BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Todd A. Leonard, M.D.
Year of Birth: 1968
License Number: 39,822

FINDINGS OF FACT, CONCLUSIONS, AND FINAL ORDER

The above-entitled matter came on for an evidentiary hearing on July 12–16 and 19, 2021, before Administrative Law Judge ("ALJ") Ann C. O'Reilly, at the request of the Minnesota Board of Medical Practice ("Board") Complaint Review Committee ("Committee"). The matter was initiated pursuant to the Notice and Order for Prehearing Conference and Hearing ("Notice of Hearing") issued by the Committee on August 18, 2020. Keriann L. Riehle and Nicholas Lienesch, Assistant Attorneys General, represented the Committee. David P. Bunde of Fredrikson & Byron, P.A., Minneapolis, Minnesota, represented Todd Arthur Leonard, M.D. ("Respondent").

On December 17, 2021, the ALJ issued Findings of Fact, Conclusions of Law, and Recommendation ("ALJ's Report"), recommending the Board take significant and appropriate disciplinary action against Respondent. (A true and accurate copy of the ALJ's Report is attached hereto and incorporated herein as Exhibit A.)

The Board convened to consider the matter on January 8, 2022, at 335 Randolph Avenue, Suite 140, St. Paul, Minnesota 55102, via WebEx videoconference. The following Board members were present: Chaitanya Anand, M.B., B.S.; Cheryl L. Bailey, M.D.; Christopher Burkle, M.D., J.D., FCLM; Tenbit Emiru, M.D., Ph.D., M.B.A.; Anjali Gupta, M.B., B.S., M.P.H.; Shaunequa B. James, MSW, LGSW; John M. (Jake) Manahan, J.D.; Allen G. Rasmussen, M.A.; Kimberly W. Spaulding, M.D., M.P.H.; Jennifer Y. Kendall Thomas, D.O., FAOCPMR; Stuart T. Williams, J.D.; and Cherie Zachary, M.D., ABAI. Keriann L. Riehle, Assistant Attorney General, appeared

and presented oral argument on behalf of the Committee. Respondent Todd A. Leonard, M.D., and his attorney, David P. Bunde, appeared and presented oral argument. Gregory J. Schaefer, Assistant Attorney General, was present as legal advisor to the Board.

The following Board members did not participate in deliberations: Cheryl L. Bailey, M.D., and John M. (Jake) Manahan, J.D. Board staff who assisted the Committee did not participate in the deliberations.

FINDINGS OF FACT[1]

The Board has reviewed the record of this proceeding and hereby accepts the December 17, 2021, ALJ's Report and accordingly adopts and incorporates by reference the Findings of Fact therein. Accordingly, the Board hereby finds as follows:

I. Background: Respondent[2] and MEnD

1. Respondent has been licensed to practice medicine and surgery in the State of Minnesota since 1997. He is board-certified in family medicine.

2. Respondent is the owner, president, and former chief medical officer of MEnD Correctional Care, PLLC (MEnD), which provides contracted medical services to inmates at county jails. MEnD has contracts to provide correctional health care services at 48 correctional facilities in five states: Minnesota, Wisconsin, Iowa, Illinois, and South Dakota. At least 75 percent of the facilities served by MEnD are located in Minnesota. With each facility housing approximately 150 to 200 inmates, MEnD is charged with overseeing the medical care of the approximately 7,200 to 9,600 inmates, in five different states, at any given time.

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[1] To conform to the standard format the Board uses for findings of fact and for ease of reading, the ALJ's citations to the record have been removed from this order and are incorporated herein pursuant to the ALJ's Report, attached as Exhibit A.

[2] The removal of Respondent's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

3. This action arises out of Respondent's work as the chief medical officer of MEnD and the supervising/attending physician for the Patient,[3] an inmate-patient at a county jail[4] who died under Respondent's care on September 2, 2018.

4. Respondent began his professional career by graduating from St. Cloud State University with a bachelor's degree in business marketing. In 1992, Respondent proceeded to medical school at the University of Minnesota-Duluth. Upon graduating from medical school in 1996, Respondent began practicing in family medicine with a health care provider[5] in the St. Paul metropolitan area.

5. In 2006, a county sheriff[6] reached out to Respondent to consult with him regarding the medical care provided to inmates at the county jail. At that time, the county jail contracted with a health organization[7] to provide health care to its inmates. Respondent reviewed the services provided by the health organization and offered his opinions regarding efficiencies and cost-saving methods for providing health care services to inmates at the jail.

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[3] The removal of the Patient's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[4] The removal of the county name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[5] The removal of the hospital name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[6] The removal of the county name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[7] The removal of the health organization's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

6. Shortly thereafter, Respondent accepted a position to serve as the medical director for the county jail. He was soon approached by a second county[8] to provide consultation services, and later, contracted with a third county[9] to provide medical services to its jail.

7. In approximately 2008, Respondent decided to create MEnD, a company that contracts to provide medical services to local jails and correctional facilities. From its inception in approximately 2008 until early 2021,[10] Respondent served as the chief medical director of MEnD, in addition to being the president and founder of the company.

A. MEnD Contract With the County Jail

8. In 2012, MEnD entered into a Medical Services Agreement with the county to provide health and medical services to detainees and inmates at the county jail. Under the initial contract, the county engaged MEnD to provide a medical director, nursing services, and a mental health specialist. The contract was amended and extended in 2013 to expand the types and hours of services provided by MEnD.

9. Under both the initial and amended contracts, the medical director was required to be "licensed" and provide "general and urgent care to detainees and inmates." In addition, the medical director was required to:

- Supervise the medical care provided to detainees and inmates;
- Make "appropriate frequency" of visits to the jail to care for inmates, which "will typically be once per week for up to 4 hours";
- Perform medical procedures at the jail whenever feasible;

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[8] The removal of the county name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[9] The removal of the county name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[10] In early 2021, MEnD hired a new corporate medical director and Respondent's positions in the company were limited to president and CEO.

- Prescribe medication for detainees and inmates;
- Assist jail and provide administration in budgeting, planning, vendor negotiations, and presentations;
- Assist in the development and review of treatment protocols, policies, and procedures;
- Supervise nursing staff and review medical charts;
- "Be available (or have another licensed provider available) at all times, by phone or in person, to assist nursing staff or answer jail staff questions regarding the medical needs of inmates;" and
- Furnish pre-employment medical examinations as requested for prospective jail personnel upon request.

10. The contract, as amended, required MEnD to provide registered nurses on site an average of 72 hours per week, "largely during the workday," as well as "[b]e available at all times by at least phone consultation to assist jail staff and answer medical questions regarding care of inmates." This was expanded from the original contract, which required registered nurses to be present 60 hours per week.

11. When the original contract was amended in 2013, it added provisions that MEnD would also provide health service technicians. These technicians included one full-time lead technician working "business hours" during weekdays and other full- or part-time technicians whose hours included "split shifts" during the weekends. These technicians would not be licensed nurses, but rather, unlicensed healthcare providers (generally nursing assistants or medical assistants) who would be on site at the jail an average of 99 hours per week. These technicians were charged with delivering medications, assisting the registered nurses with routine tasks (such as taking vital signs), and other unlicensed or administrative tasks.

12. While the contract with the county, as amended, included additional staff and services, it was not contemplated that MEnD would provide on-site, round-the-clock medical care

to inmates. MEnD nursing and medical technician staff were scheduled at the jail during daytime hours on weekdays and split-shifts (mornings and evenings) on the weekends and holidays. A registered nurse (RN) was scheduled to be on site during daytime hours weekdays (Monday through Friday, from 7:00 a.m. or 8:00 a.m. to 4:30 p.m.) and four hours each day on Saturdays, Sundays, and holidays. Medical technicians were scheduled each day for 12 hours a day, with split-shifts (mornings and evenings) on weekends and holidays.

13. The original contract provided for monthly compensation of $17,075 ($204,900 annually) to MEnD, with annual two-percent increases. When the contract was amended in 2013, and the scope of services expanded, the compensation to MEnD increased but is unavailable in the hearing record due to redaction. According to Respondent, MEnD's net profits in 2020 were "a few" hundred thousand dollars.

14. While MEnD was the contracted healthcare service provider inside the jail, the agreement expressly noted that MEnD would not be responsible for the medical services and costs provided outside the jail to inmates for whom the county was the detaining authority, including hospital, ambulance, and transportation services. In other words, MEnD was not responsible for the costs of any medical care an inmate required from clinics, hospitals, or healthcare providers outside the jail, including emergency room visits or specialized care.

B. MEnD's Internal Policy Manual

15. To ensure a proper chain of command for medical decisions, MEnD maintained a Correctional Care Policy Manual, applicable to all of its medical staff and "designated jail personnel." Under this policy, each correctional facility served by MEnD was required to have a designated "Responsible Health Authority" (RHA) and a designated medical provider reporting directly to the RHA.

16. Under MEnD's Correctional Care Policy, the RHA was responsible for

- Overseeing all of MEnD's "policies/procedures, protocols, forms, and practice philosophies in all MEnD-served facilities;"
- "Review[ing] treatments of detainees by other health care providers (in-house, boarders, outside physicians), as requested or needed by the medical providers in each facility MEnD serves;"
- "Supervis[ing] the care provided to detainees by medical staff and correctional staff." Under the policy, "[t]he RHA will have the final judgment on all medical matters related to the healthcare of detainees that reside in each facility served by MEnD;" and
- Providing peer review for staff medical providers.

17. At all times relevant herein, Respondent was the designated RHA for MEnD and the county jail. As such, he was responsible for supervising the medical care provided to inmates in the jail by MEnD medical staff. He also maintained final decision-making authority for the healthcare provided to inmates in the jail.

18. MEnD's Correctional Care Policy provided that the designated medical provider for each facility was responsible for:

- conducting medical visits and assessment for detainees, including diagnosing medical conditions and selecting appropriate treatment options;
- reviewing and prescribing medications for detainees;
- reviewing treatments for all detainees including those done inside or outside the jail during incarceration;
- making decisions for the care of detainees in the jail during their incarceration, "which includes referrals to outside facilities or providers when necessary;" and
- supervising the day-to-day healthcare provided in the jail.

19. During the relevant time frame herein,[11] with the exception of August 31, 2018, when Respondent delegated his authority to a nurse practitioner for the day, Respondent was effectively the designated medical provider for the county jail.[12]

C. Organizational Structure of MEnD

20. In 2018, the organizational structure of MEnD included a chief medical officer (Respondent) who had ultimate supervisory authority over all other company healthcare workers and employees. The positions reporting directly to the chief medical officer (Respondent) at that time included: a director of nursing, a human resources director, "medical providers" (e.g., physician assistants and nurse practitioners), a mental health director, and an office manager.

21. The director of nursing supervised all nurses, including, indirectly, the health technicians at each facility. The director of nursing reported directly to Respondent.

22. Below the director of nursing were regional "nursing directors" who had authority over supervisory RNs (one at each facility) in their regions. Each facility had a supervising RN, who oversaw staff RNs and the lead health technician at that facility. Each facility had a lead health technician, who supervised the various health technicians at that facility.

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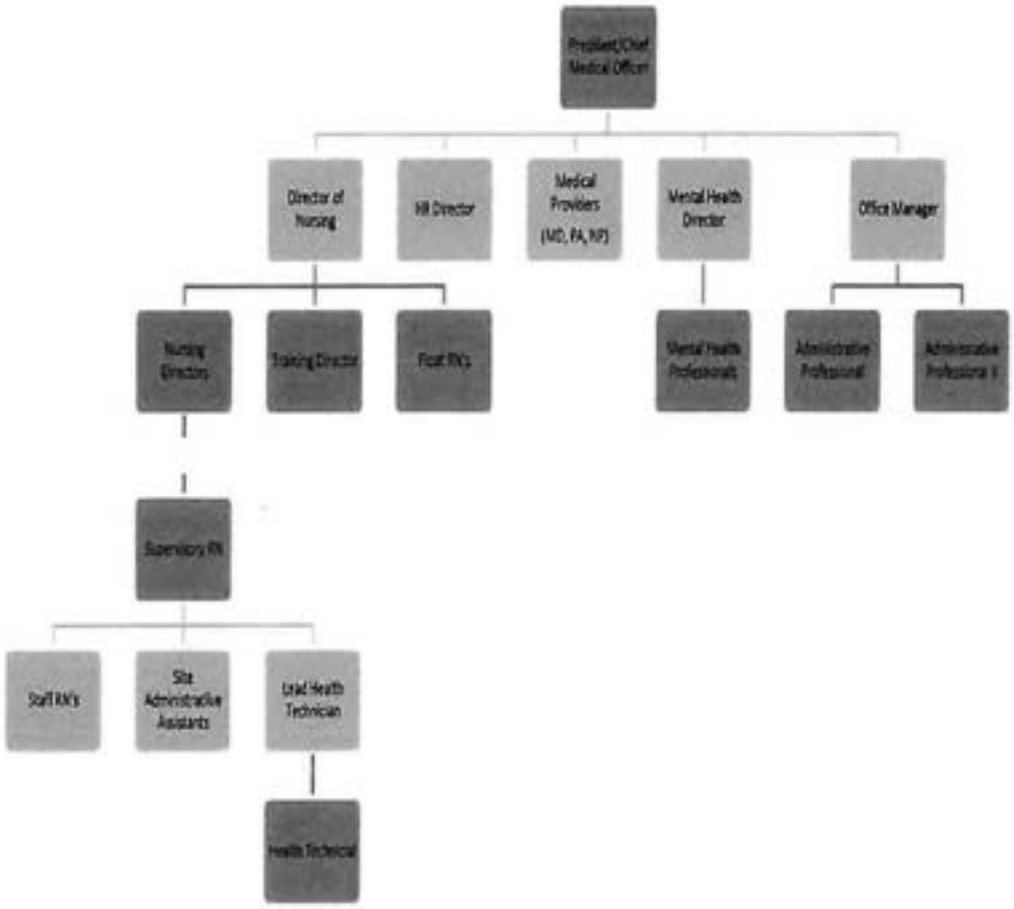
[11] August 24 to September 2, 2018.

[12] While Respondent was reluctant to admit he was the designated medical provider for the county jail during the nine days that the Patient was in the jail, it is clear from a totality of the evidence that he effectively served as the designated medical provider for the jail during that time. Medical Provider #1, a nurse practitioner had just started at the company and was in training, shadowing Respondent on his rounds. Throughout the Patient's stay in the jail, all medical staff contacted Respondent directly for consultation and direction – and no other medical provider. Medical Provider #1served as the jail's medical provider on August 31, 2018, only because Respondent, who was supposed to accompany Medical Provider #1 on rounds at the jail that day, suddenly cancelled and instructed Medical Provider #1 to complete the rounds without him. He, therefore, delegated his authority to Medical Provider #1 that day. Respondent continued to be the medical provider and supervising physician for the jail on September 1 and 2, 2018.

The removal of Medical Provider #1's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

23. The organizational chart for MEnD in 2018 was as follows:



24. Respondent served at the top of the organization chart, as the president and chief medical officer, having direct supervisory authority over the director of nursing and any medical providers assigned to a facility.[13]

25. "Medical providers" hired by MEnD were not necessarily physicians, but could include other healthcare workers, so long as they were graduates of "an accredited medical provider program" and maintained "a valid, unrestricted medical provider license." Medical

[13] In 2021, Respondent was "reassigned" from his position as medical director and a new "corporate medical director" was hired. Under the current corporate structure, MEnD has four medical doctors on staff, including Respondent (three fulltime and one parttime), who manage the healthcare staff and medical providers.

providers included physician assistants and nurse practitioners. However, in 2018, Respondent was the sole medical doctor responsible for final oversight over all facilities and medical staff serviced by MEnD.[14] In August 2018, Respondent would make approximately one visit per week to the county jail.

D. Nurse #1,[15] Director of Nursing

26. Nurse #1is the director of nursing for MEnD, a position she has held since 2016. Nurse #1 was one of the initial employees hired by MEnD after its inception. At the time, Nurse #1 was fresh out of college.

27. Nurse #1 graduated from St. Catherine's University in 2010 with a bachelor's degree in nursing and became licensed as an RN that same year. After graduation, Nurse #1 accepted her first nursing position with MEnD, where she initially served as a staff RN at three county[16] jails.

28. As the company grew, Nurse #1's position and responsibilities also expanded. Within the first few months of her employment, she assumed responsibility for MEnD's training programs for both MEnD healthcare workers and the county correctional employees working at the facilities served by MEnD. Within six years, Nurse #1 was promoted to MEnD's director of nursing, overseeing all of MEnD's nursing and medical technician staff. Aside from a short internship during college, Nurse #1's only experience as an RN was obtained through her employment with MEnD.

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[14] Respondent testified that MEnD had a parttime physician on staff, but that physician worked in Iowa. As MEnD's chief medical officer, however, Respondent had final supervisory authority over all MEnD healthcare staff.

[15] The removal of Nurse #1's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

[16] The removal of the county names is a non-substantive change made to conform with the Board's standard format in its past orders.

29. A couple years into her employment at MEnD, Nurse #1 and Respondent developed a romantic relationship. They even executed what she described as a "love contract," drafted by a lawyer for the company, to openly declare their romantic and professional relationship. At some point in the relationship, Respondent and Nurse #1 moved in together and, as of the date of hearing, they continue to reside together.[17]

30. By 2018, Nurse #1 was serving as MEnD's director of nursing and was the company's lead trainer and training developer. She was also assisting with human resource issues, helping to manage and build the business, and providing some direct patient care (approximately 10 to 15 hours per week). Her direct supervisor was Respondent, MEnD's owner, president, and chief medical officer at that time.

E. MEnD Training Materials

31. As part of her work as the company's first training director, Nurse #1 developed training materials for MEnD employees and correctional staff. The trainings are typically three to four hours initially (upon the start of a contract) and then annual and ongoing. These trainings warned of unique challenges faced by staff working with inmates in correctional facilities, including the possibility of "inmate manipulation" tactics, boundary issues, and security threats. Some of the training materials developed by Nurse #1 also made light of the inmate population that MEnD served. Examples of these training materials included:

- A cartoon of a healthcare professional physician looking out of a window, while a prisoner lays on an examination table, which included the caption, "You should get out more."
- A training slide about dealing with "demanding inmates" that contained a cartoon that stated, "No, please go on. I'm sure your internet forum has access to more medical literature and has studied it more than I have."

[17] In addition to not being able to recall her current salary, she was unable to recall how long she and Respondent have been living together.

- A slide instructing about patient care that included a cartoon of a woman in the bathroom with a caption reading, "Showering won't be enough after today. I'll need to be autoclaved."[18]

- A cartoon at the beginning of a mental health and substance abuse training that has a drawing of a "stoned hippy" with a caption reading, "You must be at least this high to enter." The MEnD commentary under the cartoon reads, "How many times do you feel like this sign should be in the front of your correctional facility???"

- A meme in training materials about inmate mental health issues with the caption, "Crazy people don't know they are crazy. I know I am crazy therefore I am not crazy, isn't that crazy."

32. The purpose of these cartoons and memes, according to Nurse #1 and Respondent, was to inject "levity" into the subject matter of the training materials and "have a chuckle."

II. Care of Inmate/Patient

33. On Friday, August 24, 2018, the Patient, a 27-year-old Black man, was transferred to the county jail for detainment on criminal charges. The Patient arrived at the jail at approximately 5:30 p.m. and began the intake process.

34. Jail video footage shows the Patient arriving at the jail, exiting a police vehicle, and walking into the facility. He appears in good health and is cooperating with the correctional staff. He is able to walk, talk, laugh, and joke with the jailers. While in the second-floor booking room, the Patient can be seen talking, walking, sitting, standing, and even dressing himself. He appears to have no difficulty ambulating or communicating with staff.

A. Saturday, August 25, 2018: Initial Health Assessment

35. As part of the jail's intake process, all inmates and detainees are subject to an initial health assessment.

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[18] An autoclave is a pressure and steam sterilization mechanism used in medical or laboratory environments.

36. On Saturday, August 25, 2018, at 9:30 a.m., Nurse #2,[19] RN, the MEnD nursing supervisor at the county jail, conducted the Patient's intake health assessment. At that time, Nurse #2 had been working for MEnD for approximately seven years.

37. The initial health assessment process conducted by MEnD included obtaining a short medical history from the inmate, as well as the collection of standard health data, such as obtaining the individual's height, weight, blood pressure, temperature, and pulse rate.

38. At the time of his initial assessment, the Patient's blood pressure measured 152/106, which was considered high for a male of his age. The Patient disclosed a history of chronic migraine headaches, hypertension, depression, and anxiety, as well as a recent incident of respiratory failure (eight months prior) and a traumatic brain injury from five years prior. The Patient also reported being treated with the prescription drug Lisinopril for high blood pressure in the past.

39. As for current issues he was experiencing, the Patient complained of mid- and upper back pain, particularly between his shoulder blades, as well as a headache.

40. The Patient reported that he had been incarcerated since August 1, 2018, at another facility. The Patient's primary concern was an ongoing migraine headache. He stated that he was nauseous, was experiencing pain behind his eyeballs, and was sensitive to light and sounds. He stated that he generally treated his migraines with ibuprofen.

41. During the assessment, Nurse #2 observed that the Patient was "kind" and "happy," was able to walk, and answered all questions presented to him. Based on her assessment, Nurse #2 decided to monitor the Patient's blood pressure and treat his migraine with Tylenol.

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[19] The removal of Nurse #2's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

42. As part of that monitoring process, MEnD Medical Technician #1[20] checked the Patient's blood pressure on Sunday, August 26, 2018, and noted that it measured 146/101, indicating continued hypertension.

B. Monday, August 27, 2018

43. On Monday, August 27, 2018, at approximately 7:35 a.m., the Patient requested another blood pressure check due to pain he was experiencing on the left side of his chest that began near his collar bone and extended into his neck. Based upon this report, Nurse #2 conducted a nursing assessment. The Patient was sweating and stated that the fingers on his left hand were tingling. He noted that he had only slept for approximately three hours, a fact confirmed by a corrections officer. The Patient explained that he had been experiencing severe pain for "some months" in his lower back and between his shoulder blades. However, this back pain was now extending into his right thigh and foot.

44. Nurse #2 noted that the Patient appeared to be in a great deal of pain. He was hunched over and appeared to be in significantly more discomfort than compared to his initial assessment two days earlier.

45. Nurse #2 took the Patient's blood pressure, which measured 159/104, and checked his pulse, which measured 101 beats per minute. Concerned with the Patient's high blood pressure, Nurse #2 decided to conduct an electrocardiogram (EKG) to ensure that the Patient was not experiencing a heart attack.

[20] The removal of Medical Technician #1's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

46. As an RN, it was within Nurse #2's scope of practice to conduct an EKG, using the jail's in-house EKG machine, but not to interpret the results, which are set forth in a paper printout. The EKG printout read, "probable inferior infarct," and registered as an "abnormal" result.

47. Nurse #2 decided to contact Respondent, MEnD's medical director and the designated medical provider for the county jail, to discuss her physical examination of the Patient and the EKG results. After reviewing the EKG record, Respondent concluded that the EKG registered a "false positive" result and that the Patient did not suffer a recent inferior infarct. Respondent determined that the EKG results were "benign."

48. Respondent ordered one dose each of ibuprofen (600 mg), Tylenol (acetaminophen) (975 mg), and hydroxyzine (50 mg), an anti-anxiety/antihistamine medication. He directed Nurse #2 to ensure that the Patient's blood pressure be checked by the visiting medical provider during the next rounds.

C. Tuesday, August 28, 2018

49. At approximately 8:30 a.m. on August 28, 2018, Nurse #2 conducted another medical assessment on the Patient. Prior to the assessment, Nurse #2 contacted the pharmacy that had last filled the Patient's prescription medications, including his blood pressure medicine and Flexeril. She learned that the Flexeril prescription was last filled in January 2018. Nurse #2 also learned that the pharmacy had not filled any other prescriptions since April 2018, indicating that the Patient was not regularly taking his high blood pressure medication.[21]

50. During the assessment, the Patient complained of back pain and numbness on his right side. He stated that it hurt to walk or lay down. The Patient recounted that he had fallen out

[21] This Finding of Fact has been revised consistent with Committee Exception #1. The revision to this Finding of Fact is consistent with the evidence presented at the hearing.

of bed sometime during the night and was left to lay on the ground of his cell for 25 minutes, even after speaking with a correctional officer. Nurse #2 observed that the Patient was in tears, moving very slowly, and favoring his right arm.

51. Nurse #2 took the Patient's vital signs, including checking his blood pressure (156/117), his pulse rate (95 beats per minute), and temperature (98.3 degrees). The Patient's blood pressure reading was consistent with continued hypertension.

52. Nurse #2 called supervising physician Respondent to discuss her assessment. Respondent believed at the time that the Patient may have suffered an injury from the fall from the bunk, which may have been causing the Patient's back pain and numbness. Respondent prescribed 600 mg of ibuprofen three times a day for seven days; 10 mg of Flexeril twice a day for seven days; and 10 mg of lisinopril (a high blood pressure medicine) daily. He also ordered that the Patient be given 600 mg of ibuprofen and 175 mg of Tylenol immediately. Respondent further directed that correctional officers allow the Patient to have a lower bunk and extra blankets. Respondent did not order any further testing or additional observations.

53. Respondent told Nurse #2 that he would order blood work to be completed on the Patient if the Patient stayed longer than one week in the jail. Notably, the Patient's medical records indicated that the Patient's "expected out/court date" was September 4, 2018, exactly one week later. In addition, on August 27, 2018 (just one day earlier), the Patient had been granted conditional release, allowing him to be released from jail pending the charges against him if bail was posted. The Patient's next court appearance was scheduled for September 4, 2018 – the Tuesday after the upcoming Labor Day holiday.

54. MEnD health tech/correctional officer incident call sheets and on-call documentation triage forms both require that an inmate's "expected out/court date" be filled in so

that providers know when an inmate is scheduled for release or for a court appearance that may result in release. According to Nurse #2, she was trained by Nurse #1 to ensure this date was always completed because it was "very important information" for Respondent to consider.

55. At approximately 8:00 p.m. on August 28, 2018, the Patient sent a "kite" or jail message asking to be taken to the hospital for medical treatment. The message read:

> I need to be seen and taken to the hospital on account of i [sic] can't feel my legs and cannot be physically mobil [sic]. Plz be fast about this because im also in incruciating [sic] pain in all my muscles all over my body.

D. Wednesday, August 29, 2018

56. At approximately 6:25 a.m. on August 29, 2018, Medical Technician #2,[22] MEnD's lead medical technician at the county jail, contacted nursing supervisor Nurse #2 to advise her that the Patient was unable to feel his legs or ambulate, and that his pain was getting worse. Nurse #2 instructed Medical Technician #2and correctional staff to place the Patient in a medical segregation cell (referred to as a "tank") until a MEnD nurse could arrive at the jail to assess him. Nurse #3,[23] RN, a MEnD staff nurse, was scheduled to arrive at approximately 7:00 a.m. to begin her shift.

57. There are two medical segregation cells in the county jail (cell #214 and #215), both of which contain surveillance cameras to allow correctional staff to observe and monitor the cells at all times. The surveillance cameras are also constantly recording footage, which can be played back by jail staff.

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[22] The removal of Medical Technician #2's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[23] The removal of Nurse #3's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

58. At approximately 9:24 a.m. on August 29, 2018, the Patient was brought to the second-floor nursing station at the jail for an evaluation by Nurse #3. Nurse #3 began by checking the Patient's foot. She then checked his vital signs, which showed blood pressure of 162/116, a pulse rate of 83 beats per minute, and blood oxygen saturation of 98 percent. In talking with the Patient, she learned that he had not been taking his Flexeril outside of the jail because he felt better without the medication.

59. The Patient explained that he had numbness starting around his belly button and traveling bilaterally down through his legs. He denied any loss of bowel or bladder control. Nurse #3 observed that the Patient was moving his arms, but when she asked him to lift his hands so she could remove the oxygen sensor, he stated that he could not move them. Once the sensor was removed, however, Nurse #3 claimed that the Patient was able to wave his arms and hands around. The Patient stated that his arms and hands would sometimes go numb, and that he had been unable to eat for two days because he could not properly lift his hands.

60. The Patient also reported that he was unable to move his legs. However, Nurse #3 noticed that when the correction officer pushed the Patient in a wheelchair, the Patient was able to lift his feet off the floor and avoid hitting his feet on a medical cart. At the same time, jail staff informed Nurse #3 that the Patient was able to stand and use the telephone earlier in the morning. Both Nurse #3 and the jail staff were skeptical of the Patient's medical claims. Nurse #3's physical examination of the Patient took less than five minutes.

61. Given her skepticism, Nurse #3 requested permission from jail staff to review video footage of the Patient's reported fall from his bunk. The jail administrator granted Nurse #3 permission to review video footage of the Patient in the medical segregation cell on the morning of August 29, 2018. The video footage that she reviewed, however, was not footage of the

Patient's fall from the bunk that the Patient reported to Nurse #2 on the morning of August 28, 2018.[24] Nonetheless, in her notes of August 29, 2018, Nurse #3 writes:

> [I] reviewed video of "fall." [Patient] eased himself to the side of bed and wheelchair and slowly guided himself to the floor.

62. The video that Nurse #3 actually reviewed was not the Patient's fall from the bunk that he reported to Nurse #2 on August 28, 2018, but rather, it was more recent video footage from the Patient in the medical segregation cell (#215) recorded the morning of August 29, 2018. Therefore, Nurse #3's notes are inaccurate and improperly imply that the Patient was exaggerating the fall from the bunk he reported on August 28, 2018.

63. Nurse #3's notes from August 29, 2018, go on to express further distrust of the Patient's reported symptoms. Nurse #3 writes:

> [Patient] was able to move himself in wheelchair in front of [me] but when [correction officers] attempted to transfer him to bed[,] he went limp and would not help them. Lunch was given and [Patient] stated [that] he was unable to eat it [due to] numbness in hands and unable to swallow. [Patient] was watched swallowing multiple times during talk with [me] [without] any difficulty, such as head movements or enhanced movements [with] swallowing. [Patient] requested to be moved back to [block].

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[24] The fall reported by the Patient on the morning of August 28, 2018, occurred either during the night of August 27 or in the early morning hours of August 28, 2018 (the report of the fall was made around 8:30 a.m. on August 28, 2018). At that time (August 27 and 28, 2018), the Patient was still in a cell with the general jail population – he was not in the medical segregation unit that was under individualized video surveillance. In addition, the Patient did not receive a wheelchair for his personal use until his transfer to the medical segregation cell. A correctional officer's report notes that he asked MEnD staff to transfer the Patient to a medical segregation cell at approximately 6:30 a.m. on August 29, 2018, so that the Patient could be monitored on camera. The Patient was moved to the medical segregation cell #215 at approximately 6:55 a.m. on August 29, 2018. The Patient was not under individualized video surveillance and did not have access to a wheelchair at the time of the fall he reported on August 28, 2018. Therefore, Nurse #3 did not view video of the fall from the bunk that the Patient reported on August 28, 2018.

This footnote has been revised consistent with Committee Exception #2. The revision to this Finding of Fact is consistent with the evidence presented at the hearing. The removal of the correctional officer's name in this footnote is a non-substantive change made to conform with the Board's standard format in its past orders.

1. Video Footage Reviewed by Nurse #3 (August 29, 2018)

64. The video that Nurse #3 reviewed begins at 7:57 a.m. on August 29, 2018, and continues until 9:52 a.m. that same day. The footage begins with the Patient sitting in a wheelchair apparently talking with someone who is outside the cell. The Patient is moving his arms and feet. The Patient pushes himself to the toilet, while in the chair, and spends a few minutes attempting to do something at the toilet. An officer enters the cell to remove bedding from the cot. At 7:21 a.m., the Patient is given medication and an officer replaces the Patient's bedding. The Patient lifts his legs using his hands and places them on the cot, while he remains seated in the wheelchair. The Patient's legs are fully outstretched, resting on the bed, while the remainder of his body is seated in the chair.

65. At 8:04 a.m., the Patient slides himself out of the chair and onto the floor. He sits upright for a minute, as he attempts to scoot his body forward, but then falls to the ground and lays on his side. He rolls and twists on the floor until 9:07 a.m., when two officers enter the cell and lift him back into the wheelchair. The Patient uses his hands to lift his legs back onto the cot, while remaining seated in the chair (his legs outstretched on the cot). An officer arranges the mattress under his legs while the Patient shakes his feet.

66. At 9:11 a.m. an officer wheels the Patient out of the cell and returns him to the cell a minute later. The officer lifts the Patient's legs onto the cot as the Patient remains seated in the chair. The Patient throws a blanket over his legs and places a pillow behind his back. At 9:25 a.m., an officer enters the cell and wheels the Patient away from the bed and out of the cell. The Patient is wiggling in the chair and is able to move his feet and arms. The Patient is brought back into the room at 9:32 a.m. The officer places the Patient's legs on the bed for him (as the Patient

remains seated in the wheelchair) and the Patient remains in that position until the end of the video at 9:52 a.m.

67. Thus, contrary to her notes, Nurse #3 did not observe video of the Patient's fall from the bunk that the Patient described to Nurse #2 the day before (August 28, 2018). Instead, Nurse #3 observed video of the Patient from the medical segregation cell shortly after he was moved to that room. As the video depicts, the Patient is not falling from a bunk – he is attempting to get out of the wheelchair and slides to the floor.

2. Nurse #3's Report to Respondent (August 29, 2018)

68. After her evaluation of the Patient on August 29, 2018, Nurse #3 called Respondent to report her findings and suspicions about the veracity of the Patient's symptoms and illness. At that time, Respondent notes that Nurse #3 had "healthy skepticism" about the Patient's complaints. Through his conversation with Nurse #3, Respondent understood that the Patient's report of a fall from the bunk on August 28 was what Nurse #3 observed on video.

69. Based upon Nurse #3's representations, Respondent ordered Nurse #3 to discontinue Flexeril and remove the Patient's access to a wheelchair. In its place, Respondent permitted the Patient to have access to a walker temporarily, but stated that access to the walker would also be discontinued "shortly." Respondent directed Nurse #3 to start 24-hour observation of the Patient in the "tank" (the medical observation unit). Respondent's rationale for removing the Patient's access to the wheelchair was to determine whether the Patient's reported symptoms of paralysis were real or merely contrived.

E. Thursday, August 30, 2018

70. The next day, August 30, 2018, Nurse #2 arrived for her shift and checked in on the Patient at approximately 7:40 a.m. The Patient stated that he could not feel anything from his

waist down and had urinated on himself because he was unable to ambulate to the toilet in the jail cell. Nurse #2 attempted to give the Patient ibuprofen and Lisinopril, but the Patient said he was unable to swallow the pills because his throat felt swollen. Nurse #2's notes from the visit state that she conducted an examination and did not notice any swelling.

71. Nurse #2 then decided to test the Patient's reflexes by running a blunt object (in this case, a thermometer) along the soles of the Patient's feet. When Nurse #2 ran the thermometer across the soles of his feet, she noticed that the Patient did not move at all. Nurse #2 then tested the Patient's vital signs, which indicated a blood pressure of 168/109 (indicating hypertension), a pulse rate of 92 beats per minute, and an oxygen saturation of 98 percent (within the normal range).

72. Nurse #2 noted that the Patient looked "very defeated;" he had urinated on himself, could not swallow, had no reflexes in his feet upon stimulation, and his blood pressure was elevated. Nurse #2 stated that she "trusted her gut" and "didn't like" what she saw when she observed him. Therefore, she decided to contact Respondent for further direction. Nurse #2 advised Respondent that the Patient needed to be seen at a hospital.

73. Respondent agreed with Nurse #2's assessment and directed Nurse #2 to send the Patient to the emergency room for evaluation.

1. Video Footage of the Patient's Condition on August 30, 2018

74. Video footage taken of the Patient in the jail cell (#215) around 7:30 a.m. shows the Patient laying in a cot, minimally responsive to medical staff and correctional officers who enter the cell. The Patient is able to move his head from side to side and move his hands, but he remains on his back without any attempt to lift his head or body when others entered the room. At one point in the video, the Patient's head is awkwardly resting against the concrete wall of the cell and a correctional officer comes into the cell to pull the Patient's cot mattress down to the foot of

the bed to free the Patient's head from against the wall. It is apparent that the Patient lacked the ability to re-position himself and free his head from against the concrete wall.

75. At approximately 9:05 a.m., three correctional officers come into the Patient's cell to lift him from the cot to a wheelchair to assist him to use the in-cell toilet. One officer removes the blanket from the Patient to reveal that the Patient is naked from the waist down; he has been laying in his cot without pants, underpants, or an adult brief. With some wrangling, three officers are able to lift the Patient's limp body into the wheelchair without any assistance from the Patient. As the officers push the wheelchair forward, the Patient's limp legs get caught under the chair as it is rolled forward – the Patient appears to be unable to move his own legs and prevent them from being run over by the chair. As a result, the officers roll the chair backwards to the toilet. Two officers lift the Patient and place him on the toilet seat, where he slumps over. At one point, the officers are able to prop the Patient against the back wall so that the Patient can remain seated on the toilet seat. After a few minutes, the officers lift the Patient off the toilet and place him back into the wheelchair. They roll the wheelchair to the cot, lift the Patient's legs onto the cot, and leave the Patient slumped in the wheelchair, with his legs resting on the bed.

2. Override of Respondent's Directive that the Patient be Transported to the ER

76. At approximately 1:30 p.m., Nurse #2 spoke with the county jail Administrator ("Administrator")[25] about transporting the Patient to the nearby emergency room. The Administrator, however, refused to authorize the Patient's release or transport, despite the medical directive from Respondent. The Administrator reasoned that the Patient was located in a medical observation cell, was being monitored by jail staff, and had been observed by correction officers

[25] The removal of the County Jail Administrator's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

using his arms and legs with no difficulty. The Administrator claimed that jail staff observed the Patient able to use his hands to open and drink a juice box. The Administrator advised Nurse #2 that the Patient was considered a flight risk and may attempt to use a hospital transfer to escape, which was why the administrator was denying Respondent's directive to transport the Patient to the emergency room.

77. Nurse #2 called Respondent again to inform him of the Administrator's refusal to allow the Patient to be transported to the hospital and the Administrator's override of Respondent's medical directive. Nurse #2 explained that correction officers had intercepted recorded phone calls in which the Patient was "plotting" an escape and that the Administrator was unyielding in her refusal to release the Patient to a hospital due to a concern that he was a "flight risk."

78. Respondent did not attempt to contact the Administrator directly to demand the Patient's transport to the hospital. Nor did Respondent call 911 himself or direct Nurse #2 to call 911 to obtain an ambulance transport of the Patient to the emergency room. Instead, Respondent directed Nurse #2 to continue monitoring the Patient. Respondent explained that a MEnD medical provider was scheduled to be present at the jail the next morning for rounds, who would be able to assess the Patient. Notably, Respondent had never had a jail administrator overrule his medical directives before.

79. At approximately 2:25 p.m., Nurse #2 entered the Patient's jail cell again. She advised him that the Administrator would not allow him to go to the emergency room and that a MEnD medical provider would be coming the next day to evaluate him.

3. Video Footage of the Patient at Time of the Administrator's Refusal to Transport the Patient to Emergency Room (2:25 p.m. on August 30, 2018)

80. Video surveillance footage from the jail cell at approximately 2:25 p.m. on August 30, 2018, shows Nurse #2 talking to the Patient as he is sitting in a wheelchair in the corner of the cell. He has no pants on and is covering his lap with a blanket. He is holding an adult brief. After Nurse #2 leaves the room, the Patient attempts to put on the adult brief but is unable to move his legs. He spends over 30 minutes attempting to put on the adult brief until he collapses onto the nearby cot from his seated position in the wheelchair. He slips from the bed and falls to the cement floor, where he lays naked from the waist down. After approximately 10 minutes, three correction officers enter the cell and lift the Patient to his cot. One officer puts some adult briefs by the Patient's head and speaks to him for several minutes. Another officer comes in to mop the floor, cleaning up what appears to be urine and a bright red liquid substance.

F. Friday, August 31, 2018

81. The Labor Day weekend of 2018 began on Friday, August 31, 2018, and continued through Monday, September 3, 2018.[26]

82. Medical Provider #1 is an RN and nurse practitioner who had recently been hired by MEnD in early August 2018, to serve as a "medical provider." Medical Provider #1 was scheduled to work on August 31, 2018, as part of her initial orientation and training with MEnD. From her start date in early August 2018, until August 30, 2018, Medical Provider #1's MEnD training included "shadowing" Respondent on rounds at the various facilities serviced by MEnD.[27]

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[26] *See* 2018 calendar at https://www.timeanddate.com/calendar/?year=2018&country=1.

[27] During the Board's investigation of this case, Medical Provider #1 noted that Respondent was the only doctor at MEnD and her supervisor. He "dictated all the care and all the orders" for inmates, although he did not actually see patients. Instead, he would mainly review charts that nurses provided, conduct medication reviews, and prescribe.

