



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director

Washington, DC 20534

February 18, 2004

Mr. William E. Reukauf
Acting Special Counsel
Office of the Special Counsel
1730 M Street, N.W., Suite 300
Washington, DC 20036

Dear Mr. Reukauf:

I am in receipt of your correspondence to the Attorney General, wherein you conclude that allegations raised by an employee of the United States Department of Justice, Federal Bureau of Prisons constitute a substantial likelihood that a violation of law, rule, or regulation and a substantial and specific danger to public health or safety has occurred. Specifically, Dr. Nahem A. Naimey, an employee and Clinical Director of the Federal Correctional Institution in Memphis, Tennessee (FCI Memphis), has made allegations related to the adequacy of medical care provided to inmates at that facility. You requested an investigation and report on the allegations made by Dr. Naimey. Please accept this correspondence as a summary of our investigation and findings. It should be noted that the Attorney General has delegated to me authority to review and sign the report, in accordance with 5 U.S.C. § 1213 (d).

First, it is important to note that the Bureau of Prisons subjects all programs at each facility to regular and extensive evaluations through its Program Review process. Program reviews of Health Services departments are conducted every two to three years by Bureau of Prisons medical staff, who are independent of the program being reviewed. The Health Services Department at FCI Memphis received a "Good" rating following a recent review. The Bureau of Prisons also pursues accreditation from the American Correctional Association (ACA) for all institutions, including an extensive examination of health care services policy and procedures. Each institution undergoes an accreditation audit by ACA every three years. FCI Memphis was fully accredited

by ACA in January 2002. Finally, in order to ensure that quality health care is delivered in a manner commensurate with local community standards, all institutions are encouraged to pursue accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). FCI Memphis was recently audited by JCAHO and received full accreditation.

Psychiatric care

Dr. Naimey alleged that management at FCI Memphis significantly reduced, then eliminated, the hours of work performed by a contract psychiatrist. Dr. Naimey alleged the reduction and subsequent elimination created a substantial and specific danger to public health and safety.

Bureau of Prisons staff visited FCI Memphis on January 13-15, 2004, to investigate Dr. Naimey's allegations. The investigators were medical staff from our South Central and Mid-Atlantic Regional Offices. The medical staff from the Mid-Atlantic Regional Office are responsible for administrative oversight of the institution but do not report to the Warden. These staff, two of whom are board-certified physicians, interviewed several FCI Memphis medical and mental health service employees and reviewed relevant Health Services Department documents, including all available charts of every inmate assigned to the Mental Health Chronic Care Clinic in October 2003.

The investigation revealed that Dr. Carlos A. Salgueiro began providing services as a psychiatrist and internal medical consultant at FCI Memphis and the nearby Federal Prison Camp (FPC) at Millington, Tennessee in early 2000 and continued through early October 2003. Dr. Salgueiro was expected to provide four 6-hour days per month as an internist at FPC Millington and three 8-hour days per month as a psychiatrist at FCI Memphis. Dr. Salgueiro's services were procured through Medical Development International (MDI). The Bureau of Prisons reimbursed MDI \$1470 per 6-hour session for his services as an internist at FPC Millington and \$400/hour for his services as a psychiatrist at FCI Memphis.

Ms. Joyce Anderson assumed her duties as Health Services Administrator (HSA) at FCI Memphis in June 2003. (Dr. Naimey served as Acting HSA for approximately six months prior to her arrival.) As part of her duties, Ms. Anderson reviewed all consultant contracts. She discovered that in the previous three fiscal years and in that current fiscal year to date, Dr. Salgueiro was paid as follows:

Year	Service	Amount Paid
2000	Medical and Psychiatry	\$61,292.66
2001	Medical and Psychiatry	\$130,575.00
2002	Medical and Psychiatry	\$145,600.00
January - July 2003	Medical and Psychiatry	\$81,800.00
Total		\$419,267.66

Based on her experience and through consultation with other agency HSAs, Ms. Anderson determined that Dr. Salgueiro's charges were excessive for the services he provided. In addition, she became aware that Dr. Salgueiro was not always present during the times required by the work order. On most days, including when he was providing psychiatric services, Dr. Salgueiro was present for only four to six hours. She determined that his services at FCI Memphis could be consolidated into two days per week, assuming he was present for the required 8-hour session on both days, and the contract was amended accordingly.

According to staff interviewed, subsequent to this change Dr. Salgueiro began to request increased time for evaluating mental health inmates. It was reported that he documented a need for more frequent follow-up on many patients at a significantly higher rate as compared to his practice prior to the contract amendment in July 2003. Over time, a backlog of patients on the Mental Health Chronic Care Clinic list occurred. It was then decided that the institution would request that MDI replace Dr. Salgueiro with a more cost efficient provider.

