Expert Opinion Report

In The Matter Of:

LISA OSTLER v. SALT LAKE City County Jail Staff

Prepared by Suzanne L. Ward, RN, MS, LNC

for

Attorney Rocky Anderson
and
Attorney Walter Mason

CONTENTS

Page

PAGE

I. ENGAGEMENT

I have been asked to provide an expert opinion regarding care or lack of care provided to Ms. Lisa Ostler at the Salt Lake County Metro Jail from March 30, 2016 thru April 2, 2016. In this report I have provided a summary of applicable standards of care and set forth my opinions as to how the treatment Ms. Lisa Ostler did or did not receive at the hands of the Defendants compared to those standards. Lisa Ostler's estate, parents, and children brought claims against the Salt Lake County Metro Jail and its staff, arising from her death, for their deliberate indifference in failing to provide or arrange for reasonable and adequate medical care for Ms. Ostler who was found unresponsive and not breathing in her cell approximately three and a half days after being booked into the jail.

II. QUALIFICATIONS

I am a Registered Nurse licensed in the State of Wisconsin with more than 46 years of experience as a practicing nurse. I hold a Multi-State Registered Nursing license. Wisconsin and Utah are part of the eNLC (Enhanced Nursing Licensure Compact) and permit my nursing practice in both states. My practice includes more than 10 years of direct clinical service in jails, prisons, and forensic mental health treatment facilities. I have been a hospital manager responsible for all care and operations of a county inpatient unit serving individuals legally detained under alcohol, drug, and mental health statutes and a unit manager of a secure detention treatment facility where patients were assessed for legal competence to stand trial. My nursing license has never been revoked or suspended for any reason.

A curriculum vitae outlining my career experience is included as **Appendix 1**.

A list of my prior deposition and court testimony experience for the past 5 years is included as **Appendix 2.**

III. COMPENSATION

I am being compensated for the professional services in connection with the preparation of this report based on my customary hourly fees, which are $75.00 per hour for medical record review and report writing. I charge $200 per hour for expert witness and deposition preparation, services, and testimony. I charge $1800 per day plus actual

expenses for travel and trial appearance. I have no financial interest in the outcome of this litigation.

IV. MATERIALS REVIEWED

The materials I reviewed to reach my opinions in this matter are listed in **Appendix 3.**

In the event additional relevant information becomes available after the issuance of my report, I reserve the right to amend my report and incorporate such information as necessary. I also may incorporate additional information in response to any expert report or opinions proffered on behalf of the Defendants.

V. EXHIBITS THAT MAY BE USED TO SUMMARIZE OR SUPPORT OPINIONS

I may use any of the materials and documents cited or referenced herein to support or summarize my opinions.

VI. SUMMARY OF RELEVANT CASE EVENTS

Ms. Lisa Ostler was booked into the Salt Lake County Metro jail on March 30, 2016 at 2:21 AM. A Pre-screen Examination and a Comprehensive Nurse Examination was conducted on 3/30/2016 (SLCo Ostler 000128-000130). Documentation in the examinations included:

- Vital Signs: Temperature of 98.3, Blood Pressure of 115/75, Respirations of 15, an oxygen saturation of 99%, Height of 69 inches, weight of 124 lbs., and a body mass index (BMI) of 18.3
- Substance abuse including tobacco, ½ pack/day, e-cig; heroin, 1 g QD; meth
- No injuries (SLCo Oster 000129)
- Broken or missing teeth
- Abnormal abdominal findings of rectal neuropathy related to sexual assault (SLCo Ostler 000129)
- Crohn's Disease (SLCo Ostler 000128)
- Abnormal musculoskeletal findings of arthritis
- History of gastric bypass in 2006
- No [menstrual] periods (SLCo Ostler 000128)
- A ½" abscess on the right breast areola and a ½" abscess on the right anterior chest (AC) with scant erythema, no drainage, and not fluctuant.
- Positive risk factors for withdrawal (SLCo Ostler 000129)

- First time in jail (SLCo 000130)
- Victim of violent abuse/assault, victim of domestic violence, victim of sexual abuse/assault/rape, PTSD secondary to victimization (SLCo Ostler 000130)

Ms. Ostler's medications verified on 3/30/2016 for diagnoses of PTSD (Post Traumatic Stress Disorder), Depression, Anxiety, Crohn's Disease, Rectal Neuropathy, ADD (Attention Deficit Disorder), Arthritis, Reflux, and Insomnia included Lexapro, Xanax, Gabapentin, Adderall, Oxycodone, Hydrocodone, Prilosec and Ambien. A prescription medication Pentaza (sic, Pentasa) for Crohn's disease was not verified (SLCo Ostler 000131).

An e-mail regarding Lisa was sent to Brad Lewis and Paula Braun on 3/30/2016 at 2:10 PM by Brad Stoney, RN (SLCo 000142, 000144) after she was booked in to the jail. The e-mail included a Patient Problem List with assigned medical diagnoses including International Classification of Diseases, 10th Revision (ICD-10) diagnoses codes and the list of verified medications. Dr. Brad Lewis documented a DOCTOR NOTE the next day, 3/31/2016, and wrote he received an e-mail regarding Lisa M. Ostler's medications on 3/31/2016. He referred continuation of her medication for post-traumatic stress disorder, depression, attention deficit disorder, and insomnia to the jail mental health providers, denied pain medications of oxycodone and Norco due to the nature of the medications, the jail not being "a chronic pain or withdrawal facility" and not being filled since December 2015. He denied Pentasa and prenatal vitamins and noted there was no record of those medications. Dr. Lewis ordered Prilosec (SLCo Ostler 000214) and placed her on the Wilcox/Wellcon Opiate Withdrawal Scale (WOWS) protocol. Paula Braun, via e-mail to Brad Stoney, RN, ordered a Librium taper for benzodiazepine withdrawal (SLCo 000144). Dr. Todd Wilcox was listed in Lisa's jail record as the Admitting, Attending and Ordering MD (SLCo Ostler 000148). There was no evidence to suggest that any of the physicians listed in Lisa Ostler's medical record - Dr. Todd Wilcox or Dr. Brad Lewis - knew her, ever saw or examined her, or had any direct clinical knowledge of her.

Lisa Ostler was booked, or rolled in to the Salt Lake County Jail on March 30, 2016, and initially placed in Housing Unit 5C. She was transferred to jail Unit 8C, Cell number 16 on April 1, 2016, at about 10 AM. Cell 16 was located in a blind spot from the camera on the unit. Ms. Ostler did not have a cellmate.

Lisa was identified to be at risk for substance withdrawal and was placed on protocol for alcohol and benzodiazepine withdrawal entitled Clinical Institute Withdrawal Assessment (CIWA) (SLCo 000155) and protocol for opiate withdrawal entitled Wellcon or Wilcox Opiate Withdrawal Scale (WOWS) (SLCo 000156). She admitted to heroin use and was apparently placed on the WOWS protocol for that reason. Lisa was prescribed a benzodiazepine, Xanax, prior to her detention at the Salt Lake County Jail, a medication that was not prescribed or continued at the jail. She was

apparently placed on the CIWA protocol for that reason. Lisa was required by written policies, physician orders, facility training documents and protocol directions to be assessed for withdrawal signs and symptoms twice per day for five days.

Vital signs were recorded on handwritten CIWA and WOWS protocol assessment sheets with dates and times of 3/30/16 at 0500 and 1500, 3/31/16 at 0920 and 1450 and 4/1/16 at 0830. Vital signs recorded in her Electronic Medical Record (PEARL EMR) were not consistent with the handwritten withdrawal protocol worksheets and reflected dates and times of 3/30/16 at 0457, 3/31/16 at 1100 and 1555 and 4/1/16 at 1105. Not only did none of the assessment times coincide, the assessment on 3/30/16 at 1500 was not recorded at all in the EMR. The information recorded in Lisa's electronic medical record for CIWA and WOWS assessments and the monitoring of her vital signs do not reflect the actual times the assessments and monitoring activities occurred.

The CIWA and WOWS withdrawal protocol worksheets contained numerous errors and omissions and alarming clinical findings that were not followed up or evaluated by nursing or clinical staff. On March 30, 2016, Lisa's respiration rate was recorded as 98 breaths per minute; on March 30, 2016, Lisa's oxygen saturation rate was recorded as zero or as not being assessed at all; on March 31, 2016, Lisa's resting heart rate was recorded as 133 beats per minute and was scored as a "2" on the WOWS scoring worksheet, even though a resting heart rate at or above 110 beats per minute was to be scored as a "4". Lisa's heart rate of 133 on March 31 followed a heart rate of 119 earlier the same day. There is no record about the failure to alert a physician about the heart rates over 110, and the written policy required that nurses contact a physician in these circumstances. Her weight on 3/30 was recorded as 124 pounds, while her weight on 4/2/16 was listed as 200 pounds. Minimal, if any, hydration was provided to Lisa over the course of four days. Salt Lake County Jail training on WOWS assessment specifically stressed the importance of identifying dehydration or elements leading up to dehydration and highlighted prevention of dehydration as a main issue in opiate withdrawal. Protocol assessment worksheets document Lisa received just two bottles of Gatorade in four days and there is no information to suggest she drank either one. (Esther Israel, a mental health professional, noted there were three Gatorade bottles in Lisa's cell and one was spilled on the floor.)

Documentation of meal intake reflected that Lisa was not eating meals. There is no record of her intake for 3/30/16. On 3/31/16 she refused breakfast and lunch; there is no record of her intake for dinner. On 4/1/16 there is no record of her intake at breakfast; she refused lunch and other inmates in Unit 8C reported she did not eat dinner. On 4/2/16 Lisa refused breakfast before she was found unresponsive and not breathing in her cell and was transported to the hospital. Lisa's BMI (Body Mass Index) at the time of her booking on 3/30/16 was 18.3. The Centers for Disease Control (CDC) and Prevention categorizes BMI below 18.5 as "underweight".[1]

[1] Centers for Disease Control and Prevention (CDC). Healthy Weight. About Adult BMI.

Throughout Lisa's electronic medical record there was no indication that any errors, omissions or inconsistencies in assessment findings were followed up by any nursing or clinical staff. There is no indication that Lisa was evaluated for dehydration, not eating, or weight loss despite nursing staff knowledge that she was not eating meals and she had only been provided two or three bottles of Gatorade since being booked into the jail and no one had monitored whether or how many she drank. Lisa was not referred for a medical examination, evaluation, or for treatment by an advanced care provider at any time, and no advanced care provider ever saw her.

Lisa Oster saw Jamie Facholas, a mental health professional, on March 31, 2016 at approximately 3:30 PM (SLCo 000154). Facholas reported past severe trauma with sexual assault. She documented an assessment of Lisa and noted she had "visible marks all over her body", would not look Facholas in the eye, "had visible signs of anxiety" and "reported symptoms of depression". There is no evidence in Lisa's medical record that the report of trauma, assault, anxiety, depression, or the visible marks all over her body was followed up or communicated to medical or mental health staff for further investigation. There is no evidence in the record that any nurse identified or addressed "visible marks all over her body" or followed up on identified anxiety or depression.

On 3/31/2016, at 6:23 PM Lisa Ostler was seen for four minutes by Esther Israel, a mental health professional for a crisis call. Israel documented the Housing Unit Officer had a strange interaction with Lisa when she got up from sleeping and stated she was supposed to meet Claudia to go to a wedding. Ms. Israel spoke to Lisa. Lisa told her she was involved in a "murder-suicide" and she was sometimes living in the past. Lisa Ostler was oriented to place. Ms. Israel noted there were three bottles of Gatorade in Lisa's cell and one of the bottles was spilled on the floor. She provided Lisa with a mood chart and educated her on the triage process. Ms. Israel's documentation of her contact with Lisa was present in Lisa's medical record. Lisa was not referred for a medical evaluation for her symptoms of disorientation or confusion.

Lisa Ostler's vital signs were not monitored as ordered and withdrawal protocol assessments were only partially completed. The last charted assessment, including purported monitoring of her vital signs, was on the morning of 4/1/2016. The vital signs recorded on that morning are highly suspect. After 4/1/2016 at approximately 8:30 AM, no vital signs were recorded and no assessments were performed until Lisa Ostler was found unresponsive and not breathing in her cell approximately 24 hours later. Withdrawal protocol assessments were to be performed twice daily for five days according to physician orders, established protocol, and training programs[2]. No vital signs or symptom assessments were performed after 8:30 AM on 4/1/2016, and, likely, vital signs had not been monitored since 3/31/2016. No vital signs or symptom assessments

[2] Salt Lake County Jail Training Program, Wellcon Opiate Withdrawal Scale (WOWS), SLCo Ostler 025540.

were performed on 4/2/2016 prior to Lisa being found unresponsive and not breathing. Nurse Seewer testified it was not his responsibility to perform the CIWA/WOWS assessment for Lisa Ostler on 4/1/2016 in the afternoon because he was not assigned to Charlie ("C") Pod that day (Seewer Deposition, pp 141 – 142; Exhibit A), although Nurse Seewer was working in C Pod that day. The responsibility for CIWA and WOWS assessments was the responsibility of the "pod nurse". An HSU daily assignment log (SLCo Ostler, 030924) identified the C Pod nurse as Disa and Ron was assigned to the Acute Mental Health Unit and not to Charlie Pod/8C. There is no evidence whatsoever that Nurse Disa provided any health care services on 8C in the afternoon of 4/1/2016, and Defendants' counsel has informed Plaintiffs' counsel that the HSU daily assignment log is not reliable. Jail medical staff reportedly did not consider the log as reliable or official as assignments often changed, unit needs required frequent, daily adjustments, and staff often traded assignments (Amended Responses to Requests for Admission and Responses to Reformulated Requests for Admission, p 2). Deposition testimony by the Responsible Health Authority (RHA), Richard Bell, indicated it was up to the pod nurse to ensure vital signs were taken (Bell Deposition, March 25, 2019, pp 44 - 46). No vital signs or withdrawal assessment was performed by any nurse on the afternoon of 4/1/2016, just hours before Lisa was found unresponsive and not breathing. None of the abnormal vital signs recorded on the CIWA and WOWS assessment forms that had actually or allegedly been taken previously were followed up, addressed or reported to an advanced level health care provider. The vital signs recorded on the morning of 4/1/2016 by Nurse Seewer were impossibly "normal" for a patient complaining of pain who had received none of her prescribed medication for existing medical conditions, who was unable to walk upright, who had the prior abnormal vital signs, and who was suffering from peritonitis.

On 4/1/16 at 3:25 PM, Officer Todd Booth recorded in the Officer Shift Log for Unit 8C that Nurse Ron was in the unit for medication pass and diabetic checks. Booth recorded that Lisa was complaining of pain and testified he informed Nurse Ron of her pain complaints. According to Officer Booth, Nurse Ron examined her and cleared her to stay in the unit (SLCo Ostler 00012). Nurse Seewer stated he did not recall assessing Lisa Ostler, did not recall taking her vital signs, and recorded no assessment or encounter whatsoever with Lisa Ostler, which he said he would have done had he had a medical encounter with Lisa Ostler. No vital signs were recorded on the CIWA or WOWS protocol assessment records for the afternoon of 4/1/16 or any time on 4/2/16. In fact, a notation of a circled number "3" was recorded for those dates and times, a notation representing that Lisa was not available or was not on the unit. There was no evidence that Lisa left the unit at any time for any reason. She was given medication three times on 4/1/16 verifying she was on the unit, available to the nurse, and therefore would also have been available for an assessment. The medication nurse was reportedly Ron Seewer and Lisa appeared to have received medication three times on 4/1. If Lisa was available to the medication nurse she would also have been available for an assessment. The notation on the CIWA and WOWS assessment forms that she was unavailable was a false entry.

Multiple inmates on Unit 8C while Lisa was there described that her pleas for help and signs that she needed emergency medical help were obvious throughout the afternoon of 4/1/2016. The inmates reported they spoke to Officer Todd Booth about their concerns but he rudely dismissed them. Officer Booth was aware of Lisa's complaints of pain and pleas for help but failed and refused to help her or ensure that any other staff helped her.

Alisha Woodruff, Kellie Sheppard and Nicole Bates were inmates on 8C at the Salt Lake County Jail during the time Lisa Ostler was there. Each of them testified they saw Lisa, observed her behavior and health condition, heard her cries and pleas for medical help, and expressed concerns, or heard other inmates express concerns, to officers about the seriousness of her health and need for medical help based upon their observations. Each inmate reported Lisa did not receive medical help.

Alisha Woodruff testified that everyone was talking about Lisa when she first came into the unit. Lisa "looked like she was dead on her feet . . . She looked dead . . . scary . . .looked just like a skeleton" (Woodruff Deposition, p 7). Ms. Woodruff noted that the color of her skin was gray and she sat hunched over on her bed (Woodruff Deposition, pp 7 - 8) and stated she looked like she might die. She was skinny and did not move. Ms. Woodruff stated it was very obvious she needed medical attention (Woodruff Deposition, pp 11 - 12).

Kellie Sheppard testified she saw Lisa on April 1st, 2016. She stated Lisa looked weak and sick and her skin color was yellowish and pale (Sheppard Deposition, p 7). She stated Lisa said to her "Please help me" and she looked like she was in pain (Sheppard Deposition, pp 8 - 9). Ms. Sheppard stated another inmate went to the guard to get medical help for Lisa but she did not observe a nurse respond (Sheppard Deposition, p 12). She saw Lisa try to put her clothes in a bin during clothing exchange but noted that Lisa was not strong enough to throw the clothes and they landed in front of her on the floor (Sheppard Deposition, p 16). Ms. Sheppard testified that one of the girls went to the guard and said "She's going to die." and the guard's response was "Well, don't do drugs." Ms. Sheppard stated she heard the conversation. She did not see or hear the guard call for a nurse (Sheppard Deposition, p 17). The guard, Holly Harris, did not summon medical attention for Lisa. On the night of April 1st, Ms. Sheppard heard Lisa screaming and saying "Help me" throughout the night. She heard the guard, Holly Harris, say that Lisa shouldn't have done drugs and did not provide any help for Lisa at any time (Sheppard Deposition, p 21). Kellie could hear Lisa screaming loudly all night and thought she was going to die. She stated it was obvious to her she needed emergency medical treatment and she was going through something more than withdrawal (Sheppard Deposition, p 24 - 25). She stated her observation was based on common sense (Sheppard Deposition, p 32 - 33).

Nicole Bates received training as a certified nursing assistant (Bates Deposition, p 8). She reported that if an inmate was going through bad heroin withdrawal the officers would have a nurse come to check them (Bates Deposition, p 26) but she did not see officers call a nurse for Lisa (Bates Deposition, p 30). She felt Lisa really needed help. Nicole testified that the unit officers were made aware Lisa was very sick. Lisa was sitting on her bed moaning (Bates Deposition, p 47). Nicole could tell Lisa was in a lot of pain by the way she was moaning. Her color was gray. She testified that more than one person tried to get the guard's attention (Officer Booth) to let him know something wasn't right with Lisa but the officer told them to mind their "own fucking business" and to leave her alone (Bates Deposition, pp 52 – 54). Bates told the officer Lisa needed medical help as something was wrong with her. She testified that Lisa wasn't withdrawing from drugs, it was more than that. Officer Booth told her if she was that sick, she would get up and see triage in the morning (Bates Deposition, p 52 - 53). When the inmates continued to try to get help for Lisa, they were warned they would lose their free time out of their cells if they did not leave her alone. Nicole described Lisa during clothing exchange as incoherent, stumbling, and having a hard time walking. She struggled to even be moving, didn't seem like she knew where she was, couldn't understand why she was being yelled at and looked like she was in a lot of pain somewhere in her abdomen (Bates Deposition, p 49 - 51). Nicole testified that Lisa told Officer Holly Harris (the graveyard shift officer) that Lisa needed help (Bates Deposition, p 128), but Harris did not summon medical to see her. Lisa's vital signs were not checked when she was in 8C (Bates Deposition, p 93). Upon her return to the unit Harris told the nurse Lisa did not need to see medical, that she could fill out a sick call kite and see triage in the morning. Lisa told Harris that something was really wrong, she was in pain, and she needed medical help but Harris told her to shut up, threatened her, kicked her cell window, and accused her of misusing medical and jail staff (Bates Deposition, p 62). Ms. Bates heard Lisa crying all night long, crying for help and moaning (Bates Deposition, p 68). Nicole Bates testified that as a lay person she knew Lisa was experiencing a serious medical condition that required medical attention and that it did not require someone who was medically trained to determine that it was a serious medical condition that needed to be addressed (Bates Deposition, p 132). Lisa's serious need for medical attention was obvious to the medically untrained laywomen detainees that simply saw her, heard her, and used their common sense to identify another human being in abject distress.

On 4/1/2016 at approximately 11:10 PM Lisa Ostler left her cell for mandatory clothing exchange. She was observed on jail video holding her abdomen, bent over, walking very slowly and shuffling (Jail Video). She appeared disoriented and confused; at one point she walked aimlessly in the wrong direction away from her cell (Jail Video). Nicole Bates testified that Lisa "looked like she was in a lot of pain" and was "incoherent, she was stumbling, she was having a hard time walking . . .You could tell she was struggling to even be moving (Bates Deposition, p 49). Kellie Sheppard testified that Lisa "was clearly not in the right frame of mind" and too "weak" to throw her clothes in the clothing bin (Sheppard Deposition, pp 15, 16). Clothing exchange was the only time

Lisa left her cell while she was on 8C before she was taken to the hospital by ambulance unresponsive and not breathing the following morning.

The graveyard shift Control Room Operator Scott Sparkuhl received a shift report from Operator Dalton and testified he was told Lisa Ostler had been calling a lot for medical treatment for several days, that medical nurses and doctors had seen her, they'd checked her out and she was coming off of heroin (Sparkuhl Deposition, pp 41-42). Sparkuhl testified that Lisa Ostler rang the button and said she was in pain and was requesting medical (Sparkuhl Deposition, p 45). He testified he contacted the Housing Officer the first time she called and the Housing Officer told Sparkuhl to "Go ahead and ignore the cell." (Sparkuhl Deposition, p 51). Sparkuhl testified that before his contact by Lisa Ostler he had previously experienced on a dozen or so occasions Housing Officers telling him to ignore inmates' calls when inmates reported they were experiencing a serious medical problem and needed help. Sparkuhl stated he followed the instructions to ignore the calls (Sparkuhl Deposition, p 68). Mr. Sparkuhl testified he received a call from an inmate checking on Lisa Ostler because she heard Lisa crying and sounding like she was in pain (Sparkuhl Deposition, p 98). Officer Sparkuhl received communications from Lisa Ostler approximately 1-2 times per hour, all night long, that she was in pain and needed medical help (Sparkuhl Deposition, pp 40-41). Lisa contacted Scott Sparkuhl up to 16 times throughout the night, but because he had been instructed to "ignore" Lisa's cell, he only passed on one or two of those communications to a Housing Officer (Sparkuhl Deposition, pp 49, 57, 59).

Housing Unit Officer Holly Harris (graveyard shift officer) stated in response to Plaintiff's Request for Interrogatories that on 4/1/2016 at approximately 11:30 PM she contacted medical and informed them other female prisoners in the unit (Unit 8C) were concerned about Prisoner Ostler. She states that she contacted medical and stated a male nurse informed her that her [Lisa Ostler's] vitals had been taken in the previous hour and were fine. (Responses to Plaintiff's Request for Interrogatories, Interrogatory No. 22), (Harris Deposition, pp 84-85, 98). No evidence, including shift logs and medical records, corroborates Officer Harris' claim that she called a nurse and no medical record documentation reflects that Ms. Lisa's vital signs had been monitored since approximately 8:30 that morning (if, in fact, her vital signs were monitored that morning). Officer Harris testified she did not record in her log that other inmates told her Lisa Ostler needed medical treatment or that she contacted a nurse (Harris Deposition, p 126), despite her typical practice of logging contacts with a nurse (Harris Deposition, p 84). The failures and refusals of custody and medical staff to take Lisa's complaints and requests for medical attention seriously demonstrated a complete disregard and an astonishing indifference to her obvious needs across multiple levels of the jail organization. The staff that functioned as gatekeepers to essential medical care for the inmates failed and refused to fulfill a basic duty and responsibility of their jobs when Lisa Ostler was obviously suffering from a serious medical condition.

On 4/2/2016 at 6:00 AM Officer Zachary Fredrickson began his shift. He was informed by Holly Harris and his supervisor, Heather Beasley, that Lisa Ostler had been crying and screaming all night (Frederickson Deposition, p 100) and asking for medical help (Frederickson Deposition, p 142). Officer Frederickson also noted that Lisa reported some vaginal bleeding. He testified that concerned him enough to call medical staff (Frederickson Deposition, p 113).

On 4/2/16 at approximately 6:38 AM Nurse Brent Tucker was on Housing Unit 8C to conduct diabetic checks. Housing Officer Zachary Frederickson informed Nurse Tucker that Lisa had been hitting the intercom all night (Frederickson Deposition, p 190). But Frederickson did not inform Tucker that Lisa had been crying and screaming all night, and repeatedly asking for medical assistance or that other inmates expressed their concerns to Frederickson that Lisa had not received medical help and might die. According to Frederickson, Nurse Tucker spoke with Lisa Ostler briefly and then left the unit. There is no evidence that Tucker did any medical evaluation of Lisa, at which time she was dying of peritonitis, which is always extremely painful. Officer Frederickson learned Lisa reported vaginal bleeding and she was not eating, which Officer Frederickson reported to Nurse Tucker by phone. Frederickson did not tell Tucker during that call that Lisa had been crying and screaming all night, repeatedly asking for medical assistance, and pressing her emergency button all night or that other inmates expressed their concerns to Frederickson that Lisa had not received medical help and might die. Nurse Tucker reportedly responded that not eating was not a concern until 72 hours had passed. Nurse Tucker submitted a note, written after Lisa Ostler's death, stating that he reviewed her medical record and assumed that because she was "W/D from ETOH and Drugs" (withdrawal from alcohol and drugs) that "explains why she may not want to eat." (SLCo Ostler 26515). Nurse Tucker asked Officer Frederickson if the bleeding was menstrual and Officer Frederickson stated he did not know. Nurse Tucker instructed Officer Frederickson to ask her and have Lisa fill out a triage kite if Frederickson did not assess her complaint as an emergency (Frederickson Deposition, pp 187-191). There was no indication that Nurse Tucker made any attempt to assess, investigate, or determine if Lisa Ostler had a medical issue or an emergency, an action that was the sole responsibility of a nurse in that instance. It was wholly inappropriate for Tucker to leave it to Frederickson to determine if Lisa had an emergency medical condition. There was no indication that Nurse Tucker considered that Lisa Ostler may have been bleeding due to an injury, or an urgent medical issue. Of note, was the entry in Ms. Ostler's medical record on the Nursing Pre-Screen Examination, a record that Nurse Tucker claims to have reviewed, that Lisa Ostler had no [menstrual] periods, had a significant medical history for Crohn's disease, gastric bypass and splenectomy. There was no indication that Nurse Tucker considered any of this information despite it being just as present in her medical record as the notation she was withdrawing from alcohol and drugs.

Bleeding, particularly in conjunction with severe abdominal pain, can indicate a serious medical emergency. Severe pain should heighten the concern for a serious underlying cause and should prompt immediate concern about a potential intra-abdominal

catastrophe. The general appearance of the patient should be noted. An "ill-appearing" patient with abdominal pain is always of great concern given the variety of potentially lethal underlying causes. Immediate assessment would be indicated. Reports of pain accompanied by reported bleeding are serious symptoms and should be assessed emergently. Bleeding from the vagina can be mistakenly identified by the patient and actually be from the rectum or in the urine. Lisa's presenting constellation of symptoms including pain, vaginal bleeding, and not eating – or any one of them - required an immediate nursing assessment by Nurse Tucker when he was made aware.

There was no indication that Nurse Tucker ever considered returning to Unit 8C to see Lisa, that he reported Lisa's medical symptoms to anyone, or that he considered arranging for another nurse to see her. He did not even make a notation in the medical record. There was no evidence to suggest that Nurse Tucker took any action in the face of the obvious potential that Lisa Ostler was experiencing a medical emergency and required assessment before symptoms were simply dismissed or referred to an untrained officer to follow up.

On 4/2/16 at approximately 7:30 AM (less than one hour after Nurse Brent Tucker was on the unit) Nurse Colby James entered the unit to conduct triage. Housing Officer Zachary Frederickson talked with Colby James about Lisa Ostler requesting to see medical. In an e-mail after Lisa Ostler's death, Nurse James described "the event timeline of triage" before the medical response was called for Lisa being unresponsive and not breathing. Nurse James stated he arrived on Unit 8C to start triage. He stated the unit officer informed him that Cell 8C16B [Lisa Ostler] was told to place a SCR [sick call request] form in for her medical concerns however she told him [the officer] that she did not want to and that she was refusing to (SLCo Ostler 026514). Nurse James told Officer Frederickson that if Lisa Ostler had a medical emergency to contact medical and if she had a triage kite, he would take it at that time. There was no indication that Nurse Colby James took any action or made any attempt to walk a few steps across Unit 8C to see or talk with Lisa Ostler. There was no indication he made any attempt to determine if she was having any medical issues or a medical emergency despite knowing she verbally made a request to the housing officer to see medical AND that he was on the unit for the very purpose of conducting triage, a process used to determine which inmates needed to be seen for medical attention. Instead, Nurse James directed Officer Frederickson to make a determination about whether or not Lisa's request for medical attention and concerns were emergent. Again, it is highly inappropriate and irresponsible for a nurse to leave it to a medically untrained Housing Officer to determine if an inmate was suffering from an emergency medical condition. It is shocking that any nurse would know that an inmate had requested medical attention and the nurse would not walk a few steps to the inmate's cell to check on her. We now know that Lisa Ostler was near death when Nurse Colby James failed and refused to walk to her cell and check her condition.

On 4/2/2016 at 8:07 AM, just 37 minutes after Nurse Colby James failed and refused to assess Lisa Ostler's request for medical attention, Officer Frederickson was

alerted by another inmate that Lisa was not breathing and discovered her in her cell unresponsive and not breathing. Lisa was transported to Intermountain Medical Center, did not regain consciousness, and was declared dead on 4/3/2016 at 1:14 AM. The cause of her death was determined to be peritonitis. She suffered a perforation of her bowel.

The protocol, standards and guidelines used in the formulation of my opinions are listed in **Appendix 4**.

VII. OPINIONS AND THE BASIS AND REASONS FOR THEM

The opinions that follow are based on my clinical experience, my education, my research, my consideration of the facts and data contained in the documents and materials described above and in Appendices 3 and 4, and the facts and reasons set forth below.

OPINION #1: The registered nurses **at the Salt Lake County Jail, including at a minimum, Nurses Ron Seewer, Brent Tucker, and Colby James, who provided care, who was in a position to provide care, or who was in a position to ensure the provision of care to Lisa Ostler breached professional standards of nursing care and their duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler. Those breaches are so egregious that their actions, as well as their failures and refusals to act, cannot have been the result of the exercise of professional nursing judgment. They failed and refused to perform obviously required assessments, failed and refused to follow up on abnormal results of assessments that were performed, failed and refused to address Lisa's serious medical conditions and needs, failed and refused to address signs and symptoms of illness that were obvious and recognizable to laypersons and would be obvious and recognizable to a medically trained and licensed nurse, failed to arrange for a physician to evaluate, diagnose, and treat Lisa Ostler, failed to arrange for Lisa Ostler to be transported for emergency care at a hospital, and failed and refused to ensure her health and safety. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.**

Basis for Opinion #1

A. The Salt Lake County Jail registered nursing staff, including at a minimum, Nurses Ron Seewer, Brent Tucker, and Colby James failed and refused to complete assessments, follow up, report or address abnormal results and failed and refused to address Lisa Ostler's serious medical needs and conditions. The Salt Lake County Jail registered nursing staff, including at a minimum, Nurses

Ron Seewer, Brent Tucker, and Colby James did not, at any point, contact an advanced care provider to report abnormal results or seek orders or direction for ensuring necessary and appropriate care for Lisa's serious medical needs.

