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Re: John Doe
Treatment Review

The Department of Corrections for the State of Vermont requested a review of the mental health treatment John Doe received during his 2003 and 2004 incarceration with a specific focus on the Lithium treatment. The following records were reviewed for this evaluation:

1. Vermont Department of Corrections file related to John Doe's 1994-1998 incarceration
2. Vermont Department of Corrections file related to John Doe's 2001-2002 incarceration
3. Vermont Department of Corrections file related to John Doe's 2003-2004 incarceration
4. Vermont Protection & Advocacy Report dated October 2004,
5. Department of Corrections Mental Health Directive & Protocols.

1994 to 1998 Incarceration Records

The Vermont Department of Corrections (DOC) file related to Mr. Doe's 1994 to 1998 incarceration indicates in the Correctional Medical Services records that Mr. Doe was diagnosed with Bipolar Disorder, hypertension and pedophilia. On the intake assessment dated 6/13/1994, Mr. Doe reported that he had had been prescribed Lithium 750 mgs daily for four years for Bipolar Disorder through the Counseling Service of Addison County (CSAC) where he had been followed. Mr. Doe said he had been last seen there on 11/23/1993. A Lithium level from June 1993 of 0.70 was reported. Records were requested from the CSAC on 6/14/1994.

The CSAC records were sent on 9/6/1994. The records were reviewed by mental health staff in corrections on 9/12/1994. In the CSAC records, the Emergency Examination of 7/2/1989 reported Mr. Doe having Bipolar Disorder Manic State. He was paranoid, grandiose and preoccupied with religious delusions. His behavior was disorganized and dangerous to himself

and others. It was not known if he had been taking medication. The Vermont State Hospital (VSH) admission of 1989 was noted. It was described how he had been stabilized at VSH with Lithium 1200 mgs daily and Loxitane 20 mgs daily. His 7/29/1989 Lithium level had been 1.09. After his return to the care of CSAC, as of 10/18/1989, Loxitane was discontinued. On 2/7/1990, a Lithium level of 1.25 was obtained. On 5/2/1990, this Lithium level was noted to have been 1.25 in January 1989 at a dose of 1200 mgs daily. His dose was reduced to 900 mgs daily. On 5/7/1991 it was noted how his Lithium level on 600 mgs daily had been elevated at 1.02. His Lithium had been increased from 600 mgs daily to 900 mgs daily on 10/11/1991 due to stress and anxiety. It was decreased from 900 mgs daily on 12/21/1991 due to sedation. The Lithium level was 0.96. He was assessed as stable.

Mr. Doe remained relatively stable during this incarceration. In a 6/14/1994 psychiatric evaluation it was recommended that Lithium 900 mgs daily be restarted. This recommendation was not followed. He was prescribed Lithium 750 mgs daily until it was reduced to 600 mgs daily by 6/30/1997 due to some concern regarding a reply from 'Capstone.' He was also prescribed Lisinopril, Accupril and Vasotec at different times for his blood pressure. On 12/5/1997, a low salt diet was advised.

From the records provided, Lithium levels were ordered and drawn approximately every three months starting on 7/5/1994 and ending 12/16/1998. There was an extra level drawn in 1996 likely related to a concern about elevated TSH levels. BUN and Creatinine were drawn every nine months on average and remained within the normal range. The laboratory results were generally signed off within one week with few exceptions where the time lapse was two weeks or one month or there was either no dated signature or no signature at all. On 6/10/1997, Mr. Doe had a Lithium level of 1.13. This was signed off by medical staff on 6/13/1997. On 6/28/1997, mental health staff increased Mr. Doe's Lithium level from 750 mgs daily to 900 mgs daily. Mental health staff reviewed the 1.3 Lithium level on 6/30/1997. On that date they decreased the dose from 900 mgs daily to 600 mgs daily.

