworthy that there are 2 versions of this form: one handwritten version completed during the interview with Ms. Ellis, then a computerized version when the information was entered into the computer. On the handwritten version, under “Disposition” – it reads: “*Placement: GP, Referral: Routine.*” On the computerized version, under “Disposition” – it reads: “*Placement: GP, Referral: H&P – Expedited (within 3-5 days).*” There is no documentation describing the reason for this difference.

On August 14, 2009 at 9:45 p.m. a PHS Progress Note written by PHS LPN #2 read: “*PPD planted ® arm, needs meds verified at Kinneys, Bomoseen VT. Also Rutland pharmacy. See empty carton and bottles.*”

On August 14, 2009 at 10:50 p.m. there is a note in the Booking Unit Log that Ms. Ellis was moved to Delta D-40 (segregation).

On August 15, 2009 at 6:14 a.m. there is a note in the Delta Unit Log that Ms. Ellis refused her meal.

The Vermont State Police Investigation Report documented that during an interview with PHS LPN #3, on August 26, 2009, she stated that “...[PHS LPN #2] was [sic] have done Ellis’ initial medical intake on Friday night (08-14-2009). [PHS LPN #3] advised that she came in to work on Saturday (08-15-2009) at 0600hrs. She works a 12 hour shift, leaving around 1800hrs. [PHS LPN #3] went on to say that when she arrived on Saturday morning there were 5-6 charts on her desk. Around 0900hrs she was able to verify Ellis’ medications from the intake chart. [PHS LPN #3] does this by contacting each pharmacy. After that was complete she called [PHS Physician]...who prescribed the Klor-Con, Folic Acid and Tums.

[PHS LPN #3] advised that she then called Rite Aid in St. Albans to have the pharmacy fill a 3 day supply of Klor-Con. [PHS LPN #3] advised the facility has the Folic Acid and Tums.

[PHS LPN #3] went on to advise that she then called the evening nurse [PHS LPN #4] to see if she would pick up the inmate’s medications on her way in to work. [PHS LPN #3] advised she left voice mail for [PHS LPN #4] and apparently she didn’t get the message as [PHS LPN #4] came to work around 1740hrs and didn’t have any medications. [PHS



*LPN #3] advised that Rite Aid closes at 1800hrs so there would not have been enough time to go there and get the medication. [PHS LPN #3] advised that somebody probably would have gotten the medication on Sunday..."*

On August 15, 2009 at 9:15 a.m. a PHS Progress note signed by PHS LPN #3 documented: *"Meds verified @pharmacy. [PHS Physician] called. Orders rec'd – suboxone not ordered @ this time due to uncertainty re: length of stay. Will follow up on Mon for lot."* It is again noteworthy that when the PHS Progress notes were faxed to the Northwestern Medical Center on August 16, 2009 after Ms. Ellis was transported there, the only PHS note on this PHS Progress note form was the one dated August 14, 2009. However, when DRVT obtained these medical records from DOC Central Office, this sheet had three PHS notes on it, dated August 14<sup>th</sup>, 15<sup>th</sup> and 16<sup>th</sup>.

On August 15, 2009 it is documented on the Medication Administration Record (MAR) that Ms. Ellis received her morning dose of Folic Acid and Tums.

On August 15, 2009 at 11:00 a.m. there is a Physician's Order which states *"T.O. [PHS Physician] / [PHS LPN #1]. Klor-Con 20 meq two TID x5 days, Folic Acid 1mg PO qd x 30 days, Tums two BID x 30 days."*

On August 15, 2009 at 3:00 p.m. it is documented on the Medication Administration Record that Ms. Ellis did not receive her dose of Klor-Con because it was "out of stock."

On August 15, 2009 at 3:03 p.m. the Delta Unit Log notes that *"Nurse in w/ meds for...Ellis,"* despite that according to the MAR, Ms. Ellis did not receive any medication at this time.

On August 15, 2009 it is documented on the Medication Administration Record that Ms. Ellis received her night-time dose of Tums, but that she did not receive her night-time dose of Klor-Con because it was "out of stock."

