

**REPORT PREPARED FOR THE
NATIONAL PRISON PROJECT OF THE ACLU:
Review of Medical Records from Ely State Prison
Dr. William Noel**

INTRODUCTION

At the request of the National Prison Project of the American Civil Liberties, I reviewed the medical records of thirty-five prisoners from Ely State Prison (ESP) in Ely, Nevada. One of these men died in custody at Ely in April 2006; the other thirty-four are currently incarcerated there. It is my understanding that the Nevada Department of Corrections (NDOC) represents that the records I reviewed are the complete working file and archived medical file for each prisoner.

On October 8-9, 2007, at the request of the Nevada Department of Corrections, I traveled to the prison to discuss my findings with the Department's Medical Director, Dr. Robert Bannister. During my visit I was able to speak with some of the men whose cases I identified in the record as especially urgent. These visits were unfortunately not confidential. NDOC denied my request to interview the patients privately and my patient visits were done in the presence of Dr. Bannister and several other ESP staff. At the prison I was also able to review the most current medical records for the men I spoke with during my visit. These files were generally a month behind in progress notes and medication sheets. During my visit I discussed my findings with Dr. Bannister, in particular those concerning the most urgent cases I had reviewed.

My credentials and qualifications to review these files are as follows: I am a Doctor of Osteopathic medicine with thirty five years clinical experience. I received my D.O. degree in 1972 from the University of Health Sciences College of Osteopathic Medicine and Surgery in Des Moines, Iowa. I am board certified in Family Practice by the American Osteopathic Board of Family Practice (ABOFP) and I maintain my medical license in the State of Nevada (#377). The vast majority of my practice has been in Primary Care and Emergency medicine in rural areas. I practiced in Ely, Nevada, the community where ESP is located, from 1991 to 1994. Thus, in reviewing these files, I was applying the community standard of care in the community where the prison is located. Since my retirement from active practice in 1996, I have accumulated at least 50 hours every year of class 1-A and 2-A Continuing Medical Education hours and maintain my Board Certification with ABOFP. State and Federal Courts in Colorado, Nevada and Idaho have qualified me to testify as an expert witness

FINDINGS

Based on my review of the medical records and my interviews at Ely State Prison, it is my opinion that the medical care provided at Ely State Prison amounts to the grossest possible medical malpractice, and the most shocking and callous disregard for human life and human

suffering, that I have ever encountered in the medical profession in my thirty-five years of practice.

I believe it is highly unlikely that these thirty-five cases are aberrations. These cases show a system that is so broken and dysfunctional that, in my opinion, every one of the prisoners at Ely State Prison who has serious medical needs, or who may develop serious medical needs, is at enormous risk.

I realize that many of the prisoners at Ely State Prison have committed horrible crimes. Indeed, several of them are on death row. But as a doctor I took an oath that all physicians are sworn to follow in the practice of medicine, "*I will make no judgments as to character or morality, but I will treat the disease.*" I honor that oath and so must every doctor in this country.

I have provided below a detailed summary of my findings with respect to the individual cases I reviewed.

I. Grossly Callous Denial of Basic Medical Care Resulting in Agonizing Pain, Injury and High Risk of Premature Death

Patrick Cavanaugh, was an insulin dependent diabetic, who lived in the Ely State Prison infirmary for at least two years before his agonizing death on April 10, 2006. Immediately after his death he was transported to a funeral home. There is no record of an autopsy or a mortality review in his file.

The cause of death was complications of Diabetes Mellitus, peripheral gangrene of both lower extremities, hypertension, and congestive heart failure – all untreated. In the best of circumstances (hospitalization, quick antibiotics, and early detection) gangrene has a 30% mortality rate, but untreated, it is essentially 100% fatal. Mr. Cavanaugh received almost no treatment for his illnesses, so his slow, painful death in the ESP infirmary was virtually assured. Given the profound and unmistakable smell of putrefying flesh, there can be no question that every medical provider and correctional officer in that infirmary was acutely aware of Patrick Cavanaugh's condition.

Although Mr. Cavanaugh was an insulin-dependent diabetic, there is an order in his chart stopping all his medications, including his insulin on August 28, 2003. There is no indication as to why this was done. The order is unsigned. Insulin was ordered sporadically thereafter but was never given – for 3 years! During this entire period Mr. Cavanaugh's blood sugars were dangerously high, running from 300 to 400. In fact, he developed leg ulcers due to diabetes as early as 2001, indicating that his disease was quite severe and negligently managed for years.

There is no indication anywhere in the record I reviewed that a single consideration was ever given to surgically removing the gangrenous limbs. Yet, this procedure could have saved Mr. Cavanaugh's life. Instead, ESP medical staff literally left him to rot to death.

The records suggest that Mr. Cavanaugh “would not let” people come into his cell. And that he started refusing all medications except for aspirin. Progress notes in his chart detail increasing paranoia and probable dementia. Moreover, gangrene is known to derange the mind. Given Mr. Cavanaugh’s demented state, an order was obtained to use force if necessary to move Mr. Cavanaugh from cell to cell once a week so that excrement, trash, food and other filth could be cleaned up. In contrast, there is no order to force life-sustaining medications. Although a typed “chronological for forced med panel” is present in the chart, there is no response from the panel and no evidence that such an order was ever sought. On April 19, 2002 his medications were being crushed and put in his food for a brief period of time. Why this practice was discontinued is unclear.

Curiously, although a signed and notarized full, non-limited Power of Attorney Authorization giving power to Elizabeth Ann Dougherty is present in his chart, there is no indication that Mr. Cavanaugh’s guardian was ever contacted regarding his medical care and the need to treat his various grave medical conditions, despite his dementia. Apparently prison officials decided not to force life-sustaining medications on Mr. Cavanaugh, even though he clearly was not able to make medical decisions himself, and they did so without consulting his legal guardian. This decision amounted to a death sentence for Patrick Cavanaugh, and one of prolonged agony and unnecessary suffering.

Even during his last days before death, where an order is given for 5 mgs. of morphine sulfate every 4 to 5 hours to alleviate his terrible pain and suffering, there is no evidence that this palliative order was ever carried out. Instead, it was ignored. And Patrick Cavanaugh was left to suffer.

