COMMONWEALTH OF MASSACHUSETTS

WORCESTER, ss

WORCESTER SUPERIOR COURT
CIVIL ACTION NO. 11-0342C

MARIO LEMANSKI, ADMINISTRATOR,
ESTATE OF ZYGMONT LEMANSKI
Plaintiff

v.

COMMONWEALTH OF MASSACHUSETTS,
KATHLEEN SHULTZ, THOMAS PATNAUDE, MD,
COLEEN R. HANNAM, LPN, NURSE JANE DOE 1
NURSE JANE DOE 2, NURSE JANE DOE 3,
Defendants

FILED
FEB 24 2011
ATTEST: CLERK

COMPLAINT AND REQUEST FOR JURY TRIAL

INTRODUCTION

1. This is an action in wrongful death for money damages arising from negligence, malpractice and/or violations of the constitutional rights of plaintiff's decedent by the Worcester County Sheriff's Office, an agency of the Commonwealth of Massachusetts, and by the medical director, nurses and correctional officers of the Worcester County House of Correction. As a direct and proximate result of these parties' misconduct, plaintiff was deprived of medical care necessary to preserve his life and suffered great pain of body and mind, awareness of impending death, and death, and members of his immediate family experienced grief and emotional distress.

JURISDICTION

2. This action is brought pursuant to 42 U.S.C.§1983 and 1988, the Eighth and Fourteenth Amendments to the United States Constitution, and the common law, Constitution and statutes of the Commonwealth of Massachusetts.

3. On information and belief all defendants are within the personal jurisdiction of this Honorable Court, and/or the Court has jurisdiction over them pursuant to the so called Long-Arm Statute of Massachusetts, M.G.L. c. 223A,§3.

4. There is no reasonable likelihood that plaintiff's recovery will be less than or equal to $25,000.

5. This Honorable Court has original jurisdiction of the action generally pursuant to M.G.L. c. 212,§3 & 4, and it has exclusive jurisdiction of claims against the Commonwealth per the 11th Amendment to the U.S. Constitution and M.G.L. c. 258,§3.

VENUE

6. Venue in this Court is proper per M.G.L. c. 223,§1 and 258§3

PARTIES

7. Plaintiff Mario Lemanski, resides in the City of Worcester, Worcester County, Massachusetts and, by decree of the Worcester Family and Probate Court in Docket No. 11P0482 (Meagher, J.) plaintiff is the duly appointed administrator of the estate of his brother the decedent, Zygmont Lemanski.

8. At all times pertinent hereto until his death from pneumonia on March 4, 2008, at the age of 44, plaintiff's decedent Zygmont Lemanski ("Mr. Lemanski" or "decedent") was an inmate of the Worcester County House of Correction ("WCHC" or "the jail") located at 5 Paul Tivnan Drive, Town of West Boylston, Worcester County, Massachusetts in custody of the Worcester County Sheriff's Office ("WCSO").

9. The defendant Commonwealth of Massachusetts ("The Commonwealth") is a sovereign with a usual business address at the City of Boston, Suffolk County, Massachusetts, and is sued for conduct of its agency, the WCSO, in operation of the jail and for the conduct of employees of the Commonwealth working at the jail under the direction of the WCSO. [1]

10. Defendant Thomas R. Patnaude, M.D., ("Dr. Patnaude") of 610 Pleasant Street, Worcester, Massachusetts, who is sued in his individual capacity and in his official capacity insofar as the law may allow, was at all times pertinent hereto a duly licensed physician in the Massachusetts and, as the Medical Director of the jail was the plaintiff's primary care physician.

11. Defendant Kathleen Shultz ("Deputy Schultz"), who is sued in her individual capacity, was at all times pertinent hereto employed at the jail as an Assistant Deputy Schultz Superintendent and the administrator of medical services and she was Dr. Patnaude's immediate superior.

12. Defendant Nurse Jane Doe 1, who is sued in his or her individual capacity, was at all times pertinent hereto a medical practitioner duly licensed in Massachusetts who provided medical care to inmates at the jail under the clinical supervision of Dr. Patnaude.

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[1] The WCSO is an independent agency of the Commonwealth of Massachusetts pursuant to Chapter 48 of the Acts of 1997, M.G.L. c. 34B as amended, with a usual place of business at 5 Paul X. Tivnan Drive, Town of West Boylston, Worcester County, Massachusetts.

13. Defendant Nurse Jane Doe 2, who is sued in his or her individual capacity, was at all times pertinent hereto a medical practitioner duly licensed in Massachusetts who provided medical care to inmates at the jail under the clinical supervision of Dr. Patnaude.

14. Defendant Nurse Jane Doe 3, who is sued in his or her individual capacity, was at all times pertinent hereto a medical practitioner duly licensed in Massachusetts who provided medical care to inmates at the jail under the clinical supervision of Dr. Patnaude.

FACTS

15. Each preceding paragraph is incorporated in this section as if fully set for herein.

16. At all times pertinent hereto the defendants acted under color of law, to wit, under color of the statutes, ordinances, regulations, policies, customs, practices, usage and authority the Commonwealth of Massachusetts and/or its agency the WCSO.

17. At all times pertinent hereto Nurse Hannam and Nurse Jane Does 1 through 3 (collectively "the nursing defendants"), Deputy Schultz, Dr. Patnaude, and the WCSO, its agents, servants, contractors, and employees, had custodial responsibilities and duties under the laws of Massachusetts and the State and Federal Constitutions for the safety and well being of jail inmates, including those afflicted with illness.

18. At all times pertinent hereto each individual defendant knew of the foregoing responsibilities and duties, including the duty to provide appropriate medical care to sick inmates and the duty to take obvious and available steps to avert a readily apparent and imminent threat of substantial harm to an inmate arising from undiagnosed and/or untreated disease.

19. The decedent was incarcerated at the jail as a pretrial detainee on November 7, 2007, and on January 7, 2008, became a sentenced inmate whose release date was subsequently estimated to be May 3, 2008.

20. On the date of decedent's incarceration a medical intake screening report of the jail documented that the plaintiff was an active abuser of heroin, with visible needle marks and signs of withdrawal, who acknowledged having used heroin the day before.

21. The aforesaid report also documented that the decedent was positive for the human immunodeficiency virus ("HIV") and positive for Hepatitis C.

22. At all times pertinent hereto Dr. Patnaude and the nursing defendants knew that the decedent was HIV positive.

23. At all times pertinent hereto each individual defendant knew that as a jailed inmate the decedent had no way of obtaining medical care essential to his health and survival except from them and others in the jail medical department.

24. At all times pertinent hereto, as the medical director of a jail with significant percentages of drug users and HIP patients in its population, Dr. Patnaude knew of the susceptibility of intravenous drug users to infection and that IV drug abusers typically had weaker immune system response to infection as compared to non-abusers.

25. On November 8, 2007, jail medical staff took a chest x-ray of the decedent and obtained information from him regarding his medical treatment and providers in the months preceding his incarceration.

26. On or about November 9, 2007 jail medical staff drew a sample of decedent's blood for laboratory testing.

27. On November 13 and 24, 2007, jail medical staff reviewed the results of decedent's laboratory tests, contacted one of his previous medical providers and sought to obtain copies of his medical records.

28. On November 15, 2007, the decent was started on daily doses of an anti-retroviral medication, Atripla.

29. Atripla, which consists of a combination of three different anti-retroviral drugs (emtricitabine, tenofovir and efavirenz), was formulated specifically and solely for treatment of HIV, and in 2006 received approval for use by HIV patients in the United States.

30. Blood work reported on January 10, 2008, indicated that after the start of HIV medications the levels of HIV in decedent's blood had been controlled.

The Ordeal of Zygmont Lemanski

31. On Saturday, February 23, 2007, Mr. Lemanski felt ill with flu-like symptoms and took to his bed.

32. In the medical record defendant Nurse Jane Doe 1 reported providing Atripla to Mr. Lemanski in his cell at approximately 10 PM on the aforesaid date.

33. At the aforesaid time and place defendant Nurse Jane Doe 1 observed Mr. Lemanski's condition and despite knowing of his HIV diagnosis made no note or report and took no other action to see that he got appropriate and timely diagnosis and treatment.

34. On Sunday, February 24, 2007, plaintiff remained in bed with the aforesaid complaint.

35. In the medical record defendant Nurse Jane Doe 2 reported providing Atripla to Mr. Lemanski in his cell at approximately 10 PM on the aforesaid date.

36. At the aforesaid time and place defendant Nurse Jane Doe 2 observed Mr. Lemanski's condition and despite knowing of his HIV diagnosis made no note or report and took no other action to see that he got appropriate and timely diagnosis and treatment.

37. On Monday, February 25, 2007, plaintiff remained in bed with the aforesaid complaint.

38. In the medical record defendant Nurse Jane Doe 2 reported providing Atripla to Mr. Lemanski in his cell at approximately 10 PM on the aforesaid date.

39. At the aforesaid time and place defendant Nurse Jane Doe 2 again observed Mr. Lemanski's condition and despite knowing of his HIV diagnosis made no note or report and took no other action to see that he got appropriate and timely diagnosis and treatment.