While Medical Provider #1 was in training, Respondent continued to serve as the designated medical provider for the county jail.[28]

83. Medical Provider #1began her day on August 31, 2018, expecting to meet Respondent at the county jail, and accompany him on his rounds as the MEnD medical provider serving the jail that day. However, on her drive, just minutes before she arrived at the jail, Respondent called Medical Provider #1and informed her that he would not be able to make it to the jail and that Medical Provider #1was to complete rounds on her own. This was the first day in her employment with MEnD that Medical Provider #1 would be working independently. Despite Respondent's knowledge of the Patient's urgent need for medical care, Respondent did not advise Medical Provider #1 about the Patient or his need for immediate care or evaluation.

84. Upon arrival at the jail, Medical Provider #1 proceeded to the nurses' station where she encountered Nurse #2 and Medical Technician #2 discussing an inmate (the Patient) who was "faking" paralysis and incontinence. In the "control room" of the jail, Medical Provider #1 also overheard three or four correction officers similarly discussing the inmate (the Patient) and how he was "faking" an illness. One officer asked Medical Provider #1, "Don't you know what he did?" and advised her that the Patient was incarcerated for child abuse. These correction officers were making fun of the Patient, laughing about how he would not wear an adult diaper.

85. Medical Provider #1 decided to review the Patient's medical charts before examining him. She noted that the Patient had been suffering with hypertension during his time

[28] While Respondent was evasive in his answers to the Judge's questions in this regard, it cannot be disputed that Respondent was serving as the acting medical provider for the county jail at all times relevant to this action. Respondent was scheduled to conduct rounds at the jail on August 31, 2018, with his trainee Medical Provider #1, but suddenly cancelled just before Medical Provider #1 arrived. Respondent continued to act as the medical director for the jail and attending physician for the Patient throughout the Patient's stay at the county jail from August 25 to September 2, 2018.

at the jail and was not taking his medications due to an inability to swallow. She also reviewed the EKG that Nurse #2 had performed on August 27, 2018, that indicated that the Patient had suffered a probable[29] inferior infarct. Nurse #2 informed Medical Provider #1 that Respondent knew about the EKG but was not concerned with the results.

86. Medical Provider #1 proceeded to conduct a medical examination of the Patient at approximately 9:45 a.m. When Medical Provider #1and Nurse #2 entered the cell to conduct the examination, they found the Patient laying on a mat on the concrete floor of the cell with a thin blanket covering his lower body. His head was not on a pillow and he was unable to lift his head. The cell smelled strongly of urine and sweat. The Patient's adult brief was fully saturated with urine, which had leaked and soaked the mat upon which the Patient was lying. The Patient expressed that he was embarrassed because of this, but no one would assist him with cleaning or changing.

87. Medical Provider #1began her examination by having Nurse #2 take the Patient's vital signs. The Patient's blood pressure measured 183/116, his oxygen saturation was at 83 percent, and his pulse count was 113 beats per minute, all indicating that he was suffering a serious medical condition. The Patient explained that he had severe back pain and he was numb from his waist down. In reviewing his medical history, Medical Provider #1noted that the Patient complained of numbness from his stomach down for three to four days, and that he was now unable to stand. During her physical examination of the Patient, Medical Provider #1 noticed that the Patient had "diffuse muscle weakness," which was most pronounced on the right side.

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[29] This Finding of Fact has been revised consistent with Committee Exception #3. The revision to this Finding of Fact is consistent with the evidence presented at the hearing.

88. Medical Provider #1observed that the right side of the Patient's mouth was drooping, he had tears on his cheeks, and his speech was slurred. He was also drooling and had urinated and defecated on himself. To test his neurological function, Medical Provider #1checked for a "Babinski sign," an involuntary reflex response to a specific form of stimulus obtained by running a blunt object along the sole of a patient's foot. An affirmative Babinski sign results in the upward bending of the big toe and the fanning of the other toes in response to the stimulus. An affirmative Babinski sign indicates that there may be an underlying nervous system or brain condition causing the reflexes to react abnormally. Medical Provider #1 noted that the Patient had no response to the Babinski test at all.

89. Medical Provider #1 also noticed that the Patient was having difficulty swallowing. He pleaded with Medical Provider #1 to believe him that something was seriously wrong. Nurse #2 described the Patient as crying and "begging for help."

90. Medical Provider #1initially thought that the Patient may have suffered a stroke. After her assessment, however, Medical Provider #1ruled out a cerebrovascular accident (CVA) and diagnosed the Patient with uncontrolled hypertension.

91. Medical Provider #1decided that the Patient needed to be immediately transported by ambulance to the nearest hospital for treatment. Medical Provider #1instructed Nurse #2 to arrange for an ambulance to transport the Patient to the hospital immediately. It is unclear in the record whether it was Medical Provider #1 or Nurse #2 who spoke with the Administrator about the transport. According to Medical Provider #1, the Administrator told Nurse #2 that she would not allow the Patient to be transported by ambulance, but that she would approve the transport to the emergency room by officers in a police vehicle.

92. To prepare him for transport, and because he was dirty and soaked in urine, Medical Provider #1decided to change the Patient into an orange set of "scrubs," the type of attire required by the jail to transport inmates outside of the facility. The Patient begged Medical Provider #1to not let the correction officers touch him because he was scared of them.

93. Nurse #2 began by changing the Patient's adult brief and putting a pair of orange pants on him. The Patient was completely limp and unable to assist Nurse #2 in the clothing change. According to Medical Provider #1, he was "like moving dead weight." Medical Provider #1further noticed that the Patient was cold to the touch, but yet covered in sweat.

94. The nurses grew frustrated because none of the correction officers were helping the women, so Nurse #2 went to the officer station to request assistance. Medical Provider #1 noted that the correction officers were reluctant to help and would not touch the Patient. Finally, Nurse #2 was able to get three male officers into the room to assist with changing the Patient and getting him into a wheelchair. Two of the three officers lifted the Patient into the wheelchair and Nurse #2 was able to change the Patient's shirt. The Patient was entirely limp and unable to assist with the change of clothes. The Patient was able to sit in the wheelchair but kept slumping forward, such that Nurse #2 had to hold him in the chair as an officer wheeled him from the room.

95. Video surveillance footage of the jail cell from 8:50 a.m. to 10:00 a.m. on August 31, 2018, corroborates the testimony of Nurse #2 and Medical Provider #1. The video depicts the Patient lying on a mat on the cell floor, limp and despondent, unable to assist the nurses or officers in their attempts to move him.

96. After sending the Patient to the emergency room, Medical Provider #1 spoke with Respondent again. Medical Provider #1explained that she had concerns about a CVA (stroke). Respondent did not oppose Medical Provider #1's decision to send the Patient to the hospital for

evaluation, but was upset with the fact that Medical Provider #1 did not contact him before giving the medical directive to send the patient to the emergency room.

97. At this point in time, a diagnosis of Guillain-Barre Syndrome crossed Respondent's mind as a potential cause of the Patient's symptoms, and he discussed this "differential diagnosis" with Medical Provider #1. Guillain-Barre Syndrome is a rare autoimmune disorder in which a person's own immune system attacks the nerves, causing progressive muscle weakness, numbness, tingling, pain in the limbs, and paralysis. In some cases, Guillain-Barre Syndrome can be fatal.

G. Two Hospital Visits – Friday, August 31, 2018

98. The county jail deputies transported the Patient to the emergency room,[30] where he arrived at approximately 10:34 a.m. on August 31, 2018. While at the hospital, the Patient was seen by ER Doctor #1.[31] ER Doctor #1's admission note reads:

> [The Patient] is a 27 yr old male who presents to the Emergency Department [f]rom jail secondary to the fact that he says that he cannot move or feel either one of his lower legs. This [has] apparently been going on for 4 days. 4 days ago he said he fell out of his top bunk and since then he's had back pain and has been unable to move his lower legs or feel his lower legs. He has pain in his lower back and also his upper back. He also says that he's had trouble moving his upper arms also [sic]. When I ask about numbness he said "everything is numb." He cannot pinpoint it. About 2 days ago he started having a left facial droop and couldn't use the left side of the face. He's not complaining of any chest or abdominal pain.

99. During the examination, ER Doctor #1 observed that the Patient had a left-side facial droop that included his forehead. He also noted that the Patient could not move his lower legs and did not react to painful stimuli. The Patient was able to move his upper extremities, although he stated that he was weak, his arms were numb, and he could not react to resistance. A

[30] The removal of the health organization's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[31] The removal of ER Doctor #1's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

rapid drug screen showed only the residual existence of Tetrahydrocannabinol (THC), the active ingredient in marijuana.

100. ER Doctor #1 ordered a CT scan of the Patient's head, cervical spine, abdomen, pelvis, and chest, along with a complete blood count. The CT scans showed no evidence of trauma. As a result, ER Doctor #1 decided to order a magnetic resonance imaging (MRI) of the Patient's brain and spine. However, ER Doctor #1 did not have access to an MRI machine at that time. As a result, he ordered that the Patient be transferred to a hospital that had an MRI machine.

101. The discharge summary written by ER Doctor #1 states:

> The patient has symptoms of uncertain etiology at this time. He continues to not move his lower extremities, the facial droop may be Bell's palsy since it does include the forehead, however[,] without MRIs[,] I cannot rule out [spinal] cord compression or CVA. I did do CAT scans which show no evidence of any fractures, dissections, or any other acute traumatic processes. Unfortunately at this time I cannot get the MRIs that are needed to rule out any significant cord compression or other significant emergent processes. I did speak to the ER director who spoke to MRI and at this time I cannot get them done, therefore they recommend I transfer the patient. I spoke to the emergency physician [. . .], and they will accept the patient. Patient will be transferred for further workup and evaluation.

102. After a physical examination and a review of the Patient's vital signs, blood work, and CT scans, ER Doctor #1 concluded that he could not diagnose the Patient's medical condition and considered the following "differential diagnoses": spinal cord compression, fracture, contusions, malingering, Bell's palsy, cerebral vascular accident, and aortic dissection.

103. The Patient was discharged from the emergency room at approximately 3:00 p.m. and transferred by ambulance to an[32]emergency room in North Dakota, approximately two hours away. The county jail deputies accompanied the Patient.

[32] The removal of the health organization's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

104. The Patient arrived at the medical facility at approximately 5:35 p.m. and was examined by ER Doctor #2.[33] The Patient's vital signs indicated a temperature of 98.1 degrees, a pulse rate of 128 beats per minute, a blood oxygen saturation of 100 percent, and blood pressure of 174/118. ER Doctor #2 noted that the Patient exhibited "facial asymmetry, weakness, and numbness," but did not notice any speech difficulty. As ordered by ER Doctor #1, MRIs of the Patient's entire spine and brain were performed, but the tests identified no abnormalities.

105. The Patient was under observation and testing at the hospital from approximately 5:30 p.m. until 11:15 p.m. It appears that the Patient remained in four-point restraints (hands and ankles handcuffed to a medical gurney) at all times at the hospital, except for when the MRI was completed. It is unclear how hospital staff conducted a full physical examination of the Patient's ability to move when he was so shackled.

106. After examination, observation, and testing, ER Doctor #2 summarized the Patient's visit, as follows:

> 27-year-old male arriving as a transfer from [another emergency room], Minnesota with request of MRI. Upon arrival[,] the patient is noted to be alert, afebrile, and hemodynamically stable with slight hypertension and tachycardia. Externally the patient has no trauma to the head or neck. He is interactive and GCS is 15. He reports generalized weakness to the upper or lower extremities[,] however sensation is intent and symmetric. I am able to elicit a[n] appropriate Babinski test. The patient does pull away from painful stimuli of lower extremities. This time he has no pain with palpation of the back. There is no evidence of overlying skin infection or abscess. I believe this would be atypical to affect both the cranial nerves and upper and lower extremities symmetrically. However[,] based on outside examination and recommendation for MRI, we did obtain MRI of the brain[,] as well as entire spinal cord[,] with no abnormalities. Laboratory studies demonstrate no obvious cause for symptoms. In the emergency department [he] remains slightly tachycardic. **Following MRI[,] [] a second deputy arrived providing further history that the patient was reportedly on a monitor last evening unknown to the patient[.] [He] was witnessed moving his extremities without apparent difficulty.** At this time[,] after a prolonged period of observation [in] the emergency

[33] The removal of ER Doctor #2's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

department[,] I do not find a cause for acute progressive neurologic condition warranting emergency hospitalization. I did discuss both with the deputy sheriffs as well as patient indications for emergent return locally or to [this emergency room]. At this time the patient will be dismissed to return to jail.

107. These notes indicate at least one county jail deputy was advising the doctor that the Patient was likely feigning his illness.

108. In addition, one nursing note reads: "[patient] witnessed wiggling toes in bed while RN's are outside of room standing in doorway."

109. Consistent with the information provided by the deputy and nurse, ER Doctor #2's final diagnosis was: (1) malingering; and (2) weakness. "Malingering" was noted as ER Doctor #2's primary clinical impression.

110. The Patient's discharge instructions read:

You have been seen today for generalized weakness. This may also be described as fatigue.

Weakness is a common problem, especially in older individuals.

It is important to understand the difference between true weakness (real weakness from a nerve or brain problem) and the more common problem of fatigue. These words might seem similar, but they do mean very different problems.

- Fatigue: When a person is describing fatigue, they may feel tired out very quickly even with just a little activity. They may also say they are feeling tired, sleepy, easily exhausted and unable to do normal daily activities because they don't seem to have enough energy.

- True Weakness: When someone has true weakness, it means that the muscles are not working right. For example, a leg might be truly weak if you can't support your weight on it or if you can't get up from a chair because the thigh muscles aren't strong enough.

There are many causes of weakness including: infections (often kidney/bladder infections or pneumonias), electrolyte abnormalities (low sodium, low potassium), depression, and neurologic (brain or nerve disorders).

After looking at the results of the blood tests or X-rays, the cause of your weakness is:

- Unclear or unknown.

It is VERY IMPORTANT to see your primary care doctor. More testing may be needed to figure out the cause of your weakness.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Confusion, coma, agitation (becoming anxious or irritable).
- Fever (temperature higher than 100.4°F / 38° C), vomiting
- Severe headache
- Signs of a stroke (paralysis or numbness on one side of the body, drooping on one side of the face, difficulty talking)
- Worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels or difficulty swallowing.

111. The Patient was discharged from the hospital at approximately 11:15 p.m. on August 31, 2018. He was then transported back to the county jail by deputies.

H. Saturday, September 1, 2018

1. Arrival Back at the Jail (12:30 a.m.)

112. The Patient arrived back at the jail at approximately 12:30 a.m. on September 1, 2018. Video footage from the jail's garage port shows the Patient's condition and treatment by deputies upon arrival back at the jail.

113. The video begins with four deputies talking in the garage, while the Patient remains locked inside the police vehicle. One of the deputies opens the car door and attempts to get the Patient out of the vehicle. The Patient falls onto the concrete garage floor. While he lays on the ground, four deputies stand over him and look down on him, but do not render any assistance. Then, two deputies attempt to drag the Patient into a nearby wheelchair by grabbing him by his arms. The Patient is completely limp and listless. He slips out of the wheelchair and falls to the ground. Once again, the deputies stand over him and appear to be talking to him. The Patient does

not move and appears unresponsive. The deputies stand over him for approximately a minute or two, as the Patient lays, face down, on the concrete floor. Finally, two deputies lift the Patient into the wheelchair and get him to sit up. The Patient is limp as his head falls backward and forward. The deputies then wheel him into the jail and place him back into a medical segregation cell (#214).

114. Video footage of the Patient in his medical segregation cell from 12:45 a.m. to 6:00 a.m. depicts three deputies carrying the Patient into the cell and placing him onto a cot, with his feet overhanging the bed. The Patient is completely limp and appears unconscious. The deputies remove handcuffs from his wrists and ankles.

115. A few minutes later, an officer comes into the room, places a pillow above the Patient's head, and lays a blanket beside him. The officer spends several minutes in the cell standing over the Patient, apparently talking to him, but the video is soundless so it is unclear whether the Patient was able to respond in any manner. The Patient appears semi-conscious. Before leaving the cell, the officer throws the blanket over the Patient's body.

116. The Patient does not change positions for the next nearly two hours (from 12:45 a.m. to 2:33 a.m.). He is lying on his back, his feet are hanging over the bed, and his left arm is hanging off the bed. At 2:33 a.m., the Patient begins to shake and rolls off the cot, falling face-first onto the concrete floor. His shirt is pulled up, exposing his bare midsection, as he remains on the floor, in the same position, until at least 5:50 a.m. (over three hours), when the video ends. This all occurs while correctional staff were apparently monitoring the Patient via video from the control room.

117. By the time the correction officers returned the Patient to the jail on September 1, 2018, they were under the impression that the Patient was faking his illness (due to the hospital diagnosis of "malingering") and attempting to "manipulate" jail staff. According to one officer,

because the Patient was facing a significant amount of prison time for his alleged criminal offense, he was deemed a "high flight risk" and could be using the illness in an attempt to escape.

2. Early Morning Briefing

118. The first note in the Patient's jail medical records from September 1, 2018, was written by Medical Technician #1, an unlicensed medical technician employed by MEnD. That note states:

> At approximately 0800 pt [Patient] stated he was on drugs while in jail and that's what caused him to get sick. Gave the pt [Patient] a specimen cup to obtain a urine drug screen to see if he was positive for anything. At 12:20 p.m. urine was still not given.

119. According to correction officer reports, the Patient told two officers that he had consumed drugs while in the county jail and gave a detailed account of how he allegedly received those drugs. Notably, however, the Patient had received a full drug screen while in the emergency room just a few hours earlier and that drug screen detected no signs of illicit drugs other than THC.

120. Nurse #1, MEnD's director of nursing at the time, was the RN on duty at the county jail the weekend of September 1 and 2, 2018. While Nurse #1 did not normally work in the county jail, she agreed to cover the holiday shift because MEnD was short-staffed that weekend. Recall that Nurse #1 was (and remains) Respondent's romantic partner and live-in girlfriend. Nurse #1 was aware of the Patient prior to the start of her shift.

121. Sergeant #1[34] was the correctional officer in charge at the county jail on September 1, 2018. Sergeant #1 began her shift that morning with a briefing by Sergeant #2[35] who told her that the Patient returned from the hospital during the night and that doctors at the hospital

[34] The removal of Sergeant #1's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[35] The removal of Sergeant #2's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

"were unable to find anything medically wrong with him." Sergeant #1 then called the Administrator to advise her of the Patient's condition and to request further direction. Sergeant #1 explained that the Patient "was continuing to not move his extremities around much and that if staff tried to assist him, he would just go limp and was dead weight." Sergeant #1 asked the Administrator if jail staff should assist the Patient with "toileting, feeding, etc." even though the hospital "found nothing medically wrong with him." The Administrator directed Sergeant #1 to speak with MEnD medical staff to obtain further instructions on what the jail should do for the Patient.

122. Sergeant #1 asked MEnD's on-duty medical technician, Medical Technician #1, to call Nurse #1 and see when she would be arriving for her shift. Medical Technician #1 responded that Nurse #1 would be arriving shortly.

123. Nurse #1 arrived for her shift at the county jail at approximately 11:22 a.m. on Saturday, September 1, 2018. Upon her arrival, Sergeant #1 spoke with Nurse #1. According to Sergeant #1's report:

> When MEnD [N]urse [#1]arrived[,] I let her know that [the Patient] was continuing to tell staff that he was unable to move his extremities and that he couldn't feel his legs. I also let her know that he was continuing to not move around much and that he was just remaining to lay on his bed. I did tell her that [he] has been communicating with staff. I asked her if she could see him and advise us what we need to be doing for him. I also asked whether or not we should be assisting him with toileting, eating, etc. due to the fact that he was cleared by the hospital. Nurse [#1] told me that she needed to review his medical records and to see him and then she would let us know.

124. Nurse #1 began her shift by reviewing the Patient's hospital discharge record that indicated that the Patient had been diagnosed with "malingering and weakness" at the hospital the night before, and that no new medical orders were given. Nurse #1 had never seen a diagnosis of "malingering" before in her career.

125. Nurse #1 also spoke with corrections staff who stated that the Patient had been laying on his back in his cot since he returned from the hospital. She was told that the Patient "wiggled himself onto the floor" during the night and had been seen moving his extremities. Nurse #1's note states: "Talking with staff. Per COs [correctional officers] that were at the hospital, [Patient] changed his story every time doctors told him nothing was wrong." Consequently, before even seeing the Patient, Nurse #1 had formed the impression that the Patient was fabricating his illness and symptoms.

126. Despite this information, and the fact that the Patient was considered a "high priority patient," Nurse #1 did not immediately check on the Patient or conduct any assessment of his condition upon the start of her shift. Instead, she waited until approximately 2:05 p.m. (over 2½ hours after the start of her shift) to make her first visit to the Patient's cell.[36]

3. Nurse #1's "Evaluation" of the Patient

127. Nurse #1's medical notes indicate that her first "visit" with the Patient was at 1:00 p.m. (This time is incorrect based upon video evidence which shows that Nurse #1 came to the room at 2:05 p.m.). Nurse #1's medical note reads as follows:

> Pt [Patient] seen in cell. Laying on bunk face up. Cell smelled like urine and feces. Pt [Patient] talking. Clearing his throat at times saying he's choking. Bouncing foot, knees, thighs, and hands at time wiggling hips back and forth stating he's trying to move and cannot. States he wants to shower but wants help sitting up. Pt [Patient] advised he needs to try himself. Reminded [him] ER imaging revealed no significant findings to causes immobility and incontinence. States he wasn't truthful as he thinks he has a[n] STD. Advised pt [Patient] STDs typically do not present in this manner and he can have those issues addressed when he's up and moving. Reports back pain/stiffness – reminded he needs to get up. Then states he was using drugs in the jail but wouldn't say more unless [I] came to him to help him up. Told [him] writer [Nurse #1] doesn't bargain. Told pt [Patient] [that] writer [Nurse #1] wants to do a UDS [urine drug screen]. Pt [Patient] calm. No fidgeting.

[36] Nurse #1 first appears at the door at 2:05:59 p.m. and stays until 2:08:39 p.m., less than three minutes

No SOB [shortness of breath]. No sweating. Will recheck tomorrow. ER called to get full note.

128. Notably, Nurse #1, an RN and MEnD's director of nursing, did not conduct an examination or full assessment of the Patient. Contrary to her notes, video evidence documents that Nurse #1 did not examine the Patient at 1:00 p.m.[37] Instead, Nurse #1 first appeared in the Patient's cell at 2:05 p.m. on September 1, 2018 – over 2½ hours after she arrived for her shift – despite the fact that the Patient was, by far, the patient with the most serious illness and despite the fact that the Patient spent the entire day prior in two emergency rooms.

129. The video shows that, instead of conducting an examination of the Patient, Nurse #1 merely stood in the doorway of the Patient's cell, at a distance of at least ten feet, and spoke briefly with the Patient from across the room. Her interaction with the Patient lasted less than three minutes. From this brief and distant interaction, Nurse #1 drafted her medical note dated September 1, 2018, listing the time as 13:00 hours (1:00 p.m.).

130. Nurse #1 admits that she did not conduct a formal nursing assessment of the Patient on September 1, 2018. She did not check the Patient's vital signs, such as his blood pressure, blood oxygen saturation, or temperature. She did not check his lung function or listen to his breath sounds with a stethoscope. She did not conduct an assessment of his ability to stand or lift his arms, nor did she test his reflexes. Indeed, she did not touch him or come near him. Despite her notes to the contrary, from the distance that Nurse #1 stood (approximately ten feet away), there is no way that Nurse #1 could have assessed the Patient's ability to breathe or swallow; nor could

[37] The video exhibit captures everything occurring in the Patient's cell from 12:04 p.m. until 3:28 p.m. on September 1, 2018.

she have determined whether he was sweating.[38] At no time does Nurse #1 assess the Patient's hydration or nutrition. Moreover, even though she notes that the cell "smelled like urine and feces," she does not attempt to change the Patient's adult briefs or clean him. In essence, Nurse #1 stood as far as possible from the Patient and provided him no care whatsoever in the two-minute interaction she had with him that day. According to Nurse #1's testimony, when the Patient pleaded for assistance, she informed him that she would not "bargain" or "negotiate" with him. She stated that she was "not coming into a room as a bargaining chip."

131. Nurse #1's next entry in the medical narrative of September 1, 2018, indicated a time of 1:50 p.m. In that note she writes:

> CO [correction officer] called and they helped him sit up and he was able to hold himself up.

132. However, Nurse #1 was not present when the correction officers came into the Patient's cell at 12:04 p.m. and again at 2:31 p.m. Nurse #1 admits that she never asked to review any video footage of the Patient in his cell. Thus, her medical note merely reflects what the correction officers allegedly told her.

4. Video Footage of the Patient: 12:00 p.m. – 3:30 p.m. September 1, 2018

133. The video evidence shows what actually occurred during those two interactions with correction officers.

134. The video begins at 12:04 p.m. on September 1, 2018. The Patient is lying on his back in the cot; he is still wearing the orange jumpsuit from the day before. His shirt is half off his body. An officer comes in at 12:05 p.m. and attempts to prop the Patient up against the wall

[38] The Administrative Law Judge urges the Board to carefully review the video evidence of Nurse #1's interaction with the Patient and forward the information from this case to the Minnesota Board of Nursing for violation of the Nurse Practice Act, if the Board has not done so already.

by putting a pillow between the Patient's head and the wall. The Patient is completely limp and his head is slumped down, with his chin resting on his shoulder. The officer then goes to the foot of the bed and pulls the Patient down by his feet so the Patient's head is not shoved up against the wall. The Patient appears semi-conscious and mostly unresponsive. The officer returns a few minutes later with a wheelchair and a lunch tray. The Patient does not react or attempt to eat or move. The Patient continues to lay on his back and does not change positions for over the next two hours. He appears to be in a sleep or unconscious state. His head is cocked to the side with his left ear on his left his shoulder. Occasionally, his feet, hands, and head twitch and jerk, but he does not change his sleeping position.

135. At 2:05 p.m., Nurse #1 comes to the door of the cell and stays for approximately two minutes (as described above). The Patient appears semi-conscious and is moving his mouth. Two and a half hours later, the Patient has still not moved from his back; he remains on his back with his head cocked to the side.

136. At 2:31 p.m., a correctional officer enters the room and walks back out. The officer returns with a second officer. The Patient does not move. One of the officers stands on the bed, straddling the Patient, and grabs the Patient's arms to lift him up to a semi-seated position. The other officer grabs the Patient's feet and swings them off the bed while the first officer holds the Patient up by his arms. The Patient is completely limp and not assisting the officers. Together, the officers then prop the Patient against the wall in a slouched, seated position. The officers remove the Patient's orange shirt and spend several minutes talking to the Patient, as he is slouched against the wall.[39] Eventually, the Patient slips down the wall and the two officers prop him up

[39] Recall that none of the videos contain sound and cannot be of assistance in determining what the officers or the Patient are saying.

again, this time to a more erect seated position against the wall. Then one of the officers grabs a urine sample jar and presents it to the Patient for a drug test.

137. Once propped up the second time, the Patient has the strength to remain upright but has his back up against the wall. He is talking and nodding his head but not moving his arms from his sides. He appears in communication with the two officers for approximately 15 minutes, but because the video does not contain sound, it cannot be determined if the Patient's speech is slurred or if he is lucid. The officer with the urine sample cup places it in the Patient's hand. The Patient is unable to maneuver it to his pants.

138. The officer pulls down the front of the Patient's pants slightly and places the Patient's hand in the waistband of his pants to apparently assist the Patient in placing the urine sample cup in his pants. The officer then leaves the room. The Patient wiggles his body but does not remove his hand from his pants. The Patient's hand remains in the waistband of his pants for the next half hour. The Patient eventually slides down the wall onto his right side (his hand still in his pants). A third officer comes into the cell and props the Patient up again against the wall and frees the Patient's hand from his pants. The Patient slides back down onto his side and again the officer comes in to prop him up against the wall. The officer grabs the Patient's hands and attempts to lift him, but the Patient slides to his side. The officer proceeds to prop the Patient up against the wall at least two more times. When it is apparent that the Patient is unable to sit up, the officer leaves the room, taking the wheelchair with him. The officer returns and pushes a walker toward the Patient, who is now slumped in the bed. The officer attempts to get the Patient to sit up and use the walker by placing the Patient's hands on the walker, but the Patient slumps over the walker while seated on the bed. The video ends at 3:28 p.m. on September 1, 2018.

139. Nurse #1 admits that she did not see the Patient again that day.

140. According to a report written by Sergeant #1, Nurse #1 advised Sergeant #1 that there was nothing medically wrong with the Patient and that correctional staff should not be assisting him with feeding, toileting, and other cares because the Patient was capable of doing those things himself "as he was medically cleared by the hospital."

141. Sergeant #1then called the Administrator to update her on the Patient's condition. Sergeant #1left a message for the Administrator stating that MEnD medical staff instructed the jail staff that they should not be doing anything for the Patient because "there is nothing wrong with him medically." The Administrator returned Sergeant #1's call and directed, "if medical states there is nothing wrong . . . then go with it."[40]

5. Nurse #1's Consult with Respondent: 5:30 p.m., September 1, 2018

142. Nurse #1's notes indicate that at 5:30 p.m. she spoke with Respondent, after receiving the Patient's emergency room records from the hospitals. This was the first time that Nurse #1 reported to Respondent about the Patient.

143. Nurse #1 read through the emergency room records with Respondent and ER Doctor #2's diagnosis of "malingering." Respondent noted that a diagnosis of "malingering" was quite "unusual."

144. Respondent did not ask about the Patient's current vital signs. He did not ask her if she had completed an assessment of the Patient's reflexes or ability to stand. He did not ask if Nurse #1 had completed any type of neurological examination or assessment on the Patient. Instead, Nurse #1 only discussed the records from the hospital the day before, what jail staff had told her, and "her observations" of the Patient. Respondent did not instruct Nurse #1 to perform any assessments or tests on the Patient; nor did Respondent ask Nurse #1 to send him a full copy

[40] Ellipsis included in Sergeant #1's report. There is no content removed from the quote.

of the emergency room records so that he could review them himself. Instead, Respondent's only directive was that the Patient should be seen by a neurologist after the holiday weekend (i.e., after Tuesday, September 4, 2018). In order for a neurologist to see the Patient during the holiday weekend, MEnD staff would need to send him back to the hospital on an emergency basis. Respondent "did not even think" about sending the Patient back to the hospital; nor did Respondent call ER Doctor #2 to discuss the diagnosis of "malingering." Yet at this time, Respondent continued to have Guillain-Barre Syndrome on his mental list of "differential diagnoses."

145. Respondent and Nurse #1 simply concluded that the Patient's symptoms and diagnosis of "malingering" were "puzzling" and "bizarre"

6. Instructions to Correctional Staff

146. Nurse #1 ended her shift at 5:45 p.m. on September 1, 2018. During her shift on September 1, 2018, Nurse #1's only visit with the Patient was when she stood at the door of his cell around 2:05 p.m. for approximately three minutes. Video footage evidences that Nurse #1 did not check the Patient's vital signs, examine the Patient, or provide the Patient any medical care on September 1, 2018.

147. Before ending her shift that evening, Sergeant #1 instructed her replacement, Sergeant #2, that "medical stated that we didn't need to assist [the Patient] with anything as there was nothing medically wrong with him and he was capable of doing it himself."

148. Similarly, two correctional officers[41] noted in their reports that at the evening shift turnover on September 1, 2018, the jailers were informed that the Patient "had been found medically sound and would be responsible for his own care until [the correctional officers] were

[41] The removal of the correctional officers' names, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

told otherwise." Later that evening, MEnD Medical Technician #1 advised a correctional officer that officers were not to be giving the Patient any medication until he was able to sit up and swallow on his own.

I. Sunday, September 2, 2018

1. Sunday Morning (8 a.m. to 10:15 a.m.)

149. Nurse #1 started her next shift at the county jail on Sunday, September 2, 2018, at approximately 8:15 a.m. When she arrived, she found the Patient sitting in a wheelchair in the hallway by the medical cells. The correctional officers were planning on showering him because he was covered in his own excrement. Nurse #1 noted that the Patient's pants were urine soaked and urine was running out of the pantleg of the same orange scrubs that the Patient had been placed in for his transport to the hospital two days earlier (Friday morning, August 31, 2018). Nurse #1 asked the Patient if he was "incontinent" and he indicated that he was unable to ambulate to the toilet, which was why he had urinated on himself.

150. One of the correctional officers told Nurse #1 that the Patient had spoken with his mother on Saturday and his mother told him "to knock this off." Nurse #1 understood this to mean, again, that the Patient was faking his symptoms.

151. Nurse #1 observed that the Patient was sitting upright in the wheelchair on his own, with his hands in his lap, and holding his leg out such that his heels were lifted off the ground. When speaking with the Patient, Nurse #1 noted that he was talking out of the right side of his mouth. Her medical notes state: "[f]ace composure normal except when talking, he only used right side of mouth. As conversation progressed, he used both sides of mouth." Nurse #1 noted that the Patient licked both sides of his lips with his "full tongue."

152. The Patient stated that he was thirsty and that he tried to eat and drink but could not. Nurse #1 obtained a juice box with a straw. At first the Patient declined to drink, but Nurse #1 insisted that he drink. The Patient was unable to hold the juice box, so Nurse #1 poured the juice into his mouth. While Nurse #1's medical note states that the Patient "swallowed" the juice, she also noted that she heard a "gargle" in his throat. The Patient expressed that he was choking, but Nurse #1 did not believe it because she thought she saw him swallow the juice.

153. Nurse #1 agreed with the correction officers that the Patient should be bathed, so she directed that he be placed in a restraint chair and wheeled into a shower stall. According to her notes, this method was the "best plan w[ith] available resources."

154. There is no video footage of Nurse #1's exchange with the Patient in the hallway because the Patient was located outside of the medical surveillance cell.[42]

155. Video footage of the Patient, prior to Nurse #1's arrival that morning and after Nurse #1's interaction with the Patient in the hallway at approximately 8:30 a.m., portrays the Patient's actual condition and contradicts the description in Nurse #1's medical notes.

2. Video Footage of the Patient from 6:00 a.m. to 12:00 p.m. (September 2, 2018)

156. The video begins at 6:00 a.m. and shows the Patient laying on his back on a thin blue mat on the concrete floor of his medical segregation cell (cell #214). He is still shirtless from when the officers removed his orange scrub shirt the day before (September 1) and he is still in the

[42] Although such video may have existed at one point in time, upon subpoenaing the county jail for such video of the hallway outside of cell 214 and 215, the county jail responded that it had already produced all videos of the relevant timeframe and if the video was not on the hard drive it had produced, then it no longer existed.

This footnote has been added consistent with Committee Exception #4. The revision to this Finding of Fact is consistent with the information considered by ALJ O'Reilly.

same orange scrub pants that he was placed in for his transport to the hospital two days earlier (August 31). There is a walker and a tray of food beside him from the night before that appears undisturbed. His legs are limp, but he is able to roll his head from side-to-side and shake his arms and hands in a non-purposeful manner. He remains lying on his back the entire time and does not change positions.

157. At 7:43 a.m., a correction officer enters the cell with another tray of food and removes the tray from the day before. The officer places the new tray on the bed, out of reach of the Patient, who is lying on the floor. The Patient does not move when the officer is in the room.

158. The Patient remains in the same position – on his back – for over two hours (until 8:18 a.m.) when a correction officer comes into the cell and drags the Patient out of the room by grabbing the mat beneath the Patient and dragging it through the cell door, into the hallway, outside of the camera range. The Patient is dragged out of the cell around the same time that Nurse #1 arrives for her shift that day (Nurse #1 clocked in at 8:16 a.m.). (Recall that Nurse #1 found the Patient in the hallway at approximately 8:30 a.m.)

159. Once the Patient is out of the cell, a jail employee comes in to mop and clean the cell. The employee mops the floor twice. The employee brings in a new white mat for the cot and a new pillow, but later removes the white mat, leaving the pillow on the bed.

160. At approximately 8:40 a.m., the correction officers take the Patient to holding cell #222 to perform a sponge bath. Video footage from that cell depicts the officers wheeling the Patient into the cell in a wheelchair. The Patient is still in the orange scrub pants and is shirtless. He is sitting upright with his hands in his lap. Using a bucket of water and some towels, an officer wipes down the Patient's upper body. The Patient does not assist in any way by lifting his arms, etc.

161. Two additional officers enter the cell at 8:55 a.m. and the three officers lift the Patient out of the wheelchair and place him on the concrete floor. They proceed to remove his pants and adult brief and sponge wash his body. The officers roll the Patient over and wash his back side, return him to the wheelchair, and roll him out of the cell.

162. The Patient is brought back to the medical segregation cell (#214) at 9:07 a.m. He is naked in a wheelchair, with a blanket draped over him. Two officers wheel him into the room and one starts wiping the Patient down with a towel, as the Patient sits, unassisted, in the wheelchair. The Patient's hands are in his lap, his feet are on the ground, he is sitting upright in the chair, and he wiggles his torso a bit, although he does not make any movement to assist the officer who is wiping him down with a towel.

163. A blue mat – like the one that the Patient was lying on when he was dragged out of the cell -- is brought into the cell. A third officer enters the cell and the three officers, together, lift the Patient out of the wheelchair and lay him on the mat. They throw a hand towel over the Patient's groin and roll the wheelchair out of the room.

164. While the Patient is able to shake his arms and hands in a random manner, he does not assist the officers when they are moving him. He remains completely limp. The officers roll the Patient to his side and towel off his back side then return him to his back.

165. It takes all three officers to place the Patient in a new adult brief. The officers lift him up by his legs and put a blue pair of scrub pants and socks on him, but they do not put him in a shirt. The Patient remains limp and shirtless, and he does not assist the officers when they are moving, bathing, diapering, or clothing him.

166. The officers then lift the Patient by his arms and legs to place him more squarely on the mat on the floor. They place a pillow under his head, a blanket over his body, and a tray of

food at his side on the floor. The Patient remains on his back and does not change positions throughout the remainder of the videos, which end at noon. The Patient does not move his legs, but randomly moves his arms and hands in a limp and listless manner.

167. At one point, around 10:12 a.m., the Patient appears to try and touch a juice box from the tray located on the floor alongside his body. While the juice box is loosely in or near the Patient's hand (resting on the floor), the Patient does not attempt to lift or control it in any manner. Periodically, the Patient twitches his right arm and hand, and shakes his head back and forth, but the Patient does not change positions or move from his back.

168. At approximately 10:39 a.m., the Patient spits a white substance from his mouth onto the pillow, which remains on his pillow until 11:38 a.m., when a correction officer enters the cell, flips the Patient's pillow over to hide the excretion, and uses toilet paper to wipe the white substance from the Patient's mouth. The officer then leaves the room.

169. At 11:51 a.m., another correction officer comes in the cell with a new tray of food, which he places beside the Patient on the floor. The officer takes away the plate of food that was left there for breakfast. The video ends at approximately 12:00 p.m.

170. While the videos of the Patient in the medical segregation cell and shower cell were available to Nurse #1 upon request, she did not ask to review any video of the Patient to evaluate his condition. In addition, because Respondent was located outside of the secured facility, he did not have access to the videos.

3. Nurse #1's Second Observation and Consultation with Respondent (11:00 a.m.)

171. Nurse #1's next note in the Patient's medical records is dated September 2, 2018, at 11:00 a.m. In that note, Nurse #1 writes:

> Pt [Patient] was showered by officers who cleansed perineum. He had been placed in an adult brief. Laying on mattress on cell floor. Apple juice in hand. Updated [Respondent]. Spoke to [Sergeant #1]. COs [correction officers] to use straws to assist him with drinking periodically and meals. Will recheck tomorrow.

172. Nurse #1's note is in stark contrast to what appears in the videos of the Patient from 8:00 a.m. to noon that day. While Nurse #1's 11:00 a.m. note would make it appear that she provided some type of care or assessment of the Patient at 11:00 a.m., she, in fact, did not. Rather, Nurse #1 merely "peeked onto his cell" from the one-foot-by-one-foot window in the door at approximately 11:00 a.m. for approximately "ten seconds or less."

173. According to Nurse #1's trial testimony, when she looked in on the Patient from the small cell window at approximately 11:00 a.m., he was "laying comfortably" and had a juice box in his hand. In reality, around the time Nurse #1 created her 11:00 a.m. note, the Patient appeared to be unconscious[43] on the floor of his cell, excreting a white substance from his mouth, which appears on his pillow from 10:39 a.m. to 11:38 a.m., for nearly an hour.

174. Nurse #1 consulted with Respondent by telephone at approximately 11:10 a.m. on September 2, 2018, to discuss the Patient. Like the day before, Nurse #1 had not taken the Patient's vital signs or conducted any formal examination or assessment of the Patient on September 2, 2018. In addition, Respondent did not ask Nurse #1 for the Patient's vitals, he did not instruct her to conduct an assessment or examination, and did not ask her to obtain any other information about the Patient. Instead, Respondent instructed her to continue monitoring the Patient. Based upon the information that he obtained from Nurse #1, Respondent did not believe that the Patient's condition warranted a return to the hospital that day.

