

NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death : FINAL REPORT OF THE
 : NEW YORK STATE COMMISSION
of Brian Tetrault, an inmate of : OF CORRECTION
the Schenectady CJ :
 :

TO: Sheriff Harry Buffardi
Schenectady County Sheriff's Office
320 Veeder Avenue
Schenectady, New York 12307

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Brian Tetrault who died on November 20, 2001 while an inmate in the custody of the Schenectady County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Brian Tetrault died from iatrogenic (physician-induced) neuroleptic malignant syndrome with bilateral pulmonary embolism as a complication of inadequately treated Parkinson's Disease while incarcerated at the Schenectady County Jail. On 11/20/01 at 2:55 p.m., Mr. Tetrault expired at Ellis Hospital. At the Schenectady County Jail, he was under the care of Prison Health Services, Inc., a business corporation which holds itself out as a medical care provider. He received grossly inadequate medical and mental health care which caused his death, specifically the abrupt withdrawal of medications prescribed for Mr. Tetrault prior to admission to jail and the abrupt and sustained diminishment of his carbidopa/levodopa dosage which precipitated fatal neuroleptic malignant syndrome. Mr. Tetrault's death was preventable had he received adequate medical and mental health care.
2. Brian Tetrault was born 12/17/56. He was estranged from his family. He was allegedly divorced and had one adolescent child.
3. Tetrault was arrested on 11/10/01 and remanded to the Schenectady County Jail. His instant offense was Burglary 2nd, Petit Larceny and Harassment. He had two prior arrests, one on 2/28/01 for Criminal Contempt and on 8/25/01 for Aggravated Harassment 2nd.
4. Tetrault was diagnosed with Parkinson's Disease fifteen years ago and had been under the care of the Albany Medical College Parkinson's Disease & Movement Disorders Center (AMCH). He had a Deep Brain Stimulator (DBS) implanted at Columbia University Hospital in New York City. He subsequently had the

DBS removed secondary to an infection. A DBS was re-implanted in June 2001.

5. Upon arrival at the Schenectady County Jail, Tetrault came under the care of Prison Health Services, Inc. (PHS, Inc.). On 11/10/01, a registered nurse completed his admission assessment and noted the following medication regimen: carbidopa/levodopa 25/100 32 tabs daily on a q2h schedule, Klonopin 1mg po TID or QID, Zoloft 100 mg po qAM, Comtan 200 mg po QID, Paraton Forte 250 mg tid - QID, Seroquel 25 mg ½ tab q2h (using 4-5 tabs/day) and Ambien 10 mg qhs. He was able to ambulate to the clinic area. His demeanor was quiet and cooperative. The facility medical director, W. Duke DuFresne, MD, was contacted for medication orders. Dr. DuFresne did not see Tetrault on 11/10/01 and ordered only the patient's carbidopa/levodopa from among the six medications he was taking as documented by the Albany Medical Center Hospital clinic. No physical exam was conducted, a violation of §7010.2(b)(1) which states, "Each prisoner shall be examined by a physician licensed to practice in the State of New York or by medical personnel legally authorized to perform such examination at the time of admission or as soon thereafter as possible, (emphasis added) but no later than 14 days after admission."
6. On 11/11/01, Tetrault was seen by the facility medical director, Dr. DuFresne. Again, no physical examination was conducted, a second violation of section 7010.2(b)(1). However, Dr. DuFresne altered Tetrault's medication regime. He ordered Sinemet, Comtan and Zantax. Later that morning, the facility medical director discontinued Comtan and adjusted the dosage of Sinemet downward. Zantax was continued. The facility medical director's medication orders were a marked departure from the regimen maintained for Tetrault by the Parkinson's Disease and Movement Disorders Clinic of Albany Medical College, which had been treating Tetrault there prior to his incarceration. Tetrault's last visit to the clinic had been on 10/26/01, only two weeks prior to admission to jail. Tetrault's medications were not ordered by Dr. DuFresne or administered as per the recommendations of AMCH where he was being treated for his Parkinson's Disease. The facility medical director did not examine Tetrault prior to withdrawing his medications. There was no consultation with the Parkinson's Disease and Movement Disorders Clinic which was managing Tetrault's illness. Klonopin, Zoloft, Seroquel, and

