EXHIBIT A

Homer Venters MD, MS
10 ½ Jefferson St.
Port Washington
NY, 11050

January 3, 2020

David J. Utter, Esq.
The Claiborne Firm, P.C.
410 E. Bay Street
Savannah, GA 31401

Dear Mr. Utter:

This is a preliminary report as to my opinions regarding the medical care and deficiencies in care in the case of Mr. Jonathan Fano. I have reviewed the materials provided to me and listed in the report in formulating my conclusions I have included the following in this document:

Attachment A: Written report of Dr. Homer Venters
Attachment B: Vita of Dr. Homer Venters (with fee schedule, list of cases, and statement of charges)

Please advise me if you require any further information.

Sincerely,

Attachment A

Dr. Homer D. Venters
10 ½ Jefferson St., Port Washington, NY, 11050
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Re: Detainee death of Jonathan Fano in East Baton Rouge Parish Prison ("EBRPP")
Preliminary Report

PRELIMINARY STATEMENT

Systematic failures and gross deficiencies in the health care system for detainees at EBRPP directly contributed to the death of Mr. Fano. The systemic failures were known to public officials since at least January of 2015, when city manager William Daniel and Warden Dennis Grimes told the Metro Council the conditions at the jail were an emergency, especially for the mentally ill. Mr. Fano was precisely the type of person Daniel and Grimes warned the council about when he arrived at EBRPP in late 2016. He was identified as being in acute distress prior to his arrival at EBRPP and upon arrival, he should have been immediately assessed by health staff as needing a level of assessment and care beyond their capacity. Instead, health staff failed to review or incorporate Mr. Fano's presentation to police or his history of suicide attempts and he was

judged to be faking or exaggerating his symptoms. After he engaged in self-harm, health staff permitted Mr. Fano's transfer to solitary confinement[1] where his risk of suicide would have been greatly amplified due to the solitary confinement setting as well as the lack of basic suicide prevention measures. Health staff failed to provide meaningful care to Mr. Fano, even as his

[1] This report utilizes the term "solitary confinement"—also called "restrictive housing" and segregation" by U.S. Dept of Justice (USDOJ)—throughout and relies on the definition provided by the USDOJ. The USDOJ identified the three elements of restrictive housing as 1) Removal from the general inmate population, whether voluntary or involuntary; 2) Placement in a locked room or cell, whether alone or with another inmate; and 3) Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more. Report available at https://www.justice.gov/archives/dag/file/815551/download EBRPP officials use "segregation," "isolation", and "disciplinary detention" when describing the conditions on the M and N lines.

condition worsened and he requested additional care. Finally, systemic failings in leadership, training, and supervision led to grossly incompetent and inadequate mental health care by jail health staff. These failings continued throughout Mr. Fano's stay, including the transition from Prison Medical Services ("PMS") to CorrectHealth East Baton Rouge, LLC ("CorrectHealth"). The continued placement of detainees with mental illness in solitary confinement, and the denial of basic health mental care by EBRPP staff to individuals detained in EBRPP and Mr. Fano represent gross departures from accepted medical practice in jails and reflect a systemic lack of concern for the survival and health of persons detained in EBRPP.

FACTS AND DATA CONSIDERED

I have reviewed documents produced by Health Management Associates ("HMA") in their assessment of health services in the EBRPP, publicly available information from the local city and parish government, depositions of HMA staff, various EBRPP and CorrectHealth officials, and Medical and Security records for Mr. Fano and others detained in EBRPP. My report is based on the following files and information;

- Tour of EBRPP 6/7/19
- 20160223 HMA notes
- 2016 PPt draft 1
- 2016 PPt final
- 2016April Batia Notes-NCCHC med std
- 20160421 Batia notes—NCCHC mental health
- Batia Karen (depositions)
- Raba M.D. Jack (depositions)
- Follenweider, Linda (depositions)

- Police arrest documents of Mr. Fano
- Mr. Fano's medical records from EBRPP, including documents generated from PMS and CorrectHealth.
- EBRSO incident reports from investigations of Mr. Fano's death and other detainee deaths at EBRPP provided by sheriff defendants in discovery
- Security video of N line
- Beatrice Stines (depositions)
- Linda Ottesen (*Lewis* deposition)
- EBRPP security logs
- PMS policies
- CorrectHealth policies
- U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing_Final Report_January 2016
- NCCHC Position Statement: Solitary Confinement (Isolation) April 2016
- Joshua Boxie (*Lewis* deposition and affidavit)
- Byron Maxon (*Lewis* deposition and affidavit)
- Joseph Jones (*Lewis* deposition and affidavit)
- Christopher Haney (*Lewis* deposition and affidavit)
- Corey Pittman (*Lewis* deposition and affidavit)
- Brodrick Samuel (*Lewis* deposition and affidavit)
- Rani Whitfield (depositions)
- Chad Guillot (depositions)
- Dennis Grimes (depositions)

- Shawn Robinson (affidavit)
- Charlie Bridges (depositions)
- Lisa Burns (deposition)
- William Daniel (depositions)
- Joyce Brown (deposition)
- Andrea Brown (deposition)
- Jean Llovet (deposition)
- Cathy Schley (deposition)
- Courtney Eichelberger (deposition)
- Tamekka Green (deposition)
- Danielle Thomas (deposition)
- Vincent Bradley (deposition)
- Sharon Allen (deposition)
- Kimberly Bates (deposition)
- Tonyala Cannon (deposition)
- Yolanda James (deposition)
- Gregory Doane (deposition)
- Natasha Jones (deposition)
- Stephen Kissinger (deposition)
- Carlo Musso (deposition)
- Rintha Simpson (*Lewis* deposition)
- Walter Smith (deposition)
- Susan Hatfield (deposition)

- Frank Brooks (affidavit and deposition)
- Daniel Hinton (affidavit and deposition)
- Emanuel Jones (affidavit)
- Metro Council Meeting video, Jan. 14, 2015, Item 13P and Q Part I, and Aug. 26, 2016
- CorrectHealth staff timesheets
- PMS final approved budgets 2015-19
- CorrectHealth 20190311 discovery production—contracts
- Public records regarding CorrectHealth, HMA and Baton Rouge communications about health care at EBRPP
- CorEMR-EBRP – Reports staff activity reports provided by CorrectHealth in discovery
- *Lewis* payroll for May 2015

EBRPP TOUR OBSERVATIONS

I toured the EBRPP facility on 6/7/19 with attorneys for both the defendants and plaintiffs in the Fano case. During that tour, I was able to visually inspect the intake area, medical clinic, infirmary, pharmacy room and Q, N, M, E housing areas. I was unable to ask questions of staff working in the facility or detainees. I have listed concerns about safety and health of EBRPP detainees from this tour limited to those relevant to the case of Mr. Fano.

1. **Seriously mentally ill detainees are held in solitary confinement cells that increase their risk of death.** Both the N and M lines appear to function as solitary confinement, with detainees held in a cell 23 to 24 hours per day. There is a white board outside one of the units that has names of patients and their apparent suicide watch status listed. None of

the patients or cells designated as SW (presumed 'suicide watch') or MHO (presumed 'mental health observation') has an officer stationed outside their cell to ensure constant observation. The cells are not visible from the central bubble where officers are stationed, and no officers are stationed in the actual housing areas. No video surveillance into cells appears to exist. Each of the units has one cell in the bubble area, the function of these cells or reason for having people in them was not clear. Inside the units, it appears as if detainees rarely exit their cells and there does not appear to be any group or congregate activity for these detainees in solitary confinement. Mental health encounters with the EBRPP psychiatrist appear to occur through the bars of the cells. Each cell has numerous suicide risks including the open bars, more than one of which had cloth ties affixed to bars at the time of our tour. In addition to the bars, the shelves and tables in each cell also pose suicide risk as easy anchor points for suicide by hanging. Some of the cells were extremely dark due to the window coverings, and some have considerably more light. These units have a foul smell from trash, rotting food or body odor and the cells are in disrepair with substantial rust and peeling paint. The catwalk between the lines have no lights in them and while the lights in the housing areas illuminate the walkways of each housing area and the front 2-3 feet of the cells, the parts of the cells farther back from the front are very difficult to see into. In addition, many of the windows in the catwalk are tinted, making it even more difficult to see past the well-lit walkways of the housing units into the cells.

2. These units pose significant risk for suicide and self-harm in two ways. First, the practice of solitary confinement is associated with self-harm and is discredited as an acceptable practice for people with mental illness.[2] Second, these units have virtually none of the

[2] In April of 2016, the National Commission on Correctional Health Care (NCCHC) took the position that solitary confinement—**defined as "the housing of an adult or juvenile with minimal to rare meaningful contact** with

standard suicide prevention measures in terms of physical plant or staffing. Placement of persons with mental illness into these units significantly increases their risk of death and self-harm. These are the most dangerous units I have observed in an American jail or prison.

