MDPH Division Of Health Professions Licensure
Board of Registration in Nursing
INVESTIGATION REPORT

Complaint Number : NUR-2014-0186 Licensee : LN66531/Peter E Kozak

Section 3A Persons Interviewed

Name & Title Of Person Interviewed	Date	Type (Phone, In-Person)	Address & Phone
Complainant	1/12/2015; and 3/2/2015	Phone	
Lt. D.D.	3/23/2015	Phone	

Section 3B Persons Unavailable For Or Declining Interview

Name/Title & Relationship To The Complaint	Date	Address & Phone	Reason (Decline, Not Able To Contact, Other)

Section 3C Other Agencies/Entities Involved In Or Investigating The Alleged Conduct

Agency	Contact Name/Title	Address & Phone

Section 4 Investigation Summary

Complaint Allegation(s):

Based on a report submitted by J. B., MSN, RN, Barnstable County Sheriff's Office, a complaint was filed against the Licensee's nursing license. It is alleged that on or about May 23, 2014, while the Licensee was employed as a licensed practical nurse at the Barnstable County Sheriff's Office, he failed to respond appropriately to a medical emergency involving an inmate; despite being previously counseled for past failures to respond appropriately to inmate medical emergencies.

Documentation, including interviews & written witness statements, that supports allegation(s):

A. Signed and dated July 24, 2014 complaint, J.B., MSN, RN states
   1. Since she has worked as the Assistant Director of Health Services at the Barnstable County Sherriff's office, she has had concerns about the Licensee's abilities to provide safe patient care. Documentation will show incompetence in ability to identify emergency equipment, operate emergency equipment, and administer emergency medications when indicated.

   2. Specifically, on 5/23/14, the Licensee failed to administer Narcan to an inmate who had overdosed. The inmate died as a result of the overdose.

B. Copy of email sent to Superintendent J.R. from Lieutenant D.D. and dated May

24, 2014:

1. Narcan was available but not administered. He spoke with Nurse M this morning and she showed him where it is stored on the aid bag that medical staff responded with. She stated transportation staff is trained in its use. It makes sense for shift supervisors to receive the same training. It is a simple device to use.

2. During the event, D.D. asked the Licensee if he had an oropharyngeal (OPA) airway that he could use to insert in the inmate's mouth due to the amount of blood and other matter blocking his airway. He doesn't recall if the Licensee answered him as he continued to work on the inmate. An OPA airway is a very simple device they train their first responders to use to help keep the airway open. He spoke to Nurse M about this issue as well. She showed him where they are kept. They are stored in the metal crash cart in medical that contains syringes and other meds. He advised Nurse M that they should be in the aid bag that nurses respond with. He never saw the crash cart brought to a unit.

3. During the event, D.D. told the Licensee they needed to get the oxygen connected to the AMBU bag. The Licensee was unable to do this. D.D. had to stop compressions, take hold of the oxygen tank, and turn the regulator on high flow in order to fill the AMBU bag.

4. During the event, he asked the Licensee if medical had any sort of portable suction device. He doesn't recall if the Licensee answered him. There are simple hand operated portable suction devices available that would have helped clear the inmate's airway of fluids.

C. Copy of the Review of Medical Incident report, dated June 4, 2014, from S.D., MD, Director of Health Services, to J.B., MSN, RN-Assistant Director of Health Services:
   1. Concerns
      a. The nurse should always verbally confirm that they have received a call for medical response on the radio. No verbal confirmation was made on radio traffic *(Investigator's Note: in reference to this inmate incident)*.
      b. The nurse should always bring an emergency bag and the O2 tank to a non-routine medical response request. If at all possible, it should be the main crash bag that is kept in the medical department (it has more tools in it than the smaller bags kept in the triage rooms). A triage bag was brought to the incident by the Licensee, after he had left the medical department where the main bag is stored.
      c. Upon arrival to an unresponsive patient, the nurse's first duty is to assess. Vital signs should have been taken, or at least attempted. At the very least, an O2 monitor should be placed on the patient's finger. The Licensee did not attempt to take vital signs.
      d. To their understanding, at some point before rescue arrived, the Licensee was informed that the inmate had overdosed on an

opiate. Even if there was no mention of suspected opiates, the inmate was an otherwise healthy man in his redacted The nurse, as a result of their training, should consider the possibility that there may have been a substance ingested. Narcan should have been administered immediately. N.B. had brought the main crash bag and O2 tank from the medical department to the scene. Narcan is kept in the main crash bag that was brought. In the video, the bag sits outside the cell, unopened. Narcan was not administered until the inmate was in the ambulance.

