



**King County**

**King County Ombudsman's Office**

**FINDINGS AND RECOMMENDATIONS**

Respondent: Public Health—Seattle & King County,  
Jail Health Services  
Ombudsman Case No. 2007-01436  
April 15, 2008

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## EXECUTIVE SUMMARY

Lynn Dale Iszley was booked into the King County Correctional Facility on July 16, 2007, and soon began exhibiting symptoms consistent with alcohol and heroin withdrawal. Mr. Iszley's symptoms worsened in the early morning of July 18, and his condition deteriorated until his death in the early morning of July 19. The cause of death was acute peritonitis<sup>1</sup> due to a perforated ulcer.

Corrections officers, who are employed by the Department of Adult and Juvenile Detention, appear to have acted appropriately and commendably by responding to Mr. Iszley's condition in a timely and professional manner.

However, based on our independent review of the record and on the opinion of our expert consultants who reviewed Mr. Iszley's medical records, we find that Jail Health Services (JHS), a division of Public Health—Seattle & King County (DPH), failed to provide Mr. Iszley with the medical care he needed. Based on his symptoms, JHS providers should have, but failed to, recognize that Mr. Iszley was suffering from an acute illness other than withdrawal. Mr. Iszley should have received intravenous fluids and been transported to a hospital emergency room on July 18, 2007. Mr. Iszley might have survived had JHS taken these actions.

This Office transmitted its preliminary findings to DPH along with recommendations for improvements. We recommended that JHS review the actions of each JHS employee involved in Mr. Iszley's care, evaluate whether discipline is appropriate, and take steps to ensure that the mistakes made in Mr. Iszley's care are not repeated. We provided DPH with an opportunity to respond to our preliminary findings and recommendations. DPH elected not to respond to our findings, but responded to our recommendations by describing JHS' ongoing efforts to improve its systems of care.

## ALLEGATION

At the request of the deceased's next of kin, this Office investigated whether Lynn Dale Iszley received adequate medical care while he was in custody at the King County Correctional Facility.

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<sup>1</sup> Peritonitis is an infection of the lining of the inner abdominal wall.  
<http://www.mayoclinic.com/health/peritonitis/DS00990>, accessed online, March 13, 2008.

## INVESTIGATIVE AUTHORITY

The King County Ombudsman's Office was created by the voters of King County in the County Home Rule Charter of 1968 and operates as an independent office within the legislative branch of King County government. The Office is authorized to investigate the administrative conduct of King County agencies in response to complaints received from the public, or on its own initiative.<sup>2</sup> The Office promotes public confidence in King County government by responding to issues in an impartial, efficient and timely manner.

## PROCEDURAL HISTORY

This investigation commenced on July 19, 2007, when this Office received a telephone call from a concerned King County resident regarding an alleged inmate death that morning at the King County Correctional Facility (KCCF).<sup>3</sup> After confirming the death of inmate Lynn Dale Iszley, and the cause of death, this Office sought and obtained relevant investigative records from the Seattle Police Department. Following an internal investigation by the King County Department of Adult & Juvenile Detention (DAJD), this Office obtained and reviewed the complete, unredacted DAJD investigative file, which contains command reviews of the incident, officer reports, deck logs, and other relevant records.

This Office met with Mr. Iszley's mother, who filed a formal complaint seeking an evaluation of the medical care her son received at KCCF. Mr. Iszley's mother also signed a release of information form allowing this Office full access to Mr. Iszley's medical records from Harborview Medical Center (HMC), Jail Health Services (JHS), and the King County Medical Examiner's Office. Mr. Iszley's mother also signed an Ombudsman complaint form seeking an evaluation of the medical care her son received at KCCF. After reviewing all of the above-noted records, this Office sought expert

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<sup>2</sup> King County Code (KCC) section 2.52. In addition, the Ombudsman's Office investigates alleged violations of the King County Employee Code of Ethics (KCC 3.04) and the Lobbyist Disclosure code (KCC 1.07), and reports of improper governmental action under the Whistleblower Protection Code (KCC 3.42).

