Exhibit T

Dr. Daphne Glindmeyer Report

Vargas v. Cook County
18 CV 1865
Exhibits to Defendants Statement of Facts

Daphne Glindmeyer, M.D.

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February 16, 2021

Joel Flaxman
Law Offices of Kenneth N. Flaxman, P.C.
200 South Michigan Avenue, Suite 201
Chicago, Illinois 60604

Re: Leticia Vargas, Administrator of the Estate of Angel Cruz v. Sheriff of Cook County, et al. No. 18-cv-1865

Dear Mr. Flaxman,
My name is Daphne Glindmeyer. My office address is 611 River Highlands Boulevard, Suite B, Covington, Louisiana. I am a medical doctor, licensed to practice medicine in the state of Louisiana and in the state of Texas.

I am a graduate of the Louisiana State University Health Sciences Center. I completed a residency in Adult Psychiatry, a fellowship in Child and Adolescent Psychiatry, and a fellowship in Forensic Psychiatry. I am board certified in Adult Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry. I am a Distinguished Fellow of the American Psychiatric Association, past President of the Louisiana Psychiatric Medical Association, and past President of the Louisiana Council on Child and Adolescent Psychiatry.

I am currently in private practice, providing psychiatric evaluation and medication management services to child, adolescent, and adult clients as well as forensic consultation. My fee for forensic consultation, charged in this case, is $450.00 per hour, with 37.5 hours spent on this review/report. Testimony, if required, is also charged at $450.00 per hour, in four-hour blocks. For further information, please refer to my attached Curriculum Vitae and Fee Agreement. In addition, I have attached my testimony log detailing depositions and courtroom testimony for the past four years.

Statement of Opinion:
Mr. Joel Flaxman requested my opinions in the above noted case. My opinions are based on my skill, education, training, experience, knowledge of medical and scientific literature, other materials reasonably relied upon by members of my medical specialty,

and my review of the case information available at this time. Should additional information become available that modifies my opinions and conclusions, an addendum will be authored.

In order to provide this opinion, information regarding this case including case pleadings, photographs, medical/mental health and other records were reviewed. For a complete listing of all information reviewed, please refer to the list of documents and pertinent information from each included below.

Based on the available evidence, it is my opinion, to a reasonable degree of psychiatric certainty, that there were significant deviations from the standard of care with regard to the medical and mental health treatment provided to Mr. Cruz. In addition, it is my opinion that the facility medical and mental health staff at Cook County Health and Hospitals System Cermak Health Services demonstrated a lack of awareness of Mr. Cruz's significant risk factors for the development of deep venous thrombosis during prolonged restraint, demonstrating a complete disregard in the care and supervision of Mr. Cruz. In my opinion, these failures on the part of both medical and mental health staff resulted in Mr. Cruz's death.

Document/Deposition Review:
As part of the evaluation, the following documents were reviewed: *(Pertinent information regarding each document will be included here. Please note, common medical abbreviations have been deciphered for the reader. The Amended Complaint will be the first item, with other documents in chronological order. Depositions will be addressed in the next section).*

1. 6.22.18-Amended Complaint filed in the United States District Court for the Northern District of Illinois Eastern Division regarding Leticia Vargas, Administrator of the Estate of Angel Cruz v. Sheriff of Cook County, et al.

2. 12.4.14-Monitor Jeffrey L. Metzner, M.D.'s Report No. 10 regarding U.S.A. v. Cook County, et al.
    - The report indicated issues with regard to restraint practices that remained below acceptable compliance, specifically "consistency of the presence of written physician's orders [for restraint] within the specified time frame, as well as documentation of consultations related to patient release from restraints and patient being provided hydration/vitals/toileting."
    - The report further noted "a most significant issue that needs immediate correction is the communication to the Chief of Psychiatry when an inmate is placed in restraints more than once in a 48-hour period."
    - There was also a need to improve as "Nursing Manager will direct nurses to consult with psychiatry regarding releasing patients from FLR's, including calling the on-call psychiatrist overnight when necessary despite their reluctance to do so. Nurses express concern about waking up an on-call

physician when there is a QMHP onsite or they feel competent in making the decision."

3. 12.8.15- Monitor Jeffrey L. Metzner, M.D.'s Report No. 11 regarding U.S.A. v. Cook County, et al.
    - At this time, the requirement that Cermak shall provide 24-hour/7-day psychiatric coverage to meet inmates' serious mental health needs and ensure that psychiatrist see inmates in a timely manner remained in Partial Compliance.
    - Requirements that Cermak shall ensure that a psychiatrist, physician or licensed clinical psychologist conducts an in-person evaluation of an inmate prior to seclusion or restraint order, or as soon thereafter as possible and that an appropriately credentialed Registered Nurse may conduct the in-person evaluation of an inmate prior to seclusion or restraint that is limited to two hours in duration, and that patients placed in restraints shall be evaluated on an on-going basis for physical and mental deterioration remained in Partial Compliance.

4. 3.3.16-Cook County Health and Hospitals System Cermak Health Services policy and procedure regarding Restraint and Seclusion approved 3.3.16 and posted 3.14.16.
    - Per policy, when restraints are used, health services staff are notified immediately to "review the health record for any contraindications or accommodations required...initiate health monitoring, which continues at designated intervals as long as the inmate is restrained. If the health of the inmate is at risk, it is immediately communicated to appropriate custody staff...If the restrained inmate has or develops a medical or mental health condition, the physician is notified immediately."
    - If restraints are initiated; "orders must be obtained from a physician within one hour following initiation of restraints."
    - Per policy, "The initial restraint order is not to exceed four hours." Within the initial two hour period, "the psychiatrist or restraint-trained Registered Nurse will...conduct a face-to-face medical and behavioral evaluation to determine if there is a need for continued restraint...review the medical record for contraindications or accommodations required for the ongoing use of restraint...update treatment plan...provide a written order within one hour of restraint...following the face-to face assessment...document in the medical record the rationale for restraints."
    - During a restraint order, the Registered Nurse is required to "monitor the patient's health and well-being every two hours while restraint, including: vital signs...checking peripheral circulation (alternating release of all four limbs...every two hours...), hydration...every two hours...toileting...every two hours...and nutrition...carry out 15 minute visual checks with documentation in the medical record...allow all patients to exercise each limb, alternating all four limbs for approximately ten minutes on a rotation basis, every two hours unless clinically contraindicated for reasons of safety

to the patient or others, to prevent physical deterioration and to promote circulation during restraint...document observations and findings...at least every 15 minutes..."

- To extend the duration of a restraint order beyond the initial four hours, the "Psychiatrist or restraint trained Registered Nurse, in consultation with the on-site or on-call Psychiatrist will...write a new order in the chart...increments not to exceed four hours...after personal examination and evaluation of the patient...each renewal must be preceded by a face-to-face medical and behavioral evaluation by the Psychiatrist, Physician in consultation with the on-site or on-call Psychiatrist or Registered Nurse in consultation with the on-site or on-call Psychiatrist...every effort must be undertaken to ensure that the patient is only restrained for the duration of time necessary to reduce/minimize risk of physical harm to self or others...once risk is reduced to a level assessed to be sufficient for consideration of reassessment of the need for restraints, the patient is to be evaluated for release from restraints..."

5. 3.12.16-3.14.16-Medical records Adventist Hinsdale Hospital
   - 3.12.16-History and Physical documents Mr. Cruz having "tangential speech and appears psychotic." Mr. Cruz "says he does not have any psychiatric issues and he has never been hospitalized for any psychiatric reason." The examination noted an elevated pulse at 112, blood pressure 148/50, temperature 99 and respirations 20. Mr. Cruz was noted to be "anxious, easily excitable, agitated, and restless...seems delusional and paranoid." The work-up included laboratory examinations, chest X-ray and brain imaging.
   - 3.12.16-Height/Weight was documented at 5'9" and 360.45 pounds with a BMI of 53.39.
   - 3.12.16-Toxicology was negative for illicit substances and alcohol.
   - 3.12.16-Laboratory examinations included a Creatine Phosphokinase level of 556 iu/L (39-308) and elevated platelets at 428 (no range noted).
   - 3.13.16- Laboratory examinations included a Creatine Phosphokinase level of 661iu/l (39-308).
   - 3.13.16-Mr. Cruz was put in four-point restraints during the hospitalization initiated at 1:24 am, discontinued 3.13.16 at 10:05 am for a total restraint time of seven hours. It was noted that restraints were ordered due to Mr. Cruz, "jumping out of bed, grabbing IV pole...hallucinating, clenching fists." During this hospitalization, subcutaneous heparin was administered prior to and during the restraint episode for deep venous thrombosis prophylaxis.
   - 3.14.16-At the time of discharge, Mr. Cruse was noted as "oriented to person, oriented to place." The discharge report indicated "Acute febrile illness; homicidal ideation; psychosis." He was discharged to Law Enforcement.
   - 3.16.16-Discharge Summary indicated the admitting and final diagnosis of "Psychosis." The secondary diagnoses were "possible rhabdomyolysis...

Morbid obesity." Per the History of Present Illness and Hospital Course, "Mr. Angel Cruz...a 20-year-old male...was brought to the emergency department after attacking his parents with a knife...was found to be psychotic, admitted for further workup and management...negative toxicology screen...patient was seen by psychiatry when medically stable for discharge to police custody with recommendations for psychiatry follow-up while incarcerated."