According to the Vermont State Police Investigation Report based on an interview with PHS LPN #4 on September 29, 2009, she stated that on August 15, 2009 *"...she did in fact receive a voice mail from [PHS LPN #3] with that request. [PHS LPN #4] advised she did not listen to the message until the following day which usually is the case. [PHS LPN #4] stated that she works midnights and usually turns her cell phone off and often times doesn't get messages until the next day...[PHS LPN #4] stated that there is no requirement for any of the*

*nurses to pick up inmate's medications, but that they do it out of courtesy." The VSP report goes on to state that PHS LPN #4 "...told me when we first met that she was no longer employed there. [PHS LPN #4] advised that she quit as a result of the incident with Ashley Ellis. [PHS LPN #4] advised that she has been a nurse for approx. 21 years and did not want to lose her license. [PHS LPN #4] advised it was her impression that PHS had Ellis' medical report and her medications should have been at the prison when she arrived."*

On August 16, 2009 at 6:03 a.m. the Delta Unit Log documents that the food cart was in the unit and that by 6:20 a.m. the food trays were all delivered.

On August 16, 2009 at 6:33 a.m. there is a PHS Progress Note which states *"Med responded to M-33 on Delta – upon arrival, CO's informed medical that I/M was unresponsive [with] pulse. I/M was in knee-chest position [with] food sticking out of mouth, unresponsive [with] mottling beginning...Skin cool, color pale. Pupils fixed & dilated. Carotid pulse checked – faint pulse palpated – unable to count. Pulse-ox applied, low pulse recorded. Food removed from mouth. Heimlick [sic] procedure done x3 followed by back blows to attempt to dislodge any blockage [with] no effect. CPR initiated..."*

On August 16, 2009 at 10:30 a.m. there is a PHS Progress Note written, with a time of 6:33 a.m. which states *"Nursing staff called to a 10-33 in Delta unit. Upon arrival I/M was not breathing and was unresponsive...I/M remained unresponsive throughout CPR. Cyanosis was detected on lower extremities. 911 was called upon arrival. They arrived at 0650...Emergency team left the building at 0700 [with] I/M in the ambulance...All management notified of the incident... Approximately 0805, nursing staff was informed I/M had expired. Time of death was 0733..."*

On August 16, 2009 at 6:37 a.m. the Delta Unit Log states *"10-33 Medical call – Ellis, Ashley D-40 non-responsive, on bunk – hunched over – appears to be choking."*

On August 16, 2009 the Delta Unit video provided to DRVT for review has a time stamp which reflects that at 6:24 a.m. the 10-33 was called, not 6:37 a.m. as noted above. It is not clear if the time reflected on the video was correct, although staff interviews with VSP indicate the timestamp on the video was not correct.

On August 16, 2009 at 6:57 a.m. the Delta Unit Log states *"Ellis, Ashley D40 out with Amcare @ this time."*

On August 16, 2009 the Delta Unit video provided to DRVT for review has a time stamp of approximately 6:40 a.m. showing Amcare Ambulance leaving the prison with Ms. Ellis.

On August 16, 2009 a Facility Report form filled out by one of the correctional officers involved noted *"...I then asked staff to get a CPR mask. None could be found in Delta unit. I left the area to attempt to get one somewhere else. I looked in Booking, Control, B unit and the CFSS office and could not find one. I returned to Delta. I observed the nurse and CO II...performing CPR on the inmate..."*

On August 16, 2009 at 7:18 a.m. the medical office at NWSCF faxed some of Ms. Ellis' medical records to the hospital. Of note is the PHS Problem List, which on this date and time listed no identified medical problems and the PHS Progress Notes page, where only one medical note is documented for August 14, 2009. On August 30, 2009 when DRVT received copies of Ms. Ellis' medical record from the Department of Corrections, the PHS Problem List had *"H/O Low Potassium"* documented on it and the PHS Progress Notes page, which begins with the identical August 14<sup>th</sup> note that was faxed to the hospital, also has a note by PHS LPN #3 dated August 15, 2009 that was not on the original form faxed to the hospital by NWSCF on August 16, 2009.