2. Recommendations
   a. Training/Retraining
      - Oxygen tank re-training for nurses
      - Re-training for nurse on where emergency meds are stored and refresher on what conditions they are used for
      - A mandatory passing of a Nurse (LPN) Refresher course for the Licensee
      - Security Staff training on the administration of Nasal Narcan
   b. Staff Competency
      - Evaluation of the Licensee's competency/ability to provide safe medical care at this facility.

D. Copy of letter to the Licensee from J.R., Superintendent, Barnstable Sheriff's Department dated July 16, 2014:
   1. This letter shall serve as the findings of the Barnstable County Sheriff's Office relative to the staff disciplinary hearing that was held on July 14, 2014, at the Barnstable County Correctional Facility

   2. Count 1: Failure to provide adequate standard of care during a medical emergency
      a. During the hearing process, ADS R.A. read into the record the investigative report findings as outlined below
      b. The Licensee failed to provide an adequate standard of care during a medical emergency on May 23, 2014, in redacted By his own admission, the Licensee did not assess the patient when he arrived on scene as outlined in the review from the Medical Director and Assistant Director who outlined the duties of the medical staff when they arrived on scene.
         - Upon arrival to an unresponsive patient, the nurse' first duty is to assess. Vital signs should have been taken, or at least attempted. At the very least, an O2 monitor should be placed on patient's finger. The Licensee did not attempt to take vital signs.
      c. The Licensee stated in his interview that he had knowledge that heroin was being used by the patient. Having this information, the Licensee said he went and retrieved Narcan from the medical department but did nothing with it. When asked why he didn't administer or tell staff on scene that he had Narcan, he said "it

was busy." When reviewing the video, it is clear that the Licensee does nothing; the radio transmission that morning specifically called for the "crash bag" to be brought to [redacted] and the Licensee who was the responding nurse did not bring the "crash bag' as required. This bag was brought by the phlebotomist and records clerk for medical. The Licensee was previously counseled on July 9, 2013, for failing to respond to a medical emergency with a crash bag, failing to take over the scene, and leaving the unit and security staff with an unresponsive inmate.

d. Upon completion of these findings, the Licensee was asked if he stipulated to the facts as read and he stated "yes." The Licensee stipulated to the following facts as presented by ADS R.A.
   - The Licensee's interview-Titled [Licensee's] interview
   - Radio Calls-Titled Radio Calls
   - Video footage of [redacted] Medical entrance
   - Reading from the Licensee's counseling session with Assistant Medical Director

e. During the hearing process, the Licensee described the above medical emergency as a "Drastic" event. While responding to this "drastic" medical emergency the Licensee entered medical to secure his medication cart, leaving behind the "medical crash cart and crash bag" (as requested by Central Control) which items are located in the same hallway in which he secured the medication cart in. The Licensee then responded to the zone three triage room to retrieve the black emergency bag and then responded to cell [redacted] Upon questioning relative to the contents of the emergency bag, the Licensee responded with "a blood pressure cuff, stethoscope and Band-Aids."

f. In July of 2013, the Licensee was counseled in regards to a similar incident where the Licensee failed to respond with the "crash bag". During that counseling session with the Assistant Medical Director the following was reviewed
   - The Licensee was unable to remember what the call on the radio had said. He stated that he did respond to the call without the crash bag, he brought assessment tools (O2 monitor, stethoscope, etc.). Stated that there was an AED and ambu-bag in the unit. He was unable to remember the name of "AED" or "ambu-bag" and referred to them as "the machine "and "the breathing bag". She stated to the Licensee that any non-routine call for medical attention requires the crash bag. She explained to him that there are many medical supplies in the crash bag that may be needed in an emergency not just the AED and ambu-bag. The Licensee stated that he understood that he should bring the crash bag to all emergency medical calls in the future."

g. W.D. (Union Representative) stated that the Medical Staff is unaware that Narcan is kept in the crash bag. As a result of this statement, he requested any documentation from the Assistant

Medical Director outlining where Narcan is stored. The following is a copy of the response he received from the Assistant Medical Director