- Psychotropic medications administered during this hospital stay:
  - i. 3.12.16 Haldol 5 IV 22:03 (IV is intravenous)
    Ativan 2 mg IV 23:07
  - ii. 3.13.16 Geodon 10 mg IM 00:06 (IM is intramuscular)
    Geodon 20 mg IM 00:55
    Geodon 20 mg IM 5:15
    Ativan 2 mg IVP 13:52 (IVP is IV push)
    Risperidone 3 mg po 20:37 (po is by mouth)
  - iii. 3.14.16 Haldol 10 mg IV 01:39
    Ativan 2 mg IVP 1:44
    Geodon 20 mg IM 1:55
    Haldol 10 mg IV 06:19
    Geodon 20 mg IM 8:06

6. 3.12.16-Adventist Hinsdale Hospital Computerized Tomography of an examination of the Head/Brain without contrast for Mr. Angel Cruz with accompanying images.
   - The examination history was noted as "Hallucinations."
   - The result of the examination, "No evidence for acute intracranial hemorrhage, mass effect, midline shift."

7. 3.12.16-Adventist Hinsdale Hospital Chest X-ray report for Mr. Angel Cruz with accompanying images.
   - The examination history was noted as "Fever."
   - The result of the examination, "Limited inspiration with right basilar atelectasis."

8. 3.12.16-Countryside Police Department Incident Report with attached photographs:
   - This document detailed Mr. Cruz's arrest and his exhibiting bizarre behavior resulting in his transfer to the Emergency Room at Adventist Hinsdale Hospital.

9. 3.14.16-Countryside Police Department Prisoner Log for Mr. Angel Cruz.
   - There was documentation of 15-minute observations of Mr. Cruz. The documentation noted that he poured soda on the floor, was banging his head on the bars, using the bunk mattress to hide, dancing/running in

place, making grunting and yelling noises, and that he took off all of his clothes and was acting as if he was showering.

10.3.15.16-3.20.16-Cook County Health and Hospital System record of Mr. Angel Cruz *(Note, these records have been arranged in chronological order).*

- Cook County Health and Hospitals System Mental Health Assessment. This document indicated an admission date of 3.15.16 and discharge date of 3.20.16. The charges were noted to be attempted murder with alleged victims his mother and step-father.
- 3.15.16 3:44 Nursing Admission Assessment noted temperature 98.9, pulse 100, blood pressure 125/79, respirations 18, height 69 inches, weight 280 pounds, BMI 41.
- 3.15.16 10:33 Chest Screening, "view of the chest...lungs are clear of suspicious densities."
- 3.15.16 19:04 Mental Health Assessment, by Christina Valle, indicating auditory hallucinations, good impulse control, blunted affect, he expressed extreme embarrassment "I feel embarrassed, that's why I need to be hidden", no thoughts of killing himself, and he had been acting or talking strange. There was also a notation that he "has difficulty remembering events that occurred today." As the score on the screen was above 8, he was referred to mental health with recommended follow-up with Intake Psychiatrist.
- 3.15.16 19:27 Psychiatric New Patient Evaluation by Usha Kartan, M.D., "20 year old male with no prior psychiatric treatment... recently seen at Hinsdale ER and then brought to Cook County Jail for attempted murder...reports the spirit of his deceased father ...came to him...and went into a stabbing rampage and attacked his step mother and step father...claims he has been hearing voices...voices started 2-3 years ago and were conversing and recently went on rampage to avenge his father's murder...past medical history hyperlipidemia, asthma...alcohol use started age 15 last time was a year ago. Marijuana started at age 16 last time was don't remember...Impression and Plan...psychotic disorder: Paranoid Schizophrenia...hypertension, asthma, high cholesterol, obesity...admit to 2 North...Risperidone 1 mg by mouth every 12 hours..."
- 3.15.16 20:45 Triage for medical clearance by Alphonse Loveless. Temperature 99.1, pulse rate 110 beats per minute, blood pressure 134/75, respirations 18 breaths per minute, oxygen saturation 100%.
- 3.16.16 1:48 General Medical Problem, Medical Clearance by Dr. Williamson, "patient presents with no acute problems...admitted to Adventist Hinsdale Hospital after deliberate pill ingestion on 3.12.16...also treated for an acute febrile illness, negative workup except positive for rhino/enterovirus...obese male in no apparent distress...low grade fever...lungs are clear to auscultation, respirations are non-labored, breath sounds are equal..."

- 3.16.16 03:56 Mental Health Inpatient Progress Note by Kimberly Myers, "diaphoretic... urinated on himself...fixed, rigid gaze on random objects...poor insight impaired judgement... hallucinations present: auditory...thoughts: disorganized...loosening of associations...religious preoccupation...Plan-continue to observe, refer to psychiatrist for further disposition...may have some cognitive delays...presents as very soft spoken, incredibly sweaty, with flat affect and thought blocking...was seen by psych MD and placed on close observation."
- 3.16.16 10:07 2 North Psych Follow-up by Dr. Paschos, "chart reviewed and patient seen at bedside...no past psychiatric history...diagnosed with paranoid schizophrenia and poly substance abuse and started on Risperdal 1 mg every 12 hours...states he is 'wonderful'...disoriented to place...mood...elevated...thought processes... disorganized... insight...poor...judgment: poor...patient observed disrobing in his room and crouching in the corner...answers with illogical responses to simple questions...previous notes indicate self-injurious behavior, strong homicidal ideation and observed responses to internal stimuli. Maintain in 2 North under close observation..."
- 3.17.16 9:25 Mental Health Note by Dr. Paschos, "refused to come out of his room initially...interviewed later at bedside...started on Risperdal 1 mg twice daily and his been taking his medications for two days now...denied any suicidal and homicidal ideations and started crying during the interview...Maintain on 2 North for observation for 1-2 days. Continue Risperdal 1 mg every 12 hours." The Multi-Axial Diagnosis indicated that for general medical problems, "none reported."
- 3.17.16 22:20 Mental Health Progress Note by Jason Sprague, "remains in therapeutic isolation, received prn Thorazine 100 mg Diphenhydramine 50 mg, Lorazepam 2 mg IM without incident...observed pacing quiet room, disrobing, urinated at base of door, unwilling to engage with this writer from door. Continue to observe."
- 3.18.16 9:15 Mental Health Note by Dr. Paschos, "very sleepy this morning status post prn medication received overnight...since yesterday evening, patient has been very agitated...was placed in seclusion and safety smock and later transferred to single cell...received one time emergency medication at around 3:30 pm yesterday...and was offered prn medication at 8:15 pm that he accepted...sleepy and dazed, could barely keep his eyes open...taking Risperdal intermittently and continues to be grossly disorganized...was placed in seclusion room and safety smock yesterday and later transferred to single cell...very sedated this morning...yesterday with fecal incontinence and some fecal play, unclear if opiate abuse/dependence/withdrawal concurrently occurring, will attempt to obtain vitals...continue close observation and safety smock. Continue to offer Risperdal 1 mg ever 12 hours, Thorazine, Benadryl, Lorazepam as needed."

- 3.18.16 17:49 Mental Health Progress Note by Dr. Paschos, "extremely disorganized, acutely psychotic, covered in feces, thrashing placing self at risk of harm and staff at risk of harm... beating his fist on the door...attempted verbal de-escalation patient stood on top of bed and jumped off bed attempting to hit head against wall...will be placed into FLR's for risk of harm to self and others...unable to be...redirected."
- 3.18.16 18:00 Cermak Health Services Cook County Health and Hospitals System Observation Status Instructions "Five-point FLR...Close Observation (level Two) requires 15-minute staggered Checks Custody/Nursing." Indicates that order for restraints obtained from Dr. Paschos. At the time of restraint, temperature was 98.1, pulse 90, blood pressure 13.
- 3.18.16 18:30 Mental Health Progress Note by Jason Sprague "observed in cell, standing on bed, jumping off and attempting to hit head, naked, feces on body and throughout cell. Approaches door with closed fist, makes striking motions while writer attempts to engage...continues to present as acutely psychotic, disorganized thought process, impulsivity. Order received for five-point FLR's, placed into restraints without incident at 1800...sexually preoccupied while restraints deployed, stating his desire to masturbate. Received PRN Thorazine 100 mg, Ativan 3 mg and Benadryl 50 mg IM...patient unable to engage appropriately at this time."
- 3.18.16 19:13 Mental Health Progress Note by Dr. Paschos, "patient continues to be agitated aggressive thrashing requiring EM."
- 3.18.16 22:29 Nursing Progress Notes by Helen Kanel, R.N., indicated an order to continue restraints per Dr. Paschos. There were no further progress notes documenting the evaluation/assessment or contact with the psychiatrist for ongoing restraint orders.
- 3.19.16 00:39 Nursing Infirmary Vital Signs by Lorraine Chatman, R.N., pulse rate 98, blood pressure 135/78, respirations 18.
- 3.19.16 1:56 Mental Health Progress Note by Anita Johnson, "on close observation due to UPB with FLR's. During unit rounds at the beginning of the shift, the patient observed in his cell and appears to be resting well...He received prn for agitation...no concern or complaints voiced at this time."
- 3.19.16 3:35 Nursing Infirmary Vital Signs by Lorraine Chatman, R.N., pulse rate 94, blood pressure 136/84, respirations 20.
- 3.19.16 5:05 Nursing Infirmary Vital Signs by Lorraine Chatman, R.N., pulse rate 90, blood pressure 140/80, respirations 18.
- 3.19.16 6:43 Mental Health Inpatient Progress Note by Anita Johnson, "...remains in FLR's...appears to be responding to internal stimuli...showed no sleep disturbances throughout the night and appears to be resting well. Currently, no agitation...no problems or incidents noted and/or observed at this time."
- 3.19.16 9:00 Nursing Infirmary Vital Signs by Manuel Manalastas, R.N., pulse 78, blood pressure 140/80, respirations 18.
- 3.19.16 11:20 Discontinue restraints.

