Marc F. Stern, MD, MPH
Consultant in Correctional Health Care
1100 Surrey Trace Drive SE
Tumwater, Washington 98501
(360) 701-6520
marcstern@live.com

December 13, 2017

This report contains my medical opinions regarding the care provided to Ms. Melissa Mae Benton at the St. Mary's County Detention Center (SMCDC) from October 8, 2013 to October 13, 2013. All medical care at SMCDC was, at the time, provided by Conmed,[1] a private vendor under contract with the County. This report is produced at the request of Joseph B. Espo, Esq., of Brown, Goldstein & Levy, LLP.

In brief, when Ms. Benton entered SMCDC she was likely dependent on benzodiazepines (alprazolam; Xanax)[2] and opiates (oxycodone). Both drugs were stopped abruptly, without replacement. After a few days she began exhibiting signs and symptoms of withdrawal from one or both substances, most importantly vomiting and diarrhea. In addition to their practice of abrupt cessation of benzodiazepines and opiates, the process at SMCDC for monitoring and treating individuals suffering from the withdrawal effects of cessation was seriously flawed as a general matter. The effects of the flawed process were compounded by an anemic – or no – medical staff response to Ms. Benton's obvious distress and medical needs. Thus, untreated vomiting and diarrhea accompanied by insufficient oral intake of fluids led, very predictably, to Ms. Benton becoming dehydrated, which in turn led to her collapse and death. Though this was the most likely mechanism of death, I describe other possible mechanisms. All these mechanisms of death share one commonality: delivery of minimally acceptable care by the jail's medical system and Ms. Benton's caregivers, more likely than not, would have prevented and/or detected her evolving deterioration, and such intervention, more likely than not, would have prevented her death.

I. Qualifications

I am a board certified internist specializing in correctional health care. I have managed correctional health care operations as an agent of public entities and a correctional health care vendor, and I have practiced correctional health care in the following settings: jail; prison; and private industry. I recently served as the Assistant Secretary for Health Care, Washington State Department of Corrections.

---

[1] I understand that at some point in time, medical care at SMCDC was provided by Correct Care Solutions, another private vendor. I use the term "Conmed" throughout this report to refer to whichever of these two entities was the relevant vendor and care provider at the time.

[2] As a convention in this report – unless citing a quotation – I use the generic name (lower case) or brand name (capitalized) of the drug which is used most often in the documents I reviewed.

Over the course of my career I have worked with, and directly or indirectly supervised, hired, fired, and taught registered nurses (RN), physician assistants (PA), primary care physicians, and administrative support staff, both in correctional settings and in the community.

On a regular basis I investigate, monitor, or evaluate the safety and appropriateness of health care delivery in correctional institutions for a variety of parties, including federal courts, the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security, the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice, state departments of corrections, county jails, and current or former inmates. I teach correctional health care principles, including practice standards related to the practice of nurses and physicians, to national audiences of physicians, nurses, and other health care professionals.

In my practice as a physician, I encounter patients with histories of opiate and benzodiazepine use, and must consider changes in patient condition due to intoxication and withdrawal from these substances in their differential diagnoses.

I thus have the training and expertise to evaluate the conduct of the Certified Nursing Assistants (CNA), nurse, physician assistant, physician, and supervisory and management authorities in this case. Additional details of my education, teaching and work experience, and publications are contained in my Curriculum Vitae, which is attached.

II. Documents

I relied upon the following documents for my report:

1. Amended Complaint
2. Defendants' Response to Request for Production
3. Defendants' Answers to Interrogatories
4. Outpatient Medical Records, Dr. Al-Banna
5. Outpatient Mental Health Records, Dr. Triggs
6. Shenandoah Memorial Hospital Records
7. St. Mary's Hospital Records
8. Contract between St. Mary's County and Conmed
9. File titled "Miscellaneous Medical Records"
10. Conmed Policies (14 policies)
11. Medical Examiner's Report and Death Certificate
12. EMS Time record
13. Jail Medical Records
14. Conmed On-Call Practitioner Schedule
15. St. Mary's County Sheriff's Death Investigation ("Death Investigation")
16. Medical Examiner's Report and Death Certificate (Revised)
17. Photographs post-mortem
18. Certificate of Meritorious Defense, Dr. Alan Abrams
19. Deposition CNA/Certified Medical Technician (CMT) Tara King
20. Deposition CNA/CMT Ashley Sampson
21. Response to Interrogatories CNA/CMT Ashley Sampson
22. Deposition CNA/CMT Brandon Hosselrode

23. Response to Interrogatories CNA/CMT Brandon Hosselrode
24. Deposition CNA/CMT James Cawley
25. Response to Interrogatories CNA/CMT James Cawley
26. Deposition CNA/CMT Kristy Randolph
27. Deposition CNA/CMT Latoya Beaumont
28. Response to Interrogatories CNA/CMT Latoya Beaumont
29. Deposition Dr. Vabian Paden
30. Response to Interrogatories Dr. Paden
31. Dr. Paden's CV
32. Deposition PA Nancy Sidorowicz
33. Deposition RN/HSA Melissa Henderson
34. Deposition Corporal Sebije Boyd
35. Deposition Corrections Officer Monica Thomas
36. Deposition Corporal Gretchen Irby
37. Deposition Ms. Michelle Autry (30(b)(6))
38. Conmed Policies on Receiving Screening, Intoxication and Withdrawal, Inmates with Alcohol or Other Drug Problems, and Medication Administration

III. Summary of Facts with *Annotations*

The first part of this summary focuses on single discrete events for which the date and time of the events are known or can be approximated. The second part focuses on continuing or repetitive events and/or events for which the date or time is indeterminate.

Part 1

Ms. Melissa Mae Benton was a 36-year-old woman who carried histories of bipolar disorder, hypertension (high blood pressure), "enlarged colon," drug addiction, unexplained loss of weight, attention deficit/hyperactivity disorder (ADHD), anxiety, suicide attempt in 2011, and removal of her gall bladder. Though her previous medical records are not fully clear, it appears that at the time of her last visit with her primary care physician, she was taking cimetidine (for stomach acid), metoprolol 100 mg thrice daily (for hypertension), amphetamine/ dextroamphetamine ("Adderall") 20 mg twice daily (for ADHD), and diazepam 5 mg twice daily (for anxiety).[3]

On **Tuesday, 10/8** (all dates are in 2013 unless otherwise specified), at 17:06, Ms. Benton was admitted to SMCDC. A corrections officer (CO) conducted a health screening revealing her

[3] The Death Investigation investigator spoke with Ashley Howes, Ms. Benton's girlfriend. Ms. Howes stated that Ms. Benton "had been vomiting a lot" in the months prior to incarceration. The investigator also spoke with Deborah Benton, Ms. Benton's mother, who stated that Ms. Benton had been having bouts of vomiting and diarrhea. I could not verify this information in previous medical records. However, even if this information is true, any chronic vomiting and diarrhea was unrelated to her acute vomiting and diarrhea which manifested, as one would predict, a few days after abrupt discontinuation of benzodiazepines and opiates in the jail. Further, Deborah Benton informed the investigator that Ms. Benton was feeling better on the medications she was taking.

history of bipolar disorder and ADHD; she denied taking medications for these conditions.

At 18:17 CNA Penny King conducted a health screening. Ms. Benton reported a history of hypertension, dental pain, loss of weight, unexplained colon enlargement, use of needles, not taking any medications, and not being under a doctor's care. For her vital signs CNA King wrote "see attached." The form was cosigned by Melissa Henderson, RN and Health Services Administrator (HSA), on 10/9 at 08:29, and by Dr. Vabian Paden, MD and Facility Medical Director (FMD), on 10/11 at 15:18. At 18:57 the CNA conducted further questioning and learned that Ms. Benton might be taking a medication for hypertension ("HTN med ?"), was taking alprazolam ("Xanax") and oxycodone which she was obtaining on the street, and had used heroin up to about two weeks earlier. The CNA decided to place Ms. Benton "on Benzo [benzodiazepine] protocol per Conmed inc. [sic] [and place a] request to mental health." A set of medication orders appears in the Medication Administration Record (MAR) for: a tapering dose of chlordiazepoxide ("Librium"; 50 mg. four times daily for 1.25 days, thrice daily for two days, twice daily for two days, once daily for two days), folic acid, multi-vitamins, and thiamine, each daily for six days, clonidine 0.1 mg once daily for six days as needed for blood pressure 150/90 – 150/109 [sic], and clonidine 0.2 mg. once daily for six days as needed for blood pressure 160/110 – 169/119 [sic]. The CNA also had Ms. Benton sign a Release of Information request for medical records from the community. No further evaluation was conducted by any higher-credentialed medical professional, nor did the CNA contact anyone to discuss Ms. Benton's case and management. She was not seen again by any health care professional until the following morning.

> *Despite the existence of extensive medical records for Ms. Benton in the community, and despite having had Ms. Benton sign a release for those records, no one ever requested any records (at least not while she was alive; some records were requested four days after she died). While the content of those records would not likely have impacted the care Ms. Benton received in the few remaining days she was alive, had she stayed alive in the jail for a longer time, they may have been invaluable. Of course, at that point medical staff did not know that Ms. Benton would soon die, nor did they know what value the medical records might provide, so failure to request them fell below the standard of care.*
>
> *Conmed Policy 50.00 Receiving Screening has the following requirements which were violated or ignored in Ms. Benton's case:*
>
> > *1. It requires "a medical screening will be conducted as soon as possible and shall be the responsibility of a licensed Healthcare Professional who has received training on the screening document." CNAs are not licensed professionals.*
> >
> > *2. It requires the healthcare professional's screening to include "Inquiry into:. . . . Use of alcohol and other drugs to include type of drugs used, mode of use, amounts used, frequency used, date or time of last use, and history of problems which may have occurred after ceasing use (i.e., convulsions, withdrawal)" and "Observation of: . . . . b. Body deformities, other physical abnormalities and ease of movement, etc. c. Condition of skin, including trauma markings, lesions, scars, bruises, jaundice, rashes and infestations, and needle marks or other indications*

of drug abuse. . . . e. Signs of Trauma." None of these inquiries were done except for determining "type of drugs used."

3. It requires the screener to complete form C-748 Chronic Care Clinic Record. In Ms. Benton's case, the chronic diseases which would have been appropriate to follow were her hypertension, drug abuse, bipolar disorder, anxiety, and ADHD. No such form was completed.

No "attached" vital signs for the 10/8, 18:17 screening can be found in Ms. Benton's record, so, as far as I could determine, none were done. Given her history of hypertension and no current medications for it, as well as her current use of illicit drugs, measurement of vital signs was particularly important. Failure to measure them placed her health at risk.

The patient's care was managed independently by a CNA. Indeed, the CNA made nursing diagnoses (presumably that Ms. Benton (a) was at risk for withdrawal from benzodiazepines, a de facto *assessment and (b) had a mental disorder) and a nursing care plan that included implementing a benzodiazepine withdrawal protocol and making a non-urgent referral to a mental health professional. As I explain later in this report, CNAs do not have sufficient training nor licensure to make assessments or care plans. Given the complexity of Ms. Benton's case at that point in time, such independent practice by a CNA put Ms. Benton's health at significant risk of harm. One key piece of evidence of the inadequacy – and danger – of having CNAs practice nursing without a license was the CNA's decision to only implement a benzodiazepine withdrawal protocol; based on the information available at that point, Ms. Benton was at risk for withdrawal from benzodiazepines AND opiates, and therefore consideration should have been given to implementing both withdrawal protocols.*[4]

The withdrawal protocol the CNA ordered should have been implemented immediately. Instead, it was not fully begun until over 19 hours later.