In sharp contrast to the other 34 records I reviewed, this chart is neatly written and organized. But much of the chart is missing. There is essentially little to no record of the 1980's or 1990's, even though Mr. Cavanaugh entered the Nevada Department of Corrections in January of 1985. Moreover, the nurse’s notes have large temporal gaps that are impossible to explain in the normal course of nurse note taking. For example, the notes go from August 7, 2003 to December 25, 2002 with nothing written in between. And notes on the same sheet go from December 11, 2002 to August 7, 2001, then back to August 6, 1996. Such notes simply do not make any sense. The Physician Progress Notes are also very sparse, starting on March 2, 2002 and ending on the date of death. And the medication sheets only start at February 24, 2002 and end at date of death. There are also no laboratory reports in the entire chart. This is very difficult to explain for a man with Mr. Cavanaugh’s dangerous health problems. In fact, the entirety of care reflected in these records makes little medical sense. The “medical” care given to Patrick Cavanaugh at ESP amounts to the grossest possible medical malpractice I have ever encountered and deliberate acts of unconscionable cruelty.

The provider progress notes prefer to label the nature of Mr. Cavanaugh’s illness as “cellulitis” but it is clear that he suffered from severe, untreated gangrene. Calling Mr. Cavanaugh’s disease “cellulitis” is akin to calling “9/11” a “high rise fire.” By stopping his medications, it was perfectly clear to all concerned - except Patrick Cavanaugh – that he would die, and die a most

miserable death. In my 35 years in the medical profession I have never heard of such behavior on the part of medical providers. It is almost too horrible to believe.

Mr. A¹ is an insulin dependent diabetic. Incredibly, like Mr. Cavanaugh, his insulin was stopped for no reason, and apparently without a physician's order. As a result of this egregious treatment, Mr. A went into a ketoacidotic coma on March 20, 2006 and was hospitalized in Ely until March 23, 2006. It is simply incredible that medical staff at ESP are cutting diabetics off life-sustaining insulin. Any person with medical training should know that this will lead to death.

Unlike Mr. Cavanaugh, Mr. A has been the recipient of forced medications in the past after he refused to take his psychiatric medications. He has been prescribed strong anti-psychotics. Over time his kites become less and less coherent and this may be the result of the drugs he was forced to take.

Mr. A's medical records during the period 2003-2006 are very sparse. After he goes into a coma as a result of having his insulin discontinued, the records become fairly complete, but prior to that time they are strangely inadequate.

Mr. B has severe seizure disorder and must wear a helmet to prevent head injury from seizures. This helmet has actually broken during the violence of his seizures. After his helmet breaks, it frequently takes ESP staff months and months before getting him a new one, regardless of repeated pleas by Mr. B and the dire nature of his attacks.

Despite the severity of his disorder, there is a standing order in his chart to wait until a seizure lasts 30 minutes before giving him 10 mgs. of valium. There is no medically justifiable reason for waiting 30 minutes while this man seizes. Such a practice can lead to irreversible damage to Mr. B or death. When Mr. B has a seizure, medical staff should give him valium at once and it should be intravenously.

Shockingly, this man has tested positive for syphilis three times, but there is no evidence in the medical record that he was ever given a course of penicillin to cure this disease. There is no evidence of any antibiotic being given to Mr. B in all his years in prison. This lack of treatment exposes staff to the disease unnecessarily, especially given Mr. B's seizure disorder. At this time, Mr. B is also showing symptoms of final stage neurosyphilis – seizures, headaches, neck stiffness. This is a slow, progressive destructive infection of the brain that leads to dementia and possible psychotic symptoms such as hallucinations and paranoia.

Mr. B also has a ventral hernia that is untreated and causes him constant pain. Given the torment this man lives in, it is not surprising that he has made multiple suicide attempts.

¹ The names of prisoners who do not wish to have their identities made public have been changed for their protection. The actual first and last names of these prisoners are in no way related to the alphabetically ordered pseudonyms used in this report.

Follow-up with Mr. B: During my visit to ESP I also spoke with Mr. B. Mr. B presented as somewhat confused and fearful during our interview with him. I noted that tears were streaming down his face while I spoke with him. Of course, because I was not allowed to speak confidentially with patients and NDOC medical staff and guards were always present during my discussions with patients, it was difficult to eliminate patient fears of retaliation and intimidation. In Mr. B's case, it is clear that he needs mental health care that is not reflected in his records.

During our consultation, Mr. B indicated that he had been treated for syphilis in Montana years ago, although I found no evidence of this in his medical file. Given that he has subsequently tested positive for the disease on several occasions and that his antibody titers show fluctuations, he must either be given a course of treatment or ESP must do three months of antibody titers testing to ensure that he does not have active syphilis. Why he has not simply been given a course of penicillin to ensure that the disease is eliminated and not infecting his brain is an example of the grossest medical abuse.

During our meeting I questioned Mr. B regarding his seizures and his answers that he loses bowel and bladder control and can't accurately remember auras before his seizures indicate to me that it is very likely that his seizures are genuine. Dr. Bannister attempted to justify the practice of not treating Mr. B until 30 minutes after the commencement of a seizure by stating that there are questions regarding the authenticity of his seizures. The condition in question is enormously serious and life-threatening. If questions regarding his actual diagnosis exist, a neurologist should be consulted and testing should be done. Grossly negligent medical practices should not be ordered and condoned on the basis of some unconfirmed suspicions of malingering by low level medical staff. The bald-faced assumption that Mr. B is somehow staging his seizures is entirely insufficient to justify the failure to treat him appropriately for a condition that could kill him. Again and again at ESP I see that denial of treatment and a belief that patients are always faking their illnesses is the first and over-riding assumption of medical staff. But staff act on this assumption without any empirical proof and very rarely do anything to establish that their treatment assumptions are correct. This is not smart medicine. This is a deliberate unwillingness to do the job.

David Riker suffers from rheumatoid arthritis (RA), fibromyalgia, and chronic fatigue syndrome. Mr. Riker's conditions were all extensively documented by the California Department of Corrections, including successful treatment regimens. These records were sent to ESP and NDOC's Director of Medical Services by the Federal Defender – twice. Despite this, Mr. Riker does not receive any care for his multiple conditions. He has repeatedly been told that Ely medical does not give pain medications, even though he has well-documented diseases that cause debilitating and chronic pain. Moreover, when an RMF doctor did review his records and conditions in August of 2006 and finally prescribed some appropriate medications and ordered x-rays, her orders were not followed. Mr. Riker never received x-rays and the order for a dosage increase in his medication was not implemented at ESP. Instead, the new Physician's Assistant at ESP, Max Carter, took him off the medications ordered by the RMF doctor and told him that

he does not have rheumatoid arthritis, a condition previously treated and diagnosed by several Rheumatologists in California.

