From: Holmes-Cain, Jane [mailto:Jane.Holmes-Cain@eog.myflorida.com]
Sent: Tuesday, September 22, 2015 10:45 AM
To: Jones, Julie
Cc: Arias, Stacy; Reimers, Thomas; Ogunsanwo, Olugbenga; Cunningham, Katie; Courtney, JM
Subject: Florida Women's Reception Center

Secretary Jones,

On September 15-17, 2015, Correctional Medical Authority (CMA) staff and licensed professional surveyors, conducted a survey of the physical and mental health care services provided at Florida Women's Reception Center (FWRC). A thorough review of FWRC's healthcare delivery system, which encompassed chart reviews and interviews with staff and inmates, revealed several deficiencies related to delays in treatment and inmate care. In accordance with s. 945.6031 (3), F.S., these findings are considered to be very serious, and require emergency notification and the Department's immediate attention.

> "Deficiencies found by the authority to be life-threatening or otherwise serious shall be immediately reported to the Secretary of Corrections. The Department of Corrections shall take immediate action to correct life-threatening or otherwise serious deficiencies identified by the authority and within 3 calendar days file a written corrective action plan with the authority indicating the actions that will be taken to address the deficiencies."

The identified delays in treatment affected multiple areas of inmate physical and mental health care. The areas include medication administration; follow-up care from on-site providers; delays in outside consultations; and clinical reviews, which include timely follow-up of abnormal labs and diagnostic services.

Some examples of delays in care include:

> Inmate 1 - This diabetic inmate reported to CMA staff that she was without insulin for 2-3 months. The record indicated the clinician ordered insulin on 6/27/15. However, a review of the medical record and discussions with institutional personnel confirmed that the inmate never received the medication. This record was brought to institutional staff who indicated she would be seen the next day.
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> Inmate 2 – In June 2015, an inmate complained of a golf ball sized lump behind her ear. An X-ray completed on 7/1/15 recommended follow-up with an MRI. The MRI was requested on 7/20/15, but was denied by Utilization Management. An alternative treatment plan was provided, which suggested evaluation by a general surgeon. There was no evidence that a surgical consultation was requested or completed.

Inmate 3 – An inmate with a history of cervical and ovarian cancers had an abnormal cervical cancer screen in May 2015. Although there was concern for a reoccurrence of malignancy, she did not undergo additional diagnostic testing until August 2015. Additionally, the inmate had been complaining of neurological symptoms consistent with metastatic disease. She submitted several sick call and inmate requests, and was seen in the emergency clinic. The inmate notified medical staff that she had been evaluated in the community, prior to her incarceration, and was found to have lesions in her brain. Medical records were not requested until July 2015, and referral to an oncologist did not take place until September 2015.

Inmate 4 – An inmate diagnosed with a psychotic and mood disorder was prescribed multiple mental health medications. There was no evidence that these medications were administered for the months of June, July, and August. Without this documentation, it is unknown if the inmate received or was even offered her medications during this time frame. Additionally, there was a delay in psychiatric follow-up contact.

Of additional concern, was the notable disorganization of medical records. Multiple portions, and in some cases, whole records could not be located. Other records were thinned, but were not in compliance with Department policies and procedures. This made it difficult and, in some cases, impossible to follow the course of treatment or to verify that treatment was provided. Poor record keeping and incomplete medical records can lead to medical errors, disrupt continuity of care, and cause further delays in treatment.

Reviews of Office of Health Services (OHS) monitoring reports indicate that these issues have been ongoing and have not been addressed successfully, which infers that there are larger systemic issues. Due to the scope and severity of these identified delays in treatment, as well as the lack of organizational structures apparent at the institution and outlined in this notification, CMA staff does not believe these issues can be properly addressed with the standard corrective action process (CAP) as outlined in s. 945.6031 (3), (4) F.S. The report detailing all findings at this institution will be published in the next several weeks.

Respectfully,

Jane Holmes-Cain LCSW
Executive Director
Correctional Medical Authority
850-717-9286