On August 16, 2009 at 7:33 a.m. Ms. Ellis was pronounced dead at Northwestern Medical Center.

On September 30, 2009 the Chief Medical Examiner issued the Final Report of Autopsy listing *Hypokalemic induced cardiac arrhythmia due to anorexia / bulimia nervosa and denial of access to medication"* as the cause of Ms. Ellis' death.

The Vermont State Police Investigation Report documented that on October 6, 2009 the Detective spoke with an investigator from the AHS Investigations Unit and *"... asked Investigator...if he had the opportunity to interview [PHS LPN #2]. Investigator...advised he had only taken a taped statement from [PHS LPN #1]. I advised Investigator ...that the reason I was asking him about interviewing [PHS LPN #2] was to ascertain whether or not he had any paperwork regarding Ashley Ellis' medical issues when she reported to jail on 08-14-2009. Investigator...advised that [PHS LPN #2] did not receive anything from [PHS LPN #1] prior to his screening her on 08-14-2009. Investigator... advised that this information is contained in [PHS LPN #1's] statement. Investigator...agreed that Ellis was treated as a typical first time prisoner and was screened with no prior information."*

The Vermont State Police Investigation Report concludes: *“It appeared that Ashley Ellis’ medical records never left [PHS LPN # 1’s] desk.”*

## **VI. DRVT Findings**

Ms. Ellis’ death is an undeniable tragedy that could have been prevented by the Department of Corrections and Prison Health Services. It is evident that Ms. Ellis, her family, and her community providers did what was reasonable and sufficient to alert the Department of Corrections to her very serious medical needs and what medications she would require while serving her 30-day sentence. Unfortunately, despite these efforts, the Department and its contracted providers failed to keep Ms. Ellis safe while she was in their custody.

With that said, DRVT would also like to commend the NWSCF correctional officers who were on duty when Ms. Ellis was found on August 16th. Based on reports from other prisoners and professionals and DRVT’s review of relevant documentation, the correctional staff acted in accordance with policies in performing their duties under very difficult circumstances. DRVT recognizes and acknowledges that Ms. Ellis’ death has been a traumatic event for all involved.

DRVT identified the following specific areas of concern regarding Ms. Ellis’ death:

### **1. Lack of communication between medical providers.**

Despite the fact that three different physicians (DOC Health Services Director, PHS Regional Director, and PHS physician) were made aware of Ms. Ellis’ condition to varying degrees and at different times, it is not clear from the record that any of the various physicians actually shared information during the relevant time period.

DOC’s Health Services Director received medical records related to Ms. Ellis on two separate occasions, once before her incarceration and once on the day of her incarceration. One set of records was faxed to the health office at NWSCF on August 12<sup>th</sup>, two days before Ms. Ellis arrived. There is no documentation in Ms. Ellis’ DOC or PHS records to show (1) when those documents were received (2) who received them (3) who reviewed them, and (4) any medical decisions or discussions with the physician about the content of the records.

DRVT also found that the DOC Health Services Director sent two e-mails to PHS staff and MHM staff regarding Ms. Ellis' medical records, but again there was no documentation in Ms. Ellis' DOC medical record to indicate this information was received.

PHS LPN #1 received Ms. Ellis' medical records as faxed by DOC Health Services Director on August 12<sup>th</sup> as evidenced by e-mail correspondence that did occur between her and PHS Regional Director regarding the information in those records. Aside from the e-mail to the PHS Regional Director in California it appears PHS LPN #1 did not share the information from the August 12<sup>th</sup> faxed records with other providers at the facility. Neither PHS LPN #2 nor PHS LPN #3 had the information about Ms. Ellis that her community providers had intended them to have by sending that information to the DOC Health Services Director in the DOC Central Office. PHS policies did require that pertinent information be shared between health and custody staff when dealing with a special needs individual, which Ms. Ellis was. The PHS physician was the local onsite physician in charge of Ms. Ellis' care. It is not clear why neither PHS LPN #1 nor DOC's Health Services Director did not notify the PHS physician of the information sent by Ms. Ellis' community providers or why PHS LPN #1 elected to contact the PHS Regional Director on August 13<sup>th</sup> regarding Ms. Ellis' special medical needs rather than the local PHS physician.

