

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**SUMMARY of
SPECIAL REPORT:**

**Quality of Care Issues Related to the
Custody of
Jonathan Magbie**

October 2005



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This Summary describes the Office of the Inspector General's (OIG) review of District agency/contractor compliance with applicable policies and procedures governing standards of care for District inmates with Mr. Magbie's medical requirements. The OIG is providing this Summary in lieu of the full report to preserve the privacy interests of Mr. Magbie.

Background and Perspective

On September 24, 2004, Jonathan Magbie (Magbie), a quadriplegic inmate with special care needs in the custody of the District of Columbia (District) Department of Corrections (DOC), died at a private, District hospital after experiencing respiratory distress. Magbie was a 27-year old man from Mitchellville, MD who was paralyzed from the neck down at 4 years old after being struck by a drunk driver. Subsequently, he lived with his mother, and required private nursing care for as much as 24 hours a day. Magbie, who could not use any of his limbs, was totally dependent upon others, used a motorized wheelchair, and had a tracheostomy tube and an implanted diaphragmatic pacemaker to help him breathe.

In April 2003, District police stopped a vehicle in which Magbie was riding that contained a gun, cocaine, and marijuana. According to District of Columbia Superior Court (Superior Court) documents, Magbie's cousin was driving the vehicle and, on instructions from Magbie, the cousin put the gun and cocaine inside the coat Magbie was wearing in order to hide them from the police. More than a year later, on September 20, 2004, Magbie pled guilty in Superior Court to possession of the marijuana found in the vehicle. Magbie testified that he had purchased the marijuana. He was sentenced to 10 days in jail, to be followed by probation. Magbie was also ordered to pay a \$50 Victim's Assessment.

Scope, Purpose, and Methodology

At the request of the District's City Administrator, the Office of the Inspector General (OIG) conducted a review of the actions of District agencies and the hospital, both prior to and after Magbie's death. Specifically, the scope and purpose of this inquiry was to determine: (1) whether District agencies and their contractors complied with policies and procedures relating to the standards of care for an inmate with Magbie's medical requirements; and (2) whether policies and procedures in place are sufficient to ensure that appropriate standards of care are met by District agencies entrusted with the custody of inmates with significant medical needs.

Although Magbie was placed in DOC custody by the Superior Court, it should be noted that this inquiry did not evaluate actions by officers or employees of the Superior Court, which by law is excluded from OIG jurisdiction.² In addition, it was not within the scope of this review to draw conclusions about the specific cause of Magbie's death, and none are drawn in this report.

The review team interviewed more than 60 individuals, including: DOC's medical staff and correctional officers; District Fire and Emergency Medical Services (FEMS) paramedics; medical employees working at the hospital, some of whom are employed by hospital contractors; Magbie's personal physician; and others with direct knowledge of Magbie's incarceration and treatment. The team made repeated but unsuccessful attempts to contact Magbie's mother through her attorney. The team sought details of Magbie's home health care in order to understand what his needs would have been while in the care of DOC medical facilities. In

¹² See D.C. Code § 2-302.08(c)(1) (2001).

addition, the team reviewed numerous documents related specifically to Magbie's incarceration and medical care, as well as general information about medical care of inmates in DOC custody.

Chronology of Events

Magbie arrived at the D.C. Jail on September 20, 2004, was given a security assessment, and was assigned an inmate number. The formal name of the D.C. Jail is the Central Detention Facility or CDF. The term "Jail" will be used throughout this report to mean the CDF.

As with all new inmates, Magbie was then taken to the Jail's Urgent Care Center (UCC) for a physical examination. The UCC conducts intake medical processing for inmates and also treats medical problems for all inmates housed in the Jail. Because of Magbie's health issues, a UCC physician decided that Magbie would serve his sentence at the Correctional Treatment Facility (CTF) infirmary. The CTF is a contractor-operated medium security detention facility. The building is physically connected to the Jail and houses approximately 800 inmates. Within the CTF is an infirmary known as Level 82 where inmates who require 24-hour treatment or monitoring are housed. The term "CTF" will be used throughout this report to mean Level 82 of the CTF infirmary.

Late in the evening on September 20, after waiting approximately 7 hours in a bed in the UCC examination room for transfer to the CTF, Magbie experienced respiratory distress, and was taken to the hospital. He was treated in the Emergency Department overnight, and was taken back to the Jail on September 21. According to the medical contractor's policy, Magbie should have been re-examined by the Jail's UCC medical staff because of his hospital visit. However, he was not re-examined, but was transferred to the CTF and processed into that facility without updated medical care instructions based on his treatment at the hospital.

