U.S. Department of Justice

Federal Bureau of Prisons

Washington, D.C. 20534

MEMORANDUM FOR [redacted], REGIONAL DIRECTOR
NORTHEAST REGION

FROM: [redacted], M.D.
Medical Director

SUBJECT: Multi-Level Mortality Chart Review
Consultant's Comments

The Office of Quality Management, Health Services Division, conducts reviews of all inmate deaths through the multi-level mortality review process as part of the Bureau of Prisons' quality improvement function. Following this review, a consultant, [redacted], M.D., provides her independent analysis of the medical records of the inmates who have died during the year. She conducted a review on September 19, 2019.

Five mortality cases were reviewed from your region. Four cases demonstrated appropriate care. One case from your region had quality of care or risk management issues identified. This case from your region will require a corrective action response.

- EPSTEIN, Jeffrey, #76318-054 died on 8/10/2019 at MCC New York.
  - Quality of care or risk management issues at MCC New York.

Please see the attachment for further information. If you have any questions or concerns, please do not hesitate to contact me or have your staff contact [redacted], Chief, Office of Quality Management, Health Services Division, at (202)514-2136.

Attachments

cc: [redacted], D.O., RMD, NER
[redacted], RIQ/RIP&C, NER
[redacted], RHSA, NER

External Reviews Review Date: 9/19/2019

Northeast Region Regional Director: [redacted]

Devens FMC

FLUKER **Roy** **40533-424** **Male** **Age** 64 **DOD** **6/18/2019**
No Findings **Expected Death?** Yes **Manner** Natural Causes
Death Category Cardiac
Death Cause Congestive heart failure

PHILLIPS **Charles** **02952-000** **Male** **Age** 68 **DOD** **5/13/2019**
No Findings **Expected Death?** Yes **Manner** Natural Causes
Death Category Cardiac
Death Cause Heart failure

Elkton FCI

GARLING **Lee** **41184-039** **Male** **Age** 78 **DOD** **5/6/2019**
No Findings **Expected Death?** Yes **Manner** Natural Causes
Death Category Pulmonary
Death Cause Pneumonia, unspecified

Loretto FCI

HORNBAKER **Anthony** **38954-068** **Male** **Age** 60 **DOD** **6/28/2019**
No Findings **Expected Death?** No **Manner** Natural Causes
Death Category Cardiac
Death Cause Atherosclerotic cardiovascular disease, so described

New York MCC

EPSTEIN **Jeffrey** **76318-054** **Male** **Age** 66 **DOD** **8/10/2019**
No Findings **Expected Death?** No **Manner** Suicide
Death Category Hanging
Death Cause Intentional self-harm (suicide) by hanging, strangulation, and suffocation

Mr. Epstein was a 66-year-old male with a history of obstructive sleep apnea, hypertriglyceridemia, L4-L5 stenosis, and no past mental health history. On 7/23/2019, at 2:00 am, Mr. Epstein was placed on suicide watch for 31 hours and 5 minutes due to abrasion found on the lower anterior surface of his neck area. On 7/24/2019, he was taken off suicide watch and was placed on psychological observation. On 7/30/2019, he was removed from psychological observation and placed in the Special Housing Unit where he was housed with a cell mate. On 8/8/2019, he was seen by Psychology Services and denied any suicidal ideation, intention or plan. On 8/10/2019, at 6:33 a.m., Special Housing Unit staff found Mr. Epstein unresponsive in his cell and attempted to wake him. A medical emergency was called and CPR was initiated by Special Housing Unit staff. At 6:35 a.m., medical staff responded and continued CPR, the AED was applied, and EMS was called. The EMS arrived at 6:45 a.m. and ACLS protocol was initiated by the EMS. No pulse found, no shock was advised and the inmate was prepared for transport to local hospital. He was pronounced dead at 7:36 am by the ER Physician.

Consultant Comments: There were quality of care issues identified in this case. However, these issues did not contribute to directly Mr. Epstein's cause of death.

Review roles and responsibilities of staff responsible for inspecting, testing and maintenance of AED units at each location at your institution. This is considered life support equipment requiring implementation of a process that assures that the AED is available and accessible to all staff in the event of a life threatening emergency.
In addition, the Health Service staff should be added to the group/committee convene to conduct the Psychological Reconstruction review for suicide. Adding the Health Services staff not only provides clarification of medical response but more importantly strengthen the review to identify risk management issues and corrective actions.

Recommendations: The Health Services leadership needs to develop a protocol and put procedure in place for monitoring AEDs throughout the institution. The QI Staff should monitor this in the quarterly Governing Body meeting. The institution, Regional and Central Office leadership will look into adding an appropriate Health Service staff member to all Psychology Suicide Reconstruction cases. The Clinical Director, HSA and the Quality Improvement staff need to develop a corrective action plan and provide necessary training to all staff involved to disseminate these expectations. Please submit the corrective action plan along with training sign-in sheet 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.