HMA FINDINGS AND EVIDENCE RELEVANT TO DETAINEE DEATHS

HMA was retained by the Parish of East Baton Rouge in 2016 to conduct an assessment of the health services in EBRPP and make recommendations about how to improve access to and quality of health services. In the time since Mr. Fano passed away due to his injuries sustained at EBRPP, at least 15 more individuals died at EBRPP or shortly thereafter in a local hospital after being transported from EBRPP.[3] Many of the observations made by HMA and their recommendations are directly tied to risks of injury and death posed by ongoing practices by health and security staff and structural barriers to evidence-based health services in EBRPP. Each of the three categories of the HMA assessment (access to care, quality of care, leadership) revealed gross deficiencies that significantly increase the risk of detainee deaths. The testimony from health staff, the Warden, and patients, and documents and video provided in discovery, support these concerns.

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other individuals"—for greater than 15 consecutive days "is cruel, inhumane, and degrading treatment, and harmful to an individual's health." NCCHC takes the position that individuals with mental illness "should be excluded from solitary confinement of any duration." NCCHC Position Statement: Solitary Confinement (Isolation) at https://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf (accessed Dec. 23, 2019). Jonathan Fano had a mental illness and was segregated in EBRPP's N wing for 92 consecutive days.

[3] Including Mr. Fano, 17 people have died at EBRPP or shortly thereafter in a local hospital after being transported from EBRPP since CorrectHealth took over from PMS. Included in the 17 deaths is Edward Jones, a diabetic mentally ill man who was found by CorrectHealth LPN Danielle Thomas at 7:30 am on Jan. 9, 2017 lying on the floor of his cell in N wing "moaning and grunting as he always does." When she returned at 11:10 am, he was "very limber and appeared to be suffering from a medical emergency." After being transported to the infirmary, he died a few minutes later. Bates No. EBRSO_002600-27. Thomas is the same CorrectHealth nurse who did not verbally interact with Mr. Fano in front of his cell during pill call on Feb. 2, 2017, instead claiming to visually monitor him from the reflection of the catwalk during morning pill call the day he hanged himself. It is unclear whether she was part of the CorrectHealth staff urged to "show more compassion" in response to medical emergencies by CorrectHealth leadership during one of the inconsistently held health care staff meetings.

Suicide prevention is another aspect of care that HMA identified as grossly deficient at EBRPP. Suicide is the leading cause of death in U.S. jails and thus, suicide must be a top priority for every health service in jails. HMA's assessment makes clear that no evidence-based suicide prevention program existed at the time of their work and that no updated policies regarding suicide prevention, tracking and quality assurance of the suicide prevention care provided or regular incident review of self-harm and suicidal behavior was in place. Although CorrectHealth's suicide prevention policies were an update from PMS, it is clear that the procedures and actual practices in place at EBRPP during Mr. Fano's detention were similarly grossly deficient. This failing is made more dangerous to the health and safety to detainees with mental illness because of EBRPP's policy of placing the mentally ill in M and N's solitary isolation cells, and HMA's findings that the bars of those cells are suicide hazards.

The lack of training identified by HMA is readily apparent in the confusion about how or whether any assessment of individuals on the N and M lines was to occur on a daily basis. One of the rudimentary safety measures employed in solitary confinement settings is to have health staff view and document the health status of every patient every day, so as to detect patients in distress or who are decompensating. EBRPP's Health Services Administrator ("HSA") in 2015, Linda Ottesen, stated in her deposition she personally changed the facility policy in 2012 to mandate that every nurse interact with and receive a response from every person, even those who were not receiving medications. She stated that a record of each of these interactions would be kept in the Medication Administration Record (MAR) books under the purview of health staff. This process was replicated in the Electronic Medical Record (EMR), per Mrs. Ottesen, so that a record of every interaction would be recorded every day, showing that nursing staff were conducting these interactions with all detainees as they made their pill call rounds, not only those receiving

medications. Deposition testimony of nursing staff, however, make clear in their testimony that there was no training on this process and no tracking of these individual assessments actually occurred, whether on paper or in the EMR. They report a mix of practices including either calling out to every cell as to whether or not the person inside was on medications, or only stopping to talk to people known to be on medications. This lack of basic rounding on patients known to have increased risk for suicide is further compounded by the practice of keeping people locked in their cells for up to 24 hours per day, without any time out of cell, which violates every established guideline of correctional practice. Deposition testimony, a review of documents provided by the sheriff and medical staff, and the limited video review available indicate that detainees on N line, including Mr. Fano, received no more than 20 minutes a day outside of their cells, and were never permitted access to the outdoor recreation area. In addition, the lack of training and confusion found by HMA continued when CorrectHealth assumed responsibility.

HMA findings and tour of EBRPP indicate a lack of timely access to care in the M and N lines where Mr. Fano was held and which operated (and continue to operate) as solitary confinement units, where serious mentally ill patients are held in their cells 23 or 24 hours per day without access to meaningful mental health care, recreation, social contact or any stimulation other than the yelling of other similarly isolated detainees. This practice of holding patients with serious mental illness, including those who were on suicide watch, in solitary confinement, was well known by all health and security staff, including CorrectHealth staff.[4]

HMA reported multiple other failures and gaps in quality assurance and improvement in the EBRPP health service. HMA reported that missed medications rate was 22% and that many

[4] Particularly troubling is CorrectHealth's leadership's refusal to even acknowledge that the conditions on N lines amount to solitary confinement, that they have any responsibility to attempt to influence the practice of placing the mentally ill on the N lines, or ameliorate the suffering of the ill detainees placed there.

patients who required specialty care were not taken for appointments. In addition, HMA noted gross deficiencies in basic medical and mental health care including suicide prevention, excessive use of antipsychotic medications for sedation of patients and chronic care, and a complete absence of mental health programing. These systemic failings appeared to stem from a lack of basic training and competency of staff as well as failure to utilize health outcomes & medical utilization data that was available in the EMR but never accessed. There is little evidence that CorrectHealth implemented any additional trainings or systems to address these deficiencies in care in any meaningful way during the time Mr. Fano was in EBRPP[5] and in fact, the overall rate of death would increase after CorrectHealth assumed responsibility (see findings below).

Two examples of how these deficiencies in the EBRPP health service can contribute to death are chronic care and suicide prevention. Persons in correctional settings are well-known to have rates of chronic medical problems, at rates far in excess of community rates. Many of the highly prevalent medical problems in correctional health settings, including epilepsy, diabetes, cardiovascular disease, hepatitis C and acute substance withdrawal can be fatal when left untreated and represent a significant portion of preventable deaths in jails. Appropriate treatment of chronic diseases behind bars requires a plan of care that is interdisciplinary and follows a protocol of diagnosis, treatment, and education. HMA reported that no such plans or programs for chronic diseases existed, which would significantly increase the likelihood that persons with these problems would miss medications or be denied care that was life-sustaining or life-saving. Perhaps the most telling example of how little things changed with CorrectHealth's assumption of

[5] The one nod to the serious issues presented by placing the mentally ill in solitary confinement—CorrectHealth's policy on segregated inmates—requires screening before placing individuals with health needs in solitary confinement and regular monitoring by health staff. Deposition testimony from CorrectHealth staff indicates that the policy was not implemented at EBRPP for many months after CorrectHealth took over on January 1, 2017, and Mr. Fano's medical records are devoid of the finding from any prescreening and segregation logs, making it clear that the policy was directly contradicted by the practice and did nothing to protect him.

responsibility for health care at EBRPP are the deaths of Edward Jones and Mr. Fano in January and early February of 2017.

Leadership: The third major category of gross deficiencies reported by HMA that are implicated in the risk of detainee death is medical and administrative leadership. This category is relevant to preventable deaths of detainees because correctional health services rely on the teamwork of a medical director, nursing director, mental health director and health service administrator as the key leaders who will ensure that sound policies exist for health staff and that these policies are followed. Moreover, this ensures that quality assurance activities are in place to monitor performance and that quality improvement and death/incident reviews are also conducted in a way that improves problems that may be associated with inmate deaths. This lack of competent leadership in key positions would continue as CorrectHealth took over responsibility for health services and included the roles of health services administrator and director of nursing. Although CorrectHealth's corporate leadership took steps to fire or replace ineffective staff in those positions in early 2018, the changes came too late for Mr. Fano and others who died in 2017.

HMA reported that the health services lacked policies that were up to date, disseminated to and known by staff, and tailored to the actual facility (EBRPP) where they worked. CorrectHealth did not tailor its policies to EBRPP into mid-2018—more than eighteen (18) months after assuming responsibility for health care at EBRPP. HMA also identified that there was no full-time administrator assigned to the health service in 2016, despite obvious need, and that the medical director "serves as a spokesperson and is not involved in operational, supervisory, monitoring or quality improvement activities." HSA Ottesen testified she left in late 2015. As indicated in her deposition testimony when compared to the findings of HMA, her failings as a leader seemed to have contributed to, rather than help fix, EBRPP's grossly deficient health care

system. Deposition testimony of Dr. Bridges reveals that although he was at one point the Medical Director for PMS, for years prior to Mr. Fano's arrival at EBRPP he was not the Medical Director and no one assumed this critical role for years.