Lisa Ostler was admitted to the Salt Lake County Metro Jail and was seen by nursing staff for a receiving screening and comprehensive nursing examination. Her history of Crohn's disease, arthritis, and previous gastric bypass surgery in 2006 was documented. Her diagnoses of PTSD, Depression, Anxiety, Rectal Neuropathy, ADD, Arthritis, Reflux, and Insomnia were also documented. Her prescribed medications were listed and verified with the exception of Pentasa and Prenatal Vitamin. Lisa was also determined to be suffering from heroin and benzodiazepine withdrawal and she was placed on withdrawal protocol assessments - CIWA and WOWS. The majority of her prescribed medication was not ordered, rather was deferred to mental health. Lisa was never seen by a mental health provider to have her medications evaluated or prescribed. Prilosec, an over-the-counter antacid that could have prevented the perforation of Lisa's gastrointestinal ulcer, which led to her peritonitis was ordered by Dr. Brad Lewis, but Lisa was denied even that medication – she did not receive a single dose.

The comprehensive nursing exam performed on 3/30 noted two minor skin abscesses on the right side of Lisa's chest and breast. The day following her booking into the jail, the mental health worker documented Lisa had "marks all over her body". Nursing documentation did not mention any bruises or marks on her body. Lisa was noted by laywomen detainees in the jail to be extremely sick, in obvious pain and distress, and in need of medical help. None of the nurses documented any abnormal medical findings for Lisa other than minor skin issues, some nausea, vomiting or diarrhea. No documentation reflected Lisa's seriously debilitated, declining medical condition. Nurses are the medical "eyes" on patients in any health care facility. The nurses' failure and refusal to identify medical issues for Lisa was unbelievable given the condition present and progressing inside of her abdomen, manifested by her cries and pleas for help, her obviously debilitated appearance, and her altered mental state.

Todd Wilcox, MD, medical director of the Salt Lake County Jail, in an article describing management of opiate withdrawal in corrections, described opiate withdrawal as a life-threatening condition requiring medical support to ensure a safe withdrawal. He developed the Wilcox Opiate Withdrawal Scale protocol (WOWS) to improve the care for this serious condition. In the Salt Lake County Jail withdrawal assessments were required to be completed twice daily for five days.

Not all withdrawal assessments were completed for Lisa Ostler. After 4/1/2016 AM no assessments, including the monitoring of vital signs, were

performed. Ms. Ostler was found unresponsive and not breathing in her cell approximately 24 hours later. Had the nursing staff performed the physician-ordered assessments and provided the basic medical care that was ordered or provided the basic medical care that was obviously needed, Lisa's dire, life-threatening condition would have been identified and she would have received life saving care.

Of the five assessments that were allegedly performed from 3/30/2016 through 4/1/2016 AM, conflicting information occurred on two of the assessments and alarming clinical findings were present on four of the assessments. The 3/31 PM CIWA assessment of symptoms was blank. Significantly abnormal findings, such as a pulse of 119 and 133, were recorded with no evidence of follow up or notification to an advanced care provider, contrary to a written policy requiring that a physician be contacted when a patient has a heart rate of over 110. Incorrect medication information and incorrect scoring of vital signs appeared on at least two occasions.

Conflicting information: On 3/31 the CIWA assessment recorded a Gatorade was given however the WOWS assessment done at the same time did not document any Gatorade given. On 3/31 the WOWS worksheet noted that vomiting or diarrhea was present during both the AM and PM assessments but no as needed (PRN) Phenergan (for vomiting) or Imodium (for diarrhea) medication was given despite there being an implied order for both medications. On 4/1 a CIWA and WOWS assessment was recorded at 0820 and both Phenergan and Imodium medications were administered. After the AM assessment on 4/1 a circled "3" was recorded that signified Lisa was "not on the unit" or "not available" and a second assessment was not done on that day, although policy required it to be done. There was no evidence that Lisa left her cell on 4/1 for any reason or was unavailable to nursing staff. Furthermore, the Medication Administration Record (MAR) for 4/1 reflects that Lisa received Librium medication TID (3 times), verification that she was available to a nurse on at least 3 occasions throughout that day. Librium is a medication that is given with several hours in between doses, therefore Lisa would have been available to the nurse for vital signs and an assessment at mid-day, in the afternoon or in the evening of 4/1 when she received medication, yet no vital signs or assessments were ever done. Nursing staff failed and refused to perform physician-ordered assessments, which, if done, would have led to actions that likely would have saved Lisa's life.

Alarming clinical findings: On 3/30 Lisa's Respiratory Rate was recorded as 98 with no subsequent evaluation or follow up. Lisa's Heart Rate on 3/31 was recorded in the AM as 119 (well above the range requiring MD contact) and was 133 (well above the range requiring MD contact) at the very next assessment that day. Her O2 Sat was recorded as "zero" on 3/31 PM. Nursing staff failed and

refused to report alarming findings that signaled a dramatic change in her condition. Incredibly, no advanced care provider was ever notified.

Missing assessments: No CIWA symptom assessments were performed in the PM of 3/31 - the column to record findings was left blank. No assessments at all were completed after 4/1 AM in the 24 hours before Lisa was found unresponsive and not breathing in her cell.

Abnormal findings: On 3/31 PM Lisa's BP was recorded as 89/68, a significant drop from any of her previous BP readings and her pulse was 133, a dramatic and significant increase over previous readings and an alarming increase from a previously elevated heart rate of 119 taken earlier in the day. Those vital signs required a physician's attention, but no physician was contacted. Lisa was given Gatorade on just 2 occasions in 3 days but it did not appear she drank the liquids. Nursing staff failed and refused to notify an advanced care provider of abnormal vital signs that signaled a significant change of condition. No nursing assessment for dehydration was done.

Incorrect information: A handwritten entry on Lisa's CIWA assessment noted: "Rx: Klonopin" however Lisa was never on Klonopin. On 3/31 PM Lisa's pulse rate of 133 was scored as a severity of "2" instead of a "4", which it should have been, resulting in an incorrect total WOWS score. Lisa was recorded as "not on the unit" after an AM assessment on 4/1/16, therefore a second assessment on that date was not done and no assessment whatsoever was done on the morning of 4/2; however, Lisa had not left the unit or her cell.

Inconsistent assessment times in record: Vital signs and symptom assessments were recorded on handwritten CIWA and WOWS protocol assessment sheets reflecting dates and times of 3/30/16 at 0500 and 1500, 3/31/16 at 0920 and 1450 and 4/1/16 at 0830. The vital signs and assessments recorded in Lisa's Electronic Medical Record (PEARL EMR) reflected dates and times of 3/30/16 at 0457, with no information recorded in the EMR for 3/30/16 PM, 3/31/16 at 1100 and 1555 and 4/1/16 at 1105. No further CIWA or WOWS assessments were performed after 4/1 AM.

The record reflects so many serious, sloppy errors and omissions that no one could reach any conclusion except that the administration of the Salt Lake County Jail and its nurses were deliberately indifferent toward the serious medical condition and needs of inmates, generally, and Lisa Ostler, specifically, which led to her suffering and death.

Absence of positive interventions: The notes section at the bottom of the WOWS protocol assessment for Lisa was blank. According to the WOWS training for opiate withdrawal issues presented to Salt Lake County Jail staff, the

notes section at the bottom of the form was for nursing staff to document the positive interventions they did to save the patient's life and for them to take credit for their work.[3] Not one nurse recorded any positive intervention they took to save Lisa's life from 3/30/16 at 0500 through 4/2/16 AM when she was found unresponsive and not breathing in her cell. Nursing staff of the Salt Lake County Jail knew of their responsibilities to take positive interventions to maintain Lisa Ostler's health and life and to document the actions they took in that regard. The nursing staff failed and refused to provide Lisa with any positive nursing interventions for her serious medical condition and, if implemented, would more likely than not have saved her life.

B. The registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, knew their responsibilities to manage and respond to Lisa Ostler's medical needs and conditions.

The registered nursing staff, including, at a minimum, Nurses Ron Seewer and Brent Tucker, was responsible to complete drug withdrawal assessments of Lisa Ostler twice daily for five days and fully and accurately document their findings according to facility protocol, policy, procedure, training information and physician orders. They were responsible to follow up and to notify an advanced level provider of abnormal findings. The medical director of the Salt Lake County Jail, Dr. Todd Wilcox, was the individual who designed the WOWS assessment protocol specifically for the Salt Lake County Jail. Dr. Wilcox wrote the following in an article:

> . . . . opiate withdrawal is . . . clinically severe and can frequently result in death if not managed appropriately. . . . In the modern world, opiate withdrawal is a life-threatening medical condition. . . . Assessment, including vital signs and self-harm assessment, should be done twice per day for five days minimum. Assess for dehydration. Assess for comorbidities including . . . underlying chronic diseases and malnourishment. . . . Hydrate, hydrate, hydrate using something that the patients will actually drink. Obtain lab work on any patients not responding to the basic protocol. Admit to an inpatient setting if the patient's clinical presentation or laboratory results dictate. . . . In my facility, any patient undergoing opiate withdrawal is assessed twice per day for a minimum of five days by nurses who have been trained in the WOWS protocol. The assessment includes a full set of vital signs, serial tracking of the patient's clinical progress and interventions

[3] Salt Lake County Jail training slide presentation, WOWS, Opiate Withdrawal Issues, SLCo Ostler 025554.

> as necessary based on clinical presentation. . . . [W]e have found that many of our opiate withdrawal patients are physiologically fragile and require medical support to withdraw from opiates safely. Patients with an abnormally low body mass index are common and they frequently experience extreme distress during opiate withdrawal.[4]

The nursing staff of the jail was medically trained and educated to accurately perform and completely document patient withdrawal assessments, provide follow up care, and notify an advanced level provider when abnormal findings occurred. Nursing staff of the Salt Lake County Jail knew what their responsibilities were for performing drug withdrawal assessments as ordered for Lisa Ostler. However, The registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, failed and refused to provide the most basic assessments that, if performed, would have revealed Lisa's progressively serious medical condition and likely saved her life.

Nurses are medically trained to monitor patients competently and must promptly and effectively communicate changes in status to the physician. The British Medical Journal found that the overall mortality rate for secondary peritonitis was just 6%, but mortality rose to 35% in patients who developed severe sepsis[5]. Had the nursing staff who came in to contact with Lisa for any reason performed the assessments her condition and complaints warranted, any one of the trained medical nurses would have identified that Lisa had a serious medical condition exclusive of drug withdrawal and was in need of immediate referral to an advanced level provider. Lisa's likelihood of survival diminished substantially with the passage of time since the onset of her symptoms. No one should die of peritonitis if medical professionals are available.

Nurses provide the first line of care to patients in the jail setting. They are in the best position to monitor a patient's condition. Importantly, they are trained to observe and report changes in the signs and symptoms of a patient. The types of changes to a patient's condition that should be reported to an advanced care provider are numerous and include: bleeding, blood pressure changes, changes in skin color, cognitive changes, confusion, disorientation, fatigue, heart rate that is abnormal, loss of body movement or function, neurological changes, oxygen saturation, pain level and weakness. The nurses report of a condition change must be timely and give the doctor or advanced provider enough information to determine the course of treatment. A patient assessment would be required to obtain enough information to provide sufficient details to a higher level provider. The nursing staff at the Salt Lake County Jail functioned as gatekeepers for

[4] Wilcox MD, Dr. Todd, *"Managing Opiate Withdrawal: The WOWS Method"*, CorrectCare, printed Summer 2016.
[5] Ross, James T., surgical resident, "Secondary peritonitis: principles of diagnosis and intervention", BMJ.

medical services and held all the keys for medical care and patient access to physician care. Lisa Ostler had to depend upon jail nursing staff for whatever medical care she received – she had no other options. She also had to depend on Housing Officers to notify nursing staff of her pain, her signs of medical distress, and her reasons for medical help.

A training session on "Nursing Documentation" presented by Colby Harris RN[6] to the Salt Lake County Jail staff described the nurses responsibility for documentation of care and stated: "If it wasn't documented, it wasn't done." (SLCo Ostler 025554). A training slide in the WOWS presentation began with a similar statement "Everyone knows 'If it wasn't documented it wasn't done'."[7] The phrase is a known and often cited adage in the nursing field. Clearly not every nursing action warrants an entry into the medical record, however documentation of any significant or potentially significant nurse-patient interaction and patient care action was to be completed as soon as possible after the care was provided at the jail. Nurse Harris noted that the times care was provided needed to be correct and documentation needed to be complete, accurate, organized and concise. The American Nurses Association (ANA) requires nurses to document relevant data in a retrievable format. Jail nurses are responsible to practice at a community level standard of care and must be able to demonstrate that standards of care were met. Documentation of care provided is essential to verify it occurred and is a standard measure to identify nursing actions taken on behalf of a patient. The absence of documentation reveals the failures and refusals of nursing staff to provide essential care and is particularly revealing in the instance of adverse, preventable events.

Nurse Colby Harris stated in his training of Salt Lake County Jail nurses that abnormal vital signs required intervention and disposition. Monitoring of a complete set of vital signs was required and any abnormalities needed to be addressed. He addressed the nursing responsibility for conducting a focused assessment that was based upon the patient's chief complaint and the importance of researching the issue in the patient's chart. Nursing staff of the Salt Lake County Jail knew of their responsibilities to completely and correctly document relevant patient care that was provided to Lisa Ostler in response to her complaints and to intervene for the abnormalities that occurred. They knew the importance of conducting a focused assessment to evaluate Lisa's medical complaints and requests for medical help yet they failed and refused to afford Lisa even the most basic nursing interventions.

[6] Nursing Documentation slide presentation by Colby Harris RN, Salt Lake County Jail, LCCo Ostler, pp 025286 - 025410.
[7] Salt Lake County Jail training slide presentation, WOWS, Opiate Withdrawal Issues, SLCo Ostler 025554.

Lisa Ostler was available on Unit 8C for required assessments on 4/1 and 4/2. Her location was handwritten on the MAR and on the withdrawal assessment protocol worksheets. Nursing staff knew her location – it was handwritten on her medical record when she was transferred from 5C. Lisa was given medication twice in the afternoon of 4/1 but nurses, including Nurse Ron Seewer, did not complete required assessments on 4/1 or 4/2. Instead, documentation on the assessment worksheet reflected that Lisa was not available or not on the unit, a designation the nurses, including at minimum Nurse Ron Seewer, knew to be false. They failed and refused to complete required assessments.

Any medically trained licensed registered nurse providing care to a patient such as Lisa Ostler in a similar circumstance would know the importance and necessity of performing assessments to evaluate a patient's health care status. They would know the importance of following standards of care, facility policies and procedures, designated protocol, and training directives. Any medically trained registered nurse would know the importance of following up abnormal findings such as abnormal vital signs or changes in a patient's condition and of notifying an advanced care provider for further care directions. Any medically trained nurse would know that documentation of care provided is essential to memorialize information about a patient's condition, assessments, and care provided. Accurate documentation is the basis upon which to ensure the patient's health condition and need has been appropriately identified and addressed and continuity of care provided. Documentation is the nurse's roadmap for outlining and verifying the patient's care and communicating with other caregivers. Medically trained registered nurses also know the importance of taking positive interventions to maintain and promote a patient's health and to prevent deterioration, degeneration or death.

C. Salt Lake County Jail registered nursing staff including, at a minimum, Nurses Ron Seewer and Brent Tucker, egregiously breached nursing standards of care for assessment, identification, intervention and follow up of Lisa Ostler's serious medical needs. The registered nursing staff including, at a minimum, Nurses Ron Seewer and Brent Tucker failed and refused to follow required standards of nursing care and practice. The registered nursing staff including, at a minimum Nurses Ron Seewer and Brent Tucker, failed and refused to assess Lisa's declining medical condition and her pain and failed and refused to refer abnormal findings to a physician or advanced care provider.

The medically trained, licensed registered nurses at the Salt Lake County Jail failed and refused to complete the CIWA and WOWS assessments as required for Lisa Ostler. They failed and refused to respond to Lisa Ostler's requests for medical attention and failed and refused to conduct essential assessments to evaluate her medical needs. They did not respond to abnormal findings present

during the assessments they did conduct and, in fact, provided no interventions whatsoever to address Lisa's rapidly declining health condition. They failed and refused to see Lisa in response to officer reports that she requested to see medical. They failed and refused to notify an advanced care provider about abnormal vital signs. On 4/1 PM and 4/2 AM, within the last hours of Lisa's life they failed and refused to conduct any assessments at all. They recorded she was not available or not on the unit but knew she was in her cell and had not left the unit. Lisa's medication administration record verifies she was available as she was given medication by nursing staff on two occasions on Unit 8C. The nurse responsible to conduct the PM assessment knew it needed to be done and refused to complete it or arrange for another nurse to complete it.

Any medically trained licensed registered nurse, who was not deliberately indifferent to a person's serious medical needs, conducting an assessment on 4/1, just before Lisa spent a night repeatedly calling out for medical help and was subsequently found unresponsive and not breathing in her cell, would have noted her grave appearance, would have been prompted to ask about her health, and would have conducted a focused assessment. Medically untrained inmates (laywomen) on the unit with Lisa observed her and were able to identify that she badly needed medical help. Registered nurses had contact with Lisa at least 6 times on 3/31 and 4/1 to administer medication and three times to perform withdrawal assessments. Vital signs on the two withdrawal assessments on 3/31 were abnormal. Any medically trained nurse providing care in a similar circumstance to that of providing care to Lisa Ostler could have identified her worsening condition by reviewing her medical record, monitoring her vital signs, observing her appearance and behavior, by talking with her, and by performing a very basic physical or abdominal exam based on Lisa's report of pain. A pain assessment and physical exam are basic skills that any registered nurse would know to perform yet none of the nurses at the Salt Lake County Jail conducted any basic focused assessment or exam to assess her complaints or requests for medical help. The nurses failed and refused to perform essential assessments for Lisa that were indicated and obviously needed based upon her clinical condition, appearance, and requests for medical care.

The failure and refusal to note Lisa's dramatic physical deterioration, worsening appearance, outward indications of pain, or marks all over her body over the course of several encounters and alleged withdrawal assessments reflects the nurses' failure and refusal to repeatedly and appropriately recognize and document Lisa's medical needs. For the medical needs that were documented, Lisa was not provided essential, basic care. Several nurses at the jail were in contact with Lisa for intake, withdrawal assessments, medication administration and at the request of officers, yet NOT ONE of them took any action to address her medical needs (including not having any of her prescribed medications), abnormal vital signs, physical appearance of deterioration, and symptoms of

serious illness or pain. Any medically trained nurse providing care to Lisa Oster in a similar circumstance would know that patients with suspected or potential drug withdrawal could also have an unrelated serious medical condition and should be assessed to rule out the presence of potential urgent or emergent conditions. Any medically trained nurse would know that abnormal findings and a patient's urgent or emergent health needs must be reported to an advanced care provider. The jail nurse functions as chief gatekeeper to advanced medical care. If the nurse fails or refuses to permit access to medical care, the inmate simply does not receive it.

Any medically trained registered nurse working in the jail environment knows they must respond to an inmate's request for medical attention in a timely manner. When a clinical symptom such as bleeding or pain is reported or when an inmate stated they need medical help, a face-to-face assessment must be conducted by a nurse, who are the members of staff who are supposed to be qualified and available to evaluate patient health status. Determination of the seriousness of a patient's medical concern must be made by a qualified medical person and may not be ignored or delegated to a non-medical unqualified staff person. Nursing staff was the only qualified staff that could have seen Lisa and obtained essential care for her serious medical condition yet they did not see her to assess her status, they did not provide care and did not obtain care for her until she was unresponsive and not breathing on the morning of 4/2.

The "Notes (Intervention documentation)" section on Lisa Ostler's WOWS protocol worksheet, designed for nurses to document the positive interventions they took to save a patient's life was BLANK. In fact, not one nurse over the course of 4 days and 7 assessment events from 3/30 through 4/2 documented a single positive intervention they took to save Lisa's life.

<u>OPINION #2</u>: The registered nursing staff of Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer, Brent Tucker, and Brad Stoney, so breached professional standards of nursing care and their duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler by knowingly refusing and failing to take actions to ensure that her prescribed medication regimen was evaluated to ensure continuity of care for her serious medical needs. Those breaches were so egregious that their actions, failures to act and refusals to act cannot have been the result of the exercise of professional nursing judgment. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #2

A. Salt Lake County Jail registered nurses including, at a minimum, Nurses Ron Seewer, Brent Tucker, and Brad Stoney, failed and refused to ensure that Lisa Ostler's medication regimen was evaluated, continued, or that a disposition of her prescribed medication was made by a qualified advanced level provider.

Along with being placed on withdrawal protocol assessments, Lisa Ostler was prescribed a Librium medication taper for withdrawal symptoms and Prilosec for gastric reflux. Her prescribed medications for PTSD, Depression, Anxiety, Rectal Neuropathy, ADD, Arthritis, and Insomnia were referred to mental health staff for review and not ordered even though they had been verified. No medication for Crohn's disease or Arthritis was provided.

No evidence suggested that any appointment with a mental health provider was scheduled to follow up on ordering the medications that had been deferred. The one medication, Prilosec, actually ordered for Lisa Ostler, was never administered – she did not receive a single dose. There is no evidence, whatsoever, that any assessment of Ms. Ostler's medical conditions was completed to determine the impact of the sudden cessation of ALL of her prescribed medications.

According to Dr. Ross J. Baldessarini, professor of psychiatry and neuroscience at Harvard Medical School and director of the psychopharmacology program at the McLean Division of Massachusetts General Hospital: "Stopping [medication] abruptly is especially dangerous," Baldessarini stated. "Depending on the medicine, stopping abruptly or 'cold turkey' can cause a variety of distressing reactions, ranging from mild to moderate early discontinuation symptoms with antidepressants, rapid return of the illness being treated, or even potentially life-threatening seizures with a high dose of benzodiazepines."[8]

Individuals entering jail are suddenly separated from their routine care and may be separated from their medication. One function of the jail intake screening is to identify patients with chronic diseases to ensure timely continuity of treatment. A patient with chronic disease requires prompt physician attention, especially for prescribing required medications. Immediate post-booking physician-directed evaluation and re-institution of therapy for patients with chronic illness is needed.[9]

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[8]Tartakovsky, Margarita M.S., Discontinuing Psychiatric Medications: What You Need to Know, October 8, 2018.

[9] Puisis, Michael, D.O., and John M. Robertson, M.D., M.P.H., Chronic Disease Management, Clinical Practice in Correctional Medicine.

The Salt Lake County Jail Medical Director, Todd Wilcox, MD, presented a list of "critical commandments" at NCCHC's Correctional Health Care Leadership Institute designed to help correctional medical directors and administrators deal with difficult institutional problems that impact health care services. The "Critical Commandments in Correctional Health Care" appeared as a 3-Part Series in the NCCHC Journal, CorrectCare. His presentation included a commandment for dealing with medication continuation: "**Thou Shalt Ensure Continuity of Care for Medication From Booking"** and identified an approach to ensure the disposition of all medications within 24 hours and of critical medications immediately".[10]

No decision other than deferral or discontinuation was made about Lisa Ostler's medication regimen, with the exception of Prilosec (which she never received) at any time during her detention in the Salt Lake County Jail much less immediately or within 24 hours. No evaluation was ever done to determine whether any of her medications were critical for continuation. No advanced level prescriber ever addressed continuity of care regarding her prescription medication despite this being a "critical" commandment in correctional health care handed down by the jail medical director.

Salt Lake County Jail staff training materials stated that verified medication information was forwarded to the on-call provider for ordering.[11] Lisa Ostler's verified medication was forwarded to Dr. Brad Lewis who ordered Prilosec 40 mg daily but deferred all the rest of her medication to mental health. The deferred medications were never reviewed by mental health. The Prilosec that Dr. Lewis ordered was never administered despite the Salt Lake County Jail Pharmacy "stocking approximately 200 different medications" and having "access to virtually every medication currently available."[12]

B. Salt Lake County Jail registered nursing staff, including, at a minimum, Nurses Ron Seewer, Brent Tucker, and Brad Stoney, knew of their responsibility to facilitate continuation of Lisa Ostler's medication and failed and refused to take any action to ensure her medications were reviewed or continued.

Any medically trained licensed registered nurse knows the importance of continuing medication prescribed for a patient's serious medical condition and would know that abrupt cessation of ALL medications for a patient such as Lisa Ostler who had multiple known serious medical and mental health needs could result in withdrawal and decline in the patient’s physical and mental health. The

[10] Wilcox, Todd, MD, MBA, CCHP-A, CorrectCare, Critical Commandments in Correctional Health Care: Part 1, Part 2, Part 3, Spring, Summer, Fall 2013.
[11] Salt Lake County Jail training program, Medication Administration, Brett Clement RN, p SLCo 025183.
[12] Ibid., SLCo, p 025182.

nurses at Salt Lake County Jail knew that not providing any of Lisa's prescribed medication could be dangerous and should be immediately evaluated by an advanced level prescriber. Any medically trained nurse providing care in a similar circumstance to that of providing care to Lisa Ostler would know the importance of medication adherence and continuation of prescribed medication for serious chronic medical and mental health conditions.

C. Salt Lake County Jail registered nursing staff, including, at a minimum, Nurses Ron Seewer, Brent Tucker, and Brad Stoney, nursing staff did nothing to ensure the continuity of prescribed medication for Lisa Ostler. One medication that was ordered for Lisa was never given.

Registered nursing staff of the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer, Brent Tucker, and Brad Stoney, refused to ensure continuation of Lisa's medication that had been prescribed for her prior to her detention. Any medically trained nurse providing care for a patient such as Lisa Ostler in a similar circumstance would know the importance of continuity of care regarding medication prescribed for serious medical needs. The nursing staff failed and refused to take any action to arrange for a medical or psychiatric medication review in a timely manner to determine whether Lisa's medications should be continued or safely discontinued. When Dr. Brad Lewis deferred Lisa's medication to mental health for review no nurse contacted a psychiatrist or mental health advanced care provider to review or determine which of Lisa's medications should be continued, substituted, or safely tapered and discontinued despite the medical director of the jail describing the need to ensure disposition of medications immediately or within 24 hours as a "critical commandment" in correctional health care. There is no indication that any nurse took any measures to assess the impact of abrupt cessation of Lisa's medication on her health and safety when all of her medications were suddenly stopped. The nursing staff did nothing to ensure that Lisa was continued on essential medication or safely discontinued from medication that would not be ordered. There is no rationale in the record to explain the delay or the failure to arrange for a medication review and reasonable disposition of her medication regimen.

OPINION #3: The Salt Lake County Jail registered nursing staff, including, at a minimum, Nurses Ron Seewer, and Brent Tucker breached professional standards of nursing care and their duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler by knowingly failing and refusing to conduct any pain assessment despite Lisa's appearance, complaints of pain, and requests for medical care. Those breaches were so egregious that their actions, failures to act, and refusals to act cannot have been the result of the exercise of professional nursing judgment. Those breaches were

caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #3

A. Salt Lake County Jail registered nursing staff, including, at a minimum, Nurses Ron Seewer and Brent Tucker, failed and refused to conduct any pain assessment of Lisa Ostler despite numerous indications that she had pain and requested medical attention on numerous occasions.

No medical record documentation, including the pre-screen examination and nursing comprehensive examination, reflected that Lisa Ostler was ever assessed in any way for pain. Lisa Ostler was never asked about pain, monitored for pain symptoms, or assessed for pain even (1) when she complained of pain and requested medical attention; (2) when she outwardly demonstrated the presence of pain by holding her abdomen and walking slowly in a bent over position, did not leave her cell, was inactive and not moving; (3) when other inmates reported she was crying out for help and needed medical attention; or (4) when she pressed the emergency call button in her cell at least 16 times during the night of 4/1 through the morning of 4/2 to request medical help for pain.

No pain medication was provided for Lisa Ostler at any time during her detention at Salt Lake County Jail despite her being on pain medication before she was detained. No medication for Crohn's disease or Arthritis was provided. No evidence suggests that any consideration was given to ordering pain medication that would have been acceptable for use in the jail setting to substitute for the pain meds Lisa had been taking. Review of medical records for other inmates revealed that certain inmates received pain medication as well as follow up for abdominal pain (Medical record of Duwayne Cotter, SLCo Ostler, pp 029170, 029213, 029219, 029221, 029247, 029326).

Dr. Todd Wilcox's, presentation of a list of "critical commandments" at for correctional health care previously referenced included a commandment for dealing with pain: "**Thou Shalt Deal With Pain in a Reasonable, Modern Way".** Good faith management of pain requires a good history and an excellent physical exam. The Joint Commission standards for pain management may be useful. The "no opiates in custody" policy is unreasonable and out of sync with current medical standards of care. It is important to distinguish between addiction and pseudo addiction. Acute pain management may involve Tylenol, nonsteroidal agents and short-acting opiates such as Lortab."

There was no indication that any staff person, including Dr. Brad Lewis or any nurse attempted to identify the reason Lisa was on pain meds, the

characteristics of her pain or her pain level despite this being a "critical" commandment in correctional health care handed down by the jail medical director. There was no documentation or evidence to suggest that Lisa was ever assessed for pain at any time even when she was screaming, moaning, crying out, requesting medical help, pressing her emergency call button at least16 times throughout the night on 4/1, and when pleas from other inmates were received about her horrific appearance and her need for medical help.

Standard nursing practice in response to complaints of abdominal pain is to obtain a history of the pain and, at minimum, palpate the abdomen. Any medically trained nurse would be aware of this standard practice, which, if performed, would have obviously indicated Lisa Ostler required urgent follow up that would have likely saved Lisa Ostler's life.

Despite Lisa Ostler complaining of pain, remaining in her cell in a crunched up position holding her abdomen, refusing meals, not taking adequate fluids, holding her abdomen while walking in a bent over posture whenever she was out of her cell, there is no documentation to suggest that any nurse evaluated or attempted to evaluate Lisa Ostler at any time regarding pain, a pain level, or for a cause for her complaints or appearance. As a result, the peritonitis that she was actually experiencing went unaddressed and undiagnosed. Her complaints of pain alone warranted an immediate assessment.

Lisa's medical history of Crohn's disease and arthritis simply added to the obvious need for a nursing evaluation since her medications for those conditions were abruptly discontinued and she was not approved to receive any of the pain medications previously prescribed to her. She was also not prescribed any alternative medications for those conditions. No nurse evaluated Lisa when she was screaming, moaning, crying out, pressing the emergency button in her cell at least 16 times during the night of 4/1, when other inmates requested medical assistance for her, or when nursing staff was notified by officers that she requested medical attention, had not eaten, and was bleeding.