[4] The CNA's failure to implement an opiate withdrawal protocol had no effect in this particular case, because the PA ordered the opiate withdrawal protocol the following morning. The potential danger was that withdrawal from opiates and withdrawal from benzodiazepines are different and need to be monitored in different ways. A withdrawal protocol for benzodiazepines is not designed or calibrated to detect dangerous physiologic changes from opiates, and thus failure to implement the second protocol may result in staff failing to recognize and adequately treat opiate withdrawal, which can be fatal. In this particular case the preceding discussion is somewhat moot as neither of the two withdrawal protocols in use at SMCDC was useful because neither was consistent with the current science or standard of care for these conditions. I discuss this in more depth in Section IV.2(1), below.

At 21:00 Ms. Benton was scheduled to receive the first dose of Librium, however, it was not administered. The documented explanation given by either CNA Tara King or CNA Cawley, both of whom were on duty, but neither of whom documented their initials, was "missed."

This was the first of several missed doses of this essential medication, as well as other medications, and, as I will explain in Part 2, the medical staff's failure to administer this medication was (a) unjustified, (b) dangerous, (c) a decision beyond the legal scope of practice of a CNA, and (d) most importantly, ***causally related to Ms. Benton's death****.*

On **Wednesday 10/9**, the living unit log maintained by the COs denotes that Ms. Benton was at the Medical Unit from 04:45 to 05:33. During that time she received a Health Assessment by PA Sidorowicz. Her vital signs were: blood pressure 142/112 (significantly above normal), pulse 112 (significantly above normal), blood oxygen saturation level (O2Sat) 98%[5] (normal), weight 135. The PA noted her current use of "Xanax 4-5 qd" and "oxycodone 300 qd." Her examination was unremarkable. In the "Assessment Diagnosis" section of the form, the PA wrote "opiate + benzo use detox please," but on the actual Physician's Orders form, she only ordered "Benzo detox protocol."[6] At 08:30 someone other than PA Sidorowicz (according to the name placed on the form and the handwriting, the order was generated by RN Henderson) placed a pre-printed set of Opioid Withdrawal orders in Ms. Benton's chart; the same person appears to have crossed out the pre-printed diet order (2400 calorie) and replaced it with a regular diet order. At an unknown time, an unknown author placed orders for loperamide (Lomotil) 4 mg thrice daily as needed for diarrhea for six days in the MAR. Finally, an unknown person placed a Detoxification Referrals Flow Sheet ("Flow Sheet") in Ms. Benton's chart, and wrote at the top, "Withdrawal From Etoh [alcohol]."

The PA failed to measure Ms. Benton's temperature or her breathing rate. Both are basic elements of a health assessment as they provide baselines for later comparison. Their role as baselines was relatively moot in Ms. Benton's case, though, because they were only measured again twice during Ms. Benton's entire stay.

The PA failed to clearly delineate Ms. Benton's level of abuse of street drugs. For the opiate oxycodone, the PA recorded that Ms. Benton was taking "300" daily, which, based on available tablet strengths, most likely meant "300 mg" not "300 tablets." However, for the benzodiazepine, the PA recorded that Ms. Benton was taking "4-5" Xanax, which could conceivably mean that she was taking a dosage of four to five 0.25 mg tablets (for a total daily dosage as low as 1 mg), or was taking four to five 2 mg tables (for a total daily dosage as high as 10 mg). These two usage levels are very disparate and predict very different withdrawal experiences. Thus, failure to clearly assess Ms. Benton's level of Xanax usage made it difficult for medical staff to design the appropriate and safe withdrawal care plan.

[5] Although the PA wrote "98" in the box for "Resp.," this would be an impossibly high respiration rate. I therefore infer that the PA meant to record Ms. Benton's blood oxygen saturation level.

[6] The terms "[Substance] Protocol," "Withdrawal Orders [or Protocol]," and "Detox Orders [or Protocol]" are used interchangeably by the parties and, therefore, also by me in this report.

The Defendants were unable to produce any document containing an actual Benzo Protocol, so I was unable to determine to which protocol – if any – the various medication orders on the MAR belong. To further confuse matters, the Flow Sheet ascribed Ms. Benton's withdrawal to alcohol, a substance which did not appear to play any part in her case.

More importantly, based on the documentation (or rather lack thereof) produced by the Defendants, no safe and legally valid benzodiazepine or opiate withdrawal protocol actually existed at SMCDC. Instead, what passed for the Benzo Protocol was an apocryphal set of beliefs in the minds of Conmed medical staff. Furthermore, as such, all the orders for medications generated by the RN or CNAs for Ms. Benton constituted the practice of medicine without a license.

To make matters worse, the belief set that served as the Benzo Protocol, the Opiate Protocol captured on the pre-printed order set, the Flow Sheet, and Conmed's Intoxication and Withdrawal Policy (Policy 70.40), are all woefully inadequate. ***The inadequacies of these protocols are causally linked to Ms. Benton's death****. I explain this in more detail in Part 2.*

Medical staff made the first assessment and entry in the Flow Sheet at 14:10 on 10/9, approximately eight hours after the PA's orders. Instead, the first assessment should have been done right after the PA's visit to ensure that there was a good baseline before Ms. Benton became symptomatic.

The PA ignored Ms. Benton's abnormal vital signs (pulse 112, blood pressure 148/112) when she did her initial assessment, especially her elevated blood pressure. There were two (likely) possible clinical explanations for this: chronic hypertension vs. drug withdrawal. Based on the PA's examination (which was mostly normal) as well as how soon the visit occurred after admission to the jail, the abnormality was probably not due to withdrawal; the PA's diagnosis of opiate and benzodiazepine use, as opposed to opiate and/or benzodiazepine withdrawal, implies that the PA herself would not have thought that the elevation was due to withdrawal. Thus the blood pressure elevation was more likely the result of untreated chronic hypertension. Regardless of the cause, however, the PA had an obligation to address it. She did not.[7]
On 10/11, Dr. Paden signed off on various previous documentation, including the Physician's Orders, the Release of Information request form, the 10/8 and 10/9 progress notes, and the PA's Health Assessment. He therefore knew that Ms. Benton gave a history

[7] One might argue that she did address it by putting the patient on a withdrawal protocol which she knew would include monitoring and treatment of elevated blood pressure readings. This argument fails for two reasons. First, Ms. Benton's blood pressure was high enough, at that very moment, to warrant treatment. Second, once the withdrawal protocol(s) ended in six days, the PA had failed to put into effect any mechanism to confirm that Ms. Benton's blood pressure had returned to normal. Thus if the blood pressure elevation were due to chronic hypertension (as is very likely), Ms. Benton's blood pressure would have remained elevated, continuing to cause damage to her heart and brain, for the rest of her incarceration.

of, among other things, hypertension and unexplained weight loss, that her blood pressure was markedly elevated (148/112), and that neither the PA during her admission history and physical, nor any other person, had made any further inquiry into, or plans to monitor and treat, these problems. Yet, he blithely approved the care without comment or question.

At 14:10 CNA Penny King conducted and documented (on the Flow Sheet) the first withdrawal check on Ms. Benton. Ms. Benton's vital signs were: blood pressure 119/90; pulse 115; temperature 99.2. Ms. Benton was due for her fourth dose of Librium at this point, however, CNA Kristy Randolph withheld the dose, giving as a justification the blood pressure of 119/90.

As I alluded to above, and elucidate in Part 2, there were numerous critical flaws in the design of Conmed's withdrawal protocols – flaws to which the Flow Sheet, a component of the protocols, was not immune. In addition to the design flaws, there were critical flaws in the ways the CNAs actually used the Flow Sheets. For example, at the time of this check, Ms. Benton's pulse was significantly elevated. This should have prompted a call to the RN, PA, or physician. Instead the CNA did nothing. As another example, the Benzo Protocol called for the CNAs to measure the patient's O2Sat at this time, but the CNA failed to do so. These types of errors permeate the 14 items documented on the Flow Sheet; I describe them in more detail in Part 2.

The CNA chose to withhold Ms. Benton's fourth scheduled dose of Librium (meaning at this point Ms. Benton had only received one of the first four scheduled doses). There was no good reason, clinical or otherwise, to have held any of the doses of Librium. First, the order for Librium did not include any instruction to hold it based on blood pressure. Second, the explanation given by the CNA (that the blood pressure was too low) was incorrect; if anything, the patient's blood pressure was high. Third, based on her certification, it was outside the CNA's legal scope of practice to make an independent decision to deviate from orders. If the CNA had concerns or doubts, she was required to contact an RN, PA, or physician. She did not. Finally, Librium was arguably the most important medication in the withdrawal protocol. Withholding it greatly increased the likelihood that Ms. Benton's withdrawal from benzodiazepines would be more dangerous and life-threatening. Indeed, this and the other failures to administer Librium and other medications ***were causally related to Ms. Benton's death.*** *I discuss the CNAs' failure to deliver scheduled medications, as well as their acts and omissions beyond their legal scope of practice, in more detail in Part 2.*

On **Thursday, 10/10**, at an unknown time between 04:46 and 05:13, according to the living unit log (the PA failed to document the time of the encounter), the PA saw Ms. Benton for a follow-up. Her vital signs were: blood pressure 126/86; pulse 81; O2Sat 100%. She noted that Ms. Benton had no vomiting or diarrhea. Her lung and heart exam were normal. She had no piloerection ("goose bumps," a sign of opiate withdrawal), but did have a tremor (a sign of

benzodiazepine and opiate withdrawal).[8] Her diagnosis and treatment were: "detox stable continue as ordered."

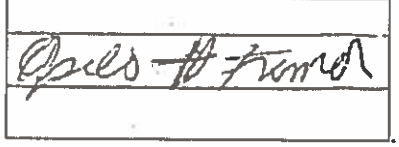
On **Friday, 10/11**, staff continued their scheduled monitoring of Ms. Benton (as seen on the Flow Sheet) and medication passes (as seen on the MARs).

> *The critical errors and omissions generally related to these two activities are captured in detailed discussions in Part 2.*

At 22:01 CNA Beaumont saw Ms. Benton for a withdrawal check and to administer medications. Up to this point Ms. Benton had only received four of her ten scheduled doses of Librium. Her blood pressure jumped to 153/106 (elevated and higher than it had been so far). For the first time she was exhibiting multiple signs and symptoms of withdrawal: tremor, agitation, vomiting, and abdominal cramps. Her total score on the Flow Sheet jumped from zeros, ones, and twos to seven. The CNA documented that she contacted the RN at this point and "fluids given phenergan [Phenergan, promethazine, a medication used to reduce nausea and vomiting] given." There is an order on the Physician's Order sheet at this time for "Phenergan 25 mg. supp[ository] rectally stat."

