State of Alaska
Ombudsman

Ombudsman Complaint J2008-0161
(Finding of Record and Closure)
Public Report
July 21, 2011

This investigative report has been edited and redacted to remove information made confidential by Alaska Statute and to protect privacy rights.

SUMMARY OF THE COMPLAINT

A female inmate at Lemon Creek Correctional Center (LCCC) contacted the Office of the Ombudsman in April 2008 to complain about medical care provided her at the institution. The inmate/complainant stated that she has multiple sclerosis and that the Department of Corrections (DOC) was not providing appropriate medication for her condition. She complained that LCCC had run out of the muscle relaxant that LCCC medical staff had been prescribing for her symptoms, and had not refilled it for several days, causing her to suffer muscle spasms and difficulty swallowing. She also stated that since her incarceration she had not received any of the drugs (disease-modifying agents) usually prescribed to delay the worsening of multiple sclerosis.

Assistant Ombudsman Beth Leibowitz opened a complaint file. After a preliminary review of the complaint, including review of medical records from DOC and the inmate's private medical providers, and discussion of the issues with DOC medical personnel, the ombudsman opened a formal investigation. The ombudsman provided written notice of investigation to DOC on November 28, 2008 in accordance with AS 24.55.140.

The ombudsman investigated the following allegations, stated in terms that conform to AS 24.55.150, which authorizes the ombudsman to investigate complaints about administrative acts of state agencies:

Allegation 1: DOC unreasonably delayed providing a disease-modifying drug to an inmate with multiple sclerosis.

Allegation 2: DOC performed inefficiently by failing to timely refill the prescription DOC medical staff had been using to mitigate an inmate's multiple sclerosis symptoms.

Assistant Ombudsman Beth Leibowitz obtained a copy of the complainant's medical file from DOC, including her copouts requesting medical care and medical grievances that she filed. Ms. Leibowitz also obtained releases from the complainant and contacted her most recent health care providers outside of DOC, Family Practice Physicians (in Juneau) and Dr. James McDowell in Olympia, Washington. Both medical providers forwarded records to the ombudsman's office.

In the course of this investigation, Ms. Leibowitz interviewed the following DOC Medical staff:

- Iris Beach, RN (LCCC Medical)
- Jamie Ash, PA (HMCC Medical)
- Dr. Henry Luban, M.D., Medical Director, Alaska Department of Corrections
- Dr. Rebecca Bingham, M.D., Alaska Department of Corrections
- AJ Lorenzen, Pharmacist, Alaska Department of Corrections
- Bonnie Dansby, ANP, Alaska Department of Corrections

The ombudsman has found both allegations ***supported*** by the evidence presented in the following report.

The Disease of Multiple Sclerosis

The ombudsman investigator reviewed layman's material on treatment of multiple sclerosis. The Mayo Clinic website[1] provides general information on medical conditions, including the following:

> Multiple sclerosis (MS) is a potentially debilitating disease in which your body's immune system eats away at the protective sheath that covers your nerves. This interferes with the communication between your brain and the rest of your body. Ultimately, this may result in deterioration of the nerves themselves, a process that's not reversible.
>
> Symptoms vary widely, depending on the amount of damage and which particular nerves are affected. People with severe cases of multiple sclerosis may lose the ability to walk or speak. Multiple sclerosis can be difficult to diagnose early in the course of the disease, because symptoms often come and go — sometimes disappearing for months.

Under the link for "Treatments and Drugs," the Mayo Clinic summary states there is currently no cure for MS. Treatment "typically focuses on combating the autoimmune response and managing the symptoms." The site lists drugs that commonly are used in treating MS:

> ■ **Corticosteroids**. The most common treatment for multiple sclerosis, corticosteroids reduce the inflammation that spikes during a relapse. Examples include oral prednisone and intravenous methylprednisolone.
>
> ■ **Interferons**. These types of drugs — such as Betaseron, Avonex and Rebif — appear to slow the rate at which multiple sclerosis symptoms worsen over time. But interferons can cause serious liver damage.

[1] http://www.mayoclinic.com/health/multiple-sclerosis/DS00188 (printed November 27, 2009).

■ **Glatiramer (Copaxone).** Doctors believe that glatiramer works by blocking your immune system's attack on myelin [which forms a protective sheath around nerve cells--ed.]. You must inject this drug subcutaneously once daily. Side effects may include flushing and shortness of breath after injection.

■ **Natalizumab (Tysabri).** This drug is designed to work by interfering with the movement of potentially damaging immune cells from your bloodstream to your brain and spinal cord. Tysabri is generally reserved for people who see no results from or can't tolerate other types of treatments. This is because Tysabri increases the risk of progressive multifocal leukoencephalopathy — a brain infection that is usually fatal.

■ **Mitoxantrone (Novantrone).** This immunosuppressant drug can be harmful to the heart, so it's usually used only in people who have advanced multiple sclerosis.[2]

The National Multiple Sclerosis Society (NMSS) also provides a website with content aimed at both MS patients and the public.[3] The NMSS website lists common symptoms of MS,[4] including fatigue, numbness of the face or limbs, problems with balance and walking, bladder and bowel dysfunction, vision problems (blurring, seeing double, lack of contrast, eye pain), pain (both occasional and chronic), sexual dysfunction, spasticity (ranging from stiffness of leg muscles to painful spasms), and cognitive and emotional changes. Somewhat less common symptoms include difficulty swallowing (dysphagia), due to damage to the nerves controlling that function. Under the heading "What is Multiple Sclerosis?,"[5] the National Multiple Sclerosis Society explains that the severity of symptoms varies widely in individual cases, ranging from numbness in the limbs to paralysis or blindness.

The NMSS website describes four categories or types of MS, each of which may vary in severity:

Relapsing-Remitting MS

People with this type of MS experience clearly defined attacks of worsening neurologic function. These attacks—which are called relapses, flare-ups, or exacerbations —are followed by partial or complete recovery periods (remissions), during which no disease progression occurs. Approximately 85% of people are initially diagnosed with relapsing-remitting MS.

Primary-Progressive MS

[2] http://www.mayoclinic.com/health/multiple-sclerosis/DS00188/DSECTION=treatments-and-drugs (printed November 27, 2009).
[3] http://www.nationalmssociety.org (viewed November 27, 2009).
[4] http://www.nationalmssociety.org/about-multiple-sclerosis/symptoms/index.aspx (viewed November 30, 2009).
[5] http://www.nationalmssociety.org/about-multiple-sclerosis/what-is-ms/index.aspx (viewed November 30, 2009)

This disease course is characterized by slowly worsening neurologic function from the beginning—with no distinct relapses or remissions. The rate of progression may vary over time, with occasional plateaus and temporary minor improvements. Approximately 10% of people are diagnosed with primary-progressive MS.

Secondary-Progressive MS

Following an initial period of relapsing-remitting MS, many people develop a secondary-progressive disease course in which the disease worsens more steadily, with or without occasional flare-ups, minor recoveries (remissions), or plateaus. Before the disease-modifying medications became available, approximately 50% of people with relapsing-remitting MS developed this form of the disease within 10 years. Long-term data are not yet available to determine if treatment significantly delays this transition.

Progressive-Relapsing MS

In this relatively rare course of MS (5%), people experience steadily worsening disease from the beginning, but with clear attacks of worsening neurologic function along the way. They may or may not experience some recovery following these relapses, but the disease continues to progress without remissions.

The NMSS has a clinical advisory board, which issued a "Disease Management Consensus Statement" in 2007.[6] The statement reads in part:

The Executive Committee of the National Clinical Advisory Board of the National Multiple Sclerosis Society has adopted the following recommendations regarding use of the current MS disease-modifying agents (in alphabetical order):

glatiramer acetate (Copaxone®)

interferon beta 1a—intramuscular (Avonex®)

interferon beta 1a—subcutaneous (Rebif®)

interferon beta 1b (Betaseron®)

mitoxantrone (Novantrone®)

natalizumab (Tysabri®)

- The Society recognizes that the factors that enter into a decision to treat are complex and best analyzed by the individual patient's neurologist.
- Initiation of treatment with an interferon beta medication or glatiramer acetate should be considered as soon as possible following a definite diagnosis of MS with active, relapsing disease, and may also be considered for selected patients with a first attack who are at high risk of MS. [The NMSS describes a "relapse (also known as an *exacerbation* or

[6] Published by the NMSS on its Web site at http://www.nationalmssociety.org/about-multiple-sclerosis/treatments/index.aspx. (viewed September 14, 2008, checked for updates November 30, 2009).

attack)… as the development of new or recurring symptoms lasting at least 24 hours and separated from a previous attack by at least one month..”]

- Natalizumab is generally recommended by the Food and Drug Administration (FDA) for patients who have had an inadequate response to, or are unable to tolerate, other multiple sclerosis therapies.
- Treatment with mitoxantrone may be considered for selected relapsing patients with worsening disease or patients with secondary-progressive multiple sclerosis who are worsening, whether or not relapses are occurring.
- **Patients’ access to medication should not be limited by the frequency of relapses, age, or level of disability.**
- **Treatment is not to be stopped while insurers evaluate for continuing coverage of treatment, as this would put patients at increased risk for recurrent disease activity.**
- **Therapy is to be continued indefinitely, except for the following circumstances: there is clear lack of benefit; there are intolerable side effects; better therapy becomes available.**
- **All of these FDA-approved agents should be included in formularies and covered by third party payers so that physicians and patients can determine the most appropriate agent on an individual basis; failure to do so is unethical and discriminatory.**
- **Movement from one disease-modifying medication to another should occur only for medically appropriate reasons.** [Emphasis added]
- None of the therapies has been approved for use by women who are trying to become pregnant, are pregnant, or are nursing mothers.