Lisa Ostler was seen by the mental health worker, Jamie Facholas, who documented that Lisa had visible marks all over her body. Entries on the Comprehensive Nursing Examination indicate she had a significant history of victimization including violent abuse/assault, domestic violence, sexual abuse/assault/rape, and PTSD secondary to victimization. There is no indication to suggest that any nurse, after Lisa Ostler was booked into the Salt Lake County Jail, conducted a physical exam to determine if she arrived at the jail with a pre-existing injury, any internal injuries or whether she sustained an injury while housed on Units 5C or 8C that would have explained the presence of visible body

marks all over her body. Nursing documentation did not mention any marks or bruising or that they conducted any evaluation sufficient to identify any physical abnormalities in Lisa's health.

Several inmates on Unit 8C were aware of Lisa's desperate medical situation and attempted to inform housing unit officers of her need for medical care. As laywomen, the inmates recognized Lisa needed medical care and her verbalizations of pain were inconsistent with any drug withdrawal they had ever seen or experienced. The nursing staff that was informed she was in pain failed and refused to conduct any pain assessment, refused to perform any focused assessment and refused to perform any hands-on assessment to verify, identify or address her complaints of pain. In fact, the nurses that were informed she was in pain and had requested medical attention failed and refused to conduct any assessment whatsoever. No documentation in Lisa's medical record suggested that any nurse conducted an assessment for pain or tried to identify the nature of her medical concerns. The decisions to ignore complaints of pain and refusals to conduct any pain assessment at all was an intentional action that any medically trained nurse would recognize as an unprofessional breach of nursing standards and duty to their patient.

B. Salt Lake County Jail registered nursing staff, including, at a minimum, Nurses Ron Seewer, and Brent Tucker, knew of their responsibility to conduct pain assessments and failed and refused to take any action or make any attempts to assess Lisa Ostler for pain.

Pain is the most common nursing diagnosis in all delivery-of-care models; therefore, the assessment and management of pain is within the purview of every professional registered nurse (RN).[13] Addressing patients' pain is a primary nursing responsibility.[14]

Standards of nursing practice require nurses to conduct a careful physical assessment when they assess patients. They are not merely assessing and treating minor health complaints, but must screen for the possibility of more serious health problems that need advanced provider intervention.[15] When Lisa received PRN (as needed) medication for nausea (Phenergan) and diarrhea (Imodium) during the CIWA/WOWS protocol assessments on 8 occasions, the level of clinical assessment and decision making at those times required the registered nurse to be mindful for conditions other than drug withdrawal. Nurses must be

[13] American Nurses Association, Scope and Standards of Practice, Pain Management Nursing, 2005.
[14] American Nurses Association, "The state of pain", The American Nurse, Official Publication of the American Nurses Association, January, 2014.
[15] Smith, Sue, MSN, RN, "The Nurse Is In: Designing Effective Nursing Sick Call Guidelines", CorrectCare, Summer 2009.

capable of critical thinking and have an ability to draw on their expert knowledge to determine if different or additional information is needed. The nurse must be prepared to include additional assessment data, consider different nursing diagnoses, and develop a plan of care that addresses any additional problems.

Poor appetite, nausea, vomiting, diarrhea, and a dull abdominal ache or tenderness that quickly turns into persistent, severe abdominal pain that is worsened by any movement or touch can be symptomatic of a number of acute abdominal conditions including peritonitis. Crohn's disease can lead to peritonitis. Clearly, a physical assessment would identify abdominal ache, tenderness, and severe pain worsened by movement or touch. Any medically trained registered nurse providing care to a patient such as Lisa Ostler in a similar circumstance would know the importance of conducting a careful and thorough patient assessment to ensure that the presence of a serious health problem was identified and not missed. Hence, the failure to conduct a careful and thorough patient assessment must have been a product of deliberate indifference toward the serious medical condition suffered by Lisa Ostler.

C. Registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, failed and refused to assess Lisa for pain or ensure pain management.

Not one nurse at the Salt Lake County Jail conducted a pain assessment or made any appropriate referral for a pain assessment for Lisa Ostler. They not only did not conduct a careful or thorough assessment for pain, they did not conduct an assessment at all despite outward signs that Lisa was in pain, reports of other inmates appealing for medical attention for her, her own cries for medical help, and officers reporting her calls for help and requests to see medical.

OPINION #4: The registered nursing staff of the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker breached professional standards of nursing care and their duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler by knowingly failing and refusing to assess Lisa Ostler for signs and symptoms of dehydration and ensuring adequate hydration for a patient undergoing drug withdrawal. Those breaches were so egregious that their actions, failures to act, and refusals to act cannot have been the result of the exercise of professional nursing judgment. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #4

A. The Salt Lake County Jail registered nurses, including, at a minimum, Nurses Ron Seewer and Brent Tucker, failed and refused to assess Lisa Ostler for signs or symptoms of dehydration and refused to provide adequate hydration to her.

A Salt Lake County Jail staff training program for opiate withdrawal issues emphasized early intervention for vomiting and diarrhea, aggressive lab monitoring, aggressive monitoring for fragile patients and emphasized the identification of dehydration or elements leading up to dehydration as a strategy for prevention. Nursing staff of the Salt Lake County Jail knew of their responsibilities for early identification of dehydration and taking measures to prevent a patient in a fragile condition, such as Lisa Ostler, from worsening.

Dr. Todd Wilcox stated in his article: "The primary focus of WOWS is to identify clinical scenarios that cause dehydration and electrolyte abnormalities". He noted that "a targeted assessment for clinically relevant dehydration became the focus of the WOWS protocol" at the Salt Lake County Jail and made a point of stressing "Hydrate, hydrate, hydrate using something that the patients will actually drink".[16]

The CIWA and WOWS assessments conducted by nursing staff reflected that Lisa Ostler was provided with just two bottles of Gatorade in four days. It was possible she received one additional bottle of Gatorade as the mental health professional that saw her on 3/31/2016 noted three bottles of Gatorade in Lisa's cell, though one was spilled on the floor. Other than responding to the clothing exchange, Lisa did not leave her cell while in Unit 8C, therefore would not have accessed fluids that may have been provided on the unit. She was refusing meals and likely did not intake any fluids that may have been provided at mealtimes. Based on the evidence on the CIWA and WOWS assessment forms that Lisa was only provided two bottles of Gatorade, any medically trained nurse would know she was at serious risk for dangerous levels of dehydration.

On 3/31/16, Lisa was disoriented and told the Housing Unit Officer she was supposed to meet someone to go to a wedding. When the mental health worker, Esther Israel spoke with her briefly, Lisa said she was involved in a "murder-suicide" and sometimes lived in the past. Ms. Israel noted she was oriented to place, however made no mention of her orientation to person, date, time or circumstance. Ms. Israel noted the three bottles of Gatorade in the cell, one of which was spilled on the floor.

[16] Wilcox MD, Dr. Todd, *"Managing Opiate Withdrawal: The WOWS Method"*, CorrectCare, printed Summer 2016.

Disorientation, confusion, fatigue and sleepiness are symptoms of dehydration. A drop in blood pressure and oxygen saturation can signal impending low blood volume shock, one of the most serious and sometimes life-threatening complications of dehydration. Low blood volume causes a drop in blood pressure and a drop in the amount of oxygen in the body.[17] Lisa Ostler's blood pressure declined from an initial reading of 115/75 on 3/30/2016 to 89 /68 on 3/31/2016.

The registered nursing staff at Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, knew that Lisa was only provided two bottles of Gatorade and was not eating. The information about Gatorade provided was recorded on the withdrawal assessments; housing unit staff notified nursing staff that Lisa was not eating meals. The nurses failed and refused to assess Lisa for dehydration.

Despite the reported emphasis placed on hydration at the Salt Lake County Jail, the CIWA and WOWS protocol assessments documented that Lisa Ostler may have been given a bottle of Gatorade on 3/31/2016 AM and one on 3/31/2016 PM. There is no indication, suggestion, or documentation to suggest that any nurse evaluated Lisa Ostler at any time for hydration status or conducted any assessment of her for dehydration. Severe dehydration requires immediate medical treatment. A doctor should be consulted in cases where an individual has diarrhea for 24 hours or more, is disoriented, is much sleepier or less active than usual, can't keep fluids down or has bloody or black stool. No evidence suggests that any nurse evaluated Lisa Ostler's lack of fluid intake, disorientation, or decreased activity to determine if she was medically compromised in any way. No evidence suggests that any nurse evaluated reports that Lisa was bleeding.

Clinical symptoms of drug withdrawal, dehydration, and more serious conditions such as peritonitis can overlap. For this reason, a face-to-face, hands-on nursing assessment is paramount to identifying the symptoms, potential cause, and the appropriate level of care required. Nursing staff failed and refused to conduct any assessments of Lisa Ostler.

B. The registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, knew of their responsibility to assess Lisa Ostler for dehydration and take measures to prevent dehydration.

Any medically trained licensed nurse would know the importance of adequate nourishment and hydration, particularly with a patient that is

[17] Mayo Clinic, Patient Care & Health Information, Diseases & Conditions, Dehydration.

underweight, not eating, and not being provided adequate hydration. Any medically trained nurse would know that two bottles of Gatorade over a period of more than 3 days is insufficient to ensure adequate hydration and would know that a patient such as Lisa that was not consuming the Gatorade given was at a high risk for severe dehydration. The nursing staff of Salt Lake County Jail failed and refused to ensure that Lisa Ostler was adequately hydrated. An assessment to follow up on hydration status would have informed any nurse that Lisa Ostler was at risk. An assessment to identify whether her mucous membranes were dry or moist, whether her skin turgor was good or poor, and whether her mental status was within normal limits or not would have revealed her worsening physical status and would also have provided Lisa an opportunity to discuss the abdominal pain she experienced related to the condition that ultimately resulted in her becoming unresponsive and not breathing 24 to 36 hours later. Hospital records later revealed minimal urine output, just 5 ml. of cloudy, dark, yellow urine from a Foley catheter that was inserted, demonstrative of severe dehydration (Ostler 001274, 001258). While jail nursing staff would not have known the miniscule amount of urine in Lisa's bladder, any physical assessment would have alerted them to dry mucous membranes, dry skin with poor turgor, confusion, disorientation, minimal intake and severe abdominal pain.

Any medically trained registered nurse would know the importance of conducting a focused assessment to follow up mental status changes, reduced intake, and changes in vital signs that could signal development of a more serious condition. The nurses working at the Salt Lake County Jail knew that a significant emphasis was placed on hydration, assessing for comorbidities including underlying chronic diseases and malnourishment as these were significant clinical “Takeaway Points” made by their medical director, Todd Wilcox, in his description of the WOWS Clinical Assessment protocol. Yet no assessment whatsoever was performed by any of the jail nurses.

C. The registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, failed and refused to assess and took no actions to prevent dehydration for Lisa.

The registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, took no action to assess Lisa's mental status, hydration status, food or fluid intake and refused to conduct any assessment for an underlying disease process. Any medically trained registered nurse would know that a change in a patient’s mental status or vital signs over the course of monitoring them for a serious and potentially life-threatening condition, such as drug withdrawal, would require a focused assessment to determine potential causes and determine the level of care required for treatment.

The nursing staff at no time took any action to institute any checks for dehydration such as orthostatic blood pressure to identify changes and took no action to contact an advanced level provider to determine if urine specific gravity, electrolytes, BUN, or creatinine should be checked. Lisa's weight was never rechecked to determine if additional weight loss occurred during detention or if her BMI dropped to a level below 18 when additional monitoring would have been clearly indicated. Nursing staff failed and refused to reassess Lisa's clinical status at any time. Orthostatic blood pressures had been done on other inmates, but were not done for Lisa (Medical record of Duwayne Cotter, SLCo Ostler 029163).

OPINION #5: The registered nursing staff of the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, breached professional standards of nursing care and their duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler when they failed and refused to address her meal refusal and nutritional status. Those breaches were so egregious that their actions and refusals to act cannot have been the result of the exercise of professional nursing judgment. They had to have known of the risks of suffering or death resulting from their failures to address Lisa Ostler's nutritional status, yet they still failed to address it. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #5

A. Salt Lake County Jail nurses failed and refused to assess Lisa Ostler, an inmate identified with weight loss, potential drug withdrawal, and Crohn's Disease for not eating meals and, in fact, completely dismissed the issue without conducting a face-to face assessment when the concerns were brought to their attention by a housing unit officer.

Housing Officer Unit logs reflected that Lisa refused meals from, at the latest, dinner on 3/30/2016 until she was found unresponsive and not breathing on 4/2/2016. On 4/1/2016 at 11:30 AM the Housing Officer recorded that Lisa Ostler was sick and refused lunch. Multiple inmates reported that she had not eaten any meals since being transferred to Unit 8C on 4/1/2016 at approximately 10 AM. Registered Nurse Brent Tucker was informed by Officer Frederickson that Lisa had not been eating and stated it would not be a concern until she had not eaten for 72 hours. There is no evidence that any

housing officer or nursing staff attempted to talk with Lisa Ostler about her not eating or attempted to determine how long it had actually been since she last ate. There is no evidence that Nurse Tucker attempted to determine how long Lisa had not been eating. He verbalized an absence of any concern about her nutritional status or intake without attempting to verify or obtain any information about Lisa's failure to eat meals.

Declining meals for 2-3 days is concerning. However, when accompanied by not drinking adequate fluids, weight loss, low BMI, abdominal pain, nausea, diarrhea, a deteriorating physical appearance and condition, and requests for medical help, failure to eat meals is dangerous and warrants, at a minimum, a face-to-face patient assessment to try to identify the cause. Lisa's Body Mass Index (BMI) at the time she was booked into the Salt Lake County Jail was 18.3. According to Todd Wilcox, MD, inmates at the Salt Lake County Jail were given heightened scrutiny when their BMI was <18. The Centers for Disease Control (CDC) and Prevention cite a BMI of 18.5 as "underweight". There is no evidence that any concern or attention was paid to Lisa being very close to the Salt Lake County Jail cutoff for BMI when she was noted to be refusing meals or that any consideration was paid to her low body weight in the context of abdominal pain, gastrointestinal symptoms, abnormal vital signs, or her requests for medical attention.

A training program prepared for the Salt Lake County Jail nursing staff on opiate withdrawal specifically stated that many opiate users were metabolically fragile with low Body Mass Index and limited physiological reserves.[18] The approach identified was to try to recognize these patients in booking. Lisa Ostler was not identified with a low BMI at any point in her jail detention despite being identified at booking with weight loss and Crohn's Disease, and later repeatedly refusing meals and declining physiologically. Training information identified "A low BMI is a risk factor for a bad outcome to occur more quickly. These patients don't have the physiological reserves to handle opiate withdrawal symptoms as well."[19] A patient with a low BMI would also not have the physiological reserve to handle an acute abdominal infection and pain without timely medical support that took her risk factors and symptoms seriously.

It is essential for patients with Crohn's Disease to maintain good nutrition. Crohn’s Disease can reduce appetite while increasing the body’s energy needs. Crohn’s symptoms like diarrhea can reduce the body’s ability to absorb protein, fat, carbohydrates, as well as water, vitamins, and minerals. It would be prudent for a registered nurse to assess a patient with Crohn's Disease who was not eating, was noted to have weight loss, was low weight and was not receiving

[18] Salt Lake County Jail, WOWS training program, SLCo Ostler 025525.
[19] Ibid, SLCo Ostler 025535.

any previously prescribed medication for control of the disease to determine a cause for not eating and identify their nutritional and physical status.

After Lisa Ostler's death, Nurse Tucker submitted a note in which he stated he reviewed her medical record after learning she was not eating and was bleeding. He assumed her withdrawing from alcohol and drugs explained why she may not want to eat. There was no indication that Nurse Tucker or any other nurse took any action to assess Lisa's specific situation or identify why Lisa Ostler was not eating. Nothing in Lisa Ostler's medical record justifies Tucker's belief that Lisa was withdrawing from alcohol and her drug withdrawal scoring was very low. The symptoms presented to Nurse Tucker of not eating and bleeding required an immediate face-to-face assessment. Additionally, abnormal vital signs recorded on the CIWA and WOWS assessments should have further prompted Tucker to follow up with a face-to-face encounter and assessment of Lisa's condition however there is no indication that he viewed abnormal vital signs, not eating in the context of a low BMI, and not being hydrated with any concern whatsoever. Tucker's refusal and failure to assess Lisa when he reviewed her chart and knew that she was displaying clinical symptoms was a breach of the clear requirement to conduct a face-to-face assessment when clinical symptoms were present. He triaged Lisa's not eating and bleeding reported to him by a non-medical unit officer over the telephone solely upon information he gleaned from Lisa's medical record. He conducted a "paper triage".

One of the "critical commandments" outlined by Dr. Todd Wilcox, in his presentation previously mentioned in this report included a commandment dealing with ensuring that all prisoner health requests are triaged properly: "**Thou Shalt Ensure All Prisoner Health Requests Are Triaged Properly**."[20] He stated: "To conduct triage a proper scope of license is required".[21] This statement confirmed that triage of Lisa's complaints could not be completed by a housing unit officer or other staff that was not medically qualified to perform triage of health requests. He went on to say "All five vital signs must be completed through face-to-face triage; paper triage is not safe or effective and should not be used."[22] Yet nursing staff, specifically Nurses Brent Tucker and Colby James, refused to appropriately triage Lisa's health requests despite this being a "critical" commandment in correctional health care handed down by the jail medical director. Nurse Brent Tucker used an unsafe and ineffective paper triage to address, or refuse to address, Lisa's concerns.

[20] Wilcox, Todd, MD, MBA, CCHP-A, CorrectCare, Critical Commandments in Correctional Health Care: Part 1, Part 2, Part 3, Spring, Summer, Fall 2013.
[21] Ibid.
[22] Ibid.

B. Registered nursing staff at the Salt Lake County Jail, including, at a minimum, Nurses Ron Seewer and Brent Tucker, knew the importance of ensuring adequate nutrition for a patient with a history of weight loss and low weight who was undergoing drug withdrawal. They would know a patient with Crohn's Disease presented additional concerns for gastrointestinal co-morbidity.

Todd Wilcox, Salt Lake County Jail medical director stated that an effective withdrawal screening and management program included assessments with attention to orthostatics, clinical signs and comorbidities.[23] Nursing staff did not at any time evaluate orthostatic blood pressures for Lisa Ostler, and did not at any time consider co-morbidities. In fact, their care and management of Lisa's health care included no assessment or follow up of her abnormal vital signs, no evaluation of her clinical signs or symptoms, and no assessments with any attention to potential comorbidities whatsoever. Their refusal to consider Lisa's presenting appearance, clinical signs and symptoms, and complaints resulted in wholly inadequate assessment, monitoring, and care by nursing staff.

Determination of the seriousness of a patient's medical issues must be made by a qualified medical person and may not be ignored or delegated to a non-medical staff person. The determination about a patient's meal refusal, lack of intake, and the potential adverse effects cannot be left to a housing unit officer for evaluation. Nursing assessment is required when an issue that could affect a patient's health is presented.

Any medically trained licensed nurse knows the importance of adequate nourishment particularly with a patient that is underweight, not eating and being monitored for drug withdrawal. There is no evidence in Lisa Ostler's medical record that she had any food intake since being booked into the jail.

Any medically trained registered nurse providing care to a patient such as Lisa Ostler in a similar circumstance would know the importance of conducting a focused assessment to follow up on an officer's report to them of an inmate's refusal of meals, repeated calls for assistance, and vaginal bleeding in the context of concurrent drug withdrawal. Any medically trained registered nurse would know that this constellation of symptoms could signal the presence or development of a more serious condition. Any nurse should have been able to see in Lisa Ostler’s medical record that she had abnormal vital signs, nausea and/or vomiting and diarrhea, a history of weight loss, no menstrual periods, and previous GI surgeries. Any medically trained registered nurse would know that the constellation of symptoms and Lisa's history could signal the presence or development of a more serious condition - a comorbidity. Any medically trained

[23] Wilcox, Todd, MD, MBA, CCHP-A, CorrectCare, Critical Commandments in Correctional Health Care: Part 2, Summer, 2013.

nurse working in the Salt Lake County Jail would know of the medical director's "takeaway point" for managing opiate withdrawal that directed nurses to assess for comorbidities including chronic disease and malnourishment. There is no evidence whatsoever that Nurse Tucker or any of the nurses working at the Salt Lake County Jail, including Nurse Seewer and Nurse James, assessed Lisa in a manner consistent with the directives of medical leadership.

C. The Salt Lake County Jail registered nurses, including, at a minimum, Nurses Ron Seewer and Brent Tucker, failed and refused to address Lisa Ostler's meal refusal and nutritional status despite documented Crohn's Disease, weight loss, low weight, and potentially life-threatening drug withdrawal.

There is no evidence that any nurse at the Salt Lake County Jail paid any attention whatsoever to Lisa's food or fluid intake. When informed she was not eating Nurse Tucker immediately dismissed the concern and informed the officer it would only be a concern if it had been 72 hours. There is no evidence that Nurse Tucker considered information he had also received about Lisa that she had been hitting her intercom button all night and was bleeding vaginally. There was also no evidence to suggest that Nurse Tucker attempted in any way to determine how long Lisa had actually been refusing food though he could not know if Lisa had been without food for 72 hours without checking with her and he took no action to talk with Lisa about her intake or medical concerns. Nurse Tucker later reported he reviewed Lisa's medical record and assumed the information she was withdrawing from alcohol and drugs explained why she was not eating. He could not know if his assumption was at all accurate. No evidence suggested Nurse Tucker assessed Lisa for the complaints reported to him by Officer Frederickson or that he took any actions to assess Lisa's failure to eat in the context of reported events (hitting her emergency intercom button all night and bleeding vaginally) all of which signaled the need for a nursing assessment. Nurse Tucker failed and refused to exercise his medical judgment and inappropriately referred decisions about Lisa needing care for her health concerns to the housing unit officer.

Opinion #6: Nurse Ron Seewer, a registered nurse employed by the Salt Lake County Jail, breached professional standards of nursing care and his duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler. Those breaches are so egregious that his actions, failures to act, and refusals to act cannot have been the result of the exercise of professional nursing judgment. Nurse Seewer failed and refused to protect Lisa Ostler's health and safety. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #6

A. Nurse Seewer knowingly failed and refused to take actions to protect Lisa Ostler's health and safety and provide appropriate nursing care to meet her serious medical needs. Nurse Seewer knowingly failed and refused to perform a pain assessment, and refused to document his actions or non-actions in response to a correctional officer's request for him to see Lisa Oster for her complaints of pain.

Nurse Ron Seewer, a registered nurse at the Salt Lake County Jail for 17 years, was an experienced, medically trained nurse. He knew the nursing standards for patient care and treatment for which he was responsible and accountable. He was trained and knew the policies, procedures, and protocol of the Salt Lake County Jail (Seewer Deposition, pp 24-26).

The Salt Lake County Jail Nurse Job Description stated that essential functions of the Jail Nurse job included assessing the physical condition of prisoners by performing physical examinations and obtaining medical histories, formulating medical plans based on the patient's condition, and initiating triage and determining priority of emergent/urgent care. Another essential function of the Jail Nurse job included complying with medical record policies regarding the complete and accurate documentation of patient care, initiating and maintaining required records and legal documents (SLCo Ostler 000263-000264).

On 4/1/2016 at approximately 3:25 PM the 8C housing officer, Todd Booth, noted in his unit log that Nurse Ron was on the unit for medication pass and diabetic checks and testified to this in his deposition. Booth testified he told Nurse Seewer to check Lisa Ostler because of her complaints of pain (Booth Deposition, p 34) and noted in his shift log that Lisa Ostler was complaining of pain. He stated he heard Lisa Ostler complaining of pain. He testified that Nurse Seewer examined Prisoner Ostler, that he spoke with her about her pain, and checked her temperature (Booth Deposition, pp 33-34). Officer Booth testified that Nurse Seewer and cleared Lisa Ostler to stay in the unit with no further medical needs and no further medical evaluation or treatment.

An untrained, non-medical officer reported Seewer "examined" Lisa and "cleared" her to remain in Housing Unit 8C. Nurse Seewer had no recollection of Lisa Ostler and no recollection of his examination of her on 4/1. He did not document any contact with Lisa or information from any encounter with her. Other than an untrained officer's mention of a temperature taken (that was not documented by Seewer) there was no evidence to suggest that any "examination" took place or that Seewer talked with Lisa about pain and no documentation suggested Lisa was medically cleared. There is no documentation

in Lisa's medical record to suggest she had any encounter with Nurse Seewer related to her complaints of pain or that she was evaluated in any way.

Seewer was trained to document all potentially significant patient encounters and knew that an inmate examination or assessment for pain at which he provided clearance to remain on a general housing unit as opposed to transfer to a medical unit or hospital was a significant encounter that required documentation in the patient's medical record. Seewer knew the importance of assessing and providing treatment that was responsive to patient complaints. He knew how to conduct assessments, including pain assessments and how to access appropriate care at the level the patient's condition required. He knew what his options were to address a patient presenting with pain issues and knew how to document an assessment or encounter with an inmate he evaluated for pain if he actually performed such an assessment.

Nurse Seewer knew the requirements and importance of documenting patient encounters and treatment in the medical record. He knew his legal responsibility to document patient observations and care in the jail medical record and knew that if care was not documented, it was not done. He received training on documentation and assessments. He knew he had an ethical and professional duty and obligation to protect Lisa Ostler's health and safety.

B. Any medically trained nurse providing care to a patient such as Lisa Ostler at the Salt Lake County Jail would know the importance of adhering to nursing standards for patient care, policies and procedures of the organization, assessment requirements, documentation requirements, and ethical behavior.

Any medically trained nurse providing care to a patient such as Lisa Ostler being monitored for drug withdrawal would know the importance of completing withdrawal protocol assessments as ordered and would completely and accurately document their findings in the medical record. A medically trained nurse would know the importance of monitoring for co-morbid conditions, a deteriorating physical status, abnormal vital signs, and other signs or symptoms of a condition that was described by their own medical director as life-threatening.

Any medically trained nurse providing care to a patient such as Lisa Ostler in a similar circumstance who was informed that she was complaining of pain would know the importance of conducting a careful pain assessment and of not ignoring the patient’s report of pain.

Any medically trained nurse would know the importance of meeting their responsibility for conducting assessments and documentation and would complete their assigned tasks as required with honesty and integrity. A medically trained

nurse would not rely on an untrained, non-medical housing officer to describe or document their nursing actions taken on behalf of a patient with medical requests or needs.

"Inmates have several ways to access health care, such as by submitting a request slip ... or through oral communication, for example, by telling a correctional officer of a need to be seen by medical or mentioning a health concern to the nurse during medication administration. Regardless of the method, the nurse has a legal and ethical obligation to respond to the request for care. In general, the nurse should see the patient to evaluate health needs and determine the level of care required. If the communication is from the officer to the nurse, the nurse has a responsibility to speak to the inmate ... Based on the information provided, the nurse must determine the type and level of nursing intervention required and then implement an action ... the nurse must document the health needs, how notification of the health need occurred, actions taken and the patient outcome."[24] Triage can be initiated by verbal notification to a nurse or officer. An inmate could request help by verbally notifying the nurse or an officer (Riser Deposition, pp 11 – 12). There is no information to suggest that Lisa was ever instructed about how to access health care or more specifically, how to access emergency health care. Yet she managed to appropriately request care via oral communication. Despite this, nursing staff did not respond in a professional, legal or ethical manner.

Any medically trained nurse, including any nurse working in the correctional health care setting, would know of their professional duty and responsibility to see patients for assessment of health care concerns. Any medically trained nurse would know of their duty and responsibility to see a patient in response to their request for medical attention and document actions in a way the information could be retrieved and reviewed. Any medically trained nurse would know of their ethical duty, responsibility, and obligation to promote, advocate for, and protect the health and safety of the patient as outlined in the Code of Ethics for Nurses, a nonnegotiable ethical standard for every individual nurse who enters and works in the profession.[25]

Peritonitis is a serious medical condition characterized by severe, worsening abdominal pain, abnormal vital signs, abdominal tenderness and guarding, rebound tenderness, decreased bowel sounds, abdominal rigidity, distension, and an overall ill appearance. Any medically trained registered nurse would know the importance of evaluating a patient who was complaining of pain and appeared very ill. Even the most basic pain evaluation of Lisa Ostler would have revealed severe abdominal pain and her emergent condition would have

[24] Muse, Mary MS, RN, CCHP-RN, CCHP-A, Ethical and Legal Issues, National Commission for Correctional Health Care, CorrectCare, Winter 2011.
[25] American Nurses Association, Code of Ethics for Nurses with Interpretive Statement. 2001.

been immediately obvious. Any attempt at palpation of her abdomen on 4/1/2016 would have elicited an overwhelming pain response - that is, if Lisa Ostler would have been able to lie on her back to permit such an abdominal exam due to the level of her pain.

Registered Nurse Ron Seewer was bound by nursing standards of practice and ethical standards and by the policies and procedures of his organization. He knew the standards and what his professional obligation was to provide care for Lisa Ostler yet he knowingly failed and refused to meet his duties and obligations to her. He performed no assessment of Lisa. He did not assess her pain. He took no action to identify her medical history or risk factors for co-morbid conditions. He refused to consider Lisa was experiencing any condition other than drug withdrawal, a condition he did not treat seriously and he did not treat her complaints of pain.

C. Nurse Seewer had been employed since 1999 as a Registered Nurse at the Salt Lake County Jail as a jail nurse (approximately 17 years) at the time he encountered Lisa Ostler. He knew or should have known the responsibilities and duties of his job position and knew or should have known the nursing standards and ethical responsibilities that applied to his nursing profession as it related to care of patients such as Lisa Ostler. Nurse Seewer breached standards of nursing care, policies and procedures of the jail, breached the nursing code of ethics and refused to protect the health and safety of Lisa Ostler, a patient under his care and supervision.

Nurse Seewer had ample time available to assess Lisa's health status and provide essential nursing care for her serious medical needs. He testified that it was common for nurses to utilize jail computers to watch videos on YouTube and television shows and testified that he would surf the internet for an hour or two throughout his shift (Seewer Deposition, pp 20-23). He testified it was common for the jail nurses to watch movies, TV shows, or surf the internet every day. An assessment of Lisa Ostler's pain complaint and medical needs would likely have taken fifteen minutes or less.

Lisa's medication administration record reflected that Lisa was given medication in the afternoon of 4/1 by a nurse, a task that verified she was available and within close eyesight of the nurse. The housing unit officer recorded that at 1525 hours on 4/1, Nurse Ron was in Unit 8C for a medication pass (Seewer Deposition, p 174). Seewer knew Lisa was available and knew her location. The initials recorded on the Medication Administration Record certainly do appear to reflect "RS". Seewer was the nurse available and responsible to assess Lisa’s medical condition.

Nurse Ron Seewer knowingly failed and refused to perform any pain assessment of Lisa and refused to assess Lisa's complaints of pain that were reported to him. Officer Todd Booth told Seewer to check Lisa because of her complaints of pain (Booth Deposition, p 34). There is no evidence whatsoever to suggest that Nurse Seewer performed any assessment or examination of Lisa for her complaints of pain. He did not even perform CIWA and WOWS assessments, including the monitoring of Lisa's vital signs, that were ordered and required. An assessment of Lisa Ostler was clearly indicated in response to knowledge that she was complaining of pain and was being monitored for life-threatening withdrawal. Documentation that was present in Lisa's record reflected that Lisa was not available for an assessment despite her being available to receive medication. The documentation portrays a conflict in nursing staff reports and reflects that no assessment was done. Officer Booth recorded that Seewer cleared Lisa to remain on the unit (Booth Deposition, p 33). Seewer testified that clearing an inmate to stay in their cell would have involved completion of an assessment including vital signs (Seewer Deposition, p 77), however, no information, including vital signs, was documented by Seewer and no evidence of an assessment was recorded. Seewer would have noted any medical encounter with Lisa Ostler, including any assessment or evaluation, in the medical records.