2001 to 2002 Incarceration Records

The Vermont Department of Corrections file related to Mr. Doe's 2001 to 2002 incarceration document in the Correctional Medical Services records that he was diagnosed with Bipolar Disorder and hypertension during this stay. Record releases were obtained for VSH and Rutland Mental Health Services (RMHS). There is no available documentation to indicate any outside records were received during this incarceration.

Mr. Doe remained relatively stable during this incarceration. He was prescribed Lithium 900 mgs daily starting on 1/9/2001. This dose was reduced to 600 mgs daily on 8/1/2001 but noted in the progress notes on 10/26/2001. He was also prescribed Prozac 20 mgs daily. Zoloft 100 mgs daily had been prescribed but was discontinued while in Virginia. He was also prescribed Cardura 2 mgs daily and Vasotec 10 mgs daily. His corrections Discharge Health Summary dated 10/21/2002 indicated he was taking Prozac 20 mgs daily, Lithium 600 mgs daily, Cardura 1 mgs daily and Vasotec 15 mgs daily. Regarding blood chemistry laboratory results, Lithium levels were obtained between 2/8/2001 and 8/7/2002 in approximately three month intervals. They were signed off and dated generally within two weeks but that could extend up to one

month. BUN and Creatinine levels remained in the reference range. While in Virginia, the Lithium level on 7/11/2001 was 1.3. This was signed off on 7/12/2001. On 8/1/2001, the Lithium dose was reduced to 600 mgs daily as noted in the Virginia medical notes. An EKG on 4/30/2002 was normal.

2003 to 2004 Incarceration Records

On 10/15/2003 John Doe was incarcerated at MVRCF. It was reported by Mr. Doe that he had been prescribed Lithium since 1989 and Prozac for 18 months. Discharge Summaries for his two admissions at the Vermont State Hospital were ordered. He signed a release for records from Mark Messier, MD. Mr. Doe also signed an undated release for VSH records at some date.

On 10/16/2003, he was assessed with Bipolar Affective Disorder that was well controlled with Lithium and Prozac. Medical records were requested by fax from Mark Messier MD.

The Mark Messier, MD records were received by corrections although the date is not clear. These records document that Dr. Messier had regular interaction with RMHS regarding his treatment of Mr. Doe. In 1999, the Lithium dose was reported as 600 mgs daily. Mild hypertension was reported. As of 11/22/1999, the EKG was normal sinus rhythm although some specific abnormalities were described. In 2000, the Lithium dose of 900 mgs daily was thought to possibly be causing increased sedation. Both Vasotec 15 mgs daily, but reduced to 10 mgs daily, and Cardura 2 mgs daily (started in corrections) were initiated in 2002. Lithium dose was 600 mgs daily at that time. He was also taking Prozac instead of Zoloft, which he had been on previously. In 8/20/2003, his Vasotec was reduced to 5 mgs daily. Laboratory results in the Messier records for Lithium, BUN and Creatinine indicated that as of 12/30/2002, the BUN was elevated at 21 (Reference Range 7-18). Other results were within the reference range with Creatinine at 1.2 (Reference Range 0.6-1.3) and the Lithium level was at 0.9. On 4/29/2003, the BUN remained elevated at 22 while the other results were in the reference range with a Creatinine of 1.3 and the Lithium level of 0.80. These were signed off but undated.

In corrections on 10/17/2003, a Lithium level, BUN, Creatinine and TSH blood levels were ordered. He was assessed by the psychiatrist as doing relatively well. The diagnoses were Personality Disorder, Rule Out Bipolar Affective Disorder and Alcohol Dependence in Remission. A reevaluation was to occur in two months. A fax was sent to VSH for the records. VSH acknowledged copying these records in an undated note. These records were also received by corrections although the date of receipt in not noted.