The Disease Management Consensus Statement adds:

> Based on several years of experience with glatiramer acetate, interferon beta 1a and 1b and mitoxantrone, and the more recent experience with natalizumab, it is the consensus of researchers and clinicians with expertise in MS that these agents are likely to reduce future disease activity and improve quality of life for many individuals with relapsing forms of MS, including those with secondary progressive disease who continue to have relapses. **For those who are appropriate candidates for one of these drugs, treatment must be sustained for years. Cessation of treatment may result in a resumption of pre-treatment disease activity.** [Emphasis added]

According to further literature on the NMSS website, all of the disease-modifying drugs commonly have side effects, ranging from injection site reactions and flu-like symptoms, to a rare but life-threatening infection that occurs in some patients receiving natalizumab (Tysabri).

INVESTIGATION -- ALLEGATION 1

Allegation 1 alleges DOC medical staff unreasonably delayed treatment of the complainant’s MS during her current incarceration, which began in July 2007.

Treatment History and Repeated Incarcerations

Complainant's history of multiple sclerosis

Dr. James McDowell, a neurologist at Olympia Neurology in Washington State, treated the complainant, in 1999, when she lived in Washington. Dr. McDowell referred her for a cranial MRI, which was done in July 1999. The report from that MRI concluded that lesions found in the brain were typical of Multiple Sclerosis. Following the MRI report in July 1999, Dr. McDowell prescribed Betaseron for the complainant. He also prescribed carisoprodol,[7] a muscle relaxant, presumably for management of symptoms.

The complainant discontinued Betaseron almost as soon as she started it, because she became pregnant. Dr. McDowell's progress note from September 23, 1999 concludes: "MS. Diagnosis is not in doubt. See note of 7/15/99. . . . Will probably resume beta interferon then. I have discouraged carisoprodol during . . . [redacted by ombudsman]."

The next record from Dr. McDowell is dated September 14, 2001, in which he noted a telephone call from an ophthalmologist who had seen the complainant during a period of incarceration in Washington. The ophthalmologist described blurred vision in the complainant's right eye, which Dr. McDowell concluded was an exacerbation of the MS. He noted that the complainant was on Betaseron at that point.

In April 2002, Dr. McDowell saw the complainant for the first time in several years. He noted that she had been off Betaseron during her two pregnancies. The complainant reported burning sensations in her right leg and in both arms, as well as her legs jerking. Dr. McDowell made note in the medical case notes that the complainant had resumed use of Betaseron, and he noted prescriptions for Flonase, carisoprodol, and for hydrocodone "once or twice a week." Overall, Dr. McDowell noted a distinct worsening, or progression, of the complainant's MS, including further abnormalities of the optic nerves.

DOC Treatment Records 2003-2006

The complainant moved to Alaska, where she was arrested for driving under the influence and pleaded guilty to felony DUI in 2003.

DOC's medical records for the complainant begin with the post-remand screening at LCCC on May 4, 2003. The screening record listed the following medications: Carisoprodol (Soma) 3x/day for last 3-4 yrs; hydrocodone 2/day as needed for last 3-4 yrs; Betaseron injections. The LCCC medical progress note dated May 16, 2003, notes a diagnosis of secondary progressive MS, and lists Dr. James McDowell as the complainant's primary doctor.

By the time DOC transferred the complainant to Hiland Mountain Correctional Center (HMCC) in early August of 2003, DOC medical staff had taken her off hydrocodone and carisoprodol. Instead, she was receiving Naproxen and Ocean Spray (a nasal spray), along with continuing Betaseron. (At HMCC, the August 6, 2003 progress notes mention that the complainant was also suffering from herniated discs, and that she argued that the

[7] The Food and Drug Administration (FDA) description of carisoprodol (brand name Soma) is that it should be used for relief of acute musculoskeletal pain in adults, and used for only two or three weeks. It has the potential to be habit-forming,

back pain – not necessarily the MS – necessitated her previous hydrocodone prescription.)

Upon release on January 1, 2004, DOC progress notes listed the following release medications: Betaseron at 0.25 mg subcutaneously every other day; Neurontin[8]; and Soma (carisoprodol).

Shortly after the complainant's release, a Juneau clinic referred her to a neurologist in Juneau, Dr. Susan Hunter-Joerns, for MS follow-up. Dr. Hunter-Joerns noted that the complainant had not received Betaseron since her release from jail, due to lack of insurance or cash. Dr. Hunter-Joerns suggested MS Pathways, an indigent drug coverage program, and indicated that her office would assist with that referral. Dr. Hunter-Joerns recommended against *any* prescriptions for narcotics (such as hydrocodone) or sedative muscle relaxants (such as Soma or Flexeril), and recommended Neurontin if needed to treat nerve pain.

In 2004, the complainant was charged with and pleaded guilty to another felony DUI. LCCC medical records show a note for the intake health screening on March 29, 2004. The complainant was released April 6, 2004, but remanded May 6, 2004. The medications listed in her medical progress notes on May 13, 2004 were: Neurontin, Betaseron, Naproxen, and Cyclobenzapine.[9]

Another note on May 19, 2004 states "[history of] polysubstance abuse & chronic pain syndrome + MS." LCCC medical staff approved Flexeril (cyclobenzapine) in 10 mg doses, not to exceed 15 doses per month. LCCC medical staff faxed a release of information (ROI) to Dr. McDowell in Olympia, WA. By June 4, 2004, the LCCC progress notes indicate contact with Dr. McDowell, and advice to prescribe Betaseron at 0.30 mg every other day.

The complainant was released from custody on August 7, 2004, but incarcerated again on October 12, 2004. She continued receiving Betaseron, along with Naproxen and Flexeril for pain and muscle spasms. She was also prescribed Neurontin (gabapentin). In June 2005, DOC transferred the complainant to HMCC.

The medical progress notes indicate that the complainant began having difficulty with Betaseron in August 2005 – she developed redness and swelling at the injection sites. (To minimize reactions, the protocol was to rotate the location of subcutaneous shots, so that no single spot received constant irritation).

DOC sent the complainant to a neurologist, Dr. Marjorie Smith, on October 13, 2005, and the neurologist's report (dated October 12, 2005) included the comment:

> She is having increasing problems with Betaseron injections with increasing redness over the last three months which tends to be clustered over her iliac crest because of privacy issues while in prison. She has really not been rotating her sides adequately.

[8] Neurontin is used to treat postherpetic neuralgia, i.e. nerve pain, and is also used to control epilepsy, according to Pfizer's description of the drug. See http://www.pfizer.com/files/products/uspi_neurontin.pdf (viewed November 30, 2009).

[9] Cyclobenzapine is a muscle relaxant, also sold under the brand name Flexeril.

On November 23, 2005, the complainant refused her Betaseron injection, stating that all of the injection sites were too painful. The progress notes state that the sites were reddened, hot to the touch, and the left and right flank sites were both discolored, with semi-firm nodules. On December 29, 2005, the DOC progress notes indicate a discussion with Dr. Marjorie Smith, who advised that the skin reaction was not uncommon, and that the complainant could discontinue the Betaseron if she wished, with the possibility of restarting it after the injection site reactions had healed.

On March 24, 2006, HMCC medical staff noted that Dr. Smith had retired, so the complainant could not be seen for a follow-up appointment. It was suggested that the complainant see another neurologist after her upcoming release in June 2006.

The complainant was released in early June of 2006. At that point, she had not received a disease-modifying drug for MS for approximately six months, apparently due to her unwillingness to resume subcutaneous Betaseron injections and because Dr. Smith's retirement kept her from a follow-up appointment.

DOC medical records indicate that the complainant was supposed to see an Anchorage neurologist, Dr. Downs, shortly after her release from custody. A DOC progress note dated May 10, 2006, states: "Ph#'s for Down's office given to I/M to independently call to verify ability to pay. I/M verbalized understanding." Subsequent medical records from both DOC and Family Practice (where the complainant was seen in 2006 and 2007) refer to a 2006 appointment with Dr. Downs, and indicate that Dr. Downs recommended Copaxone, another disease-modifying drug that is also injected subcutaneously; however, neither DOC nor Family Practice appeared to have records or a report from Dr. Downs.

The complainant's medical history after release in June 2006

The complainant established care at Family Practice in Juneau, and saw a physician's assistant (P.A.). In July 2006, the P.A. noted Dr. Downs in Anchorage as the complainant's treating neurologist, and indicated that the complainant was about to start a different MS disease-modifying drug, Copaxone. The P.A. continued the medications that the complainant said she was already taking for pain and muscle spasms, Vicodin and Soma.[10] The complainant was described as having a slight tremor and a slight limp.

However, in December 2006, notes from Family Practice state that the complainant had not in fact received Copaxone, despite the expectation in July; the complainant reported increased shakiness, and also a dislocated shoulder from an accident.

In February 2007, the complainant was remanded to LCCC. The health screening on February 5, 2007 lists medications as follows: "Copaxin – through 'MS Pathways'"; Soma 350 mg TIC/PRN[11]; Vicodin 5/500 BID/PRN/MUI. It is unclear whether the complainant had begun taking Copaxone prior to February 2007, but when she was released to the halfway house in late February 2007, she had a supply of Copaxone with her.

However, by mid-March of 2007, the complainant discontinued the Copaxone injections. According to records from Family Practice, she reported "goose-egg size lumps" at the

[10] Soma 325 mg three times a day; Vicodin 10/500, twice daily.
[11] Three times per day/ as needed.

injection sites. The P.A. at Family Practice advised the complainant to contact the doctor who had prescribed Copaxone.