The HMA assessment paints a bleak picture of the health service of EBRPP as one that has been designed and run in a manner that clearly ignores basic standards of correctional health and operates in a manner that significantly increases the risk of preventable death by failing to conduct intake assessments, denying access to sick call and other types of health services and conducting operations without adequate leadership, policies and staffing. The most obvious and critical recommendation made by HMA was that the investment in the correctional health service of EBRPP would need to double, from a current (2016) annual budget of approximately $5 million to $10 million. This estimate was based on the patient profile of EBRPP detainees and the gaps in existing correctional health staffing and expected numbers of encounters. This doubling of investment would allow for the creation of a competent health service, with leadership, policies & procedures and quality promotion that represents the standard of care in correctional health, whether through a new vendor or academic or community health partnership. Failure to follow HMA's primary recommendation regarding resource allocation would leave in place many if not all of the heightened risks of death experienced by detainees in EBRPP.

When CorrectHealth assumed responsibility for care in January 2017, it is also apparent that they failed to ensure that leadership would be present and involved in the transition, including a health services administrator and medical director working on January 1, 2017. In addition, an analysis of staffing levels highlights a central problem identified by numerous parties and which CorrectHealth chose to ignore, the lack of sufficient health staffing. When compared to staffing levels before January 1, 2017, virtually every level of health professional was utilized for fewer

hours per week after the transition than was present before. This chronic understaffing was already identified as a central failing by HMA and CorrectHealth made this failure even more pronounced. According to the deposition testimony of Dr. Rani Whitfield in the *Zavala* matter, current nursing staff report little to no change on this critical issue up to and including late 2019.

TIMELINE

Prior to his incarceration, Mr. Fano had previously been diagnosed with bipolar disorder and depression and had longstanding care that included the psychotropic medications risperdone and olanzapine (antipsychotics) and trazodone (antidepressant). Mr. Fano was arrested on October 31, 2016 for disorderly conduct and other misdemeanor charges stemming from erratic behavior on the streets of Baton Rouge. He had apparently been on a cross country bus and because of auditory hallucinations, exited the bus in Baton Rouge and was quickly approached by Police who documented that he was "naked and running around swinging his penis," speaking to an imaginary person "he kept saying him and Tatianna (Fake Imaginary person) was cross dressers and trying to find a show to make money." Police took Mr. Fano directly to EBRPP where he was booked.

Mr. Fano's medical intake questionnaire on November 1, 2016 by Sharon Allen includes that he replied "yes" to whether or not he was on any medications and "no" to all the questions regarding illicit drug use or mental health problems. That same day EBRPP security records indicate that Mr. Fano engaged in self-harm by cutting his wrists and the response of facility security staff was to charge him with a disciplinary infraction for "self-mutilation" that would result in two weeks in solitary confinement. Mr. Fano's self-harm prompted a transfer to a local hospital evaluation in the early hours of November 2. The Emergency Medical Request filled out by EBRPP health staff documents that Mr. Fano has no mental health history and also that he engaged in suicidal self-harm and was reporting hearing voices. Nurse Bradley initiates a suicide

watch for Mr. Fano, indicating that a suicide attempt has occurred and the presence of suicidal ideation. Upon his return to EBRPP, Mr. Fano was placed on suicide watch on the N line. A clinical encounter with social work staff was scheduled for November 2 and ultimately deleted on November 6 without occurring. A notation in the documentation indicates that the encounter was overdue before being deleted. On November 3, 2016, EBRPP psychiatrist Dr. Robert Blanche conducted a cell side evaluation of Mr. Fano and concluded that Mr. Fano was not suicidal and that he should be prescribed Olanzapine and Seroquel for bi-polar depression and sleep disorder respectively. No record exists of an out of cell encounter between Dr. Blanche and Mr. Fano on this date. On the following day, November 4, an appointment is made for Mr. Fano to see a psychiatrist one month later, but this appointment was not kept and ultimately labeled as 'not seen'.

On November 25, while still housed on N line, Mr. Fano submitted a request for care with the complaint that his medications "don't work anymore" without eliciting any apparent mental health services or care. Mr. Fano submitted another request for care on December 18, still housed on N line, with the complaint that "I'm having really bad anxiety and depression. Feels as if the walls are closing in, also having really bad thoughts of my time here." On December 22, Mr. Fano was moved to another cell on N line, also solitary confinement. The same day, a health encounter was scheduled for Mr. Fano with the reason of "Anxiety/Depression" which was not kept and was ultimately labeled as not seen. Another clinical encounter for Mr. Fano is documented for December 26 with the reason "Need to see Psych" but there is no clinical record of this encounter with Dr. Blanche.

On January 1, 2017, CorrectHealth assumed responsibility for health care at EBRPP. Mr. Fano had a clinical encounter on January 3, 2017, now under the auspices of CorrectHealth. This encounter documented complaints of anxiety, depression and auditory hallucinations and included

a plan of prescribing the antihistamine hydroxyzine. Another encounter for Mr. Fano occurs on January 11, 2017 in which Mr. Fano is documented to be not taking his medications and not eating. A note by C. Schley indicates that Mr. Fano is thought to be faking or exaggerating his symptoms and that he is stable. Mr. Fano's medications are listed as Zyprexa and Seroquel and that Mr. Fano is reporting a history of self-harm and suicide attempts and that he is currently experiencing auditory hallucinations. This encounter includes reference to a suicide attempt involving Mr. Fano cutting his wrists that occurred in EBRPP in November 2016 and which required hospital transfer. The note goes on to characterize Mr. Fano as either faking or exaggerating his symptoms, in part because of his subdued mood, orientation and because he is unable to hear the auditory hallucinations with sufficient clarity to know what is being said. The note records "[t]hen he tells me he can't tell me what they are saying. NO outward indication of responding and reports hearing voices INSIDE his head." And "I suspect some faking bad or exaggerating his condition on his part is possible. [P]resents as stable overall." No mention of the assessment conducted after his documented suicide attempt in November 2016 is included and no mention of the observations of police officers at his arrest is included. This encounter is labelled as a "Mental Health SOAPE [sic] Note" and the same paragraph that includes the sentences above is repeated in over 10 fields, apparently copied and pasted or otherwise entered multiple times. In the area that appears to reflect the assessment by this provider, there is an entry "Adult Antisocial Behavior (r/o mood d/o by report only; r/o psd r/o psychosis nos by report only; r/o personality d/o nos)." A referral to Dr. Blanche, now with CorrectHealth, is included in this encounter as is continuation of hydroxyzine.

On January 18, 2017 Dr. Blanche conducts his second cell side encounter with Mr. Fano and assesses that he likely does not suffer from serious mental illness and that his antipsychotic medication should be discontinued. Testimony of other detainees indicates that Mr. Fano was

experiencing a mental health crisis and that he asked others for razor blades. Mr. Frank Brooks, who was detained at the same time as Mr. Fano, provided a sworn statement that "Mr. Fano was also talking to himself, saying things out loud to no one in particular, like he was hearing and talking to voices in his head. It was obvious he wanted to hurt himself, so obvious that 4 or 5 other detainees and I told guards and medical staff that Mr. Fano needed to be moved to a cell where he could be closely watched so he did not hurt himself. Guards and medical staff would respond by saying 'he'll be alright' or 'don't worry, he's ok.' I did not understand why they kept him so far away from the cage, where staff could not see him unless they did rounds." Mr. Brooks also reported that security staff often failed to conduct their basic security rounds and that detainees were often confined to their cells for 4-5 days straight.

Mr. Emanuel Jones, who was also detained at the same time as Mr. Fano and came from another part of the jail to clean the N and M lines, reported very similar concerns about Mr. Fano, stating in deposition testimony "Mr. Fano always talked about killing himself" and "I told Dep Monroe that he needed to get Fano help and move him to a cell closer to the cage so guards could watch him." Mr. Jones also stated that "Guards do not do their rounds and counts like they are supposed to." A third person detained at the same time as Mr. Fano, Daniel Hinton, reported that Mr. Fano was expressing suicidal ideation including stating "He would talk out loud to himself as he stepped off, and stating 'man I can't handle this. Give me a razor blade. I want to kill myself.'" Mr. Hinton also reported that security staff did not conduct their required rounds.

On February 2, 2017, Mr. Fano is found hanging in his cell on N line, transported to Lady of the Lake Hospital where he died three days later.

SPECIFIC FINDINGS

The following represent major deviations from the standard of clinical care that is expected in correctional health services. Both PMS and CorrectHealth are implicated in these findings as the lapses in mental health care span the transition of one provider to the next on January 1, 2017, and there is a clear and profound lack of access to mental health services under both providers. Review of depositions by CorrectHealth staff make clear that CorrectHealth failed to appreciate and address clearly visible deficiencies in care when they assumed responsibility for the provision of health services in EBRPP.