Upon notification, MDI required 60 days to identify a new provider. A plan was developed to provide continued care and services to inmates who needed mental health care in the interim. The Clinical Director (Dr. Naimey) would renew all medications which had expired and provide evaluation of inmates as needed. The Chief Pharmacist received a verbal order from the Clinical Director not to allow any psychotropic medication to expire. All psychotropic medications were continued and available to inmates for whom they were prescribed, unless changed or discontinued by the Clinical Director. Thus, no inmate was denied his medication

following the departure of the contract psychiatrist. Further, licensed psychologists employed at the facility assisted inmates when necessary and at the inmates' request, and emergency services were to be provided by a local community facility. This plan was outlined in a report by Dr. Richard Ramirez, Clinical Specialty Consultant to the Medical Director, following his visit to FCI Memphis in November 2003. The findings were conveyed to Dr. Kendig, Bureau of Prisons Medical Director, and the Warden at FCI Memphis.

To assess Dr. Naimey's claims regarding individual inmates, medical charts of 68 of the 96 inmates assigned to the Mental Health Chronic Care Clinic in October 2003 were reviewed (28 charts were unavailable for review due to inmate transfers or other similar circumstances). In 36 of 68 cases (53%), reviewers judged that good follow-up occurred. In the remaining cases (32 of 68, or 47%), patients were not evaluated within the time frame recommended during their last evaluation. However, as was noted above, in July 2003 Dr. Salgueiro increased his frequency of follow-up visit recommendations for patients. Moreover, the reviewers could not find substantive medical evidence in the majority of those cases to justify such increased frequency of follow-up. Indeed, many appeared to be stable, despite another finding of the reviewers that many patients were noncompliant or poorly compliant with their prescribed medication regimen, a fact apparently unknown to Dr. Salgueiro. He had noted in many of his patients' charts that they were fully compliant with their medication, while the Medication Administration Record maintained in Health Services indicated otherwise. Finally, there was no evidence that any inmate decompensated due to lack of care or follow-up during the period of October 2003 through January 2004.

In his letter to the Office of Special Counsel, Dr. Naimey referred to two inmates who allegedly decompensated and engaged in assaultive behavior due to lack of mental health care. Medical staff who conducted the investigation completed a comprehensive review of both inmates' medical charts and other Bureau of Prisons files. Inmate Roberto Alonso-Llerena, Reg. No. 01121-131, whom Dr. Naimey correctly identified as diagnosed with Bipolar Disorder, was seen regularly by psychologists, by the former contract psychiatrist, and by Dr. Naimey. Records indicate that he was in poor compliance with his prescribed medication. Further, it was determined that Dr. Naimey himself discontinued this inmate's medication in early November 2003, presumably for valid reasons, and that this medication discontinuation order by Dr. Naimey occurred prior to the instance of assaultive behavior he alluded to in his letter.

The second patient referred to in Dr. Naimey's letter, Inmate Gerald Porter, Reg. No. 31185-083, was evaluated on a quarterly basis by Dr. Salgueiro until September 2003. He was subsequently evaluated by Dr. Naimey in December 2003 and also by the new contract psychiatrist in January 2004. His medication was available to him at all times; however, records indicate that he was only marginally compliant. With regard to his reported assaultive behavior, which occurred on November 15, 2003, it is noted in relevant records that Mr. Porter's poor compliance with prescribed medication may have been a contributing factor, but also that he had been sanctioned with Disciplinary Segregation for possessing intoxicants a few weeks prior to his altercation with another inmate.

In sum, the reduced hours and ultimate termination of the contract for Dr. Salgueiro's services occurred for reasons of cost-efficiency after an informed and deliberate review by the new Health Services Administrator. Prior to the arrival of the new contract psychiatrist, a plan to continue proper care for inmates at FCI Memphis was developed and implemented. The evidence suggests that this plan was successful and that no patient suffered harm during this interim period. In fact, physicians who reviewed the charts commended Dr. Naimey for the quality of care he provided during that period. As was stated earlier, there is also evidence that the reported problems with patient follow up following the reduction of hours is at least partially attributable to Dr. Salgueiro's observed increase in making follow up recommendations for patients, most of whom were judged by the reviewers to be stable despite evidence of less than full compliance with treatment.

Finally, it is relevant and appropriate to note that most of the medical and mental health staff interviewed at FCI Memphis during the course of this investigation possessed knowledge that Drs. Naimey and Salgueiro are personal friends.

Laboratory Work

Dr. Naimey further alleged that the reduction of hours for a contract laboratory technician resulted in a substantial and specific danger to public health and safety.

HSA Anderson similarly reviewed this contractor's work and productivity. It was found that a backlog of patients occurred because the contractor routinely failed to report to work on all scheduled days. Again, the institution requested that MDI supply a new provider; however, MDI reportedly could not locate an alternate technician. Given the HSA's observation that the

contractor was not reporting consistently for 30 hours per week as required, the contractor's hours were reduced by half to correspond approximately to the actual number of hours she had been reporting to the institution. Unfortunately, her practice of failing to report to work continued, as did the backlog of patients who required the services of the technician.