Information from other inmates housed with Lisa on 8C consistently described Lisa as looking deathly ill and in pain, obviously in need of medical attention. There was no information to suggest that Seewer made even a visual observation of Lisa's status, much less a focused assessment for pain, at the time he allegedly administered medication to her on 4/1, approximately 12 hours before she was found unresponsive and not breathing in her cell.

On 4/1/2016 at approximately 8:20 or 8:30 AM, Nurse Ron Seewer documented a CIWA Withdrawal Assessment for Lisa including vital signs plus an assessment of ten clinical signs and symptoms of potential withdrawal (SLCo Ostler 000155). Video footage of Unit 8C at this point in time pictures a nurse bending down toward Lisa, who was sitting on the floor. The exchange lasts a mere 30 seconds. Nurse Seewer testified that taking vital signs would take about a minute or two using an automatic blood pressure monitoring machine (Seewer Deposition, pp 33-34). Monitoring of respirations would take another 30 seconds to 1 minute (Seewer Deposition, p 146) and would require full attention of the nurse to count each chest rise and fall. The nurse, was also attending to another inmate at the same time as Lisa so did not devote full attention to her. To obtain the vital signs and symptom assessment recorded on 4/1/16 AM for Lisa would have taken a minimum of 2-3 minutes and could not have been accomplished in 30 seconds. Several of the symptoms that Seewer recorded as not present would have required an inquiry and conversation with Lisa in order to record the result as they could not have been objectively observed: nausea, anxiety, tactile disturbance, auditory hallucinations, visual disturbance, headache or fullness in

the head and orientation. To determine sweating or tremors, Mr. Seewer or another nurse would have had to touch Lisa's skin or ask her about the symptoms in order to record an accurate status. It would not be possible for Nurse Seewer or another nurse to have taken Lisa's vital signs and completed a symptom assessment in 30 seconds. The assessment, documented by Nurse Seewer on the CIWA worksheet on 4/1/2016, could not have been the result of an actual assessment. A WOWS assessment for the same time was recorded by another nurse. It is unclear why two nurses recorded an assessment for the same time when neither nurse was observed on the video tape performing the actions that would have been obvious if an assessment had actually been done

Any nurse would know that a patient evaluation cannot be performed in the middle of a cell block common area. Asking medical health questions in an open, non-private area violates a patient's right to privacy of health information and compromises the assessment process. Except in emergencies or other life-threatening situations, it is not appropriate to evaluate patients in cell, on tiers, in hallways, or other nonclinical settings.

The blood pressure, pulse, respirations, temperature and oxygen saturation recorded for Lisa on the morning of 4/1/2016 was within normal limits. The findings follow the significantly abnormal results of the previous day and precede her being found unresponsive and not breathing less than 24 hours later. Lisa was observed on the video tape holding her abdomen and having difficulty walking; she was exhibiting obvious objective signs of pain. Lisa's condition was **worsening NOT improving**. It is not reasonable to believe that Lisa's vital signs and symptoms assessment were accurately recorded on the morning of 4/1/16, if the assessment was actually completed. It is also not reasonable to believe that Lisa's vital signs had improved to completely normal given the degree of pain she exhibited and the infectious process that was taking place. It is essential to view the recorded vital signs and assessment for 4/1/16 AM in the context of the notation on 4/1/16 PM that designated Lisa was not available for vital signs and an assessment despite her being available for medication administration and being given medication and no indications she had ever left her cell. The validity of the documentation of Lisa's completely normal vital sign on the morning of 4/1 s is not believable.

Nurse Seewer failed and refused to provide any documentation of his actions taken to address Lisa Ostler's health concerns. Nurse Seewer refused to document any encounter with Lisa Ostler whatsoever and there was no documentation by Nurse Seewer that he saw Lisa on the afternoon of 4/1 other than initials on her MAR that suggest he administered medication to her. He testified he had no recollection at all of examining her or of clearing her to stay in the unit (Seewer Deposition, pp 174-175). A designation was entered on the CIWA and WOWS assessment forms that Lisa was either not available or was not

on the unit. No documentation in Lisa's record or in the unit records kept by officers suggests she left unit 8C for any reason. Lisa's medication administration record reflects she received Librium medication three times on 4/1, verifying nurse contact three times at a minimum and administration of the medication in the afternoon or early evening on 4/1. Nurse Seewer was the "medication nurse" on 8C on 4/1 and appeared to have recorded medication administration to Lisa Ostler on two occasions in the afternoon/evening of that day. If Lisa was available to receive medication, she was also available for an assessment, yet neither Seewer nor any other nurse recorded any assessment whatsoever and, in fact, some nurse erroneously documented she was not available. Seewer's documentation was, at the very least, contradictory and suggestive of a knowing decision and refusal to perform a required assessment for a patient with serious medical needs and needs for medical care.

Nurse Seewer refused to report or record care provided (or not provided). The documentation and the absence of documentation available in Lisa Ostler's medical record reflected Nurse Ron Seewer's failures and refusals to act and demonstrated he provided no assessments, care, or interventions in response to Lisa Ostler's serious medical needs or requests for medical help in the final hours of her life. He refused to assess Lisa Ostler's complaint of pain and reportedly allowed her to remain in the Housing Unit 8C as opposed to transferring her to the Medical Unit without conducting any focused nursing assessment or any assessment at all to determine her actual needs and appropriate interventions. The lack of any documentation in Lisa's medical record of any assessment done on the afternoon of 4/1/2016 and Nurse Seewer's testimony that he had no recollection of conducting an assessment of Ms. Ostler and did not document in her medical record that he evaluated her in any way was consistent with no assessment whatsoever. He testified that if he had taken Ms. Ostler's vital signs or done an assessment he would have documented the information in her medical record (Seewer Deposition, pp. 50, 78). No such documentation existed.

Any assessment of Lisa Ostler performed on 4/1/2016 at 3:25 PM, just 17 hours before she was found unresponsive and not breathing (and later determined to have peritonitis secondary to a bowel perforation), after she had been requesting medical attention would have revealed a significant, emergent condition that warranted immediate emergency intervention. Nurse Seewer testified he was trained to distinguish abdominal pain caused by withdrawal from abdominal pain caused by a different serious medical issue and had this nursing knowledge (Seewer Deposition, p 210). He further testified that symptoms of withdrawal and abdominal pain are the same thing so if a patient was having withdrawal and abdominal pain it would be a symptom of withdrawal (Seewer Deposition, p 211). Seewer's testimony verified he would dismiss the possibility that a patient with abdominal pain undergoing drug withdrawal could have a more serious condition or disease process even though he had the nursing knowledge to

make a clinical distinction. His testimony reflected his approach toward inmates such as Lisa of a blatant disregard for the possibility that they could have a serious medical condition manifested by abdominal pain even though he had the knowledge to differentiate abdominal pain with withdrawal from potential conditions that were significantly more serious. He stated that if a patient with withdrawal had abdominal pain, he would assume it was the withdrawal and that would not raise any red flags for him. His testimony reflects a disregard for serious patient needs based upon the individual's circumstance and offense, a breach of nursing standards. His testimony also reflects a disregard of the fact that, as Dr. Wilcox has emphasized, drug withdrawal is a serious medical condition and can be life-threatening. He refused to follow the very first standard of nursing practice that dictates the essential and significant nursing action of assessment, the first authoritative statement of the duties that all registered nurses, regardless of role, population, or specialty are expected to perform competently.

Nurse Seewer's failure and refusal to address Lisa Ostler's pain and serious, worsening, life-threatening medical needs demonstrates a significant breach in the standards of nursing care for assessment, diagnosis, and intervention. Had Nurse Seewer simply done an assessment of Lisa Ostler's complaint of pain, he would have been prompted to TOUCH her abdomen and would have obtained sufficient physical and clinical information to identify the health crisis that was progressively unfolding and he would have been aware of the degree of pain she was experiencing. At that point he would have had sufficient information to arrange her transfer for required emergency care as opposed to ignoring her serious medical needs and keeping her on the housing unit, alone in 8C16.

At the time Nurse Seewer was asked to see Ms. Ostler for pain, she had not eaten several, if not all, of the meals served to her since her arrival at the Salt Lake County Jail, she had not left her jail cell, she was observed and described by other inmates as looking deathly sick physically and having a gray skin appearance and she had been observed holding her abdomen, moaning and calling out in pain. Even the most basic attempt and effort to conduct an assessment of Lisa Ostler's pain would have revealed her health status sufficiently enough to prompt a more careful and thorough examination, a report to the physician, or transfer to the emergency room. Nurse Seewer was the gatekeeper for Lisa's access to appropriate medical care for her serious medical needs at a **critical time for instituting critical life saving measures on 4/1**. He failed and refused to implement any measures to assess, treat or intervene on Lisa's behalf.

If Seewer examined Ms. Ostler at the request of Officer Booth, as Booth reported, he did not check her vital signs and did not document a single indication of any examination. To the contrary, Lisa's medical record reflects that she was

"not available" a description that was not an honest or ethical description of the reason he failed to perform or refused to arrange for performance of an assessment. Nurse Seewer knew or should have known the responsibilities and duties of his job position as it related to the performance of patient assessments. He was experienced and trained. Nurse Seewer simply did not do the assessments he was required to do for Lisa.

Nurse Seewer did not take any vital signs, did not perform any assessment of reported pain, did not conduct an abdominal evaluation, did not conduct any evaluation at all for Lisa Ostler, and did not provide any other medical help in response to her complaints of pain and requests for medical help. Nurse Seewer did not refer her for any other medical diagnosis or treatment. Nurse Ron Seewer failed and refused to conduct a physical assessment of Lisa Ostler, an essential and basic responsibility that is the sole purview of the registered nurse. Refusal to conduct an assessment of a patient's complaint of pain is a significant breach of nursing standards and cannot be viewed as accidental or an oversight. The refusal to perform an assessment in response to a patient request for help and complaint of pain is an intentional disregard of a patient's serious medical need. Nurse Seewer was the gatekeeper with control over medical interventions that could have been accessed for the care of Lisa Ostler on 4/1, **a critical time period during which lifesaving care and treatment could have been provided**. He failed and refused to provide any health care intervention whatsoever.

Nurse Seewer's failure and refusal to perform assessments that were clearly indicated reflected a cultural, customary, and accepted practice among nurses at the Salt Lake County Jail to minimize and discount pain complaints and the need to do focused assessments for inmates with drug withdrawal and to ignore the need for twice daily assessments despite doctor orders and program requirements. Seewer was not the only nurse that knowingly and intentionally refused to properly assess Lisa. NONE of the nurses who had contact with her assessed her for pain, not eating, hydration, abnormal vital signs, declining physical status, medication need, or the presence of co-morbid physical conditions that resulted in the worsening of Lisa's progressive and obviously grave condition. An accepted and pervasive staff attitude and approach of ignoring patient needs was clearly and openly endorsed by registered nurses who were all trained and educated to address health concerns for every patient regardless of circumstance or offense.

I incorporate herein my Opinions numbered 1, 2, 3, 4, and 5, above. Each of those opinions applies to Nurse Ron Seewer. Nurse Ron Seewer had all knowledge attributed to nurses described in those opinions and failed to act as described in those opinions.

OPINION #7: Nurse Brent Tucker, a registered nurse employed by the Salt Lake County Jail, breached professional standards of nursing care and his duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler on April 2, 2016. Those breaches are so egregious that his actions, failures to act, and refusals to act cannot have been the result of the exercise of professional nursing judgment. Nurse Tucker failed and refused to protect Lisa Ostler's health and safety. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #7

A. Nurse Tucker knowingly failed and refused to assess Lisa Ostler in response to Officer Zachary Frederickson's report to him that she had been hitting the intercom button all night long, was not eating, and was complaining of vaginal bleeding. He blatantly disregarded her not eating as a result of drug withdrawal, took no action to verify his belief and made the assumption without any clinical corroboration**.** He did not, in any way, evaluate Lisa's report of bleeding and, in fact, instructed the non-medical, untrained housing unit officer to check into it. Nurse Tucker conducted no clinical assessment of Lisa's medical needs or complaints. Nurse Tucker breached his duty to obtain health information and appropriately assess and secure care for Lisa Ostler. Tucker failed and refused to exercise any medical judgment about Lisa Ostler's health status and condition and, instead, delegated his responsibility to an untrained housing unit officer.

Nurse Brent Tucker, a registered nurse at Salt Lake County Jail, was an experienced nurse. He knew or should have known the responsibilities and duties of his job position and knew or should have known the nursing standards and ethical responsibilities that applied to his nursing profession as it related to care of patients such as Lisa Ostler. Nurse Tucker breached standards of nursing care, policies and procedures of the jail, breached the nursing code of ethics, and refused to protect the health and safety of Lisa Ostler, a patient under his care and supervision.

The Salt Lake County Jail Nurse Job Description stated that essential functions of the Jail Nurse job included assessing the physical condition of prisoners by performing physical examinations and obtaining medical histories, formulating medical plans based on the patient's condition, and initiating triage and determining priority of emergent/urgent care. Another essential function of the Jail Nurse job included complying with medical record policies regarding the complete and accurate documentation of patient care, initiating and maintaining required records and legal documents (SLCo Ostler 000263-000264).

Nurse Tucker would have had ample time available to assess Lisa's health status and provide essential nursing care for her serious medical needs. He did nothing to assess her; he did not even take her temperature. There is no information to suggest that Nurse Tucker even bothered to ask Lisa about her repeatedly pressing the emergency button through the night, about her not eating, or about vaginal bleeding, or that he considered Lisa may have a condition unrelated to drug withdrawal. He failed and refused to respond to information about an inmate's medical condition that obviously needed an assessment by a trained professional medical staff person as opposed to an untrained, non-medical housing officer.

Tucker received training and knew the requirements and importance of documenting patient encounters and treatment in the medical record. He knew he had an ethical duty and obligation to protect Lisa Ostler's health and safety. He knew his legal responsibility to document patient observations and care in a patient's jail medical record and knew that if care was not documented, it was not done. He was trained to document all potentially significant patient encounters. Tucker testified that if there was not a note written by him in Lisa's medical record, he did not assess her (Tucker Deposition, p 47). There was no note entered by Nurse Tucker in Lisa's record.

On 4/2/2016 Housing Unit Officer Zachary Frederickson began his shift and was informed by the graveyard officer, Holly Harris and his Supervisor, Heather Beasley, that Ms. Ostler had been crying, screaming, pressing the emergency intercom call button, and asking for a nurse continuously throughout the night. Officer Frederickson spoke with nurse Brent Tucker about Ms. Ostler and informed him she had been hitting the intercom all night (Frederickson Deposition, p 190). Nurse Tucker reportedly spoke with Lisa briefly and then left the unit. He did not document any contact, observation, or information in Lisa's medical record. Officer Frederickson learned that Lisa reported vaginal bleeding and was not eating He again contacted Nurse Tucker and reported Lisa's complaint of vaginal bleeding and that she had been refusing meals.

Nurse Tucker knew the importance of conducting a review of Lisa Ostler's medical record after receiving an officer report that she was bleeding and not eating. Tucker knew that a face-to-face assessment of a patient reporting clinical symptoms needed to be performed. Tucker also knew that a housing officer was not medically trained to evaluate a patient's health status and would not be qualified to determine if reported bleeding or not eating was an emergency, yet, without performing any assessment whatsoever, Nurse Tucker told the officer that eating was not a concern until 72 hours had passed and reportedly asked Officer Frederickson if Ms. Ostler's bleeding was menstrual and if it was a medical emergency. He instructed the officer to have Lisa fill out a triage kite/sick call request form if it was not an emergency, leaving it for Frederickson to make the

medical judgment as to whether there was a medical emergency. Nurse Tucker did not ask additional questions and refused to take any action whatsoever to evaluate Lisa or assess her for the presence of an emergent condition as he was required to do.

Housing Unit Officers were trained to contact a member of the Health Services staff if they become aware of an inmate complaining of an emergency (Dumont Deposition, p 44). It was inappropriate for a Housing Unit Officer to provide an inmate with a sick call request form if the inmate believed they were experiencing an emergency and requested medical attention (Dumont Deposition, pp 45-50). If an inmate communicated they had pain and wanted to see medical, the Housing Deputy should contact medical (Dumont Deposition, p 121). Officer Frederickson contacted Nurse Brent Tucker regarding Ms. Ostler's repeated requests for medical care and complaints of vaginal bleeding. He also reported that Ms. Ostler had not been eating. He was not qualified to determine the medical implications of vaginal bleeding or not eating or to observe and assess her signs and symptoms. He was not trained to triage inmate medical complaints, but was trained to report them to the medical staff.

Brent Tucker knew it was his responsibility to conduct a face-to-face assessment of Lisa Ostler in response to her complaints of bleeding and the officer's report that she was repeatedly hitting the emergency button all night and was not eating. Tucker knew a housing unit officer was not qualified to conduct a medical assessment to determine whether health care complaints constituted a medical emergency and knew officers had no access to a patient's medical history or record. Nurse Tucker had access to Lisa's medical history and medical record and knew or should have known all of the information obtained at the time of her booking including weight loss, Crohn's Disease, low weight, drug withdrawal, sudden cessation of all of her medications, and no menstrual periods. At the time he was contacted by Officer Frederickson, Nurse Tucker was the designated medical staff person at the jail that could have intervened to evaluate Lisa Ostler's medical issues and act on her behalf to ensure her health and safety and to assess her serious medical issues. Nurse Tucker was the gatekeeper and controlled all medical interventions that could have been accessed for the care of Lisa Ostler on the morning of 4/2 at an **absolutely critical time for instituting lifesaving measures** for her serious life-threatening medical condition. He failed and refused to provide any health care intervention whatsoever.

B. Nurse Brent Tucker knew it was his responsibility to evaluate Lisa Ostler's medical complaints. She contacted a Housing Officer regarding her medical situation that she perceived was an emergency, she pressed her emergency button to summon help approximately 16 times throughout the night, she was in pain, and, according to Officer Frederickson, she complained of bleeding. It was

appropriate for Lisa Ostler to request medical attention by verbally contacting a correctional officer, as stated on sings posted in the jail and as described in a handbook at the jail.

Any medically trained nurse providing care to a patient such as Lisa Ostler in a similar circumstance who was informed she had been requesting medical help throughout the night and was complaining of pain would know the importance of conducting a careful pain assessment and of not ignoring the patient's report of pain. Any medically trained nurse would evaluate a patient's complaint of pain and bleeding to determine the location, the amount, the intensity, and whether the patient needed referral to a higher level of medical care. Any medically trained nurse providing care to a patient such as Lisa Ostler at the Salt Lake County Jail would know the importance of adhering to nursing standards for patient care, policies and procedures of the organization, assessment requirements, documentation requirements, and ethical behavior.

"Inmates have several ways to access health care, such as by submitting a request slip ... or through oral communication, for example, by telling a correctional officer of a need to be seen by medical or mentioning a health concern to the nurse during medication administration. Regardless of the method, the nurse has a legal and ethical obligation to respond to the request for care. In general, the nurse should see the patient to evaluate health needs and determine the level of care required. If the communication is from the officer to the nurse, the nurse has a responsibility to speak to the inmate ... Based on the information provided, the nurse must determine the type and level of nursing intervention required and then implement an action ... the nurse must document the health needs, how notification of the health need occurred, actions taken and the patient outcome."[26]

Any medically trained nurse, including any nurse working in the correctional health care setting, knows of their professional duty and responsibility to see patients for assessment of their health care concerns. Any nurse knows of their duty and responsibility to see a patient in response to their request for medical attention and document their actions in a way the information can be retrieved and reviewed.

Any medically trained nurse knows of their ethical duty, responsibility and obligation to promote, advocate for, and protect the health and safety of the patient as outlined in the Code of Ethics for Nurses, a nonnegotiable ethical standard for every individual who enters and works in the nursing profession.[27] Any medically trained nurse would know the importance of meeting their

[26] Muse, Mary MS, RN, CCHP-RN, CCHP-A, Ethical and Legal Issues, National Commission for Correctional Health Care, CorrectCare, Winter 2011.
[27] American Nurses Association, Code of Ethics for Nurses with Interpretive Statement. 2001.

responsibility for conducting assessments and documentation and would complete their assigned tasks as required with honesty and integrity. Any medically trained nurse would not rely on a medically untrained housing officer to describe or document their nursing actions taken on behalf of a patient with medical requests or needs and would not expect an officer to determine if a patient's complaints were emergent or not.

Nurse Tucker knew it was inappropriate for him to expect the Housing Officer to determine if Lisa Ostler was experiencing a medical emergency and knew it was inappropriate for him to expect an inmate experiencing a medical emergency to complete a sick call request form. Tucker knew that it was a breach of nursing standards to refuse to exercise his medical judgment about the health needs of a patient dependent upon his interventions for medical care.

At the time Nurse Tucker was approached about Ms. Ostler's failure to eat and vaginal bleeding she had not eaten several, if not all, of the meals served to her since her arrival at the Salt Lake County Jail. She had not left her jail cell, was observed and described by other inmates as looking very sick physically and having a gray skin appearance, and she had been observed holding her abdomen, moaning and calling out in pain, symptoms that were sufficient enough to prompt a careful and thorough examination. Any medically trained nurse would know the importance of conducting a careful assessment of vaginal bleeding in an inmate who was no longer having menstrual periods. Any medically trained nurse would know the importance of not ignoring the patient's report. Any medically trained nurse would know the need to assess a patient complaining of bleeding to determine the source, nature and extent of the bleeding and would know the importance of conducting such an assessment in any case, and especially for a patient with documented Crohn's Disease who was being monitored for drug withdrawal and had all of their prescription medication abruptly stopped.

C. Nurse Brent Tucker failed and refused to address any of the medical concerns brought to his attention by housing unit officer Frederickson on the morning of 4/2, just minutes before Lisa Ostler was found unresponsive and not breathing in her cell.

Nurse Brent Tucker was on 8C conducting diabetic checks on 4/2/16 at approximately 6:38 AM. He was told by Officer Frederickson that Lisa had been hitting the intercom all night (Frederickson Deposition, p 190). Lisa was hitting the emergency call button in her cell to obtain medical help for a health care emergency. Nurse Tucker reportedly walked over to her cell, spoke with Lisa briefly, and then left the unit. Tucker did not document any contact, conversation, observation, or interaction in Lisa's medical record. No evidence in Lisa's medical record provides any information as to her level of consciousness or

responsiveness at the time Tucker reportedly spoke to her. In light of the fact that Lisa had experienced a perforated ulcer and peritonitis, it is inconceivable that Lisa would not have expressed and manifested her pain and her need for medical help to a nurse standing at her cell door.

When Nurse Tucker was informed of Lisa's multiple requests to see medical and reportedly walked over to her cell, he would have seen Lisa Ostler just about 90 minutes before she was found unresponsive and not breathing in her jail cell. Untrained laypersons on 8C noted Lisa's grave condition and her dire need for medical attention hours before Tucker ever arrived. It is inconceivable that a trained, experienced nurse would not have, at a minimum, questioned Lisa about her concerns or visually noted her serious medical condition. Even a most basic attempt and effort to conduct an assessment of Lisa Ostler's complaints would have revealed her dire medical difficulties on the morning of 4/2. No one could have seen Lisa at that point and not perceived she was suffering extreme pain and had a serious medical condition requiring urgent medical attention.

Nurse Brent Tucker was contacted a second time by Officer Frederickson to report that Lisa Ostler was bleeding and had not been eating. Nurse Tucker asked the officer if the bleeding was from her menstrual but the officer did not know. Nurse Tucker instructed the officer to ask the inmate about the bleeding. Tucker refused to follow up or check into the housing officer's report that Lisa Ostler was bleeding and had not eaten meals. Also, had been informed by the officer that Lisa had been hitting her emergency button all night. He asked the officer if it was menstrual and if it was an emergency and then instructed him to have Lisa complete a health services form if the medically untrained officer determined it was not an emergency.

It was inappropriate for Nurse Tucker to require an inmate requesting medical help for an emergency to complete a medical sick call form. It not only does not make sense; it is not the procedure that the jail endorsed or directed inmates and staff to follow. It was not the course that the National Commission for Correctional Health Care endorses. Nurse Tucker was present on 8C when he learned of Lisa's requests and concerns. There was no discernable reason he could not have done an assessment or arranged for an assessment to be done expeditiously – a task that was his responsibility to do.

Nurse Tucker conducted no assessment of Lisa for a reported symptom of bleeding. He directed an unqualified, non-medical housing officer to ask Lisa if her bleeding was menstrual and essentially to determine the nature of her bleeding, an action that was completely inappropriate. Assessment of a patient's reported medical complaint is the sole purview of the registered nurse when they are the on-site medical provider as Nurse Tucker was. Delegation of an assessment is a clear breach of nursing standards of practice. Delegation of a

task to an individual who is not qualified to perform it is a breach of nursing standards of practice as well. Determination of the nature of a patient's bleeding would not be a task that could be delegated to a non-medical housing officer and Nurse Tucker would know this. Tucker performed no assessment of Lisa, had no information about the nature or degree of her bleeding, and knew that Lisa had been pleading for medical help throughout the entire night. Yet he refused to respond and ignored Lisa Ostler's report of a serious medical need.

Had Nurse Tucker bothered to check Lisa Ostler's medical record information that he had ready access to, he would have verified the admission information that Lisa had no menstrual periods. At that point bleeding should have prompted Nurse Tucker to perform a focused assessment. He checked her chart and noted her diagnosis of drug withdrawal. At that point he disregarded all other potential causes for her complaints and assumed they were all related to drug withdrawal. He performed no assessment whatsoever. Tucker did not even question Lisa about her symptoms. Had Nurse Tucker bothered to conduct any assessment at all of Lisa's complaint of bleeding he would very likely have identified the emergent state she was in at that time and been able to emergently refer her to a competent provider before she became unresponsive and stopped breathing. Nurse Tucker refused to evaluate Lisa at an absolutely **critical point in time when she required emergent lifesaving intervention.**

When Nurse Tucker was contacted for the second time on the morning of 4/2 and informed that Lisa was bleeding and not eating, he simply stated not eating was not a problem unless it had gone on for at least 72 hours yet he took no action to check how long Lisa had not been eating. Days after Lisa died, Nurse Brent Tucker submitted an event timeline for 4/2/16 and reported he "looked up this individual and saw she was W/D from ETOH and Drugs which explains why this pt. may not want to eat." (Brent Tucker memo, SLCo Ostler 026515). There is no evidence to suggest that Nurse Tucker considered any other reasons Lisa was not eating or that he considered her medical history when he conducted the paper triage of her medical issue. There is no indication that Nurse Tucker ever considered returning to 8C to evaluate Lisa in any way or that he considered asking another nurse, such as the triage nurse, to see her.

Mr. Richard Bell, the Responsible Health Authority at the Salt Lake County Jail, testified that it would be inappropriate for a nurse called by a unit officer to ask the Housing Officer whether the patient’s complaint was a medical emergency (Bell Deposition, p 61). Mr. Bell testified that communication from Brent Tucker asked the medically untrained housing officer if Ms. Ostler’s bleeding was menstrual and the officer did not know. There was no indication that Brent Tucker or any other health staff or medical staff ever checked on Lisa Ostler to see if she was bleeding and, if so, from where and what source (Bell Deposition, May 20, 2019, p 67). Brent Tucker apparently disregarded the

obvious risk of urgent or emergent causes for Ms. Ostler's bleeding, including possible organ damage, injury, or an intra-abdominal illness.

The Prisoner Rules and Regulations Handbook instructed inmates who had a medical emergency to notify the Housing Unit Officer immediately and Health Services would respond as quickly as possible (Prisoner Handbook, SLCo Oster p 009133). The housing officers and medical staff controlled all access to medical care for the inmates at Salt Lake County Jail. As the gatekeepers of medical care for Lisa Ostler they all failed and refused to ensure access to care and the provision of essential life-saving interventions.

Nurse Tucker blatantly disregarded Lisa's not eating (stating after Lisa's death that he attributed it to drug and alcohol withdrawal), took no action to verify his belief, and made the assumption without any clinical corroboration**.** Nurse Tucker's knowing disregard of Lisa's symptoms under the purported assumption that they were just due to withdrawal was remarkably similar to Nurse Seewer's knowing disregard for performance of an assessment for abdominal pain due to his purported assumption of it just being a result of drug withdrawal. The nursing staff failures and refusals to conduct assessments that were clearly indicated conformed to a cultural, customary, and accepted practice among nurses at the Salt Lake County Jail that symptoms exhibited by inmates undergoing drug withdrawal were not taken seriously. Rather, symptoms were assumed to be related to withdrawal and ignored. Tucker was not the only nurse that knowingly and intentionally failed and refused to properly assess Lisa. NONE of the nurses who had contact with her assessed her for pain, not eating, hydration, abnormal vital signs, declining physical status, medication need, or the presence of co-morbid physical conditions that resulted in the worsening of Lisa's progressive and obviously grave condition. An accepted and pervasive staff attitude and approach of ignoring patient needs was clearly and openly endorsed by registered nurses who were all trained and educated to address health concerns for every patient regardless of circumstance or offense. They all knew -- Nurse Tucker and Nurse Seewer both knew -- that refusal to assess a patient's presenting clinical symptoms and secure appropriate treatment to meet their serious medical needs was a violation of nursing standards, practice, duty and ethical responsibilities.

I incorporate herein my Opinions numbered 1, 2, 3, 4, and 5, above. Each of those opinions applies to Nurse Brent Tucker. Nurse Brent Tucker had all knowledge attributed to nurses described in those opinions and failed to act as described in those opinions.

<u>OPINION #8:</u> Nurse Colby James, a registered nurse employed by the Salt Lake County Jail, breached professional standards of nursing care and his duty to act as any medically trained nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler on April 2, 2016. Those breaches were so

egregious that his actions, failure to act, and refusals to act cannot have been the result of the exercise of professional nursing judgment. Nurse James failed and refused to protect Lisa Ostler's health and safety. Nurse Colby James' failure and refusal to provide or ensure care to Lisa Ostler on April 2, 2016, was yet another example and further evidence reflective of a widespread cultural, customary, and accepted practice among nurses at the Salt Lake County Jail to ignore health complaints and symptoms exhibited by inmates undergoing drug withdrawal and assume health issues were only related to withdrawal and therefore not serious.

Basis for Opinion #8

A. Nurse James knowingly failed and refused to assess Lisa Ostler in response to Officer Zachary Frederickson's report to him that she was requesting to see medical. Nurse James was the triage nurse for 8C at the time Officer Frederickson informed him of Lisa's request.

Nurse Colby James, a registered nurse at the Salt Lake County Jail, was an experienced nurse. He knew the nursing standards for patient care and treatment for which he was responsible and accountable. He was trained and knew the policies, procedures and protocol of the Salt Lake County Jail. James received training and knew the requirements and importance of documenting patient encounters and treatment in the medical record. He knew he had an ethical and professional duty and obligation to protect Lisa Ostler's health and safety. He knew his legal responsibility to document patient observations and care in a patient's jail medical record and knew that if care was not documented, it was not done. He was trained to document all potentially significant patient encounters.

The Salt Lake County Jail Nurse Job Description stated that essential functions of the Jail Nurse job included assessing the physical condition of prisoners by performing physical examinations and obtaining medical histories, formulating medical plans based on the patient's condition, and initiating triage and determining priority of emergent/urgent care. Another essential function of the Jail Nurse job included complying with medical record policies regarding the complete and accurate documentation of patient care, initiating and maintaining required records and legal documents (SLCo Ostler 000263-000264).

