



CHARLES C. FOTI, JR.
ATTORNEY GENERAL

State of Louisiana

DEPARTMENT OF JUSTICE

P.O. BOX 94005

BATON ROUGE

70804-9005

MEMORANDUM

TO: Whom It May Concern

RE: Memorial Medical Center Investigation
Documents in the custody of the Louisiana Attorney General's Office

DATE: July 24, 2007

Pursuant to the provisions of La. R.S. 44:31, and jurisprudence interpreting that statute, the attached documents are being provided in compliance with numerous written public records request made to the Office of the Attorney General on July 24, 2007.

The documents attached hereto do not comprise the totality of the records in the custody of the Office of the Attorney General in connection with this investigation. However, since particular issues of confidentiality must be considered in connection with the release of these other documents, it is the intention of the Office of the Attorney General to withhold release of these additional documents at this time. A further review of all relevant issues is in progress. It is anticipated that additional documents may be released in the near future and/or that issues concerning release of additional documents may be addressed by the appropriate court(s).

Attachments

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Dr. Pou spoke with Therese Mendez, Nurse Executive for LifeCare on the seventh floor. Pou told Mendez that she did not think the LifeCare patients were going to survive. Then Pou told Mendez that a decision had been made to administer lethal doses of Morphine to the LifeCare patients. Mendez asked "lethal doses of what?" Mendez does not recall exactly what Pou told her, but believes that Pou said Morphine, Ativan and Versed. Pou advised Mendez that the LifeCare staff needed to leave.

Meanwhile, Harris and Robichaux were unable to find Dr. Pou on the second floor and returned to the seventh floor. They found Dr. Pou there in the physical therapy charting room. Dr. Pou said that the LifeCare patients were not going to survive. Dr. Pou advised that a decision had been made to administer lethal doses to the remaining LifeCare patients. Harris asked Pou what she was going to use and she showed him a pack of 25 vials of Morphine plus a couple of loose vials of Morphine.

According to Robichaux and Harris, Pou was not familiar with the condition of the LifeCare patients. There is no indication that Pou made any attempt to talk with any nurse or doctor who was involved in the direct care of these patients and would have been able to discuss their conditions with her. There is also no indication that Dr. Pou evaluated the patients herself.

Dr. Pou advised Robichaux, Harris and Johnson that she was under the impression that the patients were not cognizant. Robichaux informed Pou that one patient, [REDACTED], was aware, conscious and alert, but that he weighed 380 pounds and was paralyzed. Dr. Pou decided [REDACTED] could not be evacuated. He could not be taken out by boat because he was not ambulatory and Dr. Pou felt he was too heavy to be evacuated by helicopter.

Dr. Pou asked if one of LifeCare's staff members would sedate [REDACTED]. Robichaux advised Dr. Pou that Andre Gremillion knew [REDACTED] well. Gremillion advised investigators that he was very familiar with [REDACTED]. [REDACTED] was a "frequent flyer" at LifeCare's Chalmette facility and was a jokester. [REDACTED] fed himself breakfast on the morning of 9/1/05 and talked with the nurses. Pou and Robichaux briefly discussed the matter of [REDACTED] with Gremillion. Gremillion advised that Dr. Pou had asked him to sedate [REDACTED]. Dr. Pou told Gremillion that if he was not comfortable with it, that he should not do it. Pou said that the first time she did it, it haunted her for two years. Gremillion refused to sedate [REDACTED]. Robichaux decided that she did not want any LifeCare staff involved.

Two nurses who Robichaux did not recognize came into the room. In December, Harris was with investigators at Memorial Medical Center when Dr. Pou, Cheri Landry and Lori Budo arrived. Harris positively identified Dr. Pou, Cheri Landry and Lori Budo as being the Dr. and two nurses that were present in the room when Harris and Robichaux arrived. As Robichaux was preparing to leave, Dr. Pou asked her if she wanted the LifeCare staff to be there. Robichaux responded that she did not want her staff there. Dr. Pou advised

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On Wednesday night, August 31, 2005, Dr. Faith Joubert, an independent physician with privileges at both Memorial Medical Center (MMC) and LifeCare Hospitals, came to the LifeCare Hospitals Unit on the seventh floor of Memorial Medical Center and evaluated all of the patients that remained there. She gave a PRN (as needed) order for any patients to have a low dose of Morphine (1-4 mg/hour) and/or Ativan (1-2 mg/hour) if needed for pain or anxiety. She also gave an order that any staff members who needed it could receive Ativan for anxiety.