In April 2007, the complainant reported to Family Practice that she would see her neurologist within the next two months. In addition, she had recently obtained Social Security disability benefits, and would therefore have medical coverage to pay for the consultation.

Summer 2007

In June 2007, the complainant's overall condition apparently deteriorated. On June 8, the P.A. noted an anonymous telephone call reporting that the complainant was suffering increased muscle weakness, speech delay, spasms of her hands, and "incoherent activity."

The P.A. saw the complainant on June 8, and the complainant reported increased muscle spasms and pain, which appeared to be a flare-up of MS symptoms. The P.A. noted the complainant exhibited delayed speech and a limp. The complainant also reported that she was drinking whiskey regularly to relieve the muscle spasms, although this violated her probation requirements. She also reported taking three Soma tablets at one time on June 6.

On June 25, 2007, Dr. James McDowell of Olympia Neurology saw the complainant. In part, he wrote:

> [The Complainant] does have multiple sclerosis. She should be on a disease-modifying agent. She has failed two. (The reason for the Copaxone discontinuation was again some sort of injection site reaction, "lumpy nodules in the skin.")
>
> It is not clear to me that she is currently have [sic] an exacerbation. It is clear to me, however, that she is still symptomatic from her disease. I would suggest that she have a current MRI, with the MS protocol. Locally, this means an axial FLAIR, a sagittal FLAIR, an axial T1 and an axial T1 plus gadolinium. Other sequences may be useful as well, but I believe that the above is a minimum.
>
> I would appreciate it if the films could be forwarded to me (the films themselves).
>
> I believe that a good choice for a disease-modifying agent for her would be natulizumab (Tysabri).
>
> Risks and goals of this particular agent are discussed. She filled out the "touch" prescribing form. We will arrange this. Medication can be administered in Juneau of course, since it is a month-to-month IV infusion. I would like to see her between her second and third infusions perhaps. I gave her some information on Tysabri to take home with her.

Unfortunately, it appears that the complainant gave Dr. McDowell an unduly rosy self-report. In contrast to Family Practice notes from early June 2007, in which the complainant reported using alcohol nightly, Dr. McDowell wrote:

> She has put her alcohol use behind her, and she tells me that she has been clean and dry for a couple of years. She had issues with incarceration and alcohol-related issues when I knew her previously. Those apparently are a thing of the past.

In July 2007, Family Practice ordered a cranial MRI and EEG at Bartlett Regional Hospital (BRH) in Juneau pursuant to Dr. McDowell's recommendation. The complainant was to call BRH to schedule the appointment. Dr. Kim Smith at Family Practice was to manage the administration of Tysabri (via infusion), but there is no indication that a date had been set for the complainant's first infusion.

DOC Medical Treatment During Current Incarceration

Return to custody

Before she obtained an MRI, an EEG, or a dose of Tysabri, the complainant was remanded to DOC custody again on July 27, 2007.[12] She was indicted on a charge of felony DUI (driving under the influence).

The post-remand screening lists medications as follows: Soma 350 mg po TID (three times per day); hydrocodone 10/660 BID/PRN (twice daily/as needed). Under "other pertinent information," the form listed Tysabri via IV infusion monthly at BRH, and also noted that the inmate was supposed to have an EEG done at BRH. On July 27, LCCC medical staff faxed a release of information form (ROI) to Family Practice Physicians and also requested the complainant's archived medical file from DOC. A progress note on August 15 indicated use of Naproxen, and either Flexeril or Soma, with a directive to "get records" from Dr. McDowell; LCCC medical staff did not continue the complainant's prescription for hydrocodone.

The August 21, 2007 progress note indicates a consultation with Dr. Bingham of DOC's central medical office. The notes state: "no narcotics, no muscle relaxers. Wait for sentencing. Will go to Anch. [Anchorage]." The LCCC nurse on duty discussed the orders with the complainant, and entered a note that the inmate had "no questions at this time." The complainant did not file a medical grievance.

On September 5, 2007, LCCC medical staff submitted a Prisoner Health Care Authorization request (HCA #76609) for an MRI and EEG, citing Dr. McDowell's recommendation and the primary care physician (Family Practice). DOC medical responded on September 10, with a conditional approval: instead of approving an MRI and EEG at Bartlett Regional Hospital in Juneau, DOC's central medical office stated that the diagnostic procedures were approved to occur "after sentencing," and were to be done at Anchorage Regional Hospital.

In the meantime, Dr. Bingham contacted Dr. McDowell. According to Dr. McDowell's notes, he received Dr. Bingham's telephone call on September 11, 2007. The DOC Medical copy of Dr. McDowell's June 25, 2007 letter is annotated with handwritten notes dated September 10, 2007. The notes are not signed legibly and are only partly readable,

[12] On July 28, 2007, the court set conditions of release including a $25,000 cash bond, no consumption of alcohol, and third-party custodian to be approved by the court. The complainant did not obtain pre-trial release.

but are probably by Dr. Bingham. The notes state in part: "Recommended against Tysabri… offer Copaxone…."; it is unclear whether the notes reflect Dr. McDowell's opinion or that of the writer.

Guilty plea and sentencing

The complainant entered a plea agreement September 27, 2007. She pleaded guilty to one count of felony DUI, and admitted to the allegations in the probation revocation petitions for two earlier cases. The plea agreement contemplated three to five years in prison for the felony DUI, plus another year for the probation violations.

From September 2007 through January 2008, LCCC medical staff saw the complainant for various ailments, including a cough and a knee injury. She was taken to a dentist for a crown on one tooth. Also, in October 2007, she reported difficulty swallowing and muscles spasms. LCCC medical – presumably Dr. Thompson – prescribed Prilosec and Soma.

The complainant was sentenced on January 4, 2008. She received five years in prison for the DUI (1JU-07-876 CR), and one year of time to serve in 1JU-03-664 CR out of a previously suspended sentence. (As of the date of this report, her scheduled release date is June 11, 2012).

Treatment of MS delayed until after transfer to Hiland Mountain

On January 23, 2008, about two weeks after sentencing, the complainant submitted a copout requesting medical care:

> Now I have been sentenced I am still requesting the follow up w/ my EKG/MRI – I am still really having problems with the muscle seizing in neck/throat and severe numbness in leg w/pain -- possible for Somas to resume usual x3 daily?

The copout is initialed and dated by staff, but there is no written response to the request. The complainant submitted a second copout the same day, complaining of being unable to eat much due to difficulty swallowing, and again requesting to have her dosage of Soma increased to three times daily. LCCC medical staff received this copout on January 24, 2008, but, again, there is no written response.

From January through April 2008, LCCC medical staff saw the complainant for problems not related to MS, including re-injury of a shoulder dislocated a year or two before, a possible fractured ankle, and abdominal pain that the medical staff suspected might be due to gallbladder disease. For the latter, DOC Medical approved an ultrasound at Bartlett Regional Hospital, which was done in February 2008.

On April 16, 2008, the DOC progress notes include the following handwritten entry:

> MS.
>
> No significant sx [symptoms]
>
> Medical move declined
>
> Will be moved to Anchorage [at] next admin [administrative] move

No new MS Rx as she was using alcohol when she came in.

On April 21, 2008, the DOC progress notes include the following entry:

MS

Missed transfer to Anch [Anchorage]

Because of parole hearing.

Was approved for MRI – MS

protocol @ ARH [Anchorage Regional Hospital] [post] sentencing (1/4/08)

sx [symptoms] consist of Calf Burn –

some sx of difficulty swallowing.

Also on April 21, LCCC medical staff submitted another health care authorization request (HCA) for an MRI with the MS protocol. This appears redundant, as there was a conditionally approved request for an MRI still outstanding from the previous September. This request was denied the same day by Dr. Bingham.

Complainant's Use of the Medical Grievance Process

When the complainant contacted the ombudsman in April 2008, she stated that she had not received any disease-modifying drugs for MS since the beginning of her current incarceration. At that point, she had been in LCCC since July 2007. The ombudsman investigator advised her to utilize the medical grievance procedure, as she indicated that she had not yet filed a medical grievance; this report includes a discussion of the responses to the medical grievance.

The complainant filed a medical grievance on April 27, 2008, requesting the following relief:

would like, in timely fashion, to have MRI-EEG performed and to start/restart infusion treatments, pain meds, muscle dosage of current medication [sic] & vitamin program (multi-iron-calcium) to [illegible] in quality of my life.

LCCC nurse Iris Beach wrote the response to the grievance on May 13, 2008:

A MRI and EEG were requested on 09-04-07. These were approved after sentencing and at Alaska Regional Hospital.

A second request was submitted on 4/21/08, for an MRI, it was denied at this time.

Medication for treatment of multiple sclerosis is to be started after sentencing. On 5/12/08 the complainant was seen by Dr. Thompson, who stated he would start her on a disease modifying agent after talking to Dr. McDowell.

Pain medication: You are on pain medication, Naprosyn, two times a day.

Muscle spasm medication: You are on Soma two times a day.

Multivitamins may be purchased on commissary.

The complainant was transferred to HMCC on this same date. The complainant appealed the grievance response to the DOC Medical Advisory Committee on May 21, 2008. The Medical Advisory Committee response, dated June 9, 2008, stated:

> Your medical care has been reviewed. You will be referred to a local neurologist for recommendations about further diagnostic tests and treatment. Pain medication and a muscle relaxant have been prescribed. Relief granted in the form of current Rx.

Inmate's medical file reviewed after transfer to HMCC

The complainant was transferred to HMCC on May 13, 2008 (per Medical Summary for Prisoner Transfer). LCCC provided a summary of her condition in the medical progress notes, dated May 12, 2008. The notes read in part:

> MS
>
> S. 37 yo w/ MS for 15 years. Now
>
> off meds 6/07 copaxone. [Illegible]
>
> was to have started on natalizumab
>
> (Tysabri) which she did not
>
> get as incarcerated 7/26/07. No
>
> release date but at least
>
> 3 years. DUI's.