From September 21 until the morning of September 24, Magbie was incarcerated in the CTF. Medical documentation indicates that nursing care was not provided as ordered during his incarceration. On the morning of September 24, he experienced respiratory distress and was found unconscious in his cell. Paramedics called to the CTF to transport Magbie to the Emergency Department found him unconscious, and informed the OIG Inspection team (team) that he was "unresponsive and very sweaty." They also stated that his diaper was saturated with urine, and it appeared that he had not been bathed for several days.

Magbie was seen by the triage nurse in the hospital's ED at 9:50 a.m. The attending physician informed the team that he looked "acutely ill and was not responsive to verbal or pain stimuli." He also stated that tests indicated pneumonia, "which may have contributed to his breathing difficulty." Throughout the afternoon, Magbie's blood oxygen level decreased. Hospital personnel stated that twice during this period, his tracheostomy tube was found to be protruding slightly and was pushed back into place. At some time after 6:00 p.m., a nurse noticed there was no respiration. Cardiopulmonary resuscitation (CPR) efforts were unsuccessful, and Magbie was pronounced dead at 6:40 p.m.

Autopsy

The District's Chief Medical Examiner (CME) conducted an autopsy on September 25, 2004. The CME opined that Magbie was medically fragile due to his multiple health issues and prone to infections and other serious health problems. The CME's review of Magbie's medical record led her to the conclusion that because of his chronic health conditions and acute infections, combined with his already compromised respiratory functions, a protruding tracheostomy tube would have affected his respiratory function enough to lead to his death.

Department of Corrections Review

In addition to its corrections responsibilities, DOC is required to meet all inmate medical and mental health needs, and has direct oversight of the medical facilities operated in the Jail and the CTF. DOC uses two contractors to oversee operations at the CTF. One contractor oversees corrections, and another contractor is responsible for providing medical services.

According to the former Director of the Department of Corrections (D/DOC), DOC was not required or asked to review and report on any aspects of Magbie's death and incarceration because he did not die in a DOC facility. However, DOC developed a "Chronology of Medical Events" covering the days Magbie was incarcerated in the Jail and the CTF. In addition, DOC asked the Department of Health (DOH) Healthcare Safety Net Administration (HCSNA) to investigate the circumstances of Magbie's death at the hospital on its behalf.

The CTF warden conducted an internal "incident investigation" that covered CTF correctional officers' actions on September 24, 2005. The warden concluded in a report that there were no indications of "policy, procedure or practice violations" on the part of correctional officers.

A "Mortality Review Case Abstract" form completed by the CTF Associate Medical Director (AMD) concluded that Magbie died due to complications of quadriplegia and cardiorespiratory failure. The CTF AMD also found that ER personnel were able to stabilize Magbie and that he was able to communicate while awaiting transfer to a hospital room. The CTF AMD noted that the reason for Magbie's subsequent death was unclear pending the results of his autopsy.

Department of Health Investigations and Reports

Health Regulation Administration. Following Magbie’s death on September 24, 2004, the DOH Health Regulation Administration (HRA) initiated an “on-site-investigation” which focused on the care provided to Magbie at the hospital. The investigation began on September 28, 2004, and resulted in the November 18, 2004, issuance of a “Statement of Deficiencies and Plan of Correction” that cited the hospital for:

- failing to evaluate the appropriateness of the discharge plan for Magbie on following his first visit to the hospital on September 20;
- lack of evidence of a reassessment of Magbie’s status after medical intervention and changes in his condition on September 20 and 24; and
- lack of documentation that respiratory treatment was performed and the patient’s response assessed on September 24.

Health Care Safety Net Administration. The Health Care Safety Net Administration (HCSNA) monitors the medical care DOC inmates receive outside the Jail and CTF, and ensures that they are provided access to appropriate, quality health care. On September 27, 2004, DOC asked HCSNA to investigate the circumstances of Magbie’s death at the hospital on its behalf. The HCSNA report issued regarding Magbie’s death³ concluded that:

Since the physician staff clearly documented that they were not sure if the patient would still require a ventilator at night, the patient should have been admitted until observation of the patient at night determined the need for a ventilator or not, especially since the physician staff was aware that the DC Jail Infirmary (CTF) could not provide this need.

The report also concluded that, among other things, “[t]his medical record had documentation of several conflicting statements from the nursing and medical staff”; “[t]he condition of the patient would suggest that the vital signs should have been monitored more frequently”; and “[t]here are three different times documented for the initiation of CPR.”