Mr. Riker's protopathic nerve pain is a living hell and must be treated. It is simply unimaginable that medical staff would tell a patient like Mr. Riker that they will not treat his chronic pain. Yet his medical records show that ESP medical staff have actually told him that treating chronic pain is against the policy of the prison. Such a policy or practice contradicts medical ethics and all community standards of care I know of in this country. It is certainly contrary to practice in the State of Nevada. I am unaware of any doctor or medical provider in this day and age who would follow such a practice with a chronic care patient like Mr. Riker.

In reviewing Mr. Riker's medical records I also noted:

- Mr. Riker undoubtedly has rheumatoid arthritis. A simple review of the Merck Manual demonstrates that he has 6 of 7 criteria for rheumatoid arthritis. And only 4 of the 7 are required for an RA diagnosis.
- He is not being adequately treated for his rheumatoid arthritis. For example, 5 mg prednisone a day is a stalwart and standard treatment for RA – in fact 10 mg a day is fine – but ESP took him off Prednisone due to “serious side effects.” Clearly the medical providers at ESP do not understand the treatment of RA. Prednisone is manageable although it has side effects that simply need to be monitored. But monitoring is not done at ESP.
- Mr. Riker must see a rheumatologist periodically but there is no record that he has ever seen one in Nevada.
- While incarcerated in California Mr. Riker received excellent care and his RA was caught early so he hasn't suffered much deformity yet. In contrast, the care in Nevada is sporadic and entirely inadequate.
- Mr. Riker suffers severe depression for which he is prescribed Escalith/Lithium. He needs to have quarterly lithium checks done but has not had one since 1997.
- He takes Plaquinel and needs to have thyroid checks, but none are given.
- He is prescribed Propanolol for migraines but the medication is frequently stopped for no reason. This medication is a beta blocker and if stopped abruptly can cause a heart attack.
- Mr. Riker is also prescribed Propanolol for his blood pressure, but his refills are frequently not sent on time so he is forced to go without his medications. You cannot stop this medication abruptly because it can cause a heart attack.
- Mr. Riker is also on methotrexate and does not get the regular cbc's he needs.
- Mr. Riker suffers from Gastric Hyperacidity (Riker self-reports that he takes about 20 Motrin a day that causes his stomach to burn up. Because Ely won't treat chronic pain, prisoners are told to get Motrin from the canteen). Motrin is useless for the type of pain Mr. Riker suffers and he should not be encouraged to take it as a substitute for genuine medical treatment of his condition.

Follow-up with David Riker: During my visit to ESP, Dr. Bannister and I discussed David Riker's case and we met with him briefly to discuss his condition. Mr. Riker indicated that the

Remicaide treatment he received in prison in California worked best for his condition. His last dose was in September of 2005 and since that time his condition has gradually worsened in elbows, hands, knees, and neck. His fingers were visibly swollen during our consult with him. In contrast to the Remicaide, he stated that the Plaquinel he receives at ESP does not seem to help his pain. He is now receiving Prednisone which is helping a little. And his prescription for Propanolol is not being interrupted as much as in the past. Although his care is somewhat improved from that reflected in the earlier records, he clearly still experiences unnecessary levels of pain.

After our meeting, Dr. Bannister stated that Mr. Riker “probably has rheumatoid arthritis.” At the same time he told the PA, Max Carter, who was also in the room, “not that it wasn’t a good idea for you to question the diagnosis.” Mr. Carter asserted that Mr. Riker had told him that he didn’t want Remicaide. I found this statement highly incredible given the numerous instances in the medical record in which Mr. Riker literally begs for Remicaide treatment and attempts to explain the efficacious care he received in California for RA.

ESP has offered no good reason not to treat Mr. Riker’s RA with Remicaide. There can be no justification for not trying to alleviate his painful suffering and retard the progress of a terrible disease.

John Snow has severe degenerative hip disease and requires surgery. An orthopedist recommended hip surgery for Mr. Snow years ago but this procedure was denied as “not life-threatening.” If he is not given surgery, Mr. Snow’s bones will eventually wear through his acetabulae, which are the large sockets at the base of the hip bones into which the head of the femur fits. In fact, those bones could wear clear through to the pelvis, but it is hard to imagine anyone enduring such agonizing pain that long. Because of Mr. Snow’s condition, he is in constant, excruciating pain but he is given NO pain medications. There is no medically justifiable reason for leaving this man to suffer in agony.

Instead of properly treating this man’s pain, he is only given Indocin for inflammation and steroids. But Mr. Snow’s kidneys are failing and prescribing him Indocin is making them fail faster. This medicine should not be prescribed to Mr. Snow given his kidney issues. In fact, based on my experience, Indocin is almost never used on humans anymore because of its harsh side effects. This medication is mostly used to treat animals, such as race horses.

Mr. Snow also tested positive for *heliobacter pylori* in 1998, but has never been treated. As a result, he suffers chronic stomach acid problems and is likely infectious to other prisoners and staff.

Follow-up with John Snow: Dr. Bannister described Mr. Snow as a good patient. He has taken him off the Indocin as I suggested and is now starting a pain regimen for him. I noted in Mr. Snow’s new records that shortly after the ACLU copied his file, he was started on pain medications beginning August 16, 2007. And Dr. Bannister put him on a nightly narcotic to control the pain of his osteoarthritis. This is a start, but Mr. Snow still needs to be given pain

medications to ease his pain throughout the day. There is no reason to make this man suffer any hour of the day. And without constant pain management, Mr. Snow experiences excruciating pain throughout the day.

Mr. Snow has no cartilage in his hips, so walking causes his bones to scrape and grate back and forth on each other. Because any movement causes great pain, there was concern that requesting a visit with Mr. Snow would force him to endure agonizing pain just to see me. The ACLU therefore asked Howard Skolnik, Director of the Nevada Department of Corrections, to allow Mr. Snow to be escorted in a wheelchair to our meeting rather than forcing him to walk in chains. This request was denied. Clearly prisons have security issues, but the fact that in this case and others, prison officials make absolutely no accommodations for severely disabled prisoners is unacceptable medical practice and no doubt unlawful.