- 3.19.16 14:13 Mental Health Progress Note Close Observation by Dr. Lassen, "seen in his room, lying on bed, facing the window...was able to sleep last night. Appetite is decreased which patient attributes to 'being in here' and that he has a lot on his mind...continue close observations every 15-minute checks... continue safety smock and blanket..."
- 3.19.16 21:46 Nursing Progress Note by Augustus Alabi, R.N., "affect is inappropriate...was banging his head and exhibiting labored breathing... Dr. Paschos was notified about this patient banging his head...ordered him medicated with all his prn."
- 3.20.16 2:40 Nursing Progress Note by Cherri Krzyzowski, R.N., "patient was observed to be standing naked at the cell door verbalizing help me, help me...patient appeared to be agitated with no respiratory distress noted, and patient verbalizing no physical complaints or problems. Patient informed to lie down, and writer would be in to give him some medications. While preparing medications for anxiety and agitation...staff notified writer that patient had gotten into bed and was now lying down. Security notified that patient would still be receiving medications...upon finishing the prep of medications...informed that patient was now lying on the floor next to toilet. Upon assessment... noted to be verbally unresponsive but assessed to have a palpable carotid pulse and breathing...Urgent Care paramedics were notified...for assistance...security notified writer that patient had moved...palpable carotid pulse and breaths noted to be diminished. Code blue called...paramedics arrived on unit...CPR initiated...911 activated... during opening of airway...patient noted to have dried and crusted dark, red blood observed to the sides of mouth and inner lips."
- 3.20.16 4:14 Nursing Progress Note by David Davis, "called to 2 North for detainee lying on floor...noted nurse walking to detainee room with AED in hand. Upon entering room...noted male lying supine on floor naked...unresponsive...after applying monitor...asystole noted...activate 911...CPR started within one minute of contact..."
- Documentation of 15-minute observations
- Assessment and Treatment Flowsheet indicating restraints were started 3.18.16 at 18:20. At 20:34, there were vital signs, but no release of extremities, but documentation of range of motion exercises. At 22:14 there was documentation of vital signs, range of motion exercises, but no release of extremities. Mr. Cruz was noted to be restless. On 3.19.20 at 00:39 there was documentation of vital signs, release of extremities and range of motion exercises. At 2:06, vital signs were noted, range of motion exercises were not performed and there was no release of extremities. Mr. Cruz was noted to be disoriented. At 4:22, there was documentation of vital signs, of release of extremities and range of motion exercises, although Mr. Cruz was noted to be "unable to understand/respond to directions or reason." At 5:05, there was documentation of vital signs performed and at 5:16 a note that Mr. Cruz's right hand was released to allow him to eat with range of

motion exercises. At 7:55, Mr. Cruz was noted as sedated, yet restraints were maintained. There was documentation of release of extremities and range of motion exercises. Vital signs at this assessment were noted as pulse 100, blood pressure 127/58, respirations 20. At 9:55, Mr. Cruz was noted as sleeping, yet restraints were maintained. There was documentation of viral signs, release of extremities and range of motion exercises. At 11:30, restraints were discontinued.

- Restraint Orders:
  i. 3.18.16 18:00 Psychiatric/Violent Restraints, ordered by Dr. Paschos and entered by Dr. Paschos.
  ii. 3.18.16 21:55 Psychiatric/Violent Restraints, ordered by Dr. Paschos and entered by Helen Kanel, R.N.
  iii. 3.19.16 03:55 Psychiatric/Violent Restraints, ordered by Dr. Paschos and entered by Lorraine Chatman, R.N.
  iv. 3.19.16 8:08 Psychiatric/Violent Restraints, ordered by Dr. Lassen entered by Manuel Manalastas, R.N.
- Medication Administration Record revealed:

3.16.16	09:24 Risperidone 1 mg po 19:44 Haldol 5 mg IM 21:37 Risperidone 1 mg pm
3.17.16	10:03 Risperidone 1 mg po 15:39 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 20:15 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM
3.18.16	05:02 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 09:33 Risperidone 1 mg po 18:15 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 19:27 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 20:39 Valium 5 mg po, Risperidone 2 mg po
3.19.16	01:11 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 09:37 Valium 5 mg po, Risperidone 2 mg po 21:43 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM

11. 3.15.16-3.20.16-Bed Assignment Associated View regarding Mr. Angel Cruz.

12. 3.16.16-3.20.16-Cermak Health Services Employee Record Report regarding Steve Paschos, M.D.

13. 3.16.16-3.20.16-Cermak Health Services Employee Record Report regarding Elizabeth Lassen, D.O.

14. 3.20.16-Medical records from Saint Anthony Hospital noting an admission date of 3.20.16.
    - The Record of Death indicated Mr. Cruz was admitted to the facility 3.20.16 at 3:58 am, and that he died 3.20.16 at 4:08 am, diagnosis "Cardiac Arrest."
    - Triage documents noted that per Emergency Medical Services, Mr. Cruz was found "lying down on jail cell floor 'with just a cloth blanket' with water all around him."

15. 3.21.16-Office of the Medical Examiner County of Cook, Illinois, Report of Postmortem Examination of Angel Cruz, Jr.
    - Opinion, "Angel Cruz, Jr., died of pulmonary thromboemboli due to deep vein thrombosis of the legs. Obesity was contributory. Deep vein thromboses can develop for a variety of reasons. Known contributing factors include obesity, genetic conditions, malignancy, immobility, certain medications and cigarette smoking."

16. 3.23.16-Draft Root Cause Analysis regarding Angel Cruz. This document reviewed the timeline of events immediately prior to Mr. Cruz's intake to the Cook County Sheriff's Department, throughout his incarceration at Cook County Sheriff's Department, and his transport to St. Anthony Hospital where he was pronounced dead. This analysis reported eight relevant findings. In the draft report, the number six was omitted:
    - "Relevant Finding #1-Collateral information from prior treatment facility(s) and family needed to be sought. Pertinent records from the arresting Police departments need to be obtained."
    - "Relevant Finding #2-Diagnosis was established primarily based on self-report and was not supported by historical and nomenclature based data."
    - "Relevant Finding #3-Reduction of risk associated with prolonged immobility in a morbidly obese patient while in restraints."
        i. "Action Item #1-Further training on emergency response to nursing staff."
    - "Relevant Finding #4- Use of Medications."
    - "Relevant Finding #5- Use of Restraints"
        i. "Action Item #2-Policy amendment-morbid obesity is a contraindication to FLR restraint."
    - "Relevant Finding #7-Examining if one of the Urgent Care Providers can participate in Emergency Response Codes at Cermak."
    - "Relevant Finding #8-Debreifing with Nursing/Patients Services Staff following the Code events using an In-House Nursing Supervisor."
    - "Relevant Finding #9-Examination of Skin."

17. 3.25.16-Central Indiana Forensic Associates, L.L.C. Autopsy report regarding Mr. Angel Cruz. This report was accompanied by 63 photographs of documenting the autopsy.
    - Per the report, the cause of death was "complications of pulmonary emboli." The report indicated there were "multiple areas of contusion to the upper and lower extremities and abdomen...morbid obesity (body weight ~335 pounds...moderate fatty liver...patterned circular bite mark on right ventral forearm...multiple peripheral pulmonary emboli within bilateral lungs...history of elevated white blood cell count on admission to hospital..."
    - The toxicology report indicated positive findings of Lorazepam at 26 ng/ml, Diphenhydramine at 710 ng/ml, and Chlorpromazine at 340 ng/ml.

18. 6.27.16-Third Step Hearing for (29) day-Suspension regarding grievance of Cherri Krzyzowski, Clinical Nurse.
    - Per this document, Ms. Krzyzowski "was charged with failing to assess, treat, and follow the established Emergency Response Plan" during a medical emergency situation regarding Mr. Cruz.
    - That specifically, "...patient was assigned to a cell in a safety smock with lights on...patient walked to the cell door nude and 'said help me'. At that point the deputies noted that the patient seemed dazed and that the deputies could only see the white part of the patient's eyes. A deputy informed the nurse of his observations. Thereafter, the Deputies heard a loud noise...deputies entered the patient's cell they observed a puddle of urine on the floor which seems to have blood in the area where the patient was previously standing...deputies informed [Ms. Krzyzowski] and she did not immediately respond to their concern...took her time to go and review what was medically taking place with the patient she went into his cell after a while to assess his condition..."
    - "This is not first incident involving [Ms. Krzyzowski] has been charged with failure to follow the Cermak Health Services policies and procedures in the handling of patients/inmates under her care...on March 20, 2016, the patient died under her care. While the patient was complaining, she told the patient to lie down instead of immediately checking and assessing his medical condition."
    - Ultimately, Ms. Krzyzowski's grievance regarding her suspension was denied. "...it is this Hearing Officer's opinion that the grievant failed to follow the Cermak Health Services emergency response protocol...failure to appropriately respond to the patient's medical condition."

19. 8.24.17-Email addressed to Ms. Sandra Hernandez authored by Ms. Cherri Krzyzowski regarding her resignation from her position as a Clinical Nurse I from Cermak Health Services of Cook County Health and Hospital Systems.
    - Ms. Krzyzowski noted that the Cermak Chief Nursing Officer, Pamela Brown, "chose to overlook the documented acknowledgement in the patient's

[indicating Mr. Cruz] record of labored breathing just hours before this young man's death and others failure to assess, treat, and implement emergency treatment including failure to communicate the above to myself and other oncoming personnel.