Regulatory Oversight of DOC Medical Facilities

HRA is required to administer all District and federal laws and regulations governing the licensing, certification, and registration of health care professionals and facilities such as nursing homes, hospitals, home health care agencies, and laboratories to protect the health and safety of citizens of the District of Columbia. HRA does not, however, license or conduct inspections of the Jail and CTF medical facilities, and has no oversight authority with respect to setting standards of health care or evaluating the quality of health care provided in these facilities. The Director of DOH (D/DOH) stated that HRA’s oversight of medical facilities is limited to those that are required to be licensed as health care facilities pursuant to either District or federal law. According to the Director, the Jail and CTF do not meet this requirement.

³ HCSNA sent OIG a “draft” report in March 2005, but did not send a final version until October 7, 2005.

OIG Review Team's Findings

Below is a list of the findings and recommendations regarding the actions of District agencies and the hospital both prior to and in the aftermath of Magbie's death.

Magbie's Discharge From the Hospital

- ***The hospital physician did not document any rationale or justification for discharging Magbie back to the Jail, which could not provide the ventilator Magbie advised that he needed.*** In spite of having information concerning Magbie's stated need for a ventilator at night, and information regarding the Jail's inability to provide one, the physician discharged Magbie back to the Jail. There is no documentation to indicate the medical rationale for this decision, or any justification for this decision in the medical record. **Recommendation:** That medical staff at the hospital develop a quality assurance mechanism to ensure that Emergency Department medical staff clearly and completely document rationale and justification for discharge decisions.

Magbie's Return to Jail

- ***Jail physicians did not conduct the required follow-up examination of Magbie when he returned from treatment at the hospital.*** DOC policy requires that when inmates return to the Jail after off-site medical services, they must be examined by the UCC physician. Magbie's medical records do not reflect such an examination. CTF physicians received no documentation regarding Magbie's treatment at the hospital. **Recommendation:** That the D/DOC and the contractor develop a quality assurance mechanism to ensure that UCC physicians at the Jail conduct a follow-up examination and assessment of inmates returning to the Jail after receiving medical care and services outside of DOC.
- ***Jail physicians did not obtain the required prior approval for Magbie's transfer to the CTF.*** The DOC medical contractor's policy requires that all transfers to the CTF infirmary be approved by the infirmary/on-call physician to ensure that the CTF can accommodate an inmate's needs. For example, Magbie required a ventilator to help him breathe at night, but the CTF did not have a ventilator. There is no documentation to indicate that physicians in the Jail consulted with CTF physicians concerning Magbie's need for total care prior to clearing him for transfer to the CTF. **Recommendation:** That the D/DOC and the contractor develop a quality assurance mechanism to ensure that physicians obtain approval from the CTF on-call physician prior to transferring inmates to the CTF.

Assignment to Correctional Treatment Facility

- ***Doctor's orders written at the Jail were not transferred to CTF caregivers.*** The doctor's orders written for Magbie following his assessment at the Jail on September

20 were not forwarded to physicians and nurses responsible for his care when Magbie was transferred to the CTF. **Recommendation:** That the D/DOC and the contractor develop a quality assurance mechanism to ensure that inmates' medical records are transferred immediately when inmates are moved to and from the Jail and the CTF.

Magbie's Care at the Correctional Treatment Facility

- ***Jail and CTF staff did not document all care provided to Magbie in the Electronic Medical Record (EMR).*** DOC medical staff stated that the EMR is the official record used to document care and services provided to inmates in the Jail and CTF. The medical contractor's policy states that, at minimum, all documentation recorded in the EMR is to be complete, including the date, time, and type of services provided, and the signatures of those providing the services. The team found that all care and services provided to Magbie were not documented in the EMR as required. **Recommendation:** That the D/DOC and the Chief Medical Officer (CMO) for the medical services contractor develop internal controls and quality control mechanisms to ensure that all medical services provided to inmates are documented in the EMR.
- ***The details of Magbie's care were not sufficiently documented in the EMR.*** The DOC contractor's policy requires that nursing documentation be recorded in a narrative format and that each entry be complete. The team found that Magbie's EMR did not provide complete written documentation of his care. Times and details of care administered were frequently missing, including results of vital signs taken and names of medications given. **Recommendation:** That the D/DOC and the CMO develop internal controls and quality assurance mechanisms to ensure that all nursing care provided to inmates is documented thoroughly in a narrative format that will provide a clear, detailed report of the care given, including the exact dates and times.
- ***CTF nurses did not follow doctor's orders consistently.*** Medical documentation and nursing notes indicate that Magbie did not receive the care and medication ordered by the admitting CTF physician. **Recommendation:** That the D/DOC and the CMO develop a quality assurance mechanism to ensure that doctors' orders are adhered to consistently.
- ***CTF physicians failed to comply with infirmary policies.*** The DOC medical contractor's policy requires that the CTF physician "make rounds" daily Monday through Friday. Another policy requires that physicians enter progress notes every 24 hours for all patients admitted to the infirmary (Level 82). The team found that CTF physicians complied with neither of these policies. **Recommendation:** That the D/DOC and the CMO develop a quality assurance mechanism to ensure that CTF physicians comply with all relevant policies.