1. Lack of meaningful response by Baton Rouge Police Department to a behavioral health crisis. Based on the initial reports via 911 and their own observations in the field, Baton Rouge Police should have arranged EMS transport of Mr. Fano to an emergency room for evaluation of his behavioral health emergency. There, physicians could have assessed the relative contributions of mental health and acute intoxication to Mr. Fano's mental status and initiated treatment. The police report by the Baton Rouge Police Department includes multiple observations by their own staff and others that Mr. Fano was acting in a bizarre manner that placed him and others at risk and that he was hallucinating and otherwise 'acting crazy.' The narrative reported by police officers in their report was that Mr. Fano was under the influence of alcohol and/or narcotics, without a single mention of any mental health concerns. Police Department staff then relied on a 'clearance' by EMS personnel for transport of Mr. Fano to the jail without medical or psychiatric evaluation of his potentially suicidal, psychotic or otherwise life-threatening status. In fact, the documentation of police that Mr. Fano was transported because of his "horribly bad behavior" supports the concerns

that police staff and their supervisors lacked the training to appropriately respond to a clear case of a behavioral health emergency.

2. Failure to redirect Mr. Fano to a hospital setting during admission to EBRPP. Both EBRPP security and health staff should have read and acted on the police arrest reports which clearly documented that Mr. Fano was in the throes of a behavioral health crisis that required evaluation by physicians in a hospital setting. One of the core responsibilities of security and health staff conducting intake assessments before a detainee is housed is to identify persons too ill or at risk of death who require immediate medical or psychiatric evaluation in a hospital. There is no indication that any EBRPP staff reviewed police arrest documents or considered the poor health of Mr. Fano during entry to the jail. The PMS staff member who conducted the health assessment on November 1, 2016, S. Allen, did not include the alarming observations of behavioral health crisis from the police arrest reports in the clinical notes and there is no evidence that police reports or observations were ever reviewed by her or any other EBRPP. In addition, despite including that Mr. Fano was reporting auditory hallucinations and that he had a "suicide gesture" at an unspecified moment in time, C. Schley makes an assessment on 1/11/17 that Mr. Fano is faking or exaggerating his symptoms, largely based on the clinically unsound rationale that Mr. Fano is experiencing auditory hallucinations that he cannot discern the words he is hearing, that he is not exhibiting any outward signs of these hallucinations and that he reports the voices as originating inside his head. Auditory hallucinations are extremely variable, in their perceived clarity, origin and level of threat, not only from one person to another, but from moment to moment in a single patient.[6] A more appropriate and

6 Flavie Waters, PhD Psychiatric Times. Auditory Hallucinations in Psychiatric Illness March 10, 2010 Volume: 27 Issue:3 https://www.psychiatrictimes.com/cme/auditory-hallucinations-psychiatric-illness.

evidence-based approach would have been to elicit a standard history about whether these auditory hallucinations were ever perceived as threatening by Mr. Fano or directed him to harm himself or others and what the impact of therapy and medication was on them. In addition, there is no documented effort to reconcile these auditory hallucinations with Mr. Fano's history of suicide attempts, which are recorded as recently as 2016 in EBRPP. This clearly deficient assessment that Mr. Fano is faking or exaggerating symptoms is copied and pasted into more than ten fields in his mental health notes, including in domains that are not intended for assessments but are for objective data gathering, such as speech, perception or thought coherence. This indicates that C. Schley's judgment that Mr. Fano was faking or exaggerating his symptoms precluded the objective collection of data through a mental health assessment. A history of suicide attempts and current behavioral health crisis documented by police should have led CorrectHealth health staff to immediately refer Mr. Fano to a hospital for evaluation.

3. Failure to provide meaningful mental health care while incarcerated in EBRPP. Having failed to redirect Mr. Fano to a hospital setting, PMS and EBRPP security staff then failed to provide adequate or timely care for his obvious, serious behavioral health concerns. During his detention, Mr. Fano was briefly transferred to the hospital and when returned, mental health staff approved his placement in solitary confinement in the N/M lines of EBRPP on suicide watch. These housing areas were (and continue to be) administered with limited access to mental health services and include the practice of solitary confinement, which is known to exacerbate existing mental health problems and is associated with high rates of self-harm and death. It appears that Mr. Fano's initial encounter with a psychiatrist (Dr. Blanche) occurred on the third of November, not in a clinical setting but through the

bars of Mr. Fano's cell. During this encounter, Dr. Blanche assessed Mr. Fano as not being suicidal and ordered his suicide watch to be stopped but did not order for his removal from solitary confinement. This is the only recorded encounter between Mr. Fano and Dr. Blanche until the new year and given his history of suicide attempt, recent self-harm, recent medication changes and auditory hallucinations, Dr. Blanche should have seen Mr. Fano at a minimum of one week after the initial encounter and should have also ordered his removal from solitary confinement and that his clinical encounters occur in a clinic setting, not through the bars of his cell. Despite his well-documented mental health history and active problems, the mental health service appears to ignore the need for clinical care of Mr. Fano, scheduling and deleting multiple encounters without actually seeing him. On December 18, 2016, Mr. Fano's request for care makes clear that his mental health is worsening in solitary confinement: "I'm having really bad anxiety and depression. Feels as if the walls are closing in, also having really bad thoughts of my time here." The response of Mr. Fano's repeated requests for more effective care was to decide on withdrawal of his medications. Deposition testimony by Dr. Bridges indicates that his referral of Mr. Fano to see Dr. Blanche on November 4, 2016 did not include any pre-determined time frame. This represents an additional failure in the mental health service since timeframes for mental health referral should be divided into categories that include known timeframes, with commonly used categories being routine (within 7 days), urgent (within 24 hours) and stat (immediate). Multiple appointments were made and cancelled for Mr. Fano to see Dr. Blanche, and he was not actually seen again by Blanche until January 18, 2017, over two and a half months after the referral by Dr. Bridges. This is exactly the type of systematic

risk that incoming CorrectHealth should have identified and addressed, especially given the alarming assessment conducted by HMA.

4. Failure of the Parish and CorrectHealth to institute basic remedies for obvious deficiencies in the mental health services upon assuming responsibility for health services in EBRPP. The deposition of Dr. Bridges makes clear CorrectHealth failed to implement even the most basic elements of assuming care in their transition into EBRPP. Having overseen, led and participated in many such transitions, I am struck by the lack of sign out or briefing on the most seriously ill or high-risk patients by CorrectHealth. When one vendor assumes responsibility for care, it is standard, and in the best interests of patients, staff and the vendor alike, to compile a list of the patients with the most serious health problems and ensure their assessments, treatments, medications etc. are not interrupted in the transition. This would include patients with active cancer, heart disease, diabetes, recent hospitalizations, those in withdrawal from any substance use and those with any suicidal ideation or serious mental illness. Dr. Bridges testified in deposition that he was never contacted by CorrectHealth to perform this type of review. In fact, he testified that he was never contacted by CorrectHealth for any reason in the months leading up to the transition on January 1 2017, or for any time after the transition. Dr. Bridges also testified that the October 2016 departure of the only other physician, Dr. Whitfield, left a gap that was not addressed with hours worked by another physician or by him. The deposition of Ms. Stines, Director of Nursing until the end of 2016, indicates that the Parish was not providing adequate funding to meet basic needs of patients, and that the acting HSA had told her that he would not be the one to obtain supplies, but that she would need to advocate herself for basic supplies and equipment. As she stated "The demand was great for the supplies. It was

greater than the utilization of the supplies. We needed more supplies. We were not getting any equipment and stuff fast, you know, like we needed it." A similar lack of resources for staffing was also reported by Ms. Stines: "We needed it, and we needed more members, more staff members." The deposition of Mr. William Daniel supports the lack of oversight and provision of resources by responsible parties. He identified EMS as the organization responsible for oversight of CorrectHealth and testified in his deposition and recorded in previous notes regarding the HMA findings that the Parish was not providing adequate care and needed to develop a new model to improve the quality of care that would include quality metrics tracked in an electronic medical record. He also testified in his deposition that "HMA pretty much confirmed what I already believed." Parish officials had publicly declared the situation in EBRPP to be a state of emergency and that the consequences of failure to dramatically increase funding and access to care would be the deaths of more people. At the Metro City Council meeting January 2015, the Chief Administrator stated that "We've had mental health patients die in the prison" and that the conditions in EBRPP represented "a serious, serious situation" and alerted officials that "people are in a position where they can be harmed or lose their life" and that increased funding for health services was "life or death" for the mentally ill in the jail. At the same meeting, the EBRPP warden labeled the jail conditions as "very deplorable as far as mental health is concerned."