During his November 2003 visit, Dr. Ramirez noted that 250 lab tests were behind schedule. In response, FCI Memphis had all medical staff assist in the drawing of blood from patients so that lab testing could be expedited. This resulted in some relief, but it was determined not to be sufficient. Management consequently recruited another phlebotomist on their own, referred this individual to MDI, and subsequently contracted with MDI for him to provide 15 hours of service per week in addition to retaining the original phlebotomist at 15 hours per week. This, in addition to an anticipated medical records technician position being filled to assist with record management duties, was judged to be sufficient in ultimately meeting the lab testing needs of inmate patients at FCI Memphis.

Thus, although it is true that lab testing did not occur in an optimally timely fashion at FCI Memphis during that period, it is important to note that there was no evidence to suggest that any harm to patients occurred as a result. Moreover, it appears management took responsive action upon becoming aware of the issue.

Conclusion

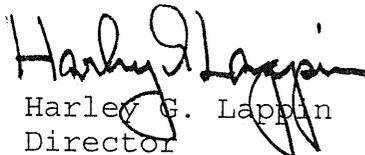
The allegations raised by Dr. Naimey understandably raised concerns on the part of the Office of Special Counsel, and on my part as well. However, after a careful and thorough review of the circumstances underlying the allegations by qualified medical personnel, I am satisfied that there was not a violation of law, rule, or regulation, nor is there a likelihood of a substantial and specific danger to public health and safety.

It was determined that inmates at FCI Memphis continued to receive adequate care during the reduction of hours, subsequent termination and replacement of the contract psychiatrist. In addition, investigating staff revealed some evidence which suggested that the former contract psychiatrist may have exaggerated the need for increased follow-up care after his hours were reduced, and was apparently unaware of the extent to which his patients were non-compliant with prescribed treatment, a circumstance which also calls into question the quality of care he provided.

It was also determined that Dr. Naimey's allegations about laboratory work did not rise to the level of a violation of law, rule, or regulation, nor was there a likelihood of a substantial and specific danger to public health and safety. While it was revealed both in the investigation and during a prior quality assurance visit that there was a significant backlog of lab testing because a technician did not fully meet the requirements of her contract, there is no evidence that any inmates were harmed due to laboratory work delays, and it appears that management took proactive and necessary steps to resolve the problem.

The Bureau of Prisons takes seriously its responsibility to provide proper and appropriate medical care to inmates and it appears that the actions of FCI Memphis staff in this matter were in accordance with that responsibility. I trust this information is helpful and pertinent to your request. Please contact me or my staff if we can be of further assistance in this matter.

Sincerely,


Harley G. Lappin
Director



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director

Washington, DC 20534

August 10, 2004

Mr. William E. Reukauf
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Dear Mr. Reukauf:

This correspondence is submitted in response to your staff's request for additional information to amplify and explain my earlier letter dated February 18, 2004, regarding concerns for inmate medical and mental health care that were raised by Dr. Nahem A. Naimey, Clinical Director, Federal Correctional Institution (FCI), Memphis, Tennessee.

In order to gather additional information, a team of six Bureau of Prisons staff traveled to FCI Memphis on June 23-24, 2004. The team consisted of Dr. Shelley Stanton, Bureau of Prisons Chief Psychiatrist; Dr. Ralph Spada, Regional Health Systems Administrator, North Central Region; Francis Coleman, Regional Health Systems Administrator, Mid-Atlantic Region; Office of Internal Affairs Agent Mike Heffron; Regional Counsel Bill Burlington; and Deputy Associate General Counsel Tamara Chrisler. While at Memphis, the team met with Dr. Naimey on two occasions, interviewed other staff, and reviewed inmate records. Regrettably, this visit disclosed that some of the information I provided you in my earlier response was in error. The receipt of such misinformation was so disturbing to the Bureau of Prisons that we forwarded the matter to the Office of Inspector General for investigation. Please accept my sincere apology for this unfortunate oversight. I hope to clarify those inaccuracies in this letter.

Mental Health Care at FCI Memphis is Consistent with Policy

In your December 17, 2003 letter to the Honorable John Ashcroft, Attorney General, Dr. Naimey is quoted as saying "inmates enrolled in chronic care clinics, such as the psychiatric clinic are supposed to be seen by a physician at

least quarterly." Further, the letter states "since the psychiatrist's hours were reduced, the Memphis facility has not succeeded in meeting this requirement for many of its psychiatric patients."

In fact, the Bureau's Health Services Manual, Program Statement 6000.05, dated September 15, 1996 (pertinent page of which is attached as Attachment 1) states:

Each HSU (Health Services Unit) shall conduct chronic-care clinics at least quarterly. The CD (Clinical Director) shall have professional responsibility for all chronic-care clinics.... A physician shall supervise and monitor all chronic-care clinics and shall examine and evaluate any patient placed in or removed from a clinic. A MLP (Mid Level Practitioner), under the direction of a physician, may manage the care of a stable patient in the clinic. The physician shall evaluate a patient requiring ongoing medication as often as clinically necessary. (Explanation added).