20. 11.14.16- Monitor Jeffrey L. Metzner, M.D.'s Report No. 12 regarding U.S.A. v. Cook County, et al.

21. 11.9.17-Cook County Health and Hospitals System Cermak Health Services policy and procedure regarding Restraint and Seclusion approved 11.9.17 and posted 12.4.17.

22. 12.13.19-Confidentiality Order filed in the United States District Court for the Northern District of Illinois Eastern Division.

23. 1.13.21-Angel Cruz timeline prepared by Joel Flaxman.

24. 2.14.21-Video summary and index to video provided by Joel Flaxman.

Depositions:

1. 9.27.19-Deposition of Elizabeth Paige Lassen, D.O. with exhibits:
    a. Dr. Lassen is a board-certified outpatient psychiatrist at Hines Veterans Hospital, where she has worked since 2011. Dr. Lassen worked moonlighting, providing weekend coverage and evening coverage, at the Cook County Jail part-time. She was never the on-call psychiatrist for the facility.
    b. Dr. Lassen stopped working at the Cook County Jail in 2016.
    c. Dr. Lassen indicated she assessed Mr. Cruz, going into the cell to have the encounter with him, then going to the computer to type her notes.
    d. Dr. Lassen documented that Mr. Cruz was on close observation, "He was...per the chart and other notes by other providers, he was attempting to hurt himself, jumping off beds...there was a threat to his own safety and probably the safety of others..."
    e. The progress note indicated that she reviewed Mr. Cruz's records, "I typically would review intake notes from medical and mental health and nursing...the MAR [Medication Administration Record]."
    f. Dr. Lassen reviewed Mr. Cruz's vital signs, noting a "slightly low diastolic blood pressure...and that wasn't an active issue." Dr. Lassen was queried regarding Mr. Cruz's heart rate, which was documented at 97 beats per minute, "the range is 80 to 100, heavier set gentlemen...some of his behavior had been somewhat agitated...I think that it wouldn't be uncommon for the heart rate to fluctuate in the range."
    g. With regard to ordering restraints, Dr. Lassen indicated, "a physician is contacted to put in the order and expected to evaluate the patient within

a certain amount of time...as far as monitoring, I think a lot of the ...vital monitoring is done by non-psychiatrists."

h. For restraints, the physician is expected to evaluate "within 2 hours, and then every 4 hours to renew...4 hours maximum."
i. Mr. Cruz was no longer in restraints when Dr. Lassen came into the unit and she did not order restraints for Mr. Cruz to be renewed...there may have been an order that might have my name on it, though I think that was not put in by me. I don't think I was on the premises at that time, but...nurses are allowed to put in an order if they need to under a psychiatrist's name."
j. With regard to individuals who are sleeping remaining in restraints, Dr. Lassen stated, "I think it happens that people that required physical restraint might end up sleeping, but we try to evaluate them frequently enough to get to the least restrictive setting as soon as possible." Dr. Lassen indicated that if she was to assess an individual in restraints who was sleeping, "I would wake them up if they happened to be sleeping...and then we could have a conversation...if they're calm enough to be sleeping and able to contract for safety...then that would be a good opportunity to let them up."
k. After assessing Mr. Cruz, Dr. Lassen ordered 15-minute checks, to continue inpatient psychiatry, and to continue Mr. Cruz's current medications. Medications consisted of Risperidone 2 mg and Valium 5 mg daily.
l. Dr. Lassen agreed that individuals in restraints should have range of motion exercises because, "you just don't want to cut off blood supply to any of the extremities with the restraints." She did not know who was responsible for providing this to individuals in restraints.
m. Dr. Lassen indicated that medical conditions patients coming out of restraints are at a higher risk of developing include "edema, perhaps deep venous thrombosis...dislocation of...joints."
n. Dr. Lassen was not aware that second generation antipsychotics pose increased risk of deep venous thrombosis. She was aware that obesity was a risk factor, and that "I think you can order a medical consult if there was something stressing."

2. 12.18.19-Deposition of Helen Kanel, R.N. with exhibits:
   a. Ms. Kanel is a clinical nurse at Cermak Health Services of Cook County, at Cook County Jail. She has been employed there since July 1999. She has a Bachelor of Science degree in nursing and is a registered nurse.
   b. Ms. Kanel typically works on the Acute Psychiatric Unit with female inmates. On March 17 and 18, 2016, she was assigned to a different unit, 2 North.
   c. Ms. Kanel recalled Mr. Cruz due to the "reason for putting him in restraints...I remember him jumping off of a bed. And I remember being covered in feces...those are what stand out to me...memory wise."
   d. Ms. Kanel reviewed a progress note she authored March 17, 2016 at 19:06 hours. At that time, she documented that his insight, judgement, and

impulse control were poor "due to his behavior and him being unresponsive to verbal redirection from staff and his behavior before."

e. Ms. Kanel reviewed her documentation in Mr. Cruz's records.
f. She indicated that observations could be done by going into the cell and interacting with Mr. Cruz while he was in restraints, or "I had my screen [indicating the video monitor] at the time."
g. Ms. Kanel described range of motion exercises that are done with individuals in four-point restraints, indicating these are done, "to maintain blood circulation." She indicated that range of motion exercise process takes, "minimum of maybe 10 minutes for range of motion...I try to do about 2 and a half—2 minutes at least per limb..."
h. Two hours after Mr. Cruz was restrained, "every two hours you need to do the assessment..." At that time, his limbs were not released, "he was agitated, confused, disoriented, restless, thrashing, threatening to hurt self, so that would be contraindicated at that time...to release a limb." The progress note indicated that range of motion exercises were done, but Ms. Kanel she was not able to do the full range of motion exercises.

3. 1.3.20-Deposition of David Kelner, M.D. with exhibits:
   a. Dr. Kelner is the Chief of Psychiatry at Cermak Health Services. In his position, his responsibilities are to "supervise staff and make sure that services are delivered appropriately and timely."
   b. Dr. Kelner did not interact with or treat Mr. Cruz while Mr. Cruz was at the jail. He was involved in the Root Cause Analysis, which he described as "an attempt to understand what might have led to a negative outcome and what are the modifiable factors...a process improving effort."
   c. The process of the Root Cause Analysis was reviewed. Dr. Kelner was not aware that a nurse involved in Mr. Cruz's care was disciplined, "I'm not in charge of the patient care or commonly known nursing department."
   d. Relevant Finding No. 1, refers to "the fact that the group believed that collateral medical records and information from prior treatment facilities and arresting agencies...needs to be sought out."
   e. Relevant Finding No. 3, "means that prolonged immobility may be associated with increased risk of deploying restraints...it is important to avoid and reduce prolonged immobility...there are medical risks [of prolonged immobility]...can lead to skin breakdown...difficulties with breathing...untoward psychological consequences...increase risks for patients with congestive heart failure...and prolonged immobility is believed to be related to what is known as hypercoagulable state—meaning that the blood clots more easily."
   f. Relevant Finding No.4, "reads use of medications..."
   g. Dr. Kelner indicated that the Root Cause Analysis did not determine a deviation in workflow. He also indicated that while "humans were implicated...human factors were not...the Root Cause Analysis is designed to flesh out deviations from work process, whether it's mechanical, human

factors, communications equipment, and identify opportunities for risk reduction."

h. Dr. Kelner summarized the Restraint and Seclusion Policy of Cermak Health Systems with the posting date of 3.14.16, "allows for the initial order for restraints to be no more than four hours. Then if clinical need persists and other less restrictive therapeutic alternative treatments have failed, that order can be further extended...in four-hour increments up to 24 hours, and then the Chief of Psychiatry...has to review the case and authorize further restraint deployment."
i. Mr. Cruz remained in restraints for 17 hours and 22 minutes and per Dr. Kelner, "it was allowable under our then existing policy."
j. The Root Cause Analysis indicated that it was unknown if Mr. Cruz was in restraints, immobilized, or in a physical confrontation prior to his arrival to 2N, and Dr. Kelner indicated, "I would say that being in restraints or immobilized for a prolonged period of time at a different facility prior to his arrival at Cermak is extremely important...the thrombus could have resulted from his immobilization...elsewhere, not at Cermak..."
k. Dr. Kelner discussed policy changes following the Root Cause Analysis, "it was decided that in order to monitor detainees with significantly elevated BMI [Body Mass Index] we would have to individually review their cases and send them to John Stroger Hospital for additional monitoring if we were to need leather restraints...it was decided that it would be safer for them to be monitored elsewhere...Cermak is not a hospital...the [indicating John Stroger Hospital] have more resources to supervise and keep these detainees in restraints safe."
l. This transfer is "part of our process. It's not something that was spelled out in the policy...a routine maneuver that we make when detainee's medical needs exceed our ability to deliver medical care to them in a safe fashion, we send them out to our sister hospital, Stroger..."
m. With regard to the use of anticoagulants for individuals in restraints, Dr. Kelner stated, "My search of the literature produced inconclusive results...my own practice makes me think it would be a very uncertain decision fraught with danger to give anticoagulants to someone who is acutely agitated, why just recently tried to leap of a bed and smash his head..."