The progress note listed the complainant's symptoms as muscle spasms, calf burn, weakness in the right leg, swallowing tightness, and some vision problems. The note also included Dr. James McDowell's name and phone number clearly written in the left margin, along with the comment "No MRI [since?] '06."

HMCC Medical staff took over the progress notes on May 13, 2008, with an entry for "intake from LCCC," and a listing of medications: Carisoprodal, Prilosec, Naproxen, and Miconazole. On May 14, the progress notes state:

> (1) Please have Dr. Bingham review chart.
>
> (2) Please send HCR# 76609 to medical scheduler for MRI – Brain.

On May 15, an additional note states: "Offer Copaxone Rx per Dr. McDowell – see my note on his dictation from 6/25/07." This appears to be signed by Dr. Bingham.

On June 9, a progress note by Advanced Nurse Practitioner (ANP) Bonnie Dansby states: "I/M requesting tx for MS – old records reviewed per note I/M did not tolerate Calpaxone & recommended natulizumab however this note was written in 6/07 – per Dr. Luban." The note also indicates a health care request (HCR) for an appointment with a neurologist, Dr. Downs.

Assistant Ombudsman Beth Leibowitz spoke with ANP Dansby on June 11, 2008. At that point, Ms. Dansby said that she had spoken with Dr. Luban and that DOC Medical would send the complainant to a neurologist, Dr. Downs, in order to "stage" her MS and start a medication regimen.

When Ms. Leibowitz spoke with Dr. Bingham on June 16, 2008, Dr. Bingham stated that the complainant was scheduled to see a neurologist, Dr. Downs, in July, and that the neurologist would decide which medication should be prescribed. Dr. Bingham added that if the complainant had not received a recent MRI, one would be scheduled before she saw the neurologist. However, Dr. Bingham also stated that the only reason for an additional MRI (in 2007) had been as a "formality" before the complainant started Tysabri infusions, and DOC would not prescribe Tysabri.

Dr. Bingham stated that she believed the complainant had stopped taking Betaseron and then Copaxone because she just did not like the red spots at the injection sites. She said that DOC was willing to offer Betaseron or Copaxone to the complainant, in lieu of Tysabri infusion treatments.[13] Dr. Bingham noted that Tysabri was extremely expensive in and of itself, and even more expensive for DOC to prescribe because the inmate would have to be escorted to a registered infusion center to receive it. Also, Dr. Bingham stated that the complainant had a history of stopping her medication when she was out of custody – she tended to begin drinking and neglect her self-care. Dr. Bingham suggested that a history of inconsistent follow-through was a factor against prescribing a drug like Tysabri, when the long-term benefit of the expensive prescription depended on the complainant continuing to take it even after release.

The investigator asked Dr. Bingham why DOC had waited approximately 10 months before moving toward prescription of a disease-modifying drug for the complainant's MS. Dr. Bingham responded that the complainant was not actually taking any disease-modifying drug when she was remanded in July 2007. If she had arrived with a prescription, DOC Medical would probably have continued prescribing the same medication, but she did not have an established regimen for DOC to continue. Instead, she had a plan to start receiving Tysabri, but had not actually done that as of July 2007. DOC Medical was unwilling to start a new medication for the complainant when they had no way of knowing whether she would make bail or be released to a halfway house.[14] DOC waited for the complainant to be tried and sentenced. Once she was sentenced, DOC Medical waited for her to be transferred from LCCC to HMCC, the long-term sentenced facility for women inmates. Dr. Bingham commented that Alaska had few neurologists available, even in the Anchorage area, and none specialized in MS.

On June 23, 2008, Dr. Bingham spoke with Ms. Leibowitz again. Dr. Bingham noted that she had reviewed the complainant's old medical records since the previous telephone conversation. Dr. Bingham reiterated her opinion that the complainant had refused to continue taking Betaseron because she "did not like" the skin reaction.

Dr. Bingham said that the complainant was being seen by a new physician's assistant at HMCC, Jamie Ash, and that Dr. Bingham had directed P.A. Ash to offer Avonex, a MS medication that Dr. Downs had used with other MS patients. Avonex was administered

[13] As Tysabri is generally recommended only when a patient has "failed" older, less hazardous medications, a patient would not be considered a candidate for Tysabri if she had discontinued other medications for frivolous reasons or minor side effects.

[14] The MS Society reference materials discussed in the background section of this report indicate that any MS disease-modifying drug is intended to be a long-term proposition, not simply a prescription for a month or two. Discussion of these drugs contemplates that a patient will follow a drug regimen indefinitely, generally for years at a time.

by intramuscular injection once per week. Dr. Bingham said that she had approved an out-of-formulary request for Avonex. She also said that DOC had approved the healthcare authorization request for an MRI.

Dr. Bingham noted that both correctional officers and HMCC medical staff reported that the complainant was holding a job within the institution, going to and from the cafeteria, etc., and did not actually seem to be in much physical distress. She added that MS is generally not painful.

Treatment for MS Begun in July 2008

The investigator spoke with the physician's assistant at HMCC, Jamie Ash, on June 24, 2008. P.A. Ash said that Avonex was a disease-modifying drug that might be better tolerated by the complainant than Betaseron or Copaxone. (In a later interview, P.A. Ash explained that Avonex is injected intramuscularly, unlike both Betaseron and Copaxone, which are administered through subcutaneous injections). P.A. Ash said that Avonex was not in the DOC formulary; however, she believed DOC would approve the non-formulary drug. She indicated that although the complainant had not yet been seen by a neurologist, DOC medical staff could discuss the use of Avonex in a telephone consultation with the neurologist. P.A. Ash believed that the intramuscular injections might be better tolerated by the complainant than the subcutaneous injections. Regarding Tysabri, P.A. Ash said that she believed it was still being studied, and was not established as a standard medication for MS. Although Tysabri has been approved for use with MS patients, it is still available only through the manufacturer's "T-Touch" program – only doctors registered with the manufacturer's program can prescribe it. This is apparently due to the risk of a life-threatening side effect necessitating close monitoring of patients receiving Tysabri.

The DOC progress notes indicate that P.A. Ash wrote a prescription for Avonex on June 24, 2008.

The complainant contacted the ombudsman's office on June 27, 2008. She left a message stating that DOC Medical had prescribed Avonex, but that she would not take it. She wanted to see a neurologist first and have an MRI to determine the current stage of her MS. The complainant also expressed concern about taking Avonex because it is in the same family of medications as Betaseron, which "her body rejected after six years" and Copaxone, which she had been unable to tolerate after six months. She added that she believed that DOC Medical was unwilling to prescribe Tysabri because of the cost of that medication. The complainant also said that she was not receiving pain medication at that point. On June 30, the complainant spoke with Ms. Leibowitz and again expressed concern about starting Avonex, and said that Naproxen was not sufficient for her pain. The complainant said that DOC had, during a previous incarceration, prescribed Ultram for pain.

P.A. Ash spoke with the complainant on July 1, 2008, to explain why she thought the complainant should try Avonex. During that visit, P.A. Ash also explained to the complainant that DOC Medical had called Dr. Downs' office, but that Dr. Downs had not reviewed the complainant's file yet.

The DOC progress notes indicate that the complainant began receiving Avonex injections on July 4, 2008. The notes describe the complainant as tolerating the new medication well.

In an interview with the ombudsman investigator on July 29, 2008, P.A. Ash said that the complainant received an MRI on July 14. According to DOC records, the complainant was seen by Dr. Downs on July 25, 2008. Dr. Downs recommended continuing Avonex, and recommended Naprosyn (naproxen) for pain control. He also requested that DOC follow up with a sleep-deprived EEG for the complainant. According to P.A. Ash, Dr. Downs also suggested Ultram, a non-narcotic painkiller, for pain management, and he recommended continued use of Avonex as a MS disease-modifying drug. P.A. Ash said that the complainant was tolerating the Avonex injections well.

Interview with Dr. James McDowell, Former Treating Physician

After obtaining a release of information from the complainant, the ombudsman investigator contacted Dr. McDowell's office in Olympia and obtained records of the complainant's care. The investigator interviewed Dr. McDowell in October 2008 and asked about his contacts with Alaska DOC's medical staff and his recommendation of Tysabri for the complainant.

Dr. McDowell said that Dr. Bingham had phoned him on September 11, 2007. He said his notes from that call were primarily Dr. Bingham's statements to him, and that Dr. Bingham did not solicit information from him. However, he said that at some point, he changed his mind about recommending Tysabri for the complainant, because he was no longer convinced that the complainant would reliably comply with treatment and because he was no longer sure that she had truly "failed" with Copaxone, which he said was usually well tolerated. He denied recommending another specific disease-modifying drug after his initial recommendation of Tysabri in June 2007.

Dr. McDowell said that he received a brief voice mail message from Lemon Creek contract physician Dr. Thompson on May 12, 2008, but did not recall details or keep a record of the message. He said that he attempted to return the call and played "phone tag," but never actually spoke with Dr. Thompson.

The ombudsman investigator asked Dr. McDowell if he would consider active alcoholism a reason to not prescribe Tysabri. He said that alcohol use/abuse was not a contraindication for Tysabri, except as it might affect the patient's ability to reliably follow through with self-care and comply with medical directives. He said that the basic reason for prescribing Tysabri was failure to tolerate or benefit from other available drugs.