Thus, current Bureau policy allows Mid-level practitioners (e.g., a Physician's Assistant, a Nurse Practitioner) to examine chronic-care inmates whose condition is stable. An inmate who is stable and enrolled in a chronic care clinic must be seen quarterly, but need not necessarily be seen by a physician. As such, staff at FCI Memphis were within policy by allowing stable inmates to be seen by an MLP under the direction of a physician.

In addition, the Bureau's medical staff have provided the Clinical Directors with formal and informal education over the last two years encouraging the Clinical Directors to take charge of the Mental Health Chronic Care Clinics and refer only new or complicated cases to the telepsychiatrist or contract psychiatrist. We have encouraged the Clinical Directors to not refer stable inmates on psychiatric medications to consultant psychiatrists. This objective was especially emphasized at the Clinical Directors' meeting in November 2003, and this objective is in line with our policy allowing such care to be provided by mid-level practitioners.

Hiring of Additional Phlebotomist/Increase in Hours of Current Phlebotomist

One of Dr. Naimey's claims that you asked us to revisit involved the hiring of an additional phlebotomist. In my February 18, 2004, letter to you, I indicated that a second phlebotomist had been hired. Dr. Naimey responded that a second

phlebotomist was never hired at Memphis. His assertion is correct. When Bureau staff first visited Memphis in January 2004, everyone agreed that a second phlebotomist should be hired. A phlebotomist working at the nearby Federal Correctional Institution, Forrest City, Arkansas, was located, and negotiations were underway for that person to provide services to FCI Memphis. At the time of our letter, I was under the impression that the new phlebotomist had actually been hired. However, prior to the letter being sent to you, information was discovered in the personal background of that individual which prevented him from working at Memphis. This information was not communicated to me at the time of my initial response.

As Dr. Naimey asserts, the hours of the phlebotomist have been increased. The team interviewed the phlebotomist and were told that she was working 30 hours per week, and as a result, she was current with the required inmate "blood draws" that had been ordered by medical staff.

Tracking the Hours of the Contract Psychiatrist

In addition, you asked us to reinvestigate our earlier statement that after assuming her duties as the new Health Services Administrator, CDR Anderson became aware that "Dr. Salgueiro was not always present during the times required by the work order." (Lappin letter of February 18, 2004, page 3). During the June visit, the team met personally with CDR Anderson regarding this statement.

CDR Anderson told the team that after assuming her new duties, she began to examine the billing procedures for all consultants, not just Dr. Salgueiro, who were coming into the institution. CDR Anderson wanted to ensure that consultants were not charging the institution for hours when they were not actually seeing patients (e.g., while eating lunch). When she first arrived at Memphis, CDR Anderson was engaged in tending to her new duties and more emergent matters, which did not permit her to closely scrutinize the time and attendance records of the contract workers. However, CDR Anderson did receive information that there were discrepancies between the time and attendance recorded and the actual time worked by Dr. Salguiero.

As such, CDR Anderson wanted to ensure that there was some reliable mechanism for tracking the actual time when consultants entered and left the institution. After being at Memphis for approximately two months, Ms. Anderson instituted a time clock procedure at the entrance to the institution, hoping they would develop reliable records to verify when inmates were actually

being seen. Unfortunately, prior to implementation of the time clock, there was really no way to guarantee that the time sheets submitted by consultants accurately reflected the time that was worked.

Sufficiency of Interview of Dr. Naimey

In the most recent telephonic communication between your staff and the Bureau, the Bureau was asked to address Dr. Naimey's claim that he was not sufficiently interviewed during the team's first visit, and that his staff were not previously interviewed at all. You asked that we provide you with the names of staff that were interviewed in January. Three of the Agency's regional health services employees traveled to Memphis in January 2004 and interviewed staff at FCI Memphis. Those interviewed, included Dr. Naimey; Warden Randy Davis; Associate Warden Gary Aaron; Dr. Stacey Spier, Chief Psychologist; CDR Joyce Anderson, Health Services Administrator; LCDR Darryl Meyers, Chief Pharmacist; Controller Demetrice Rufus, and Phlebotomist Virginia Harris.

During the June visit, the team interviewed these same individuals, as well as Physician's Assistant Danuta Gonzalez. Dr. Naimey was interviewed for approximately three hours. Dr. Naimey provided the team with the names of people he thought the team should interview, and the names of inmates whose care he felt had been compromised by lack of access to the consultant psychiatrist, or by untimely laboratory reports. Dr. Naimey suggested that the team speak with three physician's assistants, two nurses, the phlebotomist, and Dr. Salguiero. The team spoke with several of the individuals identified by Dr. Naimey (physician's assistant, phlebotomist), but did not personally interview everyone whom Dr. Naimey referenced. After having spoken with the physician's assistant and phlebotomist, the team determined that it had a solid understanding of Dr. Naimey's concerns and that additional interviews would only produce duplicative information. The team focused its efforts on reviewing the specific medical records of patients named by Dr. Naimey, as well as the records of those patients who were randomly selected for review.