40. On Tuesday, February 26, 2007, plaintiff remained in bed coughing up blood, vomiting and suffering from diarrhea and chills.

41. In the medical record defendant Nurse Jane Doe 3 reported providing Atripla to Mr. Lemanski in his cell at approximately 10 PM on the aforesaid date.

42. At the aforesaid time and place defendant Nurse Jane Doe 3 observed Mr. Lemanski's condition and despite knowing of his HIV diagnosis made no note or report and took no other action to see that he got appropriate and timely diagnosis and treatment.

43. On Wednesday, February 27, 2007, plaintiff remained in bed with the aforesaid symptoms.

44. In the medical record defendant Nurse Jane Doe 2 reported providing Atripla to Mr. Lemanski in his cell at approximately 10 PM on the aforesaid date.

45. At the aforesaid time and place defendant Nurse Jane Doe 2 observed Mr. Lemanski's condition for the third time and despite knowing of his HIV diagnosis made no note or report and took no other action to see that he got and timely diagnosis and treatment.

46. On Wednesday, February 27, 2007, submitted a written medical services request, on a form provided by the jail for that purpose, in which he stated: "I've been in bed since Saturday. I've been coughing up dark phlegm and diarrhea and feel weak and the chills. Need some antibiotic medication and [I've also had] loss of appetite."

47. Nurse Hannam wrote in the medical record she received the aforesaid request for medical care on February 28, 2008, but despite knowing of his HIV diagnosis did not examine or assess the patient and took no other action that day to see that he got appropriate and timely diagnosis and treatment.

48. On Thursday, February 28, 2007, plaintiff remained in bed with the aforesaid symptoms.

49. In the medical record defendant Nurse Jane Doe 3 reported providing Atripla to Mr. Lemanski in his cell at approximately 10 PM on the aforesaid date.

50. At the aforesaid time and place defendant Nurse Jane Doe 3 again observed Mr. Lemanski's condition and despite knowing of his HIV diagnosis made no note or report and took no other action to see that he got appropriate and timely diagnosis and treatment.

51. According to the medical record Mr. Lemanski had no medical exam, review, assessment, diagnosis or treatment of any kind from the day he took to bed ill on February 23, 2008, through February 28, 2008, and his medical record shows no activity at all in that period, except for the daily dispensing of Atripla and Nurse Hannam's receipt of his written plea for help.

52. At 8:35 AM on February 29, 2008, Cheryl D. Carter-Piper RN/NP examined Mr. Lemanski at the jail infirmary, finding he could not walk unassisted due to dizziness, had a blood pressure of 98/60, a heart rate of 137, a blood oxygen saturation of 91 percent, and had reduced lung sounds.

53. Nurse Carter-Piper attempted unsuccessfully to place an IV line in Mr. Lemanski.

54. Nurse Carter-Piper evaluated Mr. Lemanski as dehydrated and tachycardic with a question of pneumonia, and she had an ambulance summoned to take Mr. Lemanski to St. Vincent Hospital.

55. Shortly after 9 AM on the aforesaid date an ambulance arrived at the jail and medical technicians obtained a pressure of 98/60, respiration rate of 18, heart rate of 110, oxygen saturation of 90% and a capillary refill time of greater than three seconds.

56. Per the ambulance run report the ambulance medical technicians found Mr. Lemanski's skin was pale, hot, and dry and jail medical staff reported to them his temperature was 100.5 F.

57. The ambulance technicians gave Mr. Lemanski oxygen and intravenous fluids and transported him to the St. Vincent Hospital emergency department.

58. On arrival at St. Vincent Mr. Lemanski's temperature was the same and his blood pressure was 86/55.

59. Mr. Lemanski's respiratory function deteriorated despite continued oxygen at the hospital and he was intubated shortly before 7 PM.

60. Mr. Lemanski remained aware and alert up to the time of intubation.

61. Mr. Lemanski was sedated but conscious at the time of intubation.

62. Mr. Lemanski experienced difficult and labored breathing before his intubation and was advised by doctors that intubation was necessary because his respiratory function was failing.

63. On February 29, 2008, doctors at the Saint Vincent Emergency Department gave Mr. Lemanski a preliminary diagnosis of pneumonia, acute renal failure and hypokalemia, and they started him on medications to treat these conditions including antibiotics for several types of potential causes of pneumonia.

64. Back at the jail, on February 29, 2008, at approximately 10 PM Nurse Jane Doe 2 wrote in the medical record that he or she had dispensed that night's dose of Atripla to Mr. Lemanski in his cell, notwithstanding that at that time Mr. Lemanski was not at the jail but lay dying in St. Vincent Hospital.

65. On the night of February 29, 2008, as he continued to deteriorate, Mr. Lemanski was transferred from the emergency department to intensive care at St. Vincent.

66. The next day, March 1, Mr. Lemanski was diagnosed as suffering from overwhelming infection and septic shock.

67. After cultures revealed on March 1 that the source of infection was MRSA (the bacterium methicillin-resistant Staphylococcus aureus), doctors adjusted the antibiotic therapy, but Mr. Lemanski's respiratory and kidney functions continued to decline and he developed acidosis and hypoxia.

68. On March 2, Mr. Lemanski was unresponsive, and his family and jail officials were informed his condition was hopeless.

69. On the morning of March 4, after meeting doctors at the hospital, Mr. Lemanski's family members requested termination of life support.

70. Mr. Lemanski was extubated and after 10 minutes died in the presence of his family at approximately 2 PM March 4, 2008.

Medical Policies and Practices of the Defendants

71. At all times pertinent hereto the jail maintained a written policy, adopted and approved by Dr. Patnaude as medical director, for assuring that inmates had access to health care: Policy 932.09 – Sick Call.

72. The aforesaid policy provided that "[a]ccess to daily sick call is an inmate's right, not a privilege" and it guaranteed inmates "the opportunity to report a medical illness or other health problem, and to receive diagnosis and/or treatment, from medical staff."

73. The aforesaid policy required that sick call be conducted on a daily basis "by qualified healthcare professionals who shall provide appropriate response to healthcare request by inmates" who were "responsible for examining the inmate and providing appropriate triage and treatment based on approved protocols or refer the inmate to the facility physician."

74. The aforesaid policy required that inmates who submitted written medical services requests on a prescribed for, the form on which Mr. Lemanski submitted his request, must have access to daily sick call.

75. The aforesaid policy required staff of the jail medical department to collect and review medical services request forms daily from each inmate housing unit of the jail and to have ill inmates brought to the medical department for assessment.

76. At all times pertinent hereto the jail maintained a written policy, adopted and approved by Dr. Patnaude as medical director, stating that it was the policy of the jail "to provide unimpeded access to health care for all inmates," entitled Policy 832.08 – Unimpeded Access to Health Care.

77. The aforesaid policy stated that, besides gaining access to daily sick call by submitting a written medical services request, an inmate "may request assistance from any staff member for access to medical services."

78. The aforesaid policy required that "[i]nmates' health complaints shall be processed on a daily basis by the Health Service Unit."

79. The aforesaid policy required that "[i]n the event a health care complaint is other than routine in nature, medical staff shall contact the on-call physician" who could order hospitalization if necessary.

80. Mr. Lemanski's flu-like symptoms of February 23, 24, and 25 and his vomiting, diarrhea, chills and coughing up of blood on February 27, 27, and 28 were observable complaints, and complaints that on information and belief he reported to medications nurses on each of those dates, are not routine in an HIV patient but in fact were ominous indicators of life threatening illness.

81. At all times pertinent hereto nurses, including those dispensing medications to Mr. Lemanski, had a duty pursuant to 244 CMR 3.02 (3)(f) as to registered nurses and pursuant to 244 CMR 3.04(4) (g) as to licensed practical nurses, to "collaborate, cooperate and communicate with other health care providers to ensure quality and continuity of care."

82. At all times pertinent hereto regulations and policies of the Commonwealth and the jail required nurses dispensing medications to assure such medications were dispensed, according to doctors' prescriptions, only to the individuals named in the prescriptions.

83. The nursing defendants negligently, grossly negligently, recklessly, wantonly and/or intentionally with deliberate indifference to the Mr. Lemanski's serious medical needs ignored his urgent pleas and need for medical attention, which he presented and/or manifested to them repeatedly over six days, and as a direct and proximate result he suffered and died.

84. Nurse Jane Does 1 through 3, when they dispensed medications to Mr. Lemanski as aforesaid, failed to report or otherwise act in response to his condition so carelessly, negligently and with such gross negligence as to directly and proximately cause his deadly illness to go undiagnosed and untreated on each of the six days from February 23 through 28, 2008, and thereby caused his death.

85. When Nurse Jane Does 1 through 3 dispensed Atripla to Mr. Lemanski as aforesaid, he complained to them of his symptoms and/or they observed him to be ill and they each understood and appreciated the potentially mortal threat this presented to him as an HIV patient.