Dr. McDowell said that the important point was for the MS patient to remain on one of the disease-modifying drugs – the choice of one drug over another was far less important than simply continuing with a disease-modifying drug. He said that he did not think there was much difference in effectiveness among the four drugs he commonly prescribed for MS – Betaseron, Copaxone, Avonex, and Tysabri. He said Avonex was not his favorite, but said "it would do."

Dr. McDowell said that discontinuing disease-modifying drugs for a year or so was definitely a negative factor for a MS patient; however, he could not quantify how

detrimental such a treatment gap would be in a given patient, because an individual's progression in MS depended on many factors.

ANALYSIS AND FINDING

AS 24.55.150 authorizes the ombudsman to investigate administrative acts that the ombudsman has reason to believe might be contrary to law; unreasonable, unfair, oppressive, arbitrary, capricious, an abuse of discretion, or unnecessarily discriminatory, even though in accordance with law; based on a mistake of fact; based on improper or irrelevant grounds; unsupported by an adequate statement of reasons; performed in an inefficient or discourteous manner; or otherwise erroneous. "The ombudsman may investigate to find an appropriate remedy."

Under 21 AAC 20.210 the ombudsman evaluates evidence relating to a complaint against a state agency to determine whether criticism of the agency's actions is valid, and then makes a finding that the complaint is *justified*, *partially justified*, *not supported*, or *indeterminate*. A complaint is *justified* "if, on the basis of the evidence obtained during investigation, the ombudsman determines that the complainant's criticism of the administrative act is valid." Conversely, a complaint is *not supported* if the evidence shows that the administrative act was appropriate. If the ombudsman finds both that a complaint is *justified* and that the complainant's action or inaction materially affected the agency's action, the complaint may be found *partially justified*. A complaint is *indeterminate* if the evidence is insufficient "to determine conclusively" whether criticism of the administrative act is valid.

In accordance with administrative law standards, the ombudsman makes findings based on a preponderance of the evidence.

* * *

Allegation 1: DOC unreasonably delayed providing a disease-modifying drug to an inmate with multiple sclerosis.

The Office of the Ombudsman's Policies and Procedures Manual at 4040(14) discusses and defines the standard *Unreasonable* as follows:

> (A) the agency adopted and followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of the program,
>
> (B) the agency adopted and followed a procedure that defeated the complainant's valid application for a right or program benefit, or
>
> (C) the agency's act was inconsistent with agency policy and thereby placed the complainant at a disadvantage relative to all others.

DOC Health Care Regulations and Policies

22 AAC 05.121. Prisoner responsibility for health care services

(a) A prisoner will be provided medically necessary health care services regardless of the prisoner's ability to pay or arrange for payment or coverage for the services. Medically necessary health care services include medical, psychological, and psychiatric care that is

necessary to enable a prisoner to participate in or benefit from rehabilitative services made available by the department.

DOC Policy and Procedure 807.02[15] describes DOC standards for inmate medical care. The 2008 edition of DOC P&P 807.02, Procedures B(1), described "essential health care" that DOC is obligated to provide:

> B. Essential Health Care Services
>
> 1. Essential Health Care
>
> A prisoner has the right to receive essential health care services. Essential health care services include dental, psychological, psychiatric, or medical services when a health care provider, with reasonable medical certainty and exercising ordinary skill and care at the time of observation, concludes that:
>
> a. The prisoner's symptoms indicate a serious disease or injury;
>
> b. Treatment could cure or substantially alleviate the disease or injury; and
>
> c. The potential for harm if treatment is delayed or denied could be substantial; or
>
> d. Services are needed to alleviate pain and suffering, including: procedures necessary to aid in increasing the level of functioning throughout the prisoner's sentence, such as prosthetic devices; and health care needed to enable a prisoner to participate in or benefit from rehabilitative services. See Policy 807.15, Health Care Prosthetics. Rust v. State, 582 P.2d 134, modified on other grounds, 584 P.2d 38 (1978).

Attachment A to DOC Policy and Procedures section 807.02 is the "Prisoner Health Plan, Alaska Department of Corrections." The current version of the Prisoner Health Plan has been in effect since 2002,[16] and thus has remained unchanged for the duration of this ombudsman complaint. Chapter II, "Sentenced and Unsentenced Status," addresses quality of care and level of care in relation to an inmate's estimated date of release:

> The same quality of care will be provided to sentenced and unsentenced inmates. As will be explained later in this manual, however, a number of factors are related to the level of health care delivered. Among these is the "estimated date of release." This is important in a number of specific situations where the DOC makes a decision not to provide a specific service. The reason may be due to an inability to follow-up to completion on a particular intervention or treatment or the non-urgent nature of the request. Examples include non-essential dental, orthopedic, small hernia repairs and certain therapies that require an extensive evaluation prior to starting treatment such as Hepatitis C infection. In instances where delay of several months has no significant effect on functioning or long-term health and discharge is imminent or an inmate is unsentenced, care may not be approved. Regardless of status, however, it must be emphasized

[15] The current DOC P&P 807.02 is dated December 2009; however, the basic provisions discussed herein are substantially the same as in the 2008 version of the policy.
[16] Policy 807.02 Attachment A: Prisoner Health Plan, V3.1, June 26, 2002.

> that **all essential and medically necessary care will be approved** and delivered in a timely manner. In certain instances on a case-by-case basis an un-sentenced inmate may be allowed access to community-based, selective medical services not provided by the DOC at the inmate's own expense. Refer to the Appendix, infra, comparing certain levels of care that are restricted by status in the system, be it release date or sentencing situation. [Emphasis added] [17]

The Appendix divides inmates into three categories: unsentenced, sentenced, and sentenced but with less than 18 months remaining to serve.

Section III of the Prisoner Health Plan describes medical care priority levels. Level 1, "Medically Mandatory" care, includes acute problems such as major wounds and appendicitis. The next tier, Level 2, "Presently Medically Necessary" care, is defined as follows:

> Care without which the inmate's well-being could not be maintained without significant risk of either further serious deterioration of the condition or without significant pain or discomfort.
>
> Examples include, but are not limited to:
>
> - Chronic, usually fatal conditions where treatment improves life span and quality of life, such as medical management of insulin dependent diabetes mellitus, surgical treatment for treatable cancer of the uterus, and medical management of disease processes equivalent to asthma and hypertension.

Although "proven effective preventative care for adults" is also listed as a Level 2 priority, another section of the Prisoner Health Plan expressly limits preventative care for unsentenced inmates. In Section VII, "Description of Provided Services," the Prisoner Health Plan describes preventative care as follows:

> J. Preventative Care
>
> Preventative care is medical care that is delivered with the intent to prevent the development of specific medical conditions. It is delivered prior to the development of a symptom, complaint or disease process with the intent to prevent its development. As a general rule, these services are reserved for sentenced inmates because these services represent interventions that impact the chronic long-term health status of an individual, which is usually not applicable to un-sentenced persons. Exceptions include tests and examinations such as the TB skin test, voluntary HIV testing, and testing for sexually transmitted diseases.

In Section VIII, the Prisoner Health Plan provides a "partial list of services not provided by the Alaska Department of Corrections" (presumably Level 4 treatments):

> Services <u>not provided</u> by AK-DOC include, but are not limited to:

[17] Prisoner Health Plan, V3.1, June 26, 2002, page 4.

4. Pharmaceuticals that are not on the formulary (except in cases of medical necessity).

5. Pharmaceuticals that are experimental, investigational or not approved by the U.S. Food and Drug Administration (FDA) for general usage or are otherwise not generally recognized as suitable or appropriate for treatment of the diagnosed medical condition.

DOC Policy and Procedure 807.05(C)(1) which was last revised in 2001, states,

> Staff shall order all pharmaceuticals through the Department of Corrections pharmacy ***except when delay could lead to physical harm or inappropriate treatment to a patient.***" [Emphasis added]

Medical Care for the Complainant

The basic problem in this case is that the inmate, the complainant, arrived in DOC custody with a known diagnosis of MS. She remained almost a year before receiving a disease-modifying drug, even though it is accepted medical practice to manage MS with prescription of a disease-modifying drug. DOC had the complainant in custody continuously starting July 27, 2007, but the complainant did not receive a disease-modifying drug, Avonex, until July 2008.

The ombudsman notes that ombudsman investigators are not medical personnel. In this case, the conclusion that continuous use of a disease-modifying drug is standard practice is based on (1) the interview with Dr. James McDowell, the complainant's previous treating neurologist, (2) information available from the Mayo Clinic and the National Multiple Sclerosis Society, and (3) DOC medical records indicating that DOC had previously prescribed a disease-modifying drug for the complainant and expected to do so again during her current sentence.

At various times, DOC medical personnel cited different reasons for the delay in use of a disease-modifying drug:

- the complainant was not on a disease-modifying drug when she was remanded;
- the complainant was unsentenced and might be released on bail or serve little time, so DOC should not start a long-term treatment regimen;
- the complainant was sentenced, but her treatment would start after she was transferred to HMCC;
- the complainant was demanding treatment with Tysabri, which is expensive and unnecessary;
- DOC Medical had Betaseron and/or Copaxone available, but the complainant frivolously refused to accept either of those drugs;

Initially, delay in treatment was based on two factors: (1) the complainant did not have an ongoing prescription for a disease-modifying drug when she was remanded; and (2) she was unsentenced. In August 2007, the DOC progress notes mention a consult with Dr. Bingham, and state "wait for sentencing." On September 5, 2007, DOC Medical approved an MRI to check the progression (or stage) of the complainant's MS, but only after sentencing and after transfer to Anchorage. In an interview in June 2008, Dr. Bingham explained that DOC would generally be reluctant to start a new medication

regimen for an unsentenced inmate who might be released soon, and who had a history of not following through with medication regimens once released.