The only way to stop Mr. Snow from suffering on a permanent basis is to give him hip replacement surgery. Dr. Bannister is apparently considering surgery but wants to exhaust pain management through medications first. It is clear, however, that Dr. Bannister is reluctant to agree to surgery - despite the recommendations of an orthopedic surgeon. He mentioned Mr. Snow's age and "lifestyle" as barrier to hip replacement surgery. But Mr. Snow is only 65 years old. And the fact that he is a prisoner should not preclude him from surgery or effective follow-up treatment. Without surgery he will eventually be unable to move at all.

Mr. Snow's medical records also revealed that he was being treated for gout with Allopurinol but this medication was stopped and he is no longer receiving treatment - even though his uric acid is 8.7. This needs to be addressed immediately.

Keven Lisle has deep vein thrombosis in both legs; status post myocardial infarction, angina pectoris, hypertension, anxiety disorder and depression. Many of these conditions are potentially life threatening. Yet the records I reviewed indicated that no testing was completed on Mr. Lisle, the documentation by medical staff was extremely poor at best, and he is receiving no appropriate treatment for his multiple health problems – except for aspirin. In addition:

- Mr. Lisle is on clonidine for his blood pressure and the pharmacy keeps running out of it, so they stop his medications abruptly for several days until the pharmacy can get some more. If you stop this medication abruptly your blood pressure skyrockets and a stroke or myocardial infarction can result. Therefore, Mr. Lisle's life is being placed at great risk with the improper administration of this medication.
- Vital signs rarely noted in his records.
- Pain levels never noted despite the fact that pain level is now considered the 5th standard vital sign of patients; for example, the records at Ely clinics list pain levels. Those at ESP never do.
- Lisle's kites consistently complain about pain but the responses to those kites always ignore that complaint. Deep vein thrombosis is extremely painful.
- The responses to Mr. Lisle's kites are frequently unprofessional, for example, the medical provider will respond to his health concerns by saying "what's your point?"

- This patient should be on the blood thinner Coumadin and monitored constantly with blood tests to determine his clotting parameters, if not he will probably develop more clotting difficulties and be at great risk of death.
- Mr. Lisle's records show no annual exams.
- No Hepatitis C screening is evident in the record despite the patient's elevated liver enzymes.
- Mr. Lisle had a fungal infection that was never addressed. He was consistently prescribed the same ineffective cream to treat the fungus and it spread over his entire body as a result.

It is frankly amazing that this man is still alive. These records reveal that medical staff are documenting Mr. Lisle's DVT and heart attacks, but they are not treating these conditions. In fact, the treatment Mr. Lisle receives from ESP medical is often worse than no treatment at all.

Follow-up with Kevin Lisle: After reviewing Mr. Lisle's records I urged NDOC to improve his care immediately. As I advised, Dr. Bannister had Mr. Lisle taken off Clonidine and placed on Coumadin. During my visit to ESP I met with Mr. Lisle and he confirmed that he is now taking Coumadin. He also indicated that he has urinated blood recently and this should be checked immediately. Patients on Coumadin need regular INR testing to monitor the thinness of the blood. If left unmonitored, the medication can lead to serious health problems. Initially the monitoring should be done every week until the medication is stabilized and thereafter it can be done monthly and then every three months. However, no such testing is evident in Mr. Lisle's current records. The blood in his urine may be a result of the Coumadin dosage, indicating that the dosage is too high and should be changed. However, it might also be a kidney stone or a cancerous polyp in his bladder as well. He should be sent to a urologist to find out.

Dr. Bannister indicated that Mr. Lisle is a difficult patient who has "cheeked" his medications in the past - meaning that he pretended to take his medications but did not. For this reason, Dr. Bannister apparently doesn't believe there is any way to tell if Mr. Lisle has genuine pain. As a result, Mr. Lisle's pain is not treated at all. I find this an astounding way to practice medicine. It is clear that the medical care given to Mr. Lisle by ESP has been grossly inadequate. In fact, it has almost killed him. During my interview with Mr. Lisle he stated that he stopped taking some of his medications when he noticed they were making him sicker, but the medical staff just ignored this fact and refused to change his medications or indeed listen to him at all. Under the circumstances, Mr. Lisle's decision not to take his medications was not an unreasonable response, and it certainly should not be used as an excuse to deny him necessary treatment now. It also must be noted that Mr. Lisle's conditions, such as deep vein thrombosis, are known to cause extreme pain. I therefore find it astonishing that Dr. Bannister would assert that it is impossible to know if Mr. Lisle's pain is real. There is simply no medical excuse for not trying to alleviate Mr. Lisle's suffering.

Mr. C suffers from HIV, diabetes mellitus, hypertension, two spinal injuries and a botched back surgery resulting in chronic, debilitating pain, and kidney disease. In addition, even though a RMF doctor ordered a consultation with a nephrologist due to the alarmingly high protein in his urine, that consultation never occurred and he was sent back to ESP without care.

Mr. C's records also indicate:

- He is an insulin-dependent diabetic but shockingly he's been given no regular sugar checks since 2003. He should be given daily sugar tests; the fact that he is not is an example of gross malpractice.
- The fact that Mr. C hasn't had an incident with his blood sugar even though he's not being tested regularly likely means that he's being very under-treated for the diabetes.
- Mr. C only receives his HIV medications sporadically which potentially undermines their efficacy in treating the virus and puts him at great risk for resistance to entire classes of HIV medications, thereby dangerously limiting treatment options.
- Mr. C should have his high blood pressure tightly controlled, but his prescriptions are rarely refilled in a timely manner and he consistently runs out of his medications despite his vigilant efforts to obtain refills without a lapse.
- This patient suffers severe and chronic pain with no treatment.
- Mr. C finally saw a nephrologist on 6/1/07, and that doctor requested that he be taken off all ibuprofen-type medications because they are destroying his kidneys. The ibuprofen-type medications are being prescribed to Mr. C for pain instead of medications that could actually treat his extreme pain.
- A lab report from June 15, 2007 shows a large quantity of protein in urine (indicated severe kidney disease).
- Mr. C's triglycerides are dangerously high. He should be on Lopid to help control this problem. His chart reveals that he was on the medication for short periods of time in 2006 but then the medication was discontinued for no apparent reason.
- When Mr. C was put on insulin on 4/2/03, he was left on metformin (oral agent to lower blood sugar) even though the metformin can cause ketoacidosis in insulin dependent diabetics.
- Like most ESP medical records, Mr. C's chart is frequently illegible. And vital signs are rarely taken or recorded.
- His medical records are missing an unusual event file even though the other charts I reviewed all have them. This seems strange given his multiple, severe health issues.