On 4/2/2016 at approximately 7:30 AM, less than one hour after Nurse Brent Tucker left 8C, Nurse Colby James entered the unit to conduct triage of inmate medical concerns and requests. Housing Unit Officer Zachary Frederickson talked with James about Lisa requesting to see medical and that she did not want to complete a sick call request. Nurse James disregarded Lisa's verbal request and told the officer that if she had a medical emergency to contact medical and that if she had a triage kite he would take it at that time (SLCo Ostler 026514).

Nurse James was the second nurse to instruct Officer Frederickson he should contact medical if Lisa Ostler had an emergency. The officer WAS contacting medical. Officer Frederickson was a medically untrained jail officer following jail procedure to contact a nurse for a patient's medical issues. Nurse James knew that a medically untrained individual was not qualified to determine if Lisa's request for medical attention constituted an emergency and knew that was his job.

Without conducting any further inquiry into Lisa's complaints and without conducting any assessment whatsoever, Nurse Colby James left the unit. He took no action whatsoever to determine the emergent nature of Lisa's request or evaluate her medical need and request. He made no attempt whatsoever to try to determine why she purportedly did not want to complete a sick call request form. His insistence that she complete a paper form in the context of her request for medical help for an emergency is inappropriate, ridiculous, unreasonable, and a complete abdication of his nursing responsibility and duty to a patient under his care.

At 8:07 AM, just 37 minutes after Nurse James failed and refused to assess her request for medical attention, Lisa Ostler was discovered by Officer Frederickson not breathing and unresponsive in her jail cell. It is likely Lisa was unresponsive, or at least obviously critically ill and at risk of imminent death, when James was contacted by Officer Frederickson. His failure and refusal to see her represents the degree of disregard the nursing staff had for patients like Lisa undergoing drug withdrawal. He did not even bother to talk to her or check into her request for medical help.

B. Any medically trained nurse would know the importance of responding to a patient's request for medical care, particularly if triage was the nursing function they were specifically assigned to do. Any medically trained nurse would know the importance of not ignoring a patient’s request.

Like Nurses Ronald Seewer and Brent Tucker, Nurse James ignored Lisa’s request for medical attention. He then instructed Officer Frederickson to determine if she had a medical emergency. Any medically trained nurse would know the determination of a medical emergency in a circumstance such as existed with Lisa Ostler required a medical assessment by a registered nurse and should not be referred to a medically untrained housing unit officer. Nurse James ignored Lisa's request for medical attention and refused to conduct any assessment of her condition or status whatsoever. He inappropriately delegated the nursing function for assessment to determine whether or not an inmate's complaint was an emergency to an individual that was not qualified to perform it. Any medically

trained nurse would know that ignoring a patient request for medical help and refusing to conduct any assessment of a patient's medical needs or requests is a violation of nursing standards, facility policy and protocol, and a breach of their ethical duty, responsibility, and obligation to promote, advocate for, and protect the health and safety of a patient. As a result of Nurse Tucker's complete disregard for Lisa's request for help to address her medical needs, Lisa was found approximately 30 minutes later unresponsive and not breathing in her cell.

Any medically trained nurse acting in the job capacity of "triage nurse" would know the requirements and essential functions of their position. The Salt Lake County Jail policy and procedure for "Nonemergency Health Care Requests", No. J-E-07 (SLCo Ostler 001662), stated a "jail triage nurse will visit each housing section of the Jail daily to collect sick call requests and to allow all patients the opportunity to voice health complaints. The purpose of the policy and procedure was to ensure that all health care requests were documented and triaged so that patients were treated in a timely manner by qualified health care providers. The triage process consisted of addressing the patient's chief complaint, taking and recording vital signs, if indicated, and performing an appropriate nursing assessment. If the patient's condition was urgent or emergent, the nurse would provide necessary immediate care and arrange appropriate referral for medical treatment. Nurse James refused to perform a single step of the procedure to deal with Lisa's health care request.

It is inconceivable that the nurse assigned to triage inmate complaints on 8C on the morning of 4/2, who was present at the time a verbal request from an inmate to see medical was made, took absolutely no action to perform the function he was assigned to do. Nurse James knew of Lisa's request and blatantly, knowingly and intentionally failed and refused to triage her request for emergency medical help in the most egregious manner. Lisa Ostler made her request for medical attention known in accord with facility policy and procedure. Nurse James refused to follow facility policy, procedure, nursing standards, NCCHC standards, ethical duty and responsibility, professional knowledge, and reasonable decision-making.

It is absurd and unreasonable to expect that an inmate experiencing a medical emergency should fill out a triage kite to request medical care yet Nurse James did just that. He knowingly disregarded Lisa's verbal request for emergency medical attention. There is no indication that Nurse Colby James considered whether Lisa Ostler was able to complete a sick call request or whether she had a legitimate reason for not wanting to complete a written request. According to jail policies, if an inmate was experiencing a medical emergency, they were *not* supposed to fill out a sick call request form. Instead, inmates were instructed that if they had a medical emergency, they should tell the housing officer or a nurse immediately (SLCo Ostler 024817). Lisa did as she was

instructed. She notified an officer repeatedly. She was repeatedly ignored by housing officers, but even when they did notify a nurse, it was to no avail. What is evident is Nurse James's intentional choice not to see Lisa in response to her request and his failure and refusal to respond to an inmate's request for medical care for a condition she felt was emergent. It is absurd and unreasonable for the triage nurse present on the housing unit at the time of Lisa's emergent request for medical attention to defer a medical determination of her need to an unqualified, untrained, non-medical housing unit officer. Yet Nurse James did that too.

C. Nurse Colby James took no action whatsoever to respond to Lisa Ostler despite knowing she had verbally requested medical attention and he was present on unit 8C as the **triage nurse** at the time he became aware of her request. Lisa had been pleading for medical attention throughout the night. His refusal to see Lisa or assess her in response to her request for medical care is representative of the widespread disregard the nurses at Salt Lake County Jail had for inmates undergoing drug withdrawal.

Mr. Bell, the Responsible Health Authority, testified in his deposition that when Colby James came to Unit 8C he never went over to Lisa Ostler's cell to check her out and did not make any attempt to determine if she was bleeding and, if so, from where and what the source was (Bell Deposition, May 20, 2019, p 68). Nurse James did not take any vital signs and did not perform any assessment whatsoever for Lisa Ostler. He did not provide medical help in response to her requests. Nurse James did not refer her for any other medical diagnosis or treatment.

Just as Nurse Tucker before him had done, Nurse James left the determination about whether Lisa had a medical emergency to an untrained, non-medical housing unit officer. Patient assessment is the sole purview of the registered nurse. Refusal to conduct an assessment of a patient's complaint of pain and request for medical care is a significant breach of nursing standards and cannot be viewed as accidental or an oversight. The failure and refusal to perform an assessment in response to a patient request for help and complaint of pain is an intentional disregard of a patient's serious medical need.

Nurse James's failure and refusal to perform an assessment in response to Lisa Ostler's request for medical help clearly conforms to a cultural, customary and accepted practice among nurses at the Salt Lake County Jail who minimized and discounted pain complaints, patient needs and the need to do focused assessments for inmates with drug withdrawal. James was not the only nurse that knowingly and intentionally refused to properly assess Lisa. NONE of the nurses who had contact with her assessed her for pain, not eating, hydration, abnormal vital signs, declining physical status, medication need, or the presence of co-

morbid physical conditions that resulted in the worsening of Lisa's progressive and obviously grave condition. An accepted and pervasive staff attitude and approach of ignoring patient needs was clearly and openly endorsed by registered nurses who were all trained and educated to address health concerns for every patient regardless of circumstance or offense.

OPINION # 9: Brad Stoney, a registered nurse employed at the Salt Lake County Jail, breached professional standards of nursing care and his duty to act as any reasonably prudent nurse would have acted in a similar circumstance to that of providing or ensuring care to Lisa Ostler when he exceeded the scope of his nursing practice in the creation of Lisa's medical record information. Those breaches are so egregious that his actions, failures to act, and refusals to act cannot have been the result of the exercise of professional nursing judgment. Nurse Stoney failed and refused to protect Lisa Ostler's health and safety. Those breaches were caused by a widespread practice and custom of deliberate indifference toward the serious medical needs of patients, generally, which resulted in the deliberate indifference toward the serious medical needs of Lisa Ostler, specifically.

Basis for Opinion #9:

A. Nurse Brad Stoney was responsible to comply with medical record policies regarding the complete and accurate documentation of patient care. Nurse Stoney knowingly created a clinical record for Lisa Ostler that included medical diagnoses with accompanying ICD-10 codes, an action that was outside the scope of his practice. Stoney assigned erroneous diagnoses to Lisa Ostler in the absence of clinical evidence and without corroboration of an advanced licensed medical provider qualified to render diagnostic medical assignments.

Nurse Brad Stoney was an experienced, medically trained nurse. He knew the nursing standards for patient care, treatment and documentation for which he was responsible and accountable. He was trained and knew the policies, procedures and protocol of the Salt Lake County Jail. He knew the scope of his nursing practice and the importance of not exceeding the parameters of that practice.

Nurse Stoney prepared a diagnostic template that he assigned to Lisa Ostler via her medical record in the absence of qualified medical involvement. Nurse Stoney was not qualified to render medical diagnoses for a patient. The diagnoses listed in Lisa's chart served to create and support assumptions by nursing staff that her complaints of pain were simply related to drug withdrawal.

Brad Stoney e-mailed Dr. Brad Lewis and Dr. Paula Braun on March 30, 2016, regarding a new detainee, Lisa Ostler. Nurse Stoney knew that Ms. Ostler

had not been seen or evaluated by either of the physicians he contacted. She was not seen by any physician or advanced care provider at the jail. She was seen by a nurse for a physical exam. On March 30, 2016, Lisa's medical record and Nurse Stoney's e-mail included medical diagnoses, ICD-10 codes and a list of verified medications. The medical diagnoses listed included:
OPIOID USE, UNSPECIFIED WITH WITHDRAWAL [F1193],
SEDATIVE/HYP/ANXIOLYC DEPENDENCE W WITHDRAWAL, UNCOMPLICATED [F13230], AND
ENCOUNTER FOR SCREENING FOR RESPIRATORY TUBERCULOSIS [Z111].

B. Diagnosing a patient's condition is solely the responsibility of a qualified advanced care provider. Only the physician, or other qualified healthcare practitioners legally accountable for establishing the patient's diagnosis, can medically "diagnose" a patient. The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists and diagnosis coding must be based on provider documentation. It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient's clinical conditions.[28] There is no evidence to suggest that the Salt Lake County Jail staff conducted any clinical verification that Lisa Ostler's assigned diagnosed conditions actually existed.

A registered nurse is not licensed or qualified to diagnose patient medical conditions. Lisa Ostler was not diagnosed with the conditions cited by Nurse Stoney as a result of an advanced practitioner's examination and documentation. Rendering a medical diagnosis is outside the scope of registered nursing practice and is considered practicing medicine without a license. Entering medical diagnoses not assigned by a physician who actually performed and documented the patient evaluation or examination is a falsification of medical record information. No physician or other qualified healthcare provider legally accountable for establishing a medical diagnosis saw Lisa Ostler or provided medical record documentation to support the diagnoses assigned to her on March 30, 2016.

On the date and at the time Nurse Stoney sent the e-mail to Doctor Lewis and Paula Braun, Lisa Ostler was not in either opioid or sedative withdrawal and was not positive for withdrawal at any time during the days of her incarceration at the jail. Assignment of medical diagnoses by a nurse with insufficient education, training, and licensure to perform that function who based the diagnoses on inaccurate, ill-informed, erroneous clinical information demonstrated a knowing

[28] Land, Daniel, RHIA, CCS, Director of Compliance Review Services, *CD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2016.*

breach of nursing standards of care and failed to account for the accurate diagnosis of Lisa Ostler's serious medical needs.

Nurse Stoney recorded Lisa's verified medications. The medication Pentasa, for Crohn's disease, was not verified and Nurse Stoney took no actions to seek verification or determine the necessity of her medication for the arthritis condition. When Dr. Brad Lewis deferred Lisa's prescribed medication to mental health for review, Stoney took no action whatsoever to facilitate a timely appointment with a mental health provider to ensure timely consideration of continuing her medications and ensuring continuity of care for her serious medical needs. Stoney took no actions to ensure that Lisa was monitored for the sudden cessation of all of her medications.

Nursing staff minimized and even disregarded Ms. Ostler's complaints of pain, purportedly viewing them in the context of "typical" drug withdrawal. Brad Stoney, RN, without proper knowledge, training, or licensure, recklessly created a medical record reflecting an inaccurate clinical picture of Lisa Ostler's serious medical needs that overshadowed the actual and legitimate medical crisis she ultimately experienced.

Any medically trained nurse providing care and treatment in the same or similar circumstance to that of providing care for Lisa Ostler would know assignment of a medical diagnosis sets treatment and care plans in motion that guide the medical care a patient receives. Any medically trained nurse would know they are not qualified to render a medical diagnosis and would know that doing so could have a very negative impact on a patient's treatment and health.

Any medically trained nurse providing care to a patient such as Lisa Ostler would know that timely evaluation of a prescribed medication regimen is essential for management of serious medical conditions and that continuity of care was required to avoid disease progression or reoccurrence.

Any medically trained nurse would know the scope of their nursing practice and the importance of practicing according to the limits of their professional boundaries. Any medically trained nurse knows they cannot diagnose medical conditions and would know the potential consequences of misdiagnosis or failure to diagnose existing medical conditions.

C. Nurse Brad Stoney took no action to ensure that Lisa Ostler was properly evaluated by an advanced level provider to diagnose her medical conditions. Stoney took no action to ensure that Lisa Ostler was scheduled to be seen by a mental health provider to evaluate continuation of medications that were

deferred by Dr. Brad Lewis and Dr. Paula Braun and he took no action to contact a mental health provider to discuss continuation of any of Lisa's medications. He took no action to ensure that the documentation in Lisa's medical record was determined by a qualified advanced medical provider.

OPINION #10: A culture of widespread disregard for the serious medical needs of patients at risk for drug withdrawal existed among the nursing staff of the Salt Lake County Jail. Cultural, customary, and accepted practices among nurses at the jail of ignoring required assessments, refusing to perform focused assessments, minimizing and discounting pain complaints, refusing to respond to health care requests, and refusing to monitor the ongoing health status of inmates diagnosed with drug withdrawal resulted in a catastrophic outcome for Lisa Ostler.

Basis for Opinion #10:

A. All of the nurses involved in Lisa Ostler's care at the Salt Lake County Jail ignored, minimized and discounted Lisa Ostler's pain complaints and requests for medical help. Not one registered nurse conducted a pain assessment or performed a focused assessment in response to Lisa's expressed health care needs and requests or the concerns raised on her behalf by other inmates and housing unit officers. Even the Central Control operator, Sparkuhl, subscribed to the pervasive cultural approach of ignoring patient complaints when the individual was identified as undergoing drug withdrawal if instructed by a housing officer to ignore the repeated pressing of their emergency buttons and expressions of pain and desire for medical assistance.

The accepted and pervasive staff attitude and approach of ignoring patient needs was clearly and openly endorsed by registered nurses who were all trained and educated to address health concerns for every patient regardless of circumstance or offense.

NONE of the nurses who had contact with Lisa assessed her for pain, not eating, hydration, abnormal vital signs, declining physical status, medication need, or the presence of co-morbid physical conditions that resulted in the worsening of Lisa's progressive and obviously grave condition. Lisa's requests for medical help were ignored and her complaints were casually viewed as due to drug withdrawal without consideration that an inmate could have a medical emergency, related or unrelated to withdrawal. Nursing staff that were made aware of Lisa's requests for medical help and the staff that came into contact with her repeatedly and consistently ignored her signs and symptoms and pleas for medical help. As a result, Lisa did not receive essential life-saving care, leading to her death.

The multiple failures and refusals by multiple nursing staff that reflected a culture and widespread practice at the jail of ignoring Lisa Ostler's serious medical needs included:

- Refusal to complete CIWA/WOWS assessments as ordered;
- Refusal to follow training directives;
- Refusal to follow directives of medical leadership;
- Refusal to conduct assessments in response to officer reports, inmate requests for medical help, abnormal clinical findings, and clinical symptoms;
- Repeated and consistent refusals to provide basic care to meet medical needs including nutrition, hydration, pain management, and medication continuation;
- Refusal to perform clinical duties and responsibilities in a thorough, complete, and ethical manner;
- Refusal to accurately and completely document care actions, observations, and clinical findings in an accurate, ethical, and thorough manner to facilitate care follow up and continuity.

Lisa Ostler's serious medical condition steadily worsened from 3/31/2016 to 4/2/2016. **Within this critical time period jail nursing staff failed and refused to provide essential medical assessments and care that would have been lifesaving.** Jail nursing staff contacted Lisa for CIWA and WOWS assessments on five occasions following a comprehensive nursing examination that took place at the time of her booking. Three of the withdrawal assessments took place between 3/31and 4/2. Registered nursing staff at the Salt Lake County Jail, including, at a minimum, Ron Seewer, had contact with her on six occasions between 3/31 and 4/2. They had numerous opportunities to address Lisa's serious medical needs in the hours that preceded her being found unresponsive and not breathing in her cell. None of the nursing staff contacted by housing unit officers per Salt Lake County Jail policy in the last two days of her life assessed Lisa Ostler or in any way or attempted to address her serious medical needs.

By the morning of 4/1/2016, Lisa Ostler's condition had become exponentially more severe and her condition was grim. She followed the jail procedure to try to obtain health care for her emergent condition. Nurse Ron Seewer was informed she had pain by Housing Officer Todd Booth but disregarded her complaints, performed no pain assessment, did not meet her serious medical needs and, as a result, her serious medical needs worsened.

Lisa Ostler was able to walk, albeit with difficulty due to pain, in a bent posture with her arms holding her abdomen, to the clothing exchange on 4/1/2016 at 11:10 PM. She made every attempt to follow the rules, procedures, and requirements of the jail. One of the procedures to obtain needed health care was

explained in a posted sign for inmates to see at the time they were booked. The sign stated in part:

> "Health care is available at all times in the jail.
> If you need help with a medical, mental health or
> dental problem, please follow this procedure:
> 1. If it is an emergency, notify any officer or nurse of
> your need immediately…"

On the morning of 4/2/2016, Nurse Brent Tucker was informed of Lisa's repeated pressing of her emergency button, her failure to eat, and vaginal bleeding but disregarded the information, performed no assessment, inappropriately directed the Housing Officer to contact medical if it was an emergency. As a result, Lisa's serious medical needs continued to be ignored, not assessed, and not met and her condition continued to deteriorate further. Nurse Colby James was informed that Ms. Ostler was requesting to see medical but would not complete a sick call request. Nurse Colby James ignored Lisa's verbal request for medical attention, inappropriately delegated the determination of whether she had an emergency to the Housing Officer and for the third time nursing staff who were directly informed by officers of Lisa's complaints conducted no assessments and did not in any way address her medical complaints. Lisa Ostler did not have another opportunity to request medical attention before she became unresponsive and stopped breathing. Literally, she used some of her last breath to request medical attention for her serious medical needs.

The nursing staff of the Salt Lake County Jail collectively demonstrated a degree of disregard for Lisa's medical needs and requests that could only persist if it was accepted as common or usual practice and was understood by nursing staff to be "business as usual".

B. Medically trained registered nurses providing care to an inmate such as Lisa Ostler in a similar circumstance would not ignore an inmate complaint, would not dismiss officer reports of inmate symptoms and requests to see medical staff, would not ignore inmate symptoms and would not refuse to perform health assessments or refuse to provide essential nursing care. Any medically trained nurse would conduct a face-to-face assessment after receiving notice of an inmate complaint and request to see them. Based upon the nature of the complaint a medically trained nurse would conduct a review of the patient's medical history and would perform a face-to- face assessment to determine the appropriate actions to take in response to the issues presented and observed.

C. For the medical needs that were documented, Lisa was not provided reasonable, basic, essential health care. She experienced nausea and diarrhea and

received PRN medication; however, she was never assessed for dehydration, she was not provided adequate fluids, her nutritional status was completely ignored, and no nurse evaluated her abnormal vital signs.

Several nurses at the jail came into contact with Lisa for intake, assessments, medication administration, and at the request of officers yet not one of them took any action to address abrupt cessation of medications, abnormal vital signs, physical appearance of deterioration, symptoms of serious illness, or pain. Not one of the nurses conducted a pain assessment or any physical assessment for reported symptoms. Any medically trained nurse would know that patients with suspected or potential drug withdrawal could also have an unrelated serious medical condition and should be properly assessed to rule out the presence of an urgent or emergent condition.

OPINION #11: The failure and refusal of nursing staff to conduct CIWA/WOWS assessments at the Salt Lake County Jail did not simply occur with regard to Lisa Ostler. A recurring and widespread practice of not completing assessments as ordered or indicated included a failure of nursing staff to perform required withdrawal protocol assessments for many inmates and an alarming number of inmates who were not assessed, like Lisa Ostler, died at the jail or died shortly after being released.

A review of the medical records for nine other inmates with orders for CIWA and WOWS assessments revealed they all had missing or incomplete information or no assessment information at all. All of the inmates died. None of the inmates received assessments as ordered and the majority of the inmates received fewer than half of the assessments that should have been performed. The documentation and absence of documentation of withdrawal assessments for a life-threatening condition by the nursing staff of the Salt Lake County Jail illustrates enough deficiencies to conclude that the refusal by medically trained nursing staff to perform withdrawal assessments as ordered and required was a widespread systemic problem. As a medically trained nurse I am able to conclude that the frequency with which assessments were not performed reflected a widespread acceptance among nursing staff of a culture and custom of practice that ignored inmates' serious medical needs and demonstrated a failure and refusal to perform assessments designed to identify those needs.

Basis for Opinion #11:

A. Nursing staff of the Salt Lake County Jail repeatedly failed and refused to perform ordered CIWA and WOWS protocol withdrawal assessments, demonstrating a failure to meet professional nursing standards, accreditation

standards, facility policy and procedure, facility directives and training requirements, demonstrating a widespread and accepted culture and practice within a professional staff group.

B. The scope of practice of a registered nurse does not include unilateral authority to decline to follow a physician's order or the physician's expressed plan of care. All nurses owe a duty to the patients they serve. According to the American Nurses Association, a nurse "promotes, advocates for, and strives to protect the health, safety, and rights of the patient." Additionally, a nurse is both responsible and accountable for his or her individual nursing practice and is in a position to monitor the patient's illness, response to medication and interventions, display of pain and discomfort and general condition. Clearly the registered nurse is in the unique position to control all aspects of an inmate's access to care, assessment, treatment, medication, and life-saving interventions. They play a significant gatekeeping role for determining whether inmates have access to medical care and for determining what care the inmates receive. When nurses ignore inmate complaints or officer reports of an inmate's needs or requests for care, the inmate may be denied essential care for serious medical needs. This happened to Lisa Ostler.

C. There is still apparent confusion as to who was responsible for conducting WOWS and CIWA assessments, including the monitoring of vital signs, for Lisa Ostler after she was moved to Unit 8C. Making certain that everyone knew their nursing responsibilities was the responsibility of Richard Bell and other members of the jail administration such as the nursing supervisor. To neglect that responsibility leads to vital evaluations and other medical services not being done. When people do not know what they are responsible for, things slip dangerously through the cracks. In a medical setting, that can be fatal, as it was for Lisa Ostler.

Nurse Seewer testified he was not responsible for doing the assessments of Lisa Ostler when she was in Unit 8C, including taking vital signs, even though he was working in 8C on 4/1/2016. Curiously, he testified that a nurse from an adjacent jail was responsible for doing the assessments. Others, including Todd Riser, testified that the "pod nurse" was responsible for doing the assessments, not a nurse from the adjacent jail.

No document has been produced indicating who was responsible for doing the assessments. Curiously, counsel for Defendants, Bridget Romano, wrote to counsel for Plaintiffs, explaining that a roster identifying who was working where on 4/1/2016 identified "Disa" as being assigned on 4/1/2016 to C Pod. However, jail records reflect that a Disa was never in C Pod on that date. Reinforcing the chaotic situation leading to an absence of anything identifying who was responsible for conducting the WOWS and CIWA assessments, Defendants' counsel wrote a letter to Plaintiffs' counsel stating as follows:

> And though the log does indicate that a nurse named "Disa" was assigned to Charlie Pod for the shift beginning at 0600 hours and ending at 1800 hours on April 1, 2016, a careful review of the pertinent shift and medical logs now in the Jail's possession contains no indication "Disa" provided services in that pod on that day.

Defendants' counsel also wrote:

> [T]he log is not considered by the Jail to be a [sic] reliable . . . .

Incredibly, Defendants and the Responsible Health Authority, Richard Bell, and their counsel apparently are unable, to this day, to identify who was responsible for doing the CIWA and WOWS assessments for Lisa Ostler after she was taken to Unit 8C, which reflects incredible disorganization and a pattern, custom, and ongoing practice of failing to make clear who among nursing staff was responsible for doing what. That pattern, custom, and ongoing practice contributed to the failure to provide the CIWA and WOWS assessments, including monitoring vital signs, of Lisa Ostler, leading to her suffering and death.

Although Richard Bell is responsible for making certain that inmates receive timely, responsive, necessary medical services, there was no CIWA or WOWS assessment of Lisa Ostler when she was in Unit 8C, although it was ordered and was required by policy, yet neither Bell nor anyone else in the jail administration ever disciplined or identified anyone as being the nurse responsible for the assessments that were not done. That lack of response by Bell and other supervisory or administrative personnel further evidences an unconscionable and dangerous laxity in the provision of necessary medical services for inmates at the jail. The sloppiness in identifying which nurses were responsible for conducting assessments, including the monitoring of vital signs, likely explains, in at least large part, why so many inmates at the jail did not receive their ordered CIWA and WOWS assessments, including the monitoring of vital signs, recklessly and obviously creating life-threatening risks to their health.

D. Inmates other than Lisa Ostler were denied access to care and assessments. CIWA and WOWS assessments, when ordered, are to be performed twice daily for 5 days. The CIWA Alcohol Withdrawal Assessment Scoring Guidelines cites nursing assessment as vitally important. The refusal and failure of nursing staff to conduct clinical withdrawal assessments for inmates experiencing drug withdrawal were inexcusably common:

Timothy Kukuchka - WOWS assessment was ordered on 8/28/14 (SLCo Ostler 003328, 3347) but only performed once on 8/29/14 and twice on 8/30/14 - only 3 assessments of 10 were completed;

Duwayne Cotter - CIWA assessment was ordered on 8/21/12 by Dr. Wilcox (SLCo 003722, 003917-21, 4072-76) but only performed 7 times from 8/22/12 - 8/25/12 - only 7 assessments of 10 were completed;

WOWS assessment was ordered (SLCo 003699, 003779, 003993). He was booked on 5/21/15. WOWS was only performed once on 5/23/15 and once on 5/24/15;

Chris Bybee – CIWA assessment ordered on 11/6/2012 (SLCo 29654-29656). Assessments were ordered on 11/6/2012. Only one assessment was performed on 11/9/2012. No assessments were performed on 11/11/12 – only 7 of 10 assessments were completed;

Loralie Querbach - CIWA assessment was ordered on 6/5/17 for alcohol abuse (SLCo 004478,4911). She was booked on 6/5/17. CIWA was only performed twice on 6/9/17 (SLCo 4794-95). A WOWS assessment was performed just once on 6/12/17 despite a nursing pre-screen showing use of marijuana and meth;

WOWS assessment was ordered on 2/19/16 (SLCo 004533-34, 4935-36). The assessment was performed just 4 times of 10 on 2/19, 2/21, and 2/23. She refused one assessment on 2/23.

WOWS assessment was ordered on 2/5/16 (SLCo 004536, 4937). She was booked on 2/5/16. The assessment was performed 3 times of 7 as she was discharged on 2/9/16.

WOWS assessment was ordered on 12/1/15 (SLCo 004550, 4945). The assessment was performed 4 times of 10.

WOWS assessment was ordered on 9/22/15 (SLCo 004581, 4962). The assessment was performed 5 times of 10.

WOWS assessment ordered on 8/15/15 (SLCo 004591-93) 5 assessments of 10 performed.

WOWS assessment ordered on 10/21/14 (SLCo 004621-23, 4986-88) 6 assessments of 10 performed.

WOWS assessment ordered on 9/10/14 (SLCo 4638-40, 4991-93)
5 assessments of 10 performed.

WOWS assessment ordered on 8/6/14 (SLCo 4657-59)
6 assessments of 10 performed.

WOWS assessment ordered on 5/24/14 (SLCo 4672-74, 4700, 5007-09)
4 assessments of 10 performed.

WOWS assessment ordered on 4/9/14 (SLCo 4701, 5021)
7 assessments of 10 performed.

CIWA assessment ordered on 1/14/14 (SLCo 4719)
6 assessments of 10 performed.

CIWA assessment ordered on 10/15/13 (SLCo 4736)
3 assessments of 10 performed.

CIWA assessment ordered on 9/17/12 (SLCo 4787-89, 5069-71)
4 assessments performed
No assessments performed on 9/17, one performed on 9/18, no assessment on 9/19, one performed on 9/20, 2 assessments on 9/21 and was released.

Dustin Bliss - WOWS assessment ordered on 7/20/14 (SLCo 006329-31)
4 of 6 assessments completed for 7/20, 7/21, 7/22. Released 7/23.

Casie Christensen - CIWA assessment ordered on 2/26/13 (SLCo 006420-22)
5 of 10 assessments performed.

CIWA assessment ordered on 10/28/12 (SLCo 006427)
No assessment performed on 10/30/12; released 10/31/12.

Angie Turner - CIWA assessment ordered on 1/3/12 (SLCo 008041-42)
6 of 10 assessments performed.

CIWA assessment ordered on 7/8/16 (SLCo 008028-32)
7 of 10 assessments performed. Only 1 assessment performed on 7/9, 7/10, and 7/12.

Melissa Montoya - WOWS assessment ordered on 5/19/14 (SLCo 004218-19)
Only 1 assessment performed on 5/20 and only 1 performed on 5/21.

Scott Osterkamp – Seen by Robert Richards, CSW of mental health for a crisis visit

On the evening of 8/3/2016 noting that the patient was detoxing heavily off of alcohol as he had been drinking one gallon of alcohol daily. He appeared with shakiness in his hands, dizzy, restless, depressed/anxious, with some shortness of breath/sweating and trembling speech. Robert contacted the Pod nurse to inform them of the patient's appearance and presentation. Nursing informed him the patient has been evaluated with CIWA's and BP was checked X2 today. Nursing reported patient's numbers and BP were all within the appropriate range and no need to admit patient to the Medical Unit (SLCo Ostler 030642).

On 8/3/16 at 3:11 PM Scott's BP was 143/86 and his pulse was 97. His BP was not checked twice as the nurse told Robert (SLCo Ostler 030433, 030438). A CIWA total Score of "2" was entered in the PEARL Clinical Patient Summary on 8/3/16 at 10:50 AM but no CIWA assessment was done. One CIWA assessment was done that day at 3:12 PM. The next day, 8/4/16 a single incomplete CIWA assessment was performed at 3:58 PM that only included scoring for nausea and vomiting and no other symptoms. Scott's BP had increased to 162/109 with a pulse of 93 (SLCo Ostler 030438). No other assessments were done and nursing did not make a referral to Mental Health despite the presence of significant withdrawal symptoms noted by the social worker. No other CIWA assessments were performed.

