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To: Oshkosh Police Department

From: Atty. Eric Sparr

Date: May 16, 2018

Re: Winnebago Mental Health death investigation from OPD 17-37505

Thank for your request to review this matter regarding the appropriateness of criminal charges against the doctor contracted by Winnebago Mental Health Institute that personally evaluated the now deceased patient in this incident. I have reviewed information provided from the Oshkosh Police Department investigation, along with reports obtained from Winnebago Mental Health Institute concerning their own investigation into this same incident. Based on this information, criminal charges are not warranted against the doctor.

Summary of Facts

The patient, a 58 year old man from Racine County, was admitted to the Winnebago Mental Health Institute ("WMHI") on October 14, 2017 under a Chapter 51

commitment. During his time at WMHI, it was reported that the patient was defiant with staff and purposefully falling out of bed, onto the floor. Staff moved the patient's mattress to the ground after they were unable to get him to stop intentionally falling. Staff members were aware the patient had a history of self-harm, including falling from significant heights, burning himself, overdosing on medication, cutting himself, and attempting to drown himself. Staff members were also aware that the patient indicated he heard voices that he believed were the devil. During the patient's initial assessment at WMHI on October 14, 2017, the assessing doctor noted that the patient appeared very sleepy and was unable to answer questions. One nurse noted that on October 15, 2017, the patient struck a staff member with his fist. Prior to 10:00 AM on October 15, 2017, the patient caused himself to fall numerous times. Staff members stated that the patient did not say anything during these falls, and after a fall, he would stay on the ground for a period of time.

Staff reported that on October 15, 2017, around 10:00 AM, the patient stood straight up and fell backwards, hitting his head on the ground. One patient care technician ("PCT") described the patient's immediate reaction to this fall as being different from the others. For the remainder of the day, he appeared to be unresponsive, sleeping in the day room until he was moved to his bedroom around 10:00 PM. Staff members reported that the patient's vitals were normal, that he was snoring lightly, and vomited or expelled a pink mucus once. There were two occasions on October 15, 2017, that the doctor who is the subject of this memorandum made contact with the patient for assessment purposes. The doctor was summoned for the first of those assessments approximately four hours after the fall. The doctor reported

that no bruises, bumps, swelling, or injuries related to the fall were visible. On each occasion, the doctor concluded that the patient did not need to be sent for outside medical attention.

At the time of the first check, the doctor inquired as to whether the patient was on sleeping medications, and learned that he was. The doctor requested for the patient to be moved onto a mattress, as the patient had been laying on the floor. The doctor did not document his evaluations of the patient. The doctor reported that the information he was given regarding potential vomiting was understated relative to the information that was later provided by some staff members. During the investigation, it was described by some staff members as vomiting, but by others as some pink mucus coming from the patient's mouth. The doctor explained that if there had been true vomiting, the patient should have been removed from the facility. Based on the fact that the patient had not been removed, and that the reports given to him did not give him the impression that there had been true vomiting, his evaluation went differently than it otherwise may have. The doctor explained that while his opinion at that time was that the issue was behavioral, he had also considered the possibility that something medical was going on. He ultimately discounted that concern based on what he had observed and the information provided to him.

One nurse reported that she suggested the patient be taken to the emergency room, but that the doctor then gave her a "lecture" about wasting taxpayer money. Another nurse and a PCT confirmed portions of the conversation. The doctor denied recollection of that conversation. Multiple nurses indicated that the patient had been

urinating on himself, which was something he did not typically do. The doctor reported that this had not happened prior to either of the times he assessed the patient.

Night shift nurses later became concerned, based on the lack of documentation, that neurochecks were not completed during the first or second shifts. The doctor indicated later that he had conducted the checks, and did not document them because the results were normal. A nurse also indicated that she had done a neurocheck, but also did not document it. Due to the absence of documented neurochecks, the night shift nurse initiated neurochecks. The first two checks were normal. On the third check, the nurse observed that there was a change in the patient's condition. Nurses became concerned because the patient's pupils were not equal in size and contacted another doctor. This other doctor, who is not the subject of this memorandum, ultimately made the decision to have the patient sent to the emergency room.

The doctor who is the subject of this memorandum indicated that he had informed one of the nurses that the patient should be sent to the emergency room if the patient did not awaken by 8:00 PM on October 15, 2017. No nurses recalled this directive. The patient did not awaken by 8:00 PM, but was not taken to the emergency room at that point.

CT scans were completed while at the emergency room and the scans revealed a subdural hematoma. An emergency craniotomy was performed and the patient was admitted to the ICU at Mercy Medical Center. The patient never regained consciousness and was pronounced dead at 6:42 AM on November 1, 2017.

One PCT recalled an interaction with the patient around 4:30 PM on October 15, 2017, during the time when other staff members reported that the patient had been

unresponsive in the day room for a long period of time. The PCT recalled that the patient had urinated on himself. The PCT asked the patient whether he wanted to eat, and the patient responded that he did not. The same PCT reports that around 10:00 PM, the PCT assisted in changing the patient's clothes. The PCT described the patient being physically cooperative by moving his arms in an out of shirts, and described the patient covering his genitals while he was nude. No other staff members report responsiveness from the patient during this time period.

Multiple PCTs and nurses expressed concern after the death that the patient should have been sent for outside medical attention far sooner than he was. During the incident, however, the doctor, along with numerous nurses and PCTs, felt that the issue was behavioral rather than medical.