pain and sleep medications were abruptly withdrawn without a credible rationale. Dr. DuFresne's order for carbidopa/levodopa resulted in under medication of Mr. Tetrault throughout his incarceration, his having been prescribed less than the 32 pills per day he was required to take at two (2) hour intervals. Dr. DuFresne reduced this regimen, claiming that Mr. Tetrault did not take a 4 a.m. dose. The PHS, Inc. nursing staff transcribed even the reduced order incorrectly so that the most medication Mr. Tetrault ever received was eight doses, on occasion only 2-4 doses of carbidopa/levodopa daily, at best two-thirds of what was ordered, at worst 25% of what was ordered. Such abrupt reduction and withdrawal was medically reckless, was directly implicated in the neuroleptic malignant syndrome and immobilization that caused Mr. Tetrault's death, and represents flagrantly inadequate medical care by PHS, Inc. and its employees. It should be noted that none of the abruptly withdrawn medications were found in the PHS, Inc. pharmaceutical formulary for Schenectady County Jail. When questioned as to his rationale for abruptly withdrawing all of the medications except carbidopa/levodopa, Dr. DuFresne claimed that Tetrault had told him he was not taking Comtan and that he declined to prescribe any of the other medications because they were psychiatric medications and should only be prescribed by a psychiatrist. The Board did not find this a credible rationale for disruption of this seriously ill patient's medication regimen. Moreover, although Tetrault was indeed on a psychiatric medication regimen [REDACTED]

[REDACTED] he was not referred to a psychiatrist for assessment and appropriate intervention. [REDACTED]

[REDACTED] This abrupt cessation represents gross incompetence by Dr. DuFresne as medical director and coordinator of Mr. Tetrault's care and by staff of the Schenectady County Office of Community Services which contributed to Mr. Tetrault's death.

7. Tetrault's physical condition began to deteriorate on 11/13/01. Tetrault began having periods of urinary incontinence and changes in behavior (belligerent, uncooperative, delusional) due to the abrupt cessation of neuroleptic and anti-depressant therapy. He exhibited significant mental status changes beginning 11/15/01. His rigidity and spastic movements increased, and he was unable to perform ADL's and required assistance with personal hygiene, both due to a radically reduced carbidopa/levodopa dosage. No physician was called.
8. On 11/13/01, the night shift RN was unable to get Mr. Tetrault to come to the front of his cell for medications. She entered the cell with an officer to administer medications. No physician was called, and in fact Mr. Tetrault was not seen by Dr. DuFresne or any other physician after 11/11/01.
9. On the 11/14-15/01 night shift, it was noted that inmate Tetrault had been incontinent of urine. His buttocks and sacral areas were noted to be slightly reddened. His eyes were noted to be "blood shot" and red. Dr. DuFresne, the medical director, was notified at 11:45 a.m. and returned a call to the RN on duty at 2:00 p.m. The RN stated she directly informed Dr. DuFresne that Mr. Tetrault's condition was worsening. The nurse further stated that Dr. DuFresne, the facility medical director, directed her to request that the Inmate Service Coordinator seek the release of Mr. Tetrault from jail. The nurse stated that she did so. Dr. DuFresne, the medical director, took no further action to intervene with Tetrault on 11/15/01 and did not see him thereafter. Moreover, Dr. DuFresne informed nursing staff that he would see Tetrault on Friday, 11/16/01, then failed to do so. Tetrault continued to be incontinent throughout the night of 11/16/01. It was noted that Tetrault was unable to sit up for medication delivery and that his eyes remained red and "draining tears." During an interview with Commission investigators, the facility medical director, Dr. DuFresne, claimed that Mr. Tetrault's decline was a period of "off" time as typically exhibited by a patient with Parkinson's Disease. His rationale was based, he claimed, on Health Services Administrator Clinton Simmons' nursing note of 11/16/03 in which Mr. Tetrault allegedly ambulated to the medical clinic. As Mr. Simmons' note was written following Dr. DuFresne's discussion with the nursing staff on 11/15/01, in which a registered nurse told the medical director of Mr. Tetrault's deteriorating condition (whereupon Dr. DuFresne directed the nurse to seek Tetrault's release), and prior to his contact

with nursing staff on 11/17/01, whereupon he ordered Tetrault's admission to the hospital, the facility medical director's basis for assuming that Tetrault's deterioration was transitory, having not seen Tetrault (or Simmons' entry in the medical record) in the interim, was invalid. Moreover, the visit made by Health Services Administrator Simmons to Tetrault's housing area is without documented rationale. Health Services Administrator Simmons told Commission investigators that he wanted to "assess" Tetrault, yet no assessment other than vital signs is recorded. After some remarks to the patient to the effect that Tetrault had ambulated while claiming disability during a prior incarceration, Mr. Simmons escorted Tetrault on a "walk" to the clinic. Mr. Tetrault later returned to his housing area in a wheelchair. The Board found that this conduct constituted harassment and physical abuse of a seriously ill, debilitated inmate.

