

MULTI-LEVEL MORTALITY REVIEW

Date: 09/09/2019
 To: Office of Quality Management
 From: MCC New York Health Services
 Subject: Mortality Review for Inmate Epstein #76318-054

Inst: MCC-NY
 Name: Epstein, Jeffrey Reg. #: 76318-054
 DOD: 08/10/2019 DOB: 01/20/1953 Age: 66 Sex: Male Race: White

Place of Death: Inst. Community Hospital OTHER
 Name of community hospital: New York Presbyterian Lower Manhattan Hospital

Nature of Death: Natural (chronic) Natural (Acute)
 Accidental: _____
 Homicide
 Suicide (Method) Hanging

Cause(s) of Death:
Axphyxiation

NARRATIVE SUMMARY: (Should include components below)

Date of admission to the 07/06/2019
 New commit Transfer from _____ Holdover

Status: Inpatient at: Inst. Community Hospital Outpatient

Admitting

1. Sleep Apnea
 2. Hypertriglyceridemia
 3. L4 - L5 Lumbar Stenosis
 4. _____
- (Pls. continue on supplementary page if necessary)

Past diagnosis:

1. Sleep Apnea
 2. Hypertriglyceridemia
 3. L4 - L5 Lumbar Stenosis
 4. _____
- (Pls. continue on supplementary page if necessary)

Significant mental health (Yes) (No) (NA)
 Include specific information as relevant to death:

Name: Epstein, Jeffrey

Reg. #: 76318-054

DOB: 01/20/1953

Admitting diagnosis:(continue)

Past diagnosis: (Continue)

Description of course of illness (past and present) and cause of the death in sufficient detail to indicate circumstances of death, including treatment, medications, diagnostic testing, e tc. Give findings of diagnostic exams. Insert pages in this section as required.

Intake Screening History and Physical present?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Date of most recent History and Physical	<u>07/09/2019</u>		
Timeliness of Diagnostic and Treatment regimes?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Discharge summary from Attending M.D. on chart			
Institution	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA
Community Hospital	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA
Autopsy	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA
Toxicology	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA
Death Certificate Available	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> NA

INSTITUTION MEDICAL CARE REVIEW:

Severity of illness at time of admission to hospital / Health Services Unit	<input type="checkbox"/> Critical	<input checked="" type="checkbox"/> Stable	<input type="checkbox"/> Unknown
Prognosis on admission to hospital / health Services Unit	<input type="checkbox"/> Poor	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> NA
Were diagnostic procedures appropriate and timely	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Was treatment appropriate to diagnosis and instituted timely	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Prognosis with treatment	<input type="checkbox"/> Poor	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Unknown
Any complications adversely affecting outcome:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	
Describe briefly <u>Asphyxiation Secondary to Hanging.</u>	_____		
_____	_____		
_____	_____		

Was treatment appropriate to complication	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Surgical Procedures (list) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA
_____	_____		
_____	_____		

Appropriate pre-operative evaluation completed, including lab, physical exam, updated history	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA
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Complications related to surgical procedures (describe) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA
_____	_____		
_____	_____		

Prognosis following surgical procedure	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input checked="" type="checkbox"/> Unknown
Patient compliant with treatment / medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA

Discussion with patient or patient's family regarding prognosis Yes No NA

DNR order Yes _____ No
Date

Advance Directive / Living Will Yes No NA

LOCAL COMMUNITY HOSPITALIZATIONS ONLY:

Type of admission Routine Emergent Other

Method of transportation appropriate to patient condition Yes No NA

Severity of condition at time of admission to local hospital Critical Stable Unknown

Prognosis on admission to local hospital Poor Good Unknown

Were diagnostic procedures appropriate and timely Yes No

Was treatment appropriate to diagnosis and instituted timely Yes No

Prognosis with treatment Poor Good Unknown

Any complications adversely affecting outcome: Yes No

(describe briefly) Asphyxiation Secondary to Hanging.