- Email from the Assistant Medical Director to Health Services dated February 26, 2014: There is now a Nasal Narcan kit in the crash cart and one kit in the front pocket of the emergency bag where the cut downs are. The two spares are in the same drawer as the IM Valium in the stock cart. As you know, there is injectable Narcan in the crash cart. I discussed with Steve and you may use either administration method (Nasal or IM) that you feel most comfortable with. Neither is more effective than the other.

h. In closing, the Licensee failed to administer Narcan despite his training relative thereto, and knowledge of the heroin use by the inmate. In addition to the foregoing, the Licensee left the scene and returned to the medical unit to acquire paperwork and removed the Narcan from the "crash cart". The Licensee then admittedly returned to the scene with the Narcan in hand and did nothing, to wit administer the Narcan or verbalize he had it in his possession for use. The Licensee also failed to complete any assessment on the inmate. The Licensee failed to operate the oxygen tank and when asked twice by security staff, was non-responsive and unable to set the oxygen tank for use. Further, the Licensee admitted to not providing relevant information to Bourne Rescue regarding the inmate's use of heroin. As the medical staff member on scene, it was the Licensee's responsibility (as outlined in the July, 2013 counseling session) to assume control of the medical situation. The Licensee failed to take control of the medical situation as the medical staff member on scene, thereby failing in his duties as an LPN for the BCSO.

i. Based upon the information disclosed in the hearing and his review of the investigative file, he finds the Licensee guilty of the outlined charges. It is the position of the Barnstable County Sheriff's Office that additional training/retraining or a lesser discipline would not correct the Licensee's noted deficiencies in his position as a LPN for the Barnstable County Sheriff's Office. The Licensee is hereby terminated from employment at the Barnstable County Sheriff's Office effective July 17, 2014.

E. Copy of February Staff Meeting minutes dated 2/15/14 showing The Licensee was present for a Nasal Narcan Training.

F. Copy of Health Services Monthly Staff Meeting minutes dated March 5, 2014, showing the Licensee was present for a New O2 tank demonstration by K.G. Cape Medical Supply.

G. Copy of Documentation of Counseling with the Licensee on July 9, 2013, by J.B., MSN, RN

1. J.B. met with the Licensee to discuss an incident that occurred on 7/2/13

at approximately 11:15pm. According to report from Capt. E, the Licensee received a radio call for medical to respond to an unresponsive inmate. According to the report, issues with the Licensee's performance include:

- Arriving to an emergency call without emergency medical supplies (crash bag)
- Failing to take charge of a medical situation. It is reported that the Licensee looked to security staff to make a decision regarding sending the inmate to the hospital or not.
- Leaving the unit prior to the arrival of rescue services, leaving security staff with an unresponsive inmate.

2. When asked about the incident, which occurred one week ago, the Licensee struggled to remember details about the incident. The following took place in her counseling with the Licensee on July 2, 2013:
   a) The Licensee was unable to remember what the call on the radio had said. He stated that he did respond to the call without the crash bag, he brought assessment tools (O2 monitor, stethoscope, etc.) Stated that there was an AED and ambu-bag in the unit. He was unable to remember the name of the "AED" or "ambu-bag" and referred to them as "the machine" and "the breathing bag." She stated to the Licensee that any non-routine call for medical attention requires the crash bag. She explained that there are many medical supplies in the crash bag that may be needed in an emergency, not just the AED and ambu-bag. The Licensee stated that he understood that he should bring the crash bag to all emergency calls in the future.
   b) She explained to the Licensee that is the responsibility of the medical staff on duty to take charge of a medical situation and make medical decisions; that a nurse should not look to the security staff to make medical decisions. The Licensee appeared agitated and stated that he would "just start sending everyone out." She asked the Licensee for clarification of his statement and he stated that they should "send [inmate] out this morning then. " She asked what was going on with this inmate and he stated "He just doesn't want to get out of bed." She informed the Licensee that threatening to "just send everyone out" out of spite is not a professional way to react to feedback. She stated to the Licensee that he needs to send inmates out only when it is medically indicated. She asked the Licensee if she could trust that he will sent people out only when his medical assessment indicated that it is needed and he stated yes.
   c) She asked the Licensee how many times he left the unit during the incident and what he did during the times he left the unit. After some time, the Licensee stated that on one of the occasions, that he had left the unit, he called the doctor. He stated that he felt it was okay to leave the unit because the

officers were first responders. She explained to the Licensee that when medical staff is in the building, they should not leave an unresponsive inmate without medical staff and the Licensee stated he understood.