Mental Health Care at FCI Memphis

An experienced physician from the team reviewed the medical records of several inmates whom Dr. Naimey felt had not received adequate care due to the delay in laboratory work. The physician also reviewed a random sample of medical records of HIV positive inmates and diabetic inmates to determine whether the chronic

care inmates were receiving proper medical care. A psychiatrist from the team reviewed the medical, psychiatric, and psychology records from some of those same inmates, as well as a random sample of other inmates at Memphis.

Specifically, Dr. Naimey discussed at length with the team one inmate whom he believed to have decompensated as a result of the delay in lab work and the lack of a contract psychiatrist. Dr. Naimey also mentioned this inmate in his May 3, 2004 letter to Ms. Pawlawski. According to Dr. Naimey, inmate Roberto Alonso-Llerena may have seriously assaulted three other inmates due to lack of appropriate psychiatric care. I have listed below the circumstances surrounding that assault. I have also provided an analysis of the mental health care provided to the inmates involved in the assault.

Psychiatric Services

A review of the psychiatric records was conducted by a psychiatrist on the team, who visited Memphis in June 2004. The team's psychiatrist interviewed Dr. Naimey; CDR Joyce Anderson; Dr. Stacy Spier; Dr. John Weaver, Staff Psychologist; Dr. Cherrie Hunter, Staff Psychologist; LCDR Darryl Meyers, Chief Pharmacist; and Gary Tomlinson, Contract Pharmacist. The team's psychiatrist also reviewed the psychology notes and health records of the inmates involved in the assault, along with five randomly chosen inmates from the list of inmates in the mental health chronic care clinic. From the interviews conducted and from a review of the documents, the team's psychiatrist determined that there were no negative outcomes or lapses in availability of psychiatric medications during the time when there was no contract psychiatrist.

Specifically, the team's chief psychiatrist reviewed the charts of inmate Alonso-Llerena, inmate Gerald Porter, inmate Blas Gonzalez-Corrales, and inmate Rafael Urena-Quezada. A review of these records and interviews with treating physicians/psychology staff assisted the chief psychiatrist in formulating an opinion that the altercation was not a result of mental health issues or the lack of care in addressing such issues.

A review of inmate Alonso-Llerena's records established that this inmate has a long history of serious violence towards others and that he has not responded to treatment in the past. The chart reviewed by the team's psychiatrist established that previously, during a hospitalization at another agency facility, it was determined by mental health staff that the inmate did not

suffer from any mental illness, such as bipolar disorder, major depression with psychotic features, or schizophrenia. Instead, it was determined that he was an inmate who was not compliant with his medications and that his mental health symptoms were malingering. (See Attachment 2). It was determined that this inmate more than likely suffered from a severe personality disorder and not a major mental illness. In addition to that hospitalization, inmate Alonso-Llerena had been hospitalized at another Bureau of Prisons' facility where he had been given a mental health diagnosis. However, he was discharged from that facility with no medication, after having been mentally stable for over a year without medication.

When inmate Alonso-Llerena returned to FCI Memphis from these hospitalizations, he was seen regularly during the time preceding the assault. (See Attachment 3). On September 26, 2003, inmate Alonso-Llerena was seen by the contract psychiatrist, who opined that the inmate had a bipolar disorder and a borderline personality disorder. The inmate agreed to remain on anti-anxiety medication as well as try a mood stabilizer. The contract psychiatrist noted that he would like to see this inmate in four weeks.

On October 24, 2003, Dr. Weaver, a psychologist at the institution, saw inmate Alonso-Llerena and noted that he "exhibited a bright affect" and "denied any need for increased contact with this service." (See Attachment 5). Three weeks later, on November 12, 2003, Dr. Naimey saw inmate Alonso-Llerena, and Dr. Naimey noted that the inmate presented well and that he refused all medication. (See Attachment 6). Dr. Naimey wrote a comprehensive note, indicating that the patient was coherent, well groomed, oriented in all three spheres, and apparently not in any acute distress. He noted the lack of suicidal or homicidal ideation. Also in this note, Dr. Naimey discontinued the medication for inmate Alonso-Llerena. Dr. Naimey, however, did send a request to the Chief Psychologist requesting close follow-up by psychology staff.

Unfortunately, three days after seeing Dr. Naimey, and before he was seen by psychology staff, inmate Alonso-Llerena assaulted three inmates: inmate Porter, inmate Gonzalez-Corrales, and inmate Urena-Quezada. Inmate Alonso-Llerena was approached by inmate Porter. The assault began when inmate Porter confronted inmate Alonso-Llerena about an unspecified issue. Inmate Alonso-Llerena beat inmate Porter about his head and body, and then sought out inmates Gonzalez-Corrales and Urena-Quezada, and physically assaulted the two of them. Even had inmate Alonso-Llerena been seen earlier by Dr. Salgueiro, there is no

indication he would have been compliant to take the psychotropic medication that he had been previously prescribed. Under current Bureau of Prisons regulations, an inmate may not be compelled to take psychotropic medication unless his condition is such that there is a "psychiatric emergency." (See Attachment 7). From Dr. Naimey's chart note three days prior to the assault, it does not appear inmate Alonso-Llerena's condition would qualify at that time as a "psychiatric emergency." (See Attachment 6).