Nonetheless, there is no evidence that the Parish or CorrectHealth undertook efforts to improve conditions of care or even effect a safe transition of service delivery in January 1, 2017. CorrectHealth nurse practitioner Joyce Brown reported in her deposition that she could not recall a death review meeting for Mr. Fano or receiving a report or findings on this death, despite the lack of these death reviews having been profiled as a core failure by

HMA.[7] She further reported in her testimony that the 11-day delay in Mr. Fano's Seroquel order being approved by her was not out of the ordinary or concerning. Jean Llovet, the director of clinical services for Louisiana and a self-described CorrectHealth loyalist, testified that there was a period of time during the transition during which people did not receive their medications due to an unknown IT issue. The HSA for CorrectHealth during the time of the transition, Natasha Jones, reported in her deposition that she did recall a death review being done for Mr. Fano's case that involved some clinical staff and the CorrectHealth attorney, but that she did not recall any errors or discussion about the quality of care in his case. She further testified that among the 4 or 5 death reviews that she was part of for CorrectHealth at EBRPP, she did not recall any instance where the care diverged from community standards. Nurse Tamekka Green, who worked into 2018 with CorrectHealth at EBRPP, reported serious staffing shortages in the facility as well, specifically nurses that were dedicated to ensuring patients received their medications.

The lack of CorrectHealth action to address risks to patients was especially grave in the solitary confinement units of the N and M lines. Nurse Danielle Thomas testified in her deposition that when Mr. Fano died, nurses were not conducting segregation rounds, e.g. documenting the status of each person at least once per day, which is a standard practice in jail and prison settings. She also testified that she did not walk all the way down Mr. Fano's cell block during pill call on the morning of the day Mr. Fano hanged himself. Nurse Vincent Bradley reported a different practice, of walking down the cell block every time pill call was conducted, but the variation and lack of understanding among these nurses makes clear that when CorrectHealth assumed responsibility for care, they did not

[7] I understand that CorrectHealth claimed to have performed a mortality review on Mr. Fano. This report is preliminary in the sense that it was written without the benefit of that document.

establish any meaningful practice to assess and document the health of people held in solitary confinement. Social Worker Courtney Eichelberger testified in her deposition that she walked down the N line daily, but the security logs show that she only appeared on the N line once during the week and a half she worked at EBRPP when Mr. Fano was there. Dr. Kissinger, the mental health director for CorrectHealth, visited EBRPP and when he toured the N and M lines, he was aware of the placement of patients on suicide watch in those housing areas. When asked whether he had concerns about suicide risks for patient in those cells he replied "I don't recall having any thoughts about that" and when asked whether he ever had a conversation about the physical elements of the cells he replied "I don't know." When deposed in this case, the owner of CorrectHealth, Dr. Carlo Musso reported that he was unaware of the rate of death of patients at EBRPP and that regarding the comparison of the number of deaths in EBRPP reflecting a higher rate than is publicly reported by the Department of Justice for jail deaths nationally, he replied "I don't have an opinion on that nor have I been able to independently verify that." This is a stunning admission from the person who leads the organization that sought out and was granted responsibility for providing health care in EBRPP.

A review of other deaths in EPRBB raises concerns that many of the contributors to Mr. Fano's death represent systematic failings that have also contributed to other deaths.[8] In particular, review of the very limited death reviews conducted regarding the homicide of Mr. Tyrin Colbert in 2016, the death of Mr. Brian Ducre in 2016 and the suicide of Mr. Rickey Whatley five months after the death of Mr. Fano. In the case of Mr. Colbert's

[8] I understand that CorrectHealth claimed to have performed mortality reviews on the deaths at EBRPP that occurred on their watch. This report is preliminary in the sense that it was written without the benefit of those documents.

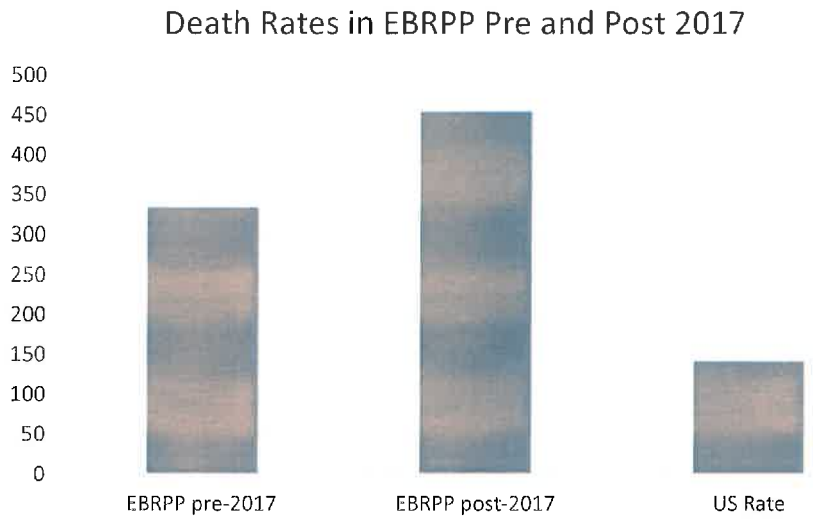
homicide, other detainees told investigators that they heard the altercation between Mr. Colbert and his cellmate, but no security intervention occurred and Mr. Colbert was only discovered after being killed by his cellmate. This lack of basic surveillance and oversight of a cell housing area represents a serious breach in basic correctional standards, especially since Mr. Colbert had recently been removed from suicide watch, as had Mr. Fano.

In the case of Mr. Ducre, who died of homicide in EBRPP, he was well-documented to have sustained numerous injuries shortly before his death including facial and head trauma. Mr. Ducre was also documented as acting erratically including having possible hallucinations and he had a history of schizophrenia. The security report into his death notes that he was "placed on Lockdown for observation." This represents a gross failure on the part of security and health staff by placing a vulnerable patient into a solitary confinement setting (N line), where is it clear he would be left alone in a cell, far from medical monitoring. In the case of Mr. Whatley, he was also held in solitary confinement and hanged himself, five months after the suicide of Mr. Fano and six months after CorrectHealth assumed responsibility for care.

The overall rate of death in EBRPP appears to be over twice the national average and ongoing the practices of CorrectHealth and EBRPP are clearly increasing the likelihood of death for detainees. Review of the number of deaths in EBRPP indicate that 25 deaths occurred in the 5 years before the CorrectHealth transition, while 17 deaths have occurred in the 2 ½ years since the transition.[9] This would translate to annual rates of death

[9] Calculations based on average daily population of 1,500 people from 2012 through July 2019. Sources include 1) Farris, S. and Armstrong, A., Dying in East Baton Rouge Parish Prison (July 2018) available at https://promiseofjustice.org/wp-content/uploads/2019/07/Dying-in-East-Baton-Rouge-Parish-Prison-Final.pdf and 2) Walter Smith deposition, Exhibit 2 (monthly statistical reports created by CorrectHealth) and 3) Mortality in Local Jails 2000-2014), U.S. Department of Justice, Bureau of Justice Statistics., available at https://www.bjs.gov/content/pub/pdf/mlj0014_sum.pdf.

of 333 per 100,000 inmates before the transition and 453 per 100,000 after the transition. By comparison, the national average rate of death was 140 per 100,000 jail inmates based on U.S. Department of Justice reporting (see Table below).



CorrectHealth staff and leadership acknowledge the use of solitary confinement as a primary response to mental health crises, despite this practice being discredited and associated with death. In addition, the ongoing short-staffing of CorrectHealth in this facility results in a lack of adequate care even when people are able to have an encounter with a health professional. Nowhere is this more apparent than the rushed and inadequate care provided to vulnerable patients held on the N and M lines in solitary confinement.

5. Taken together, these reports from staff who worked before and after the transition to CorrectHealth show that Mr. Fano was provided care in a setting that failed to make meaningful improvements despite changing the health service provider and where little effort was put into keeping close surveillance on high risk patients. These failures represent systemic and ongoing breaches in the standard of care that significantly increase the risk of death for patients in EBRPP and display an unwillingness or inability of CorrectHealth to make meaningful improvements.
6. My overall assessment is that Mr. Fano's death was preventable. My medical opinion is that the health service made substantial contributions to his death by ignoring his history of serious mental illness, ignoring his obvious signs of serious mental illness and stated

need for higher levels of care, combined with the direction by health and security staff that he be placed into solitary confinement in a unit lacking basic suicide prevention measures and left there for over three (3), made substantial contributions to his death.

Attachment B

Dr. Homer D. Venters

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HEALTH ADMINISTRATOR PHYSICIAN EPIDEMIOLOGIST

Professional Profile

- International leader in provision and improvement of health services to patients with criminal justice involvement.
- Innovator in linking care of patients with justice involvement to health systems and Medicaid coverage.
- Successful implementer of nations' first electronic health record, performance dashboards and health information exchange among detained pre-trial patients.
- Award winning epidemiologist focused on the intersection of health, criminal justice and human rights in the United States and developing nations.
- Human rights leader with experience using forensic science, epidemiology and public health methods to prevent and document human rights abuses.