On September 1, 2005, at approximately 7:00 a.m., LifeCare staff members, Kristy Johnson and Steven Harris attended an incident command meeting on the ER Ramp at MMC. At that meeting, Susan Mulderick stated that she was aware that LifeCare had nine very sick patients and that they did not expect these patients would be evacuated with the rest of the patients from MMC. It is unclear why Mulderick made this statement or where she got this information from. However, interviews with Memorial Medical Center staff and LifeCare staff indicate that a triage system was set up to evaluate by what method the patients could be evacuated. Patients rated 1 were the least critical, were ambulatory and could be evacuated by boat. Patients rated 3 were the most critical and would have to be evacuated by helicopter. The nine LifeCare patients had been evaluated by Dr. Bryant King on Wednesday evening and were all established as 3's for evacuation purposes.

At approximately 10:00 a.m. on Thursday, September 1, 2005, Johnson, Harris and Diane Robichaux (assistant administrator for LifeCare) sought out Susan Mulderick on the second floor to find out about availability of supplies and to discuss the plan for evacuating the LifeCare patients. When they found Susan Mulderick and attempted to discuss these things with her, she cut them off and said "The plan is to leave no living patients behind" and then she told them they needed to find Dr. Pou. Johnson returned to the seventh floor and Harris and Robichaux went looking for Dr. Pou, but were unable to locate her.

At some time that morning, Dr. Pou presented three prescriptions for Morphine to Phillip Duet, pharmacist for Memorial. The three prescriptions were for patients [REDACTED] [REDACTED] toxicology was performed on these patients and the results were negative for Morphine, with the exception of [REDACTED] who had low levels of Morphine in her tissues). When asked about the prescriptions, Duet said that he was presented with those prescriptions on 9/1/05 and that he filled them from the stock in the pharmacy and recorded them in the perpetual inventory. The prescriptions were for nine vials each, for a total of 27. (An inventory of the Morphine and Versed found in the Memorial Medical Center second floor pharmacy was performed during the search warrant. This inventory matched the perpetual inventory which was seized during the search warrant. The perpetual inventory includes a record of the 27 vials of Morphine dispensed for these prescriptions.)

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Robichaux that they didn't have a lot of time and that she needed to clear the floors as soon as they could.

Dr. Pou asked Harris for a tray, some saline flushes, needles and syringes. Harris went off to gather the supplies for Pou and Robichaux went to gather all of the remaining LifeCare staff to leave the floor. (Harris advised by proffer through his attorney, the he had actually provided Pou with additional Morphine and Versed. An inventory of Morphine and Versed in the LifeCare pharmacy was taken during the search warrant. Later comparison of that inventory to the perpetual inventory showed that the LifeCare pharmacy was missing a substantial amount of Morphine and Versed.)

Dr. Pou told Robichaux "I want ya'll to know I take full responsibility and ya'll did a great job taking care of the patients." Kristy Johnson and Therese Mendez returned to the seventh floor. Johnson observed Dr. Pou and two nurses drawing something up from vials into syringes.

After Harris and Robichaux left the area, Johnson was asked by Pou to show her and the nurses where all of the LifeCare patients were located. Johnson proceeded down the hall with Pou and the nurses. Dr. Pou appeared to be nervous. Dr. Pou said she was going to tell [REDACTED] that she was going to give him something to help with his dizziness. One of the nurses asked Dr. Pou if Dr. Pou wanted the nurse to go in with her but Dr. Pou said no. Then Dr. Pou entered [REDACTED] room and closed the door. Johnson then accompanied the taller nurse (later identified by Johnson as being Lori Budo) into the room occupied by [REDACTED] and [REDACTED]. Johnson saw the nurse inject [REDACTED] with something. Johnson then heard [REDACTED] say "That burns." Johnson then accompanied the nurses and Dr. Pou to all the patient's rooms and identified the patients for them. Johnson also heard Dr. Pou make a statement with regard to [REDACTED] that "I had to give her three doses, she's fighting."