On 3/8/15 at 2:53 PM a CIWA Assessment was done and the score for Scott was "4" (SLCo Ostler 030790). Another CIWA Assessment was recorded for the same date, at the same time but the score was "9" (SLCo Ostler 030791). There are no vital signs recorded for 3/8/15 at all (SLCo Ostler 030433) and there is no information to suggest that a referral to Mental Health was done.

OPINION #12: The nursing staff of Salt Lake County Jail failed and refused to follow Jail policy and procedure to notify the physician immediately when signs of withdrawal were noted. Those failures reflect a widespread practice and custom and result from a failure to ensure proper training and supervision.

Basis for Opinion #12:

A. The Salt Lake County Jail, Health Services Unit, Procedure for **Intoxication and Withdrawal** (SLCo Ostler 001717 – 001719), states that the physician is to be notified immediately for signs of withdrawal. Signs of withdrawal include a heart rate greater than 110. Todd Riser testified that a heartbeat greater than 110 can be a sign of withdrawal (Riser Deposition, p 98) and that the physician is to be notified immediately if there is a sign of withdrawal (Riser Deposition, p 99). Nursing Supervisor Riser testified that the practice of the nurses was not to notify a physician for a heart rate greater than 110 (Riser Deposition, p 100).

B. On 3/31/2016, Lisa Ostler's heart rate was 119 at 9:20 AM and increased to a more alarming rate of 133 at 2:50 PM, coupled with a dramatic decrease in her blood pressure. Shockingly, physician was contacted. In addition, no CIWA

assessment of withdrawal symptoms was performed – the entire symptoms assessment column was blank.

Any medically trained registered nurse would know the importance of following the policy and procedure of the facility in which they provided patient care and supervision. Any medically trained registered nurse would be able to evaluate a patient's vital signs and know the importance of reporting vital signs that are significantly abnormal. The American Heart Association identifies a normal heart rate for an adult as 60 – 100 beats per minute. A heart rate of 119 that elevates to 133 with a concurrent drop in blood pressure is an abnormal and alarming clinical situation. For a patient such as Lisa Ostler, being monitored for life-threatening drug withdrawal, notification of a physician was essential. Any medically trained registered nurse would know to contact an advanced medical provider to notify them of a patient's abnormal vital signs and to receive further orders or directions for patient care.

In the case of Scott Osterkamp, on 8/4/16, an increased BP of 162/109 and reports by the mental health social worker of his significant signs of withdrawal from alcohol did not result in a CIWA assessment monitoring or report to a physician or to mental health.

C. The nurses at the Salt Lake County Jail failed and refused to follow up with an advanced care provider regarding Lisa's significantly abnormal vital signs. Similar failures and refusals are again evident a few months later with Scott Osterkamp demonstrating that nothing had changed in the approach to inmates suffering alcohol and drug withdrawal as a result of Lisa's death. The refusal to seek care for Lisa's clinical presentation was consistent with an accepted and pervasive staff attitude and approach of ignoring patient health condition, presentation and medical needs, clearly and openly endorsed by registered nurses who were trained and educated to address health concerns for every patient regardless of circumstance or offense.

<u>OPINION #13:</u> Scott Sparkuhl, the night shift (graveyard shift) Central Control Operator on Unit 8C at the Salt Lake County Jail, knowingly and obviously ignored Lisa Ostler's repeated calls for medical help for her serious medical needs in violation of facility policy, procedure, training, and common knowledge that any correctional staff person would possess. Nursing staff rely on custody staff to report inmate requests for medical attention and depend on custody staff to notify them when inmates verbally request care or appear to need care.

Scott Sparkuhl, refused and failed to refer Lisa Ostler's repeated calls for emergency medical assistance throughout the night of 4/1/16 to the Housing Unit

Officer, a violation of jail facility policy and procedure. He knowingly chose not to refer her calls reporting she was in pain and needed help as facility policy and procedure and his training required (Sparkuhl Deposition, p 21). He failed to respond to numerous calls from Lisa for help despite her telling him she was in pain and needed medical help and despite also receiving calls from other inmates expressing concern for and about Lisa's health and well-being. Central Control Operator Sparkuhl intentionally chose not to respond in a manner consistent with facility requirements to refer an inmate's request for emergency medical attention. Central Control Operators and Housing Officers are not qualified or trained to determine if an inmate's requests for medical care require an urgent medical response. Medical staff are the only staff to make the determination about medical need and require that custody staff follow facility procedure to notify them that an assessment and evaluation is needed.

As a registered nurse, having worked with corrections officers and correctional control room staff for many years, including on the night shift, I am able to state an opinion that addresses staff responses to the medical requests of inmates. It is never appropriate for staff to ignore a patient's request for medical help. It is never appropriate for staff to ignore a patient's request for help in an emergency. It is never appropriate for a staff member to ignore calls from a particular inmate unless they report new information. A control operator is not trained or qualified to triage a patient's requests for medical care over an intercom and is not qualified to determine if a patient is reporting new symptoms or whether their request is new information. Control Room Operators have no access to a patient's medical record or medical history. Custody staff have a responsibility to report all medical requests from an inmate to medical staff for triage and intervention - no matter how many times the inmate calls to request medical help.

Sparkuhl's conduct of "ignoring" Lisa's repeated calls for help was pursuant to instruction by a housing officer, which, reflecting a widespread practice and custom, was the same instruction he had received "a dozen or so" times in the past. This abhorrent custom was so pervasive that the so-called "ignore protocol" could be initiated with the shorthand instruction to "ignore the cell."

> A. Scott Sparkuhl, was a Central Control Operator at the Salt Lake County Jail during the night shift or graveyard shift on 4/1/16 from 11 PM through 7 AM on 4/2/16. He testified that his job responsibilities included engaging in communications with inmates if they pushed a button in their cells (Sparkuhl Deposition, p 20). He was trained that inmates were to use the buttons in their cells to communicate with the housing officer or for emergency situations when the housing officer was not there (Sparkuhl Deposition, p 21). Sparkuhl testified that the intercom system was an emergency communication tool (Sparkuhl Deposition, p 22).

Throughout the night of 4/1/2016, Operator Sparkuhl, received calls via the emergency intercom from Lisa Ostler approximately 1-2 times per hour, up to 16 times throughout the night. She reported that she was in pain and needed medical help. Operator Sparkuhl was instructed by the housing unit officer, Todd Booth, to "Go ahead and ignore the cell" and only pass along new information (Sparkuhl Deposition, p 51). Based upon the officer's directive, Sparkuhl only communicated to the housing unit officer once or twice about Lisa's requests and took no other action to ensure that medical assistance was provided to her. He testified that he had previously been told by housing unit officers to ignore inmates' calls when they were reporting serious medical problems and needed help (Sparkuhl Deposition, p 67, 104) throughout the four and a half years he had worked in the control room. There is no information to suggest that Operator Sparkuhl questioned the direction to ignore an inmate's request for emergency medical help.

Sparkuhl knew that Lisa was calling for medical help repeatedly throughout the night shift. He knew that the correct procedure was to notify the housing unit officer each time he received a call from an inmate requesting medical help. Operator Sparkuhl was not trained to triage calls for medical help and he was not trained or qualified to determine if a medical need reported by an inmate was "new information". Sparkuhl had no access to an inmate's medical history or record.

Sparkuhl knew that intentionally ignoring an inmate's request for emergency medical attention was not consistent with jail facility training and expectations or in compliance with jail policy, procedure or protocol. Any reasonable jail officer or control room operator would know that intentionally ignoring an inmate's request for emergency help was not accepted practice. Any housing unit officer should know that it was inappropriate and a violation of jail policy, procedure and protocol to instruct another staff person to ignore calls from a particular inmate who was requesting emergency help.

Sparkuhl would have known that if he did not report Lisa Ostler's requests for medical care and assistance she would not be seen by a nurse or any other medical person for evaluation of her complaints and any serious medical condition would not be addressed. Sparkuhl would also know that he was not qualified to determine whether Lisa needed medical attention or not. There is no information to suggest that Sparkuhl was concerned about Lisa not receiving medical attention or that he was at all concerned she was repeatedly reporting a medical emergency for which she would not receive attention as he was intentionally and knowingly ignoring her and disregarding her complaints as not being "new information". There is no information to suggest he did anything but simply ignore her calls in order to get through his job without being "crushed" by

the horrible situations people like Lisa were going through (Sparkuhl Deposition, p 108). Sparkuhl's actions failed to serve Lisa's serious needs in any way.

In addition to Lisa's repeated calls for medical attention, Sparkuhl also received calls from other inmates on the unit checking on Lisa and reporting her cries. One inmate reported she heard Lisa crying and sounding like she was in pain (Sparkuhl Deposition, p 98). Sparkuhl took no action to ensure that Lisa was referred for medical attention or had her pain evaluated in response to multiple concerns expressed by other inmates. He simply ignored their calls too. Any jail staff would know that an inmate crying out, pressing their emergency call button and requesting emergency medical help in a manner that raised concerns of people around them should be assessed by a qualified medical provider. The established protocol was for a Central Control Operator to communicate an inmate's call expressing pain and the need for medical assistance to the Housing Officer to contact a nurse, then for a nurse to come to the inmate and conduct an evaluation. The failures at every one of those steps led to Lisa's suffering and death. Even the layperson inmates on 8C knew that Lisa should be given medical help. Despite attempts to intervene on Lisa's behalf, calls from other inmates were completely ignored just as Lisa's calls were ignored.

B. Regardless of the job position one holds in the jail, whether Housing Unit Officer, Central Control Operator, or Registered Nurse, it is never appropriate or acceptable to ignore an inmate's requests for medical care for an entire shift of duty, for hours, or at any time. Any custody, control room, or medical staff person providing supervision and care in a jail facility in a circumstance similar to that of providing care and supervision to Lisa Ostler would have known that ignoring requests for medical care is a violation of jail standards, policy and procedure, training, ethical and professional behavior, and common sense.

It would be clear and obvious to any jail officer, control operator or health care provider that an inmate crying out repeatedly for hours, begging for medical care, and attempting to summon help by calling on an emergency intercom system 1 to 2 times per hour required medical care or at the very least required a medical contact for assessment. Lisa Ostler's repeated appeals and cries for medical help were knowingly and intentionally ignored by both Central Control Operator Sparkuhl and Housing Officers. A Housing Officer specifically directed Sparkuhl to ignore Lisa's calls and Sparkuhl, without questioning the directive, complied. As a result, Lisa's very serious medical condition of peritonitis progressed and worsened and she did not receive the care or treatment needed to save her life.

C. Sparkuhl testified in his deposition that before his contact with Lisa Oster he previously experienced housing officers telling him to ignore inmates' calls

when inmates reported they were experiencing a serious medical problem and needed help. He stated he followed the instructions to ignore the calls (Sparkuhl Deposition, p 68). Sparkuhl intentionally ignored Lisa's cries for medical help throughout the night shift on 4/1 into the AM of 4/2 - for 8 hours - and failed to exercise any judgment whatsoever about whether his actions were reasonable or consistent with the policy, procedure, or expectations of the jail or whether those actions reflected ethical or responsible behavior toward individuals within his control and custody. Operator Sparkuhl failed to ensure the health and safety of an inmate over whom he had considerable control. When Lisa pressed the emergency button in her cell and the call went to the control room, Operator Sparkuhl owned the decision to determine how the call would be addressed. He was the individual who would decide whether her calls were reported to the housing unit officer. He repeatedly ignored her calls for emergency assistance and did not report them to the housing officer, an action that was intentional, deliberate, and inexplicable as it relates to his responsibility to ensure that an inmate's request for emergency help received attention.

Sparkuhl testified that the instruction from the Housing Officer to ignore inmate calls was part of his job. He stated he would ask if the inmate had new symptoms and pass the information along to the Deputies and assumed they were already aware of the situation. He testified he assumed that medical was also aware (Sparkuhl Deposition, p 103). No evidence suggests that Sparkuhl did anything to validate any of his assumptions when he ignored inmate calls for emergency medical help. Sparkuhl did not have access to a patient's medical information and was not trained or qualified to triage an inmate's medical situation. He had no basis upon which to determine if an inmate's request for emergency medical attention included new symptoms. He controlled the inmate's access to medical care without having sufficient knowledge, training, or hands-on, face-to-face information about their health situation or the urgency or their serious needs.

NCCHC requires the health training program for correctional officers to include a component for instruction in procedures for appropriate referral of inmates with health complaints to health staff.[29] Clearly, Operator Sparkuhl's approach to referral of inmate complaints to health care staff was knowingly deficient, inappropriate, and not consistent with essential requirements to refer an inmate with health complaints to health care staff.

PREFACE TO OPINIONS #14 AND #15:

The Salt Lake County Jail Medical Director, Todd Wilcox, M.D., M.B.A.,

[29] NCCHC, Health Training for Correctional Officers, CorrectCare, Summer 2013.

CCHP-A performed an evaluation of medical care in Arizona prisons.[30] His report, published and reviewable on the internet and publicly available, was highly critical of the care provided to inmates in several Arizona prisons and provided a remarkable and revealing outline of glaring deficiencies in a privately managed correctional health care delivery system. His evaluation included requirements and recommendations for medical care in a correctional environment and deserves careful consideration in this report on the medical care and treatment that Lisa Ostler received at Dr. Wilcox's Salt Lake County Jail facility where the privately managed WellCon correctional health care delivery system was contracted to provide inmate health care. In 2013 Dr. Wilcox's report laid bare failures that had serious negative effects for Arizona's inmate care. Three years after his report, in 2016, the very failures he cited in his assessment of the Arizona correctional facilities were conspicuously reflected at the Salt Lake County Jail, where he directed medical services - medical services that failed to ensure the health and safety of Lisa Ostler.

Wilcox noted the most important major category of a functional medical care delivery system was access to care: the seemingly simple task of getting patients to see nurses and providers. He reported seeing delays in access to care and complete denials of care where some delays were catastrophic and entirely preventable. He noted further that the systematic failure to provide timely access to care placed all patients at an unreasonable risk of serious harm. Patients with significant injuries or illnesses were not safe and were at serious risk of preventable negative outcomes. Delay in access to care, and denial of care to Lisa Ostler at the Salt Lake County Jail was indeed catastrophic and preventable. The seemingly simple task of getting Lisa to see a nurse did not occur.

Wilcox described patient access to sick call as critical, with the most critical component of a correctional healthcare sick call system being triage. He stated triage must be done face to face by an appropriately licensed healthcare provider (RN or above), and it must contain the basic elements of an assessment including brief history, vital signs, exam, and a disposition. He noted that sick call was the doorway to care, and patients must be seen quickly, sorted out, and provided quick referrals to urgent care or provider appointments as needed. Lisa Ostler was not provided access to sick call, was not triaged, did not see an appropriately licensed healthcare provider for an appropriate assessment, was not seen quickly or referred for urgent care as needed.

Wilcox noted that custody support was essential to achieve physical access to care. In Arizona, as in Salt Lake City, officers acted as gatekeepers to care, preventing patients from reaching medical staff. In the absence of a functional sick call system, custody staff acted as gatekeepers for medical care and patients had to persuade them that they needed help in order to get to medical staff. Medical staff seemed to have almost entirely abdicated responsibility to custody staff. Reliance on custody staff as gatekeepers

[30] Report of Todd Randall Wilcox, M.D., M.B.A., C.C.H.P.-A, Parsons, et al. v Ryan, et. al., No. 2:12-cv-00601-NVW November 8, 2013.

to such a degree is a dangerous practice. Unlicensed, unqualified people are making medical decisions. Lisa Ostler attempted mightily to persuade the gatekeepers, Control Operator Sparkuhl and Housing Unit Officers Booth, Holly Harris, and Frederickson, of her need to see medical staff, to no avail. The unlicensed, unqualified, untrained custody staff at Salt Lake County Jail made the medical decisions about Lisa when nursing staff abdicated healthcare decision-making and responsibility to them.

Wilcox went on to state that patients must be seen and care needs identified, both on intake and throughout their prison terms. If access to care is poor, the system blocks professional judgment from operating. Patients must not only be seen by appropriate clinicians and given appropriate diagnoses and treatment orders; they must actually receive the care – medications, labs and other diagnostic tests, special diets -- that is ordered. Teamwork, communication, and good documentation are essential to ensure that care that is ordered is actually provided to patients. Orders written by providers must actually be carried out. Prescribed medications must be provided to patients in a timely, consistent manner. Lisa Ostler did not receive care from an appropriate clinician, was not given appropriate diagnoses or treatment orders and did not even receive the meager care that she was ordered - she was not assessed as ordered, she did not receive the one prescribed medication that was ordered, she was not assessed as to her need for medications she had been prescribed prior to her incarceration, she was not referred to a physician as ordered, and she was not provided adequate nutrition or hydration.

Wilcox opined that medical care in Arizona prisons was simply inadequate to meet the basic needs of many of the prisoners who experienced illness and injury while in custody. In Arizona, Dr. Wilcox found systematic violations of policies and significant barriers to care; serious concerns regarding emergency and inpatient care; signs of custody interference with care, failure to provide patients with appropriate provider medical judgment due to chaotic and disorganized medical records, nurses acting outside of the scope of their licenses, denial of specialty care consultations, substandard decision-making; and inability to provide patients with medically necessary medications. He stated all of these problems harm patients. And all of these problems applied to the care and lack of care of Lisa Ostler at the Salt Lake County Jail. And, indeed, she was suffering and died as a result.

In my opinion, the medical care provided at the Salt Lake County Jail was, to use some of Dr. Wilcox's words, significantly below community standards and placed patients such as Lisa Ostler at serious risk of harm. In order to provide community standards of care in a correctional setting, a system must be in place that allows patients reasonable access to healthcare providers, professional clinical judgment on their case, delivery of the care that is ordered, and self-correcting processes designed to minimize preventable negative outcomes. Lisa Ostler was not afforded reasonable access to healthcare providers, did not receive professional clinical judgment about her serious medical needs, and did not receive care that was ordered. The result of the failures in care

at the Salt Lake County Jail resulted in the most egregious negative outcome. Her death was prolonged and painful. It was also preventable.

The Salt Lake County Jail Responsible Health Authority, Richard Bell, and the Salt Lake County Chief Deputy, Pamela Lofgreen were administrative supervisory staff responsible for the direction, leadership, and supervision of jail nursing and custody staff and responsible for ensuring that detainees received necessary medical services to minimize preventable negative outcomes. Mr. Bell was responsible to arrange for all levels of health care and assure quality, accessible and timely health services for inmates including medical, dental, mental health, nursing, nutrition, and environmental concerns. He was responsible to coordinate health care programs with jail administration (SLCo Ostler 001586). Mr. Bell failed to adequately train and properly supervise the nursing staff responsible for providing medical care to inmates at the Salt Lake County Jail, including Lisa Ostler.

Chief Lofgreen was the administrative law enforcement person responsible for supervising, planning, coordinating, and directing the activities and personnel of the Corrections Bureau of the Sheriff's Office. Lofgreen was responsible for ensuring that the staff at the Salt Lake County Metro Jail followed all jail policies and procedures (Lofgreen Deposition, p 23). Chief Deputy Lofgreen supervised the Health Authority, Richard Bell (Lofgreen Deposition, pp 25-26). Chief Lofgreen failed to ensure adequate training and proper supervision of the custody staff who were in charge as gatekeepers for inmate access to care.

<u>OPINION #14</u>: The Responsible Health Authority for the Salt Lake County Jail, Richard Bell, refused and failed to ensure the nursing staff under his supervision performed their patient care duties and responsibilities in keeping with standards of nursing practice, NCCHC standards, facility policy and procedure, and the intent and expressions of the Salt Lake County Jail medical director. Under his direction and supervision, jail nursing staff exceeded their scope of practice, failed on numerous occasions to conduct withdrawal assessments as ordered, failed to conduct patient assessments as indicated, failed to perform their job duties as required, inappropriately abdicated medical assessments to correctional officers, failed to document care, failed to conduct any pain assessments when indicated, failed to monitor patient food or fluid intake, failed to respond to abnormal vital signs, failed to observe and intervene for a patient with a worsening physical condition, failed to accurately and ethically document actions, and failed to respond to a patient's verbal requests for health care. Under his authority, supervision, direction and leadership, Lisa Ostler's serious health care needs were not identified, assessed, or appropriately treated.

Under Bell's leadership, a culture and pattern of failures to provide essential care and monitoring for the inmates of Salt Lake County Jail existed and was accepted by nursing staff despite their knowledge of the essential need to adhere to professional standards of nursing practice, ethical nursing standards, accreditation standards, the Utah state nurse practice act and the policies and procedures of the Salt Lake County Jail. Jail nursing staff failed to ensure that the health and safety of Lisa Ostler was maintained.

Pervasive, repeated failures to perform assessments, provide monitoring, and render care reflected an acceptance by leadership for nursing behavior that breached standards of nursing care, industry standards of practice, nurse practice acts, facility policies and procedures and the nursing code of ethics. Nursing staff attitudes and approaches were openly endorsed and resulted in patient needs being ignored. Such a collective group approach could only exist in an organizational culture of tolerance for the practice at an administrative level.

A. Mr. Richard Bell was the Responsible Health Authority (RHA) at the Salt Lake County Jail. He was responsible to ensure that health care was accessible to all inmates regardless of diagnosis or circumstance, that care was timely and appropriate, and that there was adequate staffing to cover the health care needs of the inmates. He developed policy and procedures related to the Health Services Division, oversaw the policies and procedures, and ensured that the care provided by jail staff met the policies and procedures and quality measures of care (Bell Deposition, 3/25/19 pp 28-29). Mr. Bell testified his responsibilities included making sure that staff of the Health Services Division were adequately trained to perform their jobs within the scope of their practice (Bell Deposition, 3/25/19, p 31). Mr. Bell was responsible to train nurses working at the Salt Lake County Jail to enter correct and complete information in the patient medical record, including noting medical encounters (Bell Deposition, 3/25/19, pp 32-33). He was responsible for training nurses to make certain that information in the medical records at the Salt Lake County Jail was accurate and complete. There was no evidence to suggest that Richard Bell took any action to address nursing staff failures to follow facility policy or procedures or that he took any action to address their breaches of nursing standards or ethical codes.

Richard Bell is responsible for determining, through a Morbidity and Mortality Review process, which includes a Morbidity and Mortality Review meeting, what led to in-custody deaths of inmates, whether there were any problems with what jail staff did leading to the deaths, and what can be done in the future to prevent similar occurrences. However, the Morbidity and Mortality Review process is obviously merely a pretense of reviewing the circumstances surrounding in-custody deaths at the jail, but failing to ever lead to helpful answers as to whether an error by someone at the jail contributed to a death or

what corrective actions could be taken to avoid deaths in the future. When questioned about Morbidity and Mortality Review meetings, Richard Bell made it clear that no one present was to take any notes or create any documents so there would be nothing accessible if there was later litigation. He also failed to remember even the names of several people, let alone the circumstances surrounding their deaths, who have died in the jail during his time as Responsible Health Authority.

In Lisa's case, no interviews were even conducted to determine if someone on jail staff caused or contributed to her death and no reports were obtained from anyone, except those who responded after Lisa was found unresponsive and not breathing. No report is generated from the Morbidity and Mortality Review meeting or process. In Lisa's case, no one involved in the Morbidity and Mortality Review meeting had any idea about her cause of death. Even after the Medical Examiner established the cause of death, no further Morbidity and Mortality Review was conducted regarding her death. Richard Bell testified he could not think of a reason why a further review was not conducted once the cause of Lisa Ostler's death was determined. It seems clear the reason is that no one involved in the process really cares about identifying what happened to inmates who have died, who may have been responsible, or what corrective measures could be implemented to prevent deaths in the future.

It is evident that, as a matter of custom and practice, the Morbidity and Mortality Review process is not taken seriously by Richard Bell or any other participants. No changes have been made as a result of the process, other than addressing barriers to emergency responders. No one has ever been identified as doing anything, or failing to do anything, contributing to an inmate's death. Incredibly, no one interviewed any of the nurses or housing officers who dealt with Lisa Ostler, except as to what some of them perceived or did *after* she was found unresponsive and not breathing. There seems to be a collective shrug of the shoulders by those participating in the Morbidity and Mortality Review process, being able to say they participated in the review, but that nothing was found that would implicate anyone as having done anything wrong. The record makes clear the conscious indifference of Richard Bell and other participants in the Morbidity and Mortality Review process toward determining what led to an in-custody death, who on jail staff may have been responsible, and what corrective actions could be taken to prevent such occurrences in the future.

At the Morbidity and Mortality Review meeting held regarding Lisa Ostler's death, no one identified six glaring errors on one withdrawal protocol assessment worksheet, including such obvious errors as a 0% oxygen saturation, a respiration rate of 98 breaths per minute, and a wrong value for a heart rate of 133 (marking a "2" instead of a "4" for that alarming heart rate). Neither was it

determined that the assessments, including monitoring of vital signs, that had been ordered had not been done for Lisa the entire time she was in Unit 8C.

The indifference and lack of caring about the deaths of inmates reflected in the lax approach to the Morbidity and Mortality Review process is consistent with the indifference and lack of caring reflected in the care, and lack of care, for inmates at the jail generally. It appears that those participating in that process are more interested in covering up what happened, so it will not be available during possible future litigation, than in conscientiously determining whether anything went wrong, identifying those responsible, and taking measures to make certain it does not happen again in the future.

Had the Review process previously addressed the failure to provide CIWA and WOWS assessments, including the monitoring of vital signs, for several inmates who died, it is reasonable to conclude that measures would have been taken to make sure that Lisa Ostler had received those assessments on 4/1/2016. Had the assessments been conducted on that date, Lisa Ostler likely would not have continued to suffer much long and would not have died. As a nurse, I am familiar with the fact that, in the United States, it is rare for anyone to die of a perforated ulcer and peritonitis if it is timely diagnosed and treated.

Salt Lake County Jail Policy and Procedure stated it was the responsibility of the RHA to ensure that the Health Services Unit policies allowed patients unrestricted access to health care in a timely manner, and that the policies were enforced so that there were not any barriers to patients receiving professional clinical judgments about their health care needs, and that care ordered was received (SLCo Ostler 0001584). There was no evidence to suggest that Mr. Bell took any action whatsoever to address the lack of access to care for Lisa Ostler or the barriers to receiving a professional clinical judgment about the health care needs she experienced or her failure to receive care that was ordered. That failure to take corrective action is consistent with the custom and practice reflected by the fact, as testified to by Mr. Bell, that no corrective action was taken in response to any of the Morbidity and Mortality reviews he participated in prior to Lisa’s death. That failure to correct practices and remove barriers to care contributed to the perpetuation of the flawed system that caused Lisa’s death.

Mr. Bell's RHA position required that he was capable of arranging all levels of health care and ensuring quality and accessible health services for inmates. He oversaw the medical and mental health services and was responsible to review the accessibility, quality, and timeliness of health services provided in the jail (Responsible Health Authority, SLCo Ostler 001586).

He testified that correctional officers at the jail received no training to recognize life-threatening situations involving abdominal problems (Bell

Deposition, p 189). Bell testified that the policy and custom at the Salt Lake County Jail was if an inmate experienced an emergency medical situation, they could ask a nurse or a housing officer for help without filling out a medical form (Bell Deposition, May 20, 2019, p 119); they just needed to let a housing officer or a nurse know (Bell Deposition, May 20, 2019, p 119). There is no evidence to suggest that Richard Bell took any action to address failures by Housing Officers and nursing staff to provide any help or assistance to inmates like Lisa Ostler when they asked for it.

Mr. Bell testified that the Salt Lake County Jail abided by National Commission on Correctional Health Care (NCCHC) standards and nurses at the jail were required to know the standards (Bell Deposition, 5/25/19, pp 173-174). As RHA, Mr. Bell was required to be familiar with the scope of practice for each type of health care person providing services and to have measures in place to ensure that work assigned was consistent with scope of practice. There is no evidence to suggest that Richard Bell took any action to review the practice of Nurse Brad Stoney recording medical diagnoses in a patient's medical record in the absence of clinical information from a qualified medical provider. There is no evidence to suggest that Richard Bell took any action to address nursing staff who failed to perform assessments or provide essential nursing care to an inmate with a serious medical need.

Mr. Bell testified that the policy regarding CIWA and WOWS withdrawal protocol required vital signs to be taken twice daily for five days (Bell Deposition, 3/25/19, p 149). He stated it was a violation of the policy when the nursing staff did not take Lisa Ostler's vital signs for a second time on 4/1/2016 and in the AM of 4/2/2016. There is no evidence to suggest that Richard Bell took any action when he learned that nursing staff failed to take Lisa Ostler's vital signs, performed no withdrawal assessment at all, and failed to respond to significantly abnormal results of the assessments they did perform.

Mr. Bell testified that people who aren't eating are given liquids and Gatorade type electrolytes, particularly patients undergoing withdrawal. He stated it was not uncommon for inmates to lose their appetite or not enjoy the jail food, but staff was always offering liquids so inmates were not dehydrated (Bell Deposition, 3/25/19, p 172). There is no evidence to suggest that Richard Bell took any action in response to staff failures to respond to inmates like Lisa Ostler not eating, not drinking and exhibiting signs and symptoms of malnutrition and dehydration.

The Health Authority was responsible to approve the method of recording entries and the format of the chart (SLCo Ostler 001727). Lisa Ostler's medical record was a collection of medical records and information that was not accurately reflective or representative of her actual medical status or condition

and did not accurately reflect the care she received. The medical chart was essentially a simulation of medical activity entries designed to suggest that Lisa Ostler was appropriately assessed, evaluated, and was provided care that addressed her serious medical needs. In fact, Lisa Ostler did not receive the care that the Salt Lake County Jail claimed inmates received or care that the medical record suggested she received. Lisa Ostler did not receive treatment that would remotely reflect a community standard of care. There is no evidence to suggest that Richard Bell addressed the medical record deficiencies present in Lisa Ostler's Salt Lake County Jail medical record.

The medical record documents and the nature of documentation in Lisa Ostler's chart raise significant concerns and demonstrate that the care she received did not meet or reflect her serious medical needs:

1) The admitting, attending, and ordering physician was recorded as Todd Wilcox, MD – Dr. Wilcox had no involvement in admitting or attending to Lisa Ostler and did not issue any orders for her care or treatment. His name was listed as the ordering physician for standing orders of Phenergan and Imodium on the WOWS protocol assessment worksheet but he had no involvement in the determination of medication orders for Lisa. Dr. Wilcox provided no care to Lisa whatsoever.

2) Doctor Brad Lewis was contacted by e-mail and submitted an e-mail response in which he deferred all of Lisa's prescribed medication for review by a mental health provider. He failed to direct or ensure that such a review would occur in a timely manner or at all. He took no action and ordered no monitoring to ensure that Lisa would be assessed for adverse effects of the sudden cessation of all of her medications. Lisa's medical status related to sudden discontinuation of all of her medication was never evaluated. Lisa was never seen by any advanced level provider at any time. She was never referred to a qualified mental health provider for review of her medication regimen. Her medical treatment at the jail was designed and directed by Nurse Stoney in the absence of direct involvement by a qualified medical provider.

3) A verified list of Lisa Ostler's medications was present in the medical record. None of her prescribed medication, with the exception of Prilosec, was ordered or continued. Prilosec was ordered by Dr. Brad Lewis, however not a single dose of the medication was ever administered. The rest of her prescribed medication was all deferred for consideration by mental health per an e-mail written by Dr. Brad Lewis who did not see, examine, or talk to Lisa Ostler. Lisa did not see a psychiatrist at any time during her detention, and none of her medications were ever reviewed, ordered or continued. There was no indication that she was even scheduled to see a psychiatrist to ensure that her medication regimen would be reviewed.

