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Expert Report of Michael T. Puerini, MD, CCHP-A, FACCP

Introduction

In September, 2021, I participated in a tour of the FCI Sheridan (Oregon) Federal Prison Complex, in Sheridan, Oregon, along with Mark Loveless, MD, Lisa Hay, JD, and Investigator William Teesdale. After conducting the tour of the facilities, (including the detention facility and a smaller minimum security prison camp), reviewing patient medical files and formal and informal grievances, and discussing the systems of care at the facilities with Ms. Hay, I have formulated the following opinions based on current known standards of care promoted by accreditation agencies such as the National Commission on Correctional Health Care ("NCCHC") and the American Correctional Association ("ACA"). Further discovery is still pending and I reserve the right to amend this report based on any new information that is forthcoming going forward.

Qualifications

I am a correctional physician specialist, having spent over twenty-five years of my career practicing medicine in both juvenile and adult correctional facilities. Over the course of my career I have worked with, and directly or indirectly supervised and taught registered nurses (RN), licensed practical nurses (LPN), mid-level practitioners (nurse practitioners and physician assistants) and primary care physicians both in correctional settings and in the community.

I am a medical school graduate of the Creighton University School of Medicine, having graduated in 1984. I completed my Internship and Residency in Family Medicine in 1987 at Brown University-Memorial Hospital of Rhode Island, where I was chief resident in my final year. I am a physician licensed to practice medicine in the State of Oregon and am Board eligible in Family Medicine.

I am an Advanced Certified Correctional Health Professional (CCHP-A), one of approximately fifty individuals so certified. I am the Past President of the American Academy of Correctional Physicians ("ACCP"), a national medical organization with offices in Denver, Colorado. I have served on the Board of Directors of the ACCP from 2005 until 2015, and I have been the Chair of the Policy and Practice Steering Committee. I continue to serve on the education committee. I teach correctional health care principles, including practice standards related to the practice of physicians, to national and regional audiences of physicians, mid-level practitioners, nurses, and other health care professions.

I have been the Chief Medical Officer of the Oregon State Correctional Institution ("OSCI") since 1998, until my retirement in May, 2016. I also served on the Nursing Protocol Committee, performed all mortality reviews for the Oregon Department of Corrections ("ODOC"), and acted as the Assistant to the Medical Director.

Since retiring my full time position, I have returned to work part time for the ODOC, performing most of my prior responsibilities on a part time basis. I am the director of physician education for the ODOC, planning a regional medical education program twice yearly. I assist in planning national and regional programs of education for physicians who work in correctional settings. I have practiced primary care medicine in a correctional institution setting since 1992, and continue to see patients on a part time basis. The clinical practice of medicine in correctional institutions remains my primary professional focus.

I investigate, monitor, or evaluate the safety and appropriateness of health care delivery in correctional institutions in my role as physician accreditation surveyor for the National Commission on Correctional Health Care ("NCCHC"), as an administrator at the ODOC, and in my role as technical consultant for the Wyoming Department of Corrections and the Philadelphia Prison System.

Additional details of my credentials to evaluate and offer opinions in this case can be found in my Curriculum Vitae, which is attached.

Testimonial Information

I review cases and act as an expert witness in select cases, and have been deposed six times as an expert witness as follows.

1. *Stefan Woodson v. City of Richmond, Virginia, et. al.*, Deposition on November 24, 2014;
2. *David Smith v. Campbell County Kentucky, et. al.*, Deposition on March 16, 2018;
3. *Terri Carlisle v. Douglas County, Oregon, et. al.*, Deposition on October 15, 2018;
4. *Paris Loving-Johnson v. Kaihrul Emran, MD and NaphCare Inc*, Deposition on December 16, 2019;
5. *Randy Dunn v. Centurion Correctional Healthcare of New Mexico*, Deposition on March 10, 2020;
6. *Paris Loving-Johnson v. Khairul Bashar Mohammad Emran MD*, Deposition on April 7, 2021.

Trial Deposition:

Paris Loving-Johnson v. Khairul Bashar Mohammad Emran MD, on November 23, 2021

Opinions

1. The system of care at the FCI Sheridan does not allow for adequate access to care. Access to care is a fundamental aspect of the care system —without access to care, adults in custody are essentially left without healthcare, much to their peril.