10. On 11/16/01, Tetrault's episodes of incontinence continued. There was no intervention to assess Tetrault's condition. Tetrault's sacral and buttock area was again noted to be reddened and ecchymotic. [REDACTED]

[REDACTED] At 10:00 p.m., his respirations were noted as being "heavy" (no respiratory rate is documented). Tetrault's heart rate was 82, however, it is unknown if this was an apical or radial pulse. Lungs were documented as being "clear." As noted above, Tetrault was not seen by Dr. DuFresne, the medical director, as previously planned on 11/14-15/01. The nursing staff failed to again refer Tetrault to be seen by a physician. No mental health referral was made despite a marked change in mental status. There was no nursing plan of care inclusive of interventions to address impending skin breakdown in this bedridden patient. Vital signs were not properly measured. The medical and mental health evaluation and treatment afforded Tetrault was inadequate.

11. On the 11/16-17 night shift, the RN claimed that Tetrault was "uncooperative" with medication administration, incontinent of urine, "resistant" to sitting up, "refused" to swallow and exhibiting a stage I skin breakdown of his coccyx. The Board found that based upon the evidence developed in the investigation, Tetrault's condition had deteriorated to the point where he was unable to cooperate with medication administration, could not sit up and could not swallow

(dysphagia). The nurse's documentation of this as resistance and refusal is unprofessional to the point of misconduct. During the early morning of 11/17/01, Tetrault continued to be incontinent, his speech was garbled and a skin tear was noted on his coccyx. Mr. Tetrault was not transported to Ellis Hospital until 12:30 p.m., an unwarranted delay which worsened his condition.

12. At 12:30 p.m. on 11/17/01, Tetrault was transported via ambulance to Ellis Hospital ER. He was admitted to Neurological Critical Care (NCCU). His vital signs in the ER were T-100.4, P-100, R-24, and a BP of 140/90. His O₂ saturation was 96-97% on room air. He was not verbally responsive. There was a large 2" open area on his left buttock. He exhibited conjunctivitis OU and he was severely dehydrated which, taken together with the decubitus ulcer, was indicative of grossly inadequate nursing care by PHS, Inc. at the jail. An IV was started, a Foley catheter was inserted and he was given 1 gm of Rocephin. The neurology consultation performed at Ellis Hospital for Mr. Tetrault on 11/17/01 after his admission from the jail documented that Mr. Tetrault had been under-medicated while in jail and the lack of medication as well as its abrupt withdrawal was responsible for his deteriorating condition.
13. On 11/19/01, the consultant's diagnosis was apparent septic shock, sudden hypotension and respiratory distress. Tetrault's temp was 102, CK had increased, rigidity noted with decreased responsiveness. Later in the day, his temperature elevated to 104, his BP was 60/40 and respirations were labored. His oxygen saturation was 86%, he became non-responsive with bilateral rhonchi. He was intubated and placed on vent. Large amounts of stomach contents were suctioned from his lungs. He remained febrile. he was transferred to ICU.
14. On 11/20/01, seizure activity was noted. His hospital course continued on a steady decline. He remained febrile with a temp of 102.2 and 103-104, respectively. There was no corneal response, limbs were flaccid. Asystole was noted at 2:44 p.m., CPR and ACLS measures were taken. Tetrault was pronounced dead at 2:55 p.m.
15. On 11/20/01 at 6:13 p.m., a "Release of Prisoner" order was received by fax from the Niskayuna Town Court by the Schenectady County Sheriff's Department, clearly indicating that Mr. Tetrault was in the custody of the Schenectady County

Sheriff at the time of his death at 2:55 p.m. The record of the official release of Tetrault from custody filed pursuant to New York State Correction Law 500-f was altered from showing a (false) release time of 3:07 p.m. 11/20/01 to 2:45 p.m. on that date (also false), ten (10) minutes before Tetrault was pronounced dead, in an effort to evade the mortality reporting requirements set forth in Correction Law §47 and 9 NYCRR §7022.4. The Schenectady County Jail administration failed to report Tetrault's death as required by law until 5/8/03, twenty and one-half months later when it was ordered to do so by the Commission.