The VSH records relate to John Doe's 1984 and 1989 admissions. The 1984 admission was on an Order of Observation related to a criminal charge. No psychiatric treatment was provided and no diagnosis was made. The 1989 admission was to an Emergency Examination due to bizarre behavior. He had been naked, with scissors, contemplating circumcision. He was grandiose, hallucinating, loose in his associations and with a euphoric mood. He was initially diagnosed with Schizophrenia but by discharge his diagnosis was revised to Bipolar Affective Disorder Manic with Psychotic Features. He had improved during his six week stay. There was also a history of alcohol abuse. On discharge he was prescribed Lithium 1200 mgs daily and Loxitane 20 mgs daily. His last Lithium level was 1.09.

In corrections on 10/22/2003, Mr. Doe was described as being angry, scattered, frustrated and having difficulty coping. Mental health treatment was added to his plan. On 10/28/2003, the Lithium Level was 0.80 (0.6-1.4), BUN was 22 (5-26) and Creatinine was 1.1 (0.5-1.5). This report was not signed off with a date. The report indicates having been faxed to 8027739867 on 1/26/2004 and therefore may not have been known to staff during his deterioration.

In November, on 11/13/2003, weekly blood pressure and pulse readings were ordered for 12 weeks. Mr. Doe was noted to be pressured, disorganized in thinking, having mood swings and being slightly manic. Urinalysis showed normal specific gravity. On 11/23/2003, the EKG was performed and read as abnormal, strongly suggestive of myocardial injury/ischemia. On 11/25/2003, he was tangential but not pressured.

In December, on 12/4/2003, he was angry, disorganized and paranoid about the Department of Corrections. On 12/12/2003, he was singing and making sexualized remarks. On 12/14/2003, he was assaulted by another inmate and he was moved for his safety. On 12/15/2003, Mr. Doe was described as dealing with situational stresses and coping effectively. On 12/18/2003, his behavior was escalating. He was bizarre and "dementia like."

On 12/19/2003, the Interdisciplinary Notes indicate he was anxious and confused. He was having a psychotic episode with feces smearing, auditory hallucinations and confusion. He was transported in restraints to NWSCF. He was prescribed Thorazine 100 mgs. At NWSCF, the Interdisciplinary Notes describe him as having arrived uncooperative and resistive. He was placed in chains. He was nonsensical and pressured. He was prescribed Zyprexa 20 mgs by telephone.

On 12/20/2003, the psychiatrist charted that the Lithium order was to be reviewed by the nurse practitioner on 12/22/2003. John Doe was described as manic with psychosis. Zyprexa 20 mgs was ordered. On 12/21/2003, Zyprexa 20 mgs was ordered. On 12/23/2003, Lithium was increased to 750 mgs daily. A Lithium level was ordered along with BUN, Creatinine, TSH, Free T4 and a urinalysis. Prozac dose was reduced to 10 mgs daily. On 12/24/2003, he was disorganized and loose. He was diagnosed with Bipolar Affective Disorder Manic with Psychosis. On 12/29/2003, the Interdisciplinary Notes describe him as confused and rambling. Some laboratory tests were ordered including CBC and CMP. This note was largely indecipherable. On 12/30/2003, lab work was attempted but no blood could be drawn. The "provider" was notified.

On 1/1/2004, the Interdisciplinary Progress Notes describe Mr. Doe as being nonsensical, disrobing, shredding his clothes, drinking from the toilet. He was not really eating. A "med eval" was considered needed as well as increased nursing care.

On 1/5/2004, the Interdisciplinary Progress Notes describe bruising on arms, legs, hips and buttocks. He was nonsensical. He was eating very little and dumping fluids on the floor. He appeared dehydrated. He was reported to be falling frequently. He was in a camera cell for observation. A mental health referral was completed. He was admitted onto the infirmary at 1515. He was incoherent and non-ambulatory. He was confused, labile and disoriented. Orders

were for a CT scan, a chest x-ray, electrolytes and other tests. Fluids were to be pushed. The CT scan of the head and the chest x-ray were negative. BUN was 33 (9-20), Creatinine was 1.5 (0.8-1.5), Sodium was 152 (137-145), Chloride was 118 (98-107). Ins and Outs for fluids were ordered.