4) Lisa's Medical Problem List of medical diagnoses was entered without any Salt Lake County Jail physician, physician's assistant, or nurse practitioner conducting any examination of her or even seeing her. The list of diagnoses was e-mailed to the doctors by Registered Nurse, Brad Stoney, in the absence of clinical information documented by an advanced level provider qualified to render medical diagnoses.

5) The Comprehensive Nurse Examination conducted on 3/30/2016, was little more than an expanded restatement of the Nursing Pre-screen Examination conducted on the same date. The PHYSICAL EXAM section reflected a hands-on measurement of Ms. Ostler's vital signs and noted two small skin wounds. The remainder of the physical exam reflected a systems review of oral responses. There is no indication that a physical assessment was conducted (i.e., heart sounds, lung sounds, auscultation of bowel sounds, palpation of the abdomen, etc.). No pain assessment was conducted.

6) The CIWA and WOWS protocol assessments present in Lisa Ostler's record were replete with inaccuracies and omissions. On the afternoon of 4/1/2016 and the morning of 4/2/2016 the protocol worksheets reflected that Lisa was not in her cell despite her not leaving her cell for any reason other than for a clothing exchange. Lisa's location was always known and carefully tracked and staff had access and knowledge of that information. Once she was housed on Unit 8C in Cell 16 she did not leave the unit. Her unit and cell number were written on medical record documents that nursing staff all had access to. The information entered on the protocol assessments was false.

All encounters by Health Services staff were to be entered into the Electronic Medical Record (EMR) before the end of their shift the day care was rendered (SLCo Ostler 001728). Mr. Bell testified that if medical information was not documented it was not done (Bell Deposition, May 20, 2019, p 94). He noted that missing entries for assessments and vital signs on the withdrawal protocol worksheets after the morning of April 1st did not comport with the policies of Salt Lake County Jail (Bell Deposition, May 20, 2019, p 107). There is no evidence that Richard Bell took any action to address missing entries on assessment forms, missing assessments, or staff failures to document and record patient encounters.

B. Mr. Bell was responsible to know the scope of practice for each of the staff he supervised. Mr. Bell would know that a nurse was not permitted to render medical diagnoses or enter information that was misrepresentative of actions or care provided. He would know that the medical record entries of Brad Stoney, RN, in Lisa Ostler's medical record exceeded the scope of registered nursing practice. Bell would know the medical diagnoses listed for Lisa Ostler were not

the result of a physician evaluation or physician documentation. He would know that the physicians listed as Admitting, Attending, and Ordering care for Lisa Ostler had not actually seen her. He would know that the physician who ordered, deferred, and discontinued her prescribed medication had done so without ever seeing or talking with her.

The Salt Lake County Jail was accredited by NCCHC and Mr. Bell knew the health standards that governed the jail. NCCHC required that prescribed medications for inmates were reviewed and appropriately maintained according to the medication schedule the inmate followed before admission. Mr. Bell would know that inmate medications were not being maintained according to the inmate's schedule prior to detention and that Lisa Ostler's medications were never reviewed and were clearly not maintained according to the medication schedule she had prior to being detained.

Mr. Bell was responsible to ensure that inmate assessments were performed and recorded completely and accurately and he would know that inmates were to receive the care that was ordered for them. He would also know the importance of inmate access to care and the process for inmates to follow in order to access both routine and emergency care. Richard Bell would know that Lisa Ostler did not receive the withdrawal assessments as ordered and would know that inmates were not receiving the care that was ordered for them. The absence of nursing documentation for patient assessments, medication administration, evaluation, and response to requests for medical help provides ample evidence that essential care was not provided. There is no evidence that Richard Bell took any action to address Lisa Ostler not being assessed, not receiving essential care and not being able to access emergency care when she requested and needed it.

C. Under Richard Bell's leadership, jail nursing staff deliberately failed to respond to inmate requests to be seen for medical emergencies and inmates were not seen according to the policy that allowed them to contact a Housing Officer who would notify medical to see them as soon as possible. Inmates such as Lisa Ostler with serious medical needs were ignored and their serious needs were not met. Several inmates, including Lisa Ostler, had their serious medical needs ignored and died as a result.

Under Richard Bell's leadership, a custom and practice of disregard for an inmate's medical concerns and requests and a pattern of failure to conduct face-to-face or focused assessments flourished. Inmate complaints that included clinical symptoms were not reviewed, were ignored and went unaddressed. The failure of nursing staff to address the inmates' serious needs demonstrated a group acceptance of ignoring needs, requests and serious medical issues. The failures

were not limited to a single practitioner but were evidenced in a general manner among nursing staff at all levels performing job duties across all positions: the admission nurse, the booking nurse, the medication administration nurse, the diabetic check nurse, the treatment nurse, the withdrawal assessment nurse, the triage nurse, and the nurses responding to officer requests for inmates needing medical help. Richard Bell testified that the policy at the Salt Lake County Jail provided for a Health Services staff to respond and examine an inmate as quickly as possible in response to a housing officer communicating a request for medical help (Bell Deposition, 5/20/19, p 175). He testified that the custom at Salt Lake County Jail did not permit a nurse, who was notified by a housing officer concerning an inmate's request for medical help, to refrain from responding as quickly as possible to examine the inmate (Bell Deposition, 5/20/19, p 175). Bell testified that a nurse, contacted by a housing officer about a medical problem being experienced by an inmate, would have to make the determination about the course of action needed after actually seeing the inmate rather than leaving the determination as to whether a medical emergency existed to the housing officer (Bell Deposition, 3/25/19, pp 58-59). He testified further that it would be inappropriate for a nurse to ask a housing officer to determine whether an inmate was experiencing a medical emergency if the nurse had not recently seen the individual (Bell Deposition, 3/25/19, p 61).

Richard Bell testified that he was the individual at the Salt Lake County Jail that arranged for all levels of health care and assured quality, accessible, and timely health services for inmates (Bell Deposition, 3/25/19, pp 134-135). He testified that no medical determination about Lisa Ostler's condition was made because no nurse ever went to see her to make a determination. He stated the report of the medically untrained officer did not appear to meet the level of a medical emergency, and the decision about care for Lisa was essentially based upon the officer’s observations - as a result, medical care that was needed was not provided (Bell Deposition, 3/25/19, pp 137-139). Lisa did not have access to quality or timely health care services. She was afforded no access to any health care services for her serious medical needs. Yet, Richard Bell testified that he ensured quality and accessible health services to Lisa Ostler and met his responsibilities (Bell Deposition, 3/25/19, p 139, 142).

Lisa Ostler's medical records reflect that ordered assessments were not completed at all, assessments that were completed were not completed accurately, abnormal clinical findings were not followed up, clinical protocol that was specifically developed to improve monitoring of inmates in withdrawal at Salt Lake County Jail and was touted nationally as an “industry standard” was not even followed, nurses failed to conduct essential assessments, nurses failed to monitor inmates for dehydration or pain and nurses did not document inmate encounters in accord with facility policy and nursing standards of care. Nursing

staff failed to take basic preventive measures to reduce the likelihood that medical problems progressed to catastrophic outcomes.

Richard Bell testified that he discussed entries on Lisa Ostler's CIWA and WOWS assessment worksheets with Todd Riser, the Salt Lake County Jail Nursing Supervisor (Bell Deposition, 5/20/19, pp 14-15). He stated they discussed the errors and omissions evident in the withdrawal assessments done for Lisa Ostler. He stated Riser noted errors, omissions, and abnormal findings but was not concerned that a physician was not notified even though facility policy required immediate physician notification (Bell Deposition, 5/20/19, pp 17-18). Richard Bell was aware that Lisa requested medical care when Nurse Colby James was on her unit just minutes before she was found unresponsive and not breathing in her cell. He was aware that James did not even bother to walk over to her cell to check on her request. Bell did not talk with James or try to learn any information about why he didn't go to check on Lisa in response to her request (Bell Deposition, 5/20/19, pp 56 - 61). Bell testified that to determine if an inmate had a medical emergency the nurse would have to evaluate them. Bell testified he was not concerned when he learned that Nurse Tucker or any other health staff never checked Lisa regarding her report of bleeding. There is no evidence whatsoever that Richard Bell was concerned about any of the failures of his nursing staff to evaluate Lisa, respond to abnormal findings about Lisa, or provide nursing care as ordered.

Richard Bell testified he was the person responsible for inquiring into why an inmate who died had not had her vital signs taken when they were supposed to be taken. He testified he had not inquired into why Lisa's vital signs were not taken. (Bell Deposition, 3/25/19, pp. 46-47). He stated he did not inquire because there were no significant findings that there was a history of her vital signs not being within normal limits (Bell Deposition, 3/25/19, p 47-48). In fact, Lisa's vital signs were far outside of normal limits and in the 24 hours before her death her vital signs had not been taken as ordered. None of this information prompted Mr. Bell to inquire about or review the care that Lisa had received or had not received.

Overwhelming systemic problems in the provision of health care at the Salt Lake County Jail were a direct result of leadership acceptance of an attitude for a knowing disregard of inmates' serious medical needs. Throughout his deposition testimony Mr. Richard Bell reported no attempts to learn information about why assessments were not done, why abnormal findings were not reported, or why nursing staff failed to render care or document care. He consistently reported lack of concern for care that was not provided (Bell Deposition, 5/20/19, pp 25, 56, 58, 66-67, 132, 208, 212). No recommendations were made for changes in policies or practices after review of what happened to Lisa Ostler (Bell Deposition, 5/20/19, p 118). He testified that he had not taken any steps in his

capacity as Responsible Health Authority to make certain that if an inmate was complaining of severe pain or other major symptoms that may relate to something other than withdrawal from drugs they were to get medical attention as opposed to being waved off and treated as just another inmate going through drug withdrawal (Bell Deposition, 4/17/19, p 45).

Richard Bell testified that in the course of discussion about Lisa Ostler's case he recalled hearing that a housing officer instructed Scott Sparkuhl in central control to ignore Lisa Ostler's emergency calls. He stated he did not discuss this information with anyone and there is no evidence to suggest he took any actions to ensure that inmate calls for emergency care would not continue to be ignored. In fact, his testimony reflected that he believed ignoring some inmate calls may actually be acceptable (Bell Deposition, 5/20/19, pp 188-190). Bell testified that to ensure timely, responsive, quality medical response to the needs of inmates it was crucial that central control not ignore an inmate's emergency calls and, in each instance, they contact the housing unit officer about the calls and the information they were receiving, yet he took no action whatsoever to ensure that inmate emergency calls would be addressed and not ignored. His attitude and approach reflect remarkable indifference toward an inmate that was found unresponsive and not breathing minutes after the nursing staff he was responsible to supervise was contacted but failed to provide care. Mr. Richard Bell was responsible for the culture, customs, and attitudes of indifference that led to catastrophic ends for patients such as Lisa Ostler.

Following Lisa Ostler’s death, Richard Bell did not speak with any of the jail nursing or custody staff employees who were involved in the incidents surrounding the care, failure to provide care, actions or failures to act, and refusals to act or provide care to Lisa for her serious medical needs and repeated requests for health care. Consequently, the failures, failures to act, and refusals of jail staff to provide medical care to Lisa in the final days and hours of her life were ignored by Richard Bell and therefore did not facilitate improvement to the access to care for inmates of the Salt Lake County Jail.

OPINION #15: The Chief Deputy Sheriff of Salt Lake County, Pamela Lofgreen, failed to ensure that jail staff under her direct and indirect supervision performed their duties and responsibilities in keeping with NCCHC standards and facility policy and procedures. Under her direction, supervision, and leadership, the Responsible Health Authority failed to ensure that nursing staff at the Salt Lake County Jail provided essential medical care to inmates entrusted to their care. Under her direction, supervision, and leadership, custody staff at the Salt Lake County Jail failed to notify medical staff of inmate needs and, as a result, failed to ensure the health and safety of detainees over whom they had complete control.

Under her authority, supervision, direction and leadership, Lisa Ostler's serious health care needs were not identified, assessed, appropriately treated, or managed.

A. Pamela Lofgreen was the Chief Deputy of the Salt Lake County Sheriff's Office in 2016. She was the Chief Deputy over the Corrections Bureau and oversaw overall operations, program development, and employee issues at the Salt Lake County Jail. Ms. Lofgreen supervised the RHA/Health Authority, Richard Bell.

The failures in the treatment and care Lisa Ostler experienced at the Salt Lake County Jail prior to her death are illustrative of several systemic problems with the medical care provided by jail personnel under the direction and oversight of administrators responsible for the provision of care and treatment to her[31] and responsible for ensuring care and treatment was actually available and accessible to jail inmates. There was a failure by nursing staff to take basic preventive measures to reduce the likelihood of medical problems developing into a catastrophic condition. There was a failure by the jail administrators (specifically Richard Bell and Pamela Lofgreen) to hold medical and custody staff accountable for their actions and failures to act.

Pamela Lofgreen oversaw a broken system of health care in the jail where providers did not provide ordered or needed medical care, where a culture and practice of ignoring inmates' serious medical needs was permitted and accepted, where false recordkeeping was accepted, where officers were not sufficiently trained to identify potentially emergent conditions they were frequently confronted with on an almost daily basis (e.g., abdominal pain in inmates suffering withdrawal where nausea, vomiting, cramping was a frequent occurrence) and where inconsistent or absent documentation and inconsistent log entries, particularly related to contacts with medical staff for emergent inmate needs, was common and accepted.

Under the leadership of Chief Deputy Lofgreen, Housing Unit Officers ignored inmate requests for emergency medical care, a practice that was customary and accepted. Even officers that knew they should report the inmate requests to the Housing Officer followed instructions by other officers to "ignore the cell". Housing Officers testified with troubling complacency that they

[31] Wilcox, Todd, Expert Opinion Report, Expert for the Plaintiff ,Walter Jordan 078789 Walter 078789, Died on 9/7/2017 while in the custody of the Arizona Department of Corrections (ADC), Corizon Health Care, Housed at ASPC-Florence, East Unit, Case 2:12-cv00601-DKD, Document 2496.

followed directions to ignore inmates who reported they were experiencing a serious medical problem and needed medical care including Lisa Ostler who said she was in pain and needed help (Sparkuhl Deposition, p 45, 50, 67). Under Lofgreen's leadership, Housing Officers and Central Control Operators were not trained to appropriately respond to every request for medical hep and were not trained about the inappropriateness of choosing to "ignore" an inmate's pleas for help.

Chief Deputy Matthew Dumont testified that according to the Control Room Operations Manual a Control Room operator was required to notify the Housing Officer when they received an intercom communication from an inmate that was in pain (Dumont Deposition, pp 136-137). Mr. Dumont testified that an informal custom and practice was in place [in 2016] where Housing Deputies could provide an instruction to Control Room Operators to ignore certain calls.

Under the leadership of Chief Deputy Lofgreen a culture of disregard for inmates' serious medical needs was allowed to persist. Her leadership and supervision supported a knowing disregard for the serious medical needs of Salt Lake County Jail inmates. Her tolerance for jail nursing and custody staff to ignore inmates' medical needs and requests resulted in Lisa Ostler suffering immense pain and ultimately loss of life.

B. Any individual qualified to be appointed as the Chief Deputy of Salt Lake County would know or should know the absolute importance of creating a culture of concern for an inmate's serious medical needs among health care and custody staff alike. A Chief Deputy would know or should know that the basis for ensuring inmates received needed health care required that they had access to care and their requests for care, emergent and non-emergent, were not ignored. A Chief Deputy would know the importance of complete and accurate documentation of events and that false reporting was a violation of facility policy and procedure and was not acceptable. A Chief Deputy would know or should know that custody staff were not trained to triage requests for medical care and were not qualified to limit inmate access to health care providers. An administrator in a position of Chief Deputy would ensure that custody and medical staff understood their obligations and responsibilities to ensure that inmates received competent and appropriate health care by qualified providers.

C. Chief Deputy Pamela Lofgreen knowingly and deliberately ignored the serious medical needs of Salt Lake County Jail inmates such as Lisa Ostler when, under her leadership, sworn officer staff were permitted to violate jail policy and procedure in the handling of inmate emergency medical requests. The officers followed directions to ignore inmate calls for emergent medical help in a casual

and accepting manner, a verification that the practice was usual and customary and they were familiar with the approach. Chief Deputy Lofgreen failed to create and endorse a facility culture that would prevent and discourage jail officers from openly violating policy and procedure. Under Chief Deputy Lofgreen's leadership, certain inmates were directly and repeatedly prevented from accessing any medical care in an emergency.

Under Chief Deputy Lofgreen's leadership, housing officers who dealt with inmates withdrawing from drugs on a daily basis received no training to inform them about how to distinguish gastrointestinal symptoms characteristic of withdrawal from more serious emergent abdominal conditions that should be referred to medical providers immediately. While officers were trained to refer issues such as cardiac arrest, seizures, and excessive bleeding to medical, they were not trained on gastrointestinal issues or abdominal pain even though abdominal pain, nausea, and diarrhea was common for inmates undergoing withdrawal, and was a condition they were confronted with frequently. Officers were not trained about potentially related conditions such as appendicitis, bowel obstruction, ulcer, bowel perforation, or ruptured organs which were equally critical and should be discussed as part of a training program for emergency response.

None of the officers at Salt Lake County Jail that testified in the Lisa Ostler matter received any training at all on potential abdominal emergencies. In the absence of sufficient, relevant training, the serious medical needs of inmates who experienced emergent conditions involving the gastrointestinal system were viewed as having "typical" symptoms of drug withdrawal when, in fact, an alternate life-threatening disease process was perhaps unfolding.

Officers were not qualified to make medical or nursing determinations about an inmate's health complaints and in all cases, they were required to report inmate medical complaints to the nurse. Officers received no training to increase their awareness of when to report gastrointestinal symptoms or of potential complications that would have provided knowledge for their reference and better informed them about when to refer inmates to the nurse. Jail administration failed to provide training related to the medical conditions officers on 8C were frequently faced with, including nausea, vomiting, abdominal pain and withdrawal despite any of the presentations and conditions having serious potential for complications. Under Deputy Lofgreen's leadership custody officers did not have a consistent, clear directive or training about referring ALL medical complaints to the medical staff for disposition.

Under Chief Deputy Lofgreen's leadership, jail officers had no consistent direction about completion of their shift logs, particularly related to logging contacts with medical providers. As a result, communication about an inmate's

serious medical needs or health concerns was frequently not passed on for monitoring or tracking and significant information was unavailable.

Inmates such as Lisa Ostler with serious medical needs were ignored and their needs were not met. Several inmates whose serious medical needs went unaddressed died as a result. Lisa Ostler was an inmate whose serious medical needs were deliberately ignored despite her repeated attempts to secure medical help. The culture and practice and the administrative leadership and direction at the Salt Lake County Jail supported by members of the administrative team, including Pamela Lofgeen and Richard Bell, fell below all jail standards and community standards of care, resulting in the most egregious negative outcome possible - the death of Lisa Ostler, an outcome that was preventable.

Following Lisa Ostler's death, Deputy Chief Pamela Lofgreen did not speak with any of the jail nursing or custody staff employees who were involved in the incidents surrounding the care, failure to provide care, actions or failures to act, and refusals to act or provide care to Lisa for her serious medical needs and repeated requests for health care. Consequently, the failures, failures to act, and refusals of jail staff to provide medical care to Lisa in the final days and hours of her life were ignored by Lofgreen and therefore did not facilitate improvement to the access to care for inmates of the Salt Lake County Jail.

VIII. CONCLUSION

The foregoing represents my opinions on the standards of care that non-deliberately indifferent nursing staff and jail staff would have provided in a similar circumstance to that of Ms. Ostler's incarceration in the Salt Lake County Metro Jail from March 30, 2016, through April 2, 2016, and how each of the Defendants' actions compared to those standards. I hold the foregoing opinions to a reasonable degree of nursing certainty. I reserve the right to supplement these opinions should additional facts be brought to light or in response to any expert opinion offered by the Defendants.

Respectfully submitted,

Suzanne L Ward

Suzanne L. Ward RN, MS, LNC, CCM

November 13, 2019

Appendix 1

SUZANNE L. WARD, RN, MS, LNC, CCM

N3798 County Hwy. F
Montello, Wisconsin 53949
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e-mail: SWardLNC@aol.com or miggsie2@aol.com

EDUCATION

2011 - Present - Certification as Case Manager
2007 Certification as Wisconsin Long-Term Care Functional Screener
2000 Course Completion for Legal Nurse Consultant
1997 Completed Core Curriculum in Criminal Justice Administration, Concordia
1987 Completed 3000 Supervised Hours with Mentally Ill/MR/DD Individuals
1986 Master of Science Degree, Health Care Management
1984 Bachelor of Science Degree, Health
1973 Associate Degree, Professional Nursing – Licensed Registered Nurse

PROFESSIONAL EXPERIENCE

1999 - Present
Legal Nurse Consultant, Nurse Consulting
Self-employed LNC for long term care, assisted living, developmental disabilities, mental health, forensics and corrections.
Expert witness, Court testimony and Deposition experience.

November, 2010 – 2018 (Retired)
Case Manager, Humana
Telephonic case management for Humana insurance members with specified chronic diseases.

July, 2007- October, 2010
Registered Nurse, Care Wisconsin (formerly ElderCare of Wisconsin)
Nursing Case Manager for frail elderly, physically disabled, and developmentally disabled residents of Sauk and Columbia County

2006 – July, 2007
Staff Nurse, Wisconsin Dells Living Center – a Beverly Facility
PM shift nurse for Medicare, Long Term Care, and Rehab residents.
Wound care coordinator.

1995 - 2006 (Retired from State Service - December, 2006)
Nurse; Unit Manager; Supervisor, State of Wisconsin
Nurse Clinician 2, Columbia Correctional Institute, 9/2003 – 12/2006
Nurse Clinician 2, Dodge Correctional Institute, 1/2003 – 9/2003
Unit Manager, Mendota Mental Health Institute, 7/2000 – 9/2002
Nursing Supervisor 2, Central Wisconsin Center-MR/DD, 7/99 – 7/2000
Nurse Clinician 2, King Veterans Home, 10/98 – 7/99
Nursing Supervisor 2, Central Wisconsin Center-MR/DD, 1/98 – 10/98
Nurse Clinician 2, Dodge Correctional Institute, 9/95 – 1/98

(*) Part Time employment concurrent with State of Wisconsin positions above:

*2002 - 2004
Registered Nurse, Sunnyview Health and Rehabilitation Center
AM and PM shift nurse for Medicare, Long Term Care and Rehab residents

*1999 - 2002
Community Nurse Consultant, Create-Ability, Inc.
Nursing Case Manager for community MR/DD Program clients

*1997 - 2002
Pharmacy Nurse Consultant, Pharmerica
Facility Case Manager for pharmacy services to Long Term Care, CBRF, Assisted Living, and Group Home clients, Wisconsin and Michigan

1993 -1995
Staff Education, Infection Control Coordinator, Dodge County Facilities
Coordinator for all staff education, infection control, quality assurance, and utilization review programs. Charge nurse for Head/Spinal cord injury unit, psychiatric unit, Alzheimers unit, MR/DD unit. State Certified Nursing Assistant Instructor, MDS Coordinator

1992 - 1993
Public Health Nurse, Juneau County Public Health
Community Nurse Consultant, Case Manager Mental Health Programs

1991 -1993
Nursing Supervisor, Columbia County Nursing Home
Supervisor of Long Term Care and Alzheimers/Behavioral Units

1990 - 1991
QA, IC, UR Manager, HCA Parkway Hospital of Madison
Nursing Manager of QA, UR, IC, RM and Safety Programs

1989 - 1990
Associate Director of Nursing, Rural Wisconsin Hospital Cooperative
Coordinator of $1 Million Robert Wood Johnson Foundation Grant

1989 - 1990
Clinical Nurse Specialist, Dane County Jail/Mental Health Center Dane County
Clinical Nurse Specialist on the Jail Mental Health Assessment Team

1987 - 1989
Director of Review and Program Development, Wisconsin Peer Review (WIPRO)
Directed Wisconsin review operations for Medicare and Medicaid
1982 - 1987
Director of Inpatient Services, Tri-County Human Services Center
Directed Mental Health, AODA, MR/DD inpatient staff and programs
1981 - 1982
Team Leader, St. Lukes Hospital of Milwaukee
Led inpatient team for general medical-surgical and psychiatric services
1979 - 1981
Charge Nurse, VA Medical Center, Wood/Milwaukee
Charge nurse for acute psychiatric and AODA services
1979
Nurse Clinician, Milwaukee County House of Correction
Nurse for minimum security prison health service
1977 - 1978
Nursing Supervisor, St. Mary's Hill Psychiatric Hospital
Supervised Adult, Adolescent, and Child Psychiatric Treatment Units
1975 - 1977
Team Leader, McCauley Neuropsychiatric Institute of San Francisco
Nursing leader of acute forensic medical inpatient psychiatric service
1974 - 1975
Counselor, Case Manager, Wisconsin Family Drug Treatment Center
Case manager, Women's group leader, Community Drug Treatment
1973 - 1975
Nurse Clinician, Elmbrook Memorial Hospital
Registered Nurse on medical, surgical, pediatric and AODA services
1970 - 1973
NA, Graduate Nurse, Registered Nurse, Community Memorial Hospital of Menomonee Falls
Nursing Assistant, Nurse on medical, surgical, and pediatric units

PREVIOUS UNIVERSITY AFFILIATION:

1995 – 2015
Concordia University of Wisconsin
Adjunct Faculty in Adult Education Programs
Health Care Management

1986 – 2010
Cardinal Stritch University
Adjunct Faculty in Adult Education Programs
Business Management
Health Care Administration

Appendix 2

May, 2019
Suzanne L. Ward RN, MS, LNC, CCM
Deposition and Trial Testimony – Rule 26 Disclosure

William Marsh v. Correctional Medical Services. (C.A. No. 09C-07-120 CHT). Balick & Balick. Jim Drnec (Defense Attorney). Wilmington, Delaware. Expert Witness for Defense - Delaware Correctional Center. DEPOSITION, 2/27 – 2/28/2013.

Donald Martin v. SSM Health Care of Wisconsin. (Sauk County Case No. 12-CV-517). Corneille Law Group. Melita Mullen Schuessler (Defense Attorney). Baraboo, Wisconsin. Expert witness for Defense. DEPOSITION, 5/30/2014.

Estate of Margo Anderson v. Tellurian U.C.A.N., Inc. (Case No. 13-CV-3315). Gingras, Cates & Luebke, S.C. Paul Kinne (Plaintiff Attorney). Madison, Wisconsin. Expert witness for Plaintiff. DEPOSITION, 8/07/2014.

Coger, Cleveland v. Fairlane Senior Care & Rehab Center, LLC. (Case No. 14-013135-NH).
Liss, Seder & Andrews, P. C. Nicholas Andrews (Plaintiff Attorney). Bloomfield Hills, Michigan. Expert witness for Plaintiff. DEPOSITION, 1/05/2016.

Yambert/Callahan v. Office of Sheriff of Lee County, et al. (Case No. 09 L 10). Cunningham, Meyer & Vedrine, P.C., Kipp Cornell/David Burtker (Plaintiff Attorney). Chicago, Illinois. Expert witness for Plaintiff. Inmate death r/t alcohol withdrawal. DEPOSITION, 3/08/2016.

Estate of Mark Richardson, et al. v. Correctional Healthcare Companies, Inc., et al. (Case No.: 15 CV 3200). Thomas C. Lenz. First, Albrecht & Blondis, S.C. (Plaintiff Attorney). Milwaukee, Wisconsin. Expert witness for Plaintiff. Inmate death r/t splenic rupture. DEPOSITION, 7/25/2016.

Estate of Lawrence G. Griffin v. Extendicare Health Services, Inc., et al. (Dane County Case No. 156). Jeff Scott Olson. Jeff Scott Olson Law Firm, S.C. (Plaintiff Attorney). Madison, Wisconsin. Expert witness for Plaintiff. Patient fall and death. DEPOSITION, 8/25/2016.

Michael D. O'Connell v. Village of Mount Horeb, et al. (Dane County Case No. 15-CV-1382). Jeff Scott Olson, Jeff Scott Olson Law Firm, S.C. (Plaintiff Attorney). Madison, Wisconsin. Witness for Plaintiff. Excessive Force. COURT NARRATION, 8/30/2016.

Carl E. Williams and/or Lorraine L. Williams Delaration of Trust. (Case No.: 15 PR 40). Wassel, Harvey & Schuk, LLP., Marra Spring (Plaintiff Attorney for Patricia Ashenfelter), Elkhorn, Walworth County, Wisconsin. Expert witness for Plaintiff. COURT TESTIMONY, 12/05/2016.

Tia Paradis v. Jon Nichols, et al. (Case No. 16-CV-225). Atterbury, Kammer & Haag, S.C. Attorney Alexander Kammer (Plaintiff Attorney). Expert witness for Plaintiff. DEPOSITION, 12/13/2017.

Ryan Clark v. County of Green Lake, et al. (Case No. 14-C-1402). Jeff Scott Olson Law Firm. Attorney Jeff Scott Olson (Plaintiff Attorney). Expert witness for Plaintiff. DEPOSITION, 12/20/2017.

Mario Avila. First, Albrecht & Blondis, S.C. Attorney Thomas Lenz (Plaintiff Attorney). Life Care Plan. DEPOSITION. 6/19/2018.

DANTE WILSON. First, Albrecht & Blondis, S.C. Attorney James End (Plaintiff Attorney). DEPOSITION, 6/11/2019.

Appendix 3

Materials reviewed prior to reaching my opinions and preparing a report:

- Lisa Ostler's jail medical record;
- First Amended Complaint and Proposed Second Amended Complaint
- Documents produced/provided by the parties in this litigation, including jail administrative documents regarding Lisa Ostler, shift logs, training documents, video recordings of 5C and 8C, medical records of Lisa Ostler and other detainees who died in custody, and written policies;
- Deposition Transcripts with Attachments for the following Deponents:

  Nicole Danielle Bates
  Heather Beasley
  Kathy Berrett
  Todd Booth
  Christopher Braithwaite
  Dr. Samuel Brown
  Dr. Nathan Dean
  Matthew Dumont
  Zelma Farrington
  Zachary Frederickson
  Holly Harris
  Calvin Kengike
  Elizabeth Kengike
  Brad Lewis
  Pamela Lofgreen
  Cal Ostler
  Kim Ostler
  Jason Power
  Todd Riser
  Ronald Seewer

Kellie Marie Sheppard
Scott Sparkuhl
Brent Lee Tucker
Dr. Pamela Ulmer
Todd Wilcox
Alisha Carol Woodruff

- HSU Daily Assignment Log;
- Defendants' Answers to Interrogatories
- Defendants' Answers to Reformulated Requests for Admissions;
- Letter re: Amended Responses to Requests for Admissions and Responses to Reformulated Requests for Admission;
- Medical Records for Inmates with CIWA and/or WOWS assessments;
- Utah Administrative Code;
- Utah Nurse Practice Act;
- American Nurses Association (ANA) Scope and Standards of Practice, Nursing;
- American Nurses Association (ANA) Scope and Standards of Practice, Corrections Nursing;
- American Nurses Association (ANA) Scope and Standards of Practice, Pain Management;
- American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements;
- National Commission of Correctional Health Care (NCCHC) Standards;

- independent research; and
- my skills, knowledge, professional background, education and work experience.