2. There appears to be an active deterring of patients from accessing care. For example, the computer technology, readily available as a point of access, is intentionally not being used. Inmate patients are intentionally prohibited from using an easily utilized and documented avenue for access to care.

3. The system of care for inmate patients in their non-emergency healthcare requests is further fraught with difficulty in that inmates are not able to submit their healthcare requests on a daily basis. Requests are not triaged on a daily basis by healthcare professionals, and triage of patients' clinical concerns does not happen within 24 hours, as is the current standard of care.

4. In addition, there is no organized, confidential system of delivering healthcare requests to healthcare professionals. Custody staff are frequently in charge of getting the requests to healthcare personnel. There is no locked box where inmate-patients can deliver their requests. The only locked box for patient non-emergency requests is in a box that is used for mail to home, and which healthcare staff do not check, only custody staff.

5. The fact that custody officers are often in charge of collecting inmate non-emergency healthcare requests results in a breach of patient confidentiality. While properly trained custody staff, such as the custody healthcare liaison, may have some access to confidential patient medical information, this should not in any circumstances be the default as was apparent at FCI Sheridan. Care should be taken to protect patient confidentiality as much as possible.

6. The care of potentially seriously ill patients in the facility gym is a clear breach of patient confidentiality and promotes sub-standard care. Some of the patients housed there were seemingly quite ill, having only recently been released from the hospital. Using an understaffed gymnasium (no healthcare staff were seen) as an infirmary is simply irresponsible.

7. We also noted that inmates who needed to use wheelchairs were not able to utilize the restroom facilities provided to the potentially very ill patients housed in the gym. Restroom facilities were clearly inadequate.

8. The fact that custody officers are generally in charge of collecting inmate non-emergency healthcare requests results in the very real risk of healthcare professionals losing the ability to perform healthcare without losing autonomy to the custody staff.

9. There is inadequate documentation of when a patient submits a request for care, when a nurse triages that request, and how long it takes for a nurse or physician to adequately evaluate the medical problem raised by the patient. This documentation is easily arranged and carried out at correctional institutions across the country. No such clear documentation is found at the FCI Sheridan facilities.

10. The responsible health authority ("RHA"), presumably the health services administrator at FCI Sheridan is responsible for maintaining a coordinated system of care. The system of care is inadequate in that inmate-patients do not even have minimal access to care for the reasons enumerated above.

11. Evidence suggests that the Responsible Physician, upon whom the final clinical decision-making for the institution, is not present on site often enough to be able to conduct his assigned duties to patient care.

12. On visiting the institutions, we found very adequate, in some cases superior healthcare resources and clinical diagnostic facilities, but no apparent use of these facilities. No medical or nursing clinical care was apparent to be occurring at any time during our visit. It is shameful to have such facilities, which are clearly underutilized for ongoing patient care.

13. Inmates housed in isolation or quarantine require care by healthcare staff on a regular and routine basis, similar to any patients who are segregated for other reasons. This kind of regular attention was clearly not occurring.

14. Inmate workers were a clear cut presence in delivering care to suicidal peer inmates in observed beds. There was no evidence of routine monitoring of suicidal inmates by custody and/or healthcare staff. This is clearly a breach of usual, nationally promulgated standards of care.

15. The Sheridan facility, at the time of our visit in September, was not following CDC guidelines regarding care of Covid patients in that patient who had tested positive for Covid were not being checked on a daily basis, as specified in the guidelines. CDC guidelines should be meticulously followed in federal prisons for the safety of inmates and staff.

16. Reports from inmates that newly arriving inmates were being moved from the intake area to the housing unit examination areas would breach the most fundamental COVID-19 infection control measures, should this assertion be correct.

The opinions contained in this report are based upon my understanding of the facts of the case as informed by my education, training, and experience in the field of primary care medicine and as a correctional medicine expert. All of the opinions and conclusions stated herein are given to a reasonable degree of medical certainty. I reserve the right to amend or alter these opinions or to add any needed additional exhibits should further facts illuminate a need to do so, especially after any further investigation.

Sincerely,

/s/ Michael T. Puerini, MD, CCHP-A, FACCP

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