On 1/6/2004, the Interdisciplinary Progress Notes describe how he was uncooperative, disrobing, not drinking fluids. Fluid volume deficit was due to decreased intake. Increased intake was encouraged. The facility general practitioner charted a month long gradual change in behavior including falling. Mr. Doe had decreased responsiveness. He was flaccid and incontinent of urine and feces. Consciousness level was decreased and skin turgor was poor. The review of the 1/5/2004 lab results was noted. He was assessed with Dehydration/depressed level of consciousness and hypotension.

He was sent to the emergency room by ambulance. He was to be evaluated for Dehydration and Delirium v Dementia. At North Country Hospital, his BUN was 58 (7-18), Creatinine was 3.00 (0.6-1.3), Sodium was initially elevated at 158 and dropped to 148 and Chloride was elevated at 117. He was hypotensive. A drug screen was negative. Urinalysis showed normal range specific gravity. This was reviewed on 1/6/2004. He was admitted to North Country Hospital for Lithium Toxicity.

On 1/7/2004, in the morning, BUN was 29 (7-18), Creatinine was 1.7 (0.6-1.3), Sodium was 145, Potassium was low at 3.2 (3.5-5.1), Chloride was elevated at 116. Lithium level was 1.36 (0.60-1.2). In the afternoon, BUN was 20, Creatinine was 1.5, Sodium was elevated at 153, and Chloride was elevated at 122. Lithium level was 1.10 (0.6-1.2). On 1/8/2004, BUN was 10 (7-18), Creatinine was 1.3 (0.6-1.3), Sodium was elevated at 149, Chloride was elevated at 121. On 1/9/2004 BUN was 13 (7-18), Creatinine was 1.5 (0.6-1.3), Sodium was elevated at 146, Chloride was elevated at 116. This was reviewed on 1/12/2004. Urinalysis showed normal range specific gravity. As per the Interdisciplinary Progress Notes, he was returned to NSCF. He was disoriented to the city he was in. He had some odd ideas about electricity causing hand swelling.

On 1/10/2003, BUN was 15 (7-18), Creatinine was 1.6 (0.6-1.3). Sodium was high at 147, Chloride was high at 111. This was reviewed on 1/14/2003. The Interdisciplinary Progress Notes indicate he was having difficulty holding things and was unsteady on his feet and required assistance. He complained of numb feet. He had problems with his memory. Some remarks were odd due to confusion or possibly delusional. On 1/11/2004, the Interdisciplinary Progress Notes indicated he was steadier with more motor control. He continued to complain about electricity in the floor. On 1/12/2004, BUN was 15 (7-18), Creatinine was 1.6 (0.6-1.3). Electrolytes were normal. This was reviewed on 1/16/2004. The 1/12/2004 Interdisciplinary Progress Note indicated he was diagnosed with Lithium Toxicity/Dehydration and Nephrogenic Diabetes Insipidus secondary to Lithium. These conditions were noted as resolved with the withdrawal of Lithium. Acute Renal Failure was improving. Mental status was improved. He was discharged from the infirmary.

On 1/14/2004, BUN was 24 (7-18), Creatinine was 1.6 (0.6-1.3). Electrolytes were normal. This was reviewed on 1/23/2004. Extra nourishment was ordered. On 1/19/2004, BUN was high at

21 (7-18), Creatinine was 1.3 (0.6-1.3). Electrolytes were normal. This was reviewed on 1/20/2004. On 1/27/2004, BUN was 15 (7-18). Electrolytes were in the normal range. This was reviewed on 1/27/2004. On 2/2/2004, Electrolytes were normal, BUN was 21 (5-26), Creatinine was 1.2 (0.5-1.5). This was signed off on 2/10/2004.