86. Notwithstanding the foregoing and these defendants' knowledge of measures available to them by which Mr. Lemanski could have access to timely examination, diagnosis and treatment, the said defendants negligently, grossly negligently, recklessly, wantonly and with deliberate indifference to his health and safety took no such steps, and as a direct and proximate result Mr. Lemanski suffered and died.

87. In the alternative to ¶¶85 and 86 above, in one or more instances from February 23 through 28, 2008, where the said nurse defendants placed notes in the record indicating they had dispensed Atripla to Mr. Lemanski, they had not in fact given him medication or observed his condition or listened to any of his health complaints, but fraudulently misrepresented their conduct in the record.

88. Notwithstanding their knowledge that such conduct posed grave risks to the health and well being of Mr. Lemanski due to deprivation of medication and creation of an unfounded impression that he had not complained of or otherwise manifested any illness, the said nurse defendants acted as aforesaid intentionally and with deliberate indifference to the health and safety of Mr. Lemanski, and as a direct and proximate result thereof he suffered and died.

89. At all times pertinent hereto Dr. Patnaude and Deputy Schultz were aware of previous instances at the jail of nurses failing to respond appropriately to complaints or manifestations of serious illness in inmates, with harm to such inmates resulting.

90. Notwithstanding the foregoing and their knowledge that such conduct was contrary to policy and posed serious risks to the health of inmates under their care, Dr. Patnaude and Deputy Schultz negligently, grossly negligently and/or with deliberate indifference to the health and well being of inmates, including Mr. Lemanski, failed to seek training, evaluation, discipline or termination of nurses so as to prevent the conduct from continuing.

91. Notwithstanding that on February 28, 2008, Nurse Hannam, received Mr. Lemanski's written request for medical care describing symptoms that were ominous and non-routine in an HIV patient.

92. Notwithstanding her knowledge of Mr. Lemanski's urgent need for diagnosis and treatment Nurse Hannam negligently, grossly negligently, recklessly wantonly and/or with deliberate indifference to his health and safety denied Mr. Lemanski access to medical care necessary to save his life, and he suffered and died as a direct and proximate result.

93. Notwithstanding they knew that the Massachusetts Board of Registration in Nursing reprimanded Nurse Hannam on or before February 23, 2008, for nursing misconduct, Dr. Patnaude and Deputy Schultz left her in charge of sick call on February 28, 2008, when she denied Mr. Lemanski access to medical care necessary to save his life.

94. Dr. Patnaude and Deputy Schultz acted or failed to act as aforesaid negligently, grossly negligently and/or with deliberate indifference to the health and safety of Mr. Lemanski and other inmates, and as a directly and proximate result Mr. Lemanski suffered and died.

95. The nursing defendants negligently, grossly negligently, recklessly, wantonly and/or intentionally with deliberate indifference to the plaintiff's serious medical needs ignored his condition.

96. At all times pertinent hereto the WCSO by written policy provided that medical clinical judgments "shall be the sole province of the responsible physician." (Policy 932.04, Health Care Treatment)

97. Notwithstanding the aforementioned policy, Dr. Patnaude negligently, grossly negligently, recklessly, wantonly and/or intentionally with deliberate indifference to the plaintiff's serious medical needs allowed nursing staff, primarily LPN's, to make clinical judgments as to the plaintiff's need for monitoring, examination, diagnosis and treatment, and the nursing defendants made such judgments notwithstanding their lack of competence, qualifications, or authority to do so, and as a direct and proximate result thereof Mr. Lemanski suffered and died.

COUNT I
DR. PATNAUDE
MALPRACTICE

98. Each of the preceding paragraphs in incorporated in this count as if fully set for herein.

99. At all times pertinent hereto, Dr. Patnaude represented himself to be skilled in the treatment of various illnesses and medical conditions, and in particular, represented that he was knowledgeable, competent and qualified to diagnose and treat medical conditions commonly found among inmate populations, including the plaintiff.

100. From February 23 to 29, 2008, Dr. Patnaude and persons acting under his supervision, direction or control, provided and/or failed to provide medical care to the plaintiff, his patient, so negligently, carelessly, grossly negligently and without regard for plaintiff's health and well being so as to proximately cause his suffering and death.

101. The decedent's suffering and death were the direct and proximate results of the carelessness, unskillfulness, negligence, and gross negligence of Dr. Patnaude in one or more of the following respects:

- His misrepresentations that he was sufficiently knowledgeable, skillful, and diligent to treat the decedent and others similarly situated.
- His failure, and that of medical staff under his supervision and control, to diagnose and appropriately treat the decedent's medical condition;
- His failure to recognize, or to have knowledge to recognize, his inability and lack of skill to treat the decedent, when he knew or should have known of the foreseeable consequences of his inability and failure to properly and skillfully provide decedent with appropriate medical care and treatment;
- His failure to possess and exercise the degree of skill, training and care as is or should be possessed and exercised by the average qualified member of the medical profession.

COUNT II
COMMONWEALTH OF MASSACHUSETTS
NEGLIGENCE, MALPRACTICE – M.G.L. c. 258

102. Each of the preceding paragraphs in incorporated in this count as if fully set for herein.

103. At all times pertinent hereto, the Commonwealth, acting by and through its agency the WCSO and its employee Deputy Schultz, negligently and grossly negligently provided substandard and inadequate medical care for inmates at the jail by acts and omissions including but not limited to the following:

- Failing to have an adequately staffed medical service;
- Providing medical care by inadequately trained, and/or underqualified staff;
- Failing to ensure that inmates in need of routine or acute medical care were seen by medical staff or referred to hospitals for acute care in a timely manner;
- Failing to ensure that diagnostic procedures were performed in a timely and appropriate fashion with due regard for urgent and acute conditions;
- Failing to appropriately manage and coordinate the flow of critical diagnostic information;
- Failing to ensure that the policies set forth herein regarding medical care of inmates were observed.

104. As a direct and proximate result of the foregoing, the decedent suffered and died

105. On information and belief, Deputy Schultz and the nursing defendants were at all times pertinent hereto employees of the Commonwealth at the jail and negligently acted or failed to act, as set forth herein, in the course of their employment, and therefore the Commonwealth is liable for harms resulting from their negligent conduct as per M.G.L. c. 258.

106. On or about February 25, 2010, the Commonwealth received written notice as per the aforesaid statute, of the claims set forth in this count.

107. To date, the Commonwealth has not answered or responded to the aforesaid notice and no settlement or resolution of the said claims has occurred.

COUNT III
DR. PATNAUDE, DEPUTY SCHULTZ, NURSING DEFENDANTS
42 U.S.C.§1983, DELIBERATE INDIFFERENCE

108. Each of the preceding paragraphs in incorporated in this count as if fully set for herein.

109. Each individual defendant wasaware of and deliberately and consciously indifferent to a clear and imminent danger of harm and injury to the decedent and/or to similarly situated nmates, arising from the failure to monitor, evaluate, diagnose and treat his serious medical condition in a timely fashion as set forth herein

110. The risk or harm, defendants' knowledge thereof and the failure to do the obvious, taken together, placed decedent in harm's way, and demonstrated that defendants were reckless, callous and deliberately indifferent to the harm that occurred.

111. By their actions, the said defendants subjected the plaintiff to these deprivations knowingly, intentionally, willfully, purposely, maliciously and/or with such reckless disregard of the consequences as to display a conscious indifference to the danger of harm and injury.

112. As a direct and proximate result of the foregoing plaintiff was deprived of his rights under the laws and Constitution of the United States, in particular the Eighth and Fourteenth Amendments thereof ant 42 U.S.C.§1983, 1985(2)(3), 1985 and 1988, and under the law of the Commonwealth, and thereby endured devastating injury and great pain of body and mind.

The records show the defendants failed to properly evaluate, assess or treat Mr. Lemanski's condition, and ignored his pleas for help until it was too late. These deviations from the acceptable standard of care caused Mr. Lemanski to die secondary to pneumonia related to immunodeficiency and hepatitis C on March 4, 2008, at Saint Vincent Hospital.

This Offer of Proof includes the affidavit of medical opinion by Robert B. Greifinger, M.D., a correctional medical care expert and a board certified pediatrician. Ex. 5. Dr. Greifinger has dedicated most of his career to the treatment of prison inmates. Dr. Greifinger opines that that Dr. Patnaude and members of the nursing staff at the jail breached the applicable standard of medical care and thereby caused Mr. Lemanski's fatal deterioration. The medical record unmistakably links Dr. Patnaude and the nurses that came in contact with Mr. Lemanski to conduct that Dr. Greifinger specifically identifies as malpractice causally related to harm to the patient. Plaintiff submits that this expert opinion and the medical record pose legitimate questions of liability as to Dr. Patnaude and the nurses involved in his care, appropriate for judicial review as per M.G.L. c. 231, § 60B.

