STATE OF VERMONT
Agency of Human Services
DEPARTMENT OF CORRECTIONS
103 South Main Street
Waterbury, VT 05671-1001

RECEIVED
FEB 20 2007
BY:

February 15, 2007

Ed Paquin, Executive Director
Vermont Protection & Advocacy, Inc.
141 Main Street, Suite 7
Montpelier, VT 05602

Dear Mr. Paquin,

Thank you for sending your thorough review of Mr. Estabrook's incarceration up to and including his death at Fletcher Allen Health Care from complications associated with his cardiomyopathy.

I have discussed it with our Health Services Director Susan Wehry, M.D., Facilities Executive Bob Kupec and Deputy Commissioner Andy Pallito.

Your areas of concern were as follows.

1. **Medical Furlough Issues**

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

While it is true that Mr. Estabrook *would have been able to receive this quality/level of care in a community setting,* it is not clear he would have elected to do so. At the time of the initial review of his request for a furlough, his cardiologist indicated Mr. Estabrook had in fact been quite non-compliant, to the point he (Dr. Wingett) envisioned he may have to discharge him from his care.

However, the question we ask is not whether he could/would get what he needs in the community, but conversely, whether or not he can get what he needs in the correctional setting. The answer to that was yes.

We agree his medical condition was complicated. Though the severity of his underlying heart disease ultimately resulted in his death, he suffered from a host of disorders, including lung disease, substance abuse and depression, for which he received care as well. As to your speculation that his symptoms were ignored at SSCF, we do not agree

this conclusion is supported by the record. Mr. Estabrook was monitored regularly by nursing staff, was seen regularly by the on-site physicians and had regular access to off-site specialty consultation. In this controlled environment, he also had less access to substances of abuse.

You allege there is no evidence that the caseworker pursued the medical furlough request. In response to your request for information, Dr. Wehry did provide you with documentation of her review of Mr. Estabrook's condition beginning with his call to the 1-800 line in May 2005 and her response to his caseworker on June 23, 2005. These email communications clearly document the caseworker's request for review, Dr. Wehry's acknowledgement that she was new to the system, her request for direction and subsequent review of the relevant directive. You may disagree with her decision, but the emails document that the appropriate steps were followed. We do agree there is not adequate documentation of later efforts to obtain compassionate furlough.

In 2004, it appears Mr. Estabrook was granted a furlough because it was believed he suffered from a terminal condition. As you likely know, the regulatory definition of a terminal condition presumes that death is likely within six months. A year later, his condition, though very serious, was not considered terminal. Dr. Wingett's description of Mr. Estabrook's cardiac condition in June 2005, as "relatively tenuous" does not in our view refute this. When dealing with someone this chronically ill, with potentially life threatening, inherently "unstable" chronic conditions further complicated by continued substance abuse, all judgments are relative. In June 2005, Dr. Wehry found Mr. Estabrook's condition to be chronic, serious, and relatively speaking, stable.

2. Infirmary

In your opinion, *Mr. Estabrook should have been moved to the infirmary when he made this request in January, 2006.* The decision to move someone to the infirmary is a medical one and can only be made by the Medical Director. This is a judgment call and like so many other medical decisions rests, in part, on a point in time assessment and, in part, knowledge of a case over time. This is in keeping with the community standard of care where a decision to hospitalize is made by a physician. It is not uncommon for a patient to feel as though s/he needs to be hospitalized and the physician believing a particular situation can be managed outside the hospital. Mr. Estabrook was in a special medical housing unit at the time of his request.

3. Medication Issues

In your opinion, *the frequency and length of time that critical medications were not available…is unconscionable.* This opinion appears to rest on a selective reading of the medication administration record (MAR). According to a review by our Health Services

Division, a more complete picture of the situation with Mr. Estabrook's medication in February (1st - 22nd) is as follows:

a) Amiodarine 200 mg was administered according to the order twice daily from February 1-16. On the 16th, he appears to have refused the morning dose but took the evening dose. On the 17th, he did not receive either dose. The MAR seems to indicate the morning dose was missed because the medication was out of stock; it is silent on the reason he did not receive the evening dose. On the morning of the 18th, he missed a dose because it was out of stock; he received an evening dose. He received both doses on the 19th and 20th, refused his morning dose on the 21st and took it in the evening.

b) Lasix 40 mg was ordered for every evening. Mr. Estabrook refused 7 of the 21 doses he was schedule to take.

c) Lasix 80 mg was ordered twice daily. Mr. Estabrook received all doses except one morning dose he refused on the 20th.

d) Coreg 12.5 mg was to be taken twice daily. No missed doses during this period.

e) Lisinopril 10 mg was ordered for once daily administration. Here the MAR does indicate a recurring problem with keeping this medication stocked. Mr. Estabrook received this medication from Feb 1-9th. It was temporarily out of stock and he did not receive it on the 10th or $11^{th.}$ It should have been ordered from the local pharmacy on the 10th and it is not clear why this was not done. He received it on the 12th but not on the 13^{th-} 15th, refused it on the 16th and 17th. It is reported as out of stock on the 18th and 19th. The entries on the 20th-22nd are difficult to interpret. It is not possible to tell if it were out of stock or if he again refused it.

f) Warfarin 2mg ordered and received daily except for one dose on Feb.10th.

g) Nitro-Dur patch was applied daily as ordered except for the 11th when it was held; from the 13th -21st he appears to have refused it.

h) Levothyroxine was ordered for daily administration. He appears to have missed 10 doses because of his refusal to take it and 1 dose because it was out of stock.