> *The sudden increase in Ms. Benton's score on the Flow Sheet signaled worsening of withdrawal from benzodiazepines, opiates, or both. Thus it was appropriate that the CNA contacted the RN to communicate this new finding and administered Phenergan to address the patient's vomiting. However, the care was incomplete. First, Ms. Benton's blood pressure was elevated and above the threshold for giving a dose of blood pressure medication (clonidine), according to the orders in place. However, no blood pressure medication was administered and no reason (valid or invalid) for not administering it was documented in the medical record or given during depositions. Second, the RN should then have instructed the CNA to check on the patient after administration of the medications to ensure that they were working, i.e. that Ms. Benton's vomiting stopped and her blood pressure returned to normal. Third, there is no documentation on the MAR that the Phenergan was actually administered.*
>
> *In his deposition (page 73) Dr. Paden, the FMD, confirmed that he did not physically write the stat order for Phenergan and is not sure he was contacted by phone to issue the order. That Dr. Paden was not contacted is supported by the finding that the person writing the order did not write "V/O" (verbal order) or "T/O" (telephone order) next to Dr. Paden's name; this is the universally accepted way that health care professionals in jails and throughout the community document an order they receive over the phone from*

[8] In her deposition (page 53) the PA said that she wrote no ("Ø") tremor, but she only "thinks" that is what her note says. Based on my examination of the note, it is clear to me that the PA initially wrote a "Ø pilo Ø tremor" but then changed the Ø of tremor to a "+":



a practitioner. Thus, looking at the totality of evidence available to me at this point, it is more likely than not that this order was the creation of either the CNA or RN. As neither of them has prescribing authority, the writing of this order is a serious breach of safe and legal health care by the practice of medicine without a license.

Beginning with the aforementioned encounter at 22:10 and continuing for the next five withdrawal checks over the next two days until Ms. Benton collapsed, she continued to have the same unabated level of vomiting ("2") and abdominal cramps ("ABD Cramps"; "1"), yet, she received Phenergan only once.[9]

As vomiting was one of the main ways in which Ms. Benton became dehydrated, and as failure to administer Phenergan allowed the vomiting to continue, Conmed staff's ***failure to administer Phenergan was causally related to her death.***

By **Saturday morning, 10/12** (if not sooner), it became obvious to others that Ms. Benton was getting sick. A Sheriff's Department investigator recorded the following in her report after an interview with another resident, Ms. Robin Laabs, who occupied a cell next door to Ms. Benton's beginning on 10/11:

> Laabs described Benton as "deathly sick" and stated she had been holding her stomach and begging for help. Laabs stated during the weekend Benton had been "hugging the toilet." According to Laabs, Benton was begging for medication because she was in pain and began crying when they didn't give her any. . . . Laabs stated she just remembers Benton begging for help and being "sprawled" over the toilet. . . . Laabs stated Benton also complained of being dizzy and feeling faint. Laabs was concerned Benton could have fallen and injured herself. (SMCS 93)

It was thus obvious, to even a lay observer, that Ms. Benton was very sick. Her apparent vomiting, along with her symptoms of dizziness and feeling faint, give strong support to the diagnosis of dehydration.

At 05:05, Ms. Benton went to the Medical Unit because she had been experiencing chest pain for one hour. She was evaluated by CNA Beaumont who documented that Ms. Benton was having trouble holding liquids by mouth and had intermittent bouts of diarrhea. Her vital signs were: blood pressure 148/101 (abnormally elevated); pulse 48 (dangerously slow); O2Sat 98%; breathing rate 22 (abnormally fast). Her plan was: "advised to relax and not to drink fluids in large gulps but to take sips to stay hydrated. Deferred to RN. Imodium and Phenergan orders renewed. Will f/u prn [follow up as needed]."

Phenergan and Imodium needed to be given at this point to treat Ms. Benton's vomiting and diarrhea, but were not (based on an entry on the Flow Sheet, Phenergan may have

[9] Medical staff claimed they administered it two other times, one of which was described above, but no such documentation appears on the MAR.

been given at some point later in the morning). As mentioned at previous junctures, ***failure to control her loss of fluid via vomiting and diarrhea hastened Ms. Benton's dehydration and is therefore causally linked to her death.***

It is not wholly clear whether the CNA actually contacted the RN at this time. When deposed, the CNA stated that "deferred to RN" meant she called the RN. However, I do not believe such a call was made because: (a) During her interview with the Sheriff's Department investigator, RN Henderson said she received "one late night call from a Medical technician," i.e. she did not report receiving a call in the morning;[10] (b) RN Henderson testified in her deposition that when a CNA writes "deferred to RN" she had "no idea" what it meant; and (c) There are no specific instructions documented from the RN back to the CNA, something that is surprising given the serious problems the CNA described (vomiting, diarrhea, abnormal vital signs including dangerously low pulse rate). If the CNA contacted the RN, then the serious errors described in these annotations reflect highly incompetent care on the part of the RN. If the CNA did not contact the RN, then the CNA was not only highly incompetent, but also practicing nursing or medicine without a license and falsifying medical records.

The CNA's advice to "relax" was useless – relaxation does little, if anything, to help vomiting and diarrhea in this setting.

Not only was this encounter dangerously handled because it failed to adequately address Ms. Benton's evolving dehydration, it was also dangerous with regard to her complaint of chest pain. Chest pain is one of a small handful of patient complaints that must always be taken seriously and addressed immediately. In a 36-year-old woman in jail with a history of hypertension and a dangerously slow pulse rate, one of the serious causes of chest pain is an impending or evolving heart attack. Thus this symptom needed to be addressed by an appropriate evaluation performed by a qualified health care professional. A CNA cannot possibly conduct an appropriate evaluation, and indeed, this CNA did not. The evaluation was devoid of <u>any</u> questioning about risk factors and symptoms of a heart attack (for example personal and family history of heart problems, other symptoms such as shortness of breath, etc.) and devoid of <u>any</u> examination related to the heart (for example, listening to the heart and lungs with a stethoscope, examination of the legs for edema, obtaining an electrocardiogram, etc.). It is difficult to determine to what extent a heart attack may have contributed to Ms. Benton's death, thus I cannot state with certainty whether failure to evaluate and treat her chest pain was causally related to her death. However, I can state with certainty that objectively, chest pain is a serious medical need, and subjectively any health care professional – if not any

[10] In her deposition, RN Henderson was asked about two episodes on the morning of 10/12 when a CNA recorded having contacted her – one episode recorded on the Flow Sheet and one recorded in a progress note. RN Henderson responded that she only recalled being called once in the morning. Her statement contradicts her statement to the investigator that she was only called once during the late night. Given that the latter statement was given approximately two weeks after the events in question, and the former statement was given almost four years after the events in question, I have relied upon the latter statement for my report.

reasonable lay adult – would know that failure to address chest pain places an individual at tremendous risk of harm. I therefore can state with certainty that by ignoring Ms. Benton's complaint of chest pain, Conmed staff was deliberately indifferent to her health needs. I can further state with certainty that proper medical evaluation of her chest pain – whether or not the chest pain itself was causally related to Ms. Benton's death – would inevitably have led a competent evaluator to recognize and treat her deteriorating physiologic state, which in turn, more likely than not, would have prevented her death.

At or around 06:00, COs documented for the first time that Ms. Benton refused a whole meal.

Up to this point, Ms. Benton had not been eating normally but, according to the Sheriff's Department investigation (SMCS 87), at least ate a "small amount of the food offered." Beginning now, and for the next 36 hours until her death, however, she refused all food and some fluids. I could not determine whether COs actively sought out medical staff to inform them of this, but even if they did not, medical staff had enough reason to seek this information and address it. They did not. ***This error contributed to Ms. Benton's evolving dehydration and was therefore causally linked to her death.***

At 06:30, CNA Beaumont conducted a withdrawal check and documented vital signs on the Flow Sheet: blood pressure 167/92 (abnormally high); pulse 36 (very dangerously slow). On the Flow Sheet, CNA Beaumont wrote that she contacted the RN "on HR [pulse]/BP [blood pressure]. Fluids encouraged. Phenergan given."

As with a previous progress note which alleges that a CNA contacted the RN, according to the RN's statement to the Sheriff's Office investigator, I believe the RN was not contacted. Whether or not she was contacted at this time, the handling of this situation was grossly incompetent. A pulse of 36 is very dangerously slow, so slow that for many individuals it is not compatible with sustained life. In any patient, it constitutes a clinical emergency until proven otherwise. In Ms. Benton, an abnormally slow pulse (bradyarrhythmia) may very well have independently contributed to her collapse and death, and thus failure to appropriately evaluate and address this finding may have been causally related to Ms. Benton's death. Regardless of whether it was causally related to her death, as with the earlier ignoring of Ms. Benton's chest pain, ignoring of this slow pulse constituted deliberate indifference to her serious needs. Similarly, proper medical evaluation of Ms. Benton would have led a competent evaluator to recognize and treat Ms. Benton's deteriorating physiologic state and, more likely than not, prevented her death.

There is no evidence on the MAR that Phenergan was actually given. If it was given, it was dangerous not to document it on the MAR so that subsequent care givers would know. Also, there is no record – as is required by minimally acceptable nursing practice – of how much Phenergan was given or by what route.

At 14:55, according to the unit log, Corporal Boyd took Ms. Benton to the shower. In her deposition the Corporal stated that she took Ms. Benton for a shower because she had vomited. She also stated that when CNA Cawley came to check Ms. Benton's vital signs soon after the

shower, she informed CNA Cawley of Ms. Benton's vomiting, to which CNA Cawley replied that "they were aware of it" and that "she was fine to remain on the post."

At 22:10, Ms. Benton was evaluated by CNA Sampson because of "pain to her head s/p [status post] fall on 10/11/13." Her vital signs were: blood pressure 148/106; pulse 78; breathing rate 18. The CNA wrote "10-95 [Ms. Benton?] denied LOC. No bruises or contusions noted. 10-95 stated the Phenergan suppository she received hasn't suppressed the vomiting and she thinks she needs to go to the hospital. 10-95 currently not showing signs of dehydration skin turgor WNL [within normal limits], noted heart rate WNL. 10-95 advised she would not be going to SMH [St. Mary's Hospital], currently not indicated." According to the Sheriff's Department investigation (SMCS 96), "Sampson assessed Benton and found no significant signs of dehydration."