4. 2.20.20-Deposition of Cherri A. Krzyzowski, R.N. with exhibits:
   a. Ms. Krzyzowski is a registered nurse who has been employed at the University of Illinois Chicago Hospital for a year. She does not have a special certification in psychiatric nursing but has been a psychiatric nurse for 25 years. Ms. Krzyzowski worked at Cook County, Cermak Health Services for 18 years. She left her position at Cermak Health Services in July 2017.

b. Ms. Krzyzowski recalled Mr. Cruz, "he was my patient...a patient I was caring for during my employment at Cermak Health services...on the psychiatric unit, 2 North.
c. Ms. Krzyzowski agreed that there was a complaint against her related to Mr. Cruz, "failure to assess, treat, and implement emergency procedures." Ms. Krzyzowski disagreed with the complaint, "Because I did assess him. I am not a doctor; therefore, I do not treat patients. And I did implement emergency procedures." Ms. Krzyzowski indicated that the compliant, "was...unfounded and dismissed by the county and by the professional board of regulations, my licensing board. I was cleared of all charges of any wrongdoing by the Illinois department of professional regulations in December...2017."
d. Ms. Krzyzowski indicated that she did not review the progress notes of other medical staff, "I could but I don't...we give report...there's no reason for me to go in somebody's note...nurses always give report at the beginning of the shift and at the end of the shift to the oncoming shift."
e. Ms. Krzyzowski reviewed the progress note regarding Mr. Cruz's admission to 2 North and subsequent progress notes she wrote regarding him . She recalled that he was obese, and that close observation was ordered, "every 15 minutes...we have to get up every 15 minutes and document on him." She indicated that for the 15 minute observation, she did not go into the cell, but agreed that she could look through the window of the door or use the monitor, "if it looks like I can't see him on the monitor...you must get up. If I can't see him when I come to the door...then the officer will open the door and he will go in and physically look...I can't go inside of a patient cell without an officer...in an emergency situation we do go into a cell."
f. Ms. Krzyzowski was aware that Mr. Cruz had been in restraints prior to her shift on 3.19.16, "I do remember being told that he was in restraints...a previous shift told me he was in restraints."
g. Ms. Krzyzowski recalled that on 3.19.16, "I remember Mr. Cruz coming to the door...not appearing to be in any respiratory distress, not talking to me...I remember calling for the urgent care people to come assist me to come get him downstairs...I remember losing my patient...He asked for help...I asked him what was wrong and he said noting...he didn't talk which was not uncommon for him...I remember doing a head-to-toe assessment of him...the smocks are open face. So when he came to the door, I saw all of this...and I did a head-to-toe assessment of him the same way I am looking at your right now assessing your breathing pattern, assessing whether you are in respiratory distress, any pain...and he just stood there looking at me...I told him, go lay down. I'm going to get you some help...going to get you some medicine. I am going to help you...go lay down and he eventually did lay down on his bed, so he was able to follow directions...And I went to look and see what he had ordered to help him."
h. Ms. Krzyzowski recalled that she "went to his door and did a visual assessment with him...He said help me....I said what's wrong...and he

wouldn't talk to me...I observed that his respirations were even and unlabored...he wasn't in any respiratory distress...He just stood there looking at me...He looked like a psych patient...his eyes were always the same...His eyes were always fixed, like a term we call animalistic...always looked like he was in crisis...acute..."

i. Ms. Krzyzowski recalled that "at one point in time...on this shift...I noticed that his respiration had become diminished and that's when I went out and called—got the AED machine and called for a code because I noticed...his respirations went from being even and unlabored to diminished..."

j. Ms. Krzyzowski did not use the AED because, "the paramedics had come up...I came out and called them on the phone...I didn't call 911. Urgent care did..."

k. The previous night, Ms. Krzyzowski had given Mr. Cruz medication, and she recalled that the officer told her "you don't have to give him anything. He done went to sleep...I said, no. I am going to give him something to help him because he could wake up and have the same complaint. Help me, help me, so let me give him something to calm him down like I did the previous night and he was fine..." She agreed that after finishing the preparation of the medication, she was informed by an officer that Mr. Cruz was lying on the floor, "because we heard a noise and that's when...they went to go check on the patient..."

l. Ms. Krzyzowski recalled that "when they said he was on the floor, "I went inside the cell..." Per her note, she assessed Mr. Cruz to have a palpable pulse, "and he was breathing." She then went to the phone to call the paramedics and, "while I was on the phone with the paramedics...the officer yelled out, Nurse K., he moved...I told the paramedics...that he was verbally unresponsive. He wasn't talking to me, but he had breaths and he was breathing and he had a pulse...I called urgent care because he was laying on the floor and he wasn't assisting us in getting up off the floor. So I was going to send him down to urgent care, but we could not lift him. This was...a big guy. So we needed a stretcher...that's why I called them to bring me a stretcher."

m. A Code Blue was called, "I was waiting on urgent care to come...for so long...I noticed that his vital signs were starting to diminish...his palpable pulse it's harder to engage. I decided to go out there and get the AED machine myself and call a Code Blue so people could come up and assist me...as I am grabbing my AED, I see the paramedics come at the same time..."

n. She recalled that when the paramedics intubated Mr. Cruz, there was dried and crusted red blood to the side of his mouth, "he had some on the inside. When they went to intubate him we saw that...I didn't take it to mean anything. I am a nurse. I can't diagnose..."

o. Ms. Krzyzowski notified Dr. Paschos that Mr. Cruz had been "sent out to the hospital."

p. Ms. Krzyzowski could not recall if she completed an incident report regarding Mr. Cruz.
q. An incident report completed by correctional officers was reviewed with Ms. Krzyzowski. She indicated that when the officers informed her about Mr. Cruz, she was informing another person that "their rights were being restricted...because they were suicidal..."
r. Ms. Krzyzowski's resignation letter was reviewed. She indicated that Mr. Cruz experiencing labored breathing was documented previous to her shift by Nurse Alabi, but that Nurse Alabi "didn't tell me anything about labored breathing...I would have like to have known all of this in report. Nurses choose to give what their highlights are...I would have loved to have all that, but I didn't get any of that...in report."

5. 3.9.20-Deposition of Steve Paschos, M.D. with exhibits:
   a. Dr. Paschos is a physician at Cook County Health and Hospital System, with Cermak Health Services since 2012. Dr. Paschos completed residency training in internal medicine and psychiatry. He is board-certified in psychiatry.
   b. At Cook County Jail, the "highest level of care...is the psychiatric inpatient floor in Cermak...There is no transferring out to a psychiatric hospital...2 North...is the acute care, men's...psychiatric special care unit."
   c. Dr. David Kelner is the Chief Psychiatrist of Cermak Health Services and Dr. Paschos' supervisor.
   d. Dr. Paschos indicated there are primary care providers who provide "medical call...and flowed up with the patients medically." On 2 North.
   e. One of Dr. Paschos' responsibilities was to "make a decision...as a psychiatrist, whether or not therapeutic restraints would need to be deployed, whether or not medications needed to be deployed, emergency medications needed to be deployed..."
   f. As of his last training, therapeutic restraints are "deployed for four hours, and then reviewed every four hours...to be continued up until a 24-hour max." Dr. Paschos recalled that through his career, four hours has always been the standard time period for psychiatric restraints.
   g. Dr. Paschos indicated that the Registered Nurse "can" consult with the psychiatrist, but they can "also renew them themselves." He then clarified, "but the nurse is contacting a doctor and discussing the case with the doctor." To his knowledge, he has always been consulted when a nurse is entering a renew order, "But...I'm not completely sure...Registered Nurse, I believe, could renew the order if a doctor is not available."
   h. Dr. Paschos would expect the nurse to confer with him when considering discontinuing the restraints, "I believe they can discontinue if they do not get a hold of a doctor."
   i. When Dr. Paschos first saw Mr. Cruz, he did not have access to the medical records from Adventist Hinsdale Hospital. Dr. Kartan, in intake, had an initial impression of "paranoid schizophrenia."

j. When asked about Mr. Cruz's obesity, he indicated he "didn't weigh him personally...believe I saw his weight...I could suppose that he was obese by viewing him."
k. Initially, following the evaluation on 3.16.16, Dr. Paschos prescribed Risperidone 1 mg twice daily. Later that day, a telephone order was given for Haldol, but there was no corresponding progress note from Dr. Paschos regarding that event, "it's not necessarily a requirement to document an overnight event, per se."
l. On 3.17.16, Dr. Paschos noted that Mr. Cruz initially refused to come out of his room and tried to fling his door open. The note indicated Dr. Paschos interviewed Mr. Cruz "at bedside." Dr. Paschos indicated that the standard of care in the unit is "not to interview people at bedside except for when it is the standard pf practice because if someone is violent...acutely psychotic, it is not safe to take them out of the room for interview...in the best interest of the patient to be interviewed at the bedside...when someone's in five or four-point restraints, we would interview them for sure at the bedside because they're bound to the bed..." Barring certain situations, Dr. Paschos indicated it is the usual practice to interview inmates in the interview room.
m. Later that day, Dr. Paschos entered an order to emergency medications including Thorazine, Benadryl, and Ativan. There was a progress note indicating Mr. Cruz was "agitated, attempting to leave his cell, banging the door of his cell...urinating on the floor and internally stimulated...bottom line, is psychotic...placed in seclusion and safety smock and later transferred to single cell..." Dr. Paschos indicated that he saw Mr. Cruz at bedside at that time.
n. In a note 3.18.16, Dr. Paschos documented that Mr. Cruz was "kind of sleepy...because he received these injections [indicating Thorazine, Benadryl, and Ativan] last night...two rounds of them...now in the morning, he's somewhat sedated due to said medications..."
o. In a subsequent note 3.18.16 at 6:00 pm, Dr. Paschos noted that Mr. Cruz was "extremely disorganized, acutely psychotic, covered in feces, thrashing, placing self at risk of harm and staff at risk of harm, threatening staff, beating his fists on the door and wall...room covered completely in feces, urine, and trash. Attempted verbal de-escalation...stood on top of the bed and jumped off of the bed attempting to hit head against the wall...patient will be placed into FLR's [Full Leather Restraints] for risk of harm to self and others...unable to be de-escalated or redirected."
p. Dr. Paschos indicated the restraints were "a four-hour order...It doesn't mean that they're going to be in for four hours exactly...they're going to get reassessed at four hours for sure."
q. When asked if he assessed Mr. Cruz at the time he was put into restraints, he stated, "I was there...because when we have a patient who's... extremely disorganized, acutely psychotic, covered in feces, thrashing, threatening staff, I'm not going to walk into his room and get injured...on 2