You are correct that when a medication is out of stock, our contractor is expected to fill the order at the local pharmacy. This expectation does not seem to have been met consistently in the case of the Lisinopril. We do hold our contractor accountable for

failure to meet their contractual obligations regarding the pharmacy. In CY2006, penalties of $ 36,000.00 were assessed against them.

Mr. Estabrook entered Fletcher Allen on February 22nd, 2006 and died almost two weeks later. Five days prior to his death, he was reported to be doing better. His condition then worsened. We do not agree that missed doses of temporarily out of stock medication two – three weeks prior to his death likely contributed to his death. Additionally, given his overall health condition, Dr Wehry does not believe his repeated refusal to accept medication had a material impact on his death.

4. DNR Issues

In your opinion, *the unethical issuance of a written DNR by a Prison Health Services physician for Mr. Estabrook is shocking.*

I am unclear what you found unethical in the PHS' physician's attempt to honor an advance directive written by Mr. Estabrook on November 30, 2005. The presence of the document in his chart is witness to the effort to communicate his wishes. While there may be no written *evidence that anyone within the medical system took time to discuss what a DNR is and how it is carried out*, Dr. Wehry believes this occurred, but admittedly doesn't have definitive proof. There was a great deal of discussion at the time about Mr. Estabrook's handwritten document and whether or not it was acceptable. I am assured the staff did confirm with him he understood it.

We agree the documentation was inadequate and as you know from the documents provided to you by Dr. Wehry, this was addressed.

Your comment, "[an] *example of overall questionable medical practices by DOC and its contracted providers* is unfair and disappointing, especially in light of the progress made in our health care services over the last two years. Our new directive on End of Life Care speaks to our commitment to continuous improvement in this area. I am confident that if we did not seek to honor Mr. Estabrook's handwritten request that we would be criticized for that as well.

5. DOC's Mortality Review Completed 3/23/06

VP&A finds this review to be grossly lacking factual information and its conclusion questionable.

The mortality review process follows a standardized format based on national guidelines approved by the National Commission on Correctional Health Care (NCCHC). It includes review of the medical record by a physician who was not party to the care, an

analysis of that care and a peer review composed of physicians who both were and were not directly involved in the care of the person under review. This peer review committee is a standing committee of the Executive Health Committee and is designed to allow a frank discussion of the care provided prior to and at the time of death and attempts to answer the following questions:

- was the death expected or unexpected;
- did the care provided contribute to the outcome (death); and,
- regardless of whether or not the care contributed significantly to the outcome, did it meet community standards?

In Vermont, we have added a fourth category of inquiry, though this is not required by the national standards. This last question is,

- regardless of the above, are there any systems issues which need to be addressed through a root cause analysis process?

We provided you with a copy of the findings of the peer review.

You are certainly entitled to disagree with the conclusions reached by Dr. Wehry and the other physicians who reviewed this case. I would hope, however, that you would acknowledge that the Department of Corrections has instituted and is adhering to a more formal and structured process than has existed in the past.

Recommendations

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

We do not concur there were a number of policy violations.

We do agree that issues related to end of life discussions are critically important and to that end we initiated a new directive on March 30, 2006 with which I believe you are familiar. This directive addresses many of your concerns related to protection of the rights of terminally ill persons and training of staff and contractors. Our current contractor also has conducted training on end of life issues.

Mr. Estabrook was a young man with many health issues, including severe heart disease which ended his life. His end of life course was complicated by his behaviors, which resulted in his re-incarceration and by our decision not to grant him his request for a

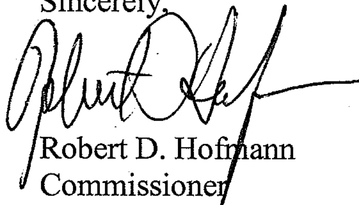
furlough. In the final analysis, we do not feel it is possible to know exactly what contribution his last year of incarceration had on the ultimate outcome but think it is equally likely his life was extended by his regular access to medical care, medications and outside specialists. According to Dr. Wingett, this was not something that Mr. Estabrook had consistently used during his previous furlough.

Mr. Estabrook's death, like all critical incidents, does provide an opportunity for us to look at our practices and those of our contractors and to improve our care. The peer review process, which includes both expected and unexpected deaths, allows for the objective and thorough review you suggest and complies with national and professional standards regarding the reporting of the findings.

I respect your vigorous advocacy on behalf of inmates such as Mr. Estabrook. If you have knowledge of other inmates whose furlough was denied and you would like to have it reviewed, we are happy to do so, but as I mentioned when I called a few days ago, I am very unlikely to approve medical furloughs to the community for chronic DUI offenders while they are still able to operate a motor vehicle. While Mr. Estabrook's condition declined over time (and with it his ability to get behind the wheel of a car), he had been convicted of DUI six previous times.

We and our medical colleagues will continue to strive to provide compassionate and effective medical services to the thousands of inmates who are incarcerated in our facilities during the course of the year.

Sincerely,



Robert D. Hofmann
Commissioner