> *It is clear that CNA Sampson managed this acute episode independently, beyond her scope of practice, constituting the practice of nursing or medicine without a license.*
>
> *The CNA's evaluation was grossly inadequate and put Ms. Benton at serious risk of harm along two prongs, one which did not ultimately cause harm, and one which did. A fall with resultant head pain can signal internal brain bleeding. Thus the CNA's examination needed to include evaluation of brain function. It did not. Autopsy did not reveal any brain injury, so in retrospect this error did not have any adverse effect. On the other hand, the fall was an important signal that Ms. Benton might be getting dehydrated and thus required further evaluation and treatment. Assessment of skin turgor is a valid test for dehydration (assuming it was performed correctly). However, it is only one test and cannot and should not have been used as the sole source of information. Other evaluations include, but are not limited to: measurement of blood pressure and pulse lying and standing (orthostatic vital signs), changes in weight, assessment of moisture levels in the mouth and eyes, estimation of the balance between fluid intake and fluid output. One, or more than one, of these evaluations, more likely than not, would have been abnormal, which, in the hands of a reasonably competent clinician, inevitably would have led to proper treatment and avoidance of the outcome. Thus* ***the independent, illegal, and incompetent handling of this event by Conmed staff was causally related to Ms. Benton's death****.*

On **Sunday, 10/13**, at 06:30, CO Thomas documented that Ms. Benton was vomiting. In her deposition she testified that she notified CNA Cawley of this vomiting at around 06:35. At 07:10 a withdrawal check by a CNA again noted that Ms. Benton was vomiting. Her vital signs were abnormal: blood pressure 163/109; pulse 106. Her total score on the withdrawal Flow Sheet was on the rise again (back up to seven). A CO documented in the Segregation Recreation/Shower Log, "Since Benton is bad can't come out per med." (SMCS 159)

Between 09:43 and 10:05 CNA Cawley administered medications to Ms. Benton. As part of the Sheriff's Department investigation, the investigator recorded the following information from his questioning of CO Thomas:

> Thomas stated the morning "med run" arrived at 0945 and at 1000 hours she attempted to rouse Benton to take her medication. Thomas

> described Benton as being a different person than who she had taken for a shower earlier. Benton said she was weak and unsteady and asked for her medicine to be brought to her within her cell. Benton had a blank stare and did not seem to even see the medic within her cell. Benton then reached up and grabbed both of the medics [sic] hands, squeezing and smashing the two small cups containing medication and water. Benton was then told to lean her head back and the medic dumped the cup of medication into her mouth and then fed her the water. . . . Thomas stated Benton spent most of the morning vomiting. . . . Thomas stated she told the medic, James [Cawley], about Benton's confusion and that is when he issued the Form 35 (memorandum) to restrict Benton from moving about outside of her cell unaccompanied.[11] . . . Thomas also stated she notified her shift supervisors about the change in Benton's mental status between shower and lunch…[Cawley] went into Benton's room during the AM medication run and Benton did not seem to see him there. When he was able to get Benton's attention, Cawley stated Benton reached out and crushed both cups he was trying to hand her. Cawley stated after Benton took her medication she got back into bed, grabbed her mattress and began rocking back and forth. Cawley described Benton as having an altered mental status.

In his deposition, CNA Cawley described these events as follows:

> A. She appeared to have a slight altered mental status, like, she reached out and crushed the cups in my hand, but she followed verbal commands very well. She ended up taking her medication, and then I cleared the cell. . . . Q. And when you say she had a "slight altered" – a "slightly altered mental status," what do you mean by "slightly"? A. She recognized who she was and followed verbal commands, but other than that, person -- like, time and place wasn't present.

Ms. Benton's unsteadiness on her feet accompanied by changes in her mental status, including not knowing when or where she was, were ominous clinical signs that Ms. Benton was sick and getting sicker and that she required immediate attention. ***The failure of Conmed's medical staff to take appropriate action at this juncture was causally related to Ms. Benton's death.***

At 11:19, CO Thomas (identified as #749) documented in the living unit log book that Ms. Benton drank water then threw up, "can't hold anything down." A few minutes later, at 11:30, the CO had a conversation with CNA Cawley who instructed the CO that "Benton can not come out into dayroom." According to her deposition testimony, during that conversation CO Thomas also informed CNA Cawley that Ms. Benton had not eaten breakfast or lunch. The investigator's interview of inmate Lisa Nowak yielded the following entry in his report:

[11] CNA Cawley actually issued his memo at 13:16 – see below.

> Nowak stated Benton had not eaten anything from her last seven food trays. According to Nowak, she was in the dayroom around noon on 10/13/2013 and looked into Benton's cell. Nowak described Benton as being covered in a blanket with her whole body shaking. Nowak's cell was beside Benton's and she stated she could hear her vomiting for two days.

The investigator's interview of CO Thomas led to the following entry:

> At lunchtime, Benton refused her food tray. Thomas stated she tried to get Benton to take the bread and she still refused. At that time, Benton was sitting directly on the cell floor. Benton told Thomas she was hot and was sitting on the floor because it was cold. Thomas noticed Benton's Gatorade bottle was empty. She asked Benton to hand her the bottle so she could refill it. Benton instead handed her a shoe. Thomas again asked Benton for the bottle. This time Benton handed her court paperwork. Thomas got the bottle and refilled it for Benton. According to Thomas, Benton drank a small amount and then vomited.

At 13:16, CNA Cawley filed a "Form 35" to notify custody that Ms. Benton was to stay in her cell due to "her being unsteady on her feet during her detox."

> *Once again, a CNA, acting beyond his scope of practice, and practicing nursing or medicine without a license, independently made an assessment (which was, in effect, nothing serious is wrong) and plan (no change in treatment). When asked during his deposition, "Did you report that Melissa Benton was unsteady on her feet to a clinician?" he answered, "No." When asked, "Why not?" he responded, "Because it wasn't significant unsteadiness; it was mild unsteadiness. She was just wobbling back and forth. She wasn't, like, on the floor or falling in the wall." Thus there is no question that CNA Cawley knew that he was making a clinical assessment and doing so independently.*
>
> *This record of events of the morning of 10/13 makes two things clear: (a) Ms. Benton's condition was bad and getting worse, and (b) Conmed medical staff were aware of it, but did nothing. Appropriate intervention would have included a clinical evaluation by a qualified medical professional with subsequent treatment, including, among other things, provision of fluid, drawing of blood samples, and correction of any blood (electrolyte) abnormalities, if not evacuation to a hospital.* ***The failure of Conmed's medical staff to take appropriate action at this juncture was causally related to Ms. Benton's death.***

At 15:25, CNA Cawley conducted the last withdrawal check that Ms. Benton would undergo before her death. According to CNA Cawley's documentation on the Flow Sheet, she continued to have vomiting, abdominal cramps, and sweating. In addition, her blood pressure was now

106/68. CNA Cawley documented that Ms. Benton was "A&Ox3" [alert and oriented x 3]. According to the Sheriff's Department investigator's further conversation with CNA Cawley:

> When [CNA] Cawley returned at 1530 hours, Benton did not remember the morning med run but seemed more alert. Cawley stated Benton was pale but her vitals were within normal limits. Cawley was familiar Benton had a history of hypertension that was untreated prior to her incarceration. Cawley stated he reviewed Benton's records which showed her vitals and heart rate had been stable since she was medicated. Cawley was also aware that Benton had not eaten since the 11th and had been vomiting profusely. Cawley stated orders had been done so Benton could have suppositories to settle her stomach. Benton had complained the suppositories were not helping.

CNA Cawley's gross errors at the time of this last withdrawal check provide a sadly perfect illustration of why allowing CNAs to operate beyond their scope of practice is dangerous. First, while CNA Cawley thought that Ms. Benton was now "more alert" than she had been during the medication administration earlier that morning, he knew from that encounter, that at one point Ms. Benton's mental status was very abnormal. Whether at the time of the medication administration, or now (which, technically, was when he was supposed to be assessing Ms. Benton's mental status as part of the formal withdrawal check), CNA Cawley had an obligation to note the abnormality, and, more importantly, notify a higher-credentialed medical professional. Second, the blood pressure CNA Cawley obtained – 106/68 – was frightening, which he failed to appreciate. The blood pressure of 106/68 might be normal for an individual who was otherwise healthy and for whom such a blood pressure was her norm. However in the setting of a sick patient who is losing fluid and unable to replace it, in whom all previous blood pressures have been above 119/83, all blood pressures for the past 72 hours have been above 141/92, and the most recent blood pressure was 163/109, the blood pressure of 106/68 was a sudden, unexpected, and marked drop that demanded immediate attention. Thus, as noted in my annotation of the events of the morning, this record of events in the early afternoon of 10/13 makes two things clear: (a) Ms. Benton's condition was bad and getting worse, and (b) Conmed medical staff were aware of it, but did nothing. Appropriate intervention would have included a clinical evaluation by a qualified medical professional with subsequent treatment, including, among other things, provision of fluid, drawing of blood samples, and correction of any blood (electrolyte) abnormalities, if not evacuation to a hospital. ***The failure of Conmed's medical staff to take appropriate action at this juncture was causally related to Ms. Benton's death.***

At 17:58 Ms. Benton was found unresponsive in her cell. COs announced a "medical emergency" to which CNA Cawley responded. CPR was started.

Ms. Benton was transported by ambulance to the hospital. She was pronounced dead shortly thereafter.

Part 2

Medication Management System

There is a well-established medication management system for the ordering, administering, and documenting of administration of medications in jails and other health care settings. It has four steps: (1) An order is written by a practitioner in the patient's medical record (from time to time the order is given orally over the phone, written by the nurse as a "verbal order from Dr. X," and then cosigned by the practitioner as soon as possible); (2) The order is then transcribed by a nurse to a MAR; (3) Nurses administer medications according to these transcribed instructions on the MAR; (4) Successful administration (or failed administration) of the medication is then documented on the MAR so that by inspecting this central information source, all care givers are aware of what medications the patient has, and has not, received. These steps ensure patient safety.

The medication management system at SMCDC in October 2013 was in disarray. Each step along the way, from order writing to documentation of execution of the order, was broken. As a result, orders for Phenergan and Imodium, two key medications in this case, intended to control vomiting and diarrhea, were largely not followed. Orders for a medication to control high blood pressure (clonidine) – with one exception – were also not followed on eight of nine occasions. None of the ordered vitamins (folate, multi-vitamin, thiamine) were given on 10/12 ("Missed"), without explanation.

Step 1: Ordering Medications

As described elsewhere in this report, there were errors in the way orders were written. For example, on 10/9, the PA wrote an order for "Benzo detox protocol," but apparently she wanted Ms. Benton placed on both a benzodiazepine protocol and an opiate protocol. As another example, on 10/11 and 10/12, a CNA wrote orders for Phenergan on the physician's order sheet as if they were issued by Dr. Paden, when in reality they were not.

Step 2: Transcribing orders to the MAR

This step was executed sloppily, inaccurately, and with poor documentation at SMCDC, as illustrated by the following examples:

- The pre-printed order set generated on 10/9 instructed staff to administer thiamine, folic acid, and multivitamins to Ms. Benton for seven days. Instead, this was transcribed to the MAR to give it for only six days.
- An order was written on 10/9 at 08:30 (pre-printed order set) for Imodium 4 mg TID for abdominal cramps and diarrhea for three days. Thus the order should have been transcribed onto the MAR to be effective from 10/9 until 10/11. Instead, the MAR instructs staff to give it from 10/8 (which makes no sense), until 10/10 (a day before it is supposed to end).
- That same MAR instruction to staff was mis-transcribed from the original order. The order was for nurses to administer Imodium for "abdominal cramps and diarrhea" but the final MAR instruction to staff was to administer Imodium for "diarrhea."

- An order was written on 10/9 at 08:30 (pre-printed order set) for Phenergan 25-50 mg by mouth or by injection for vomiting, without limit of number of administrations per day. No such order was ever transcribed to the MAR. On the other hand, there appears on the MAR an instruction for staff to administer Phenergan 50 mg by mouth as needed for nausea/vomiting, but limited to once daily, between 10/8 and 10/10. Either the order was mis-transcribed, or medication was prescribed without a physician's order.