Within hours of the assault, inmate Alonso-Llerena was interviewed by a psychologist. The notes of that interview indicate inmate Alonso-Llerena was calm, and devoid of any overt symptoms suggesting a mental illness. In fact, he boasted openly to staff about how he carried out the assault. He also made it clear that he did not wish to see psychology staff, or discuss the incident with them. (See Attachment 8). Thus, there is nothing to support Dr. Naimey's assertion that the assault was a result of the cancellation of Dr. Salguiero's contract or that the assault was a result of the delay in lab work. Inmate Alonso-Llerena was prescribed medication that he was refusing to take. As such, no delay in laboratory requests affected inmate Alonso-Llerena. In addition, inmate Alonso-Llerena had just been seen by Dr. Naimey three days prior to the assault. There is nothing to show that had inmate Alonso-Llerena been seen earlier, the assault would not have occurred.

The team's psychiatrist determined that the assaultive behavior exhibited by Alonso-Llerena was related to the personality disorder as opposed to a treatable mental illness.

Another inmate mentioned specifically by Dr. Naimey is inmate Gerald Porter. Inmate Porter was one of the victims in the assault by Alonso-Llerena. Inmate Porter has been diagnosed with medical illnesses as well as mental health illnesses, and as a result, he had been seen regularly by medical and psychology staff. A review of his charts revealed that he was seen as follows: April 16 by the contract psychiatrist, May 21 by the contract psychiatrist, August 26 by the staff psychologist, September 12 by the contract psychiatrist, September 25 by the staff psychologist, and October 14, 2003 by the staff psychologist. (See Attachment 9). He was seen by Dr. Weaver on November 15, after the assault, at which time he was noted to be calm and in no apparent distress. He was seen again on November 25, at which time Dr. Weaver noted there were no overt signs of mental illness. He was seen again by psychology on December 22 and was noted to be doing well. (See Attachment 10 for notes on November 15, 25, and December 22 visits). He was seen by the contract psychiatrist on January 9, 2004. The team's

psychiatrist noted that although this inmate was consistently noncompliant with his medications, none of the psychiatry, medical, or psychology staff noted such. The notes from the staff's sessions with the inmate, however, do reveal that there were no particular concerns with the inmate, other than willful incontinence and that there was no change in his overall presentation from May until August 2003. (See Attachment 11). During the absence of a contract psychiatrist, Dr. Naimey refilled all of the inmate's medications.

The team's psychiatrist determined that there was no evidence presented in the medical charts or provided during the staff interviews that established that the inmate's psychiatric condition contributed to the assaults by Alonso-Llerena. In addition, there was also no evidence to establish that inmate Porter's medical or psychiatric care suffered from the lack of a contract psychiatrist. The inmate continued to be seen after the contract psychiatrist's contract was terminated.

Inmate Blas Gonzalez-Corrales was also a victim of Alonso-Llerena's assault on November 15, 2003, and his records were also reviewed by the team's psychiatrist. Inmate Gonzalez-Corrales had a history of psychotic symptoms that quickly remitted with low dose antipsychotic medication. However, inmate Gonzalez-Corrales also had a history of noncompliance with his medication once he started to feel better.

Inmate Gonzalez-Corrales was seen by Chief Psychologist, Dr. Spier, on September 30, 2003, when staff reported that the inmate was threatening to hurt someone. The inmate refused to speak to Dr. Spier, and he was again seen on October 6, 2003, but this time he was seen by Dr. Weaver. (See Attachment 12). Because of the inmate's presentation during the session, Dr. Weaver consulted with Dr. Naimey and the contract psychiatrist, and they placed the inmate on antipsychotic medication at the recommendation of the contract psychiatrist.

Inmate Gonzalez-Corrales was then seen by psychology staff on October 8, October 10, October 14, October 21, and November 13, 2003. (See Attachment 13). At the last visit, two days before the assault, the inmate appeared to be free from the "acute symptoms." He was later seen on November 25, 2003, and it was noted that "n[o] overt symptoms of mental illness were observed." (See Attachment 14). His medication was discontinued by Dr. Naimey during the subsequent session on November 24, 2003, due to noncompliance. (See Attachment 15).

On December 5, 2003, this inmate was again seen by Dr.

Spier, and he appeared depressed and requested to be placed back on his medication. (See Attachment 16). Dr. Spier referred the case to Dr. Naimey, whose clinical note of December 8, 2003, states that he consulted with Dr. Spier and Dr. Weaver, and decided to place the inmate on antipsychotic medication again. The contract psychiatrist then saw the inmate on January 13 and February 6, 2004. On February 9, 2004, the medication was discontinued due to ongoing noncompliance.