OPINION:

A review of the records from John Doe's three periods of incarceration indicates several problematic issues related to Mr. Doe's mental health treatment while in the custody of the Vermont Department of Corrections. These issues will be described specifically in the context of his 2003-2004 incarceration and generally categorized with respect to concerns raised in the Vermont Protection & Advocacy Report. It should be noted that all the medical and mental health records reviewed would have been in the custody of the DOC during Mr. Doe's 2003-2004 incarceration and available for review by the treatment providers.

Continuity of Care

1.) There is not a clear consistency in DOC records regarding the pursuit and review of past mental health records. This could jeopardize the continuity of care during the transition from the community to corrections. No record release was prepared for RMHS on 10/15/2003. This was Mr. Doe's most recent treatment provider and such records would have provided information relevant to his most current treatment. It is not clear whether prior records already in the hands of the Department of Corrections were made available or reviewed. CSAC records had been obtained during his first incarceration although it appears to have taken three months to receive them. A similar delay in this most recent situation would have muted the value of seeking RMHS records. These CSAC records could have been useful during the most recent incarceration if they were referred to. VSH and RMHS records were ordered during the second incarceration but it is not clear that any of those records were received. VSH and Mark Messier, MD records were obtained during the third incarceration. The date the VSH records were received or reviewed could not be determined. While instructive regarding his remote treatment, the VSH records do not document the more recent care Mr. Doe had been receiving. The Messier records were actually more pertinent to the current care.

2.) In addition, it is not clear whether records from past incarcerations are routinely made available during subsequent incarcerations. A failure to obtain and review these readily available records could jeopardize the continuity of care. Largely illegible notes such as the 12/29/2003 Interdisciplinary Progress Note also could compromise patient safety, appropriate care, continuity of care and the quality of care. Such notes are particularly egregious in acute and potentially life threatening situations. This issue is certainly not exclusive to the DOC.

Laboratory Testing

1.) Lithium use requires monitoring of various chemistries including Creatinine, electrolytes, thyroid functioning, CBC and EKG. Lithium levels between 0.8 and 1.0 are seen as reducing relapse by a factor of 2.6 when compared to levels of 0.4 to 0.6. Normal levels are usually defined as between 0.6 and 1.2. Dosages are adjusted according to these levels unless known

changes in clearance or other dose determining factors have been determined. Usual dosages for maintenance are between 900 and 1800 mgs daily. If renal clearance is reduced, a dose around 600 mgs daily might be more suitable. Changes in water and salt levels impact on the Lithium levels with decreased salt or decreased fluid increasing the risk of toxicity.

2.) Contraindications to Lithium use include decreased renal function, restricted diet, diuretics, fluid loss, inadequate fluid intake and Lithium levels not being available. It is noted that on 12/5/1997, a low salt diet was advised. Such a diet is contraindicated for individuals taking Lithium and can lead to elevated Lithium levels. In acute mania, Lithium levels of 1.0 to 1.5 are often used to achieve stability. The levels are allowed to drop when acute symptoms are controlled. Lithium toxicity can manifest in the mild form (levels 1.5-2.0) with nausea, tremor, vomiting, abdominal pain, dizziness and slurred speech; in the moderate form (levels 2.0-2.5) with anorexia, diarrhea, vomiting, thirst, polyuria, tremor, twitching, ataxia and delirium and; in the severe form (levels >2.5) with chorea, athetosis, confusion, stupor, convulsions and renal failure. In the terminal form, there is coma.

3.) While incarcerated through the years, Mr. Doe was usually maintained on Lithium doses that yielded a stable level in the reference range. He was usually prescribed a lower than usual maintenance dose due to his susceptibility toward elevated levels or side effects such as sedation at more customary doses. For example, a dose of 1200 mgs daily led to a 1.25 level in 1990 and a dose of 900 mgs led to a 1.30 level in 2001. Through the years, his BUN and Creatinine usually remained in the reference range, although frequently near the high end. There was the rare occasion when these levels were slightly elevated. TSH had also been elevated. His history from 1989 until November 2003 demonstrated stability with intact capacities to maintain his nutrition and fluids and to collaborate with his treatment providers regarding his symptoms and care. In December 2003, these capacities declined dramatically yet he was continued on Lithium after exhibiting many contraindications to its use including a restricted diet, fluid loss, inadequate fluid intake, mental confusion and an absence of Lithium levels.