Professional Experience

President, Community Oriented Correctional Health Services (COCHS), Starting 1/1/20.

- Oversee all aspects of COCHS work including technical assistance, policy reform regarding correctional health.
- Lead new initiatives regarding suicide prevention and alternatives t solitary confinement in jail and prison settings.
- Serve as primary point of contact with COCHS board, press, stakeholders and funders regarding COCHS work.

Senior Health and Justice Fellow, Community Oriented Correctional Health Services (COCHS), Starting 11/1/18.

- Lead COCHS efforts to expand Medicaid waivers for funding of care for detained persons relating to Substance Use and Hepatitis C.
- Develop and implement COCHS strategy for promoting non-profit models of diversion and correctional health care.

Medical/Forensic Expert, 3/2016-present

- Provide expert input, review and testimony regarding health care, quality improvement, electronic health records and data analysis in detention settings.

Director of Programs, Physicians for Human Rights, 3/16-11/18.

- Lead medical forensic documentation efforts of mass crimes against Rohingya and Yazidi people.
- Initiate vicarious trauma program.
- Expand forensic documentation of mass killings and war crimes.
- Develop and support sexual violence capacity development with physicians, nurses and judges.
- Expand documentation of attacks against health staff and facilities in Syria and Yemen.

Chief Medical Officer/Assistant Vice President, Correctional Health Services, NYC Health and Hospitals Corporation 8/15-3/17.

- Transitioned entire clinical service (1,400 staff) from a for-profit staffing company model to a new division within NYC H + H.
- Developed new models of mental health and substance abuse care that significantly lowered morbidity and other adverse events.
- Connected patients to local health systems, DSRIP and health homes using approximately $5 million in external funding (grants available on request).
- Reduced overall mortality in the nation's second largest jail system.
- Increased operating budget from $140 million to $160 million.
- Implemented nation's first patient experience, provider engagement and racial disparities programs for correctional health.

Assistant Commissioner, Correctional Health Services, New York Department of Health and Mental Hygiene, 6/11-8/15.

- Implemented nation's first electronic medical record and health information exchange for 1,400 staff and 75,000 patients in a jail.
- Developed bilateral agreements and programs with local health homes to identify incarcerated patients and coordinate care.
- Increased operating budget of health service from $115 million to $140 million.
- Established surveillance systems for injuries, sexual assault and mental health that drove new program development and received American Public Health Association Paper of the Year 2014.
- Personally care for and reported on over 100 patients injured during violent encounters with jail security staff.

Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 1/10-6/11.

- Directed all aspects of medical care for 75,000 patients annually in 12 jails, including specialty, dental, primary care and emergency response.
- Direct all aspects of response to infectious outbreaks of H1N1, Legionella, Clostridium Difficile.
- Developed new protocols to identify and report on injuries and sexual assault among patients.

Deputy Medical Director, Correctional Health Services, New York Department of Health and Mental Hygiene, 11/08-12/09.

- Developed training program with Montefiore Social internal medicine residency program.
- Directed and delivered health services in 2 jails.

Clinical Attending Physician, Bellevue/NYU Clinic for Survivors of Torture, 10/07-12/11.

Clinical Attending Physician, Montefiore Medical Center Bronx NY, Adult Medicine, 1/08-11/09.

Education and Training

Fellow, Public Health Research, New York University 2007-2009. MS 6/2009
Projects: Health care for detained immigrants, Health Status of African immigrants in NYC.

Resident, Social Internal Medicine, Montefiore Medical Center/Albert Einstein University7/2004- 5/2007.
M.D., University of Illinois, Urbana, 12/2003.
M.S. Biology, University of Illinois, Urbana, 6/03.
B.A. International Relations, Tufts University, Medford, MA, 1989.

Academic Appointments, Licensure

Clinical Associate Professor, New York University College of Global Public Health, 5/18-present.

Clinical Instructor, New York University Langone School of Medicine, 2007-2018.
M.D. New York (2007-present).

Peer Reviewed Publications

Venters H. Notions from Kavanaugh hearings contradict medical facts. *Lancet.* 10/5/18.

Taylor GP, Castro I, Rebergen C, Rycroft M, Nuwayhid I, Rubenstein L, Tarakji A, Modirzadeh N, **Venters H**, Jabbour S. Protecting health care in armed conflict: action towards accountability. *Lancet.* 4/14/18.

Katyal M, Leibowitz R, **Venters H**. IGRA-Based Screening for Latent Tuberculosis Infection in Persons Newly Incarcerated in New York City Jails. *J Correct Health Care.* 2018 4/18.

Harocopos A, Allen B, Glowa-Kollisch S, **Venters H**, Paone D, Macdonald R. The Rikers Island Hot Spotters: Exploring the Needs of the Most Frequently Incarcerated.
J Health Care Poor Underserved. 4/28/17.

MacDonald R, Akiyama MJ, Kopolow A, Rosner Z, McGahee W, Joseph R, Jaffer M, **Venters H**. Feasibility of Treating Hepatitis C in a Transient Jail Population.
Open Forum Infect Dis. 7/7/18.

Siegler A, Kaba F, MacDonald R, **Venters H**. Head Trauma in Jail and Implications for Chronic Traumatic Encephalopathy. *J Health Care Poor and Underserved.* In Press (May 2017).

Ford E, Kim S, **Venters H**. Sexual abuse and injury during incarceration reveal the need for re-entry trauma screening. *Lancet.* 4/8/18.

Alex B, Weiss DB, Kaba F, Rosner Z, Lee D, Lim S, **Venters H,** MacDonald R. Death After Jail Release. *J Correct Health Care.* 1/17.

Akiyama MJ, Kaba F, Rosner Z, Alper H, Kopolow A, Litwin AH, **Venters H**, MacDonald R. Correlates of Hepatitis C Virus Infection in the Targeted Testing Program of the New York City Jail System. *Public Health Rep.* 1/17.

Kalra R, Kollisch SG, MacDonald R, Dickey N, Rosner Z, **Venters H**. Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System. *J Correct Health Care*. 2016 Oct;22(4):383-392.

Venters H. A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration. *Am J Public Health*. April 2016.104.

Glowa-Kollisch S, Kaba F, Waters A, Leung YJ, Ford E, **Venters H**. From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails. *Int J Env Res Public Health*. 2016. 13(2),182.

Jaffer M, Ayad J, Tungol JG, MacDonald R, Dickey N, Venters H. Improving Transgender Healthcare in the New York City Correctional System. *LGBT Health*. 2016 1/8/16.

Granski M, Keller A, Venters H. Death Rates among Detained Immigrants in the United States. *Int J Env Res Public Health*. 2015. 11/10/15.

Michelle Martelle, Benjamin Farber, Richard Stazesky, Nathaniel Dickey, Amanda Parsons, **Homer Venters**. Meaningful Use of an Electronic Health Record in the NYC Jail System. *Am J Public Health*. 2015. 8/12/15.

Fatos Kaba, Angela Solimo, Jasmine Graves, Sarah Glowa-Kollisch, Allison Vise, Ross MacDonald, Anthony Waters, Zachary Rosner, Nathaniel Dickey, Sonia Angell, **Homer Venters**. Disparities in Mental Health Referral and Diagnosis in the NYC Jail Mental Health Service. *Am J Public Health*. 2015. 8/12/15.

Ross MacDonald, Fatos Kaba, Zachary Rosner, Alison Vise, Michelle Skerker, David Weiss, Michelle Brittner, Nathaniel Dickey, **Homer Venters**. The Rikers Island Hot Spotters. *Am J Public Health*. 2015. 9/17/15.

Selling Molly Skerker, Nathaniel Dickey, Dana Schonberg, Ross MacDonald, **Homer Venters**. Improving Antenatal Care for Incarcerated Women: fulfilling the promise of the Sustainable Development Goals. *Bulletin of the World Health Organization*.2015.

Jasmine Graves, Jessica Steele, Fatos Kaba, Cassandra Ramdath, Zachary Rosner, Ross MacDonald, Nathanial Dickey, **Homer Venters** Traumatic Brain Injury and Structural Violence among Adolescent males in the NYC Jail System *J Health Care Poor Underserved*. 2015;26(2):345-57.

Glowa-Kollisch S, Graves J, Dickey N, MacDonald R, Rosner Z, Waters A, **Venters H**. Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail. *Health and Human Rights*. Online ahead of print, 3/12/15.

Teixeira PA[1], Jordan AO, Zaller N, Shah D, **Venters H**. Health Outcomes for HIV-Infected Persons Released From the New York City Jail System With a Transitional Care-Coordination Plan. 2014. *Am J Public Health*. 2014 Dec 18.

Selling D, Lee D, Solimo A, **Venters H.** A Road Not Taken: Substance Abuse Programming in the New York City Jail System. *J Correct Health Care.* 2014 Nov 17.