The second set of records, those that the licensed psychologist faxed to the DOC Health Services Director at the DOC Central Office on August 14<sup>th</sup> were not faxed to the medical office at NWSCF until August 18<sup>th</sup>, 2 days after Ms. Ellis' death, even though the DOC Health Services Director had written a fax cover note indicating those records should have been faxed on August 14<sup>th</sup>. DRVT was unable to identify who was responsible for actually faxing these documents and why they were not sent until 2 days after Ms. Ellis died.

DRVT concludes that PHS LPN #1 violated specific standards identified below by not accurately updating Ms. Ellis' medical records to reflect records received and her e-mail correspondence with the PHS Regional Director and by not sharing the information about Ms. Ellis that she had in her possession with other nurses on duty.

**VT DOC Medical Health Services Contract 2007, Page 35:**

*The Contractor must ensure that health records are kept current. Each encounter between a health care provider and an inmate must be documented in the health record by the end of each staff shift to ensure that the providers coming onto the next shift are aware of the medical status of any inmate treated during the prior shift.*

**PHS Policy P-A-08 Communication on Special Needs Patients**

*To ensure communication occurs between the facility administration and treating clinicians regarding inmates' significant health needs that must be considered in classification decisions in order to preserve the health and safety of that inmate, inmates, or staff.*

1. *Inmates received into the facility will be assessed and reassessed as needed by healthcare staff. The medical information will be reviewed for special needs that may affect housing, programs, and work assignment. This information will be shared as needed with the jail administration, and such communication will be documented.*
2. *Health and custody staff will communicate about inmates who are:*
  - *Chronically ill,*
  - *On dialysis,*
  - *Adolescents in adult facilities,*
  - *Physically disabled,*
  - *Pregnant,*
  - *Frail or elderly,*
  - *Terminally ill,*
  - *Mentally ill or suicidal, or*
  - *Developmentally disabled.*

In addition to PHS LPN #1's negligent conduct noted above, DRVT suggests additional review be made regarding the lack of communication between the DOC Health Services Director, PHS Regional Coordinator and local PHS physician regarding the imminent arrival and eventual treatment of Ms. Ellis. The failure of those leaders in DOC's medical provider system to assure that providers on duty and caring for Ms. Ellis had the

relevant information about her fragile condition illuminates a problem that should also be specifically addressed.

## **2. Medications**

The Department had sufficient warning to plan for and obtain the needed medication for Ms. Ellis, but failed to do so. According to the medical examiner's report, the lack of Klor-Con, a drug to treat low potassium, was identified by the Medical Examiner as having a significant role in Ms. Ellis' death. Rather than following an adequate process to acquire the medication from a community pharmacy once they realized they needed it but didn't have it in stock, PHS staff used an informal voicemail process to obtain the needed medication, an informal process that failed to work.

PHS staff violated the following contractual requirement and national standard by not having Ms. Ellis' required critical medication on hand when she arrived:

### **VT DOC Medical Health Services Contract 2007, Page 18:**

*W. Pharmaceuticals – Contractor shall provide a total pharmaceutical system in compliance with NCCHC standards that is sufficient to meet the needs of the DOC inmates. Contract shall also be responsible for the acquisition, storage and administration of pharmaceuticals.*

### **NCCHC Page 61, P-E-02: Receiving, Screening: #9.**

*Prescribed medications are reviewed and appropriately maintained according to the medication schedule the inmate was following before admission.*

## **3. Documentation in medical record after Ms. Ellis' death**

Both the PHS Problem List and PHS Progress Notes from the time period between Ms. Ellis' admission on August 14<sup>th</sup> and her transfer to the hospital on August 16<sup>th</sup> were obtained from various sources by DRVT. DRVT received a copy from the hospital indicating that on August 16<sup>th</sup> at 7:18 a.m. the medical office at NWSCF faxed the PHS Problem List to the hospital. That document listed no identified medical problems. However, a copy of the same form received from DOC on August 30, 2009 had "H/O Low Potassium" documented on the Problem List.