Facts

Zygmont Lemanski was incarcerated at the WCHC on November 7, 2007 as a pre-trial detainee and was sentenced on January 7, 2008. His release date was set for May 3, 2008. Complaint, Ex. 7, at ¶ 20. The record of his physical examination at the WCHC on November 7, 2007, showed he had been diagnosed as positive for HIV since December 2001 and had been on HIV medications since November 2007. Ex. 1, selected jail medical record p. 2-3. It also showed he weighed 160 lbs on intake. *Id.* A special needs plan was written for Mr. Lemanski at the jail on the day after his arrival, November 8, 2007. *Id.* p. 13-14. *See also* Affidavit of Dr. Greifinger Ex. 5 at ¶ 24. There were plans to start him on Atripla, a medication for HIV

infection. Ex. 1, p. 24, and Ex 5 at ¶ 24. In a progress note dated November 8, 2007, Nurse Lenault also documented that Mr. Lemanski had HIV and hepatitis C since 2001. Ex. 5 at ¶ 24.

On November 9, 2007 Mr. Lemanski complained of loose stools and gastric distress and was prescribed Immodium as well as Kool Aid packs for hydration and crackers by a practitioner whose name is illegible. Ex. 1, p. 31, 36, 60. In a note of November 13, 2007, Nurse Lenault recorded that there was no medical information from the medical provider Mr. Lemanski had before going to jail, but she did note laboratory values acquired by telephone. Dr. Eric Garcia saw Mr. Lemanski on November 15, 2007, and Atripla was ordered for his HIV infection. The patient received the Atripla daily. Medications administration record. Ex. 6. There was a seven-day lag from the special needs plan for initiation of medication, which required beginning medications for HIV within 96 hours of booking, and the date of his first dose, although his medications were noted to have been verified on November 8, 2007 Ex. 1 pp. 30-36, Ex. 5 at ¶ 26.

Mr. Lemanski received influenza vaccine on November 19, 2007. Ex. 1, pp. 11-12. Ex. 5 at ¶ 28. According to the medical records, Mr. Lemanski refused a physical examination on February 19, 2008, but there is no note regarding counseling and no signed refusal form in the record. Ex. 5 at ¶ 29. On Wednesday, February 27, 2008, Mr. Lemanski filled out a request for care complaining of decreased appetite, cough with dark phlegm, weakness and chills and stating that "[I] need some antibiotic medication and loss of appetite." Ex. 1, pp. 22. As per plaintiff's medical expert, "[t]hese are urgent serious medical needs in any patient, especially one with a compromised immune system, such as Mr. Lemanski." Ex. 5 at ¶ 30. Mr. Lemanski's medical request slip was acknowledged the next day by C. Hannam, LPN, but despite his diagnosis and reported symptoms he was not seen that day, nor referred to a physician, and not scheduled for

care. Ex. 1 at 22 and Ex. 5, at ¶ 30. The nurses delivering medications to Mr. Lemanski from February 23 – 28, 2008 ignored a patient with his life-threatening symptoms, and he became bedridden. The justodial staff ignored him as well. Ex. 5 at ¶ 31.

On Friday, February 29, 2008, an ambulance was summoned for Mr. Lemanski when Nurse Practitioner Cheryl Carter-Piper found him with tachycardia (a pulse of 137 beats per Minute), dehydration, and an oxygen saturation of 91%. Ex. 1, p. 59, and Ex. 5 at ¶ 32. An ambulance arrived at 9:02 A.M. and delivered him to the emergency department of St. Vincent's Hospital at 9:31 A.M. Ex. 5 at ¶ 32.

Ambulance Notes/Transfer to St. Vincent's Hospital

The notes of the EMTs from American Medical Response who transferred Mr. Lemanski to the hospital indicate a complaint of flu-like symptoms for one week and hemoptysis, nausea, vomiting and diarrhea for approximately three days. Ex. 2, AMR records. The notes also show that on the day of transfer he had been treated by prison staff with ibuprofen and Compazine and that the EMTs found him sitting in a wheelchair. *Id.* An electrocardiogram performed by them showed sinus tachycardia at 110 beats per minute with ectopic beats. His oxygen saturation was only 90% in room air. Prison staff reported a body temperature of 100.5 F. These records also show that he was being followed up for dehydration r/o pneumonia. *Id.*

Emergency Department records from St. Vincent's Hospital ("SVH") state Mr. Lemanski had been having flu symptoms for 6 days. Ex 3. Upon arrival at the emergency department his breathing sounds were diminished in the left upper lobe and left posterior lower lobe with bilateral crackles. Later that day Mr. Lemanski was intubated. SVH records show he was hypotensive, his blood pressure was 86/55 at 10:03. On February 29, 2008, Mr. Lemanski was transferred to a medical floor by Internist/Nephrologist Patrick Chua, M.D., who like the ED also

took a history of flu-like symptoms, rhinorrhea for 6 days with worsening of symptoms and onset of nausea, diarrhea, fever and chills for the last three days. Chest x rays showed broncopneumonia and extensive patchy bilateral consolidations with a questions of ARDS. As per the transfer note prepared by Dr. Chua, he was transferred to the intensive care unit (MICU) on February 29, 2008 and was aggressively volume resuscitated but he did not respond and was placed on pressors (Levophed and Pitressin). Blood cultures and sputum cultures were sent. Blood cultures came back 4 out of 4 Gram-positive cocci and sputum grew MRSA. Ceftazidime, Bactrim and azthromycin were discontinued and Vancomycin was continued as per an infectious disease consult by Dr. Gregory T. Williams. On the third hospital day, Mr. Lemanski was not responsive to pain and his pupils were sluggishly reactive to light. On March 4th Mr. Lemanski's family discussed the bleak prognosis of Mr. Lemanski and decided to withdraw all life support and treatment, which according to records, because Mr. Lemanski was under the jurisdiction of the WCHC, jail officials exercised. (See transfer note prepared by Dr. Chua). Zygmont Lemasnki was placed on morphine drip and he was pronounced dead on March 4, 2008 at 1:59 pm. According to the plaintiff's expert, even after Mr. Lemanski was sent to the hospital, a nurse documented giving him medication at a time he was not there. Ex. # 5 at ¶ 35.

Liability of Dr. Patnaude

Plaintiff's expert, Dr. Greifinger has practiced in the field of correctional medicine for the past 20 years. From 1987 through 1989 he managed the medical care at Riker's Island, New York City's Jail. Ex. 5 at ¶ 1. From 1989 until 1995 he was Chief Medical Officer for the New York State Department of Correctional Services and was accountable for the all inmate health services in a system with 68,000 inmates. *Id.* From 1995 to present he has consulted in the design, management and quality improvements programs for correctional health care systems

and has been court-appointed for the medical medical care in the jails in Philadelphia, Fulton County, Georgia, DeKalb County, Georgia and in other states. He has also monitored multiple jails and prison correctional health care systems for the Civil Rights Division of the United States Department of Justice and has consulted on correctional health care issues in 36 states. *Id.* at 2. Dr. Greifinger is an associate editor and author of one chapter in Second Edition of *Clinical Practice in Correctional Medicine,* published in 2006 and is the editor of *Public Health Behind Bars: From Prison to Communities,* a textbook published by Springer in 2007. He is familiar with the degree of care and skill ordinarily exercised by members of the medical and behavioral health professions involving care and treatment of inmates in correctional facilities as those operated by the Worcester County Sheriff, both generally and under the same or similar circumstances and surrounding conditions that involved Zygmont Lemanski. *Id.* at ¶ 6.

Dr. Greifinger concluded to a reasonable degree of medical certainty that:

"Mr. Lemanski's death was preventable. On intake, he had an eight-day lag to his first doses of medication, violating WCJ's clinical guideline for patients with HIV infection (special needs plan). This falls far below the standard of correctional health care."

Ex. 5 at ¶ 36.

"He developed symptoms of a life-threatening condition that should have been apparent to the nursing staff to administered medication to him on a daily basis. Had they paid attention to him, they would have known that he was ill and was deteriorating, as patientswith pneumonia and compromised immune systems typically do. On February 28, 2008, when Nurse Hannam read his request for care, she should have immediately referred him to a physician or to the hospital for evaluation and treatment. She failed to do that. She was inadequately trained and supervised to recognize and act on his life-threatening condition. This falls far below the standard of correctional health care."

Id. at ¶ 37.

"The Commonwealth failed to assure that health care staff was trained and supervised sufficiently to respond in a timely manner to a patient with known underlying Immunodeficiency when he complained of fever, chills, and loss of appetite."

Id. at ¶ 38.

Dr. Patnaude, as medical director and physician for the facility, failed to train and supervise staff to respond in a timely manner to a patient known to have immunodeficiency and symptoms of a life-threatening condition. Kathleen Schultz, as Dr. Patnaude's supervisor, failed to assure that staff was properly trained and supervised to respond in a timely manner to a patient with known immunodeficiency and symptoms of a life-threatening condition. These fall far below the standard of correctional health care.

Id. at ¶ 39.

The nurses who gave Mr. Lemanski his medication on February 23 – 28, 2008, failed to respond to his symptoms and his deteriorating condition. This falls far below the standard of correctional health care.

Id. at ¶ 40.