H. Investigator's Summary of the Licensee's Video-taped interview with Facility Official:

1. The Licensee states that he has been a nurse for 18 years, and has worked at the jail for 8 years.

2. He was in the main hallway with a cart and heard the page and pushed his cart into their office and headed to redacted stopping at the Triage Room to get the bag. He stated that he got the "Emergency Bag" and he was asked what the emergency bag was, and he stated that it is their bag for anything they should have for any type of emergency. He was asked what color the bag was and he stated black.

3. The Licensee was asked how he heard the call, and he stated that he didn't recall; and it was pointed out to him that he is pointing at the ceiling as if he heard the page overhead, and he was asked if he heard it over the PA system or his radio and he stated PA system. He does not remember if he acknowledged the call.

4. He was asked what he did when he arrived on scene, and he stated that Lt. D. was doing compressions and there was another officer there giving him oxygen "or I should say, the airbag, the small air bag that we use." He was asked what airway he was talking about, O2? The Licensee stated "Oxygen!I, we've got the oxygen, liter, but we've got the small compression air. *(Investigator's note: The Licensee is obviously having difficulty trying to find the name for the Ambu bag and is gesturing with his hands showing a squeezing motion.)*

5. He stated that there was not much he could do and he asked the Lt. D. if he could step in and the Lt. D said no, he was fine. He asked the Licensee to go get the paperwork ready for the hospital. He was asked to do this approximately 5 minutes after he arrived.

6. The Licensee returned to the office and their secretary was getting the paperwork done and he returned to the cell within 3-4 minutes.

7. He was asked if he assessed the inmate when he returned and he stated no. "No, the um, the um, the machine" (making a square with his hands and obviously struggling to find the word). He then let out a big sigh of frustration and stated "The LCD, or the er, er, can I look at the..." (Points to his statement) and reads the statement, points to the paper and says "The AED, the AED was monitoring him, they had him hooked up."

8. The Assistant Superintendent stated "So, no assessment was done on the patient due to the fact that he was hooked up to an AED and the

Licensee stated "right." He was asked if he felt this was sufficient and he stated "right."

9. He was asked how he assisted the staff with the emergency, and he stated that the only assistance he gave was getting the inmate on a stretcher.

10. The Licensee was told that they had information that when the emergency call went out, they were told that the cellmate told the officers that they had been doing heroin. He was asked if he was aware of that and he stated yes, approximately 10 minutes after he got there, he was made aware. He was asked if he took the cellmate's vital signs knowing there was heroin done and he stated he did them later.

11. The Licensee stated that when he went to the office to do the paperwork, he "took a Narcan bag down." He states that he did not administer the Narcan because Bourne Rescue got there at the same time he was going to give it.

12. He was asked why he left a second time, and he stated to go get the Narcan when he came back from doing the paperwork. He was asked what made him grab the Narcan at that time and he stated that it was right after he heard that the inmate had taken heroin.

13. He stated that he was going to administer the Narcan and had even ripped open the bag, but rescue had just arrived and Lt. D. was saying that the inmate's eyes were fixed and dilated and he did not give the Narcan.

14. He was asked what was in the emergency bag that he spoke about and the Licensee stated stethoscope, blood pressure cuff, temperature gauge (sic) and Band-Aids. He was asked if there was oxygen in the bag and he answered no. He was asked where the oxygen came into play and he stated that he didn't recall; someone brought the oxygen down and he doesn't remember who. He was asked if he set up the oxygen and he stated that he turned it on and the officer at the head of the inmate hooked it up and put it on the inmate.

15. He was asked if he had any type of dialogue with the rescue personnel when they arrived and he stated not that he can recall, no. He handed the paperwork directly to them, and did not have any dialogue with them about what was going on with the patient.

16. He was asked what the difference was between the emergency bag and the crash bag and he stated "Should be none, there should be none, but I was told later that the orange bag had Narcan in it." He stated that he was told later by his supervisor that Narcan was held in the orange/ crash bag and did not know that it was kept there. He was not aware that the crash bag was on scene because he never looked at the other bag