Similarly, the copy of the PHS Progress Notes supplied to DRVT by the hospital had only one medical note documented for August 14th. When DRVT received copies of Ms. Ellis' medical records from the DOC, the PHS Progress Notes page now also had a note by PHS LPN #3 dated August 15th which was not on the form when faxed to the hospital.

These conflicts between the copies of the forms could mean that the hospital did not receive the most current information from NWSCF medical department regarding Ms. Ellis' care and conditions.

PHS medical staff violated the following contractual requirement by not making timely notes in Ms. Ellis' medical record:

**VT DOC Medical Health Services Contract 2007, Page 35:**

*The Contractor must ensure that health records are kept current. Each encounter between a health care provider and an inmate must be documented in the health record by the end of each staff shift to ensure that the providers coming onto the next shift are aware of the medical status of any inmate treated during the prior shift.*

**4. Communication between mental health and medical staff.**

The MHM mental health clinician at NWSCF met with Ms. Ellis while in booking on Friday, August 14, 2009 at approximately 2:20 p.m. DRVT could find no evidence that this clinician discussed any of Ms. Ellis' medical issues with the medical staff, even though she documented in her note that Ms. Ellis had an eating disorder and stated she was currently under the care of a physician for that eating disorder, and was taking a mental health medication. Nor is there any evidence that this clinician did any kind of follow up on Ms. Ellis' status after the medical and security intakes were completed on August 14, 2009.

It is thus likely that this clinician violated the following standards as outlined in the contract for services between DOC and MHM:

**State of Vermont Contract for Services between AHS/Department of Corrections and MHM Services, Inc.**



## *II. Mental Health Services*

*3.1 A qualified mental health professional must conduct structured interviews with all inmates who screen positive for mental illness during the intake screening processes or who are referred for mental health services in accordance with referral guidelines. The mental health assessment will be conducted in coordination with the Responsible Health Care Authority (Medical Vendor's Medical Director or designee) at each site, according to timeframes that insure the safety and timely treatment of all inmates who have been triaged as follows:*

*emergent – Inmates in need of immediate medical / psychiatric attention are either transferred to a specialty unit capable of providing twenty-four (24) hour observation and care, or are placed on suicide watch until more suitable arrangements can be made and/or a complete mental health assessment is conducted.*

Likewise, there is no documentation to reflect that PHS nursing staff initiated any discussion with mental health about Ms. Ellis.

PHS staff violated the following contractual agreement by not communicating with the mental health providers upon Ms. Ellis' intake.

### **VT DOC Medical Health Services Contract 2007, Page 40:**

*G. Interface with DOC's Mental Health Services Provider – Contractor shall establish procedures to ensure an ongoing active interface with the DOC's Mental Health Provider system...The purpose of the interface between the parties is to ensure coordination of care occurs for inmates being treated for both physical and mental health problems.*

It seems clear that medical staff and mental health staff in the facility had only very limited knowledge about Ms. Ellis' complex treatment and safety needs as evidenced by the lack of documented and informed interchange between all relevant service providers within the DOC system in this case.

Furthermore, had the licensed psychologist's record been sent to the MHM mental health clinician when they were received, she would have had them before meeting with Ms. Ellis on

August 14<sup>th</sup> and that could have changed the outcome for Ms. Ellis.

**5. Lack of consideration of potential for detoxification issues related to not providing opiate addiction drug as prescribed in the community.**

DOC and PHS medical staff, specifically the DOC Health Services Director, PHS Regional Director and local PHS physician, were all aware that Ms. Ellis was actively being treated with Suboxone for her opiate addiction. Both the local PHS physician and PHS Regional Director gave orders to discontinue the Suboxone because of the “uncertainty” in Ms. Ellis’ length of stay. From the records DRVT reviewed there was no uncertainty found regarding the length of Ms. Ellis’ stay. Neither PHS physician attempted to contact the DOC Health Services Director or other DOC officials to inquire about the length of stay issue. The records reviewed by DRVT did not include any documentation of consideration by Ms. Ellis’ DOC medical providers about the impact on Ms. Ellis that the decision to halt her suboxone prescription may have had on her, nor any discussion about the need or advisability of beginning detoxification monitoring protocols given the decision to halt the suboxone prescription.