Glowa-Kollisch S, Lim S, Summers C, Cohen L, Selling D, **Venters H**. Beyond the Bridge: Evaluating a Novel Mental Health Program in the New York City Jail System. *Am J Public Health.* 2014 Sep 11.

Glowa-Kollisch S, Andrade K, Stazesky R, Teixeira P, Kaba F, MacDonald R, Rosner Z, Selling D, Parsons A, **Venters H**. Data-Driven Human Rights: Using the Electronic Health Record to Promote Human Rights in Jail. *Health and Human Rights*. 2014. Vol 16 (1): 157-165.

MacDonald R, Rosner Z, **Venters H**. Case series of exercise-induced rhabdomyolysis in the New York City Jail System. *Am J Emerg Med*. 2014. Vol 32(5): 446-7.

Bechelli M, Caudy M, Gardner T, Huber A, Mancuso D, Samuels P, Shah T, **Venters H.** Case Studies from Three States: Breaking Down Silos Between Health Care and Criminal Justice. *Health Affairs*. 2014. Vol. 3. 33(3):474-81.

Selling D, Solimo A, Lee D, Horne K, Panove E, **Venters H**. Surveillance of suicidal and non-suicidal self-injury in the new York city jail system. *J Correct Health Care*. 2014. Apr:20(2).

Kaba F, Diamond P, Haque A, MacDonald R, **Venters H**. Traumatic Brain Injury Among Newly Admitted Adolescents in the New York City Jail System. *J Adolesc Health*. 2014. Vol 54(5): 615-7.

Monga P, Keller A, **Venters H**. Prevention and Punishment: Barriers to accessing health services for undocumented immigrants in the United States. *LAWS*. 2014. 3(1).

Kaba F, Lewsi A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, **Venters H**. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.

MacDonald R, Parsons A, **Venters H.** The Triple Aims of Correctional Health: Patient safety, Population Health and Human Rights. *Journal of Health Care for the Poor and Underserved*. 2013. 24(3).

Parvez FM, Katyal M, Alper H, Leibowitz R, **Venters H.** Female sex workers incarcerated in New York City jails: prevalence of sexually transmitted infections and associated risk behaviors. *Sexually Transmitted Infections*. 89:280-284. 2013.

Brittain J, Axelrod G, **Venters H.** Deaths in New York City Jails: 2001 – 2009. *Am J Public Health*. 2013 103:4.

Jordan AO, Cohen LR, Harriman G, Teixeira PA, Cruzado-Quinones J, **Venters H.** Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island. *AIDS Behav. Nov.* 2012.

Jaffer M, Kimura C, **Venters H.** Improving medical care for patients with HIV in New York City jails. *J Correct Health Care*. 2012 Jul;18(3):246-50.

Ludwig A, Parsons, A, Cohen, L, **Venters H.** Injury Surveillance in the NYC Jail System, *Am J Public Health* 2012 Jun;102(6).

Venters H, Keller, AS. *Psychiatric Services*. (2012) Diversion of Mentally Ill Patients from Court-ordered care to Immigration Detention. Epub. 4/2012.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2011) Mental Health Concerns Among African Immigrants. 13(4): 795-7.

Venters H, Foote M, Keller AS. *Journal of Immigrant and Minority Health.* (2010) Medical Advocacy on Behalf of Detained Immigrants. 13(3): 625-8.

Venters H, McNeely J, Keller AS. *Health and Human Rights.* (2010) HIV Screening and Care for Immigration Detainees. 11(2) 91-102.

Venters H, Keller AS. *Journal of Health Care for the Poor and Underserved*. (2009) The Immigration Detention Health Plan: An Acute Care Model for a Chronic Care Population. 20:951-957.

Venters H, Gany, F. *Journal of Immigrant and Minority Health* (2009) African Immigrant Health. 4/4/09.

Venters H, Dasch-Goldberg D, Rasmussen A, Keller AS, *Human Rights Quarterly* (2009) Into the Abyss: Mortality and Morbidity among Detained Immigrant. 31 (2) 474-491.

Venters H, *The Lancet* (2008) Who is Jack Bauer? 372 (9653).

Venters H, Lainer-Vos J, Razvi A, Crawford J, Shaf'on Venable P, Drucker EM, *Am J Public Health* (2008) Bringing Health Care Advocacy to a Public Defender's Office. 98 (11).

Venters H, Razvi AM, Tobia MS, Drucker E. *Harm Reduct J.* (2006) The case of Scott Ortiz: a clash between criminal justice and public health. Harm Reduct J. 3:21

Cloez-Tayarani I, Petit-Bertron AF, **Venters HD**, Cavaillon JM (2003) *Internat. Immunol.* Differential effect of serotonin on cytokine production in lipopolysaccharide-stimulated human peripheral blood mononuclear cells.15,1-8.

Strle K, Zhou JH, Broussard SR, **Venters HD**, Johnson RW, Freund GG, Dantzer R, Kelley KW, (2002) *J. Neuroimmunol.* IL-10 promotes survival of microglia without activating Akt. 122, 9-19.

Venters HD, Broussard SR, Zhou JH, Bluthe RM, Freund GG, Johnson RW, Dantzer R, Kelley KW, (2001) *J. Neuroimmunol.* Tumor necrosis factor(alpha) and insulin-like growth factor-I in the brain: is the whole greater than the sum of its parts? 119, 151-65.

Venters HD, Dantzer R, Kelley KW, (2000) *Ann. N. Y. Acad. Sci.* Tumor necrosis factor-alpha

induces neuronal death by silencing survival signals generated by the type I insulin-like growth factor receptor. 917, 210-20.

Venters HD, Dantzer R, Kelley KW, (2000) *Trends. Neurosci.* A new concept in neurodegeneration: TNFalpha is a silencer of survival signals. 23, 175-80.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142.

Venters HD, Tang Q, Liu Q, VanHoy RW, Dantzer R, Kelley KW, (1999) *Proc. Natl. Acad. Sci. USA.* A new mechanism of neurodegeneration: A proinflammatory cytokine inhibits receptor signaling by a survival peptide, 96, 9879-9884.

Venters HD, Ala TA, Frey WH 2nd , (1998) Inhibition of antagonist binding to human brain muscarinic receptor by vanadium compounds. *Recept. Signal. Transduct.* 7, 137-142**.**

Venters HD, Bonilla LE, Jensen T, Garner HP, Bordayo EZ, Najarian MM, Ala TA, Mason RP, Frey WH 2nd, (1997) Heme from Alzheimer's brain inhibits muscarinic receptor binding via thiyl radical generation. *Brain. Res.* 764, 93-100.

Kjome JR, Swenson KA, Johnson MN, Bordayo EZ, Anderson LE, Klevan LC, Fraticelli AI, Aldrich SL, Fawcett JR, **Venters HD**, Ala TA, Frey WH 2nd (1997) Inhibition of antagonist and agonist binding to the human brain muscarinic receptor by arachidonic acid. *J. Mol. Neurosci.* 10, 209-217.

Honors and Presentations (past 10 years)

Oral Presentation, Dual loyalty and other human rights concerns for physicians in jails an prisons. Association of Correctional Physicians, Annual meeting. 10/16, Las Vegas.

Oral Presentation, Clinical Alternatives to Punitive Segregation: Reducing self-harm for incarcerated patients with mental illness. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Analysis of Deaths in ICE Custody over 10 Years . American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Medication Assisted Therapies for Opioid Dependence in the New York City Jail System. American Public Health Association Annual Meeting, November 2015, Chicago IL.

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. American Public Health Association Annual Meeting, November 2014, New Orleans, LA.

Training, International Committee of the Red Cross and Red Crescent, Medical Director meeting

10/15, Presentation on Human Rights and dual loyalty in correctional health.

Paper of the Year, American Public Health Association. 2014. (Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *Amer J Public Health*. 2014. Vol 104(3):442-7.)

Oral Presentation, Pathologizing Normal Human Behavior: Violence and Solitary Confinement in an Urban Jail. *American Public Health Association* Annual Meeting, New Orleans LA, 2014.

Oral Presentation, Human rights at Rikers: Dual loyalty among jail health staff. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Poster Presentation, Mental Health Training for Immigration Judges. American Public Health Association Annual Meeting, New Orleans LA, 2014.

Distinguished Service Award; Managerial Excellence. Division of Health Care Access and Improvement, NYC DOHMH. 2013.

Oral Presentation, Solitary confinement in the ICE detention system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Self-harm and solitary confinement in the NYC jail system. American Public Health Association Annual Meeting, Boston MA, 2013.

Oral Presentation, Implementing a human rights practice of medicine inside New York City jails. American Public Health Association Annual Meeting, Boston MA, 2013.

Poster Presentation, Human Rights on Rikers: integrating a human rights-based framework for healthcare into NYC's jail system. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Poster Presentation, Improving correctional health care: health information exchange and the affordable care act. *American Public Health Association* Annual Meeting, Boston MA, 2013.