Step 3: Administering medications to the patient

Due in part to the aforementioned utterly confusing state of medication administration instructions and in part to staff simply ignoring valid orders, there resulted an irresponsible and ineffective system for administering to Ms. Benton the medications she needed, as illustrated by the following examples:

- Librium was a key medication for Ms. Benton as it had the potential to reduce the severity of her withdrawal from benzodiazepines, especially vomiting and diarrhea, which played a central causative role in her death. Staff failed to administer almost half (6 of 14) of Ms. Benton's scheduled doses of Librium for no, less than good, or incredible reasons (missed, held, refused). Details are as follows:
  - The Librium dose for 10/8 at 21:00 is shown as "Missed," even though there were two CNAs, Tara King and Cawley, on post during this time. CNA Cawley, who according to the living unit log book was on post to give medications, testified he could not recall why this dose of Librium was "missed."
  - The Librium dose for 10/9 at 02:00 is shown as "No Show." This is an incredible fact: Ms. Benton was a patient in a jail. SMCDC knows where individuals in their custody are at all times, and this particular resident was always either in her living unit or in the Medical Unit.
  - The Librium dose for 10/9 at 14:00 is shown as "Held." The CNA documented on the MAR that she "held" the medication because "BP [blood pressure] 119/90." Not only was holding the Librium for this blood pressure clinically illogical and unwarranted, there was no order to hold the Librium based on the patient's blood pressure. Thus the CNA's action was beyond her legal and safe scope of practice.
  - The Librium dose for 10/9 at 21:00 is shown as "Missed," even though there were two CNAs, Randolph and Beaumont, on post during this time. CNA Randolph, who according to the living unit log book was on post at that time for the medication administration, testified she did not know if she was the one who wrote that this dose was missed. Randolph and Beaumont both testified that either of them could have been the CNA doing the medication administration at that time. CNA Beaumont could not recall why this dose was missed, and CNA Randolph testified that Ms. Benton "could have been out of the unit." However, the living unit log has an entry that shows that a withdrawal check was specifically done on Ms. Benton on post at 21:31, and in fact there is a Flow Sheet entry, completed by CNA Beaumont, for 10/9 at

21:00. Thus, it appears that Ms. Benton was on the unit, but neither CNA bothered to give her the prescribed medications.

- The Librium dose for 10/10 at 08:00 is shown as "Refused." However, under the heading of "Reason" the CNA wrote "BP [blood pressure]." This documentation makes absolutely no sense. If Ms. Benton actually refused the medication (which itself is unlikely), her reason for refusing it certainly would not have had anything to do with her blood pressure. Further, there was no blood pressure taken at 08:00.[12] So this MAR documentation lacks face validity.
- The Librium dose for 10/11 at 08:00 is shown as "Held." The reason given was "BP." As with the previous two failures to administer Librium, there was no order instructing CNAs to hold Librium due to blood pressure and thus this action was beyond the scope of practice of a CNA. Further, there was no blood pressure measurement taken at 08:00 (the most recent one was measured at 05:00 and, at 116/83, would not have precluded safe administration of Librium).

- Like Librium, Phenergan and Imodium were also key medications for Ms. Benton to control her vomiting and diarrhea. **Staff's failure to administer these medications as ordered therefore also played a central causative role in her death.** Staff administered very little Phenergan and no Imodium.[13] Details are as follows:
  - On 10/12 at 05:05 (according to a progress note), Ms. Benton suffered from vomiting and diarrhea. No medication treatment was provided. (Phenergan was given an hour-and-a-half later in response to newly recorded vomiting and abdominal cramps.) Instead of providing medication treatment for her vomiting and diarrhea, medical staff advised Ms. Benton to "relax" and "not to drink fluids in large gulps." Based on my medical experience, relaxation does little, if anything, to control vomiting and diarrhea in this setting, and the size of swallows has little effect on vomiting, and no effect on diarrhea.
  - On 10/12 at 14:55 (the event is based on the detoxification Flow Sheet; the time was not entered on the Flow Sheet, but a corresponding entry in the living unit log book provides the time), Ms. Benton had vomiting and abdominal cramps. Neither Imodium nor Phenergan was provided (a dose of Phenergan was given at 18:13 for unknown reasons).

[12] There was a blood pressure reading taken during a sick call visit with the PA, which, according to the living unit log book, took place between 04:56 and 05:13. However, it was normal (126/86) and would therefore not have constituted a reason to withhold the Librium.

[13] I only note one report of diarrhea in the jail medical record. However, there is no record of any staff having asked Ms. Benton about diarrhea after the early morning hours of 10/10. As a key symptom of withdrawal, and one upon which administration of a medication (Imodium) was based, it was important for staff to ask Ms. Benton about diarrhea and document the response. There is no evidence this happened. So the lack of documentation in the medical record of diarrhea is not convincing evidence that she did not have it. Indeed, on a CD of a phone call between Ms. Benton and a friend on 10/10, investigators heard Ms. Benton complain that she had diarrhea.

- On 10/12 at 22:30 (according to the detoxification flow sheet and a progress note at 22:10), Ms. Benton was still suffering from vomiting and abdominal cramps and asked to go to the hospital, but no treatment was provided, and she was not sent to the hospital.
- On 10/13 at 06:30 (according to the living unit log book), Ms. Benton was suffering from vomiting, but no treatment was provided.
- On 10/13 at 07:10 (according to the detoxification Flow Sheet), Ms. Benton was still suffering from vomiting and abdominal cramps, but no treatment was provided.
- On 10/13 at 11:19 (according to the living unit log book), Ms. Benton was observed vomiting the water the CO had just given her. ("[She] can't hold anything down.") At 11:30, the CO informed medical staff of Ms. Benton's inability to hold down fluids, but staff failed to provide any treatment.
- On 10/13 at 15:25 (according to the detoxification Flow Sheet), Ms. Benton was still suffering from vomiting and abdominal cramps, but no treatment was provided.

- Ms. Benton's MAR contained orders for her to receive medication (clonidine) to control her blood pressure as needed. Though not as directly linked to the outcome, untreated high blood pressure may have played a role in Ms. Benton's death. Staff failed to follow these orders on several occasions, including the following more serious examples:
  - On 10/11 at 22:01 (according to the detoxification Flow Sheet), Ms. Benton's blood pressure was 153/106, abnormally high, and above the threshold for medication treatment specified in an order written on 10/9 (and properly transcribed to the MAR), but staff failed to provide any treatment.
  - On 10/12 at 06:30 (according to the detoxification Flow Sheet), Ms. Benton's blood pressure was 167/92, still abnormally high, and above the threshold for medication treatment specified in the same order, but staff failed to provide any treatment.
  - On 10/13 at 07:10 (according to the detoxification Flow Sheet), Ms. Benton's blood pressure was 163/109, still abnormally high, and above the threshold for medication treatment specified in the same order, but staff failed to provide treatment until almost three hours later.

That this dangerous state of affairs existed is not surprising in light of the CNAs' attitude toward their own authority and that of their superiors. They seemed to view practitioner medical orders as mere suggestions. This attitude is best captured by CNA Sampson, who stated in her deposition that she would use her own judgment in deciding whether or not to follow doctor's orders:

> Q. But am I correct, for instance in number 13, that if the blood pressure is between 150 over 90 and 150 over 109 that means Clonidine is needed? A. This states that you would give it. However, based on the patient's presentation at the time, there's multiple factors that can change a patient's blood pressure. So we would have to look

> at all of the factors of the patient before we would actually give them that medication. Q. What are some of the other factors you would look at? A. Depending on what the patient was actually doing prior to us taking the blood pressure. If the patient was standing up versus if they were sitting down, laying down. And that's about it. Q. And how did you know that those are the other things you should do if the order simply says, give the Clonidine? A. We would go based off of our clinical judgment. Q. And did you receive a training that told you that's how you should interpret the orders? A. No.

And then in a later intercourse:

> Q. And I'd like to go down now to number 17. Patients with severe distress, multiple seizures, or oxygen saturation less than 92 percent give mask oxygen and call 9-1-1, notify clinician. Is this like the Clonidine; do you interpret that as using your clinical judgment as well? A. Correct.

Step 4: Documenting medication administration

In contrast to both minimally acceptable medical practice as well as Conmed's own Policies 40.20 and 40.23 that state that all medication administration will be documented on the MAR, things were done differently at SMCDC. Based on my review of Ms. Benton's medical records as described elsewhere in the Summary of Facts above, as well as deposition testimony from medical staff, there was no set way to record medication administration at the jail.

In her deposition, CNA Sampson gave several (conflicting) renditions of how medication administration was documented. She stated that CNAs do not always document medication administration on the MAR. At first she stated they might document it in a progress note or with the doctor's order. At another point she stated that they might document it in the Medical Unit's Log Book or on a document handed down from shift to shift called a "Pass Down." ("Q. So in an instance where you just said you might give a medication and it's not in the MAR or the progress notes, it's on the pass down, and then the pass down is shredded. Does that mean there's no record of the patient receiving that medication? A. Potentially, yes." "Q. Are there instances where a patient receives medication but it is not documented anywhere? A. It could happen. Yeah.")

In her deposition, CNA Beaumont stated that she gave Ms. Benton Phenergan twice, but could not find that she had documented this on the MAR.

Conmed medical staff also ignored good medical practice as well as Conmed's own Policy 40.20 Medication Administration, which requires that patients who miss medications (e.g. refused or "no response") will be counselled by a nurse, physician, or mental health staff, and that such counseling will be documented in the patient's medical record. Ms. Benton allegedly refused or missed medications seven times, yet there is no record of a single counselling by any health professional.

Performing and Documenting Withdrawal Checks

Conmed medical staff were required to monitor Ms. Benton's condition during withdrawal and document those checks on the withdrawal Flow Sheet. As described elsewhere, that Flow Sheet as well as the protocols surrounding its use were flawed. Aside from those system flaws, CNAs failed to follow the required procedure when conducting those checks. For example:

- The practitioner's orders for withdrawal monitoring clearly instructed the CNAs to "give mask oxygen and call 911, notify clinician" if the O2Sat fell below 92%. It is therefore a *sine qua non* that CNAs must measure Ms. Benton's O2Sat during monitoring. Yet, over the course of five days, Ms. Benton's O2Sat was measured during detox monitoring only once (on 10/10 during her visit with the PA). Thus if Ms. Benton's O2Sat was getting worse and could have signaled to staff that she was getting ill, it would not have been discovered since it was not measured as ordered.
- CNAs were supposed to conduct the withdrawal checks every eight hours. Instead, no one conducted the morning check on 10/9 and no one conducted the morning check on 10/10. In addition, an initial check should have been conducted in the early evening of 10/8 when CNA Penny King first placed Ms. Benton on a "Benzo Protocol."
- CNAs were supposed to document the time they conducted each check. Documenting the time of any clinical intervention is a basic component of health care delivery, especially when documenting about a patient with an acute condition, such as Ms. Benton. The time of the midday check on 10/12 is missing.
- CNAs were supposed to document Ms. Benton's temperature during every check, yet, over the course of 13 monitorings over five days, CNAs only checked her temperature twice.

IV. Analysis and Opinions

1. Cause of Death

An autopsy was performed. The Medical Examiner (ME) found

- Myocardial fibrosis
- Biventricular hypertrophy
- Renal arteriosclerosis
- Clinical history of hypertension
- Pulmonary edema
- Chronic drug and alcohol abuse
- Microscopic focally severe microvesicular steatosis
- Perforated nasal septum
- Clinical history of narcotic withdrawal during incarceration
- Vitreous humor test results: Na 137; K 8.4; Cl 119; BUN 19; Cr 0.41; BS <35.