- ***CTF physicians did not take advantage of hospital privileges available through the MOU among DOH, DOC, and the hospital.*** The MOU states that the hospital shall provide inpatient hospital services and that DOC physicians shall be eligible for clinical privileges to admit, follow, and treat persons in the custody of DOC who are hospitalized. The CTF Associate Medical Director (AMD) stated that he was concerned about the ability of the CTF to care for Magbie. However, he did not make use of available contractual privileges to admit and treat Magbie at the hospital. **Recommendation:** That the D/DOC, the DOC General Counsel, the DOC/HRA, and the DOC Chief Medical Officer review written policies, procedures, and contractual agreements regarding inmate health care, and ensure that DOC physicians are aware of their ability to utilize the hospital to provide medical care to DOC inmates.
- ***Magbie's medical record indicates a low consumption of food and supplemental nutrition.*** Magbie apparently ate and drank very little from September 20-24. For example, on September 20 there is no documentation of any food or drink offered or any consumed. On September 22, there is no documentation that he ate breakfast, and he ate only small portions of his lunch and dinner. **Recommendation:** That the D/DOC and the CMO develop a quality assurance mechanism to ensure that nutrition and hydration needs of all inmates are closely monitored with particular emphasis on inmates with special needs, such as immobility and feeding deficits.
- ***Magbie's emergency trip to the hospital was reportedly delayed by paperwork, blood sugar testing.*** On the morning of September 24, Magbie was found unresponsive in his cell. CTF medical staff made a 911 call to the District's Fire and Emergency Medical Services Department (FEMS). The responding paramedics told the team that their departure for the hospital was delayed because CTF staff members would not let them leave until DOC transport paperwork had been completed and Magbie's blood sugar level was tested. According to the paramedics, the CTF did not have a blood sugar level test kit available so that FEMS could perform the test. **Recommendations:** (a) That the D/DOC and the CMO review procedures regarding medical transport of inmates to ensure that no delays in emergency medical treatment occur because of untimely preparation of paperwork. (b) That the D/DOC and CMO develop a quality assurance mechanism to ensure that all supplies and equipment are readily available in order to respond to medical emergencies.

Magbie's Treatment and Death at the Hospital

- ***Hospital nursing documentation did not reflect the actual dates and times that nursing care was provided.*** According to a DOH nursing official, the national standards for nurses suggest that such documentation should show, either in the DATE/TIME column or in the text written in the NURSING PROGRESS NOTES area, the date and time that care or treatment was actually provided to the patient. The team found, however, that this standard was not consistently followed during Magbie's care and treatment. Consequently, in reviewing the events written about on

this form, the team could not be certain when Magbie actually received the care or treatment cited by nurses in their notes. **Recommendation:** That the hospital consider the need to adopt national standards for documenting care that clearly record the actual date/time that care and treatment are provided.

Department of Health Investigations and Reports

- ***HCSNA did not complete a final report on the treatment and care Magbie received at the hospital in a timely manner. HCSNA also lacks written policies and procedures for monitoring inmate medical care.*** DOC relies on the HCSNA to report on the hospital's care and treatment of inmates such as Magbie. DOC officials stated that HCSNA did not provide such reporting regarding Magbie, nor did HCSNA inform DOC promptly about Magbie's death. DOC requested that HCSNA investigate his treatment and care at the hospital and the circumstances of his death. HCSNA did not provide the OIG a final investigation report until October 7, 2005, and as of this writing had not provided a copy to DOC. DOC officials say this delay hampered DOC's ability to determine if the hospital fulfilled its contractual responsibilities for inmate health care in Magbie's case, as well as its ability to report knowledgeably about the care Magbie received and the circumstances of his death. **Recommendation:** That the D/DOH, in collaboration with the D/DOC, establish written policies and procedures for HCSNA reporting on medical care received by inmates outside of DOC facilities to ensure that investigative reports are submitted in a timely manner.