Oral Presentation, Management of Infectious Disease Outbreaks in a Large Jail System. American Public Health Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Diversion of Patients from Court Ordered Mental Health Treatment to Immigration Detention. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Initiation of Antiretroviral Therapy for Newly Diagnosed HIV Patients in the NYC Jail System. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Medical Case Management in Jail Mental Health Units. *American Public Health Association* Annual Meeting, Washington DC, 2011.

Oral Presentation, Injury Surveillance in New York City Jails. *American Public Health*

Association Annual Meeting, Washington DC, 2011.

Oral Presentation, Ensuring Adequate Medical Care for Detained Immigrants. Venters H, Keller A, American Public Health Association Annual Meeting, Denver, CO, 2010.

Oral Presentation, HIV Testing in NYC Correctional Facilities. Venters H and Jaffer M, *American Public Health Association,* Annual Meeting, Denver, CO, 2010.

Oral Presentation, Medical Concerns for Detained Immigrants. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Growth of Immigration Detention Around the Globe. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Role of Hospital Ethics Boards in the Care of Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Oral Presentation, Health Law and Immigration Detainees. Venters H, Keller A, *American Public Health Association* Annual Meeting, Philadelphia, PA, November 2009.

Bro Bono Advocacy Award, Advocacy on behalf of detained immigrants. Legal Aid Society of New York, October 2009.

Oral Presentation, Deaths of immigrants detained by Immigration and Customs Enforcement. Venters H, Rasmussen A, Keller A, *American Public Health Association* Annual Meeting, San Diego CA, October 2008.

Poster Presentation, Death of a detained immigrant with AIDS after withholding of prophylactic Dapsone. Venters H, Rasmussen A, Keller A, *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Poster Presentation, Tuberculosis screening among immigrants in New York City reveals higher rates of positive tuberculosis tests and less health insurance among African immigrants. *Society of General Internal Medicine* Annual Meeting, Pittsburgh PA, April 2008.

Daniel Leicht Award for Achievement in Social Medicine, Montefiore Medical Center, Department of Family and Social Medicine, 2007.

Poster Presentation, Case Findings of Recent Arestees. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Toronto Canada, April 2007.

Poster Presentation, Bringing Primary Care to Legal Aid in the Bronx. Venters H, Deluca J, Drucker E. *Society of General Internal Medicine* Annual Meeting, Los Angeles CA, April 2006.

Poster Presentation, A Missed Opportunity, Diagnosing Multiple Myeloma in the Elderly Hospital Patient. Venters H, Green E., *Society of General Internal Medicine* Annual Meeting, New Orleans LA, April 2005.

Grants: Individual

Co-Principal Investigator, Immigration Detention Health Resource Project (IDHR). Langeloth Foundation (Project 1917). January 1 2013-January 31 2017 (initial grant 2011-2013). Total grant amount $300,611.

Principal Investigator, Investigation of testosterone levels, depression and mental status as these variables associate with HIV dementia. Carle Hospital, Urbana Illinois, total Costs $1,500 (2003).

Principal Investigator, Pro-Inflammatory Cytokine Expression during Pediatric HIV-Encephalopathy in Togo, West Africa. Elizabeth Glaser Pediatric AIDS Research Foundation, total Costs $5,000 (2000-2001).

Grants: Program

Ryan White Part A - Prison Release Services (PRS). From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/17 (Renewed since 2007). Annual budget $ 2.7 million.

Ryan White Part A - Early Intervention Services- Priority Population Testing. From HHS/HRSA to Correctional Health Services (NYC DOHMH), 3/1/16-2/28/18 (Renewed since 2013). Annual budget $250,000.

Comprehensive HIV Prevention. From HHS to Correctional Health Services (NYC DOHMH), 1/1/16-12/31/16. Annual budget $500,000.

HIV/AIDS Initiative for Minority Men. From HHS Office of Minority Health to Correctional Health Services (NYC DOHMH), 9/30/14-8/31/17. Annual budget $375,000.

SPNS Workforce Initiative, From HRSA SPNS to Correctional Health Services (NYC DOHMH), 8/1/14-7/31/18. Annual budget $280,000.

SPNS Culturally Appropriate Interventions. From HRSA SPNS to Correctional Health Services (NYC DOHMH), 9/1/13-8/31/18. Annual budget $290,000.

Residential substance abuse treatment. From New York State Division of Criminal Justice Services to Correctional Health Services (NYC DOHMH), 1/1/11-12/31/17. Annual budget $175,000.

Community Action for Pre-Natal Care (CAPC). From NY State Department of Health AIDS Institute to Correctional Health Services (NYC DOHMH), 1/1/05-12/31/10. Annual budget $290,000.

Point of Service Testing. From MAC/AIDS, Elton John and Robin Hood Foundations to Correctional Health Services (NYC DOHMH), 11/1/09-10/31/12. Annual budget $100,000.

Mental Health Collaboration Grant. From USDOJ to Correctional Health Services (NYC DOHMH), 1/1/11-9/30/13. Annual budget $250,000.

Teaching

Instructor, Health in Prisons Course, Bloomberg School of Public Health, Johns Hopkins University, April 2019, June 2015, June 2014.

Instructor, Albert Einstein College of Medicine/Montefiore Social Medicine Program Yearly lectures on Data-driven human rights, 2007-present.

Other Health & Human Rights Activities

DIGNITY Danish Institute Against Torture, Symposium with Egyptian correctional health staff regarding dual loyalty and data-driven human rights. Cairo Egypt, September 20-23, 2014.

Doctors of the World, Physician evaluating survivors of torture, writing affidavits for asylum hearings, with testimony as needed, 7/2005-present.

United States Peace Corps, Guinea Worm Educator, Togo West Africa, June 1990- December 1991.

-*Primary Project;* Draconculiasis Eradication. Activities included assessing levels of infection in 8 rural villages and giving prevention presentations to mothers in Ewe and French

-*Secondary Project;* Malaria Prevention.

Books

Venters H. *Life and Death in Rikers Island*. Johns Hopkins University Press. 2/19.

Chapters in Books

Venters H. Mythbusting Solitary Confinement. In *Solitary Confinement: History, Effects, and Pathways to Reform*. Editors: Jules Lobel and Peter Scharff Smith. University of Pittsburgh Press. Expected 2019.

MacDonald R. and **Venters H.** Correctional Health and Decarceration. In Decarceration. Ernest Drucker, New Press, 2017.

Venters, H.D. Jr., R. Dantzer, G.G. Freund and K.W. Kelley. 2001. Growth hormone and insulin-like growth factor as cytokines in the immune system. *In* R. Ader, D. L. Felten and N. Cohen (Eds.) *Psychoneuroimmunology*. Third Edition. Academic Press, New York, New York. pp 339-362.

Testimony and Op-Ed Columns

New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Access to Medication Assisted Treatment in Prisons and in Correctional Settings. November 15, 2018. NY, NY.

Venters HD, New York Advisory Committee to the U.S. Commission on Civil Rights: Regarding the use of solitary confinement for juveniles in New York. July 10, 2014. NY NY.

New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Venters HD, New York State Assembly Committee on Correction with the Committee on Mental Health: Regarding Mental Illness in Correctional Settings. November 13, 2014. Albany NY.

Venters HD and Keller AS, The Health of Immigrant Detainees. Boston Globe, April 11, 2009.

Venters HD, U.S. House of Representatives, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law: Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008.

Membership in Professional Organizations

American Public Health Association

Foreign Language Proficiency

French Proficient
Ewe Conversant

Prior Testimony and Deposition

Benjamin v. Horn, 75 Civ. 3073 (HB) (S.D.N.Y.) as expert for defendants, 2015

Rodgers v. Martin 2:16-cv-00216 (U.S.D.C. N.D.Tx) as expert for plaintiffs, 10/19/17

Fikes v. Abernathy, 2017 7:16-cv-00843-LSC (U.S.D.C. N.D.AL) as expert for plaintiffs 10/30/17

Fernandez v. City of New York, 17-CV-02431 (GHW)(SN) (S.D.NY) as defendant in role as City Employee 4/10/18.

Charleston v. Corizon Health INC, 17-3039 (U.S.D.C. E.D. PA) as expert for plaintiffs 4/20/18.

Gambler v. Santa Fe County, 1:17-cv-00617 (WJ/KK) as expert for plaintiffs 7/23/18.

Hammonds v. Dekalb County AL, CASE NO.: 4:16-cv-01558-KOB as expert for plaintiffs 11/30/2018.

Mathiason v. Rio Arriba County NM, No. D-117-CV-2007-00054, as expert for plaintiff 2/7/19.

Lewis v. Gautreaux, et al., No. 17-656-JWD-RLB (M.D. La. 2017), as expert for the plaintiff, 6/25 and 7/1, 2019

Fee Schedule

Case review, reports, testimony $400/hour.

Statement of Charges:

Initial review of documents and preliminary draft (6/12/19); 7 hours, $2,800.

Review of additional documents and report finalization (12/27/19); 14 hours, $5,600.