PHS medical staff violated the following contractual agreement by not properly monitoring Ms. Ellis for withdrawal, given the fact that they were discontinuing her Suboxone treatment:

**VT DOC Medical Health Services Contract 2007, Page 19:**

*b. Medication Assisted Therapy for Opiate Addiction – Contractor shall comply with DOC policy on Suxobone [sic], Methadone, Buprenorphine and other medication-assisted therapies for opiate addiction.*

Contractor shall work with DOC to ensure that medication assisted therapy for the treatment of opiate addiction is available to inmates, as determined by and in agreement with DOC policy. Contractor shall also be expected to participate in the identification of potential candidates and coordination of such treatment.

## **6. Placement in segregation rather than in the infirmary.**

Based on the suggestion of her community treatment providers, Ms. Ellis should have been placed in the infirmary after her medical and security intakes were completed. Instead she was placed in the Delta Unit, a segregation unit, apparently due to lack of bed space in general population. DRVT found insufficient documentation in the medical records to determine that medical staff assessed and agreed with this placement decision.

PHS medical staff violated the following policy by placing Ms. Ellis in Delta Unit with no written documentation to indicate that this placement and Ms. Ellis' medical condition was given due consideration.

### **Prison Health Services Policy, Segregated Inmates P-E-09, #1.**

*Upon notification that an inmate is placed in segregation a qualified health care professional reviews the inmate's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation. Such a review is documented in the health records.*

## **7. Lack of adequate nursing coverage at facility.**

The contract between PHS and DOC required having a registered nurse (RN) on duty during the evening shift at NWSCF every day of the week. From records reviewed there is no documentation that an RN was on duty when Ms. Ellis entered DOC, or at any other time during her incarceration. It is possible that had the contract been fulfilled in this area and a higher practice level of professional such as an RN had been on duty and available to assess Ms. Ellis upon intake, a different course of treatment or evaluation of the impact of the treatment provided would have occurred and changed the outcome for Ms. Ellis.

Also concerning is that PHS LPN #1 did not fulfill her job duties on Friday, August 14, 2009 in part because another nurse did not come to work. PHS LPN #1 told the VSP that due to being shorthanded, she made the decision to not process Ms. Ellis' medical information and instead assisted PHS LPN #3 with other new intakes. DRVT found no evidence that PHS or DOC

had a plan in place to assure that when a medical staff person was out sick that another staff person would be called in to fill that open position nor that any such effort was made for the shift in question.

PHS medical staff violated the following contractual obligation by failure to adequately cover a nursing shift:

**VT DOC Medical Health Contract 2007, Page 46:**

*e. Staffing Standards and Coverage: It shall be the Contractor's final responsibility to fill all posts in accordance with the staff standards and coverage schedules per Attachment G...Contractor must also ensure that no shift is left uncovered. Attachment H reflects the minimum staffing required by facility, by shift, by type of clinical staff for Contractor to avoid a penalty under this provision. Contractor may, at its discretion and cost, fill clinical positions with lower or higher practice level professionals without penalty provided that clinical staff are not asked to operate outside of their scope of practice to cover a shift.*

**The following sections identify information that was available to DRVT under our federal access authority that cannot be shared with the public in this report due to the confidentiality requirements of our access authority.**

**VII. PHS Mortality Report**

DRVT received the PHS Mortality Review relevant to this investigation pursuant to our federal access authority and an agreement with PHS.

**VIII. VDH Root Cause Analysis Report**

DRVT received the VDH Root Cause Analysis Report relevant to this investigation pursuant to our federal access authority. DRVT will be providing comments regarding that review to DOC and VDH directly.

**IX. DOC Administrative Review of Mortality**

DRVT received the DOC Administrative Review of Mortality Report relevant to this investigation pursuant to our federal access authority. DRVT will be providing comments regarding that review to DOC directly.

**X. AHS Investigations Unit Report**

DRVT received the AHS Investigation Unit Report relevant to this investigation pursuant to our federal access authority. DRVT will be providing comments regarding that review to the AHS Investigations Unit directly.