Appendix 4:

PROTOCOL, STANDARDS, and GUIDELINES USED IN FORMULATION of OPINIONS

CIWA and WOWS Withdrawal Protocol,
National Commission on Correctional Health Care (NCCHC) Standards,
State of Utah Nurse Practice Act,
State of Utah Scope of Nursing Practice Implementation,
American Nurses Association (ANA) Standards, Standards for Corrections Nursing, Standards for Pain Management, Code of Ethics,
Nursing Expectations for Emergency Care Delivery in Correctional Facilities,
Nursing Expectations for Response to Abnormal Vital Signs,
Salt Lake County Jail Policy and Procedure, Job Descriptions, Prisoner Rules and Regulations Handbook
Dr. Todd Wilcox article "*"Managing Opiate Withdrawal: The WOWS Method"*, CorrectCare, printed Summer 2016.

B. CIWA and WOWS PROTOCOL

The Clinical Institute Withdrawal Assessment (CIWA) protocol was a quantification instrument developed for monitoring alcohol withdrawal. The Wellcon or Wilcox Opiate Withdrawal Scale (WOWS) was a targeted tool customized for opiate withdrawal at the Salt Lake County Jail. The WOWS assessment withdrawal protocol was essentially an edited version of the Clinical Opiate Withdrawal Scale (COWS). At the Salt Lake County jail withdrawal protocol required that vital signs be taken and a clinical symptom assessment be performed twice a day for five days (Seewer Deposition, p 136; Riser Deposition, p 41, 49). In his article *"Managing Opiate Withdrawal: The WOWS Method"*[32] Dr. Todd Wilcox, the medical director of the Salt Lake County Metro Jail, stated "In my facility, any patient undergoing opiate withdrawal is assessed twice per day for a minimum of five days by nurses who have been trained in the WOWS protocol. The assessment includes a full set of vital signs, serial tracking of the patient's clinical progress and interventions as necessary based on clinical presentation". He highlighted several "Takeaway Points" including that "opiate withdrawal is a life-threatening medical condition" and noted the importance of assessment for dehydration and comorbidities including underlying chronic diseases. Dr. Wilcox stated a significant emphasis was placed on oral hydration.

[32] Wilcox MD, Dr. Todd, *"Managing Opiate Withdrawal: The WOWS Method"*, CorrectCare, printed Summer 2016.

C. STANDARDS OF CARE (Not all-inclusive)

1. National Commission on Correctional Health Care (NCCHC) Standards

In 2014 the Salt Lake County Metro Jail achieved accreditation by the National Commission on Correctional Health Care (NCCHC) and maintained the accreditation in 2016. The jail facility was required to follow the NCCHC Standards for Health Services.[33] Accreditation reportedly benefits the health of inmates by assuring that those incarcerated receive adequate and appropriate health care according to nationally accepted standards.

a. NCCHC, Receiving Screening:

The receiving screening performed at the time an inmate is booked into the jail serves as "a process of structured inquiry and observation designated to ensure that patients with known illnesses and those currently on medications are identified for further assessment and continued treatment."[34]

b. NCCHC, Access to Care:

The first standard in the NCCHC's Accreditation Standards is "Access to Care". The discussion states that "this standard intends to ensure that inmates have access to care to meet their serious health needs and is the principle on which all National Commission on Correctional Health Care standards are based."[35] Nurses are the first health care professional an inmate is likely to see when they have a medical problem and it is the nurse who will determine the inmate's subsequent access to care.

Nursing sick call is considered one of the signature practices defining the specialty of correctional nursing. There are two legal principles underlying nursing sick call. The first is that inmates have daily, unimpeded access to health care. The second is that inmates are entitled to a professional clinical judgment regarding their health concerns. Simply put, inmates can request health care attention every day and their concerns must be addressed in a responsive, timely and clinically appropriate manner.

[33] NCCHC, "First Facility Surveyed Under 2014 Standards, 2014.
[34] National Commission on Correctional Health Care (NCCHC) 2008 Standards for Health Services for jails
and prisons, E-02 Standard, Receiving Screening (essential), Spotlight on the Standards article, appeared in CorrectCare, Winter 2011 edition, pp 7-8.
[35] Burrow, Gayle, "Remembering Meaningful Milestones", NCCHC National Conference, November 2016, reference: NCCHC, Accreditation Standard A-01, 2014 Standards, p 3.

The failure to see patients is a violation of these underlying legal principles and puts patients at risk of harm.[36]

Access to care is one of the basic rights guaranteed to prisoners in 1976 by the U.S. Supreme Court in the *Estelle v. Gamble* case. Unimpeded access to care means that the access is determined by qualified health care staff or health-trained staff and cannot be denied or delayed by security staff. Although lay staff [such as housing unit officers] may convey sick call requests by providing sick call request forms or contacting health care staff about inmate health concerns, they may not decide whether inmates will receive medical attention (Anno, 2001; Knox & Shelton, 2006)[37]. The right of access to care evolved into access that is available daily and is a standard that is supported by the major correctional accrediting organizations, the American Correctional Association (ACA) and the NCCHC in mandatory or essential standards that require "daily access to care".[38]

Adequate sick call operations require professional clinical judgment by health care personnel trained and licensed to carry out sick call procedures. Access to care must be provided for any condition (medical, dental or psychological) if denial of care may result in pain, continued suffering, deterioration, less likelihood of a favorable outcome, or degeneration.[39]

Correctional nurses need to be aware that, except in emergencies or other life-threatening situations, it is *not* appropriate to evaluate patients in cells, on tiers, in hallways, or other nonclinical settings.[40] The initial evaluation of a symptom or medical complaint should occur in a clinical setting. The medical record should be available for these encounters.[41] A chief complaint is obtained followed by an assessment of objective findings. A first impression about whether or not the patient looks sick is useful in determining if the patient may need a secondary referral. The next step of the objective assessment is an accurate recording of vital signs. Vital signs should be taken and documented for every clinical encounter. While normal vital signs do not exclude potentially life-threatening disease, abnormal vital signs should usually result in a consultation with a physician or mid-level provider. Vital signs outside of threshold

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[36] Knox, Catherine, "Improving productivity of sick call", posted in Sick Call, December 23, 2014.
[37] Anno, B.J. (2001). *Correctional health care: Guidelines for management of an adequate delivery system.* Chicago: NCCHC, p 49 ; Knox, C., & Shelton, S. (2006). Sick call. In M. Puisis (Ed.), *Clinical Practice in Correctional Medicine* (2nd ed.), Philadelphia: Mosby Elsevier.
[38] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Underlying Principles of Sick Call, Daily Access to Care, p 284, 2013.
[39] Correctional Health Care: Guidelines for the Management of an Adequate Delivery System, Legal Considerations in the Delivery of Health Care Services in Prisons and Jails, The Right to Access to Care, p. 47, 2001.
[40] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Nursing Care Process, Nursing Sick Call, p 287, 2013.
[41] Puisis, Michael, Clinical Practice in Correctional Medicine, "Sick Call as Medical Triage" by Joseph E. Paris, MD, Ph.D., CCHP, Clinical Assessments, p 69.

ranges should be referred for a physician or midlevel examination on an urgent basis, or at least result in a phone consultation with a higher-level provider.[42]

c. NCCHC, Sick Call and Triage:

The NCCHC standard for "Screening, Sick Call and Triage"[43] states that inmates may make a request for health care attention at any time. When the request describes a clinical symptom it must be assessed in a face-to-face encounter. Obviously, if the symptom is of an emergent nature the assessment must take place immediately.[44, 45] Sick call is intended to identify inmates with minor health complaints and to triage health complaints that need evaluation by advanced providers. Sick call provides an important first level of health care services and a gatekeeper function in which nurses assess inmate patients and determine the level of care needed. Adequate sick call operations require professional clinical judgment by health care personnel trained and licensed to carry out sick call procedures. Because sick call involves high-level assessment and clinical decision-making it must be performed by a registered nurse in accordance with specific state nurse practice acts.[46]

Nursing sick call is considered the backbone of health care delivery in correctional settings because it is the primary way inmates can access health care during incarceration. Common methods used to request health care attention are by filling out a request slip, health care request form or a "kite" that is given to a health care provider, signing up on a list, showing up at a particular time, or calling to request an appointment.[47]

Regardless of which sick call procedure is used (verbal, written or a combination), the important points are to ensure that—

- All inmates have an opportunity to make their health needs known on a daily basis.
- Access is directly controlled by health care staff and not by correctional staff (which, in a written request system, includes health care staff only picking up the request slips).

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[42] Puisis, Michael, Clinical Practice in Correctional Medicine, "Sick Call as Medical Triage" by Joseph E. Paris, MD, Ph.D., CCHP, p 69 - 70).
[43] NCCHC, *"Screening, Sick Call and Triage"*, CorrectCare, Fall 2010.
[44] Id.
[45] Knox, Catherine, "Nursing Sick Call Part 2: Pitfalls with the Face-to-Face Encounter, April 8, 2014, Posted in Sick Call.
[46] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Nursing Sick Call, p 283-284, 2013.
[47] Knox, Catherine, "Nursing Sick Call Part 1: Receiving and Responding to Requests for Care, April 1, 2014, Posted in Sick Call.

- Health care staff review all slips received daily and determine the appropriate disposition (e.g., “inmate to be seen immediately” or “scheduled for next sick call”).[48]
- Inmates are notified of the health unit's response to their requests.

The purpose of a written request form is to inform health care staff of the inmate's health needs. If other inmates or correctional staff tell a health care staff member that an inmate appears ill, it can be both foolish and costly to insist that the inmate complete a written request form. A 1990 death in the King County Jail in Seattle demonstrated the potential folly of this approach.[49]

Correctional health care is guided by several fundamental principles. Inmates may make a request for health care attention at any time. Requests that are emergent are attended to immediately. Nurses are the professionals responsible for reviewing and responding to requests for health care attention via sick call and for immediately responding to emergency requests.

d. NCCHC, Assessment:

NCCHC accreditation standards include certain standards that address individual professional practice. Most come from Section E: Patient Care and Treatment and include standards for Initial Health Assessment and Nursing Assessment Protocols.

Based on the assessment of the inmate and evaluation of the health complaint, the nurse may initiate treatment, provide advice, educate, or refer for higher level care. The nurse should, for example, refer for higher level care when the patient has abnormal vital signs, when the evaluation requires diagnostics that exceed the limits of the protocol (radiographs, lab studies, etc.), when the nurse is unable to come to a diagnostic conclusion and when the patient's complaint has not resolved (seen more than twice for the same complaint).[50]

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[48] Anno, Jaye, National Istitute of Corrections (NIC) and NCCHC (cooperative agreement), Correctional Health Care, *Guidelines for the Management of An Adequate Delivery System*, A Communications and Sick Call System, p 161.

[49] id., p 160, 184. A 21-year-old man, sentenced to serve 15 days in jail, died 6 days after admission. According to the newspaper account, both his requests for medical attention and those of other inmates on his behalf were ignored. He was told repeatedly by the officers to “fill out a kite” (a written request slip). At least two nurses making medication rounds spoke briefly to the individual and told him the same thing. By the time anyone took his complaints seriously, he was in acute distress. His appendix had ruptured. He died a few hours after being transported to a hospital. For more information on this occurrence, see the Seattle Times, June 7, 1990, page 1.

[50] Knox, Catherine, MN, RN, CCHP-RN, NCCHC accreditation surveyor, CorrectCare, Fall 2010 Issue, "Screening, Sick Call and Triage".

An essential step in the nursing process is the evaluation and reassessment of a patient's condition so that the plan of care can be adjusted to prevent harm and promote healing (ANA 2013).

e. NCCHC, Staffing:

The NCCHC Standard for "Staffing" requires that a facility have a sufficient number of health staff of varying types to provide inmates with adequate and timely evaluation and treatment consistent with contemporary standards of care.[51] "Qualified health care professionals do not perform tasks beyond those permitted by their credentials."[52]

f. NCCHC, Correctional Officer Training:

The NCCHC standard for "Health Training for Correctional Officers"[53] promotes the training of correctional officers to recognize when they need to refer an inmate to a qualified health care professional. They facilitate the workflow, and alert health staff to inmates with possible health issues. They must be aware of the potential for emergencies that may arise, know the proper response to life-threatening situations and understand their part in the early detection of illness and injury. A required component of a correctional officer training program is instruction in the procedures for appropriate referral of inmates with health complaints to health staff. The intent of the NCCHC standard is to promote the training of correctional officers to recognize when the need to refer an inmate to a qualified health care professional occurs and to provide emergency care until they arrive.[54]

NCCHC outlines required components of a correctional officer training program. Minimum requirements include cardiopulmonary resuscitation training by an approved body such as the American Heart Association, training in recognition of acute manifestations of certain chronic illnesses such as asthma, seizures, diabetes, and adverse reactions to medications. Officers must also be able to recognize and alert health staff to inmates with symptoms of intoxication and withdrawal for early intervention and treatment. Instruction in precautions and procedures with respect to infectious and communicable diseases ensures that officers are knowledgeable in preventing the spread of these diseases to other inmates, staff and visitors. In addition, proper training in the handling of infectious wastes and how to protect themselves when respiratory isolation is

[51] NCCHC, Standard C-07, Staffing.
[52] NCCHC, Standard C-01, Credentials.
[53] NCCHC, *"Health Training for Correctional Officers"*, Spotlight on the Standards. CorrectCare, Summer 2013
[54] id.

indicated is included in necessary training. Training in the administration of first aid is required. Additional components to the first aid training should include topics that are common to the correctional facility in which the officers work. Officers should be trained on recognizing signs and symptoms of mental illness and procedures for suicide prevention. The last required component of the training program is instruction in the procedures for appropriate referral of inmates with health complaints to health staff.[55]

Professional boundaries must be understood as they relate to the scope of practice of care team members. Both licensed and unlicensed staff is bound by the particulars of their job descriptions as to the functions and responsibilities to each other and to the inmate patient population. A clear delineation of responsibility between nursing staff and custody staff is essential. Nurses are the care providers.[56]

Unqualified or unlicensed staff or correctional officers should not make clinical evaluations under any circumstances. An essential standard of the NCCHC requires state licensure, certification and registration requirements to apply to health care personnel.[57]

Correctional nurses are expected to respond to emergencies and, as the first medical responder, to take charge, directing the response and arranging for definitive care. Every emergency requires that health care staff assess the patient and decide what clinical care is medically necessary.[58] Correctional officers retain responsibility for safety and security in a medical emergency. They secure and clear the area, direct traffic, carry equipment, escort EMS, and facilitate on-site transport.[59]

g. NCCHC, Delegation:

NCCHC cites the "Nurses Scope of Practice and Delegation Authority" as a resource for correctional health professionals. The position paper makes the key point that "Nurses deliver the majority of health care in correctional settings and serve as the gatekeeper for inmate access to all other health services".[60] The RN assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, predictability of the outcome, and abilities of

[55] id.
[56] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Overview of Correctional Nursing, Safety for the Nurse and the Patient pp. 61-64, 2013.
[57] Puisis, Michael, Clinical Practice in Correctional Medicine, "Sick Call as Medical Triage" by Joseph E. Paris, MD, Ph.D., CCHP, p 69.
[58] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Emergency Care Delivery, Nursing Care Process, p 323.
[59] Id., pp 308 - 309.
[60] [60] Blair, Patricia PhD, LLM, JD, MSN, CCHP, Catherine Knox MN, RN, CCHP-RN, Jessica Lee MSN, CCHP, Mary Muse MS, RN, CCHP-RN, CCHP-A, Becky Pinney MSN, RN, CCHP-RN, and Patricia Voermans MS, RN, APN, CCHP-RN, "Nurses Scope of Practice and Delegation Authority", July 2014

the staff to whom the task is delegated.[61] All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety and welfare of the public.[62]

h. NCCHC, Continuation of Medication:

The NCCHC standard requires that "prescribed medications are reviewed and appropriately maintained according to the medication schedule that the inmate was following before admission".[63]

C. STATE OF UTAH NURSE PRACTICE ACT FOR RN's[64]

The Utah Nurse Practice Act states that registered nursing acts include:

1) assessing the health status of individuals
2) identifying health care needs
3) establishing goals to meet identified health care needs
4) planning a strategy of care
5) prescribing nursing interventions to implement the strategy of care
6) implementing the strategy of care
7) maintaining safe and effective nursing care that is rendered to a patient directly or indirectly
8) evaluating responses to interventions

STATE OF UTAH SCOPE of NURSING PRACTICE IMPLEMENTATION[65]

An RN shall be expected to:

1) interpret patient data, whether obtained through a focused nursing assessment or through completion of a comprehensive nursing assessment
2) detect faulty or missing patient information
3) demonstrate appropriate decision making, critical thinking, and clinical

[61] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Management and Leadership, Professional Role and Responsibilities, p 332.
[62] ANA (American Nurses Association) and NCSBN (National Council of State Boards of Nursing, "Joint Statement on Delegation.
[63] National Commission for Correctional Health Care (NCCHC) 2008 Standards for Health Services for jails and prisons, E-02 Standard, Compliance indicator 9, CorrectCare, Winter 2011 edition, pp 7-8. *"Receiving Screening"*, CorrectCare, Winter 2011.
[64] Utah Nurse Practice Act, Title 58, Chapter 31b.
[65] Utah, R156-31b-703b. Scope of Nursing Practice Implementation.

judgment to make independent nursing decisions and to identify health care needs
4) correctly identify changes in each patient's health status
5) comprehend clinical implications of patient signs, symptoms, and changes as part of ongoing or emergent situations
6) intervene on behalf of a patient when problems are identified
7) identify patient needs
8) attend to patient concerns or requests

E. AMERICAN NURSES ASSOCIATION (ANA) SCOPE and STANDARDS of PRACTICE, NURSING
AMERICAN NURSES ASSOCIATION (ANA) SCOPE and STANDARDS of PRACTICE, CORRECTIONS NURSING
AMERICAN NURSES ASSOCIATION (ANA) SCOPE and STANDARDS of PRACTICE, PAIN MANAGEMENT NURSING
AMERICAN NURSES ASSOCIATION, CODE of ETHICS for NURSES With INTERPRETIVE STATEMENTS

The American Nurses Association (ANA) Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently. Registered nurses are accountable for nursing judgments made and actions taken in the course of their nursing practice.

1. ANA, Assessment:

The American Nurses Association scope and standards of practice for all settings including corrections identifies assessment as the first standard of professional nursing practice.[66] Assessment requires the registered nurse to collect comprehensive data pertinent to the healthcare consumer's health and/or the situation and to document relevant data in a retrievable format. It involves the systematic, orderly collection of subjective and objective information about a patient's health status; it is the foundation on which nursing care is planned.[67] The registered nurse prioritizes data collection based on the healthcare consumer's immediate condition, or the anticipated needs of the healthcare consumer or situation. Assessment and matters of nursing judgment are solely the domain of the registered nurse. "Nurses may not delegate responsibilities such as assessment and evaluation".[68]

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[37] American Nurses Association, Scope and Standards of Practice, Standard 1. Assessment. Competencies. 2010 Edition and American Nurses Association, Scope and Standards of Practice, Corrections Nursing, Standard 1. Assessment.
[67] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Underlying Principles of Sick Call, Assessment, p 293, 2013.
[68] American Nurses Association, Code of Ethics for Nurses with Interpretive Statements, 2001, p. 17.

The registered nurse in corrections must be able to demonstrate good assessment and organizational skills as well as critical decision-making and thinking skills. Facility protocols and provider-generated order sets (such as CIWA and WOWS withdrawal assessments) provide direction for the healthcare activities and specific patient care measures. However, such structures do not allow the corrections nurse to abdicate one's professional nursing responsibility for appropriate assessment, critical thinking, decision-making and patient advocacy activities."[69]

A focused assessment is performed for urgent care visits and to address symptoms related to the patient's concerns. The examination includes a subjective assessment, the information the patient describes and offers about their health complaint. A thorough history is an essential component of a focused assessment as it guides the objective assessment that follows. All objective, or physical assessments should begin with assessment of vital signs and weight as these measurements give valuable clues to the nature of the patient's specific complaint(s) and overall well-being. The nurse should then proceed to apply the techniques of inspection, palpation, auscultation, and percussion, as needed to the body system(s) related to the complaint. The patient is referred to an advanced level provider when assessment findings are significantly out of normal. Patients with severe pain or health problems that may deteriorate if left untreated require an immediate or urgent same-day referral to an advanced care provider.[70]

2. ANA, Delegation:

The American Nurses Association in collaboration with the National Council of State Boards of Nursing (NCSBN) defines delegation as the process for a nurse to direct another person to perform nursing tasks and activities. An RN can direct another individual to do something that the person would not normally be allowed to do. A key policy consideration is that the RN assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, predictability of the outcomes, abilities of the staff to whom the task is delegated, and the context of the patient needs.[71]

Individual registered nurses bear primary responsibility for the nursing care that their patients receive and are individually accountable for their own practice. The registered nurse determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care. Registered nurses may not delegate performance of assessment or evaluation of a patient's health care needs.

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[69] American Nurses Association, Scope and Standards of Practice, Corrections Nursing, 2007, p. 10.
[70] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Sick Call, Nursing Care Process, p 291 - 296.
[71] American Nurses Association and National Council of State Boards of Nursing, "Joint Statement on Delegation".

For example, a patient reporting an emergency and complaining of severe abdominal pain requires an assessment to 1) determine the specific characteristics of the pain and 2) determine the urgency or emergency of the condition. A focused assessment, a highly specific assessment that focuses on the system or systems involved in the patient's problem, is required and may only be performed by a registered nurse, mid-level or advanced level practitioner. An untrained correctional officer would not be able or qualified to perform any part of a focused assessment.

Assessment of abdominal pain necessarily includes observation of the patient's overall physical appearance. The patient should be asked about pain onset, bowel and bladder function, nausea, vomiting, food and fluid intake, and the presence of blood in the stool or emesis. The abdomen should be palpated with the nurse observing the patient for any change in pain level, guarding, rigidity, distention or masses. Particular observation of the pain location, severity, radiation to another area or body part, and what makes the pain better or worse is important. In addition to palpation of the abdomen, the nurse should auscultate abdominal sounds and perform percussion testing. Patients with peritonitis often lie very still and are very sick in general appearance as well as reporting feeling seriously ill. Failure to assess a patient's complaint of severe abdominal pain is a breach of nursing standards and practice.

3. ANA, Documentation:

The American Nurses Association, scope and standards of practice require the registered nurse to document relevant data in a retrievable format. The corrections nurse must be acutely aware of the need for appropriate documentation of care rendered.[72]

4. ANA, Delivery of Nursing Care for All Regardless of Circumstance or Offense:

The American Nurses Association scope and standards of practice for corrections, states “If the patient cannot present for healthcare services because of disability, injury or seclusion restrictions, the corrections nurse must go to the patient’s location, conduct an appropriate and timely assessment, render or secure appropriate healthcare services, and accurately complete the necessary documentation record(s).”[73] “The corrections nurse is expected to demonstrate integrity and highly ethical and moral practice, appreciating the legally mandated obligation to deliver nursing care regardless of the individual’s circumstances or offenses.”[74]

[72] American Nurses Association, Scope and Standards of Practice, Corrections Nursing, 2007, p 11.
[73] American Nurses Association, Scope and Standards of Practice, Corrections Nursing, 2007, p. 11.
[74] American Nurses Association, Scope and Standards of Practice, Corrections Nursing, 2007, p. 12.

5. ANA, Pain Management

The standard of care for correctional institutions is the same as that in the community. An inmate who suffers from chronic, intractable pain as well as an inmate who develops acute, emergent pain has a valid need for adequate pain control. Pain assessment and management have always been a key part of a nursing or medical assessment. Assessment of pain is as important as vital signs that are routinely taken. Pain level has been referred to as "the fifth vital sign" along with temperature, pulse, respirations and blood pressure by organizations such as the American Pain Society.[75]

An initial pain assessment should include the location, onset, duration, quality, radiation of pain, alleviating and provoking factors and pain level. Although the level of pain is based on the patient's subjective report, pain can be quantified (just as withdrawal symptoms can be quantified). Numerous pain assessment scales are in use nationwide.

An inmate suffering from acute onset of pain requires careful assessment for emergent or life-threatening conditions and possible referral to a higher-level practitioner or to the emergency room if necessary.[76] The first nursing Standard of Practice for Pain Management is Assessment. The registered nurse is required to collect comprehensive data pertinent to the pain problem. Appropriate pain assessment tools and techniques are used to measure pain. The registered nurse is responsible to document relevant data that facilitates retrieval, reassessment, and follow up.[77]

There are many misconceptions among healthcare workers that are barriers to patients receiving adequate pain management. One of the most common and persistent myths is is that drug abusers overreact to pain. Many times healthcare workers assume that drug abusers are always seeking to satisfy their addiction and not eliminate actual physical pain. While it is true that part of the drug-abusing syndrome involves drug-seeking behavior, it is also true that people who abuse drugs can experience pain. Unfortunately, inconsistent and incomplete assessments have been cited as major factors contributing to inadequate pain management.[78]

F. NURSING EXPECTATIONS FOR EMERGENCY CARE DELIVERY IN CORRECTIONAL FACILITIES

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[75] Falk, Kim Marie RN, BSN, MSN and Shelda L. Hudson, RN, BSN, PHN, Pain: The Fifth Vital Sign. National Center of Continuing Education.
[76] Grametbaur, Jane RN, CCHP-RN, CCHP-A, "*Pain Treatment in Corrections: Striving for a Community Standard of Care"*, CorrectCare, Summer 2011.
[77] American Nurses Association. Scope and Standards of Practice, Pain Management, Nursing. 2005.
[78] Falk, Kim Marie RN, BSN, MSN and Shelda L. Hudson, RN, BSN, PHN, Pain: The Fifth Vital Sign. National Center of Continuing Education.

All correctional nurses are expected to respond to emergencies and, as the first medical responder, to take charge, directing the response and arranging for definitive care. They are expected to exercise their clinical judgment about the patient's immediate care.[79] Notification of an emergency may come by word of mouth, over the telephone, or via radio communication. A nurse should not determine on the basis of telephone or radio contact alone that an emergency does *not* exist. A face-to face assessment and evaluation by the nurse must take place whenever staff or an inmate thinks that there is a medical emergency.[80]

In a medical emergency, inmates are entitled to a professional medical judgment. Since correctional nurses are most likely the first medical professional to respond to the medical emergency, they are therefore expected to also exercise their clinical judgment about the patient's immediate care."[81] If the emergency is an illness, the nurse needs to assess the person's health status immediately preceding the emergency. Additional information to be gathered includes whether the individual has any preexisting medical conditions and when they last consumed food or fluid. From this information the nurse determines the urgency or priority of care and if additional resources are needed. Next, the nurse systematically assesses the patient's condition. A quick 30-60 second initial primary assessment includes the patient's general appearance, respiratory status, cardiac status, and mental status. The primary assessment is followed by a quick 2-3 minute head-to-toe assessment including a full set of vital signs, an inspection of the body, and a relevant health history.[82]

G. NURSING EXPECTATIONS for RESPONSE to ABNORMAL VITAL SIGNS

Nursing response to abnormal vital signs is one of the most important levers in patient safety by providing timely recognition of early clinical deterioration. Patient deterioration is often preceded by changes in vital signs. This occurs through diligent nursing surveillance, involving assessment, interpretation of data, recognition of a problem and meaningful response (DeVita *et al*. 2011).[83] Regular assessment of multi-parameter vital signs has been shown to be important in identifying patients at risk for serious adverse events, allowing time for nursing interventions to prevent FTR [Failure to Rescue] (Storm-Versloot *et al*. 2014).[84]

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[79] Schoenly, Lorry and Catherine M. Knox, Essentials of Correctional Nursing, Emergency Care Delivery, p 308, 2013.
[80] Id., pp 310 - 311, 2013.
[81] Id., p 308.
[82] Id., pp 311-312.
[83] DeVita MA, Hillman R & Bellomo K (2011) Textbook of Rapid Response Systems, Concepts and Implementation. Springer, New York.
[84] Storm-Versloot MN, Verweij L, Lucas C, Ludikhuize J, Goslings JC, Legemate DA & Vermeulen H (2014) Clinical relevance of routinely measured vital signs in hospitalized patients: a systematic review. Journal of Nursing Scholarship 46, 39–49.

It is not just the vital signs themselves but the *interpretation and synthesis* of this data in the context of the particular circumstances of the patient that define the practice of nursing. Possible causes for an abnormal low blood pressure include pain, dehydration, and neurogenic or septic shock.[85] The standard of practice for nurses with regard to patient vital signs includes recognition of a patient's physiological deterioration, identifying the urgency of the situation and summoning appropriate assistance.[86]

H. SALT LAKE COUNTY JAIL POLICY and PROCEDURE (Not an all-Inclusive list)
SALT LAKE COUNTY JOB DESCRIPTIONS
PRISONER RULES and REGULATIONS HANDBOOK

The following policies and procedures, job descriptions, of the Salt Lake County Jail and sections of the prisoner handbook were used in formulating my opinions regarding the care that was or was not provided to Lisa Ostler at the Salt Lake County Jail from March 30, 2016 through April 2, 2016:

Access to Care, SLCo Ostler 001584
Responsible Health Authority SLCo Ostler 001586
Health Record Format and Contents SLCo Ostler 001727
Training for Correctional Officers SLCo Ostler 001619
Diagnostic Services SLCo Ostler 001640
Emergency Services SLCo Ostler 001665
Volume H – Prisoner Health Care SLCo Ostler 000653
Medical Autonomy SLCo Ostler 002480
Intoxication and Withdrawal SLCo Ostler 001717
Nonemergency Health Care Requests and Services SLCo Ostler 001662
Communication on Patient's Health Needs SLCo Ostler 002485
Procedure in the Event of An Inmate Death SLCo Ostler 001596
Staffing Plan SLCo Ostler 001625
Health Care Liaison SLCo Ostler 001627
Information on Health Services SLCo Ostler 001644

Job Description, Jail Health Administrator (Bell Deposition, Exhibit 3)
Jail Nurse SLCo Ostler 000264-000266
Correctional Officer
Chief Deputy Sheriff

Prisoner Rules and Regulations Handbook SLCo Ostler 009113-0009135

[85] Knox, Catherine, "Vital Signs: Interpretation and Synthesis, February 17, 2015.
[86] Knox, Catherine, "Vital Signs: How Often and What To Do, February 24, 2015.

I. SALT LAKE COUNTY JAIL MEDICAL DIRECTOR, DR. TODD WILCOX'S ARTICLE: "*Managing Opiate Withdrawal: The WOWS Method"*, CorrectCare, printed Summer 2016.

Todd Wilcox, MD, medical director of the Salt Lake County Jail wrote an article about the management of opiate withdrawal in the correctional jail setting stating that "the prescription strength of opiates today is substantially stronger, illegal opiates are now of much higher purity and opiate withdrawal is more clinically severe and can frequently result in death if not managed appropriately." He went on to say that "In my facility [Salt Lake County Jail] any patient undergoing opiate withdrawal is assessed twice per day for a minimum of five days by nurses who have been trained in the WOWS (Wilcox Opiate Withdrawal Scale) protocol. The assessment includes a full set of vital signs, serial tracking of the patient's clinical progress and interventions as necessary based on clinical presentation." He went on to say "In running this program we have found that many of our opiate withdrawal patients are psychologically fragile and require medical support to withdraw from opiates safely."[87]

[87] Wilcox MD, Dr. Todd, *"Managing Opiate Withdrawal: The WOWS Method"*, CorrectCare, printed Summer 2016.