4.) There were issues related to the consistent and timely review of Lithium level laboratory reports. The Lithium level drawn on 10/15/2003 may not have been reviewed in a timely manner. That report was not signed off with a date. The report indicates that the result was faxed to 802-773-9867 on 1/26/2004. A Lithium level would have been appropriate to order on 12/19/2003 assuming the result from the 10/15/2003 report was known to be in the reference range. Absent such an assumption, a Lithium level would have been a valuable treatment tool as early as 11/13/2003. There is no report found for the 12/22/2003 Lithium level request.

5.) During Mr. Doe's 1994-1998 incarceration, the length of time between a Lithium level report and the date it was signed off by correctional staff was approximately one week with a few exceptions where the length of time was up to one month. In one instance, when Mr. Doe had a higher than usual Lithium level on 6/10/1997, even though his result was signed off by medical staff within a week, mental health staff did not review it until 6/30/1997. During that interim, mental health staff increased the Lithium dose to 900 mgs. No negative result ensued although, once the laboratory report was reviewed, the dosage was reduced from 900 to 600 mgs daily. During his 2001 to 2002 incarceration the length of time to review laboratory results had been extended to an average of approximately two weeks. By the third incarceration, it is unclear

when or if the reports were being reviewed. In the mental health community, Lithium levels are routinely reviewed and usually signed and dated within a few days in outpatient settings and within a day or so in hospital settings.

6.) Monitoring Mr. Doe's Lithium level and other blood chemistries warranted consistent documentation as he had demonstrated a sensitive tolerance to Lithium with elevated levels in 1990 when taking 1200 mgs daily and in 2001 when taking 900 mgs daily. Even while achieving stability at lower doses, he had a history of borderline Creatinine levels, occasionally elevated BUN levels and thyroid issues with an elevated TSH. Given his 14 year history of Lithium use, issues such as the possibility for developing Diabetes Insipidus and kidney problems would advise ongoing careful monitoring.

7.) The increased Lithium dose ordered on 12/23/2003 occurred before a Lithium level had been obtained. There had been opportunities to obtain such a level for several days prior to this adjustment. A similar dosing issue arose during this 1994-1998 incarceration. A Lithium level report dated 6/10/1997 indicated a higher than usual level. Even though his result was signed off by medical staff, mental health staff did not review it until 6/30/1997. During that interim, the Lithium dose was increased to 900 mgs by mental health staff. No negative result ensued although, once the laboratory report was reviewed, the dosage was reduced from 900 to 600 mgs daily. In a related miscue, during that same incarceration, his admission psychiatric evaluation recommended resuming Lithium 900 mgs daily which was not Mr. Doe's current dose. Appropriate medication management would dictate that, when possible, the provider obtain and document the data that forms the basis for any treatment before instituting such treatment.

Development of Treatment Plan & Response to Deteriorating Condition

1.) There was a failure to recognize Mr. Doe's declining mental state in November and December 2003. During his two prior incarcerations, he had remained relatively stable without a decompensation of his Bipolar Affective Disorder. During the 2003-2004 incarceration, it was recognized that he required mental health intervention as early as 10/22/2004. The Treatment Plan prepared on 10/17/2003 was brief, without any problems being identified. This was possibly predicated on the two prior incarcerations during which Mr. Doe had remained stable. This plan warranted updating as soon as Mr. Doe demonstrated evidence of active symptomatology. Careful attention to his disorganized and manic state, as documented in the records as early as 11/13/2003, might have led to more aggressive care and possibly circumvented the frank psychotic deterioration that ensued by 12/19/2003. An increased level of observation and more frequent assessments would have been warranted as of 11/13/2003. By 12/19/2003, his laboratory results of 10/28/2003, while consistent with prior results, would have warranted updating. The 10/28/2003 laboratory results may not have been available making new testing essential. As of 12/19/2003, he was acutely psychotic and a clinical decision to provide intensive treatment equivalent to inpatient care would have been reasonable. An updated psychiatric evaluation would have been appropriate. Such as assessment could have assisted in clarifying Mr. Doe's condition and in directing the needed care.