Between February 25 and 28, 2008, jail staff were aware that Mr. Lemanski was bedridden. They ignored him and did not seek care for him. Ignoring him as a practice indicates a failure of training and supervision. This falls far below the standard of correctional care.

Id. at ¶ 41.

In the case of Zygmunt Lemanski, jail staff and health care staff failed to follow their policies to provide timely access to care. This falls far below the standard of correctional health care.

Id. at ¶ 42.

The time lag from his complaint of life-threatening conditions is egregious, but not inconsistent with care given in at least one other case at WCJ (Jesus Ramos v. Former Sheriff of Worcester County, et al). By ignoring his complaints on February 27, 2008, Thomas Patnaude, Nurse Hannam and the health care staff at WCJ were deliberately indifferent to Zygmunt Lemanski's serious medical needs.

Id. at ¶ 43.

Ignoring his complaints on February 27 and 28, 2008 was the proximate cause of his death.

Id. at ¶ 44.

The documentation of a dose of medication as given, when in fact the patient was hospitalized at the time, indicates a serious disregard for patient care and for integrity. It indicates deficient nursing practice at the WCJ. This falls far below the standard of correctional health care.

Id. at ¶ 45.

The care for Zygmunt Lemanski was deficient. Defendants Commonwealth of Massachusetts, Dr. Patnaude, Ms. Schultz, and the three nurses who administered medication to him were deliberately indifferent to his serious medical needs.

Id. at ¶ 46

Standard of Inquiry to be Applied by the Tribunal

In determining whether the plaintiff's Offer of Proof raises a legitimate question of liability appropriate for judicial inquiry, "the Tribunal's task should be compared ...to the trial judge's function in ruling on a defendant's motion for directed verdict." *Little v. Rosenthal,* 376 Mass. 573, 578, 382 N.E. 2d 1037, 1041 (1978).

Under that standard, the evidence must be viewed in the light most favorable to the plaintiffs..." *Curtiss-Wright Corp. v. Edel Brown Tool and Die,* 381 Mass. 1, 3-4, 407 N.E.2d 319, 322 (1980). " ' [I]t is of no avail for the defendant[s] to argue that there was [or is] some or even much evidence which would have warranted a contrary finding by the jury.'" *Curtiss-Wright,* citing *Chase v. Roy,* 363 Mass. 402, 404, 294 N.E.2d at 336, 339 (1973). At this stage of the proceeding, even if there is conflicting evidence or differences of opinion, the plaintiff should prevail under the standard of a motion for a directed verdict if he has evidence sufficient to establish each essential element of his claims against Nurse Santiago and Nurse Deyette.

The standard that this Tribunal is bound to apply requires that all rational inferences be made in the plaintiff's favor and that all evidence favorable to the plaintiff be accepted as true. "[T]he defendant, in fact is taken to have conceded the truth" of the plaintiff's evidence. See Smith & Zobel, Rules Practice, 8 Mass. Prac. Series, p. 203.

The judge presiding of the Tribunal should instruct the members of the Tribunal, during their deliberations, upon the applicable law, to the extent that it appears to be necessary. *Kapp v. Ballantine,* 380 Mass. at 189 n.3, 402 N.E.2d at 466 n. 3.

The plaintiff's Offer of Proof prevails against the defendants if there is evidence of (1) a medical provider-patient relationship, (2) the provider's failure to conform to good medical practice, and (3) damage resulting therefrom. *Id.*, at 193. "[The] opinions expressed in the affidavit of the plaintiffs' expert, based on the facts contained in the documents [he] examined, [are] sufficient to establish the scope of the duty owed by the defendant and to warrant a finding that duty has been breached." *Delicata v. Bourlesses*, 9 Mass. App. Ct. 713, 718.

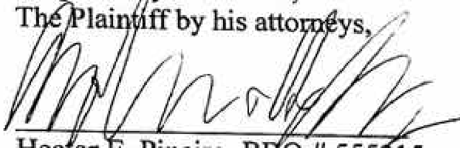
Liability of Nurses Hannam and Nurses Jane Doe 1-3

There can be no dispute that Nurses Hannam and Jane Doe 1-3 each attended Mr. Lemanski as medical professionals and that as such they each had duties to provide him with care within their qualifications. They cannot be heard to say that they were unaware of Mr. Lemanski's predicaments since medication records demonstrate they were providing daily medications through February 28, 2008. Indeed, the expert opinion of Robert Greifinger, MD, Ex. 5, provides a substantive basis for finding that each of these defendants breached his or her duty of care to Mr. Lemanski, causing a failure to provide necessary medical care that proved fatal. Dr. Greifinger concludes: "[T]he nurses giving him medication from February 23-28, 2008 ignored their patient with life threatening symptoms causing him to be bed-ridden. Custody staff ignored him as well." Ex. 5 at ¶ 31. There is, therefore, a legitimate question for judicial inquiry as to the nursing defendants' liability to Mr. Lemanski's estate in malpractice.

Conclusion

Based upon the Offer of Proof submitted by the plaintiff and in light of the standards referenced above, the plaintiff respectfully submits that there is a genuine question of liability presented as to Dr. Patnaude and the nurses involved in Mr. Lemanski's care, and the action should proceed without the imposition of bond.

Respectfully submitted,
The Plaintiff by his attorneys,



Hector E. Pineiro, BBO # 555315
Robert A. Scott, BBO # 648740
807 Main Street
Worcester, MA 01610
Tel. (508) 770-0600

DATED: June 13, 2012

Certificate of Service

I, Hector E. Pineiro, hereby certify that I caused the within document, Plaintiff's Offer of Proof, to be served as follows:

By Hand Delivery June 13, 2012:

Civil Clerk
Worcester Superior Court
225 Main Street
Worcester, MA 01608

By First Class Mail, Postage Prepaid, June 13, 2012:

Sean C. Murray, Esq.
Murray, Murray & Richards, LLP
10 Mechanic Street
Worcester, MA 01608

Michael Shear, M.D.,
32 Sawyer Lane
Harvard, MA 01451

Andrew Abdella, Esq.
General Counsel
Worcester County House of Correction
5 Paul X. Tivnan Drive
West Boylston, MA 01583

Sean E. Capplis, Esq.
Christopher M. Bracci, Esquire
Ficksman & Conley, LLP
99 North Washington Street, Suite 500
Boston, MA 02114
Via email:

ATTN: Complaint-Clerk
Mass. Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Hector E. Pineiro

8/57

M[illegible] Services Request F[illegible]m
(Formulario Para Solicitar Servicios Medicos)

Print Name: Zygmunt Lemanski I.D. #: 0062998
(Nombre) *(Numero de Identificacion)*
Date: 2/27/08 Housing Location: W.R.
(Fecha) *(Unidad / Localizacion)*

Check ONLY One Box: *(Marque el encasillado correspondiente)*
[X] Medical *(Medico)* [ ] Dental *(Dental)* [ ] Mental Health *(Salud Mental)*

Nature of Problem or Request:
(Naturaleza del problema (razon para solisitar los servicios Medicos)
Ive been in Bed Since Saturday Ive been
Coughing UP Dark Phlegm and diarhea and feel weak
and the Chills need Some antibiotic Medication
and loss of appetite.

I consent to be treated by the health staff for the condition described above.
(Yo doy consentimiento/permiso para ser atendido por los empleados de salud por las razones descritas anteriormente)

Zygmunt Lemanski
INMATE SIGNATURE
(FIRMA DEL CONFINADO)

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA
(COLOQUE EL FORMULARIO EN EL BUZON MEDICO O EN EL AREA CORRESPONDIENTE NO ESCRIBA NADA DEBAJO DE ESTA SESSION)

Date Received: 2/28/08 Triaged To: [X] Nurse [ ] PA/NA [ ] Physician [ ] Other

Triaged By: CHannam

****

Subject: Same as above
Objective: BP — P — R — T —
Assessment:
Sent to ER 2/29 admitted
Plan:

Signature: [illegible] Title: LPN Date: 3/1/08 Time:

The Commonwealth of Massachusetts

City of Worcester
Office of the City Clerk

541841

Copy of Record of Death

The below is a true copy of the original certificate placed on file in this office, and issued this date: MAR 1 8 2008

A Copy. *Attest:*

David J. Rushford
City Clerk

FOR USE BY MEDICAL EXAMINERS ONLY

The Commonwealth of Massachusetts
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

OCME CASE NUMBER: 2008-5446
REGISTERED NUMBER: 08 0650

DECEDENT

1. Decedent's Name (First, Middle, Last): ZYGMONT A. LEMANSKI
2. Sex: M
3. Date of Death: MARCH 4, 2008
4a. Place of Death (City/Town): WORCESTER
4b. County of Death: WORCESTER
4c. Hospital or Other Institution: ST VINCENT HOSPITAL
7. Social Security Number: 020-60-8073
8. If US War Veteran: NO
6b. Race: WHITE
9. Decedent's Education: 12
10a. Age – Last Birthday: 44
10b. Date of Birth: OCTOBER 14, 1963
11. Birthplace: WORCESTER, MASS.
12. Married, Never Married, Widowed or Divorced: NEVER MARRIED
13. Last Spouse: NONE
14a. Usual Occupation: LABORER
14b. Type of Business/Industry: MANUFACTURING
15a. Residence: 701 MAIN ST. WORCESTER, WORCESTER, MASS.
15b. Zip Code: 01610
16. Father: HENRYK LEMANSKI
17. State of Birth: POLAND
18. Mother: GENOWEFA CHARUBIN
19. State of Birth: POLAND

INFORMANT

20. Informant's Name: MARIO LEMANSKI
21. Mailing Address: 1 SOUTH HARLEM ST. WORCESTER, MASS 01610
22. Relationship: BROTHER

406-2008

DISPOSITION

23. Method of Immediate Disposition: Cremation
24. Funeral Service Licensee or Other Designee: PETER A. STEFAN
25. License #: 5074
26a. Place of Disposition: RURAL CEMETERY AND CREMATORY
26b. Location: WORCESTER, MASS.
27. Date of Disposition: MARCH 18, 2008
28. Name and Address of Facility or Other Designee: GRAHAM, PUTNAM & MAHONEY FUNERAL PARLORS 838 MAIN ST. - WORCESTER, MASS.