<sup>3</sup> The telephone call was from the mother of a King County Correctional Facility (KCCF) inmate who said her son told her another inmate, whom corrections officers had allegedly assaulted the night before, had died that morning. This Office relayed these allegations to KCCF staff members, the Seattle Police Department (SPD), and the King County Medical Examiner's Office. Later on July 19, 2007, this Office spoke with the pathologist who performed the autopsy on Lynn Dale Iszley. The pathologist stated that Mr. Iszley had died a natural death and that there is no evidence to support the allegation that Mr. Iszley had been assaulted. SPD's investigation supports that conclusion. This Office's independent review of the record in this case, including medical records, inmate witness statements, and corrections officers' reports, also supports that conclusion.

review of Mr. Iszley's medical records from Dean Dellinger, M.D., and Lori Kohler, M.D. Their reports are attached to this report as Appendices A and B, respectively.

Based on Dr. Dellinger's report, which was completed on February 22, 2008, this Office transmitted preliminary findings to the director of Public Health—Seattle and King County (DPH), on March 14, 2008, and requested a response by April 11, 2008. Dr. Kohler completed her report on March 25, 2008, and this Office transmitted it to DPH that same day. As Dr. Kohler's findings are substantially consistent with Dr. Dellinger's, this Office requested that DPH honor the April 11 reply deadline. This Office received DPH's response to our preliminary findings on April 11, 2008. These final Findings and Recommendations follow.

Senior Deputy Ombudsman Jon Stier led this Office's investigation into Mr. Iszley's death, with assistance and oversight from King County Ombudsman Amy Calderwood, and with assistance from other Ombudsman's Office staff members.

### **SUMMARY OF KEY FACTS**

This Office has produced a chronology of events which is attached to this report as Appendix A. We provide the following summary for the reader's convenience.

Mr. Iszley was arrested on the afternoon of July 15, 2007. Before he was booked, a JHS employee conducted a medical screening of Mr. Iszley. The screening noted bleeding on Mr. Iszley's right wrist, and skin sores on his buttocks and legs. Booking was deferred, and Mr. Iszley was taken to HMC, where he was diagnosed with abscesses and prescribed Bactrim, an antibiotic. Mr. Iszley was then transported back to KCCF and booked very early in the morning on July 16, 2007.

Mr. Iszley told JHS staff that he used heroin and alcohol daily. On the evening of July 16, Mr. Iszley appeared to be experiencing opiate withdrawals, and had been vomiting. JHS staff provided him with medication intended to help stop the vomiting.

A JHS physician evaluated Mr. Iszley on the morning of July 17. Mr. Iszley had open and scabbed wounds on his right buttock and calf. The physician diagnosed Mr. Iszley with alcohol and opiate withdrawal, and ordered antibiotics for the open wounds.

In the early morning of July 18, Mr. Iszley pressed the emergency call button in his housing unit. A corrections officer responded, and found Mr. Iszley curled on his bunk. Mr. Iszley said, "I think my liver exploded," and reported "kicking alcohol." A corrections officer made a medical status II call,<sup>4</sup> and a JHS staff member soon arrived. Mr. Iszley

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<sup>4</sup> A Medical Status II call is appropriate for a "[p]otential life-endangering medical problem and/or inmate unable to be moved". JHS Operating Procedure J-E-08(3).

complained of abdominal pain "like never before," including pain when lying on his right side. He was sweating and writhing. After examining Mr. Iszley, the responding JHS staff member cleared him to remain in his housing unit.

Later on the morning of July 18, a nurse was called to Mr. Iszley's housing unit. The nurse found Mr. Iszley lying on the floor, sweating, with tremors, and complaining of vomiting, nausea, and inability to eat or drink. The nurse notified a JHS physician, who ordered Mr. Iszley transported to the jail clinic. The physician's notes, entered later that morning, record that Mr. Iszley's symptoms were increasing, and that Mr. Iszley was dehydrated. The physician ordered vital signs three times daily, rehydration fluids, and observation in detox housing within the jail infirmary. Mr. Iszley's records show a low blood-oxygen saturation rate in the morning and low blood pressure in the afternoon. His infirmary admission note states that he denied voiding his bladder since the morning of July 15. He was administered 400mg of Motrin.

Mr. Iszley complained of rib pain, chest pain, and pain in general during the night of July 18 and/or early morning of July 19. During medication pass on the early morning of July 19, Mr. Iszley stumbled when he tried to stand. Two other inmates helped him to the floor. Mr. Iszley did not eat his breakfast.