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[43] This Finding of Fact has been revised consistent with Committee Exception #5. The revision to this Finding of Fact is consistent with the evidence presented at the hearing.

4. Nurse #1's Final Observation of the Patient (2:00 p.m.)

175. At approximately 2:00 p.m., Nurse #1 conducted a final "check" on the Patient. She did this again by merely "peeking in" through the one-foot-by-one-foot window in the Patient's jail cell door. In the ten seconds or less that she observed the Patient, she noted that the Patient was lying on his back "sleeping comfortably" and that drool was rolling down his cheek. From her position outside the room, she concluded that the Patient "was breathing normally." Nurse #1 did not enter the room, did not attempt to communicate with the Patient, did not check the Patient's vital signs, and did not conduct any assessment on the Patient. Nurse #1 also had no idea when the Patient had eaten his last meal. Instead, Nurse #1 simply ended her shift.

176. In sum, at no time, during either of her shifts on September 1 or 2, 2018, did Nurse #1 check the Patient's vital signs or conduct a formal nursing assessment on, or physical examination of, the Patient. Nurse #1's only interaction with the Patient on September 1 and 2, 2018, involved: (1) standing in the doorway of his cell for approximately three minutes at around 2:00 p.m. on September 1, 2018; (2) encountering the Patient in the hallway (outside of available[44] video coverage) at approximately 8:15 a.m. on September 2, 2018; and (3) peeking in the small window of the Patient's cell at 11:00 a.m. and 2:00 p.m. on September 2, 2018.

177. Nurse #1 ended her shift on September 2, 2018, at 2:27 p.m. Before leaving, Nurse #1 gave the following instructions to jail staff:

> Nurse [#1] advised that staff were to assist [the Patient] with drinking fluids regularly by using a straw to the mouth. She also said that we should help [the Patient] with feeding even if it was broth through a straw. Nurse [#1] also stated that we should change his briefs as needed. She went on to state that if [the Patient] isn't re[-]positioning himself, that staff should change his position and to use a blanket if necessary to re-position him.

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[44] This Finding of Fact has been revised consistent with Committee Exception #6. The revision to this Finding of Fact is consistent with the evidence presented at the hearing.

178. Surveillance video depicts the Patient laying on a mat on the floor of his cell for the remainder of the afternoon. He does not change positions from his back. His right arm twitches periodically and his head moves from side to side. At 2:55 p.m., a white substance can again be observed coming out of his mouth. By this point, Nurse #1 had already left the facility for the day.

5. The Patient's Death: 5:22 p.m.

179. At 4:46 p.m., a correctional officer enters the Patient's cell to bring him dinner. The Patient is still laying on the floor, unable to speak or sit up. The correction officer spends several minutes standing over the Patient attempting to talk to him, but the Patient remains unresponsive. The officer attempts to lift the Patient to a sitting position by grabbing him by the arms and pulling him up, but the Patient's body is completely limp. A second correction officer then comes into the cell to help prop the Patient up against a plastic storage container. The Patient's head falls straight back, as if completely lifeless, and the officers lie him down again. The officers roll the Patient onto his side and a third officer enters the room.

180. At 4:52 p.m., MEnD Medical Technician #1 enters the room with a cart to take the Patient's vitals. The officers and Medical Technician #1 were unable to get a blood pressure. The Patient's pulse rate, which, at first, measured 66 BPM, became undetectable. Neither Medical Technician #1 nor the officers attempt CPR or other lifesaving measures. At 4:58 p.m., officers came in with an Automated External Defibrillator (AED) and started chest compressions. Paramedics were called and arrived at 5:01 p.m. CPR was attempted by the paramedics but was unsuccessful. The Patient was pronounced dead at 5:22 p.m.

6. Notification of Death

181. Nurse #1 was on her drive home when she received a call from Medical Technician #1 notifying her that the Patient had died. She then called Respondent to advise him of the Patient's death.

182. At 8:07 p.m. on September 2, 2018, shortly after the Patient was pronounced dead, Sergeant #2sent an email to all correctional staff at the county jail stating:

> Anybody who had contact with [the Patient] needs to write a report under ICR# 1800969 that is created. Document all contact physical and verbal. This is a private incident and no information should be given out to anyone from the public including family members and should not be talked about outside the facility.
>
> Holding cell 214 is sealed as a crime scene until an autopsy is complete on the inmate that was in there. No one is allowed in there for any reason at all. Everything in there including the AED is part of the evidence scene. [An] [i]nvestigator [. . .][45]has left us his AED which is in 2nd floor control by the stairwell to have in the meantime. There is one still located in the first floor control as well. Lead investigator is[. . .][46] from the PD, once he gives the ok, the room can be cleaned up and put back in use.

. . .

183. Twenty-four supplemental reports were prepared by county jail staff; 18 were written in the days following the Patient's death on September 2, 2018, and six were written on September 2, 2018.

184. Medical Provider #1 returned to work at MEnD on September 4, 2018, the Tuesday after Labor Day, to learn that the Patient had died on Sunday, September 2, 2018. Medical Provider #1 heard Respondent talking to his attorney on the telephone about a death at the county jail and she inquired more from Respondent. Respondent advised Medical Provider #1 to "not

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[45] The removal of the investigator's name is a non-substantive change made to conform with the Board's standard format in its past orders.

[46] The removal of the lead investigator's name is a non-substantive change made to conform with the Board's standard format in its past orders.

jump to conclusions because it could impact the company." Respondent stated that the Patient probably "did this to himself" by giving himself a blood clot from faking an illness or perhaps stuck a sock down his own throat.

185. "Horrified" by what she described as the "neglect" and "incompetency" she witnessed from county jail and MEnD medical staff, Medical Provider #1 tendered her resignation[47] from MEnD that same day. In her mind, Medical Provider #1 believed she witnessed a "murder." Medical Provider #1 contacted several state agencies to report what she witnessed, including the Department of Corrections. She never heard back from the Department of Corrections.

186. To Nurse #2's knowledge, Respondent never asked for nursing notes or jail video footage after the Patient's death.

187. It is undisputed that Respondent did not have access from outside the jail to view the surveillance footage of the Patient in the medical segregation cell and that Respondent did not perform any evaluation of the Patient on his own. Respondent relied upon the assessments and observations of his on-site medical staff and the emergency room records from the hospitals, as described to him by Nurse #1.

188. It is not uncommon, in the system of correctional medicine, that a physician is not on-site at all times to evaluate inmates and must rely on the observations and evaluations conducted by on-site medical staff, correctional officers, and other medical professionals outside of the correctional facility who conducted their own assessments.

[47] This Finding of Fact has been revised consistent with Committee Exception #7. The revision to this Finding of Fact is consistent with the evidence presented at the hearing.

189. Respondent notes that, after the Patient's death, MEnD practices give more scrutiny to reports by correctional officers. MEnD training now emphasizes the importance of assessments, evaluations, and the taking of vital signs.

190. No adverse action was taken by MEnD against any of the employees involved in the Patient's care. In an interview with the Attorney General's Office after the Patient's death, Respondent stated that he "was very proud of the way [Nurse #1] handled the case" by "car[ing] for this patient" and "provid[ing] dignity for him."

III. Cause of Death

191. An autopsy was performed on the Patient by the Ramsey County Medical Examiner ("Medical Examiner"),[48] on September 4, 2018. The Medical Examiner made two "anatomical diagnoses": (1) pneumonia; and (2) cerebral edema. The Medical Examiner made no determinations as to the cause of death or manner of death in his report. The preliminary findings note "no anatomic cause of death." The toxicology report identifies only the presence of only Delta-9 THC and no other drugs or controlled substances.

192. Expert #1[49] is the Chief Medical Officer and Vice President of Medical Affairs at a metropolitan hospital[50] in Minnesota. He received his Bachelor of Science and medical degrees from the University of Minnesota and completed a residency in neurology at the University of Minnesota Medical Group. He has served as an Assistant Professor of Neurology and the Director

[48] The removal of the Ramsey County Medical Examiner's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[49] The removal of Expert #1's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[50] The removal of the health organization's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

of a Neurology Clinic in the Twin Cities;[51] the Head of the Department of Neurology at a hospital[52] in Fargo, North Dakota; and the Head of Neurology and Medical Director of the Neurosciences Division of a medical group[53] in Minnesota.

193. Prior to serving as the Chief Medical Officer for a metropolitan hospital, Expert #1practiced for 15 years as a general neurologist. He has researched and taught on numerous neurological topics, including Guillain-Barre Syndrome, a rare autoimmune disorder in which a person's own immune system damages the nerves, causing muscle weakness and sometimes paralysis. In rare instances, especially when medical treatment is not timely provided, Guillain-Barre can be fatal.

194. Expert #1 opined that the Patient most likely died of respiratory failure caused by Guillain-Barre Syndrome. Expert #1's expert opinion is based upon his review of the record, including MEnD and emergency room medical records, the Ramsey County Medical Examiner's Report, and surveillance video of the Patient included as Exhibit 112 to this hearing record.

195. According to Expert #1, Guillain-Barre Syndrome's "only clinical findings are typically an ascending weakness," starting in the legs, working up to the face, and affecting internal organs. This ascending muscular weakness can ultimately affect the lungs and prevents them from functioning, resulting in death by respiratory failure.

196. Guillain-Barre is largely a clinical diagnosis, although a spinal tap can be used to confirm the disease. This is what makes Guillain-Barre difficult to diagnose by medical personnel.

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[51] The removal of the health organization's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
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Generally, a family practice physician who recognizes signs of Guillain-Barre will refer a patient to a neurologist for further evaluation and diagnosis.

197. Symptoms of Guillain-Barre include pain and discomfort (including in the chest and back); tingling in the extremities; progressive muscle weakness; difficulty speaking, breathing, and swallowing; excessive sweating; erratic blood pressure; facial drooping; difficulty moving extremities; inability to stand or ambulate; and paralysis. These symptoms are progressive and can fluctuate. Ways to identify if a patient is feigning symptoms include evaluating a patient's mobility and ability to stand, and "teasing out" attempts to falsely exhibit weakness.

198. Because lungs are generally able to exchange oxygen until they are extremely weak, patients who suffer from Guillain-Barre can have normal blood oxygen saturation levels up until the patient's lungs become completely paralyzed by the disease. When the paralyzing weakness reaches the lungs, death can occur quickly if ventilatory support is not provided. In most cases, patients with Guillain-Barre are able to be treated before this happens. If the disease has progressed to the lungs, patients who receive medical care can often be intubated in an intensive care unit to avoid death until the patient's immune system is able to recover through medical treatment. However, in rare cases, individuals have died due to the progressive paralysis associated with Guillain-Barre that ultimately affects the respiratory system and stops the patient from breathing.

199. Guillain-Barre Syndrome is survivable with appropriate medical care and most patients are able to recover from the disease and live normal lives. In approximately one-third of patients diagnosed with Guillain-Barre, the disease stops progressing on its own and does not require extensive medical treatment; another one-third of the patients suffer more extensive paralysis and weakness requiring medical intervention; and approximately one-third require

ventilation to assist with breathing while their immune systems recover. Of the one-third of patients who are intubated, approximately ten percent do not recover and end up dying from the disease.

200. Expert #1 opined that, at 27 years old, the Patient would have had a better chance of surviving had he received proper medical treatment. In other words, appropriate and timely medical intervention may have saved the Patient's life.

201. Guillain-Barre is a relatively rare illness, but due to the risk of disability and death, it is a well-known neurological disease to trained neurologists. It is not, however, widely known to non-medical personnel and even physicians can miss the diagnosis, particularly if they believe there could be another explanation for the generalized weakness the patient is experiencing. This type of preconceived notion is referred to as "anchoring bias" and can affect a provider's ability to diagnose illness. In this case, the jailers and medical providers – including those at the two emergency rooms– believed the Patient may have been feigning his illness in an attempt to manipulate staff or orchestrate an escape. Therefore, they were unlikely to recognize the symptoms as part of a serious illness or diagnose it as Guillain-Barre.

202. Malingering is a rare diagnosis but is more common when a physician cannot determine the cause of the symptoms and a patient has "secondary gain" by feigning illness; for example, an inmate attempting to get out of the jail or an employee who wants to get out of work. Expert #1 was not surprised that the emergency room doctors did not include Guillain-Barre Syndrome as a possible cause of the Patient's illness because they did not have full information as to the progression of the symptoms.

203. Expert #1 did not testify as to the reasonable standard of care, but rather, testified to the probable cause of the Patient's death. He did, however, note that doctors must frequently

rely on others to provide information, including nursing reports and emergency room records. That being said, physicians must also exercise their own judgment and discretion, which may include an obligation to instruct staff to obtain more information.

204. Unlike Respondent, Expert #1 reviewed the video surveillance footage of the Patient in the days prior to his death. Expert #1 noted that these videos, depicting the progressive nature of the Patient's symptoms, helped him to reach his opinion as to the cause of the Patient's death.

IV. Complaint Made to the Board of Medicine

205. On September 5, 2018, an individual sent a letter to the Ramsey County Medical Examiner's Office expressing concern about the care provided to the Patient by Respondent prior to the Patient's death. A complaint was filed with the Board around that same time.

206. The Complaint Review Committee advised Respondent of the complaint on or around September 14, 2018, and permitted him an opportunity to respond in writing. Respondent timely filed his response on October 19, 2018. Respondent's response included: Respondent's narrative of the events involving MEnD's care of the Patient in August and September 2018; MEnD's records for the Patient's care while in the county jail; supplemental reports prepared by county jail correctional officers; and the Patient's autopsy report.

207. On November 7, 2019, the Board issued a Notice of Conference commanding that Respondent appear before the Complaint Review Committee to discuss the allegations contained in the complaint filed against him.

208. Respondent appeared before the Complaint Review Committee for the conference on December 9, 2019.

209. On August 18, 2020, the Committee issued a Notice and Order for Prehearing Conference and Hearing, thereby initiating this contested case proceeding.

V. Expert Medical Testimony

A. Expert #2,[54] Committee Expert

210. Expert #2, M.D., is a physician who has been licensed to practice medicine in the state of Minnesota since 1986. He graduated from St. Olaf Collage with a bachelor's degree in Chemistry in 1981 and earned his medical degree from the University of Wisconsin-Madison Medical School in 1985. He completed his residency in family medicine in 1988 and is certified by the American Board of Medical Specialties in family medicine.

211. Expert #2 is currently a full-time hospitalist.[55] He is the current lead hospitalist and former Chief of Staff at a hospital in[56] Minnesota. He is also the chair of the Professional Practice Evaluation and Improvement Committee at that hospital, where he reviews the work of other physicians.

212. Expert #2 also serves as the medical director for a residential facility.[57] In that position, he supervises medical and clinical staff remotely, similar to the type of medical director responsibilities that Respondent was charged with performing for MEnD in 2018.

213. Prior to joining the Minnesota hospital where he is currently employed, Expert #2 served as a hospitalist and hospitalist medical director for a Minnesota clinic, the Chief Medical

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[54] The removal of the Expert #2's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[55] A hospitalist is a doctor who provides care for patients at a hospital. Hospitalists specialize in providing hospital care, but also maintain their medical specialty. In Expert #2's case, he maintains his specialization in family medicine.
[56] The removal of the health organization's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[57] The removal of the residential facility's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

Officer for a medical group,[58] and a family practice physician at a family practice clinic.[59] In sum, Expert #2 has 36 years of practice in family medicine.

214. The Board of Medical Practice Complaint Review Committee hired Expert #2 to evaluate Respondent's work in this matter and provide expert testimony as to the minimal standards of acceptable and prevailing medical practice and Respondent's compliance with the ethical requirements set forth in Minn. Stat. § 147.091.

215. In preparing his expert medical opinion, Expert #2 considered: the letter to the Ramsey County Medical Examiner (Ex. 121); the Notice and Order for Prehearing Conference and Hearing (August 18, 2020); Respondent's written response to the Board (Ex. 111); MEnD medical record from August 25 to September 2, 2018 (Ex. 111); the emergency room records from September 1, 2018 (Ex. 111); the Ramsey County Medical Examiner's Report (Ex. 111); Expert Witness Affidavits and Reports from four physicians[60] (not in the record); the county jail correction officers' supplemental reports (Ex. 111); the MEnD Medical Services Agreement with the county (Exs. 100, 101); MEnD's Nursing Policy/Procedure for "Emergency Response to Detainees (Ex. 104); the transcripts of the Attorney General interviews with Medical Provider #1(Ex. 122) and Respondent (Ex. 123); the Minnesota Department of Corrections' Findings (May 15, 2020) (not in the record); the Transcript of the December 9, 2019, Board Conference with Respondent (Ex. 126); the county jail surveillance videos from August 24, 29, 30, 31, Sept. 1 and 2, 2018 (Ex. 112); and a video of the Fox 9 News report on the Patient's death (not in the record).

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[58] The removal of the medical group's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[59] The removal of the clinic's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.
[60] The removal of the four physicians' names is a non-substantive change made to conform with the Board's standard format in its past orders.

216. Notably, unlike Respondent, Expert #2 reviewed the surveillance video of the progression of the Patient's illness and not simply the descriptions by MEnD staff. In rendering his expert opinion, however, Expert #2 did not know that Respondent had not viewed the videos of the Patient's illness as it progressed. Expert #2 noted that the surveillance videos were important in reaching his expert opinions.

217. Upon review of Respondent's actions in this case, Expert #2 concluded that Respondent failed to conform to the minimum standard of care as a family physician by:

(1) Failing to recognize a serious medical condition and ensure the timely transfer of the Patient to the emergency room on August 30, 2018;

(2) Failing to obtain basic medical information from Nurse #1 on September 1 and 2, 2018, including vital signs and basic nursing assessment results; and

(3) Failing to return the Patient to the hospital for an emergency neurological evaluation on September 1 and 2, 2018.

218. Expert #2 further opined that, by failing to conform to the minimum standard of care on these occasions, Respondent carelessly disregarded the Patient's health, welfare, or safety and created unnecessary danger to the Patient's life, health, or safety.

1. Failing to Insist on Emergency Care on August 30, 2018

219. In his expert report, Expert #2 opined that when Respondent learned that the Administrator had overruled his directive to send the Patient to the emergency room on August 30, 2018, Respondent should have contacted the Administrator on his own accord and insisted on transferring the Patient to the hospital for care.[61] Instead, Respondent did not contact the

[61] The Committee did not solicit testimony from Expert #2 on this topic so the Administrative Law Judge relies on Expert #2's expert witness report, which was the subject of cross examination by Respondent's legal counsel.

Administrator himself and decided to wait until the next day because a MEnD medical provider was scheduled to make rounds at the jail that next morning.

220. According to Expert #2, Respondent "willfully abrogated" his responsibility for the Patient's medical care to a non-medical administrator. This not only failed to meet the minimal standard of acceptable and prevailing practice, it demonstrated a careless regard for the Patient's health, welfare, or safety and caused an unnecessary danger to the Patient's health and life.

2. Failing to Obtain Basic and Necessary Medical Information

221. In rendering his expert opinions in this case, Expert #2 uses his own experience as a residential facility medical director, where he must frequently rely on the assessments and observations of his medical staff (i.e., nurses and clinical staff) who are bedside with the patients.

222. Expert #2 explained that when a supervising physician is working remotely, the doctor is dependent upon those at the patient's bedside for information. That is why the doctor has a duty to ask the right questions of the medical staff and ensure that staff are conducting the tests and assessments to obtain the information necessary for a doctor to make treatment decisions.

223. The preliminary and most basic type of objective information that a doctor should evaluate is a patient's vital signs, which are simple to take and can easily vary, thereby signaling a change in the patient's medical condition. According to Expert #2, vital signs are the "earliest warning signs" of an illness.

224. Because vital signs can change quickly and dramatically, even if vitals have been taken from a patient days or hours earlier, it is important that a doctor have available to him the most current patient vital signs. Thus, the fact that the Patient's vital signs were taken at the hospital on August 31, 2018, did not relieve Respondent from his obligation to ask Nurse #1 for the Patient's current vital signs on September 1 and 2, 2018, when the Patient's condition was

worsening. Respondent did not, but should have, asked Nurse #1 for those vital signs and, if she did not have those results, instruct Nurse #1 to obtain that basic information.

225. Similarly, Respondent should have inquired of Nurse #1 about the type of standard nursing assessments that she had personally performed on the Patient on September 1 and 2, 2018. Given the Patient's symptoms, the prevailing standard of care required Respondent to ask Nurse #1 if she had assessed the Patient's most basic neurological functions, such as independently testing the Patient's ability to speak, stand, walk, and swallow, and testing his motor and muscle strength. According to Expert #2, the minimal standard of care required Respondent to ask Nurse #1 "probing questions," such as "can [the Patient] lift his arms?", "can he feed himself?", "can he swallow," "can he stand or walk on his own?", and "what is his muscle strength?". This was especially true where, as here, correctional officers were providing conflicting reports of the Patient's physical abilities. Hence, a nursing exam was critical for Respondent to fully evaluate whether the Patient's symptoms were getting worse. Respondent's failure to ask the necessary questions and obtain critical medical information from Nurse #1 negatively impacted Respondent's ability to fully evaluate the Patient and get him the emergency medical assistance he needed to save his life.

226. Expert #2 noted that a reasonable doctor, when presented with conflicting information regarding a patient's symptoms, would want to do their own assessment on the patient. In Expert #2's words, "I have to lay eyes on them myself. I have to do my own assessment if I'm getting mixed reports from the staff."

227. Expert #2 concluded that, by not obtaining vital signs from the Patient on September 1 and 2, 2018; by not asking Nurse #1 whether she had taken the Patient's vital signs; by not inquiring of Nurse #1 whether she had conducted her own basic nursing assessment; and

by not instructing Nurse #1 to conduct a basic nursing assessment of her own on the Patient, Respondent failed to conform to the minimal standard of acceptable and prevailing practice. Expert #2 further determined that Respondent's inactions demonstrated a careless disregard for the Patient's health, welfare, and safety, and created unnecessary danger to the Patient's life, health, and safety.

3. Failing to Return the Patient to the Emergency Room on September 1 and 2

228. According to Expert #2, even though the Patient had been seen in two hospitals on August 31, 2018, the minimum standard of care required that Respondent send the Patient back for emergency care on September 1 and 2, 2018, due to the worsening of the Patient's condition.

229. Expert #2 explained that a diagnosis of "malingering" is a highly unusual diagnosis that he has never encountered in his career. Consequently, a reasonable doctor should have a "high level of skepticism" when such a diagnosis is made by another physician. Malingering is a diagnosis of exclusion (a conclusion reached when all other options are ruled out). Therefore, a reasonable doctor would dig deeper to evaluate the symptoms to find a different root cause, especially when the symptoms were not resolving or relenting. Expert #2 noted that many of the Patient's symptoms were things a patient would have significant difficulty faking, such as a facial droop, and hard to keep up, such as soiling oneself repeatedly and being unable to stand or walk. According to Expert #2, each of these indicators would be "pretty unusual behavior for someone to exhibit as faking."

230. The minimum standard of care requires that a physician use his own judgment and discretion to evaluate a patient and not rely on diagnoses made by other physicians. This is especially true when another doctor makes a diagnosis of malingering. A reasonable doctor must think critically and independently evaluate a patient's symptoms, especially if the symptoms are

progressing from the time of the other doctor's diagnosis, as was the case here. It is the responsibility of the supervising physician to seek the assistance of experts and order the necessary tests or assessments to treat and diagnose a patient. If this requires transfer to an emergency room, as in the case at hand, Respondent had that obligation. According to Expert #2, as the attending physician, Respondent was ultimately responsible for the Patient's care and "the buck stop[ped]" with Respondent.

231. Expert #2 opined that ER Doctor #2's evaluation of the Patient at the hospital was not comprehensive enough because it appears that the Patient was in four-point restraints the entire time (except for when he underwent the MRI). Therefore, this should have raised flags for Respondent as to the validity of the malingering diagnosis.

232. Expert #2 further noted that the discharge instructions from the emergency room warned that the Patient should return to the hospital if he showed signs of "worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels, or difficulty swallowing." Yet, even though the Patient was exhibiting all of these symptoms after he returned from the emergency room, Respondent failed to recognize the fact that the Patient's condition was worsening and that the Patient needed emergency care. The reason why Respondent was not realizing that the Patient's condition was worsening and that he required emergency care was because Respondent did not ask the necessary questions of his on-site medical staff or insist that basic tests and nursing assessments be performed (see above).

233. Expert #2 explained that, while Respondent directed Nurse #1 to schedule the Patient for a neurological appointment after the holiday weekend (i.e., sometime after September 4, 2018), that directive was insufficient, given the emergent needs the Patient was

exhibiting on September 1 and 2, 2018. The only way that the Patient was going to obtain a neurological evaluation before September 4 was to return the Patient to the emergency room.

234. In addition, even though Respondent did not talk with Nurse #1 until late in the day on September 1, 2018, he still had the obligation to order the Patient's transport to the emergency room either that night or the next day when Respondent spoke with Nurse #1 again. However, because Respondent did not ask the pertinent questions or ensure that the necessary information was obtained and assessments performed, he unreasonably failed to realize that the Patient's illness had progressed.

235. Expert #2 opined that had the Patient been sent back to the emergency room on September 1 or 2, 2018, he may have been able to receive the life-saving treatment he needed (for example, ventilation). As Guillain-Barre Syndrome is treatable in most cases, it could have been a lifesaving measure for the Patient.

236. Expert #2 concluded that Respondent failed to conform to the minimal standards of acceptable and prevailing practice when he failed to have the Patient transferred to the emergency room again on September 1 or 2, 2018, and that this failure demonstrated a careless disregard for the Patient's health, welfare or safety and created unnecessary danger to the Patient's life, health, and safety.

B. Expert #3,[62] Respondent's Expert

237. Expert #3, M.D., is a is physician who has been licensed to practice medicine in the state of Minnesota since 2008. He obtained a Bachelor of Science degree from the University of Minnesota in 2001 and his medical degree from the University of Minnesota Medical School in

[62] The removal of Expert #3's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

2005. He completed his residency in family medicine in 2008 and is certified by the American Board of Medical Specialties in family medicine.

238. Expert #3 is currently a family practice physician at a clinic in Minnesota.[63] In his position with the clinic, Expert #3 has held various leadership positions, including President of the clinic, member of the clinic's Board of Directors, member of the Clinic Leadership Council, and Director of Performance Improvement. He also previously served as the Chief of Staff of a county hospital.[64]

239. Expert #3 was retained by Respondent to provide expert opinion as to the minimal standards of acceptable and prevailing medical practice. Expert #3 acknowledges, however, that he is not familiar with the Minnesota Medical Practice Act, Minn. Stat. §§ 147.001-.381 (2020), or the requirements set forth therein.

240. In preparing for his testimony, Expert #3 reviewed the Patient's MEnD medical records from August 25 to September 2, 2018 (Ex. 111); the emergency room records from September 1, 2018 (Ex. 111); the Ramsey County Medical Examiner's Report (Ex. 111); and the Expert Witness Affidavits and Reports from Expert #1 (Ex. 119) and Expert #2 (Ex. 120).

241. Expert #3 did not review the video surveillance footage of the Patient entered into the hearing record as Exhibit 112. As a result, Expert #3 did not observe the Patient's actual condition, the symptoms he was displaying, and the progression of his illness, which would have been apparent to MEnD staff and, in particular, to Nurse #1, during the final days of the Patient's life.

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[63] The removal of the clinic's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

[64] The removal of the hospital's name, repeated throughout the document, is a non-substantive change made to conform with the Board's standard format in its past orders.

242. While Expert #3 summarily opined that Respondent "met the standard of care in his treatment of [the Patient]" and "made appropriate decisions for the care of [the Patient], based on the information that [Respondent] was provided," Expert #3 was unaware of several important facts. First, Expert #3 was not aware that Nurse #1 had not taken any vital signs from the Patient in the last two days of his life and that Respondent had never asked for that information from Nurse #1. Second, Expert #3 was unaware that Nurse #1 had not conducted any physical examinations of the Patient, including her own assessment of the Patient's ability to stand or walk. Third, Expert #3 did not know Respondent and Nurse #1 were involved in a sexual relationship at the time.

243. Expert #3 conceded that vital signs (such as temperature, blood pressure, pulse/heart rate, blood oxygen saturation, and respiratory rate) are the most basic measurement of a patient's overall health and are important, objective measures to be reviewed by treating physicians for "every patient." Expert #3 further acknowledged that vital signs would be "especially" important for an attending physician to know when treating a patient like the Patient, who was being monitored for high blood pressure.

244. Ultimately, Expert #3 was not asked, and he did not provide an opinion, as to whether Respondent's failure to obtain more information from Nurse #1 regarding the Patient's vital signs and physical condition on September 1 and 2, 2018, fell below the minimal standard of acceptable and prevailing medical practice.

245. Expert #3 opined that Respondent complied with the minimal standard of care when he recommended that the Patient be sent to the emergency room on August 30, 2018. However, Expert #3 was not aware that Respondent failed to follow up with the Administrator after learning that his directive for emergency services had been overruled. When confronted with this information, Expert #3 conceded that if an administrator were to overrule his medical directive, as

an attending physician, to send a patient to the hospital in an emergency situation, he would want to know why his instructions were not followed and he would want to have a direct conversation with the administrator.

246. In sum, Expert #3 was not asked, and he did not provide, an opinion as to whether Respondent's failure to ensure that the Patient received emergency medical care on August 30, 2018, fell below the minimal standard of acceptable and prevailing medical practice. Expert #3 simply opined that Respondent's recommendation that the Patient be sent to a hospital for evaluation on August 30, 2018, was a correct one. Expert #3 did not address whether Respondent acted improperly by failing to ensure that his medical directive was completed.

247. Expert #2's assessments and conclusions were better reasoned and more consistent with the evidence contained in the hearing record than those presented by Expert #3. The Judge, therefore, adopts the expert opinions of Expert #2, as set forth in these Findings.

CONCLUSIONS

The Board has reviewed the record of this proceeding and hereby accepts the December 17, 2021 ALJ's Report and accordingly adopts and incorporates by reference the Conclusions of Law and Memorandum therein. Accordingly, the Board makes the following Conclusions:

1. The Board and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50, 147.141, 147.091 (2020), and Minn. R. 5615.0100 - .1300 (2021).

2. Respondent received due, proper, and timely notice of the contested case hearing in this matter.

3. The Committee has complied with all relevant procedural requirements of rule and law.

4. This matter is, therefore, properly before the Board and the Administrative Law Judge.

5. The Board is charged with the authority to impose disciplinary action, as described in Minn. Stat. § 147.141, against any physician who engages in conduct that violates any of the provisions of Minn. Stat. §§ 147.01 to .22 under Minn. Stat. §§ 147.091, 147.141.

6. Disciplinary action may include: the revocation or suspension of a license or registration to perform interstate telehealth; the imposition of limitations or conditions on the physician's practice of medicine; the imposition of a civil penalty not exceeding $10,000 for each violation; the requirement that a physician provide unremunerated professional service; or the censure or reprimand of the physician under Minn. Stat. § 147.141.

7. Before imposing disciplinary action, the Committee has the burden to prove, by a preponderance of the evidence, that the physician violated one or more of the provisions of Minn. Stat. §§ 147.01 to 147.22, including, specifically, the grounds for discipline set forth in Minn. Stat. § 147.091 under Minn. R. 1400.7300, subp. 5.

8. A "preponderance of the evidence" means that the ultimate facts must be established by a greater weight of the evidence. 4 Minn. Prac.; CIV JIG 14.15 (2014). "It must be of a greater or more convincing effect and . . . lead you to believe that it is more likely that the claim . . . is true than . . . not true." *State v. Wahlberg*, 296 N.W.2d 408, 418 (Minn. 1980).

9. Among the various grounds for which the Board may take disciplinary action against a physician, are the following:

- Engaging in any unethical or improper conduct, including but not limited to conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient, in violation of Minn. Stat. § 147.091, subd. 1(g)(3);

- Engaging in unethical or improper conduct, including but not limited to conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established, in violation of Minn. Stat. § 147.091, subd. 1(g)(5); and
- Engaging in conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice, in which case proof of actual injury need not be established, in violation of Minn. Stat. § 147.091, subd. 1(k).

10. The Committee has established by a preponderance of the evidence that Respondent failed to conform to the minimal standards of acceptable and prevailing medical practice when he: (1) failed to ensure the timely transfer of the Patient to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about the Patient from his attending nurse on September 1 and 2, 2018, including vital signs and basic assessment results; and (3) failed to return the Patient to the hospital for emergency care on September 1 and 2, 2018.

11. The Committee has established by a preponderance of the evidence that Respondent demonstrated a careless disregard for the health, welfare, or safety of the Patient when he: (1) failed to ensure the timely transfer of the Patient to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about the Patient from his attending nurse on September 1 and 2, 2018, including vital signs and basic assessment results; and (3) failed to return the Patient to the hospital for emergency care on September 1 and 2, 2018.

12. The Committee has established by a preponderance of the evidence that Respondent created an unnecessary danger to the Patient's life, health, and safety when he: (1) failed to ensure the timely transfer of the Patient to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about the Patient from his attending nurse on September 1 and 2, 2018,

including vital signs and basic assessment results; and (3) failed to return the Patient to the hospital for emergency care on September 1 and 2, 2018.

13. Accordingly, the Board has proper grounds to impose reasonable and appropriate disciplinary action against Respondent's license to practice medicine in the state of Minnesota pursuant to Minn. Stat. § 147.091, subd. 1 (g)(3), (5), and (k).

14. An order by the Board taking reasonable and appropriate disciplinary action against Respondent's license is in the public interest.

15. The form of disciplinary action the Board shall impose is beyond the province of the Administrative Law Judge.

16. Based upon these Findings of Fact and Conclusions of Law, the Administrative Law Judge makes the following recommendation: The Board should take reasonable and appropriate disciplinary action against the medical license of Respondent.

The Administrative Law Judge's Memorandum

On pages 65 through 74 of the ALJ's Report, the ALJ provided the following reasoning in support of the conclusions, which the Board adopts as follows:

Respondent contends that he cannot be held responsible for the negligent actions (or inactions) of his staff and others, or for the information he did not know when remotely providing and supervising the care of an inmate patient. But this disciplinary action is not about the negligence of others; nor is it about what information Respondent knew or did not know. Instead, it is about the information Respondent should have known and could have known – information the minimal standard of care required him to gather so that he could make appropriate medical decisions for his patient. It is also about the duty of a doctor to protect a patient under his care and not abdicate that duty to others, including other medical or non-medical staff.

The Medical Practice Act, Minn. Stat. § 147.091, subd. 1, provides, among other things, that disciplinary action may be brought against a physician for the following:

- engaging in any unethical or improper conduct, including but not limited to conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient, Minn. Stat. § 147.091, subd. 1(g)(3);
- engaging in unethical or improper conduct, including but not limited to conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established, Minn. Stat. § 147.091, subd. 1(g)(5); and
- engaging in conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice, in which case proof of actual injury need not be established, Minn. Stat. § 147.091, subd. 1(k).

A preponderance of the evidence in this case establishes three distinct occasions in which Respondent's conduct fell below the minimal standard of acceptable and prevailing medical practice. First, Respondent failed to ensure the Patient's timely transfer to the emergency room on August 30, 2018, after the Administrator overrode Respondent's medical directive for a patient over whom Respondent had an ethical and professional duty to protect. Second, on both September 1 and 2, 2018, Respondent failed to obtain basic medical information about the Patient from his on-site medical staff that would have enabled him to make informed and proper medical decisions for the Patient's care. Finally, as a result of his failure to obtain necessary information from his on-site medical staff, Respondent neglected to return the Patient to the hospital for emergency care, when such care was clearly needed.

In each of these instances, Respondent's conduct demonstrates a careless disregard for the health, welfare, and safety of his patient, and created unnecessary danger to that patient's life, health, and safety. The resulting harm -- while none is required to be shown for a violation to exist -- was the tragic suffering and death of a young man. For these violations, disciplinary action is not only warranted, but is in the public interest to prevent a tragedy like this from ever recurring.

Failure to Ensure the Patient's Timely Transfer to a Hospital on August 30, 2018

Respondent's first ethical and professional breach was failing to ensure that the Patient was transported to a hospital on August 30, 2018, when the Patient's medical condition required urgent care and when Respondent's own on-site staff recommended that emergency care be provided. Instead, Respondent abdicated his duty to protect his patient to the administrative demands of non-medical jail staff. Such action failed to conform to the minimal standard of acceptable and prevailing care, created unnecessary danger to the Patient, and demonstrated a careless disregard for the Patient's health, welfare and safety.

On Friday, August 24, 2018, the Patient was transferred to the county jail for detainment on criminal charges. Jail surveillance video from his intake meeting depicts a vibrant and seemingly healthy young man. However, the Patient's initial health assessment, conducted the next day, uncovered a history of medical conditions uncommon for a man of his young age, including high blood pressure, recent respiratory failure, and ongoing migraine headaches.

By Monday, August 27, 2018, the Patient was complaining of numbness, as well as pain in his chest and lower extremities. The Patient exhibited continued high blood pressure and his EKG result read as an "abnormal." Consequently, Respondent directed that the Patient be treated with medication and regular blood pressure checks.

On Tuesday, August 28, 2018, the Patient's pain had not subsided and he reported a fall from his bunk. But by Tuesday night, the Patient's pain had become "excruciating," so much so that he sent a note pleading to be taken to the hospital. He was not.

On Wednesday morning, August 29, 2018, MEnD Nurse #3 conducted an assessment and physical examination of the Patient. Crediting correction officer reports that the Patient was faking his symptoms,[65] Nurse #3 called Respondent, the attending physician, to request direction. To ferret out untruthful claims, Respondent directed Nurse #3 to remove the Patient's access to a wheelchair and keep him in the medical segregation cell under constant video surveillance.

By Thursday morning (August 30, 2018), the Patient's symptoms had worsened. He had lost sensation from his waist down and had urinated on himself because he was unable to ambulate to the toilet. After conducting an examination, which included taking his vital signs, testing his reflexes, and inspecting his throat for swelling, Nurse #2 recognized that the Patient needed to be seen at a hospital with the proper equipment, staff, and resources to diagnose and treat his reported illness. Thus, she recommended to Respondent that the Patient be transported to an emergency room for urgent care. Respondent concurred with this recommendation.

Both experts in this case agreed that Respondent's directive (based upon Nurse #2's recommendation) to send the Patient to the hospital on August 30, 2018, was consistent with the reasonable standard of medical care. This instruction acknowledged the seriousness of the Patient's symptoms and the emergent need for medical assistance at that time.

Despite the Patient's obvious medical distress, readily apparent to Nurse #2, jail staff refused to acknowledge the Patient's symptoms or Nurse #2's assessment of them. Sometime

[65] This is not surprising considering MEnD's training materials and overall culture mock and belittle the individuals entrusted to their care.

around 1:30 p.m. on August 30, 2018, Nurse #2 informed Respondent that the Administrator overrode his medical directive to send the Patient to the emergency room because the jail viewed him as a "flight risk." But instead of calling the administrator himself to insist that the Patient receive necessary medical care, Respondent yielded to the administrator's will and discretion. In making this choice, Respondent abdicated his duty to protect his patient to a person without any apparent medical knowledge or training, and he put the interests of the facility and his company ahead of his patient's wellbeing.

It cannot be ignored that, as the founder and owner of MEnD, Respondent had a significant financial interest in maintaining a good business relationship with the jail and its administration. At the same time, as the MEnD chief medical officer overseeing the healthcare provided at the jail, and as the attending physician for the Patient, Respondent had overriding professional and ethical duties to ensure that his patient receive the care necessary to protect the Patient's health, life, and safety at all times. Respondent's first duty was to his patient, not to the convenience of jail administration or his company's client relations.

The minimal standard of care required Respondent to ensure that the Patient receive necessary and appropriate medical care to treat and diagnose his emergent condition on August 30, 2018. Given the severity of the Patient's symptoms that day, the minimal standard of care dictated that the Patient be taken to an emergency room immediately. Instead, Respondent acquiesced to the Administrator's dictate and left the Patient to suffer an additional day in a jail cell without any medical assistance, despite knowing that the Patient required urgent care.

Fortunately, when Medical Provider #1 arrived the next morning (Friday, August 31, 2018), she took charge of the situation and demanded the Patient's immediate transfer to a hospital. Medical Provider #1 did not hesitate; nor did she allow the Administrator to prevent her from

getting the Patient the medical attention he required. Medical Provider #1 took the swift and decisive action necessary to protect the Patient – action that Respondent neglected to take a day earlier.

The fact that the Patient was eventually transported to the hospital on Friday, August 31, 2018, after Medical Provider #1 intervened, does not remedy or negate Respondent's ethical violation on August 30, 2018. Minnesota Statutes section 147.091, subd. 1(g)(5) and (k), expressly provide that "proof of actual injury need not be established" when a physician's conduct fails to conform to the minimal standard of care or when such conduct creates an unnecessary danger to a patient's life, health, or safety. Here, however, resultant harm has been established by the evidence: the Patient suffered an additional day in the jail without proper medical attention before he was transferred to the hospital on August 31, 2018.[66]

By acquiescing to the will and discretion of the Administrator instead of advocating to ensure that his patient received the emergency care he needed on August 30, 2018, Respondent failed to conform to the minimal standard of acceptable and prevailing medical practice. This conduct created unnecessary danger to the Patient and demonstrated a careless disregard for the Patient's health, welfare and safety.