Given the grossly inadequate medical treatment revealed in Mr. C's records, I find it astonishing that he is still alive.

Follow-up with Mr. C: I met with Mr. C during my tour of ESP. He indicated that his medications have been refilled on time recently but he still experiences medication stoppages whenever he is transferred to Carson City for specialty care. He has also been taken off all ibuprofen-type medications as directed by the nephrologist.

When I met Mr. C, a large goiter on his neck was immediately noticeable and it was clearly tender to the touch. The patient indicated that swallowing is often difficult, his neck is often very painful, and he experiences throbbing pain during the night. In response to my questioning why nothing is being done about this alarming goiter, Dr. Bannister asserted that Mr. C's thyroid recently tested normal in May 2007. But regardless of one test from five months ago, the state of

this large, tender goiter on Mr. C's neck indicates that he must have a thyroid scan immediately. This man's health is simply too fragile to delay care in the face of such a visible problem.

Mr. C stated that he experiences chronic back pain due to his botched back surgery and numbness in his left foot. His feet and ankles have also been swollen since about January 2007 due to diabetic neuropathy. The pain caused by these conditions remains largely untreated for no apparent reason. And the one effort to treat Mr. C's pain in the new medical records I reviewed indicate that he was prescribed a Medrol dose pack in June of 2007. These are steroids and very bad for diabetics like Mr. C. While treating pain and diabetic neuropathy is medically indicated for Mr. C, medical staff at ESP should not be prescribing medications that are contraindicated for his other serious medical conditions.

During our meeting, Mr. C indicated that his blood pressure has recently improved because he is now prescribed Atenolol three times a day and his medications have recently been delivered on time and without lapses. When I checked his recent medical records, I noted that the patient is receiving Atenolol and Clonidine for blood pressure. This combination, if prescribed consistently and not allowed to run out as in the past, does seem to be working. It should be noted, however, that Clonidine is an alpha blocker and patients should never be taken off such a drug without graduated removal. Therefore, any sudden medication stoppages would be extremely dangerous for Mr. C. Given the history of unfilled refills and medication delays at ESP, there is cause to worry that Mr. C's Clonidine might be discontinued suddenly with potentially disastrous results.

When I reviewed Mr. C's medication records on October 9, 2007, I also noted that like many of the recent records I reviewed that day, his medication records were a month behind. In Mr. C's case, the last medication record noted in his file was on September 10, 2007. This constitutes unacceptable and dangerously negligent charting practice.

Michael Mulder had a stroke in prison in 2001. He suffers paralysis of his right side and has difficulty talking. Based on the medical records I reviewed, it appears that he had a stroke on March 15, 2001 but he wasn't transferred to the infirmary in ESP until March 31, 2001. And the next note in his chart on April 2, 2001 states simply "transfer to RMF (regional medical facility) ASAP!" Based on the records, it appears that this man received no acute treatment for his stroke at all. This is not the correct way to treat strokes. If medical providers at ESP had treated his stroke adequately, he would not suffer the paralysis he does today.

Follow-up with Michael Mulder: Dr. Bannister also reviewed Mr. Mulder's case with me. He told me that Mr. Mulder had actually been sent immediately to UMC for care. I do not know how the actual medical charts could support that assertion. But after meeting Mr. Mulder in person, I am even more concerned about his current care.

Mr. Mulder was severely disabled by his stroke and he has been given absolutely no physical therapy to repair that damage. His right side is extremely impaired and he has difficulty walking and talking. His right arm, hand and fingers are also hideously contorted in an

agonizing position that will only grow worse without treatment. The medical term for this disabling process is contracture. Without intervention Mr. Mulder's arm will contract until it rips itself from its own socket and his hand will bend in upon itself until the wrist breaks. It is unconscionable that this man has not even been given a simple brace to prevent the terrible contracture that has already occurred on his right side. A nurse tried to excuse this gross malpractice during my consult with the patient, but Mr. Mulder tried desperately to tell me with the greatest possible difficulty and frustration of speech that in the past the medical staff had ordered a brace that would not fit over his gnarled hand so that he could not use it. Dr. Bannister then asserted a vague security justification for not treating this man's disability, but given that the security justification does not seem to apply to braces ordered out of incompetence and indifference to the actual needs of the patient, his assertion seems a hollow excuse.

During my visit with Mr. Mulder he also told me that he is unable to shower because he cannot manage the step into the shower stalls and he has fallen unassisted several times. This problem was affirmed by staff and Dr. Bannister asserted that a ramp could be provided to compensate for Mr. Mulder's disability. I hope that Dr. Bannister has followed through on this suggestion. I am frankly shocked that no provisions seem to be made for disabled inmates at ESP. And it is extremely unlikely that of the 1000+ men at ESP, Mr. Mulder is the only one that requires special accommodation. Mr. Mulder must also be immediately provided with an appropriate brace to prevent further contracture in his right arm and hand, and he should be given therapy to undo some of the damage that has been done through ESP's medical malpractice.

Robert Ybarra suffers from deep vein thrombosis (DVT) and chronic, non-healing venous stasis ulcers on both lower legs and ankles. Prior to December 2006, Mr. Ybarra was placed in leg irons that cut into his flesh creating wounds that do not heal. Yet he receives no pain medications even though he is forced to live with open wounds.

I also noted the following in Mr. Ybarra's records:

- Because of his DVT, Mr. Ybarra should be treated with Coumadin, but he receives no treatment at all. This puts his life at great risk of pulmonary embolism.
- Mr. Ybarra's chronic leg ulcers could be cured in three weeks in a hyperbaric chamber, yet he's suffered with them untreated for years. He lives with open, draining wounds and using hydrogen peroxide and dressings are a useless treatment for this problem. Without adequate treatment, Mr. Ybarra will lose his feet and legs.
- DVT is extremely painful and Ybarra clearly suffers severe and chronic pain that is not treated.
- Vital signs rarely recorded.
- Mr. Ybarra suffers severe migraines without treatment.
- Mr. Ybarra is severely hypothyroid because his thyroid gland was destroyed for hyperthyroidism on 5/2/83.

- He was previously prescribed Seroquel for his manic depression and he responded to this treatment. But this drug was stopped and replaced with Trazidone. He hasn't done well since this change. Basically he was given a junk drug to replace a more expensive drug – this appears common at Ely State Prison.