Based on a review of this medical documentation, as well as the information gathered from the interviews with medical staff, the team's psychiatrist found no evidence to suggest that this inmate was assaulted due to the presence of an untreated or inadequately treated mental illness. The evidence supported that the inmate had been appropriately treated in a timely manner on the two occasions he presented with active symptoms of mental illness, in spite of the absence of a contract psychiatrist. His noncompliance with medication was a consistent problem for him whether under active treatment with a psychiatrist or not, and appeared to be related to his remission of symptoms and lack of insight into the likelihood of their eventual return, rather than a lack of appropriate medical care.

The third victim of the assault, Rafael Urena-Quezada, had a history of a psychotic disorder. He was first seen by the contract psychiatrist on May 14, 2003. (See Attachment 17). He was then seen regularly on May 21, June 4, July 9, and July 11, 2003. (See Attachment 18). Psychology also saw this inmate on July 24, 2003. On August 21, 2003, the notes from the psychology visit indicated that the inmate showed positive progress with less frequent hallucinations. (See Attachment 19). The contract psychiatrist saw the inmate again on September 12, 2003 and increased the inmate's nighttime medication to address the increased nightmares and occasional auditory hallucinations. Psychology noted mild improvement with this inmate on September 16, 2003.

Inmate Urena-Quezada had no further visits with the psychiatrist due to the termination of the contract. However, the inmate continued to be seen on a monthly basis by psychology. On October 24, 2003, psychology saw this inmate, and it was noted that he was in full compliance with his medication. On October 31, 2003, Dr. Naimey approved renewal of the inmate's psychiatric medication.

Because inmate Urena-Quezada was severely injured during the assault of November 15, 2003, he was rushed to the local hospital and was not seen by psychology staff until November 25, 2003.

The notes from this meeting indicate that the inmate was doing well from a psychiatric standpoint. He was again seen by the psychologist on December 17, 2003. On January 9, 2004, this inmate was seen by the contract psychiatrist. The contract psychiatrist continued to see this inmate regularly: on January 23, January 30, and March 26, 2004.

In summary, there is no evidence that inmate Urena-Quezada's condition of chronic low grade psychotic and depressive symptoms in any way contributed to his being a victim of the assault on November 15, 2003. Nor does it appear that his psychiatric condition was negatively impacted by the decrease in the psychiatrist's hours, or by the absence of a psychiatrist from October through December 2003. He was seen regularly by the psychiatrist while the contract was still in effect. After the termination of the contract, the inmate was seen regularly by psychology, and Dr. Naimey continued the inmate's medication.

The team's psychiatrist noted that during the absence of a contract psychiatrist from October through December 2003, there was only one patient, of those patients receiving medication through the chronic care clinic, whose medication regimen was interrupted. This patient was not one specifically named by Dr. Naimey, but one whose records were reviewed randomly by the team's psychiatrist. The patient's prescription expired on August 26, 2003 (during the time when the contract psychiatrist was still under contract). This inmate went without medication for seventeen days, from September 1 through September 16, 2003. However, there is nothing in his records (nor did the interviewed staff indicate otherwise) that suggest any negative outcome related to the delay in medication.

In addition to the review of the charts of inmates specifically named by Dr. Naimey, the team's psychiatrist reviewed a random sample of charts of inmates in the chronic care clinic to ascertain whether there were any negative outcomes related to the contract psychiatry issues. The review revealed that these inmates appeared to have received appropriate care. The records showed that the inmates were monitored appropriately and that they continued to get their psychotropic medication during the absence of the contract psychiatrist.

In short, the team did not feel the serious assault committed by inmate Alonso-Llerena was an event that would have been prevented if Dr. Salguiero's contract had not been cancelled. Nor did the team feel reduction in the hours of the contract phlebotomist had negatively impacted inmate care.

Laboratory Work

In addition to discussing his concerns about inmate Alonso-Llerena, Dr. Naimey described to the team the condition of six inmates whose medical care he believed had been compromised when the institution reduced the hours of the contract phlebotomist. One of the two physicians reviewed each of these cases. The physician spoke with Dr. Naimey about each of the cases. Of the six cases, Dr. Naimey provided five names and register numbers of inmates; he could not recall the identity of one of the inmates. The sixth inmate had been transferred to another institution. As a consequence, the transferred inmate's medical file was not available for review. Thus, four of the six cases were reviewed by one of the team's physicians.

In the first case, the physician found that an inmate with hyperthyroidism received lab work every three months (and not every month), which was an acceptable practice. The physician found that in October 2003, the inmate became non-compliant with his medication and subsequently became "symptomatically hypothyroid." This situation was addressed, however, by medical staff and corrected. (See Attachment 20).

The second inmate suffered from hyperlipidemia. A lipid panel for this inmate was ordered and performed in August 2003, but was not given to the physician until November 6, 2003. Although there was a delay between the lab work being performed and the results being provided to the physician, no harm resulted from the delay, as the inmate did not become symptomatic during this period. The physician noted that the inmate's lipids were not well controlled for the year prior to this delay in lab work, and they only became better controlled when appropriate combination therapy was instituted by Dr. Naimey sometime between January and March, 2004.