Failure to Obtain Basic Medical Information from Staff Upon Which to Render Informed Medical Decisions for the Patient

In the two days following the Patient's return from the hospital, Respondent demonstrated a dangerous pattern of practice whereby he neglected to obtain basic medical information about the Patient from his on-site staff and failed to ensure that his staff was conducting the necessary

[66] The fact that the hospitals failed to properly diagnose and provide medical treatment to the Patient on August 31, 2018, does not relieve Respondent from his duty to ensure the Patient's transport to the hospital on August 30, 2018, so that the Patient could be evaluated, diagnosed, and treated at that time.

assessments and evaluations so that he could competently direct the Patient's care. Specifically, Respondent: (1) blindly relied on incomplete, inaccurate, and subjective information provided by his romantic partner and subordinate employee, Nurse #1; (2) failed to reasonably question or test his staff's deficient (or nonexistent) assessments of the Patient; and (3) neglected to obtain basic, objective health data a reasonable doctor would need to make competent medical decisions about a patient's care. As a result, Respondent failed to conform to the minimal standard of acceptable and prevailing medical practice, created an unnecessary danger to his patient, and demonstrated a careless disregard for the health, welfare, and safety of his patient.

The Patient returned to the jail from the hospital in the early morning hours of September 1, 2018. The Patient's hospital discharge instructions, which were brought back to the jail with the Patient early that morning, specifically directed that the Patient should be "immediately" returned to the hospital if he showed symptoms of paralysis, numbness, facial drooping, difficulty speaking, worsening weakness, difficulty standing, loss of bladder or bowel control, or difficulty swallowing. In the two days preceding his death – September 1 and 2 – the Patient would exhibit each and every one of these warning signs. Yet Respondent did not direct the Patient's return to the hospital. Instead, Respondent contends that he was unaware of the extent to which the Patient's symptoms were worsening because he was not on-site to observe the Patient and the reports he was receiving from his staff painted a different picture. Therefore, Respondent asserts he did not violate any professional standards. Respondent is wrong in this conclusion.

As the owner and chief medical director of MEnD, Respondent assumed an express contractual duty to oversee the healthcare provided at the jail and ensure that MEnD staff were providing the type of care necessary to protect the life, health, and safety of the inmates at the jail. In addition, as the medical director for the jail and the attending physician remotely directing the

Patient's medical care, Respondent had the additional duty to critically test and examine his on-site staff's reports, as well as obtain basic medical data to enable him to direct the Patient's care. Respondent failed in each of these duties.

The evidence establishes that Nurse #1 arrived at approximately 11:22 a.m. on September 1, 2018, but did not bother to examine or assess the Patient, let alone check on him, until after 2:00 p.m., over 2½ hours later. When she finally did come to the Patient's cell at 2:05 p.m., she did not enter the room. She stood in the doorway, approximately ten feet away from the critically ill patient, for less than three minutes. She did not bother to check the Patient's vital signs; use her stethoscope to listen to the Patient's breath or heart sounds; assess his ability to swallow; test his muscle strength, reflexes, or ability to ambulate; or change his soiled brief and clothing. She did not even come near the Patient or touch him. After less than three minutes of "observing" the Patient from the doorway of his cell, Nurse #1 left and did not return to check on him for the rest of the day – that was the extent of the "care" MEnD provided to the Patient on September 1, 2018.

At approximately 5:30 p.m., Nurse #1 called Respondent to summarize the Patient's hospital records and update him as to the Patient's condition. Despite a history of hypertension and an abnormal EKG result, Respondent did not ask Nurse #1 for any of the Patient's vital signs – the most basic, objective measures of a patient's health. He did not ask his nurse to describe what nursing assessments or physical examinations she had conducted. He did not ask for the basic and pertinent information that a reasonable physician would need to evaluate the Patient's condition or the adequacy of his staff's care. Instead, Respondent blindly accepted what his nurse described – an inmate who was feigning an illness. Had Respondent asked Nurse #1 for the Patient's vital signs or what physical examinations or tests she performed on the Patient, he would have learned that she had conducted none; and that the extent of her "assessment" of the Patient

that day was her "observation" of the Patient from the doorway of his cell, ten feet away, for approximately three minutes.

The next morning, September 2, Nurse #1 returned to the jail. She found the Patient in a wheelchair, in the hallway, with urine dripping from his pantlegs. He was wearing a brief and clothing from two days earlier. He was talking out of only one side of his mouth and was unable to swallow. Despite these observations, Nurse #1 poured juice down his throat until he choked. She did not check his vital signs or use her stethoscope to listen to his throat, lungs, or heart. She did not test his reflexes, muscle strength, or his ability to ambulate.

At 11:00 a.m., Nurse #1 "peeked in" on the Patient through the one-foot-by-one-foot window of the cell door for approximately ten seconds. Because Nurse #1 did not come into the cell or assess him, she did not notice that the Patient was foaming at the mouth.

Ten minutes later, at 11:10 a.m., Nurse #1 spoke with Respondent to update him on the Patient's condition. Once again, Respondent asked for no objective evidence of the Patient's symptoms that would have permitted him to make an independent assessment of the Patient's condition. He did not ask for the Patient's vital signs. (Had he asked for that information, he would have learned that Nurse #1 did not take any vitals on the Patient that day.) Respondent did not inquire from Nurse #1 what assessments or physical examinations she had performed on the Patient (Had he asked her for such information, he would have learned that she had performed no tests or examinations on the Patient that day.) Ultimately, Respondent failed to obtain any pertinent information about the Patient and failed to ensure that his subordinate had performed the most basic evaluations of the Patient, including taking his vital signs or listening to his breath sounds, for more than two days while the Patient deteriorated.

Although the Patient was displaying each of the warning signs indicated on his hospital discharge instructions, which directed an immediate return to the hospital, Respondent did not return the Patient to the hospital. Instead, Respondent decided to take a "wait and see" approach. After all, the Patient was scheduled for a court appearance on September 4 and could be released on bail that day.

At 2:00 p.m., shortly before ending her shift, Nurse #1 "peeked in" again on the Patient through the small cell door window. While she saw him drooling, she did not bother to come into the room, check his vital signs, listen to his heart or breath sounds, or perform any examination of him. She simply left for the day.

At 4:46 p.m., a correction officer entered the cell and found the Patient completely unresponsive. For the first time that weekend, a MEnD medical technician was called into the cell by a correction officer to take the Patient's vitals. But it was too late. By 5:22 p.m., the Patient was pronounced dead.

The most generous interpretation of the two discussions between Respondent and Nurse #1 on September 1 and 2, is that Respondent did not ask the questions or obtain the information that the minimal standard of care required. A far more disturbing possibility is that Nurse #1 actually informed Respondent that she had done nothing to assess the patient or obtain critical health information, and Respondent accepted that woefully deficient level of care from his staff.

In attempting to defend the indefensible, Respondent asserts that it is not his fault that his director of nursing, Nurse #1, did not tell him about the Patient's deteriorating condition. Respondent also blames others who he claims provided him inaccurate or incomplete information, including doctors at both the hospitals. Respondent claims that he did nothing wrong, given the information that he had at the time. But Respondent's professional and ethical obligations

extended beyond relying upon the information that was immediately available to him. Respondent's professional and ethical duties required him to obtain and test the accuracy of the information he was relying on to provide (or not provide) healthcare to a patient. This is especially true in a correctional care setting where the attending physician is largely off-site and must rely on the reports of on-site staff.

In directing the care of a patient remotely, an attending physician must ask probing questions of his staff to ensure they are doing their jobs and competently assessing the patient. The attending doctor must also measure the subjective reports of on-site staff against the objective medical data that can be determined from the taking of simple vital signs (blood pressure, pulse, oxygen saturation, pulse rate, etc.).

Respondent emphasizes that he did not have access to jail video footage or the opportunity to personally observe the Patient because he was acting remotely. That is false. It was certainly within Respondent's power to go to the jail to make his own observations. Instead, he elected to act remotely. By making this choice, it was even more imperative that he ensure that he had accurate and complete information to make remote assessments. He chose to make his staff his eyes and ears. He had direct supervisory authority and contractual obligations, as well as professional and ethical responsibilities, to oversee his staff. A doctor cannot just ignore incompetent medical staff[67] and then rely on their judgment to make medical decisions for patients under the doctor's ultimate care.

[67] Nurse #1's reprehensible conduct does not excuse Respondent's abdication of responsibility to a patient under his care. In fact, it could be argued that Nurse #1's dereliction of duty and shocking indifference to the Patient's suffering suggests she was unconcerned about being held accountable by the attending physician – her direct supervisor and romantic partner.

The diagnosis of malingering made on August 31, 2018, would have alerted a reasonably competent and diligent physician to the need to closely monitor the Patient. As noted by Expert #2, a diagnosis of malingering is only made when all other causes have been ruled out. All three experts in this case agreed that a diagnosis of malingering is highly unusual. In addition, both Expert #2 and Expert #3 note that a diagnosis of malingering should be viewed with skepticism, especially when a patient continues to present with symptoms of serious illness. Consequently, it was imperative for Respondent and his staff to be particularly vigilant when the Patient returned to the jail to ensure that his condition was not worsening. This was especially true considering that the discharge instructions from the hospital warned that the Patient should obtain "IMMEDIATELY MEDICAL ATTENTION" at "AN EMERGENCY ROOM" if he displayed numbness, paralysis, facial drooping, difficulty standing, loss of bladder or bowel control, or difficulty swallowing. At a minimum, Respondent had a duty to monitor his patient's condition and inquire as to these specific symptoms when consulting with his staff. He did not.

Finally, Respondent contends that he cannot be held responsible for the negligent care of his nursing staff. But Respondent is not being held responsible for the negligence of his staff. He is being held responsible for his own negligent actions and inaction, for his own failure to obtain information and adequately supervise his staff.

This is not a situation where Respondent was merely a physician working for a hospital, alongside nursing staff, over whom he had little authority. Respondent's company, MEnD, undertook by contract the responsibility to provide competent and ethical medical care to inmates at the jail. The contract with the county specifically provided that MEnD shall provide a "medical director" to supervise all medical care provided to inmates, supervise MEnD nursing staff, and be available at all times to assist nursing staff or answer jail staff questions about inmate medical care

at the facility. On September 1 and 2, 2018, Respondent was serving in the capacity as the medical director for the facility. Therefore, he had final responsibility by contract to competently supervise the medical care provided to the Patient.

Respondent was also the chief medical officer of the MEnD corporation. As such, Respondent had the ultimate responsibility to ensure competent and proper healthcare to inmates confined in all facilities served by MEnD, as well as to oversee the work of MEnD staff in all facilities served by the company. In addition, under MEnD's own Correctional Care Policy, Respondent was the Responsible Health Authority (RHA) for all medical staff at the county jail. Under that policy, Respondent was ultimately responsible for reviewing all treatment provided by other healthcare providers to inmates (including healthcare provided by outside medical providers) and supervising the care provided to inmates by MEnD medical staff and jail correctional staff. The policy specifically provided that Respondent, as the RHA for the jail, had "the final judgment on all medical matters related to the healthcare of detainees that reside in each facility served by MEnD."

Accordingly, Respondent affirmatively assumed the responsibility to supervise his staff and ensure they were providing competent medical care to inmates confined in all facilities served by MEnD. Respondent cannot now hide behind the incompetent work of his medical staff, including his own girlfriend and MEnD director of nursing, who's work, judgment, and words he so blindly relied upon. It was not his staff's duty to ensure his treatment decisions were made upon sufficient information. As the Patient's attending physician, it was Respondent's duty to obtain sufficient information and ensure its reliability before determining that his patient required no further care. Whether this failure was the result of his romantic relationship with Nurse #1, the absurd notion that a single physician can appropriately care for somewhere between 7,200 and

9,600 inmates across five states, or sheer negligence, is immaterial. Respondent's duty to care for his patient with the minimal standard of care for medical doctors required him to obtain necessary information from his on-site staff. Whatever the reason for his ignorance, his ignorance is no defense.

Respondent, as the Patient's attending physician, the acting medical director for the facility, and MEnD's chief medical officer, had a duty to ask probing questions and ensure that the kind of basic assessments, tests, and examinations that a competent medical professional would conduct to properly evaluate a patient were undertaken. This is especially true for a patient who had just returned from a hospital and who was exhibiting clear signs of a serious illness, all of which were identified in the Patient's hospital discharge instructions as symptoms requiring an immediate return to the emergency room.

A physician must do more than hope his staff will provide him with the information needed to provide appropriate care – he must take reasonable measures to ensure it. In this case, Respondent is not being held responsible for what he could not know. He is being held responsible for what he would have known had he acted as a reasonable attending physician conforming to the minimal standard of care.

Respondent failed in his duty to the Patient as an ordinary attending physician by not conducting the necessary inquiry to render appropriate healthcare decisions for the Patient. That duty was heightened here, because as the owner and chief medical director of MEnD, and the acting medical director of the jail, Respondent assumed an affirmative duty to train and supervise his own MEnD staff, and to ensure that they were providing the type of care necessary to protect the life, health, and safety of their patients. By failing to verify his negligent subordinate's on-site reports in even a cursory fashion, Respondent breached his ethical and professional duties.

In sum, the evidence establishes that the minimal standard of acceptable and prevailing medical practice required Respondent to obtain basic health information from Nurse #1 on September 1 and 2, which he could have used to make informed medical decisions for a patient committed to his care. Instead, Respondent did not obtain critical information he should have known and the Patient was denied potentially life-saving medical treatment. By failing to conform to the minimal standard of care, Respondent demonstrated a careless disregard for the health, welfare, and safety of his patient, and created an unnecessary danger to the Patient's life, health, and safety. Accordingly, disciplinary action is warranted and in the public interest.

Failure to Return the Patient to the Hospital on September 1 and 2, 2018

As set forth above, as a result of Respondent's failure to obtain necessary medical data and information from his on-site staff, he neglected to return the Patient to the hospital for emergency care on September 1 and 2, when such care was clearly needed and expressly directed in his hospital discharge instructions. By neglecting to return the Patient to the emergency room on September 1 and 2, 2018, Respondent failed to conform the minimal standard of acceptable and prevailing medical practice. Respondent's conduct demonstrated a careless disregard for the health, welfare and safety of his patient, and created unnecessary danger to his patient's life, health, and safety. Accordingly, disciplinary action is warranted and in the public interest.

Conclusion

The Patient entered the county jail on August 24, 2018, a vibrant, seemingly healthy 27-year-old man. He was carried from that same jail nine days later to be laid to rest, after having endured days of suffering, begging those responsible for his care – medical providers and correction officers alike – for help that never came. His condition had already been dismissed by his custodians and "caregivers"– he was a criminal defendant feigning an illness, not a man

presumed innocent and in desperate need of care. And given their preconceived notions of inmates, no evidence could convince them otherwise. Even in his final hours, as he sat in a wheelchair, in filthy scrubs, with urine streaming down his legs, his caregivers would not believe him. As he laid unconscious, half-naked on the floor of his jail cell, white foam coming from his mouth, they still did not believe him. It took his death to convince medical professionals and jail staff that the Patient was not "malingering."

Given the egregious facts of this case, the Administrative Law Judge recommends that the Board impose significant and appropriate discipline against Respondent. The Judge further urges that the State of Minnesota investigate all who callously disregarded their duty to this man. Foremost among them are Nurse #1, the county jail, and jail staff. Scrutiny should also be applied to the contracts MEnD maintains with Minnesota counties and municipalities, and all the other medical providers who were involved in the Patient's "care" between August 25 and September 2, 2018.

A tragedy like this should never have occurred. And it must never be allowed to happen again.

ORDER

Based on the foregoing Findings of Fact and Conclusions, the Board issues the following Order:

1. NOW, THEREFORE, IT IS HEREBY ORDERED that the license of Respondent to practice medicine and surgery in the State of Minnesota is **SUSPENDED** effective March 1, 2022, for an indefinite period of time. Respondent must not engage in any act which constitutes the practice of medicine and surgery and must not imply by words or conduct that Respondent is authorized to practice medicine and surgery as defined in Minnesota Statutes chapter 147.

2. IT IS FURTHER ORDERED that Respondent shall pay a $30,000 civil penalty to the Board within six months from the date of this Order.

3. IT IS FURTHER ORDERED that Respondent may petition the Board to have the suspended status removed from his license no sooner than six months from the March 1, 2022, effective date of suspension. Prior to petitioning for reinstatement of his license, Respondent shall submit a paper report for the Board President's review and approval establishing policies and procedures to improve his past practice and describing how such policies and procedures would be implemented. The report shall include policies and procedures for: 1) appropriate assessments of patients; 2) the education and training of staff under Respondent's supervision; 3) monitoring and evaluating the effectiveness of staff education and training; and 4) measurement of improvements in the medical care of patients. Upon reviewing his petition, the President may recommend the Board continue, modify, or remove the suspension or impose conditions or restrictions as deemed necessary.

4. Respondent's violation of paragraph 1 of this Order shall constitute a violation of Minnesota Statutes sections 147.081 and 147.082 and provide grounds for the Board to seek injunctive relief to halt such violation.

Dated: 01/21/2022

MINNESOTA BOARD OF
MEDICAL PRACTICE

KIMBERLY W. SPAULDING, M.D., M.P.H.
President

MINNESOTA
OFFICE OF
ADMINISTRATIVE
HEARINGS

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December 17, 2021

VIA EFILING ONLY
Ruth Martinez
Executive Director
Minnesota Board of Medical Practice
335 Randolph Ave Ste 140
Saint Paul, MN 55102
eden.scarver@state.mn.us;
elizabeth.huntley@state.mn.us

Re: ***In the Matter of the Medical License of T.A.L., M.D. License No. 39,822***
OAH 65-0903-37019

Dear Executive Director Martinez:

Enclosed herewith and served upon you is the Administrative Law Judge's **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** in the above-entitled matter. The Report together with the official record will be sent to you under separate cover. The Office of Administrative Hearings' file in this matter is now closed.

If you have any questions, please contact me at (651) 361-7874, michelle.severson@state.mn.us, or via facsimile at (651) 539-0310.

Sincerely,

Michelle Severson

MICHELLE SEVERSON
Legal Assistant

Enclosure

cc: Docket Coordinator
Nicholas Lienesch
Keriann L. Riehle
David P. Bunde

EXHIBIT
tabbies A

OAH 65-0903-37019

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE BOARD OF MEDICAL PRACTICE

In the Matter of the Medical License of [redacted], M.D.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION

This matter came before Administrative Law Judge Ann C. O'Reilly for a contested case hearing on July 12, 13, 14, 15, 16, and 19, 2021, at the Office of Administrative Hearings in St. Paul, Minnesota.

Keriann Riehle and Nicholas Lienesch, Assistant Attorneys General, appeared on behalf of the Complaint Review Committee (Committee) of the Minnesota Board of Medical Practice (Board). David Bunde, Fredrikson & Byron, P.A., appeared on behalf of [redacted] (Licensee or Dr. [redacted]).

The hearing record closed on September 27, 2021, upon receipt of the parties' final post-trial briefs.

STATEMENT OF THE ISSUES

1. Did Dr. [redacted] engage in unethical or improper conduct, including but not limited to conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient in violation of Minn. Stat. § 147.091, subd. 1(g)(3) (2018)?

2. Did Dr. [redacted] engage in unethical or improper conduct, including but not limited to conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established, in violation of Minn. Stat. § 147.091, subd. 1(g)(5) (2018)?

3. Did Dr. [redacted] engage in conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice in which case proof of actual injury need not be established, in violation of Minn. Stat. § 147.091, subd. 1(k) (2018)?

4. If so, is disciplinary action by the Board appropriate, reasonable, and in the public interest?

SUMMARY OF RECOMMENDATION

A preponderance of the evidence establishes that Dr. [redacted] engaged in conduct that departed from, or failed to conform to, the minimal standards of acceptable and prevailing medical practice when he: (1) failed to ensure the timely transfer of [redacted] to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about [redacted] from his on-site nurse on September 1 and 2, 2018, including vital signs and basic nursing assessment results; and (3) failed to return [redacted] to the hospital for emergency care on September 1 and 2, 2018, when [redacted]'s condition required such treatment. Dr. [redacted]'s failure to conform to the minimal standards of acceptable and prevailing medical practice demonstrated a careless disregard for [redacted]'s health, welfare, and safety, and created an unnecessary danger to [redacted]'s life, health, and safety. Accordingly, the Board has sufficient grounds to impose disciplinary action against Dr. [redacted]'s license to practice medicine in the state of Minnesota. The Administrative Law Judge further finds that disciplinary action is in the public interest.

Based upon the evidence in the hearing record, the Administrative Law Judge makes the following:

FINDINGS OF FACT

I. Background: Dr. [redacted] and MEnD

1. Dr. [redacted] has been licensed to practice medicine and surgery in the State of Minnesota since 1997.[1] He is board certified in family medicine.[2]

2. Dr. [redacted] is the owner, president, and former chief medical officer of MEnD Correctional Care, PLLC (MEnD), which provides contracted medical services to inmates at county jails.[3] MEnD has contracts to provide correctional health care services at 48 correctional facilities in five states: Minnesota, Wisconsin, Iowa, Illinois, and South Dakota.[4] At least 75 percent of the facilities served by MEnD are located in Minnesota.[5] With each facility housing approximately 150 to 200 inmates, MEnD is charged with overseeing the medical care of the approximately 7,200 to 9,600 inmates, in five different states, at any given time.[6]

3. This action arises out of Dr. [redacted]'s work as the chief medical officer of MeND and the supervising/attending physician for [redacted], an inmate at the [redacted] County Jail who died under Dr. [redacted]'s care on September 2, 2018.[7]

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[1] Notice and Order for Prehearing Conference and Hearing (Aug. 18, 2020).
[2] *Id.*
[3] Testimony (Test.) of [redacted] (Tr. at Vol. III, p. 491).
[4] Test. of [redacted] (Tr. at Vol. V, p. 1183).
[5] Ex. 18 at 13.
[6] Test. of [redacted] (Tr. at Vol. V, p. 1183).
[7] Notice and Order for Prehearing Conference and Hearing (Aug. 18, 2020).

4. Dr. [redacted] began his professional career by graduating from St. Cloud State University with a bachelor's degree in business marketing.[8] In 1992, Dr. [redacted] proceeded to medical school at the University of Minnesota-Duluth.[9] Upon graduating from medical school in 1996, Dr. [redacted] began practicing in family medicine with [redacted], a health care provider in the St. Paul metropolitan area.[10]

5. In 2006, the [redacted] County Sheriff reached out to Dr. [redacted] to consult with him regarding the medical care provided to inmates at the [redacted] County Jail.[11] At that time, the [redacted] County Jail contracted with [redacted] to provide health care to its inmates.[12] Dr. [redacted] reviewed the services provided by [redacted] and offered his opinions regarding efficiencies and cost-saving methods for providing health care services to inmates at the jail.[13]

6. Shortly thereafter, Dr. [redacted] accepted a position to serve as the medical director for [redacted] County Jail.[14] He was soon approached by [redacted] County to provide consultation services, and later, contracted with [redacted] County to provide medical services to its jail.[15]

7. In approximately 2008,[16] Dr. [redacted] decided to create MEnD, a company that contracts to provide medical services to local jails and correctional facilities.[17] From its inception in approximately 2008 until early 2021,[18] Dr. [redacted] served as the chief medical director of MEnD, in addition to being the president and founder of the company.[19]

A. MEnD Contract with [redacted] County

8. In 2012, MEnD entered into a Medical Services Agreement with [redacted] County to provide health and medical services to detainees and inmates at the [redacted] County Jail.[20] Under the initial contract, the County engaged MEnD to provide a medical director, nursing services, and a mental health specialist.[21] The contract was amended and extended in 2013 to expand the types and hours of services provided by MEnD.[22]

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[8] Test. of [redacted] (Tr. at Vol. V, p. 1055).
[9] *Id.* at Tr. at Vol. V, p. 1056.
[10] *Id.* at Tr. Vol. V, p. 1056-1057).
[11] *Id.* at Tr. Vol. V, p. 1057).
[12] *Id.* at Tr. Vol. V, p. 1057.).
[13] *Id.* at Tr. Vol. V, p. 1058-1061.
[14] *Id.* at Tr. Vol. V, pp. 1062-1063.
[15] *Id.* at Tr. Vol. V., pp. 1064-1065.
[16] *Compare* https://mendcare.com/about/ (asserting an "inception" date of 2006) *with* Test. of [redacted] (Tr. at Vo. 5, p. 1066) (testifying that MEnD was started in 2008).
[17] Test. of [redacted] (Tr. at Vol. III, p. 491).
[18] In early 2021, MEnD hired a new corporate medical director and Dr. [redacted]'s positions in the company were limited to president and CEO. Test. of [redacted] (Tr. Vol. III, p. 491-493).
[19] Test. of [redacted] (Tr. at Vol. III, pp. 491-493).
[20] Ex. 100.
[21] *Id.*
[22] Ex. 101.

9. Under both the initial and amended contracts, the medical director was required to be "licensed" and provide "general and urgent care to detainees and inmates."[23] In addition, the medical director was required to:

- Supervise the medical care provided to detainees and inmates;
- Make "appropriate frequency" of visits to the jail to care for inmates, which "will typically be once per week for up to 4 hours";
- Perform medical procedures at the jail whenever feasible;
- Prescribe medication for detainees and inmates;
- Assist jail and provide administration in budgeting, planning, vendor negotiations, and presentations;
- Assist in the development and review of treatment protocols, policies, and procedures;
- Supervise nursing staff and review medical charts;
- "Be available (or have another licensed provider available) at all times, by phone or in person, to assist nursing staff or answer jail staff questions regarding the medical needs of inmates;" and
- Furnish pre-employment medical examinations as requested for prospective jail personnel upon request.[24]

10. The contract, as amended, required MEnD to provide registered nurses on site an average of 72 hours per week, "largely during the workday," as well as "[b]e available at all times by at least phone consultation to assist jail staff and answer medical questions regarding care of inmates."[25] This was expanded from the original contract, which required registered nurses to be present 60 hours per week.[26]

11. When the original contract was amended in 2013, it added provisions that MEnD would also provide health service technicians.[27] These technicians included one full-time lead technician working "business hours" during weekdays, and other full- or part-time technicians whose hours included "split shifts" during the weekends.[28] These technicians would not be licensed nurses, but rather, unlicensed healthcare providers

[23] Exs. 100, 101.
[24] Exs. 100, 101.
[25] Ex. 101.
[26] Ex. 100.
[27] Ex. 101.
[28] *Id.*

(generally nursing assistants or medical assistants),[29] who would be on-site at the jail an average of 99 hours per week.[30] These technicians were charged with delivering medications, assisting the registered nurses with routine tasks (such as taking vital signs), and other unlicensed or administrative tasks.[31]

12. While the contract with [redacted] County, as amended, included additional staff and services, it was not contemplated that MEnD would provide on-site, round-the-clock medical care to inmates.[32] MEnD nursing and medical technician staff were scheduled at the jail during daytime hours on weekdays and split-shifts (mornings and evenings) on the weekends and holidays.[33] A registered nurse (RN) was scheduled to be on-site during daytime hours weekdays (Monday through Friday, from 7:00 a.m. or 8:00 a.m. to 4:30 p.m.) and four hours each day on Saturdays, Sundays, and holidays.[34] Medical technicians were scheduled each day for 12 hours a day, with split-shifts (mornings and evenings) on weekends and holidays.[35]

13. The original contract provided for monthly compensation of $17,075 ($204,900 annually) to MEnD, with annual two-percent increases.[36] When the contract was amended in 2013, and the scope of services expanded, the compensation to MeND increased but is unavailable in the hearing record due to redaction.[37] According to Dr. [redacted], MEnD's net profits in 2020 were "a few" hundred thousand dollars.[38]

14. While MEnD was the contracted healthcare service provider inside the jail, the agreement expressly noted that MEnD would not be responsible for the medical services and costs provided outside the jail to inmates for whom [redacted] County was the detaining authority, including hospital, ambulance, and transportation services.[39] In other words, MEnD was not responsible for the costs of any medical care an inmate required from clinics, hospitals, or healthcare providers outside the jail, including emergency room visits or specialized care.[40]

B. MEnD's Internal Policy Manual

15. To ensure a proper chain of command for medical decisions, MEnD maintained a Correctional Care Policy Manual, applicable to all of its medical staff and "designated jail personnel."[41] Under this policy, each correctional facility served by MEnD

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[29] Ex. 103 at 000033_0015.
[30] Ex. 101.
[31] *Id.*
[32] Test. of [redacted] (Tr. at Vol. III, pp. 498-499, 513).
[33] *Id.* at pp. 508-510.
[34] *Id.* at pp. 508-509, 513-514.
[35] *Id.* at pp. 314-315.
[36] Ex. 100.
[37] Ex. 101.
[38] Test. of [redacted] (Tr. at Vol. III, pp. 494-495).
[39] Ex. 101.
[40] *Id.*
[41] Ex. 104 at TAL000027_0044.

was required to have a designated "Responsible Health Authority" (RHA) and a designated medical provider reporting directly to the RHA.[42]

16. Under MEnD's Correctional Care Policy, the RHA was responsible for

- Overseeing all of MEnD's "policies/procedures, protocols, forms, and practice philosophies in all MEnD-served facilities;"
- "Review[ing] treatments of detainees by other health care providers (in-house, boarders, outside physicians), as requested or needed by the medical providers in each facility MEnD serves;"
- "Supervis[ing] the care provided to detainees by medical staff and correctional staff." Under the policy, "[t]he RHA will have the final judgment on all medical matters related to the healthcare of detainees that reside in each facility served by MEnD;" and
- Providing peer review for staff medical providers.[43]

17. At all times relevant herein, Dr. [redacted] was the designated RHA for MEnD and the [redacted] County Jail.[44] As such, he was responsible for supervising the medical care provided to inmates in the jail by MEnD medical staff.[45] He also maintained final decision-making authority for the healthcare provided to inmates in the jail.[46]

18. MEnD's Correctional Care Policy provided that the designated medical provider for each facility was responsible for:

- conducting medical visits and assessment for detainees, including diagnosing medical conditions and selecting appropriate treatment options;
- reviewing and prescribing medications for detainees;
- reviewing treatments for all detainees including those done inside or outside the jail during incarceration;
- making decisions for the care of detainees in the jail during their incarceration, "which includes referrals to outside facilities or providers when necessary;" and

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[42] *Id.*
[43] *Id.*
[44] Test. of [redacted] (Tr. at Vol. III, p. 578).
[45] Test. of [redacted] (Tr. at Vol. III, pp. 578-579); Ex. 104 at TAL000027_0044.
[46] Test of [redacted] (Tr. at Vol. III, p. 579); Ex. 104 at TAL000027_0044.

- supervising the day-to-day healthcare provide in the jail.[47]

19. During the relevant timeframe herein,[48] with the exception of August 31, 2018, when Dr. [redacted] delegated his authority to a nurse practitioner for the day, Dr. [redacted] was effectively the designated medical provider for the [redacted] County Jail.[49]

C. Organizational Structure of MEnD

20. In 2018, the organizational structure of MEnD included a chief medical officer (Dr. [redacted]) who had ultimate supervisory authority over all other company healthcare workers and employees.[50] The positions reporting directly to the chief medical officer (Dr. [redacted]) at that time included: a director of nursing, a human resources director, "medical providers" (e.g., physician assistants and nurse practitioners), a mental health director, and an office manager.[51]

21. The director of nursing supervised all nurses, including, indirectly, the health technicians at each facility.[52] The director of nursing reported directly to Dr. [redacted].[53]

22. Below the director of nursing were regional "nursing directors" who had authority over supervisory RNs (one at each facility) in their regions.[54] Each facility had a supervising RN, who oversaw staff RNs and the lead health technician at that facility.[55] Each facility had a lead health technician, who supervised the various health technicians at that facility.[56]

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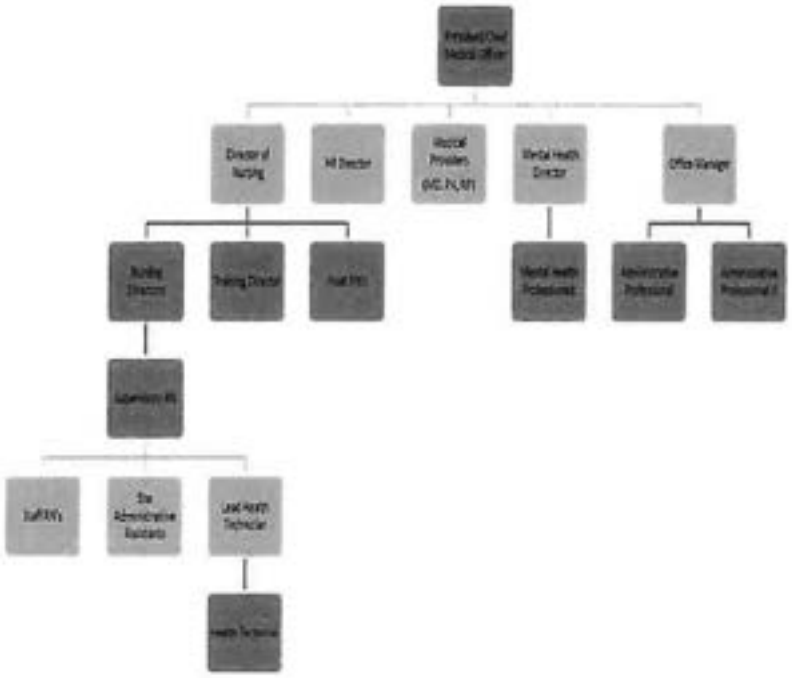
[47] *Id.*
[48] August 24 to September 2, 2018.
[49] Ex. 123 at 0605, 0621, 0627; Test. of [redacted] (Tr. at Vol. III, pp. 518-520). While Dr. [redacted] was reluctant to admit he was the designated medical provider for the [redacted] County Jail during the nine days that [redacted] was in the jail, it is clear from a totality of the evidence that he effectively served as the designated medical provider for the jail during that time. Nurse Practitioner [redacted] had just started at the company and was in training, shadowing Dr. [redacted] on his rounds. Throughout [redacted]'s stay in the jail, all medical staff contacted Dr. [redacted] directly for consultation and direction – and no other medical provider. Nurse Practitioner [redacted] served as the jail's medical provider on August 31, 2018, only because Dr. [redacted], who was supposed to accompany [redacted] on rounds at the jail that day, suddenly cancelled and instructed [redacted] to complete the rounds without him. He, therefore, delegated his authority to [redacted] that day. Dr. [redacted] continued to be the medical provider and supervising physician for the jail on September 1 and 2, 2018.
[50] Ex. 102 at TAL000009_0001.
[51] *Id.*
[52] *Id.*
[53] *Id.*; Test. of [redacted] (Tr. at Vol. III, p. 516).
[54] Ex. 102 at TAL000009_0001; Test. of [redacted] (Tr. at Vol. III, p. 492).
[55] Ex. 102 at TAL000009_0001.
[56] *Id.*

23. The organizational chart for MEnD in 2018 was as follows:[57]



24. Dr. [redacted] served at the top of the organization chart, as the president and chief medical officer, having direct supervisory authority over the director of nursing and any medical providers assigned to a facility.[58]

25. "Medical providers" hired by MEnD were not necessarily physicians, but could include other healthcare workers, so long as they were graduates of "an accredited medical provider program" and maintained "a valid, unrestricted medical provider license."[59] Medical providers included physician assistants and nurse practitioners.[60] However, in 2018, Dr. [redacted] was the sole medical doctor responsible for final oversight over

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[57] *Id.*

[58] *Id.* In 2021, Dr. [redacted] was "reassigned" from his position as medical director and a new "corporate medical director" was hired. Test. of [redacted] (Tr. at Vol. III, p. 492). Under the current corporate structure, MEnD has a four medical doctors on staff, including himself (three fulltime and one parttime), who manage the healthcare staff and medical providers. Test. of [redacted] (Tr. at Vol. V, p. 1180).

[59] Ex. 103.