Dr. Pou told Johnson to make a list of all the remaining patients and their locations and leave the list on the desk in the Therapy Charting room. Dr. Pou told Johnson that she needed the list because they would be coming back to the seventh floor and checking on the patients and wanted to make sure they didn't miss anyone. Dr. Pou told the LifeCare staff that they needed to evacuate, that the LifeCare patients were in "our care now" and "you've done everything you can."

Johnson, Robichaux, Harris and Mendez went room to room to make sure that all the LifeCare staff had left the floor. Dr. Pou instructed them to cover any deceased patients with a sheet. During this final sweep of the floor, they found that one patient had died and pulled the sheet over his head. Johnson, Robichaux, Harris and Mendez then left the seventh floor and went downstairs.

Harris advised that he had met Dr. Pou at Northshore Medical Center following the evacuation, and that Dr. Pou had told him that what happened on the 7th floor was going

to happen regardless of LifeCare staff's cooperation or objection.

Dr. John Skinner advised that he made rounds of Memorial Medical Center on the afternoon of September 1, 2005 to make sure that he had documented all of the deceased and that no one had been left behind because the hospital was to be locked down at 5:00 p.m. on that day and everyone had to be out by then. During his rounds, Skinner encountered Dr. Pou on the seventh floor with a patient who he believed was still alive. Skinner told Dr. Pou that he thought the patient was still alive and offered Dr. Pou assistance with evacuating the patient, but Dr. Pou said she wanted to talk to an anesthesiologist first. Skinner returned to the seventh floor around 3:00 p.m. or 3:30 p.m. and found that all the patients remaining on the seventh floor were deceased at that time.

The bodies of the following nine patients of LifeCare were removed from Memorial Medical Center on September 11, 2005:

[REDACTED]

Autopsies were performed at DMORT on all of these patients and various tissue and fluid samples were taken during the autopsies. These tissue samples were sent to National Medical Services in Willow Grove, PA. The toxicology results on each of these nine patients revealed high levels of Morphine and/or Versed.

On November 15, 2005, the last four days of the patient charts for the first four patients listed above, along with the toxicology reports for the same patients were sent to Dr. Cyril Wecht, (pathologist) for review. Dr. Wecht reviewed the records and on December 23, 2005, Dr. Wecht advised that in his opinion, these patients had died from Morphine overdoses. Dr. Wecht later reviewed the charts of the other five patients listed above and advised that he believed that these patients had also died of Morphine or Morphine/Versed toxicity and that he believed that all nine deaths should be classified as homicides.

The patient charts and toxicology for all nine of the patients listed above were also reviewed by Dr. James Young (pathologist). Dr. Young also believes that the cause of death for all nine patients is Morphine or Morphine/Versed toxicity and that the manner of death in all nine cases is homicide. According to Dr. Young, the toxicology reports indicate that large doses of these drugs were present in the patients, but the administration

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of these drugs to these patients was not documented in their charts. Dr. Young also noted that all nine of these patients died within 3 and ½ hours, and to have all nine patients die of drug toxicity in such a short time frame is "beyond coincidence."

A review of the patient charts by Special Agents Victoria Sweeney and Elizabeth Engels (who are both registered nurses) with the Attorney General's office indicates that all nine of these patients had physician's orders for emergency evacuation discharge. Four of the patients were full codes and five were DNR.

Following is a very brief summary of the patients' conditions prepared by Special Agents Sweeney and Engels:

██████████ Was alert and oriented times three and was admitted to LifeCare frequently for chronic (long standing) conditions. There was no documentation in the record to indicate ██████████ was compromised. The nurse exception charting indicated ██████████ was essentially within normal limits. ██████████ diagnosis included history of a stroke with paralysis of bilateral lower extremities, non insulin dependant diabetes, Hepatitis C with Hepatic encephalopathy, Chronic Ileus, Pitting Edema (swelling) and anemia. The chronic ileus was the main reason for the current admission. No order for Morphine or Versed

██████████ was admitted to LifeCare for IV antibiotics, rehabilitation, and nutritional support along with oxygen therapy. ██████████ diagnoses included asthma, hypoxia, high potassium, osteoarthritis and renal insufficiency. Last physician progress note was 08/27/05 and read patient found resting comfortably, vital signs good, no new medical complaints.