Delay prior to sentencing

the complainant was originally held in pre-trial status, and could, at least in theory, have met bail conditions at any point or been acquitted and released. Initially, DOC's reluctance to schedule an MRI or begin a long-term medication made sense. It was also consistent with DOC policy minimizing long-term treatments for unsentenced inmates.

the complainant entered a guilty plea to one count of felony DUI on September 27, 2007. As noted in the court hearing, the sentencing range, without mitigators, was expected to be three to five years. As a class C felony, felony DUI has a sentencing range of zero to five years; however, AS 28.35.030(n) imposes minimum sentencing requirements specific to felony DUI. For a person convicted of DUI four or more times, the minimum sentence is a year. Given that this was the complainant's *third felony DUI* since 2003, all parties expected a sentence well above that minimum. At that point, DOC had little reason to be concerned about her imminent release. Although the Prisoner Health Plan does not provide a category for convicted-but-unsentenced inmates, there was no longer a practical reason to postpone treatment. However, DOC took no notice of the obvious implications of the guilty plea, and continued to wait for the complainant to be sentenced.

The Prisoner Health Plan indicates that preventative care is generally not provided to unsentenced inmates; however, disease-modifying drugs for MS may not be so much "preventative" as ongoing management of a chronic, progressive disease. The complainant's unsentenced status is a weak rationale for delaying care, especially once the complainant pleaded guilty and was expected to receive a multi-year sentence.

Further delay after sentencing

The complainant was sentenced on January 4, 2008 to serve six years in prison (five years for the 2007 felony DUI and one year for probation violations). At that point, as a sentenced inmate with more than 18 months to serve, she was in the category of the Prisoner Health Plan that receives all medically necessary care, including recognized preventative care in addition to management of chronic disease. The complainant submitted a copout on January 23, 2008, asking: "Now I have been sentenced I am still requesting the follow up w/ my EKG/MRI." LCCC medical staff knew that the inmate was sentenced.

Nothing happened. There was no written response to the copout. LCCC Medical treated the complainant for non-MS related complaints, and continued prescriptions for MS symptom managements (naprosyn and Soma), but there was no sign of progress toward selecting a disease-modifying drug. In fact, the next mention of the matter was in mid-April, when a DOC progress note dated April 16, 2008 stated:

> MS.
>
> No significant sx [symptoms]
>
> Medical move declined
>
> Will be moved to Anchorage [at] next admin [administrative] move

No new MS Rx as she was using alcohol when she came in.

This portion of the note implies that the LCCC medical staff believed that the complainant's alcoholism was a reason for not prescribing a disease-modifying drug to treat her MS. One hopes that this implication results merely from reading the progress note out of context, as alcoholism does not appear to be a medically valid reason for refusing treatment. The neurologist who had most recently seen the complainant, Dr. McDowell, stated unequivocally that alcohol use (or abuse) did not contraindicate use of a disease-modifying drug; furthermore, the complainant has presumably been sober since beginning her current incarceration.

The progress notes for April 21 stated that an MRI was approved for post-sentencing, at Alaska Regional Hospital in Anchorage.

In the grievance response in May 2008, DOC Medical reiterated that treatment was to start after sentencing, but that response occurred ***five months*** after the complainant was sentenced.

Neither the criteria in the Prisoner Health Plan nor medical necessity required DOC to defer treatment until after the complainant's transfer. A diagnostic MRI could have been done in Juneau. There is only one neurologist in Juneau, but an Anchorage-area neurologist could have reviewed the complainant's medical records and discussed a choice of disease-modifying drug telephonically. In May 2008, shortly before the complainant's transfer to HMCC, a DOC progress note by Dr. Thompson indicated that he intended to start her on a disease-modifying agent after talking to Dr. McDowell. In June 2008, HMCC medical staff proposed to start the complainant on Avonex and to consult Dr. Downs telephonically about starting that prescription. There does not appear to have been any genuine barrier to starting drug treatment before the complainant was transferred to HMCC.

It was five months after the sentencing before the complainant was transferred to HMCC. Once there, Dr. Bingham reviewed her file – again, an action that need not have waited on the transfer. Treatment began a month and a half after the transfer – about six months after sentencing.

Given the variable course of MS, it is not possible to quantify how much the complainant was harmed by a year of delay in resuming use of a disease-modifying drug. The delay was based on factors unrelated to medical necessity: waiting for sentencing, waiting for transfer to Anchorage, file review at DOC medical. It does not appear to be based on any actual assessment that a disease-modifying drug was not medically indicated.

Choice of disease-modifying drug

The complainant did, at the time of her arrest, have a physician's recommendation that she begin taking Tysabri as a disease-modifying drug; however, DOC Medical does not appear to have ever considered this a viable option. DOC Medical appears to have viewed the complainant's requests for Tysabri as another reason to delay prescribing a disease-modifying drug, on grounds that the patient was demanding a specific medication that DOC did not deem necessary or feasible. Tysabri was not on the DOC formulary; it

is apparently very expensive, and it must be administered by intravenous infusion by a doctor registered and specially trained by the manufacturer, which would necessitate repeated hospital escorts for the complainant.

Tysabri is accepted as an effective drug for relapsing forms of MS but it is not recommended unless the patient is not benefitting from other available MS drugs, or cannot tolerate the less risky medications. The complainant has been diagnosed with secondary progressive MS; it is not obvious whether Tysabri would be a preferred choice for the secondary progressive form of MS.

Even Dr. McDowell, who initially recommended Tysabri for the complainant, was willing to reconsider that recommendation when contacted by the ombudsman investigator, and did not consider it to be the only remaining treatment option.

The FDA approved Tysabri to treat MS in 2004, but the manufacturer took it off the market in 2005, due to association with increased instances of progressive multifocal leukoencephalopathy (PML), which is rare but usually fatal. When reintroduced in 2006, the manufacturer required that any patient receiving the drug be enrolled in the manufacturer's TOUCH Prescribing Program, which is described by the FDA as a risk minimization program.

Further, Tysabri can only be prescribed by a physician enrolled in the TOUCH program, and only administered by an approved infusion center. Dr. McDowell, who saw the complainant in 2007 in Olympia, Washington, is listed on the manufacturer's Website as an enrolled provider, as is Dr. Downs, the neurologist selected by DOC in 2008 to see the complainant. Three general practice physicians in Juneau are also listed as enrolled prescribers, but they do not include Dr. Thompson, the contract doctor for LCCC. Approved infusion centers to administer Tysabri include Bartlett Regional Hospital in Juneau, and several facilities in Anchorage, including Alaska Regional Hospital and Providence Alaska.

Even though DOC Medical had reason to reject Tysabri, DOC Medical appears to have refused to consider other available options in a timely manner. As noted in June 2008, DOC Medical tried Avonex, which proved to be a tolerable alternative for the complainant. There is nothing in the DOC records to explain why it took most of a year to actually consider the medication options.

In addition to DOC's objections to Tysabri, some of the DOC records appeared to reflect a belief that the complainant was frivolously refusing Betaseron or Copaxone, which were apparently in the DOC formulary. In other words, the lack of treatment was attributed to the inmate's refusal to accept a reasonable medication. In a June 2008 telephone interview, Dr. Bingham stated that DOC Medical was willing to prescribe Betaseron or Copaxone, but that the complainant "just did not like" the skin reactions. A DOC progress note dated May 15, 2008, stated, "Offer Copaxone Rx." Earlier annotations (apparently by Dr. Bingham) on a copy of Dr. McDowell's letter to Family Practice state "offer Copaxone."

The complainant's difficulties with Betaseron were thoroughly documented in DOC medical records. While another patient might have tolerated the pain and swelling for longer, the earlier DOC records did not imply that the complainant casually discontinued

Betaseron, which she had taken for several years. The complainant discontinued Copaxone when out of custody, but there does not appear to be any reason to disbelieve her report that she suffered injection site reactions similar to her problems with subcutaneous Betaseron injections.

Further, the DOC records from 2007 and 2008 do not contain any indication that DOC medical staff actually discussed resumption of Copaxone or Betaseron with the complainant. Despite the notes about offering Copaxone, there is no documentation of any action until after the complainant was transferred to HMCC. Not only did DOC discount the actual side effects of these medications, DOC did not attempt to provide those (or any other) disease-modifying medications to the complainant until June 2008.

Finding on Allegation 1

Allegation 1: DOC unreasonably delayed providing a disease-modifying drug to an inmate with multiple sclerosis.

The evidence indicates that the complainant has had difficulty maintaining a consistent MS treatment regimen when outside prison – due probably to both financial difficulties and lack of coping skills. That history may well explain DOC's initial reluctance to renew a treatment plan when she was first remanded in July 2007 pending trial on new charges. It does less to explain the continued delay after the complainant was convicted of a felony with an expected sentence of several years. It does nothing to explain the months of delay after the complainant was sentenced.

DOC regulations and policy commits DOC to providing medically necessary care. Standard medical management of MS appears to include use of disease-modifying drugs for as long as possible to slow the physical and cognitive deterioration caused by MS. DOC left the complainant untreated for nearly a year. The justifications offered do not appear related to a determination that the complainant would be medically better off for the delay, nor do the facts seem to indicate that DOC was genuinely unable to provide treatment in a timely fashion.

The ombudsman finds the allegation of unreasonable delay in medical treatment ***justified.***

* * *

Allegation 2: DOC performed inefficiently by failing to timely refill the prescription DOC medical staff had been using to mitigate an inmate's multiple sclerosis symptoms.

On April 16, 2008, the complainant complained of neck and throat spasms and difficulty swallowing. The nurse on duty telephoned Dr. Thompson, who ordered a "full liquid diet . . . until the Soma (Rx) arrives."