Regulatory Oversight of Correctional Medical Facilities

- ***DOC medical facilities are not required to be licensed and lack independent oversight.*** Although DOH is required to administer all District and federal laws and regulations that govern facilities such as hospitals, nursing homes, and home health care agencies, there are no District or federal requirements that the Jail or CTF medical facilities and operations be licensed. **Recommendations:** (a) That the Mayor and the City Council consider legislation-based formal oversight by the Department of Health for all aspects of medical care facilities and services provided to Department of Corrections' inmates. (b) That the Mayor consider establishing an appointed advisory board or commission comprised of corrections and health care experts and citizen stakeholders that would have authority to independently monitor, evaluate, and report directly to the Mayor on all key operations of District correctional facilities, including medical facilities and health care operations.

Contradictory Statements Noted by the Review Team

Throughout this review, the team noted statements made by parties with direct knowledge of the events surrounding Magbie's care and treatment often appeared to be contradictory. For example:

- According to a Superior Court official, after Magbie's sentencing and prior to his transport to DOC, a Superior Court employee gave a Medical Alert form on Magbie to one of the two contract correctional officers who transported Magbie to the Jail. The correctional officer who received the Superior Court paperwork stated that no Medical Alert form on Magbie was included in the paperwork.
- During an interview, the AMD for the CTF stated that the medical staff was able to stabilize Magbie prior to the FEMS paramedics' arrival on September 24, 2005. FEMS paramedics stated, however, that Magbie was never stable at any time during their treatment of him at the CTF.
- FEMS paramedics stated that they were delayed in transporting Magbie to the hospital approximately 20-30 minutes because the CTF medical staff would not let them leave before transport paperwork had been completed and Magbie's blood sugar level had been taken. When interviewed, CTF physicians denied that paperwork or blood sugar testing delayed the paramedics.
- DOC correctional officers who were present on September 24 in Magbie's room at the CTF prior to the arrival of FEMS, during Magbie's transport to the hospital, and continuously during the day in the Emergency Department, reported that Magbie was unconscious and unresponsive throughout the day. This account contradicts Emergency Department nursing documentation.

In this regard, the review team cautions that the resolution of all such contradictions was not within the scope or purpose of this inquiry, which was intended to ascertain the facts and provide District officials with recommendations that might improve the level of care and treatment provided to DOC inmates with medical needs. To that end, we have provided an unbiased chronology of events. This chronology is based on information found in documentation and witness statements available to us from parties who participated in Magbie's care and treatment from the time of his arrival at the D.C. Jail to his subsequent death at the hospital. Within the context of this chronology, we made findings concerning: (1) the existence of policies and procedures for care of an inmate with Magbie's medical requirements; and (2) the level of compliance with the policies and procedures that governed the actions of those in charge of Magbie's care during his incarceration.

The team found that, in general, the DOC and its medical contractor had written policies and procedures, but found numerous instances of noncompliance with those policies and procedures. In addition, the team found that the HCSNA, under the DOH, did not have any

written policies and procedures governing its oversight responsibilities for inmates receiving medical care outside of DOC medical facilities.

Conclusions and Recommendations

The OIG Review Team concludes that:

1. DOC and its medical contractor had sufficient written policies and procedures on appropriate standards of care to guide those entrusted with the custody and care of inmates who have significant medical needs. The medical facility in the CTF is accredited by the National Commission on Correctional Health Care (NCCHC), which has established national standards for medical care and services provided in correctional facilities.
2. The Healthcare Safety Net Administration under the Department of Health did not have written policies and procedures for its oversight and monitoring responsibilities for inmates receiving care at facilities outside of DOC, such as the hospital.

DOC contract employees did not comply with many of the written policies and procedures in place to care for an inmate with Magbie's medical requirements. For example:

- ***individual care givers*** in the CTF failed to consistently provide care and treatment to Magbie as ordered;
- ***individual care givers*** in the CTF failed to properly document Magbie's care, treatment, and condition in official medical records; and
- ***medical and nursing staff*** at the Jail and CTF did not have sufficient internal controls and quality assurance mechanisms in place to monitor the performance and record keeping of the medical and nursing staff.

Accordingly, the Team recommends the following:

1. That the City Administrator and appropriate District officials ensure the development of a comprehensive quality assurance program that covers (a) the day-to-day medical care and treatment activities of the Jail and CTF medical staffs; and (b) DOH oversight of care provided to inmates at outside facilities such as at the hospital.
2. That the City Administrator and DOC officials conduct a formal, independent assessment of the need to license the D.C. Jail and CTF medical facilities. Licensing would ensure that the medical care they provide to inmates receives the same government oversight and meets the same requirements as hospitals, clinics, and other licensed medical facilities.

The reader should note that unlike routine OIG inspections and evaluations, this special review was not intended to be an in-depth evaluation of the care and services delivered to all DOC inmates, but was focused specifically on the care and services provided to Jonathan Magbie.