Follow-up with Robert Ybarra: During my visit at ESP I had hoped to meet with Mr. Ybarra as he is clearly an urgent case. He had just been sent to Carson City, however, for a consultation with a Vascular Surgeon. Dr. Bannister discussed the possibility of skin grafts to deal with Mr. Ybarra's chronic ulcerations, but I still recommend treatment in a hyperbaric chamber as a first step. Skin grafts are generally the treatment of last resort. I must note that I was pleased to see that Mr. Ybarra is finally being seen by an appropriate doctor after years and years of needless suffering. But sadly, that does not mean that the problem is solved. In my review of ESP medical records I repeatedly saw specialists recommending that prisoners receive an urgent procedure or treatment that ESP never followed through with or that was later denied for some unexplained reason. In Mr. Ybarra's case there can be no legitimate medical reason for not treating his condition.

II. Grossly Inappropriate and Inadequate Medical Care

Mr. G is 45 years old and he suffers from an enlarged prostate and difficulty urinating. He is on medications to shrink the size of his prostate, but he must be given a urology consult to ensure that he does not have prostate cancer. Without an ultrasound and biopsy it is impossible to know if his condition is benign.

Mr. G is prescribed Flomax, but obtaining refills for the medication is a constant problem so that he is on a dangerous medical yo-yo.

His medical charts also reveal ear problems that are ignored by medical staff. Their stock response to these problems is that his conditions is not "urgent."

His charts also reveal that he has severe skin rashes that are totally refractive to treatment. And the severity of his untreated rashes appears to be driving him crazy. But providers will not refer him to a dermatologist. He needs a dermatological consult and a biopsy. Overall, Mr. G's medical issues seem to be largely ignored by the medical staff at ESP.

Follow-up with Mr. G: Although I requested to meet with Mr. G, he was not at ESP during my visit. I discussed his case with Dr. Bannister, however, and he told me that Mr. G had tested with a PSA of 0.2 and that a digital exam found that his prostate was moderately enlarged. Given that an enlarged prostate of and by itself is not necessarily a sign of cancer, Dr. Bannister thinks it unlikely that Mr. G has prostate cancer. This PSA test was not in the records I reviewed for Mr. G, but regardless of that, the PSA can be an ineffectual measure and does not preclude the need for further testing to ensure that Mr. G does not have a deadly cancer.

Dr. Bannister also speculated that Mr. G may have urinary problems related to medications, but there is no proof in Mr. G's record lending credence to that theory without further follow-up. This patient still requires a urology consult and this should be done immediately.

Rickey Sechrest has chronic intermittent Herpetic Iritis of his right eye which is not treated promptly. When not treated promptly this disease leads to scarring and blindness. Given the care at ESP, Mr. Sechrest is at great risk of going blind.

Syphilis testing was also recommended for this man but never done. Mr. Sechrest is also extremely hypothyroid but he receives no treatment. And he has chronic lower leg swelling which is untreated as well. Moreover, he experiences chronic urinary tract infections.

Despite long-standing elevated liver enzymes no testing was ever done until 2005 when he was finally diagnosed with Hepatitis C. But he has never been treated for Hepatitis C. Moreover, he is frequently placed on steroids, which is contraindicated for patients with Hepatitis C. There is no indication in his medical records that he has ever been evaluated under a treatment protocol to determine whether or not he is a good candidate for Hepatitis C treatment.

Mr. Sechrest's file has no record of his age, the progress notes are extremely scanty, and there is almost no mental health record. His chart seems extremely incomplete for a man with considerable health problems.

Follow-up with Rickey Sechrest: During my visit with Dr. Bannister he informed me that Mr. Sechrest does not have iritis in his eye at this time. He agreed, however, that if the iritis is Herpetic, Mr. Sechrest needs antibiotics. Because Mr. Sechrest did not come to the patient consultation during my visit, I was unable to do a consultation with him or examine his eye. Dr. Bannister must follow-up with this patient and ensure that he is given all the antibiotics that he needs. Moreover, a full review of his health problems should be done and suitable treatment prescribed.

Miguel Castro is 52 years old and he has a dense cataract in his right eye, and a mild cataract in his left eye. Prison officials will only approve surgery if Mr. Castro pays for the procedure himself, although he faces certain disability without the surgery. Strangely, when he was given a physical exam on May 7, 2007, the record indicates that he has no disability even though he is already blind in his right eye.

Mr. Castro tested positive for *heliobacter pylori*, and was treated in 2001 but he was never retested to see if the bacteria were wiped out.

He also suffers from a degenerative joint disease in his neck and will need surgery shortly.

This record has large, unexplained gaps.

Mr. I is an insulin dependent diabetic but he is on beta blocker drugs for hypertension. Beta blockers make diabetes mellitus very hard to control and should never be prescribed to patients like Mr. I if other, less harmful drugs can be used. In this case, it is hard to believe that another, safer option is unavailable. He is also frequently given steroid injections, and these steroids make his diabetes mellitus very hard to control. The use of these contraindicated medications is contributing to the fact that Mr. I has very poorly controlled diabetes.

The lab reports in Mr. I's file are essentially unreadable.

Also, like many of the patient records I reviewed, Mr. I is on chronic stomach acid blockers but has never been tested for *heliobacter pylori* even though it is apparently an epidemic at ESP.

Antonio Doyle is very anemic with a low white count and he has sickle cell trait as well. The combination of these conditions places him at high risk of infection.

He was supposedly seen by a cardiologist for his hypertension, and by an Internist for his anemia and low white count. However, I could only find a single EKG from the Cardiology consult and no report at all from the Internal Medicine consult.

He has severe lactose intolerance and medical providers treated him very badly in 2002 for this problem.

Mr. Doyle also has a hernia and is treated with a truss even though trusses are ultimately damaging to this condition.

Mr. K is a diabetic and like Mr. I, ESP medical is treating him with steroids that make his diabetes hard to control. Mr. K also suffers from diabetic neuropathy which is extremely painful. But he is never given any pain medication. In 2001 Mr. K was put on Fluvastatin (cholesterol lowering drug) and Lopid (triglyceride lowering drug) at the same time. This can cause rhabdomyolysis (muscles dissolve and proteins plug up kidneys and destroy kidneys). All doctors should know that this drug combination is potentially very, very dangerous for a patient. Mr. K was on these drugs for almost a year, maybe longer, as the record is mostly illegible.