Shortly after 7:00 a.m. on July 19, a corrections officer attempted to wake Mr. Iszley, but he did not respond. The officer called a nurse, who also could not wake Mr. Iszley. The officer made a medical status III call.<sup>5</sup> JHS personnel arrived and attempted to revive Mr. Iszley. Mr. Iszley was declared deceased at 7:50 a.m. An autopsy conducted by the King County Medical Examiner's Office concluded that Mr. Iszley died of acute peritonitis due to perforated duodenal ulcer.<sup>6</sup>

## EXPERT REVIEW

This Office obtained review of Mr. Iszley's medical records from two physicians who practice and teach outside of the Seattle area. Each possesses experience and expertise specifically relevant to Mr. Iszley's medical care.

Dean Dellinger, M.D., was certified by the American Board of Internal Medicine in 1995, and serves as an Assistant Professor of Medicine in the Internal Medicine Division of Oregon Health and Science University in Portland, Oregon. Lori S. Kohler, M.D., an

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<sup>5</sup> A Medical Status III call is appropriate for a "[c]ritical, life-threatening emergency." JHS Operating Procedure J-E—8(4).

<sup>6</sup> Mr. Iszley's mother, and a friend of Mr. Iszley's interviewed by this Office, stated that Mr. Iszley knew he was suffering from an ulcer, and had obtained treatment for it from medical providers. However, Mr. Iszley's records do not contain any indication that he told corrections staff or jail health staff about the ulcer.

expert in correctional health, is Professor of Clinical Family and Community Medicine at the University of California, San Francisco, and serves as Director of the Correctional Medicine Consultation Network.<sup>7</sup>

Prior to this case, this Office had no relationship with either Dr. Dellinger or Dr. Kohler, and neither of them knew that the other was reviewing Mr. Iszley's medical records. Dr. Dellinger's report is attached to this report as Appendix B. Dr. Kohler's report is attached as Appendix C.

Overall, Dr. Dellinger identified the following problems with the care that JHS provided to Mr. Iszley:

- JHS staff initially failed to document that they continued Mr. Iszley's antibiotic prescribed by HMC.
- Monitoring vital signs twice per day was not consistent with hospital practice.
- Documentation of patient history was limited.
- Abdominal pain and lack of voiding were not specifically noted as negatives or positives in MD history.
- Chart contains no documentation of evening vital signs.
- More careful evaluation of hydration status would have been appropriate.
- Full orthostatic vital signs were not taken during July 18 medical status II call.
- Low oxygen saturation level noted on the morning of July 18, if accurate, required more urgent evaluation.
- Tachycardia (heart rate above 100 beats per minute) such as that experienced by Mr. Iszley is associated with acute illness as well as dehydration and withdrawal, but JHS did not transport Mr. Iszley to the emergency room.

Dr. Dellinger stated his opinion that "the patient should have been transferred to the emergency room by mid afternoon of 7/18/08 (sic)". In this regard, Dr. Dellinger wrote,

In Mr. Iszley's case the severity of the pain and the fact that he localized his abdominal pain should have raised concerns earlier for another source of his abdominal pain after his evaluation early 7/18/07. Neither of [the JHS physician's] evaluations on the 18<sup>th</sup> listed any alternative causes for the abdominal pain, such as gastritis, ulcer, pancreatitis—all of which are more likely in the setting of alcohol abuse.

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<sup>7</sup> The Correctional Medicine Consultation Network (CMCN) is a program of the Department of Family and Community Medicine at the University of California, San Francisco, in collaboration with the California Department of Corrections and Rehabilitation (CDCR). CMCN's mission is to improve the quality of healthcare, the dignity, and the quality of life of inmates in California prisons, through, among other things, peer education and professional development for CDCR clinicians, assessment of care and consultation for high risk patients, and evaluation of medical care delivery systems. <http://www.ucsf.edu/cmcn/index.html>, accessed online, April 7, 2008.

Regarding Mr. Iszley's apparent worsening dehydration on the morning of July 18, Dr. Dellinger noted that Mr. Iszley's records reflect that full orthostatic vital signs<sup>8</sup> were not taken during the medical status II call. This was not consistent with the relevant standard of care, according to Dr. Dellinger. He further stated that Mr. Iszley's report of not voiding his bladder for three days,

would suggest severe dehydration and possible renal failure. These signs of dehydration, and especially the lack of voiding in the face of 2 days of antiemetics<sup>9</sup> should have warranted—at the least—IV hydration and closer monitoring. . . . [Mr. Iszley's] low BPs and persistent tachycardia<sup>10</sup> are concerning for worsening dehydration and other more acute illness. . . . the standard of care would have been starting IV fluids at 9am or at the latest 1pm—and had vital signs repeated every 2-3 hours.