[60] Test. of [redacted] (Tr. at Vol. V, p. 1118).

all facilities and medical staff serviced by MEnD.[61] In August 2018, Dr. [redacted] would make approximately one visit per week to the [redacted] County Jail.[62]

D. [redacted], Director of Nursing

26. [redacted] is the director of nursing for MEnD, a position she has held since 2016.[63] Nurse [redacted] was one of the initial employees hired by MEnD after its inception.[64] At the time, Nurse [redacted] was fresh out of college.[65]

27. Nurse [redacted] graduated from St. Catherine's University in 2010 with a bachelor's degree in nursing and became licensed as an RN that same year.[66] After graduation, Nurse [redacted] accepted her first nursing position with MEnD, where she initially served as a staff RN at the [redacted], [redacted], and [redacted] County jails.[67]

28. As the company grew, Nurse [redacted]'s position and responsibilities also expanded.[68] Within the first few months of her employment, she assumed responsibility for MEnD's training programs for both MEnD healthcare workers and the county correctional employees working at the facilities served by MEnD.[69] Within six years, Nurse [redacted] was promoted to MEnD's director of nursing, overseeing all of MEnD's nursing and medical technician staff.[70] Aside from a short internship during college, Nurse [redacted]'s only experience as an RN was obtained through her employment with MEnD.[71]

29. A couple years into her employment at MEnD, Nurse [redacted] and Dr. [redacted] developed a romantic relationship.[72] They even executed what she described as a "love contract," drafted by a lawyer for the company, to openly declare their romantic and professional relationship.[73] At some point in the relationship, Dr. [redacted] and Nurse [redacted] moved in together and, as of the date of hearing, they continue to reside together.[74]

30. By 2018, Nurse [redacted] was serving as MEnD's director of nursing and was the company's lead trainer and training developer.[75] She was also assisting with human

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[61] *Id.* Dr. [redacted] testified that MEnD had a parttime physician on staff, but that physician worked in Iowa. (Test. of [redacted] Tr. at Vol. V, p. 1118-1119). As MEnD's chief medical officer, however, Dr. [redacted] had final supervisory authority over all MEnD healthcare staff.
[62] Test. of [redacted] (Tr. at Vol. III, pp. 570-571).
[63] Test. of [redacted] (Tr. at Vol. I, p. 169).
[64] *Id.* at Vol. IV, p. 792.
[65] *Id.* at Vol. I, p. 167.
[66] *Id.*
[67] *Id.* at Vol. IV, p. 794.
[68] *Id.* at Vol. I, p. 168.
[69] *Id.* at Vol. IV, p. 796.
[70] *Id.* at Vol. I, p. 169.
[71] *Id.* at Tr. Vol. IV, p. 791.
[72] *Id.* at Vol. II, p. 259-260; Vol. IV, p. 828.
[73] *Id.* at Vol. II, p. 260; Vol. IV, pp. 831-832.
[74] *Id.* at Vol. II, pp. 259-260. In addition to not being able to recall her current salary, she was unable to recall how long she and Dr. [redacted] have been living together. Tr. at Vol. II, p. 260.
[75] *Id.* at Vol. I, pp. 172-173.

resource issues, helping to manage and build the business, and providing some direct patient care (approximately 10 to 15 hours per week).[76] Her direct supervisor was Dr. [redacted], MEnD's owner, president, and chief medical officer at that time.[77]

E. MEnD Training Materials

31. As part of her work as the company's first training director, Nurse [redacted] developed training materials for MEnD employees and correctional staff.[78] The trainings are typically three to four hours initially (upon the start of a contract) and then annual and ongoing.[79] These trainings warned of unique challenges faced by staff working with inmates in correctional facilities, including the possibility of "inmate manipulation" tactics, boundary issues, and security threats.[80] Some of the training materials developed by Nurse [redacted] also made light of the inmate population that MEnD served. Examples of these training materials included:

- A cartoon of a healthcare professional physician looking out of a window, while a prisoner lays on an examination table, which included the caption, "You should get out more."[81]
- A training slide about dealing with "demanding inmates" that contained a cartoon that stated, "No, please go on. I'm sure your internet forum has access to more medical literature and has studied it more than I have."[82]
- A slide instructing about patient care that included a cartoon of a woman in the bathroom with a caption reading, "Showering won't be enough after today. I'll need to be autoclaved."[83] [84]
- A cartoon at the beginning of a mental health and substance abuse training that has a drawing of a "stoned hippy" with a caption reading, "You must be at least this high to enter."[85] The MEnD commentary under the cartoon reads, "How many times do you feel like this sign should be in the front of your correctional facility???"[86]

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[76] *Id.* at p. 173.
[77] *Id.* at p. 171-172.
[78] Test. of [redacted] (Tr. at Vol. I, p. 168).
[79] Ex. 128 at 22-24.
[80] Ex. 105 at J.
[81] *Id.* at A (TAL000012_0001).
[82] *Id.* at S (TAL000108_0018).
[83] An autoclave is a pressure and steam sterilization mechanism used in medical or laboratory environments.
[84] Ex. 105 at S (TAL000108_0011).
[85] *Id.* at GG (TAL000122_0002).
[86] *Id.*

- A meme in training materials about inmate mental health issues with the caption, "Crazy people don't know they are crazy. I know I am crazy therefore I am not crazy, isn't that crazy."[87]

32. The purpose of these cartoons and memes, according to Nurse [redacted] and Dr. [redacted], was to inject "levity" into the subject matter of the training materials[88] and "have a chuckle."[89]

II. Care of Inmate/Patient [redacted]

33. On Friday, August 24, 2018, [redacted], a 27-year-old Black man, was transferred to the [redacted] County Jail for detainment on criminal charges.[90] [redacted] arrived at the jail at approximately 5:30 p.m. and began the intake process.[91]

34. Jail video footage shows [redacted] arriving at the jail, exiting a police vehicle, and walking into the [redacted] facility.[92] He appears in good health and is cooperating with the correctional staff.[93] He is able to walk, talk, laugh, and joke with the jailers.[94] While in the second-floor booking room, [redacted] can be seen talking, walking, sitting, standing, and even dressing himself.[95] He appears to have no difficulty ambulating or communicating with staff.[96]

A. Saturday, August 25, 2018: Initial Health Assessment

35. As part of the jail's intake process, all inmates and detainees are subject to an initial health assessment.[97]

36. On Saturday, August 25, 2018, at 9:30 a.m., [redacted], RN, the MEnD nursing supervisor at the [redacted] County Jail, conducted [redacted]'s intake health assessment.[98] At that time, Nurse [redacted] had been working for MEnD for approximately seven years.[99]

37. The initial health assessment process conducted by MEnD included obtaining a short medical history from the inmate, as well as the collection of standard

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[87] *Id.* at GG (TAL000122_0058).
[88] Test. of [redacted] (Tr. at Vol. III, pp. 559, 561, 562).
[89] Test. of [redacted] (Tr. at Vol. IV, pp. 816-817).
[90] Ex. 112 at 0959.
[91] *Id.*
[92] *Id.*
[93] Ex. 112 at 0960.
[94] *Id.*
[95] Ex. 112 at 0961.
[96] *Id.*
[97] Test. of [redacted] (Tr. at Vol. I, p. 91).
[98] Ex. 111 at 0100-101.
[99] Test. of [redacted] (Tr. at Vol. I, p. 70).

health data, such as obtaining the individual's height, weight, blood pressure, temperature, and pulse rate.[100]

38. At the time of his initial assessment, [redacted]'s blood pressure measured 152/106, which was considered high for a male of his age.[101] [redacted] disclosed a history of chronic migraine headaches, hypertension, depression, and anxiety, as well as a recent incident of respiratory failure (eight months prior) and a traumatic brain injury from five years prior.[102] [redacted] also reported being treated with the prescription drug Lisinopril for high blood pressure in the past.[103]

39. As for current issues he was experiencing, [redacted] complained of mid- and upper back pain, particularly between his shoulder blades, as well as a headache.[104]

40. [redacted] reported that he had been incarcerated since August 1, 2018, at another facility.[105] [redacted]'s primary concern was an ongoing migraine headache.[106] He stated that he was nauseous, was experiencing pain behind his eyeballs, and was sensitive to light and sounds.[107] He stated that he generally treated his migraines with ibuprofen.[108]

41. During the assessment, Nurse [redacted] observed that [redacted] was "kind" and "happy," was able to walk, and answered all questions presented to him.[109] Based on her assessment, Nurse [redacted] decided to monitor [redacted]'s blood pressure and treat his migraine with Tylenol.[110]

42. As part of that monitoring process, MEnD medical technician [redacted] checked [redacted]'s blood pressure on Sunday, August 26, 2018, and noted that it measured 146/101, indicating continued hypertension.[111]

B. Monday, August 27, 2018

43. On Monday, August 27, 2018, at approximately 7:35 a.m., [redacted] requested another blood pressure check due to pain he was experiencing on the left side of his chest that began near his collar bone and extended into his neck.[112] Based upon this report, Nurse [redacted] conducted a nursing assessment.[113] [redacted] was sweating and stated that

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[100] Ex. 111 at 0100-101.
[101] *Id.*; Test. of [redacted] (Tr. at Vol. I, p. 90).
[102] Ex. 111 at 0100-101.
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] *Id.*
[108] *Id.*
[109] Test. of [redacted] (Tr. at Vol. I, pp. 87-88, 90).
[110] Id. at pp. 88, 91.
[111] Ex. 111 at 0121.
[112] *Id.* at 0120.
[113] *Id.*

the fingers on his left hand were tingling.[114] He noted that he had only slept for approximately three hours, a fact confirmed by a corrections officer.[115] [redacted] explained that he had been experiencing severe pain for "some months" in his lower back and between his shoulder blades.[116] However, this back pain was now extending into his right thigh and foot.[117]

44. Nurse [redacted] noted that [redacted] appeared to be in a great deal of pain.[118] He was hunched over and appeared to be in significantly more discomfort than compared to his initial assessment two days earlier.[119]

45. Nurse [redacted] took [redacted]'s blood pressure, which measured 159/104, and checked his pulse, which measured 101 beats per minute.[120] Concerned with [redacted]'s high blood pressure, Nurse [redacted] decided to conduct an electrocardiogram (EKG) to ensure that [redacted] was not experiencing a heart attack.[121]

46. As an RN, it was within Nurse [redacted]'s scope of practice to conduct an EKG, using the jail's in-house EKG machine, but not to interpret the results, which are set forth in a paper printout.[122] The EKG printout read, "probable inferior infarct," and registered as an "abnormal" result.[123]

47. Nurse [redacted] decided to contact Dr. [redacted], MEnD's medical director and the designated medical provider for the [redacted] County Jail, to discuss her physical examination of [redacted] and the EKG results.[124] After reviewing the EKG record, Dr. [redacted] concluded that the EKG registered a "false positive" result and that [redacted] did not suffer a recent inferior infarct.[125] Dr. [redacted] determined that the EKG results were "benign."[126]

48. Dr. [redacted] ordered one dose each of ibuprofen (600 mg), Tylenol (acetaminophen) (975 mg), and hydroxyzine (50 mg), an anti-anxiety/antihistamine medication.[127] He directed Nurse [redacted] to ensure that [redacted]'s blood pressure be checked by the visiting medical provider during the next rounds.[128]

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[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] Test. of [redacted] (Tr. at Vol. I, p. 93).
[119] *Id.* at p. 94.
[120] Ex. 111 at 0120.
[121] Test. of [redacted] (Tr. at Vol. I, p. 93).
[122] Ex. 129 at 24; Ex. 111 at 0105.
[123] Ex. 111 at 0105.
[124] *Id.* at 0120.
[125] Test. of [redacted] (Tr. at Vol. III, p. 593).
[126] *Id.* at Tr. Vol. III, p. 591.
[127] Test. of [redacted] (Tr. at Vol. III, pp. 587-588); Test. of [redacted] (Vol. I, p. 95).
[128] Ex. 111 at 0120.

C. Tuesday, August 28, 2018

49. At approximately 8:30 a.m. on August 28, 2018, Nurse [redacted] conducted another medical assessment on [redacted].[129] Prior to the assessment, Nurse [redacted] contacted the Walgreens pharmacy that had last filled [redacted]'s blood pressure medicine, Flexeril.[130] She learned that it was last filled in January 2018, indicating that [redacted] was not regularly taking his high blood pressure medication.[131]

50. During the assessment, [redacted] complained of back pain and numbness on his right side.[132] He stated that it hurt to walk or lay down.[133] [redacted] recounted that he had fallen out of bed sometime during the night and was left to lay on the ground of his cell for 25 minutes, even after speaking with a correctional officer.[134] Nurse [redacted] observed that [redacted] was in tears, moving very slowly, and favoring his right arm.[135]

51. Nurse [redacted] took [redacted]'s vital signs, including checking his blood pressure (156/117), his pulse rate (95 beats per minute), and temperature (98.3 degrees).[136] [redacted]'s blood pressure reading was consistent with continued hypertension.[137]

52. Nurse [redacted] called supervising physician Dr. [redacted] to discuss her assessment.[138] Dr. [redacted] believed at the time that [redacted] may have suffered an injury from the fall from the bunk, which may have been causing [redacted]'s back pain and numbness.[139] Dr. [redacted] prescribed 600 mg of ibuprofen three times a day for seven days; 10 mg of Flexeril twice a day for seven days; and 10 mg of lisinopril (a high blood pressure medicine) daily.[140] He also ordered that [redacted] be given 600 mg of ibuprofen and 175 mg of Tylenol immediately.[141] Dr. [redacted] further directed that correctional officers allow [redacted] to have a lower bunk and extra blankets.[142] Dr. [redacted] did not order any further testing or additional observations.[143]

53. Dr. [redacted] told Nurse [redacted] that he would order blood work to be completed on [redacted] if [redacted] stayed longer than one week in the jail.[144] Notably, [redacted]'s medical records indicated that [redacted]'s "expected out/court date" was September 4, 2018, exactly one week

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[129] *Id.* at 0119; Test. of [redacted] (Tr. at Vol. I, pp. 95-96).
[130] Ex. 111 at 0119.
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] *Id.*
[135] *Id.*
[136] *Id.*
[137] *Id.*
[138] *Id.*
[139] Test. of [redacted] (Tr. at Vol. III, pp. 594-595).
[140] Ex. 111 at 0119.
[141] *Id.*
[142] *Id.*
[143] Test. of [redacted] (Tr. at Vol. I, pp. 97-98).
[144] *Id.* at p. 98).

later.[145] In addition, on August 27, 2018 (just one day earlier), [redacted] had been granted conditional release, allowing him to be released from jail pending the charges against him if bail was posted.[146] [redacted]'s next court appearance was scheduled for September 4, 2018 – the Tuesday after the upcoming Labor Day holiday.[147]

54. MEnD health tech/correctional officer incident call sheets and on-call documentation triage forms both require that an inmate's "expected out/court date" be filled in so that providers know when an inmate is scheduled for release or for a court appearance that may result in release.[148] According to Nurse [redacted], she was trained by Nurse [redacted] to ensure this date was always completed because it was "very important information" for Dr. [redacted] to consider.[149]

55. At approximately 8:00 p.m. on August 28, 2018, [redacted] sent a "kite" or jail message asking to be taken to the hospital for medical treatment.[150] The message read:

> I need to be seen and taken to the hospital on account of i [sic] can't feel my legs and cannot be physically mobil [sic]. Plz be fast about this because im also in incruciating [sic] pain in all my muscles all over my body.[151]

D. Wednesday, August 29, 2018

56. At approximately 6:25 a.m. on August 29, 2018, [redacted], MEnD's lead medical technician at the [redacted] County Jail, contacted nursing supervisor Nurse [redacted] to advise her that [redacted] was unable to feel his legs or ambulate, and that his pain was getting worse.[152] Nurse [redacted] instructed Ms. [redacted] and correctional staff to place [redacted] in a medical segregation cell (referred to as a "tank") until a MEnD nurse could arrive at the jail to assess him.[153] [redacted], RN, a MEnD staff nurse, was scheduled to arrive at approximately 7:00 a.m. to begin her shift.[154]

57. There are two medical segregation cells in the [redacted] County Jail (cell #214 and #215), both of which contain surveillance cameras to allow correctional staff to observe and monitor the cells at all times.[155] The surveillance cameras are also constantly recording footage, which can be played back by jail staff.[156]

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[145] Ex. 111 at 0111.
[146] Ex. 130.
[147] *Id.*
[148] *See e.g.*, Ex. 111 at 0111, 0112; Test. of [redacted] (Tr. at Vol. I, pp. 99-102).
[149] Test. of [redacted] (Tr. at Vol. I, pp. 102-103).
[150] Ex. 111 at 0118.
[151] *Id.*
[152] Ex. 111 at 0111, 0112.
[153] *Id.*
[154] Test. of [redacted] (Tr. at Vol. I, p. 101); Ex. 111 at 0111, 0118.
[155] Ex. 131.
[156] Test. of [redacted] (Tr. at Vol. I, p. 101).

58. At approximately 9:24 a.m. on August 29, 2018, [redacted] was brought to the second-floor nursing station at the jail for an evaluation by Nurse [redacted].[157] Nurse [redacted] began by checking [redacted]'s foot.[158] She then checked his vital signs, which showed blood pressure of 162/116, a pulse rate of 83 beats per minute, and blood oxygen saturation of 98 percent.[159] In talking with [redacted], she learned that he had not been taking his Flexeril outside of the jail because he felt better without the medication.[160]

59. [redacted] explained that he had numbness starting around his belly button and traveling bilaterally down through his legs.[161] He denied any loss of bowel or bladder control.[162] Nurse [redacted] observed that [redacted] was moving his arms, but when she asked him to lift his hands so she could remove the oxygen sensor, he stated that he could not move them.[163] Once the sensor was removed, however, Nurse [redacted] claimed that [redacted] was able to wave his arms and hands around.[164] [redacted] stated that his arms and hands would sometimes go numb, and that he had been unable to eat for two days because he could not properly lift his hands.[165]

60. [redacted] also reported that he was unable to move his legs.[166] However, Nurse [redacted] noticed that when the correction officer pushed [redacted] in a wheelchair, [redacted] was able to lift his feet off the floor and avoid hitting his feet on a medical cart.[167] At the same time, jail staff informed Nurse [redacted] that [redacted] was able to stand and use the telephone earlier in the morning.[168] Both Nurse [redacted] and the jail staff were skeptical of [redacted]'s medical claims.[169] Nurse [redacted]'s physical examination of [redacted] took less than five minutes.[170]

61. Given her skepticism, Nurse [redacted] requested permission from jail staff to review video footage of [redacted]'s reported fall from his bunk.[171] The jail administrator granted Nurse [redacted] permission to review video footage of [redacted] in the medical segregation cell on the morning of August 29, 2018.[172] The video footage that she reviewed, however, was not footage of [redacted]'s fall from the bunk that [redacted] reported to Nurse [redacted] on the

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[157] Ex. 111 at 0118; Ex. 112 at 1953.
[158] Ex. 112 at 1953.
[159] Ex. 111 at 0118.
[160] *Id.*
[161] *Id.*
[162] *Id.*
[163] *Id.*
[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] *Id.*
[169] *Id.*
[170] Ex. 112 at 1953.
[171] Ex. 111 at 0118.
[172] *Id.*

morning of August 28, 2018.[173] Nonetheless, in her notes of August 29, 2018, Nurse [redacted] writes:

> [I] reviewed video of "fall." [Patient] eased himself to the side of bed and wheelchair and slowly guided himself to the floor.[174]

62. The video that Nurse [redacted] actually reviewed was not [redacted]'s fall from the bunk that he reported to Nurse [redacted] on August 28, 2018, but rather, it was more recent video footage from [redacted] in the medical segregation cell (#215) recorded the morning of August 29, 2018.[175] Therefore, Nurse [redacted]'s notes are inaccurate and improperly imply that [redacted] was exaggerating the fall from the bunk he reported on August 28, 2018.

63. Nurse [redacted]'s notes from August 29, 2018, go on to express further distrust of [redacted]'s reported symptoms.[176] Nurse [redacted] writes:

> [Patient] was able to move himself in wheelchair in front of [me] but when [correction officers] attempted to transfer him to bed[,] he went limp and would not help them. Lunch was given and [patient] stated [that] he was unable to eat it [due to] numbness in hands and unable to swallow. [Patient] was watched swallowing multiple times during talk with [me] [without] any difficulty, such as head movements or enhanced movements [with] swallowing. [Patient] requested to be moved back to [illegible].[177]

1. Video Footage Reviewed by Nurse [redacted] (Aug. 29, 2018)

64. The video that Nurse [redacted] reviewed begins at 7:57 a.m. on August 29, 2018, and continues until 9:52 a.m. that same day.[178] The footage begins with [redacted] sitting in a wheelchair apparently talking with someone who is outside the cell.[179] [redacted] is moving his arms and feet.[180] [redacted] pushes himself to the toilet, while in the chair, and spends a

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[173] The fall reported by [redacted] on the morning of August 28, 2018, occurred either during the night of August 27 or in the early morning hours of August 28, 2018. *See* Ex. 111 at 0119 (the report of the fall was made around 8:30 a.m. on August 28, 2018). At that time (August 27 and 28, 2018), [redacted] was still in a cell with the general jail population – he was not in the medical segregation unit that was under video surveillance. *See* Ex. 111 at 0119, 0080. Officer [redacted] report notes that he asked MEnD staff to transfer [redacted] to a medical segregation cell at approximately 6:30 a.m. on August 29, 2018, so that [redacted] could be monitored on camera. *See* Ex. 111 at 0080. [redacted] was moved to the medical segregation cell #215 at approximately 6:55 a.m. on August 29, 2018. *Id.* [redacted] was not under video surveillance at the time of the fall he reported on August 28, 2018. Therefore, Nurse [redacted] could not have viewed video of the fall from the bunk that [redacted] reported on August 28, 2018.

[174] Ex. 111 at 0118.

[175] Ex. 133.

[176] Ex. 111 at 0118.

[177] *Id.*

[178] Ex. 133

[179] *Id.*

[180] *Id.*

few minutes attempting to do something at the toilet.[181] An officer enters the cell to remove bedding from the cot.[182] At 7:21 a.m., [redacted] is given medication and an officer replaces [redacted]'s bedding.[183] [redacted] lifts his legs using his hands and places them on the cot, while he remains seated in the wheelchair.[184] [redacted]'s legs are fully outstretched, resting on the bed, while the remainder of his body is seated in the chair.[185]

65. At 8:04 a.m., [redacted] slides himself out of the chair and onto the floor.[186] He sits upright for a minute, as he attempts to scoot his body forward, but then falls to the ground and lays on his side.[187] He rolls and twists on the floor until 9:07 a.m., when two officers enter the cell and lift him back into the wheelchair.[188] [redacted] uses his hands to lift his legs back onto the cot, while remaining seated in the chair (his legs outstretched on the cot).[189] An officer arranges the mattress under his legs while [redacted] shakes his feet.[190]

66. At 9:11 a.m. an officer wheels [redacted] out of the cell and returns him to the cell a minute later.[191] The officer lifts [redacted]'s legs onto the cot as [redacted] remains seated in the chair.[192] [redacted] throws a blanket over his legs and places a pillow behind his back.[193] At 9:25 a.m., an officer enters the cell and wheels [redacted] away from the bed and out of the cell.[194] [redacted] is wiggling in the chair and is able to move his feet and arms.[195] [redacted] is brought back into the room at 9:32 a.m.[196] The officer places [redacted]'s legs on the bed for him (as [redacted] remains seated in the wheelchair) and [redacted] remains in that position until the end of the video at 9:52 a.m.[197]

67. Thus, contrary to her notes, Nurse [redacted] did not observe video of [redacted]'s fall from the bunk that [redacted] described to Nurse [redacted] the day before (August 28, 2018).[198] Instead, Nurse [redacted] observed video of [redacted] from the medical segregation cell shortly after he was moved to that room.[199] As the video depicts, [redacted] is not falling from a bunk – he is attempting to get out of the wheelchair and slides to the floor.[200]

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[181] *Id.*
[182] *Id.*
[183] *Id.*
[184] *Id.*
[185] *Id.*
[186] *Id.*
[187] *Id.*
[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] *Id.*
[192] *Id.*
[193] *Id.*
[194] *Id.*
[195] *Id.*
[196] *Id.*
[197] *Id.*
[198] *Compare* Ex. 111 at 0118 ([redacted] notes) with 0119 ([redacted] notes); Ex. 133 (video from morning of August 29, 2018).
[199] Ex. 133.
[200] *Id.*

2. Nurse [redacted]'s Report to Dr. [redacted] (August 29, 2018)

68. After her evaluation of [redacted] on August 29, 2019, Nurse [redacted] called Dr. [redacted] to report her findings and suspicions about the veracity of [redacted]'s symptoms and illness.[201] At that time, Dr. [redacted] notes that Nurse [redacted] had "healthy skepticism" about [redacted]'s complaints.[202] Through his conversation with Nurse [redacted], Dr. [redacted] understood that [redacted]'s report of a fall from the bunk on August 28 was what Nurse [redacted] observed on video.[203]

69. Based upon Nurse [redacted]'s representations, Dr. [redacted] ordered Nurse [redacted] to discontinue Flexeril and remove [redacted]'s access to a wheelchair.[204] In its place, Dr. [redacted] permitted [redacted] to have access to a walker temporarily, but stated that access to the walker would also be discontinued "shortly."[205] Dr. [redacted] directed Nurse [redacted] to start 24-hour observation of [redacted] in the "tank" (the medical observation unit).[206] Dr. [redacted]'s rationale for removing [redacted]'s access to the wheelchair was to determine whether [redacted]'s reported symptoms of paralysis were real or merely contrived.[207]

E. Thursday, August 30, 2018

70. The next day, August 30, 2018, Nurse [redacted] arrived for her shift and checked in on [redacted] at approximately 7:40 a.m.[208] [redacted] stated that he could not feel anything from his waist down and had urinated on himself because he was unable to ambulate to the toilet in the jail cell.[209] Nurse [redacted] attempted to give [redacted] ibuprofen and Lisinopril, but [redacted] said he was unable to swallow the pills because his throat felt swollen.[210] Nurse [redacted]'s notes from the visit state that she conducted an examination and did not notice any swelling.[211]

71. Nurse [redacted] then decided to test [redacted]'s reflexes by running a blunt object (in this case, a thermometer) along the soles of [redacted]'s feet.[212] When Nurse [redacted] ran the thermometer across the soles of his feet, she noticed that [redacted] did not move at all.[213] Nurse [redacted] then tested [redacted]'s vital signs, which indicated a blood pressure of 168/109 (indicating hypertension), a pulse rate of 92 beats per minute, and an oxygen saturation of 98 percent (within the normal range).[214]

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[201] Ex. 111 at 0118.
[202] Test. of [redacted] (Tr. at Vol. V, p. 1099).
[203] *Id.* at Vol. V, pp. 1100-1102.
[204] Ex. 111 at 0118.
[205] *Id.*
[206] *Id.*
[207] Test. of [redacted] (Tr. at Vol. V, pp. 1097-1098).
[208] Ex. 111 at 0117.
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] Ex. 111 at 0117; Test. of [redacted] (Tr. at Vol. I, pp. 106-107).
[213] Ex. 111 at 0117.
[214] *Id.*

72. Nurse [redacted] noted that [redacted] looked "very defeated;" he had urinated on himself, could not swallow, had no reflexes in his feet upon stimulation, and his blood pressure was elevated.[215] Nurse [redacted] stated that she "trusted her gut" and "didn't like" what she saw when she observed him.[216] Therefore, she decided to contact Dr. [redacted] for further direction.[217] Nurse [redacted] advised Dr. [redacted] that [redacted] needed to be seen at a hospital.[218]

73. Dr. [redacted] agreed with Nurse [redacted]'s assessment and directed Nurse [redacted] to send [redacted] to the emergency room for evaluation.[219]

1. Video Footage of [redacted]'s Condition on August 30, 2018

74. Video footage taken of [redacted] in the jail cell (#215) around 7:30 a.m. shows [redacted] laying in a cot, minimally responsive to medical staff and correctional officers who enter the cell.[220] [redacted] is able to move his head from side to side and move his hands, but he remains on his back without any attempt to lift his head or body when others entered the room.[221] At one point in the video, [redacted]'s head is awkwardly resting against the concrete wall of the cell and a correctional officer comes into the cell to pull [redacted]'s cot mattress down to the foot of the bed to free [redacted]'s head from against the wall.[222] It is apparent that [redacted] lacked the ability to re-position himself and free his head from against the concrete wall.[223]

75. At approximately 9:05 a.m., three correctional officers come into [redacted]'s cell to lift him from the cot to a wheelchair to assist him to use the in-cell toilet.[224] One officer removes the blanket from [redacted] to reveal that [redacted] is naked from the waist down; he has been laying in his cot without pants, underpants, or an adult brief.[225] With some wrangling, three officers are able to lift [redacted]'s limp body into the wheelchair without any assistance from [redacted].[226] As the officers push the wheelchair forward, [redacted]'s limp legs get caught under the chair as it is rolled forward – [redacted] appears to be unable to move his own legs and prevent them from being run over by the chair.[227] As a result, the officers roll the chair backwards to the toilet.[228] Two officers lift [redacted] and place him on the toilet seat, where he slumps over.[229] At one point, the officers are able to prop [redacted] against the back wall so

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[215] Test. of [redacted] (Tr. at Vol. I, pp. 104-105).
[216] *Id.* at p. 105.
[217] *Id.*
[218] *Id.* at pp. 108-109.
[219] Test. of [redacted] (Tr. at Vol. I, p. 109); Test. of [redacted] (Tr. at Vol. III, p. 617).
[220] Ex. 112 at 1977.
[221] *Id.*
[222] *Id.*
[223] *Id.*
[224] Ex. 112 at 1979.
[225] *Id.*
[226] *Id.*
[227] *Id.*
[228] *Id.*
[229] *Id.*

that [redacted] can remain seated on the toilet seat.[230] After a few minutes, the officers lift [redacted] off the toilet and place him back into the wheelchair.[231] They roll the wheelchair to the cot, lift [redacted]'s legs onto the cot, and leave [redacted] slumped in the wheelchair, with his legs resting on the bed.[232]

2. Override of Dr. [redacted]'s Directive that [redacted] be Transported to the ER

76. At approximately 1:30 p.m., Nurse [redacted] spoke with Beltrami Jail Administrator [redacted] about transporting [redacted] to the nearby emergency room.[233] [redacted], however, refused to authorize [redacted]'s release or transport, despite the medical directive from Dr. [redacted].[234] [redacted] reasoned that [redacted] was located in a medical observation cell, was being monitored by jail staff, and had been observed by correction officers using his arms and legs with no difficulty.[235] [redacted] claimed that jail staff observed [redacted] able to use his hands to open and drink a juice box.[236] [redacted] advised Nurse [redacted] that [redacted] was considered a flight risk and may attempt to use a hospital transfer to escape, which was why the administrator was denying Dr. [redacted]'s directive to transport [redacted] to the emergency room.[237]

77. Nurse [redacted] called Dr. [redacted] again to inform him of Administrator [redacted]'s refusal to allow [redacted] to be transported to the hospital and the administrator's override of Dr. [redacted]'s medical directive.[238] Nurse [redacted] explained that correction officers had intercepted recorded phone calls in which [redacted] was "plotting" an escape and that Administrator [redacted] was unyielding in her refusal to release [redacted] to a hospital due to a concern that he was a "flight risk."[239]

78. Dr. [redacted] did not attempt to contact [redacted] directly to demand [redacted]'s transport to the hospital.[240] Nor did Dr. [redacted] call 911 himself or direct Nurse [redacted] to call 911 to obtain an ambulance transport of [redacted] to the emergency room.[241] Instead, Dr. [redacted] directed Nurse [redacted] to continue monitoring [redacted].[242] Dr. [redacted] explained that a MEnD medical provider was scheduled to be present at the jail the next morning for rounds, who would be able to assess the patient.[243] Notably, Dr. [redacted] had never had a jail administrator overrule his medical directives before.[244]

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[230] *Id.*
[231] *Id.*
[232] *Id.*
[233] Ex. 111 at 0117; Test. of [redacted] (Tr. at Vol. I, p. 109).
[234] Test. of [redacted] (Tr. at Vol. I, p. 109).
[235] Ex. 111 at 0117.
[236] *Id.*
[237] Ex. 111 at 0117; Test. of [redacted] (Tr. at Vol. I, pp. 109-110).
[238] Ex. 111 at 0117; Test. of [redacted] (Tr. at Vol. I, p. 109).
[239] Test. of [redacted] (Tr. at Vol. V, pp. 1122-1123).
[240] *Id.* at Vol. III, p. 626.
[241] *Id.*
[242] Test. of [redacted] (Tr. at Vol. I, p. 109); Test. of [redacted] (Tr. at Vol. III, p. 627).
[243] Test. of [redacted] (Tr. at Vol. I, p. 109); Test. of [redacted] (Tr. at Vol. III, p. 627).
[244] Test. of [redacted] (Tr. at Vol. V, p. 1128).

79. At approximately 2:25 p.m., Nurse [redacted] entered [redacted]'s jail cell again.[245] She advised him that the jail administrator would not allow him to go to the emergency room and that a MEnD medical provider would be coming the next day to evaluate him.[246]

3. Video Footage of [redacted] at Time of Administrator [redacted]'s Refusal to Transport [redacted] to Emergency Room (2:25 p.m. on Aug. 30, 2018)

80. Video surveillance footage from the jail cell at approximately 2:25 p.m. on August 30, 2018, shows Nurse [redacted] talking to [redacted] as he is sitting in a wheelchair in the corner of the cell.[247] He has no pants on and is covering his lap with a blanket.[248] He is holding an adult brief.[249] After Nurse [redacted] leaves the room, [redacted] attempts to put on the adult brief but is unable to move his legs.[250] He spends over 30 minutes attempting to put on the adult brief until he collapses onto the nearby cot from his seated position in the wheelchair.[251] He slips from the bed and falls to the cement floor, where he lays naked from the waist down.[252] After approximately 10 minutes, three correction officers enter the cell and lift [redacted] to his cot.[253] One officer puts some adult briefs by [redacted]'s head and speaks to him for several minutes.[254] Another officer comes in to mop the floor, cleaning up what appears to be urine and a bright red liquid substance.[255]

F. Friday, August 31, 2018

81. The Labor Day weekend of 2018 began on Friday, August 31, 2018, and continued through Monday, September 3, 2018.[256]

82. [redacted] is an RN and nurse practitioner (NP) who had recently been hired by MEnD in early August 2018, to serve as a "medical provider."[257] NP [redacted] was scheduled to work on August 31, 2018, as part of her initial orientation and training with MEnD.[258] From her start date in early August 2018, until August 30, 2018, NP [redacted] MEnD training included "shadowing" Dr. [redacted] on rounds at the various

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[245] Ex. 112 at 1995.
[246] Test. of [redacted] (Tr. at Vol. I, pp. 111-112).
[247] Ex. 112 at 1995.
[248] *Id.*
[249] *Id.*
[250] *Id.*
[251] *Id.*
[252] *Id.*
[253] *Id.*
[254] *Id.*
[255] *Id.*
[256] See 2018 calendar at https://www.timeanddate.com/calendar/?year=2018&country=1.
[257] Test. of [redacted] (Tr. at Vol. I, pp. 139, 142).
[258] *Id.* at p. 144.

facilities serviced by MEnD.[259] While NP [redacted] was in training, Dr. [redacted] continued to serve as the designated medical provider for the [redacted] County Jail.[260]

83. NP [redacted] began her day on August 31, 2018, expecting to meet Dr. [redacted] at the [redacted] County Jail, and accompany him on his rounds as the MEnD medical provider serving the jail that day.[261] However, on her drive to [redacted] just minutes before she arrived at the jail, Dr. [redacted] called NP [redacted] and informed her that he would not be able to make it to the jail and that NP [redacted] was to complete rounds on her own.[262] This was the first day in her employment with MEnD that NP [redacted] would be working independently.[263] Despite Dr. [redacted]'s knowledge of [redacted]'s urgent need for medical care, Dr. [redacted] did not advise NP [redacted] about [redacted] or his need for immediate care or evaluation.[264]

84. Upon arrival at the jail, NP [redacted] proceeded to the nurses' station where she encountered Nurse [redacted] and [redacted] (the medical technician) discussing an inmate ([redacted]) who was "faking" paralysis and incontinence.[265] In the "control room" of the jail, NP [redacted] also overheard three or four correction officers similarly discussing the inmate ([redacted]) and how he was "faking" an illness.[266] One officer asked NP [redacted] "Don't you know what he did?" and advised her that [redacted] was incarcerated for child abuse.[267] These correction officers were making fun of [redacted], laughing about how he would not wear an adult diaper.[268]

85. NP [redacted] decided to review [redacted]'s medical charts before examining him.[269] She noted that [redacted] had been suffering with hypertension during his time at the jail and was not taking his medications due to an inability to swallow.[270] She also reviewed the EKG that Nurse [redacted] had performed on August 27, 2018, that indicated that [redacted] had suffered an inferior infarct.[271] Nurse [redacted] informed NP [redacted] that Dr. [redacted] knew about the EKG but was not concerned with the results.[272]

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[259] *Id.* at p. 143. During the investigation of this case, Nurse [redacted] noted that Dr. [redacted] was the only doctor at MEnD and her supervisor. Ex. 22 at 0560. He "dictated all the care and all the orders" for inmates, although he did not actually see patients. *Id.* Instead, he would mainly review charts that nurses provided, conduct medication reviews, and prescribe. *Id.*

[260] Test. of [redacted] (Tr. at Vol. III. p. 518-520) (while Dr. [redacted] is evasive in his answers to the Judge's questions in this regard, it cannot be disputed that Dr. [redacted] was serving as the acting medical provider for the [redacted] County Jail at all times relevant to this action. Dr. [redacted] was scheduled to conduct rounds at the jail on August 31, 2018, with his trainee NP [redacted], but suddenly cancelled just before NP [redacted] arrived. Dr. [redacted] continued to act as the medical director for the jail and attending physician for [redacted] throughout [redacted]'s stay at the [redacted] County Jail from August 25 to September 2, 2018).

[261] Test. of [redacted] (Tr. at Vol. I, p. 144).

[262] *Id.* at p. 144.

[263] *Id.* at p. 163

[264] *Id.* at pp. 163-164.

[265] *Id.* at pp. 144-145.

[266] *Id.* at 145-147.

[267] *Id.* at pp. 147-148.

[268] Ex. 122 at 0567.

[269] Test. of [redacted] (Tr. at Vol. I, p. 145).

[270] *Id.*

[271] Test. of [redacted] (Tr. at Vol. I at p. 145).

[272] *Id.* at Tr. Vol. I at 145.

86. NP [redacted] proceeded to conduct a medical examination of [redacted] at approximately 9:45 a.m.[273] When NP [redacted] and Nurse [redacted] entered the cell to conduct the examination, they found [redacted] laying on a mat on the concrete floor of the cell with a thin blanket covering his lower body.[274] His head was not on a pillow and he was unable to lift his head.[275] The cell smelled strongly of urine and sweat.[276] [redacted]'s adult brief was fully saturated with urine, which had leaked and soaked the mat upon which [redacted] was lying.[277] [redacted] expressed that he was embarrassed because of this, but no one would assist him with cleaning or changing.[278]

87. NP [redacted] began her examination by having Nurse [redacted] take [redacted]'s vital signs.[279] [redacted]'s blood pressure measured 183/116, his oxygen saturation was at 83 percent, and his pulse count was 113 beats per minute, all indicating that he was suffering a serious medical condition.[280] [redacted] explained that he had severe back pain and he was numb from his waist down.[281] In reviewing his medical history, NP [redacted] noted that [redacted] complained of numbness from his stomach down for three to four days, and that he was now unable to stand.[282] During her physical examination of [redacted], NP [redacted] noticed that [redacted] had "diffuse muscle weakness," which was most pronounced on the right side.[283]

88. NP [redacted] observed that the right side of [redacted]'s mouth was drooping, he had tears on his cheeks, and his speech was slurred.[284] He was also drooling and had urinated and defecated on himself.[285] To test his neurological function, NP [redacted] checked for a "Babinski sign," an involuntary reflex response to a specific form of stimulus obtained by running a blunt object along the sole of a patient's foot.[286] An affirmative Babinski sign results in the upward bending of the big toe and the fanning of the other toes in response to the stimulus.[287] An affirmative Babinski sign indicates that there may be an underlying nervous system or brain condition causing the reflexes to react abnormally.[288] NP [redacted] noted that [redacted] had no response to the Babinski test at all.[289]

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[273] Test. of [redacted] (Tr. at Vol. I, pp. 151-152); Ex. 112 at 2014.
[274] Ex. 112 at 2014.
[275] *Id.*; Ex. 122 at 0568.
[276] Test. of [redacted] (Tr. at Vol. I, p. 148); Test. of [redacted] (Tr. at Vol. I, p. 116).
[277] Test. of [redacted] (Tr. at Vol. I, p. 148).
[278] Ex. 122 at 0568.
[279] Ex. 111 at 0122.
[280] Ex. 111 at 0122; Test. of [redacted] (Tr. at Vol. I, pp. 151-152).
[281] Test. of [redacted] (Tr. at Vol. I, p. 150).
[282] Ex. 111 at 0122.
[283] *Id.*
[284] Test. of [redacted] (Tr. at Vol. I, p. 148); Ex. 122 at 0568.
[285] Test. of [redacted] (Tr. at Vol. I, p. 117).
[286] Ex. 111 at 0117; Test. of [redacted] (Tr. at Vol. V, p. 1112).
[287] Test. of [redacted] (Tr. at Vol. III, pp. 619-620).
[288] *Id.* at Vol. III, pp. 620-621.
[289] Ex. 111 at 0122.

89. NP [redacted] also noticed that [redacted] was having difficulty swallowing.[290] He pleaded with NP [redacted] to believe him that something was seriously wrong.[291] Nurse [redacted] described [redacted] as crying and "begging for help."[292]

90. NP [redacted] initially thought that [redacted] may have suffered a stroke.[293] After her assessment, however, NP [redacted] ruled out a cerebrovascular accident (CVA) and diagnosed [redacted] with uncontrolled hypertension.[294]

91. NP [redacted] decided that [redacted] needed to be immediately transported by ambulance to the nearest hospital for treatment.[295] NP [redacted] instructed Nurse [redacted] to arrange for an ambulance to transport [redacted] to the hospital immediately.[296] It is unclear in the record whether it was NP [redacted] or Nurse [redacted] who spoke with [redacted], the jail administrator, about the transport.[297] According to NP [redacted], [redacted] told Nurse [redacted] that she would not allow [redacted] to be transported by ambulance, but that she would approve the transport to the emergency room by officers in a police vehicle.[298]

92. To prepare him for transport, and because he was dirty and soaked in urine, NP [redacted] decided to change [redacted] into an orange set of "scrubs," the type of attire required by the jail to transport prisoners outside of the facility.[299] [redacted] begged NP [redacted] to not let the correction officers touch him because he was scared of them.[300]

93. Nurse [redacted] began by changing [redacted]'s adult brief and putting a pair of orange pants on him.[301] [redacted] was completely limp and unable to assist Nurse [redacted] in the clothing change.[302] According to NP [redacted], he was "like moving dead weight."[303] NP [redacted] further noticed that [redacted] was cold to the touch, but yet covered in sweat.[304]

94. The nurses grew frustrated because none of the correction officers were helping the women, so Nurse [redacted] went to the officer station to request assistance.[305] NP [redacted] noted that the correction officers were reluctant to help and

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[290] Test. of [redacted] (Tr. at Vol. 1 at p. 148).
[291] *Id.*; EX. 122 at 0568.
[292] Test. of [redacted] (Tr. a Vol. I at p. 117).
[293] Test. of [redacted] (Tr. at Vol. I, p. 150)
[294] Ex. 111 at 0122.
[295] Test. of [redacted] (Tr. at Vol. I, pp. 151-152).
[296] Test. of [redacted] (Tr. at Vol. I, p. 154).
[297] Test. of [redacted] (Tr. at Vol. I, p. 154) (testifying that [redacted] arranged the transport); Test. of [redacted] (Tr. at Vol. I, p. 118) (testifying that NP [redacted] arranged the transport).
[298] Test. of [redacted] (Tr. at Vol. I, pp. 153-154).
[299] *Id.* at p. 151.
[300] *Id.* at p. 151; Ex. 122 at 0569.
[301] Ex. 112 at 2014.
[302] *Id.*
[303] Test. of [redacted] (Tr. at Vol. I, p. 152); Ex. 122 at 0569.
[304] Test. of [redacted] (Tr. at Vol. I, p. 153).
[305] *Id.* at p. 152.

would not touch [redacted].[306] Finally, Nurse [redacted] was able to get three male officers into the room to assist with changing [redacted] and getting him into a wheelchair.[307] Two of the three officers lifted [redacted] into the wheelchair and Nurse [redacted] was able to change [redacted]'s shirt.[308] [redacted] was entirely limp and unable to assist with the change of clothes.[309] [redacted] was able to sit in the wheelchair but kept slumping forward, such that Nurse [redacted] had to hold him in the chair as an officer wheeled him from the room.[310]

95. Video surveillance footage of the jail cell from 8:50 a.m. to 10:00 a.m. on August 31, 2018, corroborates the testimony of Nurse [redacted] and NP [redacted].[311] The video depicts [redacted] lying on a mat on the cell floor, limp and despondent, unable to assist the nurses or officers in their attempts to move him.[312]

96. After sending [redacted] to the emergency room, NP [redacted] spoke with Dr. [redacted] again.[313] NP [redacted] explained that she had concerns about a CVA (stroke).[314] Dr. [redacted] did not oppose NP [redacted]'s decision to send [redacted] to the hospital for evaluation,[315] but was upset with the fact that NP [redacted] did not contact him before giving the medical directive to send the patient to the emergency room.[316]

97. At this point in time, a diagnosis of Guillain-Barre Syndrome crossed Dr. [redacted]'s mind as a potential cause of [redacted]'s symptoms, and he discussed this "differential diagnosis" with NP [redacted].[317] Guillain-Barre Syndrome is a rare autoimmune disorder in which a person's own immune system attacks the nerves, causing progressive muscle weakness, numbness, tingling, pain in the limbs, and paralysis.[318] In some cases, Guillain-Barre Syndrome can be fatal.[319]

G. Two Hospital Visits – Friday, August 31, 2018

98. [redacted] County deputies transported [redacted] to the [redacted] Medical Center emergency room, where he arrived at approximately 10:34 a.m. on August 31, 2018.[320] While at the [redacted] hospital, [redacted] was seen by [redacted].[321] [redacted]'s admission note reads:

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[306] Ex. 122 at 0569.
[307] Test. of [redacted] (Tr. at Vol. I, pp. 152-153).
[308] Test. of [redacted] (Tr. at Vol. I, p. 153); Test. of [redacted] (Tr. at Vol. I, p. 120).
[309] Test. of [redacted] (Tr. at Vol. I, p. 152).
[310] Ex. 112 at 2014.
[311] *Id.*
[312] *Id.*
[313] Test. of [redacted] (Tr. at Vol. III, p. 634).
[314] *Id.* at p. 635.
[315] *Id.*
[316] Ex. 122 at 0572.
[317] Test. of [redacted] (Tr. at Vol. III, pp. 636-637); Test. of [redacted] (Tr. at Vol. I, p. 155).
[318] Test. of [redacted] (Tr. Vol. II at 268-270); Ex. 120 at 5-6 and attachment.
[319] Test. of [redacted] (Tr. Vol. II at 268-270); Ex. 120 at 5-6 and attachment.
[320] Ex. 111 at 0240.
[321] *Id.* at 0242.