RECOMMENDATIONS:

TO PRISON HEALTH SERVICES, INC.:

1. PHS, Inc. should terminate the services of W. Duke DuFresne, M.D., facility medical director, for malpractice and gross incompetence, specifically his unwarranted disruption of Mr. Tetrault's treatment regimen for Parkinson's Disease planned and implemented by recognized specialist experts, for dangerously abrupt withdrawal of psychiatric medications prescribed as adjunct therapy for his Parkinson's Disease and radical underdosing of carbidopa/levodopa causing fatal neuroleptic malignant syndrome, and for failure to attend to a patient with a life-threatening neurological disease as his condition deteriorated to a critical medical emergency.
2. PHS, Inc. should discipline six (6) of the Schenectady County Jail nurses who encountered and were responsible for caring for Tetrault from 11/13-17/01 for failure to adequately assess his deteriorating condition, failure to provide basic supportive nursing care which hastened his deterioration and caused additional medical problems resulting from neglect, and in one case, harassment of the patient followed by a coerced or forced walk by the patient an extended distance to the ambulatory clinic, constituting physical abuse.
3. PHS, Inc. should establish and maintain a schedule whereby a physician is present at the facility to see patients a minimum of four (4) hours daily, three (3) days per week.
4. PHS, Inc. should comply with the requirements of 9 NYCRR 7010.1(b) for a physical examination of inmates at the time of admission or as soon thereafter as possible.

TO THE SCHENECTADY COUNTY OFFICE OF COMMUNITY SERVICES:

1. The Director of Community Services should discipline the Certified Social Worker who evaluated Tetrault for failure to refer a patient on psychiatric medications for evaluation by a psychiatrist.
2. The Director of Community Services should conduct a quality assurance inquiry into the failure of the mental health staff to maintain continuity of care for a patient dependent upon multiple psychiatric medications as an adjunct to control of the psychiatric manifestations of his advanced Parkinson's Disease and its therapy.

TO THE SCHENECTADY COUNTY SHERIFF:

1. The Sheriff should consider terminating the contract with PHS, Inc. for cause, specifically an inability or refusal to oversee and require their employees to provide adequate care to a patient with a life threatening neurological disorder whose condition had deteriorated to a medical emergency.
2. The Sheriff shall immediately comply with New York State Correction Law §47(2) and with 9 NYCRR 7022.4, Reporting Inmate Deaths, and provide written assurance of same.
3. The Sheriff should require the presence of a physician at the Schenectady County Jail at least four hours per day, three days per week.

TO THE DEPUTY COMMISSIONER, NYS DEPARTMENT OF EDUCATION, OFFICE OF THE PROFESSIONS:

That the Office of the Professions investigate the business practices of PHS, Inc., a business corporation engaged in unlawful corporate medical practice.

TO THE NYS DEPARTMENT OF HEALTH, OFFICE OF PROFESSIONAL MEDICAL CONDUCT (OPMC):

That the OPMC investigate the professional conduct of W. Duke DuFresne, M.D. as to his treatment of Brian Tetrault at the Schenectady County Jail in November 2001.

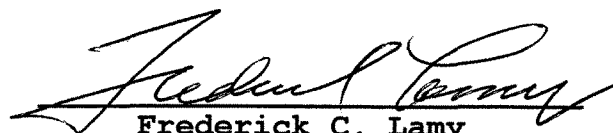
TO THE NYS EDUCATION DEPARTMENT, OFFICE OF PROFESSIONAL DISCIPLINE:

That the Office of Professional Discipline investigate the unprofessional conduct of the Health Services Administrator during his encounter with Brian Tetrault on 11/16/01 beginning at 9:55 a.m. The Medical Review Board has reason to believe that the Health Services Administrator verbally harassed the patient, directly implied he was malingering, then required him to walk an extended distance when in fact the patient was wheelchair-bound, was rapidly deteriorating, and would be admitted to the hospital in critical condition the following day.

TO THE OFFICE OF THE DISTRICT ATTORNEY OF SCHENECTADY COUNTY:

That the Office of the District Attorney investigate the alteration and filing of the official record of admission and release of Brian Tetrault to and from the Schenectady County Jail in November 2001 and take such action as is deemed warranted. In addition, the Office of the District Attorney should inquire into the circumstances of the patient abuse set forth herein also referred to the State Office of Professional Discipline.

WITNESS, HONORABLE FREDERICK C. LAMY, Commissioner, NYS Commission of Correction, 4 Tower Place, in the City of Albany, New York 12203 this 23rd day of June, 2004.


Frederick C. Lamy
Commissioner

FCL:mj
01-M-235
2/04

cc: Karen Rapoch, RN, CCHP, Prison Health Services,
Region 1
Jack Cadalso, Jr., Director of Community Services,
Schenectady County Office of Community Services
Robert M. Carney, Esq., Schenectady
County District Attorney
Frank Muñoz, Office of the Professions,
NYS Education Department