██████████ was awake but did not verbalize due to a stroke in 2000 and again in 4/2005. Watson had peripheral vascular disease and was admitted to LifeCare with long standing infection of multiple decubiti on bilateral lower extremities. The plan was to treat with antibiotics and surgical evaluation for bilateral above the knee amputations. The family was in agreement with proceeding with the surgical amputations to stop the disease process.

██████████ was admitted to Life Care for infection resolution, IV antibiotics, rehabilitation, nutritional support, and pain management. ██████████ other diagnoses included organic brain syndrome, schizophrenia, dementia, tardive dyskinesia, and colostomy. Alford had an order written on 08/31/05 for Morphine 1-4 mg IVP/IM every hour for restlessness/agitation. This order was not documented on the medication administration record (MAR) and there was no documentation in the nurses notes to indicate ██████████ ever received this medication.

The following persons have made proffers to this office through their attorneys and are seeking immunity:

Toxicology Reports

Dr. Michael Baden, Forensic Pathologist

“It is my opinion, to a reasonable degree of medical certainty, that the administration of morphine and Versed shortened the lives of all nine patients; that the patients died as the result of the improper administration of morphine with and without Versed; that the immediate cause of eight of the deaths was acute morphine and Versed poisoning and of one death was acute morphine poisoning; and that the *manner of death for each is homicide*”.

Michael M. Baden, M.D.

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2 October 2006

*Via Facsimile (504) 658-9674
and Federal Express*

Dr. Frank Minyard
2612 Martin Luther King Drive
New Orleans, Louisiana 70113

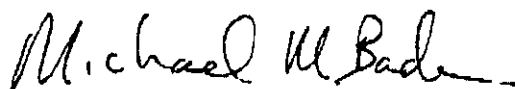
Re: Deaths at Memorial Medical Center

Dear Dr. Minyard:

Enclosed are my reports on the deaths of [REDACTED]
[REDACTED] and [REDACTED]

It is my opinion that each died of morphine poisoning or combined morphine and Versed poisoning. It is further my opinion that the circumstances surrounding these simultaneous deaths mandate a homicidal manner of death.

Yours very truly,



Michael M. Baden, M.D.

MMB:ph
Enclosures

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30 September 2006

DEATHS AT MEMORIAL MEDICAL CENTER

██████████ was a ██████ year old ██████████ with a past history of stroke, paraplegia, marked obesity ██████████, and ██████████ not requiring insulin, who was admitted to Life Care of Chalmette on July 13, 2005 for chronic fecal impaction and pitting edema of ██████ lower extremities. The medical chart shows that ██████ physician wrote a progress note every day at that hospital. The chart shows that ██████ was awake, alert, well-oriented and had improved considerably from ██████ prior CVA and that ██████ was cooperative and medically stable. A surgical procedure was being considered to relieve the impaction when on August 27th, ██████ was evacuated to Life Care in New Orleans on the seventh floor of Memorial Medical Center because of the approaching hurricane.

There are no physician notes in ██████ medical record at Life Care New Orleans. A nurse's note is written in the chart on August 31st: "Discharge: Disaster evacuation discharge all patients RBVO" – received by verbal order from Dr. Thien. ██████████ had called ██████ wife on August 29th to check on ██████ safety. Nurses described ██████ to be alert, in no pain and in no acute distress. ██████ body was recovered with others on September 11, 2005 and an autopsy was performed on September 21st.

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The autopsy showed post-mortem decomposition changes, an enlarged heart that weighed 580 grams, a single focal area of 60% narrowing of a secondary coronary artery by an arteriosclerotic plaque and cirrhosis of the liver. No evidence of pre-mortem trauma was found. A temporary death certificate was issued by the Coroner on October 7, 2005, in order to permit the family to bury the body, stating "Pending investigation" and listing Hurricane Katrina related death, cirrhosis of the liver and coronary arteriosclerosis. Subsequent toxicologic analyses showed significant levels of morphine and midazolam (Versed) to be present in body tissues and fluid. Neither medication had been ordered by [REDACTED] physician nor would have been indicated by the patient's medical condition. Both act on the brain to cause respiratory depression.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the medical materials that I have reviewed, the autopsy findings, the toxicology finding and the circumstances of death, that the cause of [REDACTED] death is acute morphine and Versed poisoning and that the manner of [REDACTED] death is homicide.