The third case mentioned by Dr. Naimey involved an inmate with chronic hepatitis. Laboratory work was ordered on this inmate July 15, 2003 and performed October 1, 2003. Dr. Naimey claimed that this inmate suffered harm with respect to his chronic hepatitis. According to this inmate's medical records, however, he was never considered a candidate for a liver biopsy. Thus, the recommended course of following his enzymes would have been once or twice a year, and the delay in laboratory work did not result in any harm to this inmate.

Finally, Dr. Naimey states that an inmate with a history of hypertension and renal insufficiency suffered harm when lab work ordered on October 6, 2003 was not completed until November 24,

2003. This inmate received quarterly chronic care visits, and there was no determination during those visits that his slow decline in renal failure was abnormal for his condition. In fact, a review of this inmate's records established that lab work to obtain his creatine levels was performed more frequently and regularly after July 2003 than for the year prior.

It is apparent that there was a delay in lab work from the time requested to the time performed. However, after careful review of these four medical records, the team's physician concluded that the four cases reviewed did not demonstrate that a delay in the performance of the requested laboratory procedure had any impact on the inmate's medical status or in the ability of the physician to manage the condition.

The team's physician conducted a random review of medical files of inmates whose conditions would necessitate frequent laboratory work to see if he could detect cases where inmate care was impacted by laboratory tests not being done in a timely fashion. The physician reviewed 10 files of inmates with diabetes and found the required HgbA1c laboratory studies were performed as recommended and in the charts more regularly after July 2003 (the month when the phlebotomist's hours were reduced from 30 to 15) than they had been before July 2003. A review of 10 cases of inmates infected with HIV was conducted, and again, the physician found that the required viral loads and CD4 counts were obtained as recommended after July 2003.

Conclusion

It is clear that Dr. Naimey believed that the changes to operating procedures at FCI Memphis negatively impacted the mental and physical health of inmates in the chronic care clinic. It is also unfortunate that my original response was negatively skewed by inaccurate information. However, I am confident from this second review that my original assertions remain valid. The records reviewed by the team's physician did not demonstrate that a delay in the performance of the requested laboratory procedure had any impact on the inmate's medical status or in the ability of the physician to manage the condition. Nor did the records reviewed by the chief psychiatrist reveal that there was a negative outcome with any chronic care clinic patient during the relevant time period.

Dr. Naimey specifically mentions the assault by inmate Alonso-Llerena and implies that the assault was the result of the absence of a contract psychiatrist and delay in laboratory work. However, a careful review of this inmate's records, as well as

the other inmates involved in the assault, establish the absence of any evidence that correlates the assault with the treatment given to the inmates. In fact, the records show no evidence of any active mental illness in any of the inmates involved at the time of the assault. In addition, the records showed that each one of these inmates was seen regularly by either psychiatry or psychology. The records also showed that each inmate's medications continued uninterrupted, even though most of these inmates were non-compliant with their medication.

Dr. Naimey insinuates that the inmates in the chronic care clinic were not seen as regularly as policy dictates or as safety requires. However, comparison of statistics from 33 other male, non-Medical Referral Center institutions with 4 to 6% of their inmates in mental health chronic care clinics, reveals that the average number of hours of coverage by a psychiatrist (staff, contract, or telepsychiatrist) was approximately seven hours monthly per 1000 inmates. FCI Memphis has approximately 5% of its inmates in mental health chronic care clinics, and, prior to July 2003, was averaging anywhere from 24-32 hours of coverage per month. This is equivalent to approximately 15 to 20 hours per month per 1000 inmates, approximately 1.5-2 times beyond the hours provided by other similarly situated institutions. (See Attachment 21). Currently, the contract psychiatrist is providing the equivalent of 12 hours per month per 1000 inmates. There is no indication that the reduction in contract hours resulted in less than usual psychiatric coverage as practiced in a large number of our male facilities.

Notwithstanding the initial regrettable conflicts in the information I provided, I am confident that the information provided in this response is accurate and sufficiently addresses the allegations raised by Dr. Naimey in his initial correspondence, as well as the concerns raised by staff in their subsequent telephonic contact with the Bureau. There is no evidence that the changes in operating procedures were inappropriate. The laboratory delays and cancellation of the contract psychiatrist's duties did not place inmates' lives, well-being, or safety in jeopardy. In addition, the medical department at Memphis meets, and in some areas, exceeds agency standards.

After this subsequent review of the care provided to inmates in the chronic care clinic at FCI Memphis, I am comfortable stating that there was not a violation of law, rule, or regulation in providing mental health care to inmates at FCI Memphis. I can also state with confidence that there is no likelihood of a substantial and specific danger to public health

and safety. I appreciate the opportunity to provide additional information to you and trust that this information is responsive to your concerns.

Sincerely,


Harley G. Lappin
Director