[redacted] is a 27 yr old male who presents to the Emergency Department [f]rom jail secondary to the fact that he says that he cannot move or feel either one of his lower legs. This [has] apparently been going on for 4 days. 4 days ago he said he fell out of his top bunk and since then he's had back pain and has been unable to move his lower legs or feel his lower legs. He has pain in his lower back and also his upper back. He also says that he's had trouble moving his upper arms also [sic]. When I ask about numbness he said "everything is numb." He cannot pinpoint it. About 2 days ago he started having a left facial droop and couldn't use the left side of the face. He's not complaining of any check or abdominal pain.[322]

99. During the examination, [redacted] observed that [redacted] had a left-side facial droop that included his forehead.[323] He also noted that [redacted] could not move his lower legs and did not react to painful stimuli.[324] [redacted] was able to move his upper extremities, although he stated that he was weak, his arms were numb, and he could not react to resistance.[325] A rapid drug screen showed only the residual existence of Tetrahydrocannabinol (THC), the active ingredient in marijuana.[326]

100. [redacted] ordered a CT scan of [redacted]'s head, cervical spine, abdomen, pelvis, and chest, along with a complete blood count.[327] The CT scans showed no evidence of trauma.[328] As a result, [redacted] decided to order a magnetic resonance imaging (MRI) of [redacted]'s brain and spine.[329] However, [redacted] did not have access to an MRI machine at that time.[330] As a result, he ordered that [redacted] be transferred to a hospital in Fargo that had an MRI machine.[331]

101. The discharge summary written by [redacted] states:

The patient has symptoms of uncertain etiology at this time. He continues to not move his lower extremities, the facial droop may be Bell's palsy since it does include the forehead, however[,] without MRIs[,] I cannot rule out [spinal] cord compression or CVA. I did do CAT scans which show no evidence of any fractures, dissections, or any other acute traumatic processes. Unfortunately at this time I cannot get the MRIs that are needed to rule out any significant cord compression or other significant emergent processes. I did speak to the ER director who spoke to MRI and at this time I cannot get them done, therefore they recommend I transfer the patient. I

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[322] *Id.* at 0244.
[323] *Id.* at 0245.
[324] *Id.* at 0245.
[325] *Id.* at 0245.
[326] *Id.* at 0162.
[327] *Id.* at 0243.
[328] *Id.* at 0242.
[329] *Id.* at 0242.
[330] *Id.*
[331] *Id.*

spoke to the emergency physician at [redacted], and they will accept the patient. Patient will be transferred for further workup and evaluation.[332]

102. After a physical examination and a review of [redacted]'s vital signs, blood work, and CT scans, [redacted] concluded that he could not diagnose [redacted]'s medical condition and considered the following "differential diagnoses": spinal cord compression, fracture, contusions, malingering, Bell's palsy, cerebral vascular accident, and aortic dissection.[333]

103. [redacted] was discharged from the [redacted] emergency room at approximately 3:00 p.m. and transferred by ambulance to the [redacted] Medical Center emergency room in [redacted], North Dakota, approximately two hours away.[334] [redacted] County deputies accompanied [redacted] to [redacted].[335]

104. [redacted] arrived at the [redacted] medical facility at approximately 5:35 p.m. and was examined by [redacted].[336] [redacted]'s vital signs indicated a temperature of 98.1 degrees, a pulse rate of 128 beats per minute, a blood oxygen saturation of 100 percent, and blood pressure of 174/118.[337] [redacted] noted that [redacted] exhibited "facial asymmetry, weakness, and numbness," but did not notice any speech difficulty.[338] As ordered by [redacted], MRIs of [redacted]'s entire spine and brain were performed, but the tests identified no abnormalities.[339]

105. [redacted] was under observation and testing at the [redacted] hospital from approximately 5:30 p.m. until 11:15 p.m.[340] It appears that [redacted] remained in four-point restraints (hands and ankles handcuffed to a medical gurney) at all times at the [redacted] hospital, except for when the MRI was completed.[341] It is unclear how [redacted] hospital staff conducted a full physical examination of [redacted]'s ability to move when he was so shackled.

106. After examination, observation, and testing, [redacted] summarized [redacted]'s visit, as follows:

> 27-year-old male arriving as a transfer from [redacted] Minnesota to [redacted] and [redacted] with request of MRI. Upon arrival[,] the patient is noted to be alert, afebrile, and hemodynamically stable with slight hypertension and tachycardia. Externally the patient has no trauma to the head or neck. He is interactive and GCS is 15. He reports generalized weakness to the upper or lower extremities[,] however sensation is intent and symmetric. I am able to elicit a[n] appropriate Babinski test. The patient does pull away from

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[332] *Id.*
[333] *Id.* at 0243.
[334] *Id.* at 0240, 0277.
[335] *See* Ex. 111 at 0158.
[336] Ex. 111 at 0167.
[337] *Id.* at 0157-0158.
[338] *Id.* at 0157.
[339] *Id.* at 0144-0155.
[340] *Id.* at 0134-0139.
[341] Ex. 111 at 0073, 0082.

painful stimuli of lower extremities. This time he has no pain with palpation of the back. There is no evidence of overlying skin infection or abscess. I believe this would be atypical to affect both the cranial nerves and upper and lower extremities symmetrically. However[,] based on outside examination and recommendation for MRI, we did obtain MRI of the brain[,] as well as entire spinal cord[,] with no abnormalities. Laboratory studies demonstrate no obvious cause for symptoms. In the emergency department [he] remains slightly tachycardic. **Following MRI[,] [] a second deputy arrived providing further history that the patient was reportedly on a monitor last evening unknown to the patient[.] [He] was witnessed moving his extremities without apparent difficulty.** At this time[,] after a prolonged period of observation [in] the emergency department[,] I do not find a cause for acute progressive neurologic condition warranting emergency hospitalization. I did discuss both with the deputy sheriffs as well as patient indications for emergent return locally or to [redacted]. At this time the patient will be dismissed to return to jail.[342]

107. These notes indicate at least one [redacted] deputy was advising the doctor that [redacted] was likely feigning his illness.[343]

108. In addition, one nursing note reads: "[patient] witnessed wiggling toes in bed while RN's are outside of room standing in doorway."[344]

109. Consistent with the information provided by the deputy and nurse, [redacted] final diagnosis was: (1) malingering; and (2) weakness.[345] "Malingering" was noted as [redacted] primary clinical impression.[346]

110. [redacted]'s discharge instructions read:

You have been seen today for generalized weakness. This may also be described as fatigue.

Weakness is a common problem, especially in older individuals.

It is important to understand the difference between true weakness (real weakness from a nerve or brain problem) and the more common problem of fatigue. These words might seem similar, but they do mean very different problems.

- Fatigue: When a person is describing fatigue, they may feel tired out very quickly even with just a little activity. They may also say they are

[342] Ex. 111 at 0158-0159 (emphasis added).
[343] *Id.*
[344] *Id.* at 0139.
[345] *Id.* at 0168.
[346] *Id.* at 0128.

feeling tired, sleepy, easily exhausted and unable to do normal daily activities because they don't seem to have enough energy.

- True Weakness: When someone has true weakness, it means that the muscles are not working right. For example, a leg might be truly weak if you can't support your weight on it or if you can't get up from a chair because the thigh muscles aren't strong enough.

There are many causes of weakness including: infections (often kidney/bladder infections or pneumonias), electrolyte abnormalities (low sodium, low potassium), depression, and neurologic (brain or nerve disorders).

After looking at the results of the blood tests or X-rays, the cause of your weakness is:

- Unclear or unknown.

It is VERY IMPORTANT to see your primary care doctor. More testing may be needed to figure out the cause of your weakness.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Confusion, coma, agitation (becoming anxious or irritable).
- Fever (temperature higher than 100.4°F / 38° C), vomiting
- Severe headache
- Signs of a stroke (paralysis or numbness on one side of the body, drooping on one side of the face, difficulty talking)
- Worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels or difficulty swallowing.[347]

111. [redacted] was discharged from the [redacted] hospital at approximately 11:15 p.m. on August 31, 2018.[348] He was then transported back to the [redacted] County Jail by deputies.[349]

[347] *Id.* at 0128-0129.
[348] *Id.* at 0167.
[349] Ex. 112 at 2040.

H. Saturday, September 1, 2018

1. Arrival Back at the Jail (12:30 a.m.)

112. [redacted] arrived back at the jail at approximately 12:30 a.m. on September 1, 2018.[350] Video footage from the jail's garage port shows [redacted]'s condition and treatment by deputies upon arrival back at the jail.[351]

113. The video begins with four deputies talking in the garage, while [redacted] remains locked inside the police vehicle.[352] One of the deputies opens the car door and attempts to get [redacted] out of the vehicle.[353] [redacted] falls onto the concrete garage floor.[354] While he lays on the ground, four deputies stand over him and look down on him, but do not render any assistance.[355] Then, two deputies attempt to drag [redacted] into a nearby wheelchair by grabbing him by his arms.[356] [redacted] is completely limp and listless.[357] He slips out of the wheelchair and falls to the ground.[358] Once again, the deputies stand over him and appear to be talking to him.[359] [redacted] does not move and appears unresponsive.[360] The deputies stand over him for approximately a minute or two, as [redacted] lays, face down, on the concrete floor.[361] Finally, two deputies lift [redacted] into the wheelchair and get him to sit up.[362] [redacted] is limp as his head falls backward and forward.[363] The deputies then wheel him into the jail and place him back into a medical segregation cell (#214).[364]

114. Video footage of [redacted] in his medical segregation cell from 12:45 a.m. to 6:00 a.m. depicts three deputies carrying [redacted] into the cell and placing him onto a cot, with his feet overhanging the bed.[365] [redacted] is completely limp and appears unconscious.[366] The deputies remove handcuffs from his wrists and ankles.[367]

115. A few minutes later, an officer comes into the room, places a pillow above [redacted]'s head, and lays a blanket beside him.[368] The officer spends several minutes in the cell standing over [redacted], apparently talking to him, but the video is soundless so it is

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[350] *Id.*
[351] *Id.*
[352] *Id.*
[353] *Id.*
[354] *Id.*
[355] *Id.*
[356] *Id.*
[357] *Id.*
[358] *Id.*
[359] *Id.*
[360] *Id.*
[361] *Id.*
[362] *Id.*
[363] *Id.*
[364] Ex. 112 at 2041.
[365] *Id.*
[366] *Id.*
[367] *Id.*
[368] *Id.*

unclear whether [redacted] was able to respond in any manner.[369] [redacted] appears semi-conscious.[370] Before leaving the cell, the officer throws the blanket over [redacted]'s body.[371]

116. [redacted] does not change positions for the next nearly two hours (from 12:45 a.m. to 2:33 a.m.).[372] He is lying on his back, his feet are hanging over the bed, and his left arm is hanging off the bed.[373] At 2:33 a.m., [redacted] begins to shake and rolls off the cot, falling face-first onto the concrete floor.[374] His shirt is pulled up, exposing his bare midsection, as he remains on the floor, in the same position, until at least 5:50 a.m. (over three hours), when the video ends.[375] This all occurs while correctional staff were apparently monitoring [redacted] via video from the control room.

117. By the time the correction officers returned [redacted] to the jail on September 1, 2018, they were under the impression that [redacted] was faking his illness (due to the hospital diagnosis of "malingering") and attempting to "manipulate" jail staff.[376] According to one officer, because [redacted] was facing a significant amount of prison time for his alleged criminal offense, he was deemed a "high flight risk" and could be using the illness in an attempt to escape.[377]

2. Early Morning Briefing

118. The first note in [redacted]'s jail medical records from September 1, 2018, was written by [redacted], an unlicensed medical technician employed by MEnD.[378] That notes states:

> At approximately 0800 pt [patient] stated he was on drugs while in jail and that's what caused him to get sick. Gave the pt [patient] a specimen cup to obtain a urine drug screen to see if he was positive for anything. At 12:20 p.m. urine was still not given.[379]

119. According to correction officer reports, [redacted] told two officers that he had consumed drugs while in the [redacted] Jail and gave a detailed account of how he allegedly received those drugs.[380] Notably, however, [redacted] had received a full drug screen while in the emergency room just a few hours earlier and that drug screen detected no signs of illicit drugs other than THC.[381]

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[369] *Id.*
[370] *Id.*
[371] *Id.*
[372] *Id.*
[373] *Id.*
[374] *Id.*
[375] *Id.*
[376] Ex. 111 at 0072-0074, 0082-0083, 0088.
[377] *Id.* at 0088.
[378] Ex. 111 at 0116.
[379] *Id.* at 0116.
[380] *Id.* at 0077-0078.
[381] Ex. 111 at 0162.

120. [redacted], MEnD's director of nursing at the time, was the RN on duty at the [redacted] County Jail the weekend of September 1 and 2, 2018.[382] While Nurse [redacted] did not normally work in the [redacted] County Jail, she agreed to cover the holiday shift because MEnD was short-staffed that weekend.[383] Recall that Nurse [redacted] was (and remains) Dr. [redacted]'s romantic partner and live-in girlfriend.[384] Nurse [redacted] was aware of [redacted] prior to the start of her shift.[385]

121. Sgt. [redacted] was the correctional officer in charge at the [redacted] County Jail on September 1, 2018.[386] Sgt. [redacted] began her shift that morning with a briefing by Sgt. [redacted], who told her that [redacted] returned from the [redacted] Hospital during the night and that doctors at the hospital "were unable to find anything medically wrong with him."[387] Sgt. [redacted] then called Jail Administrator [redacted] to advise her of [redacted]'s condition and to request further direction.[388] Sgt. [redacted] explained that [redacted] "was continuing to not move his extremities around much and that if staff tried to assist him, he would just go limp and was dead weight."[389] Sgt. [redacted] asked [redacted] if jail staff should assist [redacted] with "toileting, feeding, etc." even though the Fargo Hospital "found nothing medically wrong with him."[390] [redacted] directed Sgt. [redacted] to speak with MEnD medical staff to obtain further instructions on what the jail should do for [redacted][391]

122. Sgt. [redacted] asked MEnD's on-duty medical technician, [redacted], to call Nurse [redacted] and see when she would be arriving for her shift.[392] Ms. [redacted] responded that Nurse [redacted] would be arriving shortly.[393]

123. Nurse [redacted] arrived for her shift at the [redacted] County Jail at approximately 11:22 a.m. on Saturday, September 1, 2018.[394] Upon her arrival, Sgt. [redacted] spoke with Nurse [redacted].[395] According to Sgt. [redacted]'s report:

> When MEnD nurse [redacted] arrived[,] I let her know that [redacted] was continuing to tell staff that he was unable to move his extremities and that he couldn't feel his legs. I also let her know that he was continuing to not move around much and that he was just remaining to lay on his bed. I did tell her that [he] has been communicating with staff. I asked her if she could see him and advise us what we need to be doing for him. I also asked

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[382] Test. of [redacted] (Tr. at Vol. I, pp. 191-192).
[383] *Id.* at Vol. IV, pp. 830, 835-836.
[384] *Id.* at p. 828.
[385] *Id.* at p. 837.
[386] Ex. 111 at 0095-0096.
[387] *Id.* at 0095.
[388] *Id.*
[389] *Id.*
[390] *Id.*
[391] *Id.*
[392] *Id.*
[393] *Id.*
[394] Ex. 115.
[395] Ex. 111 at 0095-0096.

whether or not we should be assisting him with toileting, eating, etc. due to the fact that he was cleared by the hospital. Nurse [redacted] told me that she needed to review his medical records and to see him and then she would let us know.[396]

124. Nurse [redacted] began her shift by reviewing [redacted]'s hospital discharge record that indicated that [redacted] had been diagnosed with "malingering and weakness" at the [redacted] hospital the night before, and that no new medical orders were given.[397] Nurse [redacted] had never seen a diagnosis of "malingering" before in her career.[398]

125. Nurse [redacted] also spoke with corrections staff who stated that [redacted] had been laying on his back in his cot since he returned from the hospital.[399] She was told that [redacted] "wiggled himself onto the floor" during the night and had been seen moving his extremities.[400] Nurse [redacted]'s note states: "Talking with staff. Per COs [correctional officers] that were at the hospital, [patient] changed his story every time doctors told him nothing was wrong."[401] Consequently, before even seeing [redacted], Nurse [redacted] had formed the impression that [redacted] was fabricating his illness and symptoms.[402]

126. Despite this information, and the fact that [redacted] was considered a "high priority patient,"[403] Nurse [redacted] did not immediately check on [redacted] or conduct any assessment of his condition upon the start of her shift.[404] Instead, she waited until approximately 2:05 p.m. (over 2½ hours after the start of her shift) to make her first visit to [redacted]'s cell.[405]

3. Nurse [redacted]'s "Evaluation" of [redacted]

127. Nurse [redacted]'s medical notes indicate that her first "visit" with [redacted] was at 1:00 p.m.[406] (This time is incorrect based upon video evidence which shows that Nurse [redacted] came to the room at 2:05 p.m.).[407] Nurse [redacted]'s medical note reads as follows:

Pt [patient] seen in cell. Laying on bunk face up. Cell smelled like urine and feces. Pt [patient] talking. Clearing his throat at times saying he's choking. Bouncing foot, knees, thighs, and hands at time wiggling hips back and forth stating he's trying to move and cannot. States he wants to shower but wants help sitting up. Pt [patient] advised he needs to try himself. Reminded [him]

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[396] *Id.* at 0095.
[397] Ex. 111 at 0115; Ex. 128 at 26.
[398] Test. of [redacted] (Tr. at Vol. IV, pp. 851-852).
[399] Ex. 111 at 0115; Ex. 128 at 28.
[400] Ex. 111 at 0115; Ex. 128 at 28.
[401] Ex. 111 at 0115.
[402] *Id.*
[403] Ex. 128 at 28.
[404] Test. of [redacted] (Tr. at Vol. I, pp. 193, 201-202).
[405] Ex. 111 at 0115; Ex. 112 at 2045. (Nurse [redacted] first appears at the door at 2:05:59 p.m. and stays until 2:08:39 p.m., less than three minutes).
[406] Ex. 111 at 0115.
[407] Ex. 112 at 2045.

> ER imaging revealed no significant findings to causes immobility and incontinence. States he wasn't truthful as he thinks he has a[n] STD. Advised pt [patient] STDs typically do not present in this manner and he can have those issued addressed when he's up and moving. Reports back pain/stiffness – reminded he needs to get up. Then states he was using drugs in the jail but wouldn't say more unless [I] came to him to help him up. Told [him] writer [ ] doesn't bargain. Told pt [patient] [that] writer [ ] wants to do a UDS [urine drug screen]. Pt [patient] calm. No fidgeting. No SOB [shortness of breath]. No sweating. Will recheck tomorrow. ER called to get full note.[408]

128. Notably, Nurse , an RN and MEnD's director of nursing, did not conduct an examination or full assessment of [409] Contrary to her notes, video evidence documents that Nurse did not examine at 1:00 p.m.[410] Instead, Nurse first appeared in 's cell at 2:05 p.m. on September 1, 2018[411] – over 2½ hours after she arrived for her shift[412]– despite the fact that was, by far, the patient with the most serious illness[413] and despite the fact that spent the entire day prior in two emergency rooms.[414]

129. The video shows that, instead of conducting an examination of , Nurse merely stood in the doorway of 's cell, at a distance of at least ten feet, and spoke briefly with from across the room.[415] Her interaction with lasted less than three minutes.[416] From this brief and distant interaction, Nurse drafted her medical note dated September 1, 2018, listing the time as 13:00 hours (1:00 p.m.).[417]

130. Nurse admits that she did not conduct a formal nursing assessment of on September 1, 2018.[418] She did not check 's vital signs, such as his blood pressure, blood oxygen saturation, or temperature.[419] She did not check his lung function or listen to his breath sounds with a stethoscope.[420] She did not conduct an assessment of his ability to stand or lift his arms, nor did she test his reflexes.[421] Indeed, she did not touch him or come near him.[422] Despite her notes to the contrary, from the distance that Nurse stood (approximately ten feet away), there is no way that Nurse

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[408] Ex. 111 at 0115.
[409] Ex. 112 at 2045.
[410] *Compare* Ex. 111 at 0115 *with* Ex. 112 at 2045 (the video captures everything occurring in 's cell from 12:04 p.m. until 3:28 p.m. on September 1, 2018).
[411] Ex. 112 at 2045.
[412] Ex. 115.
[413] Test. of (Tr. at Vol. I, p. 201).
[414] Ex. 111 at 0128-0176.
[415] Ex. 112 at 2045; Test. of (Tr. at Vol. I, pp. 204-205).
[416] Ex. 112 at 2045.
[417] Ex. 111 at 0115.
[418] Ex. 128 at 34. (Test. of (Tr. at Vol. I, pp. 218-220; Vol. II, pp. 202-203, 239-241)
[419] Ex. 112 at 2045; Ex. 128 at 33; Test. of (Tr. at Vol. I, pp. 202-203, Vol. II, p. 241).
[420] Ex. 112 at 2045; Test. of (Tr. at Vol. IV, p. 886).
[421] Ex. 112 at 2045; Ex. 128 at 33; Test. of (Tr. at Vol. I, pp. 202-203).
[422] Ex. 112 at 2045.

could have assessed [redacted]'s ability to breath or swallow; nor could she have determined whether he was sweating.[423] At no time does Nurse [redacted] assess [redacted]'s hydration or nutrition.[424] Moreover, even though she notes that the cell "smelled like urine and feces,"[425] she does not attempt to change [redacted]'s adult briefs or clean him.[426] In essence, Nurse [redacted] stood as far as possible from [redacted] and provided him no care whatsoever in the two-minute interaction she had with him that day.[427] According to Nurse [redacted]'s testimony, when [redacted] pleaded for assistance, she informed him that she would not "bargain" or "negotiate" with him.[428] She stated that she was "not coming into a room as a bargaining chip."[429]

131. Nurse [redacted]'s next entry in the medical narrative of September 1, 2018, indicated a time of 1:50 p.m.[430] In that note she writes:

> CO [correction officer] called and they helped him sit up and he was able to hold himself up.[431]

132. However, Nurse [redacted] was not present when the correction officers came into [redacted]'s cell at 12:04 p.m. and again at 2:31 p.m.[432] Nurse [redacted] admits that she never asked to review any video footage of [redacted] in his cell.[433] Thus, her medical note merely reflects what the correction officers allegedly told her.[434]

4. Video Footage of [redacted]: 12:00 p.m. – 3:30 p.m. Sept. 1, 2018

133. The video evidence shows what actually occurred during those two interactions with correction officers.[435]

134. The video begins at 12:04 p.m. on September 1, 2018.[436] [redacted] is lying on his back in the cot; he is still wearing the orange jumpsuit from the day before.[437] His shirt is half off his body.[438] An officer comes in at 12:05 p.m. and attempts to prop [redacted] up

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[423] *See* Ex. 112 at 2045; Test. of [redacted] (Tr. at Vol. IV, pp. 907-908). The Administrative Law Judge urges the Board to carefully review the video evidence of Nurse [redacted]'s interaction with [redacted] and forward the information from this case to the Minnesota Board of Nursing for violation of the Nurse Practice Act, if the Board has not done so already.
[424] *See* Ex. 111 at 0115.
[425] Ex. 111 at 0115.
[426] Ex. 112 at 2045.
[427] Ex. 112 at 2045.
[428] Test. of [redacted] (Tr. Vol. IV, p. 900-901).
[429] *Id.* at 900.
[430] Ex. 111 at 0115.
[431] *Id.*
[432] Ex. 112 at 2045.
[433] Test. of [redacted] (Tr. at Vol. I, pp. 190-191).
[434] Ex. 111 at 0115.
[435] Ex. 112 at 2045.
[436] *Id.*
[437] *Id.*
[438] *Id.*

against the wall by putting a pillow between [redacted]'s head and the wall.[439] [redacted] is completely limp and his head is slumped down, with his chin resting on his shoulder.[440] The officer then goes to the foot of the bed and pulls [redacted] down by his feet so [redacted]'s head is not shoved up against the wall.[441] [redacted] appears semi-conscious and mostly unresponsive.[442] The officer returns a few minutes later with a wheelchair and a lunch tray.[443] [redacted] does not react or attempt to eat or move.[444] [redacted] continues to lay on his back and does not change positions for over the next two hours.[445] He appears to be in a sleep or unconscious state.[446] His head is cocked to the side with his left ear on his left his shoulder.[447] Occasionally, his feet, hands, and head twitch and jerk, but he does not change his sleeping position.[448]

135. At 2:05 p.m., Nurse [redacted] comes to the door of the cell and stays for approximately two minutes (as described above).[449] [redacted] appears semi-conscious and is moving his mouth.[450] Two and a half hours later, [redacted] has still not moved from his back; he remains on his back with his head cocked to the side.[451]

136. At 2:31 p.m., a correctional officer enters the room and walks back out.[452] The officer returns with a second officer.[453] [redacted] does not move.[454] One of the officers stands on the bed, straddling [redacted], and grabs [redacted]'s arms to lift him up to a semi-seated position.[455] The other officer grabs [redacted]'s feet and swings them off the bed while the first officer holds [redacted] up by his arms.[456] [redacted] is completely limp and not assisting the officers.[457] Together, the officers then prop [redacted] against the wall in a slouched, seated position.[458] The officers remove [redacted]'s orange shirt and spend several minutes talking to [redacted], as he is slouched against the wall.[459] Eventually, [redacted] slips down the wall and the two officers prop him up again, this time to a more erect seated position against the

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[439] *Id.*
[440] *Id.*
[441] *Id.*
[442] *Id.*
[443] *Id.*
[444] *Id.*
[445] *Id.*
[446] *Id.*
[447] *Id.*
[448] *Id.*
[449] *Id.*
[450] *Id.*
[451] *Id.*
[452] *Id.*
[453] *Id.*
[454] *Id.*
[455] *Id.*
[456] *Id.*
[457] *Id.*
[458] *Id.*
[459] *Id.* (Recall that none of the videos contain sound and cannot be of assistance in determining what the officers or [redacted] are saying).

wall.[460] Then one of the officers grabs a urine sample jar and presents it to [redacted] for a drug test.[461]

137. Once propped up the second time, [redacted] has the strength to remain upright but has his back up against the wall.[462] He is talking and nodding his head but not moving his arms from his sides.[463] He appears in communication with the two officers for approximately 15 minutes, but because the video does not contain sound, it cannot be determined if [redacted]'s speech is slurred or if he is lucid.[464] The officer with the urine sample cup places it in [redacted]'s hand.[465] [redacted] is unable to maneuver it to his pants.[466]

138. The officer pulls down the front of [redacted]'s pants slightly and places [redacted]'s hand in the waistband of his pants to apparently assist [redacted] in placing the urine sample cup in his pants.[467] The officer then leaves the room.[468] [redacted] wiggles his body but does not remove his hand from his pants.[469] [redacted]'s hand remains in the waistband of his pants for the next half hour.[470] [redacted] eventually slides down the wall onto his right side (his hand still in his pants).[471] A third officer comes into the cell and props [redacted] up again against the wall and frees [redacted]'s hand from his pants.[472] [redacted] slides back down onto his side and again the officer comes in to prop him up against the wall.[473] The officer grabs [redacted]'s hands and attempts to lift him, but [redacted] slides to his side.[474] The officer proceeds to prop [redacted] up against the wall at least two more times.[475] When it is apparent that [redacted] is unable to sit up, the officer leaves the room, taking the wheelchair with him.[476] The officer returns and pushes a walker toward [redacted], who is now slumped in the bed.[477] The officer attempts to get [redacted] to sit up and use the walker by placing [redacted]'s hands on the walker, but [redacted] slumps over the walker while seated on the bed.[478] The video ends at 3:28 p.m. on September 1, 2018.[479]

139. Nurse [redacted] admits that she did not see [redacted] again that day.[480]

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[460] *Id.*
[461] *Id.*
[462] *Id.*
[463] *Id.*
[464] *Id.*
[465] *Id.*
[466] *Id.*
[467] *Id.*
[468] *Id.*
[469] *Id.*
[470] *Id.*
[471] *Id.*
[472] *Id.*
[473] *Id.*
[474] *Id.*
[475] *Id.*
[476] *Id.*
[477] *Id.*
[478] *Id.*
[479] *Id.*
[480] Test. of [redacted] (Tr. at Vol. I, p. 215; Vol. IV, p. 915)

140. According to a report written by Sgt. [redacted], Nurse [redacted] advised Sgt. [redacted] that there was nothing medically wrong with [redacted] and that correctional staff should not be assisting him with feeding, toileting, and other cares because [redacted] was capable of doing those things himself "as he was medically cleared by the hospital."[481]

141. Sgt. [redacted] then called Jail Administrator [redacted] to update her on [redacted]'s condition.[482] Sgt. [redacted] left a message for [redacted] stating that MEnD medical staff instructed the jail staff that they should not be doing anything for [redacted] because "there is nothing wrong with him medically."[483] [redacted] returned Sgt. [redacted]'s call and directed, "if medical states there is nothing wrong. . . then go with it."[484]

5. [redacted]'s Consult with Dr. [redacted]: 5:30 p.m., Sept. 1, 2018

142. Nurse [redacted]'s notes indicate that at 5:30 p.m. she spoke with Dr. [redacted], after receiving [redacted]'s emergency room records from the Bemidji and Fargo hospitals.[485] This was the first time that Nurse [redacted] reported to Dr. [redacted] about [redacted][486]

143. Nurse [redacted] read through the emergency room records with Dr. [redacted] and [redacted]'s diagnosis of "malingering."[487] Dr. [redacted] noted that a diagnosis of "malingering" was quite "unusual."[488]

144. Dr. [redacted] did not ask about [redacted]'s current vital signs.[489] He did not ask her if she had completed an assessment of [redacted]'s reflexes or ability to stand.[490] He did not ask if Nurse [redacted] had completed any type of neurological examination or assessment on [redacted].[491] Instead, Nurse [redacted] only discussed the records from the hospital the day before, what jail staff had told her, and "her observations" of [redacted].[492] Dr. [redacted] did not instruct Nurse [redacted] to perform any assessments or tests on H.S.;[493] nor did Dr. [redacted] ask Nurse [redacted] to send him a full copy of the emergency room records so that he could review them himself.[494] Instead, Dr. [redacted]'s only directive was that [redacted] should be seen by a neurologist after the holiday weekend (i.e., after Tuesday, September 4, 2018).[495] In order for a neurologist to see [redacted] during the holiday weekend, MEnD staff would need to send

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[481] Ex. 111 at 0095.
[482] *Id.*
[483] *Id.*
[484] *Id.* (Ellipsis included in [redacted]'s report. There is no content removed from the quote.)
[485] Ex. 111 at 0115.
[486] Test of [redacted] (Tr. at Vol. V, pp. 1140-1141).
[487] Test. of [redacted] (Tr. at Vol. I, p.218; Vol. IV, p. 915-917); Test. of [redacted] (Tr. at Vol. V, p. 1146).
[488] Test. of [redacted] (Tr. at Vol. I, p. 221; Vol. V, p. 1161).
[489] Test. of [redacted] (Tr. at Vol. I, p. 218, Vol. II, p. 241); Test. of [redacted] (Tr. at Vol. III, pp. 659-660).
[490] Test. of [redacted] (Tr. at Vol. I, pp. 218-220); Test. of [redacted] (Tr. at Vol. III, pp. 660-661).
[491] Test. of [redacted] (Tr. at Vol. I, p. 220).
[492] Test. of [redacted] (Tr. at Vol. I, pp. 218-220); Ex. 128 at 38-39.
[493] Test. of [redacted] (Tr. at Vol. I, pp. 218-220); Test. of [redacted] (Tr. at Vol. III, pp. 660-663).
[494] Ex. 128 at 39; Test. of [redacted] (Tr. at Vol. I, p. 218); Test. of [redacted] (Tr. at Vol. III, p. 675).
[495] Ex. 111 at 0115; Test. of [redacted] (Tr. at Vol. I, p. 221); Ex. 128 at 39; Test. of [redacted] (Tr. at Vol. III, pp. 675-676).

him back to the hospital on an emergency basis.[496] Dr. [redacted] "did not even think" about sending [redacted] back to the hospital; nor did Dr. [redacted] call [redacted] to discuss the diagnosis of "malingering."[497] Yet at this time, Dr. [redacted] continued to have Guillain-Barre Syndrome on his mental list of "differential diagnoses."[498]

145. Dr. [redacted] and Nurse [redacted] simply concluded that [redacted]'s symptoms and diagnosis of "malingering" were "puzzling" and "bizarre"[499]

6. Instructions to Correctional Staff

146. Nurse [redacted] ended her shift at 5:45 p.m. on September 1, 2018.[500] During her shift on September 1, 2018, Nurse [redacted]'s only visit with [redacted] was when she stood at the door of his cell around 2:05 p.m. for approximately three minutes.[501] Video footage evidences that Nurse [redacted] did not check [redacted]'s vital signs, examine [redacted], or provide [redacted] any medical care to [redacted] on September 1, 2018.[502]

147. Before ending her shift that evening, Sgt. [redacted] instructed her replacement, Sgt. [redacted], that "medical stated that we didn't need to assist [redacted] with anything as there was nothing medically wrong with him and he was capable of doing it himself."[503]

148. Similarly, correctional officers [redacted] and [redacted] noted in their reports that at the evening shift turnover on September 1, 2018, the jailers were informed that [redacted] "had been found medically sound and would be responsible for his own care until [the correctional officers] were told otherwise."[504] Later that evening, MEnD medical technician [redacted] advised Officer [redacted] that officers were not to be giving [redacted] any medication until he was able to sit up and swallow on his own.[505]

I. Sunday, September 2, 2018

1. Sunday Morning (8 a.m. to 10:15 a.m.)

149. Nurse [redacted] started her next shift at the [redacted] County Jail on Sunday, September 2, 2018, at approximately 8:15 a.m.[506] When she arrived, she found [redacted] sitting in a wheelchair in the hallway by the medical cells.[507] The correctional officers were

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[496] Ex. 128 at 39-40; Test. of [redacted] (Tr. at Vol. V, p. 1169).
[497] Test. of [redacted] (Tr. at Vol. III, p. 656; Vol. V, pp. 1169-1170).
[498] Test. of [redacted] (Tr. at Vol. III, p. 678).
[499] Test. of [redacted] (Tr. at Vol. I, p. 221); Test. of [redacted] (Tr. at Vol. V, p.1160).
[500] Ex. 115.
[501] Ex. 112 at 2045.
[502] *Id.*
[503] Ex. 111 at 0096.
[504] Ex. 111 at 0086, 0090.
[505] *Id.* at 0087.
[506] Ex. 115.
[507] Test. of [redacted] (Tr. at Vol. II, pp. 231-232); Ex. 111 at 0114.

planning on showering him because he was covered in his own excrement.[508] Nurse [redacted] noted that [redacted]'s pants were urine soaked and urine was running out of the pantleg of the same orange scrubs that [redacted] had been placed in for his transport to the hospital two days earlier (Friday morning, August 31, 2018).[509] Nurse [redacted] asked [redacted] if he was "incontinent" and he indicated that he was unable to ambulate to the toilet, which was why he had urinated on himself.[510]

150. One of the correctional officers told Nurse [redacted] that [redacted] had spoken with his mother on Saturday and his mother told him "to knock this off."[511] Nurse [redacted] understood this to mean, again, that [redacted] was faking his symptoms.[512]

151. Nurse [redacted] observed that [redacted] was sitting upright in the wheelchair on his own, with his hands in his lap, and holding his leg out such that his heels were lifted off the ground.[513] When speaking with [redacted], Nurse [redacted] noted that he was talking out of the right side of his mouth.[514] Her medical notes state: "[f]ace composure normal except when talking, he only used right side of mouth. As conversation progressed, he used both sides of mouth."[515] Nurse [redacted] noted that [redacted] licked both sides of his lips with his "full tongue."[516]

152. [redacted] stated that he was thirsty and that he tried to eat and drink but could not.[517] Nurse [redacted] obtained a juice box with a straw.[518] At first [redacted] declined to drink, but Nurse [redacted] insisted that he drink.[519] [redacted] was unable to hold the juice box, so Nurse [redacted] poured the juice into his mouth.[520] While Nurse [redacted]'s medical note states that [redacted] "swallowed" the juice, she also noted that she heard a "gargle" in his throat.[521] [redacted] expressed that he was choking, but Nurse [redacted] did not believe it because she thought she saw him swallow the juice.[522]

153. Nurse [redacted] agreed with the correction officers that [redacted] should be bathed, so she directed that he be placed in a restraint chair and wheeled into a shower stall.[523] According to her notes, this method was the "best plan w[ith] available resources."[524]

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[508] Test. of [redacted] (Tr. at Vol. IV, p. 936); Ex. 111 at 0114.
[509] Test. of [redacted] (Tr. at Vol. II, p. 231); Ex. 111 at 0114; Ex. 128 at 42.
[510] Ex. 128 at 42.
[511] Ex. 111 at 0114.
[512] Test. of [redacted] (Tr. at Vol. IV, p. 940).
[513] Ex. 111 at 0114; Ex. 128 at 41.
[514] Ex. 111 at 0114
[515] *Id.*
[516] *Id.*
[517] *Id.*
[518] *Id.*
[519] *Id.*
[520] *Id.*
[521] *Id.*
[522] Ex. 111 at 0114; Ex. 128 at 43-44.
[523] Ex. 111 at 0114.
[524] *Id.*

154. There is no video footage of Nurse [redacted]'s exchange with [redacted] in the hallway because [redacted] was located outside of the medical surveillance cell.[525]

155. Video footage of [redacted], prior to Nurse [redacted]'s arrival that morning and after Nurse [redacted]'s interaction with [redacted] in the hallway at approximately 8:30 a.m., portrays [redacted]'s actual condition and contradicts the description in Nurse [redacted]'s medical notes.[526]

2. Video Footage of [redacted] from 6:00 a.m. to 12:00 p.m. (Sept. 2, 2018)

156. The video begins at 6:00 a.m. and shows [redacted] laying on his back on a thin blue mat on the concrete floor of his medical segregation cell (cell #214).[527] He is still shirtless from when the officers removed his orange scrub shirt the day before (September 1) and he is still in the same orange scrub pants that he was placed in for his transport to the hospital two days earlier (August 31).[528] There is a walker and a tray of food beside him from the night before that appears undisturbed.[529] His legs are limp, but he is able to roll his head from side-to-side and shake his arms and hands in a non-purposeful manner.[530] He remains lying on his back the entire time and does not change positions.[531]

157. At 7:43 a.m., a correction officer enters the cell with another tray of food and removes the tray from the day before.[532] The officer places the new tray on the bed, out of reach of [redacted], who is lying on the floor.[533] [redacted] does not move when the officer is in the room.[534]

158. [redacted] remains in the same position – on his back – for over two hours (until 8:18 a.m.) when a correction officer comes into the cell and drags [redacted] out of the room by grabbing the mat beneath [redacted] and dragging it through the cell door, into the hallway, outside of the camera range.[535] [redacted] is dragged out of the cell around the same time that Nurse [redacted] arrives for her shift that day (Nurse [redacted] clocked in at 8:16 a.m.).[536] (Recall that Nurse [redacted] found [redacted] in the hallway at approximately 8:30 a.m.)[537]

159. Once [redacted] is out of the cell, a jail employee comes in to mop and clean the cell.[538] The employee mops the floor twice.[539] The employee brings in a new white mat

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[525] See Tr. at Vol. IV, pp. 927-928.
[526] Ex. 112 at 2053.
[527] *Id.*
[528] *Id.*
[529] *Id.*
[530] *Id.*
[531] *Id.*
[532] *Id.*
[533] *Id.*
[534] *Id.*
[535] *Id.*
[536] Ex. 115.
[537] Ex. 111 at 0114.
[538] Ex. 112 at 2053.
[539] *Id.*

for the cot and a new pillow, but later removes the white mat, leaving the pillow on the bed.[540]

160. At approximately 8:40 a.m., the correction officers take [redacted] to holding cell #222 to perform a sponge bath.[541] Video footage from that cell depicts the officers wheeling [redacted] into the cell in a wheelchair.[542] [redacted] is still in the orange scrub pants and is shirtless.[543] He is sitting upright with his hands in his lap. Using a bucket of water and some towels, an officer wipes down [redacted]'s upper body.[544] [redacted] does not assist in any way by lifting his arms, etc.[545]

161. Two additional officers enter the cell at 8:55 a.m. and the three officers lift [redacted] out of the wheelchair and place him on the concrete floor.[546] They proceed to remove his pants and adult brief and sponge wash his body.[547] The officers roll [redacted] over and wash his back side, return him to the wheelchair, and roll him out of the cell.[548]

162. [redacted] is brought back to the medical segregation cell (#214) at 9:07 a.m.[549] He is naked in a wheelchair, with a blanket draped over him.[550] Two officers wheel him into the room and one starts wiping [redacted] down with a towel, as [redacted] sits, unassisted, in the wheelchair.[551] [redacted]'s hands are in his lap, his feet are on the ground, he is sitting upright in the chair, and he wiggles his torso a bit, although he does not make any movement to assist the officer who is wiping him down with a towel.[552]

163. A blue mat – like the one that [redacted] was lying on when he was dragged out of the cell -- is brought into the cell.[553] A third officer enters the cell and the three officers, together, lift [redacted] out of the wheelchair and lay him on the mat.[554] They throw a hand towel over [redacted]'s groin and roll the wheelchair out of the room.[555]

164. While [redacted] is able to shake his arms and hands in a random manner, he does not assist the officers when they are moving him.[556] He remains completely limp.[557] The officers roll [redacted] to his side and towel off his back side then return him to his back.[558]

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[540] *Id.*
[541] Ex. 132.
[542] *Id.*
[543] *Id.*
[544] *Id.*
[545] *Id.*
[546] *Id.*
[547] *Id.*
[548] *Id.*
[549] Ex. 112 at 2053.
[550] *Id.*
[551] *Id.*
[552] *Id.*
[553] *Id.*
[554] *Id.*
[555] *Id.*
[556] *Id.*
[557] *Id.*
[558] *Id.*

165. It takes all three officers to place [redacted] in a new adult brief.[559] The officers lift him up by his legs and put a blue pair of scrub pants and socks on him, but they do not put him in a shirt.[560] [redacted] remains limp and shirtless, and he does not assist the officers when they are moving, bathing, diapering, or clothing him.[561]

166. The officers then lift [redacted] by his arms and legs to place him more squarely on the mat on the floor.[562] They place a pillow under his head, a blanket over his body, and a tray of food at his side on the floor.[563] [redacted] remains on his back and does not change positions throughout the remainder of the videos, which end at noon.[564] [redacted] does not move his legs, but randomly moves his arms and hands in a limp and listless manner.[565]

167. At one point, around 10:12 a.m., [redacted] appears to try and touch a juice box from the tray located on the floor alongside his body.[566] While the juice box is loosely in or near [redacted]'s hand (resting on the floor), [redacted] does not attempt to lift or control it in any manner.[567] Periodically, [redacted] twitches his right arm and hand, and shakes his head back and forth, but [redacted] does not change positions or move from his back.[568]

168. At approximately 10:39 a.m., [redacted] spits a white substance from his mouth onto the pillow, which remains on his pillow until 11:38 a.m., when a correction officer enters the cell, flips [redacted]'s pillow over to hide the excretion, and uses toilet paper to wipe the white substance from [redacted]'s mouth.[569] The officer then leaves the room.[570]

169. At 11:51 a.m., another correction officer comes in the cell with a new tray of food, which he places beside [redacted] on the floor.[571] The officer takes away the plate of food that was left there for breakfast.[572] The video ends at approximately 12:00 p.m.[573]

170. While the videos of [redacted] in the medical segregation cell and shower cell were available to Nurse [redacted] upon request, she did not ask to review any video of [redacted]

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[559] *Id.*
[560] *Id.*
[561] *Id.*
[562] *Id.*
[563] *Id.*
[564] *Id.* at 2053, 2054.
[565] *Id.*
[566] *Id.* at 2053.
[567] Ex. 112 at 2053, 2054.
[568] *Id.*
[569] *Id.* at 2054.
[570] *Id.*
[571] *Id.*
[572] *Id.*
[573] *Id.*

to evaluate his condition.[574] In addition, because Dr. [redacted] was located outside of the secured facility, he did not have access to the videos.[575]

3. [redacted]'s 2nd Observation and Consultation with Dr. [redacted] (11:00 a.m.)