[REDACTED] was an [REDACTED] year old [REDACTED] nursing home resident who was admitted to Life Care at Memorial Hospital on August 3, 2005 for non-healing decubitus ulcers of [REDACTED] lower extremities and buttocks. [REDACTED] had a past medical history of cerebrovascular accidents, dementia, pernicious anemia and contractures. [REDACTED] was chair and bed bound and required total care for all activities. On admission [REDACTED] was awake and alert but was unable to verbalize.

The decubitus ulcers did not resolve on the lower extremities and it became necessary to perform bilateral above the knee amputation. While awaiting surgery the progress notes indicate

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that [REDACTED] was awake and in no distress on August 26th and 27th. On August 30th, there is a verbal note from Dr. LaCorte: "Disaster evacuation discharge." On August 31st, a Code Blue was called because of a temperature of 105°F and a sinus tachycardia of 123/minute and increased respirations. [REDACTED] was evaluated, a diagnosis of probable aspiration was made and [REDACTED] survived the Code. [REDACTED] had not complained of pain. [REDACTED] body was recovered on September 11, 2005. Autopsy revealed gangrene of toes on the right foot, cerebral atrophy and prominent post-mortem changes. The heart was not remarkable. Toxicology showed the presence of morphine and Versed in [REDACTED] body, neither of which had been prescribed by [REDACTED] physician.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the medical records I have reviewed, the autopsy and toxicology findings and the circumstances of her death, that [REDACTED] died of morphine and Versed poisoning. The manner of death, in my opinion, is homicide.

[REDACTED] was a [REDACTED] year old [REDACTED] who was transferred from Chalmette Medical Center to Life Care New Orleans on August 22, 2005 with acute bronchitis, hyperkalemia and renal insufficiency. Medical progress notes on August 25th state that [REDACTED] health, renal function and hematocrit were improving and that [REDACTED] was "resting comfortably, vital signs good." [REDACTED] was given Darvocet once on August 24th for pain and [REDACTED] received a Durgesic Fentanyl Patch on August 28th. A pm Demerol order for pain was never exercised. The last physician order was verbal on August 30th: "Emergency Evacuation Discharge." There was no order for morphine in the chart.

██████████ body was recovered from Life Care's seventh floor at Memorial Hospital on September 11th and an autopsy was performed on September 18th. ██████ body showed "moderate to advanced" decomposition. ██████ heart was normal in size and there was 80% narrowing of the left circumflex coronary artery by arteriosclerotic plaque. Toxicology analyses showed a very high level of morphine in the liver.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the medical records that I have reviewed, the autopsy and toxicologic findings and the circumstances of death, that the cause of ██████████ death was morphine poisoning and the manner of death was homicide.

██████████ was a ██████ year old ██████████ nursing home resident who was admitted to Life Care at Memorial Medical Center from Methodist Hospital on July 1, 2005 for coffee ground emesis, sepsis and hypotension. ██████ had a past medical history of organic brain syndrome, and tardive dyskinesia and had a colostomy. Physician progress notes are skimpy. On August 7th ██████ underwent surgical treatment for ██████ cellulites. On August 30th there is a note from Dr. Cashman: "Disaster evacuation discharge." The last physician order was given verbally by Dr. Joubert on August 31, 2005: "May have MS04 1-4 mgm IVP/IM q 1^o pm restlessness/agitation." Dr. Joubert had not seen the patient and there is no documentation in the chart that this medication was given to ██████████ by ██████ nurse on August 31st.

██████████ body was recovered on September 11, 2005 from Life Care's seventh floor at Memorial Hospital together with other simultaneously deceased patients. An autopsy was performed on September 19th and ██████ showed extensive decomposition changes. ██████ heart was

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normal in size. there were bronchopneumonic changes limited to the lower lung lobes and pyelonephritic changes were present in both kidneys. Subsequently, toxicology showed the presence of morphine and Versed sufficient to cause death by impairing [REDACTED] ability to breathe.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the medical materials that I have reviewed, the autopsy findings, the toxicology findings and the circumstances of death, that the cause of [REDACTED] death is acute morphine and Versed poisoning and that the manner of death is homicide.