CERTIFIER

29. Part I – Cause of Death
a. Immediate Cause: PNEUMONIA — Approx. Interval: DAYS
b. Due to:
c. Due to:
d. Due to:

30. Part II – Other Significant Conditions Contributing to Death: IMMUNODEFICIENCY; HEPATITS C

31. Autopsy: Yes

34. Manner of Death: ✓ Natural

36. Medical Examiner Certification: RICHARD J [illegible]
Time of Death: 01:59 PM
37a. Date Pronounced: March 04, 2008
37b. Time Pronounced: 01:59 PM
License #: 58622
[illegible]STON, MA 02118
37c. Date Signed: March 12, 2008

PERMANENT BLACK INK ONLY

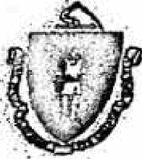
PRONOUNCEMENT FORM ON FILE

40. RN/PA/NP Pronouncement? No

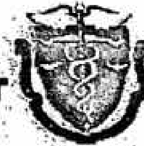
41. Date Burial Permit Issued: March 1[illegible]
WORCESTER
42. Date of Record: MARCH 17, 2008

Burial Agent Signature: Leonard J. Morse, M.D.
COMMISSIONER OF PUBLIC HEALTH
Clerk's Signature: [signature]

FORM 301-ME-010107



The Commonwealth of Massachusetts
Office of the Chief Medical Examiner



DEATH NOTIFICATION REPORT

DATE/TIME OF NOTIFICATION: 3/4/2008 3:30:00PM CASE NUMBER: 08-5446 (WOR)

OCME OFFICIAL NOTIFIED: KDELGRECO TITLE:

NOTIFICATION BY: SARGEANT LENNY SMITH TITLE: SARGEANT

AGENCY / FACILITY: WORCESTER COUNTY SHERRIFS - WORCESTER

CONTACT NUMBER(S): (774) 261-3207

DECEDENT: LEMANSKI (LAST) ZYGMUNT (FIRST) A (MIDDLE)

SEX: MALE AGE: 45 RACE/ETHNICITY: WHITE APPROXIMATE WEIGHT (LBS): 160

DATE OF BIRTH: 10/14/1963 SOCIAL SECURITY NUMBER: 020-50-8073

DECEDENT'S ADDRESS: 1 SOUTH HARLEM ST 70 Main St
WORCESTER, MA

LOCATION OF DEATH:
ICU, ST VINCENTS HOSPITAL WORCESTER WORCESTER Single

CROSS STREET(S) / MARKER(S): no children

SCENE CONTACT NUMBER(S): () -

PRONOUNCEMENT OF DEATH DATE: 3/4/2008 1:58:00PM PRONOUNCEMENT OF DEATH TIME:

PRONOUNCED BY: DR. CHENG TITLE:

MEDICAL RECORD #: DATE / TIME OF ADMISSION: 2/27/2008 12:00:00AM

PHYSICIAN(S): , MA

CONTACT NUMBER(S):

LAW ENFORCEMENT: TITLE / BADGE:

AGENCY: CONTACT NUMBER(S):

CIRCUMSTANCES OF DEATH:
INMATE WORCESTER COUNTY SHERIFF'S OFFICE; ADMIITTED WITH PNEUMONIA; HAS BEEN IN ICU SINCE

3-7-08 Dr. RJE spoke with Acting Chief Henry Nields and he believes an autopsy is not necessary

3-10-08

DEATH NOTIFICATION REPORT: Page 2

Case Number: 08-5446 (WOR)

NEXT OF KIN: MARIO LEMANSKI Gina

RELATIONSHIP: BROTHER

ADDRESS: SAME 1 South D1610 Harlem St

CONTACT NUMBER(S): (508) 797-9555 508 612-2360

NOTIFIED: YES NO PENDING PRESENT AT SCENE

NOTIFIED BY: TITLE:

ORGAN DONATION REQUEST:

REQUEST BY: TITLE:

CONTACT NUMBER(S):

NEXT OF KIN CONSENTING: RELATIONSHIP:

ORGANS REQUESTED: Organ Bank - Decline per Marlene 3-4-08

MEDICAL EXAMINER APPROVING: DATE / TIME: L Anderson

AUTOPSY: OBJECTION REQUEST AT HOSPITAL

OBJECTION / REQUEST BY: RELATIONSHIP:

CONTACT NUMBER(S):

FUNERAL HOME: Graham Putnam

FUNERAL DIRECTOR:

CONTACT NUMBER(S): 508 754-1717

INVESTIGATOR NOTIFIED: DATE / TIME NOTIFIED:

NOTIFIED BY: TITLE:

MEDICAL EXAMINER NOTIFIED: DATE / TIME NOTIFIED:

NOTIFIED BY: TITLE:

DISPOSITION / JURISDICTION: ACCEPTED YES ACCEPTED / DME DECLINED

DISPOSITION BY: Dr. Parker DATE / TIME: 3/4/08 1535

DISPOSITION NOTED BY: DelGrleco TITLE: AATI

DISTRICT MEDICAL EXAMINER NOTIFIED: DATE / TIME:

NOTIFIED BY: TITLE:

TRANSPORT NOTIFIED: Nicole Valverde DATE / TIME: 3/4/08 1542

NOTIFIED BY: Del Grleco TITLE: AATI

DATE / TIME DECEDENT ARRIVED AT OCME:

ARRIVAL NOTED BY: TITLE:

OCME #14 Revised 2005

FOR USE BY MEDICAL EXAMINERS ONLY

The Commonwealth of Massachusetts
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

OCME CASE NUMBER: 08-5446

REGISTERED NUMBER

STATE USE ONLY

1 DECEDENT – NAME FIRST MIDDLE LAST | 2 SEX | 3 DATE OF DEATH (Mo., Day, Yr.)

4a PLACE OF DEATH (City/Town) | 4b COUNTY OF DEATH | 4c HOSPITAL OR OTHER INSTITUTION – Name (if not in either, give street and number)

5 PLACE OF DEATH (Check only one) Hospital ☐Inpatient ☐ER/Outpatient ☐DOA Other ☐Nursing Home ☐Residence ☐Other (specify): | 6 SOCIAL SECURITY NUMBER | 7 IF US WAR VETERAN Specify War

8a WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify) ☐No ☐Yes | 8b RACE (specify) | 9 DECEDENT'S EDUCATION (highest grade completed) Elem-Sec (0-12) College (1-4, 5+)

DECEDENT

10a AGE – Last Birthday (Yrs) | b UNDER 1 YEAR MOS DAYS | c UNDER 1 DAY HRS MINS | 10d DATE OF BIRTH (Mo., Day, Yr.) | 11 BIRTHPLACE (City and State or Foreign Country)

12 MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED | 13 LAST SPOUSE (full name at birth or adoption) | 14a USUAL OCCUPATION (Prior, if retired) | 14b TYPE OF BUSINESS/INDUSTRY

15a RESIDENCE – No. and Street, City/Town, County, State/Country | 15b Zip Code

16 FATHER – full name at birth or adoption | 17 STATE OF BIRTH (if not in US) | 18 MOTHER – full name at birth or adoption | 19 STATE OF BIRTH (if not in US)

DISPOSITION

23 METHOD OF IMMEDIATE DISPOSITION ☐Burial ☐Cremation ☐Entombment ☐Removal from State ☐Donation ☐Other | 24 FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE | 25 LICENSE #

26a PLACE OF DISPOSITION (Name of cemetery, crematory, or other) | 26b LOCATION (City/Town/State)