2.) As of 11/13/2003, Prozac should have been decreased and discontinued over a short time frame. Mr. Doe was becoming manic and Prozac could have been contributing to this decline.

As of 12/19/2003, Prozac was not an appropriate treatment and, if not already discontinued, it should have been discontinued. Antidepressants are generally not recommended in the treatment for Bipolar Disorder in part due to the potential of "switching" from depression to mania. This treatment guideline was less the standard in 2001.

3.) Corrections assumed the responsibility for treating Mr. Doe's acute psychosis on 12/19/2003. His needs for care at that time would have been equivalent to inpatient care. Mr. Doe did not receive the comprehensive assessment and treatment he would have had in an inpatient setting. Such care might have averted his ultimate Dehydration and Lithium toxicity. The 12/29/2003 psychiatric assessment was brief and failed to acknowledge the lack of laboratory findings. The improvement noted is not consistent with other observations made around that time by other staff, suggesting a failure in communication and/or the continuity of care between caretakers/providers.

4.) On 12/23/2003, Lithium was increased to 750 mgs daily for one month's duration. Zyprexa was prescribed at 20 mgs daily for one month's duration. In treating an acutely manic patient, these month long orders are not adequate. They might represent an appropriate initial treatment order but, in a patient with an acute condition, daily assessments are necessary. Medication adjustments and other changes in the treatment could then occur on an ongoing basis as required until stability was achieved or another plan implemented, such as a transfer if appropriate. In addition, while Mr. Doe had been transferred to NWSCF for more intensive mental health treatment, the specificity of that treatment was not documented in the record. Mr. Doe was admitted to the most intensive treatment unit. This was probably coordinated by staff although it was not charted.

5.) Lithium should have been discontinued if not before at least by 1/5/2004 due to his compromised physical condition with poor fluid intake and mental confusion. Lithium should not be used in individuals who have a compromised diet or fluid intake. Lithium should not be used in situations where there is mental confusion such that a careful mental status assessment cannot occur.

6.) The potential interactions between multiple medications prescribed to Mr. Doe warranted oversight. Mr. Doe was prescribed Vasotec during his 2003-2004 incarceration. During his 1994-1998 incarceration at the time when his Lithium level was found higher than usual, he was also receiving Vasotec. During that first incarceration, there was almost a five month lapse between the initiation of Vasotec treatment and the Lithium level which was the 6/10/1997 level noted previously. Vasotec is known to possibly increase Lithium levels due to sodium loss. Caution need be used when combining them. Lithium levels may need to be reduced and an increased frequency of monitoring is recommended.

7.) Prozac has been reported to potentially increase or decrease Lithium levels and Lithium toxicity has been reported. Zyprexa can possibly cause an acute encephalopathic syndrome followed by irreversible brain damage. Close monitoring for early neurological signs of toxicity are advised with discontinuation of Zyprexa if such occurs. Zyprexa can also lead to hypotension. Mr. Doe's combination of medications was not unusual or uncommon. While there was no contraindication to the medication regimen he was taking, increased caution would

still have been advisable. The past increased Lithium level while on Vasotec, if noticed, could have warranted more frequent monitoring of Lithium levels.