North have a big glass window...he's easily observed to be doing what he's doing. So I assessed him with my eyes..."

r. After Mr. Cruz was in restraints, Dr. Paschos could not recall how much longer he was on the unit. Then per a note at 7:13pm, he "went in to talk to him while he was in FLR's...I document...that he was agitated, aggressive, thrashing, and that he required emergency medications." He then stated, "I can't say 100 percent I remember that I went into his room...I always do. This is what I do..."
s. There were three subsequent restraint renewal orders that were not entered by Dr. Paschos, but no further notes authored by him. Dr. Paschos indicated that if the order was "in, I got a call and approved it." It was his understanding that when nurses contacted him to renew an order, that the nurse had done an assessment of the patient. The exception was the restraint renewal order dated 3.19.16 entered by nursing with the ordering physician noted as Dr. Lassen.
t. Dr. Paschos was unable to remember calls from nursing regarding renewing the restraint orders. The only specific call regarding Mr. Cruz he was able to recall was when he was called and told that Mr. Cruz was "unresponsive."
u. Dr. Paschos was aware that Mr. Cruz had been released from restraints prior to being found unresponsive. He indicated that following release from restraints, "nursing always does an assessment."
v. With regard to the initial restraint period ordered by Dr. Paschos, he stated, that with regard to obesity, "you have to weigh the risks versus benefits of the procedure...I've put countless people into restraints that were obese. That's part If the standard of care for risk of harm to self."
w. Dr. Paschos indicated that guidelines indicate that [when in restraints] "vitals every four hours...whatever nurses are doing...their appropriate checks...we have certain policies in place for the nurses to be doing them...many times, obese or not obese, we allow people to have...free range of motion exercises...during restraints at intervals..."
x. Dr. Paschos indicated that there is not standard of care for the use of anticoagulants for the prevention of deep vein thrombosis in psychiatric patients in restraints. He indicated that Mr. Cruz was not someone who had complex medical comorbidities. He indicated if anticoagulants were prescribed, that "the primary care people would do it."
y. Dr. Paschos ultimately stated that "could there possibly have been a situation where I considered it [meaning anticoagulants during restraints], sure...I would have to do it with conjunction with primary care."

6. 9.23.20-Deposition of Hythem Zayed, M.D. with exhibit:
   a. Dr. Zayed is an internal medicine physician who works as a hospitalist.
   b. Dr. Zayed was the admitting physician for Mr. Cruz at Adventist Hinsdale Hospital 3.12.16.
   c. Dr. Zayed believed that Mr. Cruz was experiencing psychiatric issues, "he seemed agitated...pressured speech..."

d. Dr. Zayed noted that Mr. Cruz's lungs were clear and unlabored, "I used a stethoscope...listened to his lungs...didn't have any unusual sounds...not gasping for air...not breathing any faster than a normal person would."
e. It was Dr. Zayed's impression that Mr. Cruz was experiencing psychosis, "based on the way he was acting and talking and based on his exam as well as his laboratory data, that is the conclusion I made."
f. Dr. Zayed indicated that "a doctor who was a psychiatrist evaluated Mr. Cruz."
g. Dr. Zayed treated Mr. Cruz with Heparin, because Mr. Cruz "was in bed...in restraints...I didn't know when he was going to be able to move again. He was also a larger person, and they have an increased risk of blood clots...If I anticipate a patient to be immobile for a while, the longer the immobility, the higher the risk of clot."
h. Dr. Zayed reviewed the order for Mr. Cruz to have four-limb restraints. He also reviewed his progress note where it was documented that Mr. Cruz has "not chest pain, shortness of breath." Dr. Zayed indicated that four-point restraints "increases [Mr. Cruz's] risk of blood clots" so he continued heparin.
i. Dr. Zayed recalled that psychiatry was consulted for Mr. Cruz, but there was no documentation of a consultation evaluation.

7. 11.9.20-Deposition of Ravi Yalamanchi, M.D.:
   a. Dr. Yalamanchi is an internal medicine physician, practicing as a hospitalist at Adventist Hinsdale Hospital.
   b. Dr. Yalamanchi was involved in Mr. Cruz's care during his admission 3.12.16 as "I was working nights for our group...I handled the cross-coverage for our service."
   c. Dr. Yalamanchi was called because Mr. Cruz as experiencing difficulties and he ordered four-point restraints.
   d. Dr. Yalamanchi indicated that psychiatry was consulted in Mr. Cruz's case.
   e. He indicated that "every patient that I take care of that I'm the attending has an order for deep venous thrombosis prophylaxis...Heparin or Lovenox...if it's chemical...mechanical are...sequential compression devices."

Case Summary:

Mr. Angel Cruz was born May 31,1995 and was 20 years old at the time of his death March 20, 2016. Mr. Cruz was incarcerated at the Cook County Department of Corrections on March 20, 2016, when at 2:40 am, he was found unresponsive in his cell. He was transferred via Emergency Medical Services to St. Anthony Hospital where he arrived in cardiac arrest. He was pronounced dead at 4:08 am.

Mr. Cruz was incarcerated at the Cook County Department of Corrections beginning March 15, 2016 due to charges of attempted murder of his mother and step-father. At the time of his arrest March 12, 2016, there was documentation that Mr. Cruz was acting

bizarrely, prompting his transfer to the Emergency Room at Adventist Hinsdale Hospital. Mr. Cruz was admitted to Adventist Hinsdale Hospital where he was diagnosed with psychosis, morbid obesity, and possible rhabdomyolysis.

The documentation from Adventist Hinsdale Hospital indicated that Mr. Cruz had no history of prior psychiatric symptoms/diagnosis, and screens for illicit substances and alcohol were negative. Brain imaging was performed, with the results indicating "no evidence for acute intracranial hemorrhage, mass effect, or midline shift" indicating an essentially normal imaging study. A chest X-ray revealed "limited inspiration with right basilar atelectasis." Mr. Cruz had abnormal vital signs and laboratory examinations on admission to the hospital. Specifically, he had a low-grade temperature, an elevated pulse rate, an elevated white blood cell count, and an elevated creatine phosphokinase level. These abnormalities were complicated by Mr. Cruz's morbid obesity. Mr. Cruz's height and weight were documented at 5'9" and 360.45 pounds with a body mass index of 53.39.

After admission to Adventist Hinsdale Hospital, Mr. Cruz was in the Intensive Care Unit and ultimately required four-point restraints due to exhibiting agitation and hallucinations. Documentation indicated he was restrained for approximately seven hours. Prior to and during the restraint episode, doctors ordered subcutaneous heparin in an effort to reduce the possibility of the development of deep venous thrombosis, the incidence of which would be increased due to Mr. Cruz's body habitus and prolonged immobility. There were two ordered heparin dosages that were not administered, the first on March 12, 2016 at 20:00 as Mr. Cruz refused and the second March 14, 2016 at 1:00 as Mr. Cruz was agitated at that time.

Mr. Cruz was discharged from Adventist Hinsdale Hospital March 14, 2016. During his hospitalization, he was treated with psychotropic medications including Haldol, Ativan, Geodon, and Risperidone. On discharge, Mr. Cruz was transferred to the Countryside Police Department, where he remained overnight.

While at Countryside Police Department, Mr. Cruz was monitored every 15 minutes with his behavior documented. Overnight, the documentation of Mr. Cruz's psychiatric symptoms indicated that he was continuing to experience mental health difficulties. For example, documentation noted that he poured soda on the floor, was banging his head on the bars, using the bunk mattress to hide, dancing/running in place, making grunting and yelling noises, and that he took off all of his clothes acting as if he was showering.

Mr. Cruz was transferred to the Cook County Department of Corrections on March 15, 2016. On intake, the Nursing Admission Assessment documented an elevated pulse rate, with other vital signs within normal limits. The Nursing Admission Assessment indicated that Mr. Cruz's weight was 280 pounds with a body mass index of 41, this was markedly different than the measurement obtained at Adventist Hinsdale Hospital. In

addition, Mr. Cruz had a chest X-ray with results noted as "lungs are clear of suspicious densities."

Mr. Cruz was evaluated by a psychiatrist in intake on March 15, 2016 who diagnosed obesity and Paranoid Schizophrenia. He received a medical clearance evaluation on March 16, 2016. Per this evaluation, Mr. Cruz's lungs were "clear to auscultation, respirations are non-labored, breath sounds are equal." The examining physician documented that Mr. Cruz was admitted to Adventist Hinsdale Hospital due to a deliberate pill ingestion on March 12, 2016. This information does not appear in the records from the hospital. Following medical clearance, Mr. Cruz was transferred to the Cook County psychiatric unit.