Potential criminal charges

Wis. Stat. § 940.295(3)(a)3 makes it a crime to negligently abuse a patient or to neglect a patient. Given the facts of this case, other charges would require additional proof, so the analysis related to potential criminal charges will focus on this section. An employee acting "in the scope of his or her practice or employment who commits an act or omission of mere inefficiency, unsatisfactory conduct, or failure in good performance as the result of inability, incapacity, inadvertency, ordinary negligence, or good faith error in judgment or discretion" is not subject to criminal charges under this section. Wis. Stat. § 940.295(3)(am). An individual that violates Wis. Stat. § 940.295(3)(a)3 where the act or omission results in death could face a Class D felony.

In the context of negligent abuse of a patient, Wis. JI-Criminal 1271 and 925 require proof that a defendant negligently abused a patient under circumstances likely to cause death or great bodily harm, that the risk of death or great bodily harm was unreasonable and substantial, and that the defendant should have been aware that his conduct created such a risk. If charged with negligently causing death, the State would further have to prove that such abuse was a substantial factor in the death.

With regard to the potential charge of neglecting a patient, Wis. JI-Criminal 1272 requires proof that a defendant neglected a patient under circumstances likely to cause death or bodily harm. Like the other potential charge, if a charge of neglect causing death was issued, the State would further have to prove that neglect was a substantial factor in the death. "Neglect" is defined as creating significant risk to the physical or mental health of an individual by the failure of a caregiver to maintain adequate care, services, or supervision for that individual.

Proof of either charge would be required beyond a reasonable doubt.

Analysis

This case involves uncertainty regarding precisely what information the doctor had at the times he checked the patient. Some of this uncertainty could have been resolved by appropriate documentation of the doctor's and the nurses' interactions with the patient. The doctor concedes that he did not document his contacts, and that he should have done so. However, failure to document does not itself create a risk of death or bodily harm, nor does it necessarily follow that the doctor's treatment of the patient was abusive or criminally negligent.

Institutional protocol dictates that neurochecks should have been completed during the time period the doctor was in contact with the patient. Based on WMHI records, and the statements of witnesses, it is not completely clear whether the checks were completed, and if they were, at what times they were completed. In evaluating whether such checks would have improved the patient's prognosis, it is notable that after the checks were started by the night shift nurse, the first two checks raised no significant concern. This was consistent with the earlier results as reported after the fact by the doctor and nurse. It was not until the third nighttime check that the patient's condition seemed to have changed. This raises doubt about whether earlier checks would have resulted in a different course of treatment for the patient.

I have considered whether there are factors that would lead the doctor's decision making to be influenced by something other than his best judgment about appropriate medical care for the patient. There is no financial benefit to the doctor that would give him an incentive to keep the patient on site if the patient's condition required outside attention. In fact, if the decision had been made to send the patient elsewhere for care, staff members' time, which is at a premium, would have been freed up to deal with other patients, and the doctor would no longer have had the responsibility of monitoring the patient. The doctor would have remained at WMHI even if the patient had been sent out earlier. I understand the concern expressed by staff members that the doctor was focused on unnecessary use of taxpayer resources. Medical professionals are entitled to utilize their own professional judgment regarding what treatment or testing is necessary for a given situation. While this is an issue of concern here, it has not been established that there was criminally irresponsible deference to financial concerns.

During the checks, the doctor was made aware that the patient was on sleeping medications, which he indicates contributed to his conclusion that the patient's behavior was based on behavioral issues rather than medical issues. Many of the observable signs did not make it clear that the patient had a significant medical issue: he appeared at most times to be sleeping peacefully, there was a lack of physical evidence of injury, and the patient's condition was to some degree consistent with his prior behavior.

The timing of the calls to the doctor is significant. The doctor notes that if staff had significant concerns in the time immediately following the fall, he should have been called sooner than approximately four hours after the incident. This is compelling in evaluating what his impressions of the severity of the situation should have been. It also raises concern that even if he should have been aware that there was a significant medical issue during his first contact with the patient, the negative impact on the patient may already have occurred. Put another way, it makes it far more difficult to show that the worsening of the patient's condition was due to the doctor not immediately sending the patient to the emergency room.

The inconsistencies in the versions of events from various witnesses also make it difficult to formulate a definitive version of events that suggests the doctor was abusive or neglectful. Individuals often give narratives that portray themselves in a positive light, and it would be possible to take the view that the doctor's own statements would tend to minimize any of his own wrongdoing. However, some of the statements of the PCTs and nurses are even inconsistent with one another. Most alarming is the statement of the PCT describing the patient as not completely unresponsive, even later in the day on October 15, 2017.

Conclusion

This analysis is limited to whether criminal charges against the doctor are appropriate. I am not in a position to address other inquiries, such as whether there is potential civil liability or whether there should be licensing consequences. I do not evaluate whether the doctor's conclusions and actions were correct. My role is simply to determine whether the doctor's decisions were *criminally* unreasonable. I can say firmly that they were not.

The majority of witnesses to this incident concluded, as it was happening, that the patient was acting out behaviorally on October 15, 2017. This conclusion fits with his long term history, as well as his short term behavior at Winnebago Mental Health Institute. It is possible that the patient's prior behavior clouded the judgment of the professionals tasked with maintaining the safety of this patient and the other patients at the facility. It is possible that absent such a history, the doctor may have come to different conclusions in his evaluation of the situation as it developed. However, this history is real, and I cannot conclude it was taken into account inappropriately. It is possible that sending the patient to the emergency room at a much earlier point may have saved this patient's life. We cannot prove, beyond a reasonable doubt, precisely what impact that decision would have made.

The issue here is not whether one agrees with the doctor's decision making. The issue is not even whether the doctor came to the wrong conclusion based on the information he had available. The issue is whether the doctor displayed criminal negligence or neglect. He did not.

This incident is a horrible tragedy, but this tragedy cannot be criminally attributed to the doctor.

Eric Sparr