Follow-up with Mr. K: Mr. K is a highly motivated patient. Although his medical records did not reflect this, he has made significant health strides by exercising religiously and watching his diet. He says that he's lost 50 pounds in the last year. In fact, when I met him for his consultation, he had just come back from the exercise yard. Mr. K has not taken medication for his diabetes since January 2007 and his blood pressure medications were just discontinued. While he has obviously made strides in his health, the medical department needs to continue monitoring his sugars and blood pressure to make sure that he can maintain good health without medications.

His recent medical records also revealed an LDL cholesterol of 102 which is very concerning and must be monitored. Also, a blood sugar taken on February 1, 2007 was 105 (not fasting). This is 6 points over normal but much, much lower than a blood sugar taken on March 17, 2006 which was 316.

Mr. K indicated that he was given Elavil for his diabetic neuropathy and that this has helped his left foot. His right foot, however, is still painful. A prescription for Neurontin might benefit this problem immediately. Mr. K now takes Priolosec but his dosage was cut in half suddenly and his acid reflex problem has returned.

Mr. L has a right inguinal hernia and is wearing a truss. Having a patient wear a truss for a hernia is not good medical practice. It weakens the inguinal ring and musculature and will, over time, make the hernia worse. The proper treatment is surgery if the patient can tolerate it. There appears to be no reason why Mr. L could not have a hernia operation.

Mr. L's physical exams are marked "normal" even though he has a large hernia. He also has chronic back pain that seems to be merely treated with ibuprofen.

Although Mr. L is on Mellaril (an antipsychotic medicine), and his hallucinations and paranoia are constantly being referred to, he is listed as having no mental illness in his mental health records. This is even stranger because the psychiatrist is signing the medical charts. Such poor record keeping practices can lead to improper or even disastrous medical care.

Mr. L's medical file is also strangely sparse. There are essentially no progress notes from 2002-2007.

Roy Moraga is an insulin dependent diabetic who also has Hepatitis C. He is not being treated for his Hepatitis. He also has hydradenitis suppurativa (abscessed sweat glands) on buttocks, with large boils on back, neck, and under both arms, with cylinder shaped abscesses on scalp. This condition is extremely painful. In 2006, his untreated condition became so bad that he was forced to have a surgical excision of abscesses on buttocks. Accutane was recommended by a specialist, but the prison will not approve the drug. And it is probably the only thing that will clear Mr. Moraga's condition up. In addition MRSA (methicillin resistant staph aureus) has been cultured from his abscesses but is untreated. MRSA is a terrible threat to all staff and prisoners at ESP and should never be allowed to go untreated. Mr. Moraga's records also show that medical staff at ESP have actually refused to treat his skin infections for months at a time, and on at least one occasion stopped all of his medications without cause.

Finally, Mr. Moraga's records show that he is severely allergic to fish and has been on a "No Fish" diet for a long time. But inexplicably medical staff at ESP refused to renew this special diet without stating a cause.

Follow-up with Mr. Moraga: I met with Mr. Moraga during my visit to ESP and found that his skin condition is much improved. His diabetes remains difficult to control and unless his blood sugar can be brought down, it will be difficult to ever rid him of the MRSA virus when his skin abscesses. The providers indicated that Mr. Moraga sometimes refuses his insulin so I asked him why. He indicated that his medications are often brought to him at 3 am and he is not given food until 6 am. Without any food in his stomach, forcing him to take insulin at that time makes him sick. So, he declines that morning dose and takes a dose in the afternoon with food.

It is inappropriate medical care to give patients medications without food when those medications may cause wide blood sugar swings. ESP may be a large correctional institution, but it should be able to manage basic care with adequate staffing and planning. This type of medical negligence is an example of a totally unjustified indifferent practice.

III. Unprofessional Conduct and Grossly Improper Medical Charting Practices

The remaining records I reviewed were often too illegible to discern the type of care being provided or too sparse to know if the patient has significant health concerns. Below I give a brief overview of my concern with these records.

Charles Randolph's medical records are very illegible. Ten of twenty-six lab reports are unreadable. And most of his medical notes cannot be deciphered. But one in particular is readily discernible.

Mr. Randolph submitted this medical note to the Physician's Assistant, Max Carter, on June 14, 2007. The note asks why his medication was changed because he felt the medication worked for him and he had been taking it for many years. Mr. Randolph had been prescribed atenolol and it was apparently discontinued for another medication, lisinopril, without informing the patient why the change was made. The PA's responded as follows to Mr. Randolph's question:

I direct you to a recent cardiology study (if needed) which shows that atenolol as monotherapy resulted in increased cardiac deaths - but then you are still alive and I'll be happy to put you back on the medicine so that your chances of expiring sooner are increased ... In fact I am putting you back on atenolol, don't note for a change since you don't trust my knowledge of medicine.

Mr. Randolph's records show that PA Carter in fact did put him back on atenolol subsequent to this note so that not only does Mr. Carter threaten the patient with a medication he claims is deadly, he then proceeds to deliberately put him back on the medication out of spite. This is outrageous, inexcusable conduct by a medical professional, but an excellent example of the overriding ethos of medical care at ESP.

James Beverly is prescribed an albuterol inhaler but it is impossible to know why from reading this chart. His lab reports are also illegible. He is given cortizone shots in both shoulders which

may be done because he has arthritis, but you can't tell by reading his medical records. There is also a mass at the base of his skull, but this too is unexplained in his chart.

Terrence Brothers' medical records are also largely illegible. He is 36 years old and apparently developed a bulging protusion after hernia surgery. It is unclear what, if anything has been done. X-rays in his records have conclusions that are deliberately blacked out and the practitioner signed them a year after they were taken. Like many others, this record is strangely sparse.

Mr. N has Hepatitis C and is totally untreated. There is no indication in his chart why he is untreated or if any protocol for treatment has been used to evaluate his case. This prisoner has been on administrative segregation since 4/8/02, but no reason is given in the chart. He has intermittent abdominal pain, but the cause is unknown. This chart lacks basic information like the prisoner's age. It is also strangely sparse, especially given that he's been in prison since 1996.

Robert Chappell has an inguinal hernia and is wearing a truss. I have given my views on trusses. He also asked for surgery on the hernia but was refused. The lab reports in this record are totally illegible. He suffers from hemochromotosis, a condition in which a person has too much iron in their body. It is impossible to tell from his records, however, what, if any treatment or monitoring he gets for this disease.

Mr. O suffers from back pain and chronic headaches. Provider responses in these records tell him that ESP medical will not treat chronic pain. His record also shows that he injured his right hand but no orthopedic consult was allowed.