Was treatment appropriate to complication Yes No

Surgical Procedures (list) _____ Yes No

Appropriate pre-operative evaluation completed, including lab, physical exam, updated history Yes No

Complications related to surgical procedures Describe _____ Yes No

Prognosis following surgical procedure Poor Good Unknown

Patient compliant with treatment / medications Yes No NA

Discussion with patient or patient's family regarding patient prognosis Yes No NA

DNR order

Yes _____ No
Date

Advance Directive / Living Will

Yes _____ No
Date

REVIEW OF EMERGENCY MEDICAL CARE:

Was death related to a medical emergency

Yes _____ No

Response to medical emergency

notification timely

Yes _____ No _____ NA

Physician

Yes _____ No _____ NA

Physician Assistant

_____ No NA

Nurse Practitioner

_____ No NA

Nurse(s)

Yes _____ No _____ NA

Emergency Medical Techs

_____ Yes _____ No NA

Others

_____ Yes

_____ Yes

CPR

Yes _____ No _____ NA

ACLS List protocol (s) used (if appropriate)

Yes _____ No _____ NA

By EMS.

Problems encountered during medical emergency, e.g.,
equipment, communications, transportation.

_____ Yes No _____ NA

Describe briefly:

Providers responding maintain current certification / credentials in
BCLS, ACLS (if required)

Yes _____ No _____ NA

SUMMARY REVIEW:

Inmate Jeffery Edward Epstein #73618-054 a 66 year old male with a history of Obstructive Sleep Apnea on CPAP at night, a history of Hypertriglyceridemia treated with Vascepa, no past Mental Health History prior to incarceration and L4-L5 Stenosis. On July 23, 2019, at 2:00 a.m. he was placed on Suicide Watch for 31 hours and 5 minutes due to abrasion located on the lower anterior surface of his neck area. On July 24, 2019 he was taken off Suicide Watch and was placed on Psychological Observation. On July 30, 2019, he was removed from Psychological Observation and was placed in the Special Housing Unit where he was housed with a cell mate. On August 8, 2019, he was seen by Psychology Services and denied suicidal ideation, intention or plan.

On August 10, 2019, at 6:33 a.m. Special Housing Unit Staff found inmate Epstein unresponsive in his cell and attempted to wake him. The body alarm was activated in SHU and the Control Center announced a medical emergency. CPR was initiated by Special Housing Unit Staff. At 6:35 a.m. medical staff responded and continued CPR and the AED was applied. The Control Center called for an ambulance. The EMS arrived at 6:45 a.m. and the paramedics continued CPR. Inmate Epstein remained unresponsive. Inmate Epstein was intubated, and the ACLS Protocol was initiated by the EMS. No pulse found, no shock was advised and the inmate was prepared for transport to local hospital while continuing CPR. At 7:10 a.m. the EMS departed institution en route to New York Presbyterian Lower Manhattan Hospital. At 7:36 a.m. the inmate was pronounced dead by the ER Physician

Documentation in medical record reviewed by Mortality Review Committee and found to be within acceptable limits. If no, describe _____

Yes

No

NA

Did patient receive appropriate and adequate health care, consistent with community standards, during his incarceration in the Federal Bureau of Prisons? If no, explain

Yes

No

NA

State any strengths and weaknesses that existed:

- 1. The Mortality Review Committee reviewed the Medical Record. The patient received timely and appropriate medical and psychological care.

27. Recommendation(s) if any.

The Mortality Review Committee reviewed the Medical Record. No recommendations at this time.

28. Attachments:

___ 1. Medical Record

___ 2. Narrative Summary

___ 5. Other Documents as appropriate (list) _____

___ 3. Death Certificate

___ 4. Autopsy Report

ALL INFORMATION CONTAINED IN THIS REPORT IS EXEMPT AND TO BE CONSIDERED FOR REVIEW/VIEWING ON A NEED TO KNOW BASIS ONLY.

REVIEW COMMITTEE:



A-W, (M)

, HSA

D of N



(CD)

, QAC

, PA

OFFICE OF THE REGIONAL DIRECTOR

Comments:

— Agree with Institution MRC

— Disagree with Inst. MRC

Recommendations or Action taken:

Regional HSA

Date

Regional Director

Date

OFFICE OF QUALITY MANAGEMENT

Comments:

Signature of Review Committee Member