171. Nurse [redacted]'s next note in [redacted]'s medical records is dated September 2, 2018, at 11:00 a.m.[576] In that note, Nurse [redacted] writes:

> Pt [patient] was showered by officers who cleansed peridium. He had been placed in an adult brief. Laying on mattress on cell floor. Apple juice in hand. Updated Dr. [redacted]. Spoke to Sgt. [redacted]. COs [correction officers] to use straws to assist him with drinking periodically and meals. Will recheck tomorrow.[577]

172. Nurse [redacted]'s note is in stark contrast to what appears in the videos of [redacted] from 8:00 a.m. to noon that day.[578] While Nurse [redacted]'s 11:00 a.m. note would make it appear that she provided some type of care or assessment of [redacted] at 11:00 a.m., she, in fact, did not.[579] Rather, Nurse [redacted] merely "peeked onto his cell" from the one-foot-by-one-foot window in the door at approximately 11:00 a.m. for approximately "ten seconds or less."[580]

173. According to Nurse [redacted]'s trial testimony, when she looked in on [redacted] from the small cell window at approximately 11:00 a.m., he was "laying comfortably" and had a juice box in his hand.[581] In reality, around the time Nurse [redacted] created her 11:00 a.m. note, [redacted] was unconscious on the floor of his cell, excreting a white substance from his mouth, which appears on his pillow from 10:39 a.m. to 11:38 a.m., for nearly an hour.[582]

174. Nurse [redacted] consulted with Dr. [redacted] by telephone at approximately 11:10 a.m. on September 2, 2018, to discuss [redacted].[583] Like the day before, Nurse [redacted] had not taken [redacted]'s vital signs or conducted any formal examination or assessment of [redacted] on September 2, 2018.[584] In addition, Dr. [redacted] did not ask Nurse [redacted] for [redacted]'s vitals, he did not instruct her to conduct an assessment or examination, and did not ask her to obtain any other information about [redacted].[585] Instead, Dr. [redacted] instructed her to continue monitoring

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[574] Ex. 128 at 21.
[575] Ex. 128 at 21; Test. of [redacted] (Tr. at Vol. III, p. 573).
[576] Ex. 111 at 0114.
[577] *Id.*
[578] *Compare* Ex. 111 at 0114 *with* Ex. 112 at 2053 and 2054.
[579] Test. of [redacted] (Tr. at Vol. 2, p. 246).
[580] Test. of [redacted] (Tr. at Vol. V, p. 1029).
[581] Test. of [redacted] (Tr. at Vol. II, pp. 244-247, 253; Vol. IV, p. 965).
[582] Ex. 112 at 2054.
[583] Test. of [redacted] (Tr. at Vol. II, p. 240).
[584] *Id.* at Vol. II, pp. 239-241.
[585] Test. of [redacted] (Tr. at Vol. II, pp. 239-241); Test. of [redacted] (Tr. at Vol. III, pp. 683-684, 689).

[redacted][586] Based upon the information that he obtained from Nurse [redacted], Dr. [redacted] did not believe that [redacted]'s condition warranted a return to the hospital that day.[587]

4. Nurse [redacted]'s Final Observation of [redacted] (2:00 p.m.)

175. At approximately 2:00 p.m., Nurse [redacted] conducted a final "check" on [redacted].[588] She did this again by merely "peeking in" through the one-foot-by-one-foot window in [redacted]'s jail cell door.[589] In the ten seconds or less that she observed [redacted], she noted that [redacted] was lying on his back "sleeping comfortably" and that drool was rolling down his cheek.[590] From her position outside the room, she concluded that [redacted] "was breathing normally."[591] Nurse [redacted] did not enter the room, did not attempt to communicate with [redacted], did not check [redacted]'s vital signs, and did not conduct any assessment on [redacted].[592] Nurse [redacted] also had no idea when [redacted] had eaten his last meal.[593] Instead, Nurse [redacted] simply ended her shift.[594]

176. In sum, at no time, during either of her shifts on September 1 or 2, 2018, did Nurse [redacted] check [redacted]'s vital signs or conduct a formal nursing assessment on, or physical examination of, [redacted].[595] Nurse [redacted]'s only interaction with [redacted] on September 1 and 2, 2018, involved: (1) standing in the doorway of his cell for approximately three minutes at around 2:00 p.m. on September 1, 2018;[596] (2) encountering [redacted] in the hallway (outside of video coverage) at approximately 8:15 a.m. on September 2, 2018;[597] and (3) peeking in the small window of [redacted]'s cell at 11:00 a.m. and 2:00 p.m. on September 2, 2018.[598]

177. Nurse [redacted] ended her shift on September 2, 2018, at 2:27 p.m.[599] Before leaving, Nurse [redacted] gave the following instructions to jail staff:

> Nurse [redacted] advised that staff were to assist [redacted] with drinking fluids regularly by using a straw to the mouth. She also said that we should help [redacted] with feeding even if it was broth through a straw. Nurse [redacted] [sic] also stated that we should change his briefs as needed. She went on to state that if [redacted] isn't re[-]positioning himself, that staff should change his position and to use a blanket if necessary to re-position him.[600]

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[586] Test. of [redacted] (Tr. at Vol. II, 247-248); Ex. 128 at 50.
[587] Test. of [redacted] (Tr. at Vol. V, p. 1174).
[588] Ex. 111 at 0114; Test. of [redacted] (Tr. at Vol. II, pp. 252, 254).
[589] Test. of [redacted] (Tr. at Vol. II, pp. 252-254); Ex. 128 at 50-52.
[590] Test. of [redacted] (Tr. at Vol. II, pp. 252-254); Ex. 111 at 0114; Ex. 128 at 51.
[591] Test. of [redacted] (Tr. at Vol. II, p. 253).
[592] Test. of [redacted] (Tr. at Vol. II, p. 523-524, 252-254, 261-262); Ex. 128 at 51-52, 53-54.
[593] Ex. 128 at 52.
[594] Ex. 115.
[595] Test. of [redacted] (Tr. at Vol. I, pp. 218-220; Vol. II, pp. 239-241).
[596] Test. of [redacted] (Tr. at Vol. I, pp. 202-203); Ex. 112 at 2045.
[597] Test. of [redacted] (Tr. at Vol. II, pp. 238-240).
[598] *Id.* at Vol. II, pp. 244-254, 261-262).
[599] Ex. 115.
[600] Ex. 111 at 0096. *See also*, Ex. 111 at 0114; Test. of [redacted] (Tr. at Vol. II, 250).

178. Surveillance video depicts [redacted] laying on a mat on the floor of his cell for the remainder of the afternoon.[601] He does not change positions from his back.[602] His right arm twitches periodically and his head moves from side to side.[603] At 2:55 p.m., a white substance can again be observed coming out of his mouth.[604] By this point, Nurse [redacted] had already left the facility for the day.[605]

5. [redacted]'s Death: 5:22 p.m.

179. At 4:46 p.m., a correctional officer enters [redacted]'s cell to bring him dinner.[606] [redacted] is still laying on the floor, unable to speak or sit up.[607] The correction officer spends several minutes standing over [redacted] attempting to talk to him, but [redacted] remains unresponsive.[608] The officer attempts to lift [redacted] to a sitting position by grabbing him by the arms and pulling him up, but [redacted]'s body is completely limp.[609] A second correction officer then comes into the cell to help prop [redacted] up against a plastic storage container.[610] [redacted]'s head falls straight back, as if completely lifeless, and the officers lies him down again.[611] The officers roll [redacted] onto his side and a third officer enters the room.[612]

180. At 4:52 p.m., MEnD medical technician [redacted] enters the room with a cart to take [redacted]'s vitals.[613] The officers and [redacted] were unable to get a blood pressure.[614] [redacted]'s pulse rate, which, at first, measured 66 BPM, became undetectable.[615] Neither [redacted] nor the officers attempt CPR or other lifesaving measures.[616] At 4:58 p.m., officers came in with an Automated External Defibrillator (AED) and started chest compressions.[617] Paramedics were called and arrived at 5:01 p.m.[618] CPR was attempted by the paramedics but was unsuccessful. [redacted] was pronounced dead at 5:22 p.m.[619]

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[601] Ex. 112 at 2056, 2057.
[602] *Id.*
[603] *Id.*
[604] *Id.*
[605] Ex. 115.
[606] Ex. 111 at 0096-0098; Ex. 112 at 2057.
[607] Ex. 111 at 0097; Ex. 112 at 2057.
[608] *Id.*
[609] *Id.*
[610] *Id.*
[611] *Id.*
[612] *Id.*
[613] Ex. 111 at 0097; Ex. 112 at 2057.
[614] Ex. 111 at 0097.
[615] *Id.*
[616] Ex. 112 at 2057.
[617] Ex. 111 at 0097-0098; Ex. 112 at 2057.
[618] Ex. 111 at 0097-0098.
[619] Ex. 111 at 0096-0098; Ex. 112 at 2057.

6. Notification of Death

181. Nurse [redacted] was on her drive home when she received a call from [redacted] notifying her that [redacted] had died.[620] She then called Dr. [redacted] to advise him of [redacted]'s death.[621]

182. At 8:07 p.m. on September 2, 2018, shortly after [redacted] was pronounced dead, Officer [redacted] sent an email to all correctional staff at the [redacted] County Jail stating:[622]

> Anybody who had contact with [redacted] needs to write a report under ICR # 1800969 that is created. Document all contact physical and verbal. This is a private incident and no information should be given out to anyone from the public including family members and should not be talked about outside the facility.
>
> Holding cell 214 is sealed as a crime scene until an autopsy is complete on the inmate that was in there. No one is allowed in there for any reason at all. Everything in there including the AED is part of the evidence scene. Investigator [redacted] has left us his AED which is in 2nd floor control by the stairwell to have in the meantime. There is one still located in the first floor control as well. Lead investigator is Sgt. [redacted] from the PD, once he gives the ok, the room can be cleaned up and put back in use.

183. Twenty-four supplemental reports were prepared by [redacted] County Jail staff; 18 were written in the days following [redacted]'s death on September 2, 2018, and six were written on September 2, 2018.[623]

184. NP [redacted] returned to work at MEnD on September 4, 2018, the Tuesday after Labor Day, to learn that [redacted] had died on Sunday, September 2, 2018.[624] NP [redacted] heard Dr. [redacted] talking to his attorney on the telephone about a death at the [redacted] County Jail and she inquired more from Dr. [redacted].[625] Dr. [redacted] advised NP [redacted] to "not jump to conclusions because it could impact the company."[626] Dr. [redacted] stated that [redacted] probably "did this to himself" by giving himself a blood clot from faking an illness or perhaps stuck a sock down his own throat.[627]

185. "Horrified" by what she described as the "neglect" and "incompetency" she witnessed from [redacted] County Jail and MEnD medical staff, NP [redacted] tendered her

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[620] Ex. 128 at 67.
[621] *Id.* at 66-67.
[622] Ex. 127.
[623] Ex. 111 at 00626-0099.
[624] Test. of [redacted] (Tr. at Vol. I, p. 157).
[625] Ex. 122 at 0571.
[626] Test. of [redacted] (Tr. Vol. I, p. 157); Ex. 122 at 0573-0574.
[627] Ex. 122 at 0573.

termination from MEnD that same day.[628] In her mind, NP [redacted] believed she witnessed a "murder."[629] NP [redacted] contacted several state agencies to report what she witnessed, including the Department of Corrections.[630] She never heard back from the Department of Corrections.[631]

186. To Nurse [redacted]'s knowledge, Dr. [redacted] never asked for nursing notes or jail video footage after [redacted]'s death.[632]

187. It is undisputed that Dr. [redacted] did not have access from outside the jail to view the surveillance footage of [redacted] in the medical segregation cell and that Dr. [redacted] did not perform any evaluation of [redacted] on his own.[633] Dr. [redacted] relied upon the assessments and observations of his on-site medical staff and the emergency room records from the Bemidji and Fargo [redacted] Hospitals, as described to him by Nurse [redacted].[634]

188. It is not uncommon, in the system of correctional medicine, that a physician is not on-site at all times to evaluate inmates and must rely on the observations and evaluations conducted by on-site medical staff, correctional officers, and other medical professionals outside of the correctional facility who conducted their own assessments.[635]

189. Dr. [redacted] notes that, after [redacted]'s death, MEnD practices give more scrutiny to reports by correctional officers.[636] MEnD training now emphasizes the importance of assessments, evaluations, and the taking of vital signs.[637]

190. No adverse action was taken by MEnD against any of the employees involved in [redacted]'s care.[638] In an interview with the Attorney General's Office after [redacted]'s death, Dr. [redacted] stated that he "was very proud of the way [Nurse [redacted]] handled the case" by "car[ing] for this patient" and "provid[ing] dignity for him."[639]

III. Cause of Death

191. An autopsy was performed on [redacted] by [redacted], the Ramsey County Medical Examiner, on September 4, 2018.[640] [redacted] made two "anatomical diagnoses": (1) pneumonia; and (2) cerebral edema.[641] [redacted] made no

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[628] Test. of [redacted] (Tr. Vol. I, p. 159-161).
[629] *Id.* at Tr. Vol. I, p. 160
[630] Ex. 122 at 0577.
[631] *Id.*
[632] Test. of [redacted] (Tr. at Vol. I, pp. 122-123).
[633] Test. of [redacted] (Tr. at Vol. III, pp. 573, 701); Ex. 123 at 0607.
[634] *See* Test. of [redacted] *generally* (Tr. at Vol. III; Vol. V); Ex. 123 at 0607.
[635] Test. of [redacted] (Tr. at Vol. IV, pp. 760-763).
[636] Test. of [redacted] (Tr. at Vol. III, p. 700).
[637] *Id.* at Tr. at Vol. III, p. 700.
[638] *Id.* at Tr. at Vol. III, p. 701.
[639] Ex. 123 at 0630.
[640] Ex. 111 at 0179-0191.
[641] *Id.* at 0179.

determinations as to the cause of death or manner of death in his report.[642] The preliminary findings note "no anatomic cause of death."[643] The toxicology report identifies only the presence of only Delta-9 THC and no other drugs or controlled substances.[644]

192. [redacted] is the Chief Medical Officer and Vice President of Medical Affairs at [redacted] Hospital in Minnesota.[645] He received his Bachelor of Science and medical degrees from the University of Minnesota, and completed a residency in neurology at the University of Minnesota Medical Group.[646] He has served as an Assistant Professor of Neurology and the Director of the Neurology Clinic at [redacted] the Head of the Department of Neurology at [redacted] in Fargo, North Dakota; and the Head of Neurology and Medical Director of the Neurosciences Division of [redacted] Medical Group in Minnesota.[647]

193. Prior to serving as the Chief Medical Officer for [redacted] Hospital, [redacted] practiced for 15 years as a general neurologist.[648] He has researched and taught on numerous neurological topics, including Guillain-Barre Syndrome, a rare autoimmune disorder in which a person's own immune system damages the nerves, causing muscle weakness and sometimes paralysis.[649] In rare instances, especially when medical treatment is not timely provided, Guillain-Barre can be fatal.[650]

194. [redacted] opined that [redacted] most likely died of respiratory failure caused by Guillain-Barre Syndrome.[651] [redacted]'s expert opinion is based upon his review of the record, including MEnD and [redacted] Health medical records, the Ramsey County Medical Examiner's Report, and surveillance video of [redacted] included as Exhibit 112 to this hearing record.[652]

195. According to [redacted], Guillain-Barre Syndrome's "only clinical findings are typically an ascending weakness," starting in the legs, working up to the face, and affecting internal organs.[653] This ascending muscular weakness can ultimately affect the lungs and prevents them from functioning, resulting in death by respiratory failure.[654]

196. Guillain-Barre is largely a clinical diagnosis, although a spinal tap can be used to confirm the disease.[655] This is what makes Guillain-Barre difficult to diagnose by

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[642] Ex. 111 at 0179-0191.
[643] *Id.* at 0190.
[644] *Id.* at 0179-0181.
[645] Ex. 119 at Ex. A.
[646] *Id.*
[647] *Id.*
[648] Ex. 119 at Ex. A; Test. of [redacted] (Tr. at Vol. II, pp. 264-265).
[649] Ex. 119 at 2-3, Ex. A; Ex. 120 at 5-6 and attachment; Test. of [redacted] (Tr. at Vol. II at 267-270).
[650] Ex. 119 at 3; Ex. 120 at 5-6 and attachment; Test. of [redacted] (Tr. at Vol. II, pp. 283-285).
[651] Ex. 119 at 2-3; Test. of [redacted] (Tr. at Vol. II, pp. 268, 285).
[652] Ex. 119 at 1.
[653] Ex. 119 at 2-3; Test. of [redacted] (Tr. at Vol. II, p. 269).
[654] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 269).
[655] Test. of [redacted] (Tr. at Vol. II, p. 283).

medical personnel.[656] Generally, a family practice physician who recognizes signs of Guillain-Barre will refer a patient to a neurologist for further evaluation and diagnosis.[657]

197. Symptoms of Guillain-Barre include pain and discomfort (including in the chest and back); tingling in the extremities; progressive muscle weakness; difficulty speaking, breathing, and swallowing; excessive sweating; erratic blood pressure; facial drooping; difficulty moving extremities; inability to stand or ambulate; and paralysis.[658] These symptoms are progressive and can fluctuate.[659] Ways to identify if a patient is feigning symptoms include evaluating a patient's mobility and ability to stand, and "teasing out" attempts to falsely exhibit weakness.[660]

198. Because lungs are generally able to exchange oxygen until they are extremely weak, patients who suffer from Guillain-Barre can have normal blood oxygen saturation levels up until the patient's lungs become completely paralyzed by the disease.[661] When the paralyzing weakness reaches the lungs, death can occur quickly if ventilatory support is not provided.[662] In most cases, patients with Guillain-Barre are able to be treated before this happens.[663] If the disease has progressed to the lungs, patients who receive medical care can often be intubated in an intensive care unit to avoid death until the patient's immune system is able to recover through medical treatment.[664] However, in rare cases, individuals have died due to the progressive paralysis associated with Guillain-Barre that ultimately affects the respiratory system and stops the patient from breathing.[665]

199. Guillain-Barre Syndrome is survivable with appropriate medical care and most patients are able to recover from the disease and live normal lives.[666] In approximately one-third of patients diagnosed with Guillain-Barre, the disease stops progressing on its own and does not require extensive medical treatment; another one-third of the patients suffer more extensive paralysis and weakness requiring medical intervention; and approximately one-third require ventilation to assist with breathing while their immune systems recover.[667] Of the one-third of patients who are intubated, approximately ten percent do not recover and end up dying from the disease.[668]

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[656] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 283).
[657] Test. of [redacted] (Tr. at Vol. II, p. 283).
[658] Test. of [redacted] (Tr. at Vol. II, p. 268-271).
[659] *Id.* at Vol. II, p. 271.
[660] Test. of [redacted] (Tr. at Vol. II, p. 277).
[661] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 279).
[662] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 279).
[663] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 284).
[664] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, pp. 284-285).
[665] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 284).
[666] Test. of [redacted] (Tr. at Vol. II, pp. 284-285).
[667] *Id.* at Tr. Vol. II, p. 284.
[668] *Id.*

200. [redacted] opined that, at 27 years old, [redacted] would have had a better chance of surviving had he received proper medical treatment.[669] In other words, appropriate and timely medical intervention may have saved [redacted]'s life.[670]

201. Guillain-Barre is a relatively rare illness, but due to the risk of disability and death, it is a well-known neurological disease to trained neurologists.[671] It is not, however, widely known to non-medical personnel and even physicians can miss the diagnosis, particularly if they believe there could be another explanation for the generalized weakness the patient is experiencing.[672] This type of preconceived notion is referred to as "anchoring bias" and can affect a provider's ability to diagnose illness.[673] In this case, the jailers and medical providers – including those at the two [redacted] Hospitals -- believed [redacted] may have been feigning his illness in an attempt to manipulate staff or orchestrate an escape.[674] Therefore, they were unlikely to recognize the symptoms as part of a serious illness or diagnose it as Guillain-Barre.[675]

202. Malingering is a rare diagnosis but is more common when a physician cannot determine the cause of the symptoms and a patient has "secondary gain" by feigning illness; for example, an inmate attempting to get out of the jail or an employee who wants to get out of work.[676] [redacted] was not surprised that the emergency room doctors did not include Guillain-Barre Syndrome as a possible cause of [redacted]'s illness because they did not have full information as to the progression of the symptoms.[677]

203. [redacted] did not testify as to the reasonable standard of care, but rather, testified to the probable cause of [redacted]'s death.[678] He did, however, note that doctors must frequently rely on others to provide information, including nursing reports and emergency room records.[679] That being said, physicians must also exercise their own judgment and discretion, which may include an obligation to instruct staff to obtain more information.[680]

204. Unlike Dr. [redacted], [redacted] reviewed the video surveillance footage of [redacted] in the days prior to his death.[681] [redacted] noted that these videos, depicting the progressive nature of [redacted]'s symptoms, helped him to reach his opinion as to the cause of [redacted]'s death.[682]

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[669] Test. of [redacted] (Tr. at Vol. II, p. 285).
[670] *Id.*
[671] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 280).
[672] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, p. 289).
[673] Test. of [redacted] (Tr. at Vol. II, pp. 289-290).
[674] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, pp. 296-297).
[675] Ex. 119 at 3; Test. of [redacted] (Tr. at Vol. II, pp. 297-298).
[676] Test. of [redacted] (Tr. at Vol. II, p. 310).
[677] Test. of [redacted] (Tr. at Vol. II, pp. 312-313).
[678] Ex. 119.
[679] Test. of [redacted] (Tr. at Vol. II, p. 318, 332).
[680] *Id.* at Tr. Vol. II, pp. 328-329.
[681] Test. of [redacted] (Tr. at Vol. II, p. 322).
[682] *Id.* at Tr. Vol. II, pp. 322-323.

IV. Complaint Made to the Board of Medicine

205. On September 5, 2018, an individual sent a letter to the Ramsey County Medical Examiner's Office expressing concern about the care provided to [redacted] by Dr. [redacted] prior to [redacted]'s death.[683] A complaint was filed with the Board around that same time.[684]

206. The Complaint Review Committee advised Dr. [redacted] of the complaint on or around September 14, 2018, and permitted him an opportunity to respond in writing.[685] Dr. [redacted] timely filed his response on October 19, 2018.[686] Dr. [redacted]'s response included: Dr. [redacted]'s narrative of the events involving MEnD's care of [redacted] in August and September 2018; MEnD's records for [redacted]'s care while in the [redacted] County Jail; supplemental reports prepared by [redacted] County Jail correctional officers; and [redacted]'s autopsy report.[687]

207. On November 7, 2019, the Board issued a Notice of Conference commanding that Dr. [redacted] appear before the Complaint Review Committee to discuss the allegations contained in the complaint filed against him.[688]

208. Dr. [redacted] appeared before the Complaint Review Committee for the conference on December 9, 2019.[689]

209. On August 18, 2020, the Committee issued a Notice and Order for Prehearing Conference and Hearing, thereby initiating this contested case proceeding.[690]

V. Expert Medical Testimony

A. [redacted], Committee Expert

210. [redacted] is physician who has been licensed to practice medicine in the state of Minnesota since 1986.[691] He graduated from St. Olaf College with a bachelor's degree in Chemistry in 1981 and earned his medical degree from the University of Wisconsin-Madison Medical School in 1985.[692] He completed his residency in family medicine in 1988 and is certified by the American Board of Medical Specialties in family medicine.[693]

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[683] Ex. 121.
[684] Notice and Order for Prehearing Conference and Hearing (Aug. 18, 2020).
[685] *See* Ex. 111 at 0044.
[686] Ex. 111.
[687] *Id.*
[688] Ex. 124.
[689] Ex. 126.
[690] Notice and Order for Prehearing Conference and Hearing (Aug. 18, 2020).
[691] Ex. 120 at Ex. A. Test. of [redacted] (Tr. at Vol. II, p. 336).
[692] Ex. 120 at Ex. A; Test. of [redacted] (Tr. at Vol. II, pp. 335-336).
[693] Ex. 120; Test. of [redacted] (Tr. at Vol. II, p. 338).

211. [redacted] is currently a full-time hospitalist.[694] He is the current lead hospitalist and former Chief of Staff at [redacted] Hospital [redacted] in [redacted] Minnesota.[695] He is also the chair of the Professional Practice Evaluation and Improvement Committee at [redacted] Hospital, where he reviews the work of other physicians.[696]

212. [redacted] also serves as the medical director for [redacted] a residential facility.[697] In that position, he supervises medical and clinical staff remotely, similar to the type of medical director responsibilities that Dr. [redacted] was charged with performing for MEnD in 2018.[698]

213. Prior to joining [redacted] Hospital [redacted], [redacted] served as a hospitalist and hospitalist medical director for [redacted] Medical Clinic in [redacted] the Chief Medical Officer for the [redacted] Medical Group, and a family practice physician at the [redacted] Family Practice Clinic.[699] In sum, [redacted] has 36 years of practice in family medicine.[700]

214. The Board of Medicine Complaint Review Committee hired [redacted] to evaluate Dr. [redacted]'s work in this matter and provide expert testimony as to the minimal standards of acceptable and prevailing medical practice and Dr. [redacted]'s compliance with the ethical requirements set forth in Minn. Stat. § 147.091.[701]

215. In preparing his expert medical opinion, [redacted] considered: the letter to the Ramsey County Medical Examiner (Ex. 121); the Notice and Order for Prehearing Conference and Hearing (August 18, 2020); Dr. [redacted]'s written response to the Board (Ex. 111); MEnD medical record from August 25 to September 2, 2018 (Ex. 111); the [redacted] Emergency Room Records from September 1, 2018 (Ex. 111); the Ramsey County Medical Examiner's Report (Ex. 111); Expert Witness Affidavits and Reports from [redacted], [redacted], [redacted], [redacted] (not in the record); the [redacted] County Jail correction officers' supplemental reports (Ex. 111), the MEnD Medical Services Agreement with [redacted] County (Exs. 100, 101); MEnD's Nursing Policy/Procedure for "Emergency Response to Detainees (Ex. 104); the transcripts of the Attorney General interviews with NP [redacted] (Ex. 122) and Dr. [redacted] (Ex. 123); the Minnesota Department of Corrections' Findings (May 15, 2020) (not in the record); the Transcript of the December 9, 2019, Board Conference with Dr. [redacted] (Ex. 126);

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[694] Ex. 120 at Ex. A; Test. of [redacted] (Tr. at Vol. II, p. 337). A hospitalist is a doctor who provides care for patients at a hospital. Test. of [redacted] (Tr. at Vol. II, p. 337). Hospitalists specialize in providing hospital care, but also maintain their medical specialty. *Id.* at pp. 337-338. In [redacted]'s case, he maintains his specialization in family medicine. *Id.* at p. 338.
[695] Ex. 120 at Ex. A.
[696] *Id.*
[697] Ex. 120 at Ex. A.
[698] Test. of [redacted] (Tr. at Vol. II, pp. 339, 348, 351-352).
[699] Ex. 120 at Ex. A.
[700] *Id.*
[701] Test. of [redacted] (Tr. at Vol. II, p. 389); Ex. 120.

the [redacted] County Jail surveillance videos from August 24, 29, 30, 31, Sept. 1 and 2, 2018 (Ex. 112); and a video of the Fox 9 News report on [redacted]'s death (not in the record).[702]

216. Notably, unlike Dr. [redacted], [redacted] reviewed the surveillance video of the progression of [redacted]'s illness and not simply the descriptions by MEnD staff.[703] In rendering his expert opinion, however, [redacted] did not know that Dr. [redacted] had not viewed the videos of [redacted]'s illness as it progressed.[704] [redacted] noted that the surveillance videos were important in reaching his expert opinions.[705]

217. Upon review of Dr. [redacted]'s actions in this case, [redacted] concluded that Dr. [redacted] failed to conform to the minimum standard of care as a family physician by:

(1) Failing to recognize a serious medical condition and ensure the timely transfer of [redacted] to the emergency room on August 30, 2018;[706]

(2) Failing to obtain basic medical information from Nurse [redacted] on September 1 and 2, 2018, including vital signs and basic nursing assessment results;[707] and

(3) Failing to return [redacted] to the hospital for an emergency neurological evaluation on September 1 and 2, 2018;[708]

218. [redacted] further opined that, by failing to conform to the minimum standard of care on these occasions, Dr. [redacted] carelessly disregarded [redacted]'s health, welfare, or safety and created unnecessary danger to [redacted]'s life, health, or safety.[709]

1. Failing to Insist on Emergency Care on August 30, 2018

219. In his expert report, [redacted] opined that when Dr. [redacted] learned that Jail Administrator [redacted] had overruled his directive to send [redacted] to the emergency room on August 30, 2018, Dr. [redacted] should have contacted [redacted] on his own accord and insisted on transferring [redacted] to the hospital for care.[710] Instead, Dr. [redacted] did not contact [redacted] himself and decided to wait until the next day because a MEnD medical provider was scheduled to make rounds at the jail that next morning.

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[702] Ex. 120.
[703] Ex. 120; Test. of [redacted] (Tr. at Vol. II, p. 391).
[704] Test. of [redacted] (Tr. at Vol. II, p. 391).
[705] *Id.*
[706] Ex. 120 at 6-7.
[707] Test. of [redacted] (Tr. at Vol. II, pp. 354-355, 362-364, 378-379, 385, 485).
[708] Ex. 120 at 7-8; Test. of [redacted] (Tr. at Vol. II, pp. 365-369, 386-387).
[709] Ex. 120 at 6-9; Test. of [redacted] (Tr. at Vol. II, pp. 365-369, 378-379, 385-387, 485).
[710] Ex. 120 at 7. The Committee did not solicit testimony from [redacted] on this topic so the Administrative Law Judge relies on [redacted]'s expert witness report, which was the subject of cross examination by Dr. [redacted]'s legal counsel. *See* Test. of [redacted] (Tr. at Vol. II, pp. 397-403).