While housed in the Cook County psychiatric unit, Mr. Cruz was treated by Steve Paschos, M.D., a psychiatrist. There was documentation that Dr. Paschos performed a follow-up visit on March 16. 2016. In his deposition, Dr. Paschos indicated that he did not have the benefit of the medical records from Mr. Cruz's hospital stay. The progress note, dated March 16, 2016 at 10:07, indicated that Mr. Cruz was "seen at bedside." On this date; however, the attendance record for Dr. Paschos indicated he did not arrive at the facility until 10:44. Dr. Paschos next documented a progress note on March 17, 2016 at 9:25. At that time, Dr. Paschos again indicated that Mr. Cruz was "interviewed...at bedside." The attendance record for Dr. Paschos on this date indicated he did not arrive at the facility until 11:05.

During his stay on the psychiatric unit, Mr. Cruz was prescribed oral medication, Risperidone. In addition, he received multiple intramuscular injections of psychotropic medications including Haldol, Benadryl, Lorazepam, and Thorazine. Over time, Mr. Cruz's condition deteriorated to the point that on March 18, 2016 at 18:00, Dr. Paschos ordered 5-point leather restraints. At the time the restraints were ordered, Dr. Paschos did not interact with Mr. Cruz, indicating in his deposition that he "assessed him with my eyes." Dr. Paschos next documented a progress note regarding Mr. Cruz on March 18, 2016 at 19:13, indicating that Mr. Cruz continued with "agitated aggressive thrashing" and that he required emergency medication administration.

As indicated above, Mr. Cruz was placed in 5-point restraints on March 18, 2016 at 18:00 hours. He would remain in 5-point restraints for approximately 17.5 hours. Per policy in effect at that time, restraints could be ordered in four-hour increments, with a restraint renewal requiring an in-person examination by either a psychiatrist or a Registered Nurse in consultation with psychiatrist and a subsequent physician's order.

Following the initial restraint order, restraints were renewed at 21:55 by Ms. Kanel, a registered nurse. The progress note documenting this renewal indicated that the continuation of restraints was per Dr. Paschos. The next renewal documented was March 19, 2016 at 3:55. The surveillance video does not show any medical personnel entering Mr. Cruz's cell between the hours of 1:01 and 4:56, so the in-person examinations did not occur. The last renewal order was documented March 19, 2016 at

8:09, indicating that Elizabeth Lassen, D.O. was the ordering physician. Dr. Lassen stated at her deposition that she was not at work at this time, and did not provide on-call services at the facility, so she did not give that order.

Other than the initial restraint order, there was no documentation authored by Dr. Paschos indicating consultation with nursing staff overnight regarding continuation of 5-point restraints. Documentation from Jeff Metzner, M.D., the facility monitor reviewing mental health services at the facility pursuant to a consent decree reported in 2014 that nursing consultation with psychiatry on-call was an issue, as nurses "express concern about waking up an on-call physician."

While in restraints, policy in effect in 2016, required nursing staff to monitor vital signs, check circulation, and alternate release of all four limbs, allowing individuals in restraints to exercise each limb, alternating all four limbs for approximately ten minutes on a rotation basis every two hours. Documentation of the nursing encounters during the restraint episode include notations that Mr. Cruz's extremities were released March 19, 2020 at 00:30,4:44, 7:55, and 9:55. The surveillance video shows that a nurse was with Mr. Cruz from 19:36 to 19:37, 20:06 to 20:11, 22:56, 23:06, 0:21 to 0:31, 0:59 to 1:01, 4:56 to 4:59, 5:58 to 6:06, 7:24 to 7:29, 9:31 to 9:35, and 11:17 to 11:19 indicating that the ten-minute exercises could not have occurred. Further, although Ms. Kanel documented vital signs checks for Mr. Cruz on March 18, 2016 at 20:34 and 22:13, video surveillance of her entering Mr. Cruz's cell that evening did not show her bringing the sphygmomanometer [blood pressure machine] into the cell with her. Dr. Metzner also commented that documentation of the patients in restraints being provided hydration/vitals/toileting remained below acceptable compliance. Further, some of the nursing documentation noted that while in restraints, Mr. Cruz was either sleeping or sedated, yet restraints were not discontinued.

Mr. Cruz was released from restraints on March 19, 2016 at 11:30 am. Dr. Lassen documented a visit with Mr. Cruz at 14:13. Later that day, at 21:26, there is a nursing note indicating Mr. Cruz was "banging his head and exhibiting labored breathing." Dr. Paschos was notified and ordered the administration of emergency intramuscular medication.

March 20, 2016 at 2:40, a nursing progress note documented by Ms. Krzyzowski indicated Mr. Cruz was verbalizing "help me" and "appeared to be agitated." Per the nursing progress note, the nurse did not assess Mr. Cruz other than to instruct him to lie down and she proceeded to obtain emergency intramuscular medications. In the interim, Mr. Cruz was found lying on the floor in his cell. Nursing called for the Urgent Care Paramedics and Mr. Cruz was transported to St. Anthony Hospital where he was pronounced dead.

The medical examiner determined that Mr. Cruz's cause of death was "pulmonary thromboemboli due to deep vein thrombosis of the legs," with obesity as a contributing factor. A second autopsy concluded the cause of Mr. Cruz's death was

"complications of pulmonary emboli." The report indicated there were "multiple areas of contusion to the upper and lower extremities and abdomen...morbid obesity (body weight ~335 pounds)."

Following Mr. Cruz's death, a Root Cause Analysis was performed by personnel at the Cook County Jail. This analysis determined relevant findings including that collateral information from prior treatment facilities and family need to be sought. Action items were identified including the need for further training for nursing staff on emergency response and a policy amendment indicating that morbid obesity is a contraindication to full leather restraint. Per the deposition of Dr. Kelner, the facility changed policy such that individuals with morbid obesity are assessed on a case by case basis to determine if restraints are appropriate. Further, it is the current practice to transport individuals with morbid obesity who require full leather restraints to a hospital for monitoring.

Conclusions:
The National Commission on Correctional Health Care indicated Restraint and Seclusion as an essential standard outlined in Standards for Mental Health Services in Correctional Facilities 2015.[1] The intent of the standard is that "when restraints are used for clinical...reasons...the inmate is not harmed by the intervention." Further, the standard states, "when clinical restraint...is used, it is employed for the shortest time possible...Health monitoring consists of checks for circulation and nerve damage, airway obstruction, psychological trauma, and prevention of deep vein thrombosis."

The Cook County Health and Hospitals System Cermak Health Services policy and procedure regarding Restraint and Seclusion approved 3.3.16 and posted 3.14.16 designated procedures for the evaluation of individuals requiring restraints. This included the requirement for consultation with a physician to obtain orders to continue restraint. The requirement for nursing staff to monitor the patient's health and well-being includes 15-minute visual checks. The requirement for nursing to monitor an individual in restraints every two hours while restrained includes obtaining vital signs, checking peripheral circulation, alternating release of all four limbs, range of motion exercise, hydration, toileting, and nutrition.

Mr. Cruz died as a result of the development of pulmonary thromboemboli due to deep vein thrombosis of the legs. The factors causing Mr. Cruz to develop deep vein thrombosis included morbid obesity, the use of multiple antipsychotic medications, the use of intramuscular injections, the use of low potency antipsychotic medications (e.g. Thorazine), prolonged immobility, and medical record review and reported video evidence revealed that policy and procedure were not followed by facility health care personnel during Mr. Cruz's restraint episode. Further, there was a delay in response to Mr. Cruz when he cried out for help from medical staff on March 20, 2016 at 2:40.

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[1] National Commission on Correctional Health Care (2015) Standards for Mental health Services in Correctional Facilities. Chicago, Illinois.

Extreme Obesity

Mr. Cruz's height and weight were measured at Adventist Hinsdale Hospital, where it was documented that he was 5'9" and 360.45 pounds with a body mass index of 53.39 these measurements were corroborated by the forensic examination performed following Mr. Cruz's death. The medical records from Cook County Health and Hospitals Cermak Health Services grossly underreported Mr. Cruz's weight and body mass index measuring him at 69 inches (5'9"), weight 280 pounds, with a body mass index of 41. Mr. Cruz's body mass index of 53.39 is categorized as Class 3, severe or extreme obesity, by the Centers for Disease Control (CDC).[2] The CDC indicates that a body mass index greater than 40 is categorized as Class 3.

In his deposition, Dr. Paschos admitted that he deviated from the standard of care, he did not request, nor did he have the Adventist Hinsdale Hospital records to review. He stated that he reviewed the weight in the Cermak records and "I could suppose that he was obese by viewing him." As noted above, the Cermak measurements were inaccurate. While Dr. Paschos would have been able to discern visually that Mr. Cruz was obese, knowledge that Mr. Cruz was categorized as "severe" or "extreme" would be necessary to appropriate management. In fact, the Root Cause Analysis performed by the Cook County Health and Hospitals Cermak Health Services as a result of Mr. Cruz's death supports the need to obtain collateral information from prior treatment facilities as a relevant finding.