Much of his chart seems to be missing. He had an MRI on 7/24/96, but there is no MRI report in his chart and there is a reference in the records to a CAT of his head in 1996, but no report in the chart. Medical record reviews and photocopying dates are blacked out for no apparent reason.

Marty Fitzgerald has chronic neck pain that is caused by a congenitally narrow cervical canal. An MRI for his chronic neck pain was requested by an orthopedic consultant in June, 2006, but this was refused by the prison. He takes chronic acid blockers (Zantac), but has never been tested for *heliobacter pylori* even though it is virtually an epidemic at ESP.

Mr. Fitzgerald is on Indinol. Indinol is a very old drug and lots of patients at ESP are on this drug. But Indinol is a betablocker so that suddenly stopping the drug puts a patient at risk for heart attack. Given the problems with refills from the pharmacy and delays in giving medications at ESP, this is an especially dangerous drug to prescribe.

Mr. P suffers from chronic disuria (painful urine) and a moderately enlarged prostate. His medical records are largely illegible. The medical kites are difficult to read as are the physician notes. In 2004 there is a kite in which the patient is begging for help and the doctor refuses any pain medications. In another legible kite, Mr. P states that staff told him to beg for his medications. Based on the state of this record, it is impossible to discern any true picture of Mr. P's health

Jimmy Kirksey had leg pain in 2005 and saw the neurologist. He told the neurologist that his urine stream was irregular and exited sideways. As a result, the neurologist requested that he be seen by a urologist. But no referral was made by the prison doctors, there is no evidence of any urological consult in his chart, and he was never given any definitive treatment for his leg and groin pain. There appears to be a large amount of information missing from this record.

James Mack has Hepatitis C, but has never been treated for the disease. Like other Hepatitis C positive inmates at ESP, there is no indication in his file as to why he is not receiving treatment or whether or not a treatment protocol was applied to his case.

Mr. Mack is hypothyroid. In 2005 he was given surgery to try to destroy his thyroid. His file contains two letters from Internist, John Sutton, complaining that he cannot obtain the lab reports or medication lists from ESP that he needs to treat Mr. Mack and that these incompetent practices are endangering Mr. Mack's health.

The inmate complaint section of most of Mr. Mack's charts are also illegible, but the provider remarks can be read. Most of the lab reports in his record are also illegible.

Dennis McCabe has had several surgeries, and has suffered stab wounds. He is chronically anemic. He had three consults in 2004 for erythema multiformi (large red raised areas that are related to allergy and autoimmune disorders). There are, however, no consult reports in his chart. Mr. McCabe was on vistaril (an antihistamine type drug used as calmativ and for allergies) long-term for his erythema multiformi. The medication appeared to work but the record shows that the prison doctor refused to give vistaril to Mr. McCabe, stating that he "doesn't believe in it." Mr. McCabe is now on prednisone for his erythema multiformi. Prednisone has serious side effects and therefore patients on the drug must be monitored.

All of Mr. McCabe's lab reports before 2003 are unreadable. There are no progress notes in this chart after 2006.

Mr. Q's records contain very little information. He has an abdominal hernia, most of his colon was removed and he suffers from depression. There is no clinical history in this chart.

Lawrence Seville Parks tested positive to *heliobacter pylori* in 2003 but medical providers have never given him any treatment or follow-up for that condition. He's also been prescribed Indocin for years which can suppress bone marrow, and is very hard on kidneys and liver. Despite this, he has never had any indicated laboratory tests to ensure that he is not suffering those side effects. As I've stated earlier, this drug is rarely used on human beings anymore and should be used sparingly at most.

Donald Phillips is an HIV+ prisoner who cannot seem to get enough food to maintain his weight. He also has Hepatitis C but has never been treated for the disease. Like other Hepatitis C positive inmates at ESP, there is no indication in his file as to why he is not receiving treatment or whether or not any treatment protocol was used to evaluate him as a candidate for Hepatitis C treatment.

Mr. R is another prisoner on large doses of Indocin without any of the required lab follow-up. He is also on chronic stomach acid blockers but has never been tested for *heliobacter pylori*. He was treated in 2006 with oral ketoconazole (an anti-fungal) but this treatment was not followed with required lab testing to ensure that no liver damage results from taking the drug. Mr. R suffers from an over-active bladder which could be treated, but he's never been given any medications to alleviate his problem.

Norman Powell has a prosthetic in his right eye and glaucoma in his left eye. His glaucoma medications are almost never refilled on time which is unnecessarily straining the remaining eye. His vision comes and goes in the left eye, and it is sometimes gone for 48 hours. This temporary blindness in the left eye has been diagnosed as ophthalmic artery migraine. He suffers from chronic low back pain which is treated with ibuprofen and given plavix for his ophthalmic artery migraine.

Cary Williams is 44 years old and he has chronic dyspepsia. He was treated several times for *heliobacter pylori* but he is still on constant stomach acid blockers. Starting in 1990 he's suffered severe labyrinthitis periodically. Although Mr. S has been incarcerated since 1982, there are only 68 kites in his whole medical file and his chart has very few physician orders or progress notes for such a long incarceration.

Matthew White is a 25-year old man with little medical contact documented in his file. He tested borderline positive for Hepatitis C in 2001. His kites indicate that he's been alternately told that he's positive and negative for the virus. Needless to say, this would be concerning for any patient. And a definitive answer should be sought. In order to determine his actual Hep. C status a viral count needs to be taken.

CONCLUSION

The pervasive disregard for human suffering and the shocking medical malpractice revealed in the 35 case files I reviewed is almost unbelievable. In my opinion these show a system that is so broken and dysfunctional that every one of the prisoners at Ely State Prison who has serious medical needs, or who may develop serious medical needs, is at enormous risk.

I would strongly recommend the following to address the crisis in the delivery of medical care at Ely State Prison:

- (1) The Nevada Department of Corrections should immediately hire a qualified full-time physician to oversee the medical department at ESP. This doctor must have the authority to order consults and testing and ensure that these orders are carried out.
- (2) An independent, highly qualified auditor should be retained to conduct a thorough audit of the system of delivery of medical care at ESP, with written findings and recommendations.
- (3) Following the initial audit, there needs to be regular independent monitoring to ensure that necessary reforms are implemented and an adequate standard of care maintained.

- (4) A standard a standard record-keeping protocol must be implemented to ensure that the records at Ely State Prison are no more than a week behind.
- (5) An outside prisoner advocate should be appointed immediately to monitor prisoner requests for medical attention and the responses they received, and to provide reports to the auditor.

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