External Consultant Review

Date of Review	9/19/2019
Inmate Name/Number	Epstein, Jeffrey #76318-054
DOD - AGE	8/10/2019 66
COD	Hanging/Suicide
FACILITY/RGN	MCC New York/NER
Consultant's Sig	

Medications:

Docusate Sodium 100 MG Cap, Take one capsule (100 MG) by mouth twice daily for 30 days
Milk of Magnesia Susp (OTC) (473ML) 400MG/5ML, shake well take 10ml by mouth twice daily AS NEEDED
methylPREDNISolone 4 MG Tab (21 count Pack), Take the tablet by mouth as directed
Omega 3 (Vascepa) 1 GM Capsule, Take two capsules (2 GM) twice daily by mouth with food
Insulin Reg (10 ML) 100 UNITS/ML Inj, Inject regular insulin subcutaneously per sliding scale: each morning

Consultant Comments:

Although there were no medical issues that contributed to this patient's death. The following is offered to strengthen and improve our medical processes:

1. Review Tracking system for diagnostic and screening tests when ordered. An FOBT and ECG were ordered for this patient on 7/6/19, date of admission to the institution. However, there is no documentation of results and no follow-up noted addressing lack thereof even though this patient was seen on 7/9/19 (History and Physical) and 7/14/19 (Chronic Care Clinic).
2. Review roles and responsibilities of staff responsible for inspecting, testing and maintaining your AED at all institutions. This is considered life support equipment requiring implementation of a process that assures that the AED is available and accessible on the event of a life threatening emergency. The suicide reconstruction review report noted that documentation of AED inspections in the institution was often incomplete.
3. Page 9 of the Suicide Reconstruction Report inaccurately reported that the patient's History and Physical was performed outside the required BOP policy. The BOP policy requires this to be done within 14 days of admission. This patient's History and Physical was conducted on 7/9/19. He entered the institution on 7/6/19. Unless the institution has a more stringent policy, the History and Physical was completed in compliance of policy.
4. Approximately 3 years ago, I recommended that a Health Services staff be added to the group/committee that meet to conduct the Psychological Reconstruction Review. A Health Services staff addition can provide clarification, but more importantly, strengthen our knowledge as part of the team providing comprehensive care for our patients.

Were there findings from the medication mortality review?

No

Recommendations:

None.

Please submit the above stated recommendations (i.e., RCA, Corrective Action Tool, training presentations, and/or training rosters) to the HSD/Quality Management~@bop.gov mailbox and carbon-copying the respective Regional Director, RHSA, and RIOP within 45 days of the Warden's receipt of this notification.

Findings Category:

- ☐ Unexpected Death within 30 days of hospital discharge

Delay in Care:

- ☐ Untimely evaluation of symptoms/signs including red flags
- ☐ Untimely completion of diagnostics/consultations
- ☐ Untimely review of diagnostic or consultation reports
- ☐ Medical Hold not applied appropriately
- ☐ Untimely rendering of final diagnosis

Communication Errors (Check all that apply)

- ☐ During Diagnosis
- ☐ During Treatment

Improper Care (Check all that apply):

- ☐ Incorrect/missed diagnosis
- ☐ Failure to detect or address abnormal VS
- ☐ Medication mismanagement
- ☐ Incorrect treatment provided
- ☐ Treatment/condition not monitored properly
- ☐ Treatment not properly supervised
- ☐ CPG not followed (BOP or other)
- ☐ Treatment not provided