Medications

A review of Mr. Cruz's medical records from Adventist Hinsdale Hospital and Cook County Health and Hospitals Cermak Health Services revealed that Mr. Cruz was treated with second-generation antipsychotics (e.g. Geodon, Risperidone), low potency antipsychotics (e.g. Thorazine), he received polytherapy as he was treated with multiple medications, he had recently started antipsychotic therapy as he had no history of psychiatric treatment previously, and medications were provided both intravenous and intramuscularly. The following is a listing of the date, medication administered, route and time of administration of the medication to Mr. Cruz:

Adventist Hinsdale Hospital:	3.12.16	Haldol 5 IV 22:03 Ativan 2 mg IV 23:07
	3.13.16	Geodon 10 mg IM 00:06 Geodon 20 mg IM 00:55 Geodon 20 mg IM 5:15 Ativan 2 mg IVP 13:52 Risperidone 3 mg po 20:37
	3.14.16	Haldol 10 mg IV 01:39 Ativan 2 mg IVP 1:44

[2] Centers for Disease Control and Prevention. Defining Adult Obesity. cdc.gov

		Geodon 20 mg IM 1:55 Haldol 10 mg IV 06:19 Geodon 20 mg IM 8:06
Cook County/Cermak	3.16.16	Risperidone 1 mg po 09:24 Haldol 5 mg IM 19:44 Risperidone 1 mg pm 21:37
	3.17.16	Risperidone 1 mg po 10:03 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 15:39 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 20:15
	3.18.16	Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 05:02 Risperidone 1 mg po 09.33 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 18:15 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 19:27 Valium 5 mg po, Risperidone 2 mg po 20:39
	3.19.16	Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 01:11 Valium 5 mg po, Risperidone 2 mg po 09:37 Thorazine 100 mg IM, Benadryl 50 mg IM, Ativan 2 mg IM 21:43

Shulman et.al (2013) reported the association between antipsychotic medication and increased risk for deep venous thrombosis (DVT) and pulmonary embolism (PE) has been reported since soon after the introduction of first-generation antipsychotic medications in the 1950's. Per a review of the literature, they determined that "there was substantial evidence...that antipsychotic drugs increase the risk of venous thromboembolic events. The average reported odds ratio was 3.51compared with patients not receiving these drugs." The factors that increased risk were "the use of second-generation antipsychotics, low potency antipsychotics, antipsychotic polytherapy...The risk factors for antipsychotic related thromboembolic events include recently started antipsychotic therapy...higher doses of drug, concomitant multiple antipsychotic therapy, intravenous or intramuscular administration...and use of second-generation antipsychotics."[3]

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[3] Shulman et al. Thrombotic complications of treatment with antipsychotic drugs. Minerva Med. 2013 Apr;104(2):175-84.

Given that Dr. Paschos did not have or request the medical records from the previous hospital stay, he would not have the benefit of knowing what medications had been administered. Further, given Mr. Cruz's extreme obesity, the medications that Dr. Paschos was prescribing to Mr. Cruz, the number of medications, and the use of multiple intramuscular injections, extra vigilance was required for Mr. Cruz with regard to the development of DVT. Failure to provide extra vigilance including ensuring that Mr. Cruz was monitored by nursing, ensuring review of ongoing restraint, and ensuring that Mr. Cruz was released as soon as he was calm is not appropriate medical care and a deviation from the standard of care.

Prolonged Immobility

Mr. Cruz was restrained at Adventist Hinsdale Hospital for approximately seven hours. At the time of his admission to Cook County Health and Hospitals Cermak Health Services, a chest x-ray and physical examination were performed, both of which revealed no issues with Mr. Cruz's pulmonary functioning. Mr. Cruz was then restrained for approximately 17.5 hours at Cook County Health and Hospitals Cermak Health Services.

As Dr. Paschos and the treatment team at Cook County Health and Hospitals Cermak Health Services did not have the prior treatment records, they would have been unaware of the prior restraint episode. During Mr. Cruz's 17.5 hours in restraint, in conflict with facility policy and procedure, there was minimal documentation regarding extremity release and range of motion exercise. Extremity release was documented March 19, 2016 at 00:39, 4:22, 5:16, 7:55, and 9:55. At 5:16, only Mr. Cruz's right hand was released. Range of motion exercises were documented March 18, 2016 at 20:34 and 22:14 and on March 19, 2016 at 00:39, 4:22, 5:16, 7:55 and 9:55. This is contradicted by video surveillance evidence showing that nursing staff either did not enter Mr. Cruz's room or did not stay the estimated ten minutes required to perform limb release and range of motion exercise.

There were no range of motion exercises performed on March 19, 2016 between 00:39 and 4:22, a period of approximately four hours. Further, there was no release of extremities from the time of the start of restraints on March 18, 2016 at 18:00 through March 19, 2016 at 00:39, a period of approximately 6.5 hours, and again between 00:39 and 4:22, a period of approximately four hours. Given Mr. Cruz's extreme obesity, prolonged restraint episode, use of medications, and intramuscular injections, the lack of attention to Mr. Cruz's health maintenance and prevention of health deterioration during the restraint episode is egregious, not appropriate medical care, and a deviation from the standard of care.

Subsequent to Mr. Cruz's death and the Root Cause Analysis performed, the Cook County Health and Hospitals Cermak Health Services changed their policy and procedure indicating that restraints and prolonged immobility for individuals with the type of risk factors exhibited by Mr. Cruz would be evaluated on a case-by-case basis and if restraints were required, the individuals would be transferred to a hospital setting.

Failure to Monitor

The failure of nursing staff to monitor and provide health maintenance to Mr. Cruz during restraints is discussed above; however, there were additional failures with regard to the lack of assessment and consultation with psychiatry for continuing restraint. Per policy in effect at the time, staff were required to assess an individual in restraints and consult with the physician every four hours in order to continue the restraints.

Dr. Paschos entered the initial restraint order and documented the rationale for initiating restraint on March 18, 2016 at 18:00. Subsequent restraint orders were attributed to Dr. Paschos March 18, 2016 at 21:55 and March 19, 2016 at 3:55. There was no nursing documentation of consultation with Dr. Paschos regarding the evaluation or assessment indicating the need for ongoing restraint for either subsequent order. There was also no documentation by Dr. Paschos indicating consultation. Further, there was a six-hour gap in the orders, from March 18, 2016 at 21:55 through March 19, 2016 at 3:55, indicating that for approximately two hours, Mr. Cruz remained in full leather restraints in the absence of a physician's order. Finally, the last restraint order, dated March 19, 2016 at 8:08 was attributed to Dr. Lassen. Per Dr. Lassen, she did not order this restraint as she was not on-site at the facility at that time, nor did she provide on-call services.

Video evidence does not support nursing evaluation or assessment of Mr. Cruz at the time of restraint re-orders. In fact, the report of Jeff Metzner, M.D., the facility monitor for mental health services, had documented issues in this area, indicating that nursing staff were reluctant to contact psychiatry on-call overnight in order to review restraint assessments. Dr. Metzner noted that the Nursing Manager was to direct nurses to consult with psychiatry. Regardless, there was no clinical documentation of the evaluation or assessment of Mr. Cruz indicating that ongoing restraints were necessary and no clinical documentation regarding the physician consultation. Further, there was documentation that on March 19, 2016 that at 7:55, Mr. Cruz was sedated and at 9:55 he was asleep, questioning the need for ongoing restraint.

This failure to adequately assess and evaluate Mr. Cruz for the necessity of ongoing restraint indicated that he likely remained in restraints for longer than necessary. This is a deviation from the standard of care. Mr. Cruz was in restraint for a period of time in the absence of a physician's order. This is a deviation from the standard of care. Although there were periods of time where Mr. Cruz was noted to be sedated and sleeping, restraints were maintained, this is a deviation from the standard of care. Further, each of these failures is a deviation from facility policy in effect at the time. The standard of care requires individuals to be evaluated/assessed for ongoing restraint every four hours, to have active restraint orders, for documented consultation with the ordering physician to occur, and to be released when they are calm.

Delay of Treatment

On March 19, 2016, at 21:46, there was nursing documentation of Mr. Cruz experiencing labored breathing. At this time, additional psychotropic medications were administered

in the absence of other medical interventions. Later, on March 20, 2016 at approximately 2:35, Mr. Cruz reportedly called out for help from his cell. Rather than assessing his vital signs at that time, the nurse, Ms. Krzyzowski, instructed him to lie down and proceeded to gather further psychotropic medications, assuming that he required additional medications. During this interim period, security staff found Mr. Cruz on the floor of his cell, unresponsive. At that time, the paramedics were contacted, and Mr. Cruz was transferred to St. Anthony Hospital where he was pronounced dead.

Ms. Krzyzowski admitted that she was not aware that Mr. Cruz had experienced labored breathing earlier that day as this occurrence was not discussed in shift report and, in a deviation from the standard of care, it was not her practice to read the patient's record from the previous shift. Further, it was a deviation from the standard of care for Ms. Krzyzowski to fail to physically assess Mr. Cruz when he asked for help. This is tantamount to no treatment at all. Mr. Cruz's cry for help was dismissed by Ms. Krzyzowski. Given Mr. Cruz's condition, this would be terrifying for him, inflicting unnecessary psychological trauma on an already mentally ill individual.

In summary, Mr. Cruz's death due to pulmonary thromboemboli resulting from deep venous thrombosis was caused by a confluence of evaluation and treatment failures. These failures were identifiable as deviations from the standard of care by nursing and psychiatry staff at the Cook County Health and Hospitals Cermak Health Systems.

Please note the above opinions are provided to a reasonable degree of psychiatric certainty. In the event that additional information or collateral documentation becomes available, the examiner reserves the right to change opinions based on such, and that will be included as an addendum to this report. Should you have any questions, or require any further information regarding these opinions, please contact me at 504.392.8348.

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