The complainant first contacted the Office of the Ombudsman on Thursday, April 17, 2008. During that telephone interview, the complainant said that she had been out of Soma for four days, and that April 17 was her fifth day without the prescription. She said that the nurse did not know when the Soma refill would arrive. The complainant alleged that, without the Soma, she suffered throat spasms and difficulty swallowing as part of the symptoms of MS. The complainant said that Dr. Thompson had ordered that she be put on a liquid diet due to the throat spasms.

The ombudsman investigator telephoned the infirmary at LCCC and spoke with Iris Beach, the nurse on duty that afternoon. Ms. Beach said that LCCC had run out of Soma the previous weekend (April 12-13), and that LCCC medical staff had faxed the reorder form to the DOC pharmacy on Saturday, April 12. Ms. Beach acknowledged receipt of a cop-out from the complainant. Ms. Beach also stated that the doctor wanted to decrease the complainant's prescription for Soma.

According to the DOC medication administering chart, the complainant received Soma at 6:30 a.m. on Monday, April 14. At that point, LCCC had run out of the medication. LCCC received the prescription from DOC's pharmacy on Friday, April 18 and resumed dosing the complainant that evening.

The ombudsman investigator contacted DOC Medical Director Dr. Henry Luban. Dr. Luban indicated that the prescription for Soma had been filled and shipped out of the DOC pharmacy in Anchorage. He said that the complainant going without the prescription for a few days was the result of a mistake, but that mistakes, such as the late reordering of a prescription, happen occasionally. Dr. Luban said that a correctional facility's medical staff could use a local pharmacy for drugs in an emergency, but that the complainant's lack of Soma did not constitute an emergency.

The next day (April 18), the complainant telephoned the ombudsman's office and said that she had not been offered an actual liquid diet, but that the corrections officers were apparently supposed to watch what she ate. The complainant said that she had filed copouts about these medical issues but hadn't received a response yet. She also said she suffered additional symptoms: muscle spasms in her neck that woke her up at night and spasms in her calf muscles. In contrast, on April 18, 2008, the nurse on duty, Shirley Hawkins, noted in the DOC medical progress notes that the complainant had been observed running and jumping on the way to the dining hall.

On April 18, DOC's lead pharmacist, AJ Lorenzen, said that a reorder of carisoprodol (Soma) was processed by the DOC pharmacy on April 15, 2008, the Tuesday after LCCC faxed the order on Saturday, April 12. As of April 18, he believed the shipment had been delivered to LCCC.

On Monday, April 21, the complainant contacted the ombudsman's office and confirmed that she began receiving Soma again as of Friday evening (April 18th), and that she was receiving doses twice daily. She said that her throat was better.

DOC pharmacy procedure

The ombudsman investigator interviewed DOC pharmacist AJ Lorenzen regarding DOC procedures for refilling prescriptions. Mr. Lorenzen explained that the DOC pharmacy is closed on Saturday and Sunday, and opens for the week at 7 a.m. Monday. On Monday morning, the pharmacy staff sorts the requests that have come in over the weekend and pull any that are marked "Urgent" for priority handling. Those are handled first on Monday. Otherwise, orders are handled by facility, with LCCC orders filled later, because the daily courier for Juneau does not arrive until 3 p.m. Mr. Lorenzen noted that it is common for some of the non-urgent orders from the weekend to be filled on Tuesday, as the pharmacy catches up with the weekend backlog.

Mr. Lorenzen said that DOC has procedures designed to prevent lapses in prescription coverage. First, each prescription that is intended to be refilled has a "reorder" sticker that should be pulled by the institution's medical staff seven days before the prescription actually runs out. Second, if the order sent to the DOC pharmacy is marked "urgent" or "all out" then it receives priority handling at the pharmacy. (Mr. Lorenzen added that he considers all prescriptions for antibiotics to be "urgent," so orders for antibiotics also move to the top of the queue.) Third, medical staff at the correctional facility have the discretion to use a local pharmacy to fill a prescription for critical medication.

In the complainant's case, the DOC pharmacy read the April 12 fax from LCCC on Monday morning, April 14. The pharmacy staff entered the order into the computer system on April 15 and shipped the prescription via courier on Wednesday, April 16. The courier delivered the packet to LCCC two days later, on Friday, April 18. Mr. Lorenzen said that the fax from LCCC was not marked "urgent" or "all out," or otherwise labeled to indicate a need for priority handling.

Mr. Lorenzen also commented that Soma is not usually stocked in the DOC pharmacy; they had some available this time, but a non-formulary drug usually has to be ordered from DOC's contractor in Washington, and takes several days longer to refill the prescription.

ANALYSIS AND FINDING

> ***Allegation 2: DOC performed inefficiently by failing to timely refill the prescription DOC medical staff had prescribed to mitigate an inmate's multiple sclerosis symptoms.***

The Office of the Ombudsman's Policies and Procedures Manual at 4040(14) discusses and defines the standard *performed inefficiently* as follows:

> "Performed inefficiently" generally covers instances of unreasonable agency delay and ineffectual performance.
>
> > (A) The timeliness of an administrative act is sometimes an issue. An agency performed inefficiently when an administrative act exceeded:
> >
> > (a) a limit established by law (statute, regulation, or similar enacted source) or
> >
> > (b) a limit or a balance established by custom, good judgment, sound administrative practice, or decent regard for the rights or interests of the person complaining or of the general public.

This allegation involves a specific set of events in April 2008. At that time, LCCC Medical – presumably Dr. Thompson – was prescribing carisoprodol (Soma) at a dosage of 350 mg PO BID[18] as a muscle relaxant to reduce muscle spasms associated with MS. The complainant and the nurse on duty, Iris Beach, both initially said that the complainant's prescription for Soma had run out over the weekend (April 12-13);

[18] 350 mg to be taken by mouth, twice a day.

however, the medication administering chart indicated that the prescription actually ran out on Monday morning, April 14. The refill arrived late on Friday (April 18), in time for the evening medication rounds. Assuming that the Monday morning dose was effective for at least part of that day, the complainant went four days without the prescribed medication.

Ms. Beach initially said that the doctor had wanted to decrease the complainant's dosage of Soma; the implication was that the Soma was not necessary and therefore it was not a problem that the complainant had to do without it for several days.

The ombudsman notes, however, that the carisoprodol was a valid prescription issued by a physician on contract with DOC. It was therefore presumably medically necessary. If it were not in fact providing a benefit, then DOC medical staff would be expected to discontinue the prescription altogether; if it were providing a benefit, then neglecting to provide it for four days indicates considerable indifference to the patient's suffering.

The DOC pharmacist described three layers of procedures intended to prevent this type of problem. First, refills are supposed to be ordered seven days before the prescription runs out, but LCCC staff did not reorder the drug on schedule. Second, refills that are needed immediately are supposed to be marked "urgent" or "all out," but LCCC did not so mark the order even though they knew that the prescription would run out on Monday. This meant that it would be several days before the refill arrived, because it would not receive priority in handling. The refill could easily have taken longer, as Soma is not on the DOC formulary and therefore usually not in stock in the DOC pharmacy. Third, DOC procedures allow local medical staff to obtain a temporary supply from a local pharmacy, but DOC medical staff did not consider the medication "critical" enough to take that step.

Dr. Luban said that allowing the prescription to lapse was a mistake, but that the lack of Soma was not an emergency; therefore he did not believe DOC personnel should use a local pharmacy to obtain the medication while the DOC refill was pending. It is true that the Soma was not being used as a life-or-death medication. It is unclear, however, why DOC Medical should allow an inmate to suffer for a DOC error. The suffering could have been avoided easily by contacting a local pharmacy for a temporary supply.

In this case, it took not one, but three instances of inaction to produce the situation – the situation being several days of avoidable suffering for the inmate complainant. Throat spasms sufficient to justify recommending a liquid diet appear to fall into the category of suffering beyond the usual discomforts of being incarcerated. The ombudsman finds the allegation of inefficiency ***justified***.

RECOMMENDATIONS

The ombudsman's recommendations are directed at preventing similar problems. The ombudsman reviewed its database of complaints to determine whether DOC had experienced problems similar to those presented in this report. The ombudsman has found that since 2005, 365 complaints have been filed alleging DOC did not properly address medical issues.

During that time, the ombudsman investigated the following two cases that involved, as in this report, delays in providing necessary medication to inmates in DOC custody. These cases are summarized below to underscore both the threat to inmate health and to

DOC liability if the agency continues an indifferent attitude toward providing necessary medications without delay or interruption.

A2006-0027 Failure to provide hemophilia drugs

On January 9, 2006, a 40-year-old inmate complained that DOC unreasonably kept him in medical segregation for nearly two months after he was hospitalized for internal bleeding in September 2005.

The inmate suffered from hemophilia. He said that on August 27, 2005, he told DOC staff at Anchorage Correctional Complex (ACC) that he had abdominal pain that he knew from experience was probably due to internal bleeding. He requested that medical staff provide him with Factor 9, a blood clotting agent, to relieve his symptoms and prevent internal damage caused by such bleeding. DOC staff failed to obtain the needed medication promptly, and six days later, on September 1, 2005, the inmate was transported to Alaska Regional Hospital for emergency treatment and spent five days there.

The investigative issue was lack of responsiveness by ACC weekend medical staff to medical complaints by a known hemophiliac inmate. This resulted in $138,000 in medical expenses paid by the state, which may have been avoided if DOC had provided the Factor 9 medication promptly. The inmate said that during previous incarcerations he would inform DOC medical staff that he needed Factor 9 and they would either provide it to him, call his family to bring in his home supply, or contact the Alaska Hemophilia Society to obtain it. That did not happen in this case.