Informed Consent

1.) General informed consent was given in writing by Mr. Doe on 10/15/2003, 11/13/2003 and 1/21/2004. This included "pharmacotherapy." The 1/21/2004 form has added "mood stabilizer." A specific form for informed consent for psychotropic medications, specifically Valproic Acid, was signed on 1/31/2004. The general form does not explicitly state the reasons and risks for the medication treatment that was to be provided. Even though Mr. Doe had been treated with Lithium for many years in and out of the correctional setting, a review of his informed consent should occur upon his reentry into corrections. The community standard would usually include a charted note documenting a risk benefit discussion and verbal consent although this practice is often lax. A signed consent form for psychotropic medications would have been consistent with the DOC Policy and Procedure Manual which exceeds the community standard.

SUMMARY:

Mr. Doe experienced a severe life threatening condition in January 2004. This followed 14 years of Lithium treatment leading to an increased susceptibility for Diabetes Insipidus and renal disease. He experienced a decompensation of his Bipolar Affective Disorder with manic and psychotic symptomatology. This decompensation could have been due to a low Lithium level, Prozac use, stresses he was experiencing such as the recent assault on 12/14/2003 or the normal cycling of his Bipolar Affective Disorder.

Once he was in the manic state, his self care declined, most importantly in this instance his nutrition and fluid intake. Major water deficits can occur within hours in Diabetes Insipidus. This can result even before the diagnosis of Diabetes Insipidus is suspected, particularly when the individual has a clouded sensorium and cannot partake in adequate fluids. The ensuing salt imbalance and fluid depletion may have led to the Lithium toxicity. Vasotec or Prozac use may also have been contributors in this toxicity.

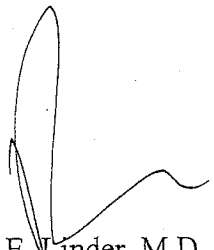
The dehydration resulting from the water depleting Diabetes Insipidus accompanied by his failure to take adequate fluids and restore some fluid balance eventually led to the renal failure. In addition, the combined use of Zyprexa and Lithium may have contributed to his mental confusion and possibly an encephalopathic state.

Rapid and severe medical events can occur almost without warning and at times without being preventable. Caution need be used in a record review where certain remedies might appear obvious to the reviewer when in fact the complexity of the situation at the time of the treatment may have clouded diagnostic and treatment clarity. In addition, no care is absent some discretion and without some flaws. Nonetheless, it is the almost two month prelude to the resulting catastrophic events, when issues and complications were not recognized, resolved and managed in a more thorough and coordinated manner, that placed Mr. Doe in his increased jeopardy.

Department of Corrections procedures identify issues relevant to Mr. Doe's mental health treatment. When admitted into corrections in 2003, he was screened within 24 hours and the required evaluation, when severe mental illness is present in the history, was obtained. While records were obtained, they were not the most recent ones, compromising continuity of care. A treatment plan, while limited, was implemented. This plan was not modified when Mr. Doe's condition changed. Monitoring for Lithium levels did not follow community standards or DOC protocol, which is more rigorous. There was the apparent failure to review the laboratory results in a timely manner and the failure to request a new Lithium level and review it when his condition began to deteriorate.

A major deficiency in the care appears to exist in staff education and/or training around the identification of adverse reactions to psychotropic medications and the identification of mental health/medical emergencies. Such capacities were not consistently demonstrated by the staff involved in care of Mr. Doe. Continuity of care suffered within the facility as well. There was a delay or failure in communication between professionals at times, possibly due in part to the lack of diagnostic clarification resulting from absent mental health testing and assessments that would have been needed to recognize potential or incipient medical and/or mental health complications. This may have thwarted possibly earlier intervention by medical personnel.

In summary, the standard of care available in the community does not appear to have been met in the treatment of John Doe while in the custody of the Department of Corrections. The care most closely approximated such a standard while Mr. Doe's mental status remained relatively stable. As he deteriorated, the intensity of the level of care did not increase in the heightened increments that would have been anticipated and expected in the community, leaving Mr. Doe more vulnerable to further deterioration.



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Mental Health Directive & Protocols

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