The ME opined that Ms. Benton died of "cardiac arrhythmia due to myocardial fibrosis and hypertensive heart disease," with "chronic drug and alcohol abuse" contributing to her death, and stated that "[e]vidence of starvation and dehydration were not established as acetone was not detected in the blood and the vitreous electrolytes were within normal limits."

While I agree with much of the ME's conclusions, I do not think they tell the whole story. Some of the ME's findings are subject to question. First, she diagnosed Ms. Benton with alcohol abuse. There is no evidence of this in the record.[14] Second, she diagnosed Ms. Benton with a "clinical history of narcotic withdrawal during incarceration." While I agree that this is likely, I believe it is an incomplete conclusion: the pre-mortem evidence makes it difficult to distinguish whether Ms. Benton suffered from opiate (narcotic) withdrawal, benzodiazepine withdrawal, or both. Most likely she suffered from both. Third, the ME concluded that Ms. Benton did not suffer from starvation or dehydration, in part, because "acetone was not detected in the blood." However, I was unable to find that any tests were performed, either ante-mortem in the hospital, or post-mortem by the ME, for acetone or either of its two closely related compounds, acetoacetate, or beta-hydroxybutyrate. Fourth, the ME concluded that Ms. Benton did not suffer from starvation or dehydration, in part, because her "vitreous electrolytes were within normal limits." Indeed, the levels of sodium, creatinine, and urea nitrogen in Ms. Benton's vitreous are not high, as would be typical of someone who is dehydrated. However, these substances do not always accurately reflect the corresponding levels of these compounds in the patient's blood at the time of death because the vitreous humor is "slow to catch up" with the blood. It is possible that the final stages of dehydration came upon Ms. Benton so rapidly that there was not enough time for the compounds in her eye to reflect the changes in the rest of her body. Further, if, as part of her dehydration, she were replacing salt faster than she was replacing water, she could have still been dehydrated despite the vitreous sodium level. Finally, the vitreous sample was obtained at least 14 hours post-mortem, during which time it is known that the vitreous sodium level can drop.

In my opinion, Ms. Benton died of dehydration due to some combination of acute withdrawal from benzodiazepines and opiates. While this is the most likely diagnosis, there is also good evidence supporting that Ms. Benton died of the sole effects of benzodiazepine withdrawal. Her physical findings in the hours and days before her death (elevated blood pressure, elevated pulse, tremors, agitation, vomiting, diarrhea, and abdominal cramps) all support this, as do her acute and severe changes in mental status showing that she was becoming delirious.[15] It is also possible that Ms. Benton died of a cardiac arrhythmia, as the ME states. In that case, the most likely arrhythmia was a bradyarrhythmia (dangerously slow heart beat). Individuals with

---

[14] In her 30(b)(6) deposition testimony, Michelle Autry stated that Ms. Benton's record did indicate a history of alcohol use. She based this conclusion on the appearance of the word "ETOH" (ethanol) in the progress note written during Ms. Benton's intake. Ms. Autry's conclusion is incorrect. The word "ETOH" does appear in the progress note. However, it appears as a heading, and the content under this heading is "Denies AU [alcohol use]."

[15] One might counterargue that Ms. Benton could not have suffered and died from benzodiazepine withdrawal because she was getting Librium, which is the mainstay of treatment to prevent withdrawal, and she had measurable levels of the drug in her blood (0.7 mg/l = 700 ng/ml). This counterargument fails, however, on a few fronts. First, Ms. Benton was administered only a little more than half the doses (8 of 14) she was prescribed. Second, given her frequent vomiting, it is likely that she did not retain some of the doses that were administered. Third, treatment of benzodiazepine withdrawal with Librium is not a "one-size-fits-all" therapy. Thus, the fact that there was any measurable Librium in her blood does not mean that that level was sufficient to prevent serious withdrawal.

damaged heart tissue, such as Ms. Benton had on autopsy, are prone to arrhythmias. There is ample evidence that she sustained a bradyarrhythmia twice prior to her death: once on 10/12 at 05:05 when she complained of chest pain (pulse 48) and again on 10/12 at 06:30 (pulse 36). A bradyarrhythmia can be intermittent and non-fatal at one moment, and fatal at another. The physiological stress of withdrawal (e.g. elevated blood pressure, tremors, vomiting) would be expected to increase stress on a damaged heart and increase both the likelihood and lethality of a bradyarrhythmia. Finally, it is not outside the realm of possibility that Ms. Benson's core symptoms of vomiting, diarrhea, and mental status changes were the result of another condition, such as a viral or bacterial infection, either in addition to, or instead of, drug withdrawal.

Any uncertainty as to which of the above mechanism(s) played the most prominent role in Ms. Benton's death does not impair my certainty as to the role of Conmed medical staff in Ms. Benton's death. All of the above mechanisms of death share a common core. Ms. Benton provided staff with obvious signals – risk factors, signs, and symptoms – that she was sick and getting sicker. Appropriate evaluation of these signals by minimally competent medical professionals would have inevitably led to either remediation of her known condition(s), or discovery and remediation of unknown condition(s), which in turn would have prevented her death, more likely than not. Specifically, monitoring of her withdrawal status and evaluation for chest pain, accompanied by treatment of her vomiting, diarrhea, elevated blood pressure, and delirium, among others, would have eliminated most of her cardiac stress factors and ensured that she was nourished, adequately hydrated, had normal blood electrolytes, and had a normal heart rhythm.

2. Deficient Withdrawal Policies/Procedures/Protocols:
The most striking deficiency at SMCDC with regard to withdrawal protocols is that the jail did not have protocols, or at least none for benzodiazepines or alcohol – for which there was, at best, an apocryphal set of beliefs among staff of what treatment they were supposed to provide. Relying on such an informal system for governing health care is not only illegal and unheard of in the health care profession, it is dangerous.

Whether based on their beliefs, handed down from "generation to generation" of staff, or upon the single pre-printed order set for opiate withdrawal, a one-page policy on intoxication and withdrawal, and a Flow Sheet, the policies/procedures/protocols were (1) very poorly designed, and (2) ignored by staff.

(1) Poor design of withdrawal policies/procedures/protocols
In 2013, withdrawal from opiates and alcohol/benzodiazepines had already been widely recognized as a common and potentially serious or life-threatening problem in jails. For a number of years, the standard of care for these two conditions, both in corrections and in the community, included the use of two very well-validated and widely-accepted monitoring tools: the Clinical Opiate Withdrawal Scale (COWS) for managing opiate withdrawal, and the Clinical Institute Withdrawal Assessment (CIWA) for managing alcohol, and to some extent,

benzodiazepine[16] withdrawal. While the protocol in use at SMCDC – which apparently is used for withdrawal from all three substances – bears some vague resemblance to these validated tools, containing some similarities, it is quite different and seems to be "home-grown." One of the striking differences is the lack of any monitoring guidelines using the tool's total scores to help staff know when the patient is getting better, or more importantly, worse. (RN Henderson deposition, page 210: "So there's no part of the protocol that mandates that they call you or the PA or a doctor based on this total number? THE WITNESS: No, ma'am."[17]) Most importantly, one protocol cannot scientifically and safely be used for three different withdrawal syndromes.

There is a mismatch between the pre-printed order set that is part of the protocol and the corresponding Flow Sheet which is supposed to be used for executing the protocol. For example, the order sheet calls for staff to monitor the patient's O2Sat, but the Flow Sheet is missing a place to record this.

There are obvious errors in the pre-printed order set. For example, for blood pressure monitoring, the instructions include:

> For blood pressure 150/90 – 150/109, give Clonidine 0.1 mg PO PRN [orally, as needed]
> For blood pressure 160/110 – 169/119, give Clonidine 0.2 mg PO PRN
> Call clinician for blood pressure > 170/120.

These orders have multiple errors. First, there is a serious typographical error: the systolic (upper number) blood pressure range of 151-159 is simply missing from the instructions. Second, "as needed" is confusing and misleading. The "need" is already established by the blood pressure readings. There is not, nor should there be the need to, make any further "needs" assessment. Third, the stated blood pressure ranges make no sense physiologically. They assume that if a patient's systolic blood pressure is between 160-169, for example, that their diastolic (lower number) blood pressure will always be between 110-119. This is a false assumption. A patient's blood pressure may very well be 155/115. If that were the case, the order would be confusing (and therefore potentially result in a medication error). Or, a patient's blood pressure might be 160/130, a dangerously high blood pressure, but might not trigger a call to the clinician.

---

[16] The CIWA is not as well calibrated for managing benzodiazepine withdrawal as it is for managing alcohol withdrawal, but in the absence of a better tool, it is used as the starting point for the former condition. In other words, it is better than using nothing or a tool that has not been studied. A tool called the CIWA-B is also available for monitoring benzodiazepine withdrawal.

[17] In her testimony as Conmed's 30(b)(6) witness, Michelle Autrey, stated that there existed in October of 2013 a scoring sheet of some kind which could be used by medical staff, in apparent contradiction to the testimony of RN Henderson cited above. Her statement, however, does not negate RN Henderson's testimony nor change my opinion for two reasons. First, looking at the totality of Ms. Autrey's testimony, it is clear that she was not very familiar with the specific operational practices of Conmed staff at SMCDC in October of 2013, and was certainly less familiar with these practices than RN Henderson. Second, it is not clear whether the scoring sheet to which Ms. Autrey refers simply provides guidance to staff as to how to score each of the 14 items of the Flow Sheet assessment tool (e.g. "pulse 80 or below = 0 points, pulse 81-100 = 1 point, pulse 101-120 = 2 points," etc.), or whether the scoring sheet provides guidance to staff as to what actions to take depending on the total score for all 14 items of the tool.

There are also clinical errors in the pre-printed order set with regard to the use of medications. For example, order #4 instructs staff: "For abdominal cramps and diarrhea, give Imodium 4 mg TID x 3 days." The errors include: (a) many withdrawal episodes continue well beyond three days; (b) Imodium should be administered even if the patient experiences diarrhea without cramps; (c) a single dose of Imodium thrice daily may be too low and too slow. The FDA-approved prescribing instructions for this medication read: "The recommended initial dose is 4 mg (two capsules) followed by 2 mg (one capsule) after each unformed stool. Daily dose should not exceed 16mg (eight capsules)."

The various protocol documents are worded at a level that is above the level of understanding of the staff whom Conmed expects to implement them. When asked in his deposition what "hematemesis" (vomiting blood, the subject of order #5 in the order set) meant, CNA Hosselrode responded, "I'm not sure." When asked in her deposition what "ataxia" (generally, unsteady gait, the sixth item on the Flow Sheet) meant, RN Henderson responded, "difficulty breathing." CNA Hosselrode is one of the CNAs responsible for conducting withdrawal monitoring on a regular basis and had presumably been doing so for about 10 months, and, frighteningly, RN Henderson was the Health Services Administrator, and for three years had been responsible for training and supervising the CNAs.

(2) Policies/Procedures/Protocols ignored by staff

As described previously: CNAs failed to collect important clinical information as required by the pre-printed order set (e.g. O2Sat) or the Flow Sheet (temperature; conducting check every eight hours); and the RN simply changed the diet order from 2400 calories to "regular diet."