27 DATE OF DISPOSITION (Mo., Day, Yr.) | 28a/b NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE

CERTIFIER

29 PART I – CAUSE OF DEATH – SEQUENTIALLY LIST IMMEDIATE CAUSE THEN ANTECEDENT CAUSES THEN UNDERLYING CAUSE | APPX INTERVAL

a. Immediate Cause: PNEUMONIA | DAYS

b. Due to

c. Due to

d. Due to

30 PART II – OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: IMMUNODEFICIENCY; HEPATITIS C

31 AUTOPSY? ☐Yes ☒No

34 MANNER OF DEATH ☒Natural ☐Accident ☐Homicide ☐Suicide ☐Could not be determined ☐Pending investigation ☐

35a DATE OF INJURY | 35b TIME OF INJURY AM PM | 35c INJURY AT WORK? ☐Yes ☐No

35d DESCRIBE HOW INJURY OCCURRED | 35e PLACE OF INJURY (Type) | 35f LOCATION/ADDRESS OF INJURY

38 MEDICAL EXAMINER CERTIFICATION (Name and Address): RICHARD EVANS 720 ALBANY ST BOSTON MA

37c APPX TIME OF DEATH: 1 57 PM

37d DATE PRONOUNCED: MARCH 4, 2008

39 LICENSE #: 58622

37e TIME PRONOUNCED: 1 57 PM

37a On the basis of examination and/or investigation, in my opinion death occurred at the time, date, and place and due to the cause(s) stated. (Signature) ☒MD ☐DO

37b DATE SIGNED: MARCH 5, 2008

40a RN/PA/NP PRONOUNCEMENT? ☐Yes ☒No | 40b IF YES, DATE | 40c IF YES, TIME AM PM | 40d NAME OF PRONOUNCER | TITLE: ☐RN ☐PA ☐NP

41 DATE BURIAL PERMIT ISSUED | 42 RECEIVED IN CITY/TOWN OF | 43 DATE OF RECORD

BURIAL AGENT SIGNATURE | CLERK'S SIGNATURE

E-010107

USE ONLY PERMANENT BLACK INK

GENERAL INSTRUCTIONS

This form is to be initiated by Massachusetts medical examiners only.

Contact the Registry of Vital Records and Statistics if you require forms or additional instructions: (617) 740-2600.

MILITARY SERVICE (IF US VETERAN)

Date entered military service: ____________ Discharge date: ____________

Service number: ____________ Rating: ____________

MEDICAL EXAMINER Complete the following items:

1. DECEDENT – NAME FIRST	MIDDLE	LAST	2. SEX	3. DATE OF DEATH (OR APPROX)
Zygmont		Lemanski	male	march 4, 2008

4a PLACE OF DEATH (CITY/TOWN)	4b COUNTY OF DEATH	4c HOSPITAL OR OTHER INSTITUTION – Name (if not in either, give street and number)
Worcester	Worcester	St Vincent Hospital

5 PLACE OF DEATH

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☐ Residence ☐ Other (specify):

Plaintiff(s)

FOR USE BY MEDICAL EXAMINERS ONLY

The Commonwealth of Massachusetts
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

2008-5446
OCME CASE NUMBER | REGISTERED NUMBER | STATE USE ONLY

DECEDENT

1 DECEDENT – NAME FIRST MIDDLE LAST | 2 SEX | 3 DATE OF DEATH (Mo., Day, Yr.)

4a PLACE OF DEATH (City/Town) | 4b COUNTY OF DEATH | 4c HOSPITAL OR OTHER INSTITUTION – Name (if not in either, give street and number)

5 PLACE OF DEATH (Check only one) Hospital ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other ☐ Nursing Home ☐ Residence ☐ Other (specify) | 6 SOCIAL SECURITY NUMBER | 7 IF US WAR VETERAN Specify War

8a WAS DECEDENT OF HISPANIC ORIGIN? (If yes, specify) ☐ No ☐ Yes | 8b RACE (specify) | 9 DECEDENT'S EDUCATION (highest grade completed) Elem/Sec (0-12) College (1-4, 5+)

10a AGE – Last Birthday (Yrs) | 10b UNDER 1 YEAR Mos Days | 10c UNDER 1 DAY Hrs Mins | 10d DATE OF BIRTH (Mo., Day, Yr.) | 11 BIRTHPLACE (City and State or Foreign Country)

12 MARRIED, NEVER MARRIED, WIDOWED OR DIVORCED | 13 LAST SPOUSE (full name at birth or adoption) | 14a USUAL OCCUPATION (Prior, if retired) | 14b TYPE OF BUSINESS/INDUSTRY

15a RESIDENCE – No. and Street, City/Town, County, State/Country | 15b Zip Code

16 FATHER – full name at birth or adoption | 17 STATE OF BIRTH (if not in US, name country) | 18 MOTHER – full name at birth or adoption | 19 STATE OF BIRTH (if not in US, name country)

INFORMANT

20 INFORMANT'S NAME | 21 MAILING ADDRESS | 22 RELATIONSHIP

DISPOSITION

23 METHOD OF IMMEDIATE DISPOSITION ☐ Burial ☐ Cremation ☐ Entombment ☐ Removal from State ☐ Donation ☐ Other | 24 FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE | 25 LICENSE #

26a PLACE OF DISPOSITION (Name of cemetery, crematory, or other) | 26b LOCATION (City/Town/State)

27 DATE OF DISPOSITION (Mo., Day, Yr.) | 28 NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE

CERTIFIER

29 PART I – CAUSE OF DEATH – SEQUENTIALLY LIST IMMEDIATE CAUSE THEN ANTECEDENT CAUSES THEN UNDERLYING CAUSE | APPX INTERVAL

a Immediate Cause PNEUMONIA | DAYS

b Due to

c Due to

d Due to

30 PART II – OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH
IMMUNODEFICIENCY; HEPATITIS C

31 AUTOPSY? ☐ Yes ☐ No Yes

34 MANNER OF DEATH ✔ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Could not be determined ☐ Pending Investigation | 35a DATE OF INJURY | 35b TIME OF INJURY AM PM | 35c INJURY AT WORK? ☐ Yes ☐ No

35d DESCRIBE HOW INJURY OCCURRED | 35e PLACE OF INJURY (Type)

35f LOCATION/ADDRESS OF INJURY

36 MEDICAL EXAMINER CERTIFICATION | 37c APPX TIME OF DEATH 01:59 PM | 37d DATE PRONOUNCED March 04, 2008

38 LICENSE # 58622 | 37e TIME PRONOUNCED 01:59 PM AM PM

(Name and Address) RICHARD J. EVANS, MD 720 ALBANY STREET, BOSTON, MA 02118

37a On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated.
(Signature) ☐ MD ☐ DO | 37b DATE SIGNED March 12, 2008

40a RN/PA/NP PRONOUNCEMENT? ☐ Yes ☐ No No | 40b IF YES, DATE | 40c IF YES, TIME AM PM | 40d NAME OF PRONOUNCER | TITLE: ☐ RN ☐ PA ☐ NP

41 DATE BURIAL PERMIT ISSUED | 42 RECEIVED IN CITY/TOWN OF | 43 DATE OF RECORD

BURIAL AGENT SIGNATURE | CLERK'S SIGNATURE

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ROBERT B. GREIFINGER, M.D.

May 4, 2011

Hector Piniero, Esq.,
807 Main Street
Worcester, MA 01610

Re: Zygmunt Lemanski

Dear Mr. Piniero:

This is a report on the medical care provided to Zygmunt Lemanski from November 7, 2007 to February 29, 2008 at the Worcester County, MA Jail and House of Correction (WCJ). My opinions are based on the materials I have reviewed and are expressed to a reasonable degree of medical certainty. You have indicated to me that you will forward WCJ Policy 932.20A regarding care for patients with HIV and other communicable disease, HIV information sheets, and perhaps additional materials received in discovery. In that case, I reserve the right to update or supplement my report.

Background

1. I am a physician licensed in New York and Pennsylvania. I have been a physician since 1971. I have practiced in the field of correctional medicine for the past 20 years. From 1987 to 1989, I managed the medical care at Rikers Island, New York City's jail. From 1989 until 1995, I was the Chief Medical Officer for the New York State Department of Correctional Services. Directing a staff of 1,100 and a budget of $140 million, I was accountable for all inmate health services in a system with 68,000 inmates.

2. From 1995 until the present, I have consulted in the design, management, and quality improvement programs for correctional health care systems. As part of this work, I was a court-appointed monitor for the medical care in the jails in Philadelphia, Fulton County, Georgia, DeKalb County, Georgia, and Albuquerque, New Mexico. Until recently, I was the court monitor for the Alabama prison for women. I currently monitor the medical care in the New Mexico juvenile system. I monitor multiple jails and prison correctional health care systems for the Civil Rights Division of the United States Department of Justice. I am a consultant to the Office of Civil Rights and Civil Liberties of the Department of Homeland Security. I have consulted on correctional health care issues in 36 states.