Ombudsman staff addressed this issue with DOC pharmacy staff and was assured that the DOC pharmacy was being reorganized and procedures improved to prevent similar issues in the future. Therefore the case was discontinued.

A2004 -0601 Failure to timely provide anti-clotting medications

In May 2004 an inmate complained that DOC failed to provide prescribed post-surgery anti-blood clotting medications in a timely manner. The complainant had a history of pulmonary blood clotting and was taken into DOC custody two days after her release from the hospital from surgery. The complainant said DOC failed to provide the prescription medication Lovenox, a blood thinner, in a timely manner despite her chronic medical condition.

The inmate was especially concerned because she had a heredity blood clotting disorder that she said had killed her sister.

Ombudsman review showed that the inmate experienced considerable lapses and interruptions in receiving medication while incarcerated, presenting continuity in care and cost issues. The timely administration of medication is important because of increased health risks, particularly for those inmates who—as in this case—require uninterrupted medication administration. This in turn presents potential liability to the state.

From examination of the record it appeared DOC failed to recognize that a delay in treatment could result in physical harm or be life threatening to the inmate. She was

overdue for follow-up treatment with her orthopedic surgeon for suture and cast removal. While in DOC custody the inmate contracted an infection on her incision. Also, DOC did not follow the dosage of Lovenox prescribed by the inmate's hematologist after she was hospitalized with lateral blood clots in both of her legs.

Further, institutional transfers resulted in lapses of medication and medical care. DOC failed to facilitate the examination and consultation of the inmate by a DOC physician in a timely manner. Despite her medical condition, numerous cop-outs requesting to be seen by a physician, and a hospital emergency room visit, DOC records show this inmate was not seen by a DOC physician for a period of nearly three months.

DOC attributed some of the delays and gaps in medication administration to the inmate's repeated refusal to take the medications. The inmate denies she refused to take her twice daily dosages of Lovenox except on one occasion when she said DOC health care staff did not call her down for her second daily dose until it was within hours of her next scheduled dose. She said she decided to wait for her next scheduled dosage instead. The DOC medical administration charts appear to indicate that the inmate refused only one dose. DOC did, however, document that she failed to make "med line" a few times.

Also, DOC health care staff treated the inmate with Ibuprofen while she was on Lovenox. Ibuprofen may increase the effects of Lovenox which could be dangerous and may lead to bleeding.

As a result of this investigation into the complainant's complaints, and considering the two cases summarized above, the ombudsman proposed the following recommendations:

> ***Proposed Recommendation 1: Upon sentencing, DOC should begin necessary medical treatment of chronic conditions immediately, instead of waiting for transfer to another institution. If recommended medical treatment cannot be obtained at the institution where the inmate is located at the time of sentencing, DOC should immediately transfer the inmate to a facility where treatment is available.***

The complainant was sentenced in early January 2008. She had already been without a disease-modifying drug for five months at that point – not counting the period before her current incarceration. Although further delay would have no medical benefit and was probably to her detriment, she did not receive a disease-modifying drug for another six months. The only reason given for that six-month delay was DOC's decision to defer treatment until after the complainant was transferred to the Anchorage area, something that was done apparently at DOC's convenience and without concern for the inmate's medical needs. The Prisoner Health Plan does not provide for differing levels of treatment depending on whether the inmate is in Juneau or Anchorage, but that is what happened here.

* * *

> ***Proposed Recommendation 2: DOC should not delay treatment pending sentencing when the inmate has already been convicted of a felony with a probable multi-year sentence.***

This case illustrates the problem with treating a convicted felon the same as a pre-trial detainee. The complainant pleaded guilty to her third felony DUI on September 27, 2007,

only two months after her arrest. At that point, it was unlikely that she would leave DOC custody anytime soon, and DOC Medical could have logically concluded that they would be responsible for her medical treatment for at least a year and probably longer. The main rationale for withholding some types of treatment from unsentenced prisoners is the uncertainty whether those prisoners will be in custody long enough to benefit. In the complainant's case, that rationale did not apply after her conviction.

If medical staff had any doubts, they could have consulted with the complainant's institutional probation officer or the probation officer drafting the pre-sentence investigation report for the sentencing judge. To deny all unsentenced felons medical treatment because of a supposed "uncertainty" is to cause unnecessary suffering and invite litigation.

* * *

Proposed Recommendation 3: DOC should treat multiple sclerosis with as much attention as is provided to other chronic conditions such as diabetes.

It is admittedly difficult to quantify the benefit to an individual MS patient of a disease-modifying drug, but it is accepted medical practice to prescribe such drugs long-term to delay the loss of function as the disease progresses. Presumably, DOC Medical would not wait 11 months to address diabetes or hypertension, even if the inmate had failed to exercise good self-care prior to incarceration.

* * *

Proposed Recommendation 4: DOC should review its procedures and policies for obtaining prescription medicine for its inmates including but not limited to establishing protocol in policy and procedure for accessing and obtaining medications from a pharmacy in the community or contract pharmacy on an emergency basis or in the case of DOC pharmacy staffing shortages.

DOC's current process has three levels: (1) ordering prescription refills well in advance, (2) marking late prescriptions as "urgent," and (3) obtaining medicine from a local pharmacy when, for whatever reason, the DOC pharmacy cannot supply it in time. This would seem to be an adequate fail-safe, but the complainant's situation shows it is not. A review of why the process failed and how to correct it is imperative.

In the overall battle to keep inmates alive and relatively healthy, the complainant's lack of a muscle relaxant for four days seems like a minor problem. It *is* a minor problem in the sense that the complainant did not die, or even require the Heimlich maneuver due to choking during a throat spasm. Yet it is a minor problem that could have been avoided easily. The ombudsman cannot endorse suffering that occurs for no other reason than inefficiency.

* * *

Recommendation 5: DOC should establish clear policies and procedures to be followed during and after inmate transfers so that medication and treatment plans are followed as closely as possible.

In summary, the ombudsman proposed to find the two allegations in this complaint ***justified***. Pursuant to AS 24.55.180, the ombudsman requested that DOC comment on the

proposed findings and recommendations before the ombudsman released a final report to the complainant or the public.

Department of Corrections Response

The purpose of the preliminary findings and proposed recommendations in the ombudsman's preliminary investigative report was to allow DOC staff whose actions were examined in this investigation the opportunity to correct any mistakes of fact, omissions, or incorrect interpretations. The ombudsman also asked that DOC review the analysis and findings for areas where DOC might disagree and asked the department to consider the proposed recommendations.

The department's April 25, 2011 response signed by Acting Health Services Administrator Laura Brooks did not note any errors of fact in the investigative report and did not object to the proposed findings.

The department's response commented on each of the proposed recommendations.

> ***RECOMMENDATION 1: Upon sentencing, DOC should begin necessary medical treatment of chronic conditions immediately, instead of waiting for the inmate to transfer to another institution. If recommended medical treatment cannot be obtained at the institution where the inmate is located at the time of sentencing, DOC should immediately transfer the inmate to a facility where treatment is available.***

DOC response:

> DOC endeavors to provide essential medical care to the inmates in our custody. If the level of care necessary is not available at their current facility, every effort will be made to transfer the inmate to a location where their medical needs will be met.

Ombudsman Response: The ombudsman understood this response to say that DOC did not disagree with this recommendation and therefore accepted it.

> ***RECOMMENDATION 2: DOC should not delay treatment pending sentencing when the inmate has already been convicted of a felony with a probable multi-year sentence.***

DOC response:

> DOC will not unnecessarily delay providing essential medical care

Ombudsman Response: The ombudsman understood this response to say that DOC did not disagree with this recommendation and therefore accepted it.

> ***RECOMMENDATION 3: DOC should treat multiple sclerosis with as much attention as is provided to other chronic conditions such as diabetes.***

DOC response:

DOC fully recognizes the significant nature of an illness like multiple sclerosis.

Ombudsman Response: The ombudsman understood this response to say that DOC did not disagree with this recommendation and therefore accepted it..

RECOMMENDATION 4: DOC should review its procedures and policies for obtaining prescription medicine for its inmates including but not limited to establishing protocol in policy and procedure for accessing and obtaining medications from a pharmacy in the community or contract pharmacy on an emergency basis or in the case of DOC pharmacy staffing shortages.

DOC response:

In cases where emergency medications are required to maintain patient health, DOC staff has the authority to have those prescriptions filled, on a limited basis, by the local pharmacy rather than wait for medications to arrive from the DOC pharmacy in Anchorage.

Ombudsman Response: The ombudsman understood this response to say that DOC believed department policy already complied with this recommendation. The facts set out in the investigative report show, then, that **DOC personnel failed to follow DOC policy.**

RECOMMENDATION 5: DOC should establish clear policies and procedures to be followed during and after inmate transfers so that medication and treatment plans are followed as closely as possible.

DOC response:

Per Policy 807.14, when an inmate is transferred from one DOC facility to another, the inmate's medical chart goes with him/her. It is the practice of the receiving facility to conduct a chart review of each inmate as they arrive. In addition, a medical transfer summary is written by the sending institution and is immediately available to the receiving facility for review.

Ombudsman Response: The ombudsman understood this response to say that DOC believed department policy 807.14 already complied with this recommendation. The facts set out in the investigative report show, then, that **DOC personnel failed to follow DOC policy 807.14**.

Findings of Record and Closure

The findings of record are that the allegations were *justified* by the evidence uncovered in this investigation, and that DOC accepted recommendations 1-3 and believed that DOC policy and procedures already complied with recommendations 4-5. It is, however, clear that DOC did not comply with recommendations 4-5 in this case.

Based on DOC's response, this case is closed in accordance with ombudsman procedure as ***justified*** and ***partially rectified***.