In addition, the Intoxication and Withdrawal Policy (70.40) in effect at the jail stated:

> "Inmates experiencing severe, life-threatening intoxication or withdrawal from Alcohol or other drugs (AOD) will be transferred to the community hospital." Ms. Benton was experiencing severe life-threatening withdrawal, but was not transferred to the hospital until she was found unresponsive.
>
> "If an inmate's condition deteriorates during the detoxification process, the inmate will be transferred to the community hospital for specialized care." As stated above, Ms. Benton was not transferred to the hospital. Even if staff (erroneously) did not believe Ms. Benton's condition was severe or life-threatening, according to this policy statement she should have been sent to the hospital if her condition was simply deteriorating. Clearly her condition was deteriorating over the course of the three or four days prior to her death. Such deterioration was clear from a number of signals, the simplest and most obvious of which was the change in her total score on the Flow Sheet: whereas her total score was zero to two during the period from 10/9 to 10/11, it rose to four to seven during the period from 10/11 to 10/13.

In summary, **many of the deficiencies of the policies/procedures/protocols for substance abuse withdrawal, whether due to poor design or failure of staff to adhere to them, were causally linked to Ms. Benton's death.**

3. Independent practice by CNAs outside their legal scope.
Conmed employed two types of nursing personnel: RNs and CNAs. Under Maryland law (and consistent with minimally acceptable nursing practice across the nation in all sectors of health care), RNs and CNAs undergo very different training, are awarded different credentials by the state, and perform very different functions. RNs train for two to four years. CNAs train for 100 hours. RNs are licensed. CNAs are certified. Most notably, RNs are licensed to assess, make nursing diagnoses, and plan treatment (Md. Code Ann. Health Occ. §8-101(n)(1)). In sharp contrast, a CNA "assists the nurse [RN] in collecting data for a nursing assessment; and…[under the] instruction, direction, and supervision of a nurse…Collect[s] and record[s] routine health data identified by the nurse on assigned clients…Identif[ies] when the client's condition or behavior has changed from one day to another or from one part of the assigned shift to another and report[s] any change to the nurse…Provide[s] feedback to the nurse regarding the nurse-directed plan of care which is being implemented; Provide[s] feedback to the nurse about the client's expressed wishes concerning the plan of care." (Md. Code Reg. 10.39.05.03). While RNs may delegate certain nursing tasks to CNAs, "[t]he following nursing functions require nursing knowledge, judgment, and skill and may not be delegated: (1) The nursing assessment including, but not limited to, the admission, shift, transfer, or discharge assessment; (2) Development of the nursing diagnosis; (3) The establishment of the nursing care goal; (4) Development of the nursing care plan; (5) Evaluation of the client's progress, or lack of progress, toward goal achievement; and (6) Any nursing task which requires nursing knowledge, judgment, and skill." (Md. Code Reg. 10.27.11.05). Finally, even if one were to construe any of the nursing functions delegated by the RN to CNAs as allowable under the law, the law further states that such tasks may be delegated, "provided that acceptance of delegated nursing tasks does not become a routine part of the unlicensed individual's job duties." (Md. Code Ann. Health Occ. §8-6A-02(c)).

This report is replete with examples of complex nursing activities that required nursing judgment – something reserved for the RN – but that were performed by CNAs at SMCDC and, further, activities which, based on the totality of evidence in this case, have all become routine parts of the CNAs' job duties. Examples include: each of the several withdrawal checks when Ms. Benton's vital signs were abnormal or she complained of vomiting or diarrhea; each of the several times CNAs withheld or otherwise failed to administer a dose of Ms. Benton's Librium or clonidine; ordering the placement of Ms. Benton on the "Benzo Protocol" on the night of her admission; managing Ms. Benton's complaint of chest pain on 10/12 at 05:05; managing Ms. Benton's complaint of a head injury on 10/12 at 22:10 following a fall; and managing Ms. Benton's marked deterioration in mental status over the course of the morning and early afternoon of 10/13, the day she died.

Not only is it patently clear that CNA activities exceeded the safe limits of what they could perform, and that these activities all violated the Maryland Code, Regulations, and minimally acceptable practice of nursing throughout the health care profession, it is also clear to me that this was an established pattern at SMCDC and that CNAs were aware of what they were doing. For example, when asked in deposition about failing to administer to Ms. Benton her prescribed dose of Librium when her blood pressure was 119/90, and noting that there was no documentation of the CNA discussing this decision with any RN, PA, or physician, the following conversation took place with CNA Randolph: "Is it also possible that you made the decision to

withhold the medication without talking to somebody? A. Could be possible. I don't remember." In another CNA deposition, CNA Sampson stated she would use her own judgment in deciding whether or not to follow orders: "Q. And I'd like to go down now to number 17. Patients with severe distress, multiple seizures, or oxygen saturation less than 92 percent give mask oxygen and call 9-1-1, notify clinician. Is this like the Clonidine; do you interpret that as using your clinical judgment as well? A. Correct. Q. So does that mean somebody could have oxygen saturation less than 92 percent, but you wouldn't give oxygen and call 9-1-1? A. Correct."(page 32)

That Conmed expected CNAs, as a custom, to operate beyond their scope of practice, is illustrated by the testimony of Conmed's 30(b)(6) witness, Michelle Autrey. When asked how a CNA would know when a blood pressure reading was abnormal enough to prompt a call to the nurse or physician, she replied that the CNA should make such a call when the blood pressure was outside the normal limit. But when asked how the CNA would know what that normal limit is, Ms. Autry replied that it varies from person to person and that these normal limits had not been determined for Ms. Benton. It therefore fell on the CNAs to make a clinical judgment – well beyond their legal and safe scope of practice – as to what a patient's normal limits were, and when to notify the nurse or physician. (Autry Deposition pages 202-206)

In summary, CNAs at SMCDC practiced outside their safe and legal scope of practice. They had an obligation, as part of their certification, to be familiar with the limits of their practice and yet, they knowingly breached those limits. Further, their supervisor, herself a licensed nurse, had an obligation to be familiar with, and follow, the law with regard to what nursing tasks her subordinates could perform, either independently or as delegated nursing tasks from herself. Yet, she, too, knowingly breached those limits. Based on the medical record in this case as well as the CNAs' and RN's collective testimonies, it is also reasonable to infer that CNAs conducted themselves in this illegal manner not only specifically with Ms. Benton, but as a general custom with other patients.

In addition to violating the laws and regulations in their jurisdiction as well as the standard of care in the profession, these breaches had a material effect on the care Ms. Benton received. At almost each – if not each – of the junctures where CNAs used independent professional judgment, Ms. Benton either failed to receive medically necessary care (especially receipt of medications) or exhibited a sign or symptom of worsening withdrawal from drugs, worsening dehydration, or increased cardiac stress. Had she received the medications she was prescribed, her symptoms may have been abated, avoiding the outcome. Had CNAs referred her to the supervising RN, PA, or physician when she exhibited deteriorating signs or symptoms, such referral, in the hands of a reasonably competent professional, would have inevitably led to further evaluation, which would have led to treatment that would have avoided her death. Thus the actions and inactions of the CNAs at SMCDC were causally related to Ms. Benton's death, and as they resulted, in part, from the regular and knowing flaunting of the law and safe medical practice by the involved professionals for a condition that they knew or should have known was serious and potentially fatal, they constitute negligence and deliberate indifference on the part of these professionals to the serious medical needs of Ms. Benton and other jail residents.

4. Deficient Supervision/Oversight by HSA/RN Henderson, Dr. Paden, and Conmed
In the previous subsection, I described the independent practice by CNAs outside their safe and legal scope of practice. While the CNAs have a responsibility to know and adhere to their limits, this responsibility was shared with RN Henderson, who was also the HSA and supervised the CNAs. Yet, the record shows that RN Henderson was aware of, and condoned, the fact that CNAs were using their own judgment to make nursing assessments, as illustrated in the following examples:

> A. For abdominal cramps and diarrhea, give Imodium four milligrams three times a day for three days. Q. And again, since this is in the orders, a med tech[18] can give it without calling someone; is that correct? A. Yes, ma'am. That's correct. Q. And is it just based on the med tech's judgment whether the abdominal cramps and diarrhea warrant Imodium? A. Yes. Q. And for number three for the vomiting, is that the same that it's based on their assessment whether the vomiting is sufficient to warrant Phenergan? A. Or the patient says, 'I have been vomiting." (pages 65-66)

When asked about the total score on the withdrawal Flow Sheet, this conversation took place:

> Q. Is there a cutoff for this total number where a medic is supposed to call somebody? A. No. Q. Okay. So is it within the medic's discretion whether the total number is high and is something they should be worried about? A. Correct. (page 210)

RN Henderson was not only out of touch with the legality of her CNAs' practice, she was also out of touch with key day-to-day activities of her staff. For example, she was under the impression that the PA would have reviewed the MARs of patients undergoing detoxification each time she saw them. (Henderson deposition page 143) However, according to the PA, no such thing happened: "A. I don't recall reviewing [MARs] on a regular basis. There may have over time [sic] somebody showed me something, it isn't like I've never seen one, but it wasn't something I reviewed. Q. Okay. That, that wasn't part of your daily duties, to make -- strike that. That, that wasn't part of your daily duties? A To review a medical administration record? Q. Medicine administration record, yes. A No." (Sidorowicz deposition page 57) Review of Ms. Benton's MAR would have revealed the deficiencies described elsewhere in this report which in turn may have led to adequately treating her withdrawal and avoiding her death.

The HSA was also under the impression that the PA saw patients undergoing detoxification every time she was at the jail, which at the time would have been Monday, Tuesday, Thursday, and Friday. At least in Ms. Benton's case, this did not happen: the PA did not see Ms. Benton on Friday, 10/11. However, I am unable to determine whether this was an isolated event or a pattern.

---

[18] During depositions, the CNAs were also sometimes referred to as med techs because they all also held a certification as Certified Medication Technicians. This certification requires 20 hours of training and allowed CNAs to administer ordered medications. The term medic was also used on occasion.

The HSA was also out of touch with what her CNAs were doing during medication administration rounds. She was under the impression that CNAs actually went to each person during rounds if they were undergoing withdrawal (deposition page 146-147). However her impression is inconsistent with recordings on Ms. Benton's MAR of missed medications, such as "No Show" or "Missed."

As an RN, the HSA would have known the serious risks to which Ms. Benton was exposed by deficient care during her withdrawal. That she had actual subjective knowledge is demonstrated by her response to a question during her deposition. When asked why the jail kept a record of food and fluid intake for people undergoing detoxification, Ms. Henderson responded that "dehydration is very easy with detox." She later stated that if someone starts to get dehydrated they must be sent to the hospital (deposition pages 172-174). Thus the HSA had subjective awareness that dehydration was a serious medical condition, and yet she failed to ensure that her staff operated in a manner to prevent and/or treat such dehydration.