**XI. Conclusion and Recommendations**

DRVT concluded that Ms. Ellis' death would have been avoided had appropriate communication and planning occurred between medical providers working for DOC. Due to identifiable failures by DOC and its contractors to communicate and plan, Ms. Ellis' community providers' efforts to insure adequate medical treatment of their patient once she came with the DOC's control and custody proved insufficient. Areas of significant concern and suggested for further review and remedial action include the lack of adequate communication between the DOC Health Services Director and facility medical staff and PHS physicians specifically. Clearly the DOC Health Services Director received important information about Ms. Ellis and made an effort to forward this information to the facility medical staff. The failure to follow up and assure that the information arrived and was reviewed by the appropriate facility personnel, as well as the failure to access PHS physicians to assure that this complicated new patient was treated appropriately should be reviewed and systems put into place to avoid this kind of miscommunication in the future.

PHS medical providers' failure to communicate with other facility staff and to assure that medication was obtained, either prior to Ms. Ellis' admission or soon thereafter, also contributed to her death. The failure of PHS to have adequate medications, specifically Klor-Con, in stock or to know to order it when they had knowledge it would be needed is also an area needing improvement. Finally, the decision by PHS doctors to discontinue Suboxone without initiating detoxification procedures was also a relevant omission in Ms. Ellis' death.

There was a staffing deficiency within the medical department at NWSCF during Ms. Ellis' stay that contributed to poor decision making and failure to follow through with physician's orders, a situation that should not be allowed to be repeated.

In addition, as noted by other commentators on Ms. Ellis' death, the lack of a registered nurse on duty during Ms. Ellis'

admission and stay appears to be a contributing factor to the failure to properly identify the risk and needs presented by Ms. Ellis.

Finally, it appears that documentation was added to Ms. Ellis' medical records after she died based on the differences between the documentation faxed to the hospital and those provided by the DOC from Ms. Ellis' medical file. Any decision to augment such medical records after the fact deserves added scrutiny and appropriate disciplinary action.

### **Recommendations**

1. Department staff and contractors should receive verifiable and ongoing staff training in recognizing and reporting behaviors that are potentially life threatening for the individual experiencing them;
2. The Department should assure, through repeated testing, that policies, directives, and procedures are taught to all staff and contracted employees and that these rules are followed consistently;
3. The Department should assure, through repeated training and random record reviews, that nursing staff are correctly documenting medication administration times and that physician's orders are properly written and carried out;
4. The Department should assure that physicians follow up on their orders for prisoners who have complicated and potentially life-threatening medical and/or mental health conditions when they enter DOC and that the physicians adequately supervise the medical staff;
5. Department staff and contracted providers who violated policies or standards of care should be terminated and complaints should be filed with the appropriate licensing agencies;
6. The management of severe withdrawal and detoxification should no longer be done in the correctional setting. The Department should develop a policy whereby this type of treatment is conducted only in a licensed acute care facility in order to prevent future deaths from the failure to adequately monitor and treat life-threatening withdrawal situations;

7. The Department should strictly monitor the care provided by the contracted medical provider and consider changing the manner by which medical care is provided within the Vermont system, i.e., making it a not-for-profit venture.

8. The Department should create a policy that clearly identifies the process to follow when medical information about an incoming or current prisoner is received at the DOC Central Office. This policy should require that, in cases where the medical information received is important to adequate patient care, the information is promptly, and at least within 2 hours, forwarded to both the medical department at the appropriate facility and the contracted physician in charge, with verification that the information is received and reviewed. In addition, a policy should be created that requires facility contracted medical providers and mental health providers to document their review of community provider information and information received from the DOC Central Office relevant to patient medical care. This policy should also require any medical decision to discontinue medication be accompanied by a detailed description of what risks are involved and whether or not, and on what basis, detoxification protocols will be implemented if applicable.

9. The Department and its contracted providers should assure that registered nurses rather than licensed practical nurses are on duty during nights and weekends at each facility in order to provide for adequate assessment and evaluation of all medical needs and circumstances.