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Mario Lemanski Administrator, Zygmont Lemanski Estate, Plaintiff(s)

vs

3. As the principal investigator for a study and report issued by the National Commission on Correctional Health Care in 2002, I made recommendations to Congress on identifying public health opportunities for soon-to-be-released inmates. In addition, I am a consultant on public health issues in corrections for the Centers for Disease Control and Prevention. I have written numerous articles in the field and I am an associate editor and author of one chapter in the Second Edition of *Clinical Practice in Correctional Medicine*, published in 2006. I am the editor of *Public Health Behind Bars: From Prisons to Communities*, a textbook published by Springer in 2007.
4. I am Professor (Adjunct) of Health and Criminal Justice and Distinguished Research Fellow at the John Jay College of Criminal Justice.
5. A more detailed listing of my experience in correctional health care, my participation in the development of national correctional policy and standards, my experiences as a consultant and expert witness, and a list of my publications are included in my curriculum vitae, which is attached. I have also attached my fees for this case and a list of testimony within the past four years.
6. I am familiar with that degree of care and skill ordinarily exercised by members of the medical and behavioral health professions involving the care and treatment of inmates and pre-trial detainees, in correctional facilities such as those operated by the Worcester County Sheriff, both generally and under the same or similar circumstances and surrounding conditions that involved Zygmunt Lemanski, as is reflected in the records that I have reviewed.

Materials Reviewed

7. Complaint;
8. Lemanski medical records;
9. Harry Soba Complaint;
10. Thomas Patnaude deposition transcript, dated September 10, 2008;
11. WCJ policies 926, 932.04, through 932.08;
12. Mortality reviews;
13. Soba photos (2);
14. Lemanski death certificate;
15. Medication administration record;
16. Chief Medical Examiner file;
17. Complaint, dated February 24, 2011; and
18. Medico-legal report of Richard Sullivan, PhD, MD, in connection with care provided to Harry Soba;

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19. Medical records from St. Vincent's Hospital;

20. Paramedic notes from American Medical Response.

Findings

21. Zygmunt Lemanski was a 45-year-old man infected with HIV and hepatitis, A, B, and C (Bates pp. 1-3). These are serious medical needs.[1] He received medical care in the community from the Family Health Center and the Homeless Outreach and Advocacy Project in Worcester, MA (Bates pp. 11-12).

22. Mr. Lemanski was incarcerated at the WCJ on November 7, 2007, when he reported his history of being on psychotropic medication and medication for HIV infection (Bates pp. 13-16). His weight on intake was recorded as 160 pounds. He apparently refused a complete blood count and serologic test for syphilis, but there is no documentation in the medical record that he was counseled and no signed refusal form.

23. On November 7, 2007, he was begun on a four-day regimen of tranxene, an antianxiety medication, and donnatol, a medication used for gastrointestinal upset (Bates p. 18).

24. Special needs plans were written on November 8, 2007, with plans to start him on Atripla, a medication for HIV infection (Bates pp. 24-26). In a progress note, dated November 8, 2007, Nurse Lenault documented that he had HIV and hepatitis C since 2001 (Bates p. 19). Nurse Lenault noted his recent visit for medical care in the community and she noted his laboratory results. Nurse Lenault noted that a release of information had been faxed and she referred Mr. Lemanski to the physician.

25. On November 9, 2007, Mr. Lemanski complained of loose stools and gastric distress (Bates p. 20). Immodium was prescribed, as well as Kool Aid packs for hydration and crackers by a practitioner, whose signature is illegible (Bates pp. 17, 20).

26. In a note dated November 13, 2007, Nurse Lenault noted that there was no medical information from Mr. Lemanski's community provider, but she did note laboratory values acquired by telephone. Dr. Eric Garcia saw Mr. Lemanski on November 15, 2007 and Atripla was ordered for his HIV infection. He received the Atripla daily (medication administration record). There was a seven-day lag from the special needs plan for initiation of medication, which requires beginning medications for HIV within 96 hours of booking and the date of his first dose, although his medications were noted to have been verified on November 8, 2007 (Bates pp. 24-26).

27. Mr. Lemanski was also seen at Great Brook Valley Health Center on November 15, 2007, where Atripla was ordered (Bates pp. 29-32).

28. Mr. Lemanski received influenza vaccine on November 19, 2007.

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[1] A serious medical need is a valid health condition that, without timely medical intervention,

29. According to the medical records, Mr. Lemanski refused a physical examination on February 19, 2008, but there is no note regarding counseling and no signed refusal form in the record (Bates p. 27).

30. On Wednesday, February 27, 2008, Mr. Lemanski filled out a request for care complaining of decreased appetite, cough with dark phlegm, weakness and chills for several days. These are urgent serious medical needs in any patient, especially one with a compromised immune system, such as Mr. Lemanski. The slip was acknowledged the next day by C. Hannam, LPN, but despite his urgent medical need he was not seen that day, nor referred to a physician, and not scheduled for care (Bates p. 36).

31. The nurses giving him medication from February 23 – 28, 2008 ignored their patient with his life-threatening symptoms causing him to be bed-ridden. Custody staff ignored him as well.

32. On Friday, February 29, 2008, an ambulance was summoned for Mr. Lemanski when Nurse Practitioner Cheryl Carter-Piper found him with have a pulse of 137 beats per minute, dehydration, and an oxygen saturation of 91% (low) (Bates pp. 27, 38). The ambulance arrived at 9:02 A.M. and delivered him to the emergency department of St. Vincent's Hospital at 9:31 A.M. (Bates p. 46).

33. The notes from American Medical Response indicate that he had flu-like symptoms for one week and hemoptysis, nausea, vomiting and diarrhea for approximately three days. They also show that on the day of transfer he had been treated by prison staff with ibuprofen and Compazine and that he was found sitting in his wheelchair. An electrocardiogram performed by them showed sinus tachycardia at 110 beats per minute with ectopic beats. His oxygen saturation was only 90% in room air. Prison staff reported a body temperature of 100.5 F. These records also show that he was being followed up for dehydration r/o pneumonia.

34. Mr. Lemanski was hospitalized at St. Vincent's Hospital where, despite intensive care and intervention, he died of pneumonia related to immunodeficiency and hepatitis C, on March 4, 2008 (Bates pp. 39, 40, 43-72). On admission to the hospital, he was noted to have had hemoptysis (blood in his sputum) for three days (Bates pp. 46-47).

35. After he was sent to the hospital, a nurse documented giving him medication at a time he was not there.

Opinions and Conclusions

36. Mr. Lemanski's death was preventable. On intake, he had an eight-day lag to his first doses of medication, violating WCJ's clinical guideline for patients with HIV infection (special needs plan). This falls far below the standard of correctional health care.

37. He developed symptoms of a life-threatening condition that should have been apparent to the nursing staff to administered medication to him on a daily basis. Had they paid attention to him, they would have known that he was ill and was deteriorating, as patients

with pneumonia and compromised immune systems typically do. On February 28, 2008, when Nurse Hannam read his request for care, she should have immediately referred him to a physician or to the hospital for evaluation and treatment. She failed to do that. She was inadequately trained and supervised to recognize and act on his life-threatening condition. This falls far below the standard of correctional health care.

38. The Commonwealth failed to assure that health care staff was trained and supervised sufficiently to respond in a timely manner to a patient with known underlying immunodeficiency when he complained of fever, chills, and loss of appetite.

39. Dr. Patnaude, as medical director and physician for the facility, failed to train and supervise staff to respond in a timely manner to a patient known to have immunodeficiency and symptoms of a life-threatening condition. Kathleen Schultz, as Dr. Patnaude's supervisor, failed to assure that staff was properly trained and supervised to respond in a timely manner to a patient with known immunodeficiency and symptoms of a life-threatening condition. These fall far below the standard of correctional health care.

40. The nurses who gave Mr. Lemanski his medication on February 23 – 28, 2008, failed to respond to his symptoms and his deteriorating condition. This falls far below the standard of correctional health care.

41. Between February 25 and 28, 2008, jail staff were aware that Mr. Lemanski was bed-ridden. They ignored him and did not seek care for him. Ignoring him as a practice indicates a failure of training and supervision. This falls far below the standard of correctional care.

42. In the case of Zygmunt Lemanski, jail staff and health care staff failed to follow their policies to provide timely access to care. This falls far below the standard of correctional health care.

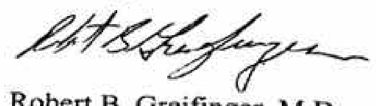
43. The time lag from his complaint of life-threatening conditions is egregious, but not inconsistent with care given in at least one other case at WCJ (Jesus Ramos v. Former Sheriff of Worcester County, et al). By ignoring his complaints on February 27, 2008, Thomas Patnaude, Nurse Hannam and the health care staff at WCJ were deliberately indifferent to Zygmunt Lemanski's serious medical needs.

44. Ignoring his complaints on February 27 and 28, 2008 was the proximate cause of his death.

45. The documentation of a dose of medication as given, when in fact the patient was hospitalized at the time, indicates a serious disregard for patient care and for integrity. It indicates deficient nursing practice at the WCJ. This falls far below the standard of correctional health care.

46. The care for Zygmunt Lemanski was deficient. Defendants Commonwealth of Massachusetts, Dr. Patnaude, Ms. Schultz, and the three nurses who administered medication to him were deliberately indifferent to his serious medical needs.

Sincerely,



Robert B. Greifinger, M.D.

Attachments: Resume, list of publications, fees, and list of testimony