Dr. Paden, in his role as attending physician and facility medical director, also had a responsibility to keep patients safe. However, based on the totality of his deposition testimony, it appears to me that his level of involvement in overseeing medical care at SMCDC was minimal. Examples from his deposition testimony include the following passages:

- I mean, when I went to, when I went to, what's that, Walden Sierra, just like at the other Conmed facilities, the nurse, nurses there, they basically ran the, ran the show. And basically I was there basically as the physician because they needed someone with credentials in order to -- for the, for the process to move forward. (page 57-58)
- Q. Did you participate in any way in establishing what the benzodiazepine withdrawal protocol was at the St. Mary's Correctional Center? A. No, no, I did not. (page 60)
- [Speaking about the treatment protocol used for Ms. Benton] Q. Okay. And, and you accepted that that was an appropriate treatment protocol. A. Well, you know, it's, it's, it's a detention center. It's a prison. You have to work within the constraints of whatever it is that they have agreed upon with the correctional facility. (page 70)
- I was, I was only responsible for things while I was there physically at that, at that center. Q. And that was, and that was two hours a week in the case of St. Mary's? A. Sometimes it might be three to four hours depending on how many charts there were. (page 77)

Dr. Paden's impression of his responsibilities lie in sharp contrast to those required by Conmed Policy 10.00 Responsible Health Authority:

- 4. The responsibilities of the [on-site] Medical Director include, but are not limited to:
    a. Establishing a mission statement in collaboration with Conmed's Chief Medical Officer that defines the scope of health services.
    b. Developing mechanisms in collaboration with Conmed's Chief Medical Officer that include written agreements, when necessary, to assure that the scope of services is provided and properly monitored.
    c. Developing operational health policies in collaboration with Conmed's Quality Assurance and Standards Department...[sic]

d. Identifying the type of health care providers needed to provide the determined scope of service with collaboration with Conmed's Chief Medical Officer.
e. Establishing systems for coordination of care among multidisciplinary health care providers in collaboration with Conmed's Chief Medical Officer.
f. Developing and implementing a quality management program in collaboration with Conmed's Quality Assurance and Standards Department.

Dr. Paden rarely examined patients, spending most of his time reading and signing off on the paperwork which appeared in patient medical records. While even this limited task *could* have led to significant insight into, and remediation of, the quality of health care delivery at SMCDC, based on my review of Ms. Benton's record, it did not. For example, Dr. Paden read and cosigned the intake progress note written by CNA Penny King on 10/8 at 18:57. The progress note clearly indicated that the CNA was ordering Ms. Benton to be placed on the "Benzo Protocol," and that this order was independent and without consultation with him or any other higher level medical professional. Yet, he cosigned (agreed/approved) the note and took no further action. In another example, Dr. Paden read and cosigned the Health Assessment conducted by PA Sidorowicz on 10/9 (at an undocumented time). The Health Assessment clearly shows that Ms. Benton had a markedly elevated blood pressure (142/112), and elsewhere in the record it showed that she had a history of hypertension. The record also showed that PA Sidorowicz had apparently missed or ignored this elevated blood pressure and took no measures to treat it acutely nor to make sure it was addressed beyond the seven days of Ms. Benton's planned substance detoxification. As a physician, Dr. Paden would have known the dangers associated with acutely and chronically untreated hypertension. Yet, again, he cosigned (agreed/approved) the note and took no further action.

Based on the totality of Dr. Paden's deposition testimony, and his interaction with Ms. Benton's chart, it is more likely than not that Dr. Paden was aware, or should have been aware, of the fact that CNAs were practicing beyond their safe scope of practice, and that the policies/procedures/protocols in place for monitoring and treating withdrawal were not consistent with the standard of care and/or not being followed, but he took no action to remedy the situation. As it is likely that these conditions existed prior to Ms. Benton's arrival, previous remediation on Dr. Paden's part would have cured the problems that led to her death. Thus, the customs and practices tolerated, if not created, by Dr. Paden materially contributed to Ms. Benton's death.

Finally, in addition to Ms. Henderson's and Dr. Paden's responsibilities to ensure safe care for Ms. Benton and other jail residents in their roles as HSA and FMD, respectively, they shared this responsibility with Conmed leaders. Based on my general knowledge of the provision of health care to U.S. jails by private health care vendors, I infer that Conmed leaders played a material role in establishing the policies/procedures/protocols in place at SMCDC, hiring and supervising the work of RN Henderson and Dr. Paden, and monitoring the quality of care to patients at the jail. To the extent that they created, knew about, or should have known about, the deficiencies in health care described in this report extant at SMCDC and material to the death of Ms. Benton, then they share in responsibility for her outcome. It is further troubling that more than four years after the death of Ms. Benton, Conmed seems to have failed to fully learn from the Benton case.

V. Conclusions

Melissa Benton walked into St. Mary's County Detention Center on 10/8/13 with some underlying medical problems, including hypertension and opiate and/or benzodiazepine use disorder, none of which was a terminal disease. Medical staff at the jail were aware of these medical problems. These are common problems among jail residents and are known to result in serious medical consequences if mismanaged. The jail had the personnel, medications, and resources to treat these problems. However, Conmed, the company responsible for hiring and supervising personnel and overseeing operations; Dr. Vabian Paden, the Facility Medical Director and Ms. Benton's attending physician, responsible for medical oversight of jail health care operations and Ms. Benton's care at the jail; PA Nancy Sidorowicz, Ms. Benton's practitioner, responsible for setting in motion the overarching orders to manage these problems; Health Services Administrator and RN Melissa Henderson, responsible for hiring and supervising the jail's CNAs and overseeing the health care operation; and the CNAs,[19] responsible for delivering the care that was ordered, each failed in its, his, or her duties to Ms. Benton. Ms. Benton developed signs and symptoms of withdrawal from opiates and/or benzodiazepines, most importantly vomiting and diarrhea, and was unable to maintain an adequate intake of fluids. She also developed other important physiologic abnormalities, including high blood pressure, low pulse rate, and acute mental status changes (delirium). The systems and people in place failed to recognize and/or treat these initial and evolving conditions in a manner consistent with the standard of care. Whether via dehydration and cardiovascular collapse, primary bradyarrhythmia, bradyarrhythmia or other fatal cardiac arrhythmia exacerbated by cardiac stress and/or electrolyte disturbance, or some other acute condition, the delivery of minimally acceptable care by the jail's medical system and Ms. Benton's caregivers, more likely than not, would have prevented and/or detected her evolving deterioration, and such intervention, more likely than not, would have prevented her death. Further, the utter disregard displayed by the various parties as a general practice or custom, for the science of medicine, the careful operation of a health care system, and adherence to basic principles of the good medical care and the legal limits of professional practice, constituted not only a deviation from the standard of care, but a deliberate indifference to the potentially serious health care needs of residents at the St. Mary's County Detention Center, in general, and the actual serious health care needs of Melissa Benton.

VI. Expert Declaration

I was compensated at a rate of $600 per hour for the study and testimony in this case. My qualifications are contained in this report and my accompanying curriculum vitae which also lists the cases in which I have given testimony in the past four years. I hereby certify that I do not

[19] Throughout this review, I attempted to determine the identity of the staff member responsible for the act or omission I describe. There are acts or omissions, however, for which it was impossible for me to determine the staff member's identity. For example, the second of three withdrawal monitorings documented on the Flow Sheet on 10/12 is deficient (e.g. the time of the event was not recorded). The initials of the staff member – who, I infer, was a CNA – is not legible, and no deposed CNA accepted responsibility for being the author. As another example, on a number of occasions, CNAs failed to administer scheduled doses of medications, but also failed to document their initials on the MAR. Thus defendant CNAs – or possibly others – are responsible for harmful acts or omissions for which I am unable to identify the actor. My inability to identify the actor results from poor documentation practices on the part of those actors. Even with those limitations, it is clear that CNAs Cawley, Penny King, Sampson, Randolph, Beaumont, and Tara King each deviated from the standard of care in their treatment of Ms. Benton and their deviations contributed to her death.

devote annually more than 20 percent of my professional activities to activities that directly involve testimony in personal injury claims.

Marc F. Stern, MD, MPH

Marc F. Stern, MD, MPH
Consultant in Correctional Health Care
1100 Surrey Trace Drive SE
Tumwater, Washington 98501
(360) 701-6520
marcstern@live.com

December 31, 2017

This report contains medical opinions that supplement my report of December 13, 2017 regarding the care provided to Ms. Melissa Mae Benton at the St. Mary's County Detention Center (SMCDC) from October 8, 2013 to October 13, 2013. This supplemental report is based on a one-page document produced by defendants on December 21, 2017, six days after the deadline for my previous report.

The one-page document is entitled "Modified Selective Severity Assessment (MSSA) Detoxification Scoring." It appears to contain the rules guiding Conmed medical staff when endeavoring to assign a numerical score to each of the 14 items of the detoxification Flow Sheet.

After scouring the world medical literature from 1965 to present, I was unable to find any published scientific literature concerning a "Modified Selective Severity Assessment" (MSSA) tool containing the 14 items in defendants' document. I was able to find some mention of an MSSA, but it is significantly different from the document provided by defendants.

My review of this one-page document modifies my previous report in the following minor way. In footnote 17 on page 25 of my report, I cite the testimony of Conmed's 30(b)(6) witness, Michelle Autrey, who stated that there existed in October of 2013 a scoring sheet of some kind which could be used by medical staff. I wrote that "it is not clear whether the scoring sheet to which Ms. Autrey refers simply provides guidance to staff as to how to score each of the 14 items of the Flow Sheet assessment tool (e.g. "pulse 80 or below = 0 points, pulse 81-100 = 1 point, pulse 101-120 = 2 points," etc.), or whether the scoring sheet provides guidance to staff as to what actions to take depending on the total score for all 14 items of the tool." It is clear from my review of the newly provided document that there was most likely a scoring sheet available to staff, and that the scoring sheet provided the former guidance, i.e. guidance to staff as to how to score each of the 14 items. This does nothing to change my conclusions.

My review of this one-page document augments my previous report in the following way. Throughout my report I described the failure of Conmed medical staff to follow policies/procedures/protocols. Discovery of this document reinforces that conclusion by providing more examples of these failures. It is now evident that a patient's temperature figured into a calculation of the patient's total score on the flow sheet. However, staff only measured Ms. Benton's temperature on two of the 12 times they monitored her and attempted to calculate a total score. As another example, on the morning of 10/13/13, staff needed to administer clonidine to Ms. Benton due to her elevated blood pressure. According to the rules contained in the newly provided scoring sheet, such administration required staff to add two points to the total score (see

last item on the Flow Sheet). These errors in calculating a total score on the Flow Sheet would compound other scoring errors. Such errors, in turn created a risk that worsening of Ms. Benton's condition would be missed, leading to her unfortunate outcome.

Marc F. Stern, MD, MPH

Marc F. Stern, MD, MPH
Consultant in Correctional Health Care
1100 Surrey Trace Drive SE
Tumwater, Washington 98501
(360) 701-6520
marcstern@live.com

February 13, 2018

This report contains supplementary opinions to my report of December 13, 2017 regarding the care provided to Ms. Melissa Mae Benton at the St. Mary's County Detention Center (SMCDC) from October 8, 2013 to October 13, 2013.

1. On page 23 of my previous report, I wrote, "Further, if, as part of [Ms. Benton's] dehydration, she were replacing salt faster than she was replacing water, she could have still been dehydrated despite the vitreous sodium level." That sentence is in error and should be ignored.

2. On page 23 of my previous report, I opined that death due to benzodiazepine withdrawal was less likely than death due to dehydration. On further consideration of the totality of the evidence, I believe that benzodiazepine withdrawal is at least as likely a cause or contributing cause of Ms. Benton's death as is dehydration.

Marc F. Stern, MD, MPH