220. According to [redacted], Dr. [redacted] "willfully abrogated" his responsibility for [redacted]'s medical care to a non-medical administrator.[711] This not only failed to meet the minimal standard of acceptable and prevailing practice, it demonstrated a careless regard for [redacted]'s health, welfare, or safety and caused an unnecessary danger to [redacted]'s health and life.[712]

2. Failing to Obtain Basic and Necessary Medical Information

221. In rendering his expert opinions in this case, [redacted] uses his own experience as a nursing home medical director, where he must frequently rely on the assessments and observations of his medical staff (i.e., nurses and clinical staff) who are bedside with the patients.[713]

222. [redacted] explained that when a supervising physician is working remotely, the doctor is dependent upon those at the patient's bedside for information.[714] That is why the doctor has a duty to ask the right questions of the medical staff and ensure that staff are conducting the tests and assessments to obtain the information necessary for doctor to make treatment decisions.[715]

223. The preliminary and most basic type of objective information that a doctor should evaluate is a patient's vital signs, which are simple to take and can easily vary, thereby signaling a change in the patient's medical condition.[716] According to [redacted], vital signs are the "earliest warning signs" of an illness.[717]

224. Because vital signs can change quickly and dramatically, even if vitals have been taken from a patient days or hours earlier, it is important that a doctor have available to him the most current patient vital signs.[718] Thus, the fact that [redacted]'s vital signs were taken at the hospital on August 31, 2018, did not relieve Dr. [redacted] from his obligation to ask Nurse [redacted] for [redacted]'s current vital signs on September 1 and 2, 2018, when [redacted]'s condition was worsening.[719] Dr. [redacted] did not, but should have, asked Nurse [redacted] for those vital signs and, if she did not have those results, instruct Nurse [redacted] to obtain that basic information.[720]

225. Similarly, Dr. [redacted] should have inquired of Nurse [redacted] about the type of standard nursing assessments that she had personally performed on [redacted] on September 1 and 2, 2018.[721] Given [redacted]'s symptoms, the prevailing standard of care

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[711] Ex. 120 at 7.
[712] Ex. 120 at 6-7.
[713] Test. of [redacted] (Tr. at Vol. II, pp. 346-348, 351, 352).
[714] *Id.* at pp. 348, 352, 474-476.
[715] *Id.* at pp. 378, 474-476.
[716] *Id.* at pp. 348, 378.
[717] *Id.* at p. 362.
[718] *Id.* at pp. 362-363.
[719] *Id.* at pp. 362-363.
[720] *Id.* at pp. 353, 378-379.
[721] *Id.* at pp. 353, 378, 475.

required Dr. [redacted] to ask Nurse [redacted] if she had assessed [redacted]'s most basic neurological functions, such as independently testing [redacted]'s ability to speak, stand, walk, and swallow, and testing his motor and muscle strength.[722] According to [redacted], the minimal standard of care required Dr. [redacted] to ask Nurse [redacted] "probing questions," such as "can [redacted] lift his arms?", "can he feed himself?", "can he swallow," "can he stand or walk on his own?", and "what is his muscle strength?".[723] This was especially true where, as here, correctional officers were providing conflicting reports of [redacted]'s physical abilities.[724] Hence, a nursing exam was critical for Dr. [redacted] to fully evaluate whether [redacted]'s symptoms were getting worse.[725] Dr. [redacted]'s failure to ask the necessary questions and obtain critical medical information from Nurse [redacted] negatively impacted Dr. [redacted]'s ability to fully evaluate [redacted] and get him the emergency medical assistance he needed to save his life.[726]

226. [redacted] noted that a reasonable doctor, when presented with conflicting information regarding a patient's symptoms, would want to do their own assessment on the patient.[727] In [redacted]'s words, "I have to lay eyes on them myself. I have to do my own assessment if I'm getting mixed reports from the staff."[728]

227. [redacted] concluded that, by not obtaining vital signs from [redacted] on September 1 and 2, 2018; by not asking Nurse [redacted] whether she had taken [redacted]'s vital signs; by not inquiring of Nurse [redacted] whether she had conducted her own basic nursing assessment; and by not instructing Nurse [redacted] to conduct a basic nursing assessment of her own on H.S, Dr. [redacted] failed to conform to the minimal standard of acceptable and prevailing practice.[729] [redacted] further determined that Dr. [redacted]'s inactions demonstrated a careless disregard for [redacted]'s health, welfare, and safety, and created unnecessary danger to [redacted]'s life, health, and safety.[730]

3. Failing to Return [redacted] to the Emergency Room on September 1 and 2

228. According to [redacted], even though [redacted] had been seen in two hospitals on August 31, 2018, the minimum standard of care required that Dr. [redacted] send [redacted] back for emergency care on September 1 and 2, 2018, due to the worsening of [redacted]'s condition.[731]

229. [redacted] explained that a diagnosis of "malingering" is a highly unusual diagnosis that he has never encountered in his career.[732] Consequently, a reasonable doctor should have a "high level of skepticism" when such a diagnosis is made by another

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[722] *Id.* at pp. 353-354, 363-364, 378, 476, 478.
[723] *Id.* at pp. 353-354, 378, 384, 475, 478.
[724] *Id.* at pp. 474-476, 477-478.
[725] *Id.* at pp. 363-364, 384, 475-476.
[726] *Id.* at pp. 475-476.
[727] *Id.* at p. 477.
[728] *Id.*
[729] *Id.* at pp. 354-355, 362-364, 378-379, 385, 485.
[730] *Id.* at pp. 378-379, 385-386, 485.
[731] *Id.* at p. 365.
[732] *Id.* at pp. 357, 358.

physician.[733] Malingering is a diagnosis of exclusion (a conclusion reached when all other options are ruled out).[734] Therefore, a reasonable doctor would dig deeper to evaluate the symptoms to find a different root cause, especially when the symptoms were not resolving or relenting.[735] [redacted] noted that many of [redacted]'s symptoms were things a patient would have significant difficulty faking, such as a facial droop, and hard to keep up, such as soiling oneself repeatedly and being unable to stand or walk.[736] According to [redacted], each of these indicators would be "pretty unusual behavior for someone to exhibit as faking."[737]

230. The minimum standard of care requires that a physician use his own judgment and discretion to evaluate a patient and not rely on diagnoses made by other physicians.[738] This is especially true when another doctor makes a diagnosis of malingering.[739] A reasonable doctor must think critically and independently evaluate a patient's symptoms, especially if the symptoms are progressing from the time of the other doctor's diagnosis, as was the case here.[740] It is the responsibility of the supervising physician to seek the assistance of experts[741] and order the necessary tests or assessments to treat and diagnose a patient.[742] If this requires transfer to an emergency room, as in the case at hand, Dr. [redacted] had that obligation.[743] According to [redacted], as the attending physician, Dr. [redacted] was ultimately responsible for [redacted]'s care and the "the buck stop[ped]" with Dr. [redacted].[744]

231. [redacted] opined that [redacted]'s evaluation of [redacted] at the [redacted] hospital was not comprehensive enough because it appears that [redacted] was in four-point restraints the entire time (except for when he underwent the MRI).[745] Therefore, this should have raised flags for Dr. [redacted] as to the validity of the malingering diagnosis.[746]

232. [redacted] further noted that the discharge instructions from the [redacted] Emergency Room warned that [redacted] should return to the hospital if he showed signs of "worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels, or difficulty swallowing."[747] Yet, even though [redacted] was exhibiting all of these symptoms after he returned from the emergency room, Dr. [redacted] failed to recognize the fact that [redacted]'s condition was worsening and that [redacted] needed emergency care.[748] The reason

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[733] *Id.* at p. 358.
[734] *Id.*
[735] *Id.* at pp. 358-360, 370.
[736] *Id.* at p. 359.
[737] *Id.*
[738] *Id.* at pp. 370-371.
[739] *Id.* at pp. 357-359, 370.
[740] *Id.* at pp. 357-360, 370-371.
[741] *Id.* at p. 360.
[742] *Id.* pp. 365, 370-371, 478.
[743] *Id.* at pp. 365, 370-371.
[744] *Id.* at pp. 370-371, 478.
[745] *Id.* at pp. 356-357.
[746] *Id.*
[747] Ex. 111 at 0141; Test. of [redacted] (Tr. at Vol. II, pp. 360-361).
[748] Test. of [redacted] (Tr. at Vol. II, pp. 361-362, 386).

why Dr. [redacted] was not realizing that [redacted]'s condition was worsening and that he required emergency care was because Dr. [redacted] did not ask the necessary questions of his on-site medical staff or insist that basic tests and nursing assessments be performed (see above).[749]

233. [redacted] explained that, while Dr. [redacted] directed Nurse [redacted] to schedule [redacted] for a neurological appointment after the holiday weekend (i.e., sometime after September 4, 2018), that directive was insufficient, given the emergent needs [redacted] was exhibiting on September 1 and 2, 2018.[750] The only way that [redacted] was going to obtain a neurological evaluation before September 4 was to return [redacted] to the emergency room.[751]

234. In addition, even though Dr. [redacted] did not talk with Nurse [redacted] until late in the day on September 1, 2018, he still had the obligation to order [redacted]'s transport to the emergency room either that night or the next day when Dr. [redacted] spoke with Nurse [redacted] again.[752] However, because Dr. [redacted] did not ask the pertinent questions or ensure that the necessary information was obtained and assessments performed, he unreasonably failed to realize that [redacted]'s illness had progressed.[753]

235. [redacted] opined that had [redacted] been sent back to the emergency room on September 1 or 2, 2018, he may have been able to receive the life-saving treatment he needed (for example, ventilation).[754] As Guillain-Barre Syndrome is treatable in most cases, it could have been a lifesaving measure for [redacted].[755]

236. [redacted] concluded that Dr. [redacted] failed to conform to the minimal standards of acceptable and prevailing practice when he failed to have [redacted] transferred to the emergency room again on September 1 or 2, 2018, and that this failure demonstrated a careless disregard for [redacted]'s health, welfare or safety and created unnecessary danger to [redacted]'s life, health, and safety.[756]

B. [redacted], Licensee's Expert

237. [redacted], is a is physician who has been licensed to practice medicine in the state of Minnesota since 2008.[757] He obtained a Bachelor of Science degree from the University of Minnesota in 2001 and his medical degree from the University of Minnesota Medical School in 2005.[758] He completed his residency in family

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[749] *Id.* at pp. 354-355, 362-364, 378-379, 385-388, 485.
[750] *Id.* at p. 366.
[751] *Id.* at pp. 366-367.
[752] *Id.* at p. 441.
[753] *Id.* at pp. 354-355, 362-364, 378-379, 385-388, 485.
[754] *Id.* at pp. 367-368, 387.
[755] *Id.* at pp. 368, 387.
[756] *Id.* at pp. 365-369, 386-387.
[757] Ex. 118 at Ex. A.
[758] Ex. 118 at Ex. A; Test. of [redacted] (Tr. at Vol. VI, p. 1200).

medicine in 2008 and is certified by the American Board of Medical Specialties in family medicine.[759]

238. [redacted] is currently a family practice physician at the [redacted] Clinic in [redacted] Minnesota.[760] In his position with [redacted] Clinic, [redacted] has held various leadership positions, including President of the clinic, member of the clinic's Board of Directors, member of the Clinic Leadership Council, and Director of Performance Improvement.[761] He also previously served as the Chief of Staff of the [redacted] County Hospital.[762]

239. [redacted] was retained by Dr. [redacted] to provide expert opinion as to the minimal standards of acceptable and prevailing medical practice.[763] [redacted] acknowledges, however, that he is not familiar with the Minnesota Medical Practice Act, Minn. Stat. §§ 147.001-.381 (2020), or the requirements set forth therein.[764]

240. In preparing for his testimony, [redacted] reviewed [redacted]'s MEnD medical records from August 25 to September 2, 2018 (Ex. 111); the [redacted] Emergency Room Records from September 1, 2018 (Ex. 111); the Ramsey County Medical Examiner's Report (Ex. 111); and the Expert Witness Affidavits and Reports from [redacted] (Ex. 119) and [redacted] (Ex. 120).[765]

241. [redacted] did not review the video surveillance footage of [redacted] entered into the hearing record as Exhibit 112.[766] As a result, [redacted] did not observe [redacted]'s actual condition, the symptoms he was displaying, and the progression of his illness, which would have been apparent to MEnD staff and, in particular, to Nurse [redacted], during the final days of [redacted]'s life.

242. While [redacted] summarily opined that Dr. [redacted] "met the standard of care in his treatment of [redacted]" and "made appropriate decisions for the care of [redacted], based on the information that [Dr. [redacted]] was provided,"[767] [redacted] was unaware of several important facts. First, [redacted] was not aware that Nurse [redacted] had not taken any vital signs from [redacted] in the last two days of his life and that Dr. [redacted] had never asked for that information from Nurse [redacted].[768] Second, [redacted] was unaware that Nurse [redacted] had not conducted any physical examinations of [redacted], including her own

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[759] Ex. 118 at Ex. A; Test. of [redacted] (Tr. at Vol. VI, p. 1200-1201, 1204).
[760] Ex. 118 at Ex. A; Test. of [redacted] (Tr. at Vol. VI, pp. 1200-1202).
[761] Ex. 118 at Ex. A.
[762] Ex. 118 at Ex. A; Test. of [redacted] (Tr. at Vol. VI, p. 1203).
[763] Ex. 118 at 1.
[764] Test. of [redacted] (Tr. at Vol. VI, pp. 1303-1304).
[765] Ex. 118 at 2-3.
[766] Ex. 118 at 7; Test. of [redacted] (Tr. at Vol. VI, p. 1282).
[767] Ex. 118 at 11.
[768] Test. of [redacted] (Tr. at Vol. VI, pp. 1272, 1291, 1301-1302).

assessment of [redacted]'s ability to stand or walk.[769] Third, [redacted] did not know Dr. [redacted] and Nurse [redacted] were involved in a sexual relationship at the time.[770]

243. [redacted] conceded that vital signs (such as temperature, blood pressure, pulse/heart rate, blood oxygen saturation, and respiratory rate) are the most basic measurement of a patient's overall health and are important, objective measures to be reviewed by treating physicians for "every patient."[771] [redacted] further acknowledged that vital signs would be "especially" important for an attending physician to know when treating a patient like [redacted], who was being monitored for high blood pressure.[772]

244. Ultimately, [redacted] was not asked, and he did not provide an opinion, as to whether Dr. [redacted]'s failure to obtain more information from Nurse [redacted] regarding [redacted]'s vital signs and physical condition on September 1 and 2, 2018, fell below the minimal standard of acceptable and prevailing medical practice.[773]

245. [redacted] opined that Dr. [redacted] complied with the minimal standard of care when he recommended that [redacted] be sent to the emergency room on August 30, 2018.[774] However, [redacted] was not aware that Dr. [redacted] failed to follow up with the jail administrator after learning that his directive for emergency services had been overruled.[775] When confronted with this information, [redacted] conceded that if an administrator were to overrule his medical directive, as an attending physician, to send a patient to the hospital in an emergency situation, he would want to know why his instructions were not followed and he would want to have a direct conversation with the administrator.[776]

246. In sum, [redacted] was not asked, and he did not provide, an opinion as to whether Dr. [redacted]'s failure to ensure that [redacted] received emergency medical care on August 30, 2018, fell below the minimal standard of acceptable and prevailing medical practice. [redacted] simply opined that Dr. [redacted]'s recommendation that [redacted] be sent to a hospital for evaluation on August 30, 2018, was a correct one.[777] [redacted] did not address whether Dr. [redacted] acted improperly by failing to ensure that his medical directive was completed.

247. [redacted]'s assessments and conclusions were better reasoned and more consistent with the evidence contained in the hearing record than those presented by [redacted]. The Judge, therefore, adopts the expert opinions of [redacted], as set forth in these Findings.

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[769] *Id.* at pp. 1297-1300).
[770] *Id.* at p. 1302.
[771] *Id.* at pp. 1272, 1317-1318.
[772] *Id.* at p. 1272.
[773] *See* Test of [redacted] (Tr. at Vol. VI, pp. 1199-1319).
[774] Ex. 118 at 5.
[775] Test. of [redacted] (Tr. at Vol. VI, p. 1290).
[776] *Id.*
[777] Ex. 118 at 5.

Based on these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Board and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 14.50, 147.141, 147.091 (2020), and Minn. R. 5615.0100 - .1300 (2021).

2. Dr. [redacted] received due, proper, and timely notice of the contested case hearing in this matter.

3. The Committee has complied with all relevant procedural requirements of rule and law.

4. This matter is, therefore, properly before the Board and the Administrative Law Judge.

5. The Board is charged with the authority to impose disciplinary action, as described in Minn. Stat. § 147.141, against any physician who engages in conduct that violates any of the provisions of Minn. Stat. §§ 147.01 to .22.[778]

6. Disciplinary action may include: the revocation or suspension of a license or registration to perform interstate telehealth; the imposition of limitations or conditions on the physician's practice of medicine; the imposition of a civil penalty not exceeding $10,000 for each violation; the requirement that a physician provide unremunerated professional service; or the censure or reprimand of the physician.[779]

7. Before imposing disciplinary action, the Committee has the burden to prove, by a preponderance of the evidence, that the physician violated one or more of the provisions of Minn. Stat. §§ 147.01 to 147.22, including, specifically, the grounds for discipline set forth in Minn. Stat. § 147.091.[780]

8. A "preponderance of the evidence" means that the ultimate facts must be established by a greater weight of the evidence.[781] "It must be of a greater or more convincing effect and . . . lead you to believe that it is more likely that the claim . . . is true than . . . not true."[782]

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[778] Minn. Stat. §§ 147.091, .141.
[779] Minn. Stat. § 147.0141.
[780] Minn. R. 1400.7300, subp. 5 (2021).
[781] 4 Minnesota Practice, CIV JIG 14.15 (2014).
[782] *State v. Wahlberg*, 296 N.W.2d 408, 418 (Minn. 1980).

9. Among the various grounds for which the Board may take disciplinary action against a physician, are the following:

- engaging in any unethical or improper conduct, including but not limited to conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient;[783]

- engaging in unethical or improper conduct, including but not limited to conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;[784] and

- engaging in conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice, in which case proof of actual injury need not be established.[785]

10. The Committee has established by a preponderance of the evidence that Dr. [redacted] failed to confirm to the minimal standards of acceptable and prevailing medical practice when he: (1) failed to ensure the timely transfer of [redacted] to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about [redacted] from his attending nurse on September 1 and 2, 2018, including vital signs and basic assessment results; and (3) failed to return [redacted] to the hospital for emergency care on September 1 and 2, 2018.

11. The Committee has established by a preponderance of the evidence that Dr. [redacted] demonstrated a careless disregard for the health, welfare, or safety of a [redacted] when he: (1) failed to ensure the timely transfer of [redacted] to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about [redacted] from his attending nurse on September 1 and 2, 2018, including vital signs and basic assessment results; and (3) failed to return [redacted] to the hospital for emergency care on September 1 and 2, 2018.

12. The Committee has established by a preponderance of the evidence that Dr. [redacted] created an unnecessary danger to [redacted]'s life, health, and safety when he: (1) failed to ensure the timely transfer of [redacted] to the emergency room on August 30, 2018; (2) failed to obtain basic medical information about [redacted] from his attending nurse on September 1 and 2, 2018, including vital signs and basic assessment results; and (3) failed to return [redacted] to the hospital for emergency care on September 1 and 2, 2018.

13. Accordingly, the Board has proper grounds to impose reasonable and appropriate disciplinary action against Dr. [redacted]'s license to practice medicine in the state of Minnesota pursuant to Minn. Stat. § 147.091, subd. 1 (g)(3), (5), and (k).

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[783] Minn. Stat. § 147.091, subd. 1(g)(3).
[784] *Id.* at subd. 1(g)(5).
[785] *Id.* at subd. 1(k).

14. An order by the Board taking reasonable and appropriate disciplinary action against Dr. [redacted]'s license is in the public interest.

15. The form of disciplinary action the Board shall impose is beyond the province of the Administrative Law Judge.[786]

16. Based upon these Findings of Fact and Conclusions of Law, the Administrative Law Judge makes the following:

RECOMMENDATION

The Board should take reasonable and appropriate disciplinary action against the medical license of [redacted]

Dated: December 17, 2021

ANN C. O'REILLY
Administrative Law Judge

NOTICE

This Report is a recommendation, not a final decision. The Board of Medical Practice (Board) will make the final decision after a review of the record. The Board may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendations. Under Minn. Stat. § 14.61 (2020), the Board shall not make a final decision until this Report has been made available to the parties to the proceeding for at least ten calendar days. The parties may file exceptions to this Report and the Board must consider the exceptions in making a final decision. Parties should contact the Executive Director of the Minnesota Board of Medical Practice, Suite 140, 335 Randolph Avenue, St. Paul, MN 55102, telephone (612) 548-2150, to ascertain the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the Report and the presentation of argument to the Board, or upon the expiration of the deadline for doing so. The Board must notify the parties and the Administrative Law Judge of the date the record closes. If the Board fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2020). In order to comply with this statute, the Board must then return the record to the

[786] *See Padilla vs. Minnesota State Bd. Of Medical Examiners*, 382 N.W.2d 876, 886-887 (Minn. Ct. App. 1986) ("The legislature has conferred upon this Board, and not upon the ALJ, a discretion to determine the type of discipline to impose. To hold that the ALJ should make a recommendation as to the type of discipline would be to usurp the power delegated to the Board").

Administrative Law Judge within ten working days to allow the Judge to determine the discipline to be imposed.

Under Minn. Stat. § 14.62, subd. 1 (2020), the Board is required to serve its final decision upon each party and the Administrative Law Judge by first-class mail or as otherwise provided by law.

MEMORANDUM

Dr. [redacted] contends that he cannot be held responsible for the negligent actions (or inactions) of his staff and others, or for the information he did not know when remotely providing and supervising the care of an inmate patient. But this disciplinary action is not about the negligence of others; nor is it about what information Dr. [redacted] knew or did not know. Instead, it is about the information Dr. [redacted] should have known and could have known -- information the minimal standard of care required him to gather so that he could make appropriate medical decisions for his patient. It is also about the duty of a doctor to protect a patient under his care and not abdicate that duty to others, including other medical or non-medical staff.

The Medical Practice Act, Minn. Stat. § 147.091, subd. 1, provides, among other things, that disciplinary action may be brought against a physician for the following:

- engaging in any unethical or improper conduct, including but not limited to conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient;[787]

- engaging in unethical or improper conduct, including but not limited to conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;[788] and

- engaging in conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice, in which case proof of actual injury need not be established.[789]

A preponderance of the evidence in this case establishes three distinct occasions in which Dr. [redacted]'s conduct fell below the minimal standard of acceptable and prevailing medical practice. First, Dr. [redacted] failed to ensure [redacted]'s timely transfer to the emergency room on August 30, 2018, after Jail Administrator [redacted] overrode Dr. [redacted]'s medical directive for a patient over whom Dr. [redacted] had an ethical and professional duty to protect. Second, on both September 1 and 2, 2018, Dr. [redacted] failed to obtain basic medical information about [redacted] from his on-site medical staff that would have enabled him to make informed and proper

[787] Minn. Stat. § 147.091, subd. 1(g)(3).
[788] Minn. Stat. § 147.091, subd. 1(g)(5).
[789] Minn. Stat. § 147.091, subd. 1(k).

medical decisions for [redacted]'s care. Finally, as a result of his failure to obtain necessary information from his on-site medical staff, Dr. [redacted] neglected to return [redacted] to the hospital for emergency care, when such care was clearly needed.

In each of these instances, Dr. [redacted]'s conduct demonstrates a careless disregard for the health, welfare, and safety of his patient, and created unnecessary danger to that patient's life, health, and safety. The resulting harm – while none is required to be show for a violation to exist -- was the tragic suffering and death of a young man. For these violations, disciplinary action is not only warranted, but is in the public interest to prevent a tragedy like this from ever recurring.

Failure to Ensure [redacted]'s Timely Transfer to a Hospital on August 30, 2018

Dr. [redacted]'s first ethical and professional breach was failing to ensure that [redacted] was transported to a hospital on August 30, 2018, when [redacted]'s medical condition required urgent care and when Dr. [redacted]'s own on-site staff recommended that emergency care be provided. Instead, Dr. [redacted] abdicated his duty to protect his patient to the administrative demands of non-medical jail staff. Such action failed to conform to the minimal standard of acceptable and prevailing care, created unnecessary danger to [redacted], and demonstrated a careless disregard for [redacted]'s health, welfare and safety.

On Friday, August 24, 2018, [redacted] was transferred to the Beltrami County Jail for detainment on criminal charges. Jail surveillance video from his intake meeting depicts a vibrant and seemingly healthy young man. However, [redacted]'s initial health assessment, conducted the next day, uncovered a history of medical conditions uncommon for a man of his young age, including high blood pressure, recent respiratory failure, and ongoing migraine headaches.

By Monday, August 27, 2018, [redacted] was complaining of numbness, as well as pain in his chest and lower extremities. [redacted] exhibited continued high blood pressure and his EKG result read as an "abnormal." Consequently, Dr. [redacted] directed that [redacted] be treated with medication and regular blood pressure checks.

On Tuesday, August 28, 2018, [redacted]'s pain had not subsided and he reported a fall from his bunk. But by Tuesday night, [redacted]'s pain had become "excruciating," so much so that he sent a note pleading to be taken to the hospital. He was not.

On Wednesday morning, August 29, 2018, MEnD Nurse [redacted] conducted an assessment and physical examination of [redacted] Crediting correction officer reports that [redacted] was faking his symptoms,[790] Nurse [redacted] called Dr. [redacted], the attending physician, to request direction. To ferret out untruthful claims, Dr. [redacted] directed Nurse [redacted] to remove [redacted]'s access to a wheelchair and keep him in the medical segregation cell under constant video surveillance.

[790] This is not surprising considering MEnD's training materials and overall culture mock and belittle the individuals entrusted to their care.

By Thursday morning (August 30, 2018), [redacted]'s symptoms had worsened. He had lost sensation from his waist down and had urinated on himself because he was unable to ambulate to the toilet. After conducting an examination, which included taking his vital signs, testing his reflexes, and inspecting his throat for swelling, Nurse [redacted] recognized that [redacted] needed to be seen at a hospital with the proper equipment, staff, and resources to diagnose and treat his reported illness. Thus, she recommended to Dr. [redacted] that [redacted] be transported to an emergency room for urgent care. Dr. [redacted] concurred with this recommendation.

Both experts in this case agreed that Dr. [redacted]'s directive (based upon Nurse [redacted]'s recommendation) to send [redacted] to the hospital on August 30, 2018, was consistent with the reasonable standard of medical care.[791] This instruction acknowledged the seriousness of [redacted]'s symptoms and the emergent need for medical assistance at that time.

Despite [redacted]'s obvious medical distress, readily apparent to Nurse [redacted], jail staff refused to acknowledge [redacted]'s symptoms or Nurse [redacted]'s assessment of them. Sometime around 1:30 p.m. on August 30, 2021, Nurse [redacted] informed Dr. [redacted] that Jail Administrator [redacted] overrode his medical directive to send [redacted] to the emergency room because the jail viewed him as a "flight risk." But instead of calling the administrator himself to insist that [redacted] receive necessary medical care, Dr. [redacted] yielded to the administrator's will and discretion. In making this choice, Dr. [redacted] abdicated his duty to protect his patient to a person without any apparent medical knowledge or training, and he put the interests of the facility and his company ahead of his patient's wellbeing.

It cannot be ignored that, as the founder and owner of MEnD, Dr. [redacted] had a significant financial interest in maintaining a good business relationship with the jail and its administration. At the same time, as the MEnD chief medical officer overseeing the healthcare provided at the jail, and as the attending physician for [redacted], Dr. [redacted] had overriding professional and ethical duties to ensure that his patient receive the care necessary to protect [redacted]'s health, life, and safety at all times. Dr. [redacted]'s first duty was to his patient, not to the convenience of jail administration or his company's client relations.

The minimal standard of care required Dr. [redacted] to ensure that [redacted] receive necessary and appropriate medical care to treat and diagnose his emergent condition on August 30, 2018. Given the severity of [redacted]'s symptoms that day, the minimal standard of care dictated that [redacted] be taken to an emergency room immediately. Instead, Dr. [redacted] acquiesced to the jail administrator's dictate and left [redacted] to suffer an additional day in a jail cell without any medical assistance, despite knowing that [redacted] required urgent care.

Fortunately, when NP [redacted] arrived the next morning (Friday, August 31, 2018), she took charge of the situation and demanded [redacted]'s immediate transfer to a hospital. NP [redacted] did not hesitate; nor did she allow Administrator [redacted] to prevent her from getting [redacted] the medical attention he required. NP [redacted] took the swift and

[791] Ex. 118 at 5; Ex. 120 at 7.

decisive action necessary to protect the patient – action that Dr. [redacted] neglected to take a day earlier.

The fact that [redacted] was eventually transported to the hospital on Friday, August 31, 2018, after NP [redacted] intervened, does not remedy or negate Dr. [redacted]'s ethical violation on August 30, 2018. Minn. Stat. § 147.091, subd. 1(g)(5) and (k), expressly provide that "proof of actual injury need not be established" when a physician's conduct fails to conform to the minimal standard of care or when such conduct creates an unnecessary danger to a patient's life, health, or safety. Here, however, resultant harm has been established by the evidence: [redacted] suffered an additional day in the jail without proper medical attention before he was transferred to the hospital on August 31, 2018.[792]

By acquiescing to the will and discretion of Jail Administrator [redacted] instead of advocating to ensure that his patient received the emergency care he needed on August 30, 2018, Dr. [redacted] failed to conform to the minimal standard of acceptable and prevailing medical practice. This conduct created unnecessary danger to [redacted] and demonstrated a careless disregard for [redacted]'s health, welfare and safety.

Failure to Obtain Basic Medical Information from Staff Upon Which to Render Informed Medical Decisions for the Patient

In the two days following [redacted]'s return from the hospital, Dr. [redacted] demonstrated a dangerous pattern of practice whereby he neglected to obtain basic medical information about [redacted] from his on-site staff and failed to ensure that his staff was conducting the necessary assessments and evaluations so that he could competently direct [redacted]'s care. Specifically, Dr. [redacted]: (1) blindly relied on incomplete, inaccurate, and subjective information provided by his romantic partner and subordinate employee, Nurse [redacted]; (2) failed to reasonably question or test his staff's deficient (or nonexistent) assessments of [redacted]; and (3) neglected to obtain basic, objective health data a reasonable doctor would need to make competent medical decisions about a patient's care. As a result, Dr. [redacted] failed to conform to the minimal standard of acceptable and prevailing medical practice, created an unnecessary danger to his patient, and demonstrated a careless disregard for the health, welfare, and safety of his patient.

[redacted] returned to the jail from the hospital in the early morning hours of September 1, 2018. [redacted]'s hospital discharge instructions, which were brought back to the jail with [redacted] early that morning, specifically directed that [redacted] should be "immediately" returned to the hospital if he showed symptoms of paralysis, numbness, facial drooping, difficulty speaking, worsening weakness, difficulty standing, loss of bladder or bowel control, or difficulty swallowing. In the two days preceding his death – September 1 and 2 -- [redacted] would exhibit each and every one of these warning signs. Yet Dr. [redacted] did not direct [redacted]'s return the hospital. Instead, Dr. [redacted] contends that he was unaware of the extent to which [redacted]'s symptoms were worsening because he was not on-site to observe [redacted] and

[792] The fact that the hospitals in Fargo and Bemidji failed to properly diagnose and provide medical treatment to [redacted] on August 31, 2018, does not relieve Dr. [redacted] from his duty to ensure [redacted]'s transport to the hospital on August 30, 2018, so that [redacted] could be evaluated, diagnosed, and treated at that time.

the reports he was receiving from his staff painted a different picture. Therefore, Dr. [redacted] asserts he did not violate any professional standards. Dr. [redacted] is wrong in this conclusion.

As the owner and chief medical director of MEnD, Dr. [redacted] assumed an express contractual duty to oversee the healthcare provided at the jail and ensure that MEnD staff were providing the type of care necessary to protect the life, health, and safety of the inmates at the jail. In addition, as the medical director for the jail and the attending physician remotely directing [redacted]'s medical care, Dr. [redacted] had the additional a duty to critically test and examine his on-site staff's reports, as well as obtain basic medical data to enable him to direct [redacted]'s care. Dr. [redacted] failed in each of these duties.

The evidence establishes that Nurse [redacted] arrived at approximately 11:22 a.m. on September 1, 2018, but did not bother to examine or assess [redacted], let alone check on him, until after 2:00 p.m., over 2½ hours later. When she finally did come to [redacted]'s cell at 2:05 p.m., she did not enter the room. She stood in the doorway, approximately ten feet away from the critically ill patient, for less than three minutes. She did not bother to check [redacted]'s vital signs; use her stethoscope to listen to [redacted]'s breath or heart sounds; assess his ability to swallow; test his muscle strength, reflexes, or ability to ambulate; or change his soiled brief and clothing. She did not even come near [redacted] or touch him. After less than three minutes of "observing" [redacted] from the doorway of his cell, Nurse [redacted] left and did not return to check on him for the rest of the day – that was the extent of the "care" MEnD provided to [redacted] on September 1, 2018.

At approximately 5:30 p.m., Nurse [redacted] called Dr. [redacted] to summarize [redacted]'s hospital records and update him as to [redacted]'s condition. Despite a history of hypertension and an abnormal EKG result, Dr. [redacted] did not ask Nurse [redacted] for any of [redacted]'s vital signs – the most basic, objective measures of a patient's health. He did not ask his nurse to describe what nursing assessments or physical examinations she had conducted. He did not ask for the basic and pertinent information that a reasonable physician would need to evaluate [redacted]'s condition or the adequacy of his staff's care. Instead, Dr. [redacted] blindly accepted what his nurse described – an inmate who was feigning an illness. Had Dr. [redacted] asked Nurse [redacted] for [redacted]'s vital signs or what physical examinations or tests she performed on [redacted], he would have learned that she had conducted none; and that the extent of her "assessment" of [redacted] that day was her "observation" of [redacted] from the doorway of his cell, ten feet away, for approximately three minutes.

The next morning, September 2, Nurse [redacted] returned to the jail. She found [redacted] in a wheelchair, in the hallway, with urine dripping from his pantlegs. He was wearing a briefand clothing from two days earlier. He was talking out of only one side of his mouth and was unable to swallow. Despite these observations, Nurse [redacted] poured juice down his throat until he choked. She did not check his vital signs or use her stethoscope to listen to his throat, lungs, or heart. She did not test his reflexes, muscle strength, or his ability to ambulate.

At 11:00 a.m., Nurse [redacted] "peeked in" on [redacted] through the one-foot-by-one-foot window of the cell door for approximately ten seconds. Because Nurse [redacted] did not come into the cell or assess him, she did not notice that [redacted] was foaming at the mouth.

Ten minutes later, at 11:10 a.m., Nurse [redacted] spoke with Dr. [redacted] to update him on [redacted]'s condition. Once again, Dr. [redacted] asked for no objective evidence of [redacted]'s symptoms that would have permitted him to make an independent assessment of [redacted]'s condition. He did not ask for [redacted]'s vital signs. (Had he asked for that information, he would have learned that Nurse [redacted] did not take any vitals on [redacted] that day.) Dr. [redacted] did not inquire from Nurse [redacted] what assessments or physical examinations she had performed on [redacted] (Had he asked her for such information, he would have learned that she had performed no tests or examinations on [redacted] that day.) Ultimately, Dr. [redacted] failed to obtain any pertinent information about [redacted] and failed to ensure that his subordinate had performed the most basic evaluations of [redacted], including taking his vital signs or listening to his breath sounds, for more than two days while [redacted] deteriorated.

Although [redacted] was displaying each of the warning signs indicated on his hospital discharge instructions, which directed an immediate return to the hospital, Dr. [redacted] did not return [redacted] to the hospital. Instead, Dr. [redacted] decided to take a "wait and see" approach. After all, [redacted] was scheduled for a court appearance on September 4 and could be released on bail that day.

At 2:00 p.m., shortly before ending her shift, Nurse [redacted] "peeked in" again on [redacted] through the small cell door window. While she saw him drooling, she did not bother to come into the room, check his vital signs, listen to his heart or breath sounds, or perform any examination of him. She simply left for the day.

At 4:46 p.m., a correction officer entered the cell and found [redacted] completely unresponsive. For the first time that weekend, a MEnD medical technician was called into the cell by a correction officer to take [redacted]'s vitals. But it was too late. By 5:22 p.m., [redacted] was pronounced dead.

The most generous interpretation of the two discussions between Dr. [redacted] and Nurse [redacted] on September 1 and 2, is that Dr. [redacted] did not ask the questions or obtain the information that the minimal standard of care required. A far more disturbing possibility is that Nurse [redacted] actually informed Dr. [redacted] that she had done nothing to assess the patient or obtain critical health information, and Dr. [redacted] accepted that woefully deficient level of care from his staff.

In attempting to defend the indefensible, Dr. [redacted] asserts that it is not his fault that his director of nursing, Nurse [redacted], did not tell him about [redacted]'s deteriorating condition. Dr. [redacted] also blames others who he claims provided him inaccurate or incomplete information, including doctors at both the Bemidji and Fargo hospitals. Dr. [redacted] claims that he did nothing wrong, given the information that he had at the time. But Dr. [redacted]'s professional and ethical obligations extended beyond relying upon the information that was immediately available to him. Dr. [redacted]'s professional and ethical duties required him to

obtain and test the accuracy of the information he was relying on to provide (or not provide) healthcare to a patient. This is especially true in a correctional care setting where the attending physician is largely off-site and must rely on the reports of on-site staff.

In directing the care of a patient remotely, an attending physician must ask probing questions of his staff to ensure they are doing their jobs and competently assessing the patient. The attending doctor must also measure the subjective reports of on-site staff against the objective medical data that can be determined from the taking of simple vital signs (blood pressure, pulse, oxygen saturation, pulse rate, etc.).

Dr. [redacted] emphasizes that he did not have access to jail video footage or the opportunity to personally observe [redacted] because he was acting remotely. That is false. It was certainly within Dr. [redacted]'s power to go to the jail to make his own observations.[793] Instead, he elected to act remotely. By making this choice, it was even more imperative that he ensure that he had accurate and complete information to make remote assessments. He chose to make his staff his eyes and ears. He had direct supervisory authority and contractual obligations, as well as professional and ethical responsibilities, to oversee his staff. A doctor cannot just ignore incompetent medical staff[794] and then rely on their judgment to make medical decisions for patients under the doctor's ultimate care.

The diagnosis of malingering made on August 31, 2018, would have alerted a reasonably competent and diligent physician to the need to closely monitor [redacted] As noted by [redacted], a diagnosis of malingering is only made when all other causes have been ruled out. All three experts in this case agreed that a diagnosis of malingering is highly unusual. In addition, both [redacted] and [redacted] note that a diagnosis of malingering should be viewed with skepticism, especially when a patient continues to present with symptoms of serious illness. Consequently, it was imperative for Dr. [redacted] and his staff to be particularly vigilant when [redacted] returned to the jail to ensure that his condition was not worsening. This was especially true considering that the discharge instructions from the [redacted] hospital warned that the [redacted] should obtain "IMMEDIATELY MEDICAL ATTENTION" at "AN EMERGENCY ROOM" if he displayed numbness, paralysis, facial drooping, difficulty standing, loss of bladder or bowel control, or difficulty swallowing.[795] At a minimum, Dr. [redacted] had a duty to monitor his patient's condition and inquire as to these specific symptoms when consulting with his staff. He did not.

Finally, Dr. [redacted] contends that he cannot be held responsible for the negligent care of his nursing staff. But Dr. [redacted] is not being held responsible for the negligence of his staff. He is being held responsible for his own negligent actions and inaction, for his own failure to obtain information and adequately supervise his staff.

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[793] Tr. 29 ¶¶ 17–21; Tr. 1104 ¶¶ 6– 16.

[794] Nurse [redacted]'s reprehensible conduct does not excuse Dr. [redacted]'s abdication of responsibility to a patient under his care. In fact, it could be argued that Nurse [redacted]'s dereliction of duty and shocking indifference to [redacted]'s suffering suggests she was unconcerned about being held accountable by the attending physician – her direct supervisor and romantic partner.

[795] Ex. 111 at 0128-0129 (emphasis in original).

This is not a situation where Dr. [redacted] was merely a physician working for a hospital, alongside nursing staff, over whom he had little authority. Dr. [redacted]'s company, MEnD, undertook by contract the responsibility to provide competent and ethical medical care to inmates at the jail.[796] The contract with [redacted] County specifically provided that MEnD shall provide a "medical director" to supervise all medical care provided to inmates, supervise MEnD nursing staff, and be available at all times to assist nursing staff or answer jail staff questions about inmate medical care at the facility.[797] On September 1 and 2, 2018, Dr. [redacted] was serving in the capacity as the medical director for the facility. Therefore, he had final responsibility by contract to competently supervise the medical care provided to [redacted]

Dr. [redacted] was also the chief medical officer of the MeND corporation. As such, Dr. [redacted] had the ultimate responsibility to ensure competent and proper healthcare to inmates confined in all facilities served by MEnD, as well as to oversee the work of MeND staff in all facilities served by the company. In addition, under MEnD's own Correctional Care Policy, Dr. [redacted] was the Responsible Health Authority (RHA) for all medical staff at the [redacted] County Jail.[798] Under that policy, Dr. [redacted] was ultimately responsible for reviewing all treatment provided by other healthcare providers to inmates (including healthcare provided by outside medical providers) and supervising the care provided to inmates by MEnD medical staff and jail correctional staff.[799] The policy specifically provided that Dr. [redacted], as the RHA for the jail, had "the final judgment on all medical matters related to the healthcare of detainees that reside in each facility served by MEnD."[800]

Accordingly, Dr. [redacted] affirmatively assumed the responsibility to supervise his staff and ensure they were providing competent medical care to inmates confined in all facilities served by MEnD. Dr. [redacted] cannot now hide behind the incompetent work of his medical staff, including his own girlfriend and MEnD director of nursing, who's work, judgment, and words he so blindly relied upon. It was not his staff's duty to ensure his treatment decisions were made upon sufficient information. As [redacted]'s attending physician, it was Dr. [redacted]'s duty to obtain sufficient information and ensure its reliability before determining that his patient required no further care. Whether this failure was the result of his romantic relationship with Nurse [redacted], the absurd notion that a single physician can appropriately care for somewhere between 7,200 and 9,600 inmates across five states, or sheer negligence, is immaterial. Dr. [redacted]'s duty to care for his patient with the minimal standard of care for medical doctors required him to obtain necessary information from his on-site staff. Whatever the reason for his ignorance, his ignorance is no defense.

Dr. [redacted], as [redacted]'s attending physician, the acting medical director for the facility, and MEnD's chief medical officer, had a duty to ask probing questions and ensure that the kind of basic assessments, tests, and examinations that a competent medical professional would conduct to properly evaluate a patient were undertaken. This is

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[796] Ex. 101.
[797] Ex. 101.
[798] Test. of [redacted] (Tr. at Vol. III, p. 578).
[799] Ex. 104 at TAL000027_0044.
[800] *Id.*

especially true for a patient who had just returned from a hospital and who was exhibiting clear signs of a serious illness, all of which were identified in [redacted]'s hospital discharge instructions as symptoms requiring an immediate return to the emergency room.

A physician must do more than hope his staff will provide him with the information needed to provide appropriate care – he must take reasonable measures to ensure it. In this case, Dr. [redacted] is not being held responsible for what he could not know. He is being held responsible for what he would have known had he acted as a reasonable attending physician conforming to the minimal standard of care.

Dr. [redacted] failed in his duty to [redacted] as an ordinary attending physician by not conducting the necessary inquiry to render appropriate healthcare decisions for [redacted] That duty was heightened here, because as the owner and chief medical director of MEnD, and the acting medical director of the jail, Dr. [redacted] assumed an affirmative duty to train and supervise his own MEnD staff, and to ensure that they were providing the type of care necessary to protect the life, health, and safety of their patients. By failing to verify his negligent subordinate's on-site reports in even a cursory fashion, Dr. [redacted] breached his ethical and professional duties.

In sum, the evidence establishes that the minimal standard of acceptable and prevailing medical practice required Dr. [redacted] to obtain basic health information from Nurse [redacted] on September 1 and 2, which he could have used to make informed medical decisions for a patient committed to his care. Instead, Dr. [redacted] did not obtain critical information he should have known and [redacted] was denied potentially life-saving medical treatment. By failing to conform to the minimal standard of care, Dr. [redacted] demonstrated a careless disregard for the health, welfare, and safety of his patient, [redacted], and created an unnecessary danger to [redacted]'s life, health, and safety. Accordingly, disciplinary action is warranted and in the public interest.

Failure to Return [redacted] to the Hospital on September 1 and 2, 2018

As set forth above, as a result of Dr. [redacted]'s failure to obtain necessary medical data and information from his on-site staff, he neglected to return [redacted] to the hospital for emergency care on September 1 and 2, when such care was clearly needed and expressly directed in his hospital discharge instructions. By neglecting to return [redacted] to the emergency room on September 1 and 2, 2018, Dr. [redacted] failed to conform the minimal standard of acceptable and prevailing medical practice. Dr. [redacted]'s conduct demonstrated a careless disregard for the health, welfare and safety of his patient, and created unnecessary danger to his patient's life, health, and safety. Accordingly, disciplinary action is warranted and in the public interest.

Conclusion

[redacted] entered the [redacted] County Jail on August 24, 2018, a vibrant, seemingly healthy 27-year-old man. He was carried from that same jail nine days later to be laid to rest, after having endured days of suffering, begging those responsible for his care – medical providers and correction officers alike – for help that never came. His condition had already been dismissed by his custodians and "caregivers"– he was a criminal defendant feigning an illness, not a man presumed innocent and in desperate need of care. And given their preconceived notions of inmates, no evidence could convince them otherwise. Even in his final hours, as he sat in a wheelchair, in filthy scrubs, with urine streaming down his legs, his caregivers would not believe him. As he laid unconscious, half-naked on the floor of his jail cell, white foam coming from his mouth, they still did not believe him. It took his death to convince medical professionals and jail staff that [redacted] was not "malingering."

Given the egregious facts of this case, the Administrative Law Judge recommends that the Board impose significant and appropriate discipline against Dr. [redacted]. The Judge further urges that the State of Minnesota investigate all who callously disregarded their duty to this man. Foremost among them are Nurse [redacted], the [redacted] County Jail, and jail staff. Scrutiny should also be applied to the contracts MEnD maintains with Minnesota counties and municipalities, and all the other medical providers who were involved in [redacted]'s "care" between August 25 and September 2, 2018.

A tragedy like this should never have occurred. And it must never be allowed to happen again.

A. C. O.