While Dr. Dellinger could not identify the exact time when Mr. Iszley's ulcer perforated, "the most likely time would have been early on the morning of the 17<sup>th</sup> [when he] complained of the most severe abdominal pain." Dr. Dellinger concluded that while Mr. Iszley's substance abuse history would have reduced his chance of survival, "Mr. Iszley's chance of survival would have been significantly improved if he had been diagnosed with perforation within 12-24 hours of the event" and Mr. Iszley "likely would have benefited" from transfer to a hospital emergency room on July 18.

Dr. Kohler's findings are consistent with those of Dr. Dellinger. Dr. Kohler wrote,

It is obvious from reading the records that his [Mr. Iszley's] was not a case of the usual withdrawal syndromes from etoh [alcohol] and heroin. . . . This patient had an 'acute abdomen' and should have been transferred to an emergency room where prompt surgical evaluation most likely would have saved his life. JHS did not respond appropriately to multiple signs and symptoms that should have prompted immediate transfer to a higher level of care.

Dr. Kohler's report specifically criticized JHS for keeping incomplete patient records, failing to perform various tests indicated by Mr. Iszley's symptoms, and failing to take appropriate action based on the information JHS had.

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<sup>8</sup> Orthostatic vital signs are "serial measurements of blood pressure and pulse taken with the patient in supine, sitting, and standing positions . . ." <http://enw.org/Research-Orthostatic.htm>, accessed online, March 12, 2008.

<sup>9</sup> Antiemetics are drugs that prevent vomiting. <http://www.britannica.com/eb/topic-27951/antiemetic>, accessed online, March 13, 2008.

<sup>10</sup> Tachycardia is a heart rate above 100 beats per minute. <http://www.mayoclinic.com/health/tachycardia/DS00929>, accessed online, March 13, 2008.

## **OMBUDSMAN FINDINGS**

This office makes findings based on a preponderance of the evidence standard of proof. A preponderance of the evidence means we are persuaded, considering all the available evidence, that the facts at issue are more likely true than not true.

While corrections officers appear to have responded promptly and appropriately to Mr. Iszley's medical condition, based on our review of the complete DAJD investigative file, Mr. Iszley's medical and autopsy records, and the analyses provided by Drs. Dellinger and Kohler, this Office finds that JHS failed to provide Mr. Iszley with the medical care he needed while he was in custody at KCCF. Mr. Iszley was observed suffering from severe localized abdominal pain and other intense symptoms on the morning of July 18, 2007, and yet he was initially cleared to remain in his general population housing unit. He was later transferred to the infirmary, but the anti-vomiting medications and attempts at oral hydration were not working. Moreover, Mr. Iszley's vital signs, including persistent tachycardia, and his overall deteriorating condition, indicated the possibility of acute illness. JHS should have transferred Mr. Iszley to the emergency room on July 18. JHS's failure to do so may have contributed to Mr. Iszley's death.

We note that symptoms of perforated ulcer and peritonitis may overlap with those of opiate and alcohol withdrawal, thereby complicating diagnosis in cases such as Mr. Iszley's. Lay observers might initially assume that withdrawal symptoms would fully mask the symptoms of acute illness present here. However, as Dr. Dellinger's and Dr. Kohler's reviews establish, professionally-trained medical providers should have recognized and acted on Mr. Iszley's symptoms that indicated the presence of illness more acute than withdrawal.

## **RECOMMENDATIONS AND CONCLUSION**

While this Office's investigation focused on determining the appropriateness of the medical care that JHS provided to Mr. Iszley, in our preliminary report to DPH we also recommended that in response to Mr. Iszley's death, JHS should review the actions of each JHS employee involved with Mr. Iszley's care, and evaluate whether to discipline employees found to have violated relevant medical standards of care, or those who otherwise deviated from applicable protocols.

We also recommended that JHS undertake a comprehensive review of how it responds to inmates in severe pain, how it determines whether to transport patients to the emergency room, and how it evaluates patients for acute illness when those patients suffer from complicating symptoms such as those associated with alcohol and heroin withdrawal. We further recommended that JHS assess its basic care protocols, such as documentation of continued dosing of medicines prescribed by HMC providers, and the