Michael Baden

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3 October 2006

DEATHS AT MEMORIAL MEDICAL CENTER

██████████ was a █████ year old █████ nursing home resident who was admitted to Life Care with multiple infected decubitus ulcers and malnutrition on July 19, 2005. █████ was conscious, alert, partially oriented and could speak. █████ underwent left hip debridement on July 26; right leg debridement on August 19; and right below knee amputation on August 26th. █████ tolerated these procedures well and did not receive morphine or Versed. The last physician order was dated August 30: "Disaster Evacuate Discharge." █████ was found dead with other patients on the seventh floor at Memorial Medical Center on September 11th.

The autopsy performed on September 17th showed moderate decomposition and bronchopneumonia changes in the right lung. No acute pathologic change was found that would have caused █████ death. Toxicologic studies showed the presence of Vicodan (hydromorphone and its metabolite hydromorphone) which had been ordered by █████ physician and morphine and Versed which had not been so ordered. There were no medical indications to prescribe morphine and Versed.

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It is my opinion, to a reasonable degree of medical certainty, on the bases of the hospital records that I have reviewed, the autopsy and toxicology findings and the circumstances of death, that the cause of [REDACTED] death is acute morphine and Versed poisoning and that the manner of [REDACTED] death is homicide.

[REDACTED] was a [REDACTED] year old [REDACTED] nursing home resident who was admitted to Life Care Chalmette on August 12, 2005 for treatment of decubitus ulcers. [REDACTED] is described as awake, alert and responsive to simple verbal commands and not complaining of pain. [REDACTED] was evacuated to Life Care New Orleans on August 27th because of the approaching hurricane. [REDACTED] had a history of congestive heart failure, organic brain syndrome and chronic obstructive pulmonary disease. On August 30th, orders were written for "Emergency Evacuation Discharge." On August 31, [REDACTED] had a temperature of 100.8 but was otherwise in [REDACTED] usual state of health. [REDACTED] had not received morphine or Versed. [REDACTED] body was found on September 11th and an autopsy was performed on September 21. It showed slight enlargement of the heart and aortic and mitral valve calcific stenosis, and no acute pathologic change that would cause death. Toxicology showed the presence of morphine and Versed.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the hospital records that I have reviewed, the autopsy and toxicology findings and the

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circumstances of death, that the cause of [REDACTED] death is acute morphine and Versed poisoning and that the manner of her death is homicide.

[REDACTED] was a [REDACTED] year old [REDACTED] who was admitted to Memorial Medical Center on August 2, 2005 and transferred to Life Care on August 10th for care of severe sacral decubitus ulcers. [REDACTED] had a history of arteriosclerotic heart disease, a cerebrovascular accident, hypertension and rectal surgery for cancer with a permanent colostomy. On August 22nd, an inferior vena cava filter was inserted because of bilateral deep vein thrombosis. A CT scan on August 25th showed osteomyelitis and an abscess in the right pubic bone and [REDACTED] had a temperature of 104° on August 29th. A note on August 30th said [REDACTED] was in no acute distress. A signed physician's order on August 31, 2005 stated "Discharge Disaster Evacuation." This was followed by another unsigned order "May have morphine 1-4 mg IV/IM every hour for restlessness/agitation. Ativan 1-2 mgm every hour IV/IM as needed for restlessness/agitation." The last nurse's note on August 31st states that Vicodan - a narcotic analgesic - was given for complaints of pain. There was no further indication to prescribe morphine or Versed, and no such order was given. Neither drug was administered by treating health professionals.

Autopsy showed a moderate to advanced degree of decomposition and arteriosclerotic heart disease. There was no pulmonary embolism or other acute pathologic

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change that would cause death. Toxicologic studies showed the presence of morphine and Versed.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the hospital records that I have reviewed, the autopsy and toxicology findings and the circumstances of death, that the cause of [REDACTED] death is acute morphine and Versed poisoning and that the manner of [REDACTED] death is homicide.

[REDACTED] was a [REDACTED] year old [REDACTED] admitted on August 12, 2005 to Chalmette Medical Center for treatment of pneumonia and sepsis. On August 25th, [REDACTED] was transferred to Life Care Chalmette and on August 27th evacuated to Life Care New Orleans because of the approaching hurricane. [REDACTED] was treated for arteriosclerotic heart disease and congestive heart failure, for hypertension and for acute renal failure with [REDACTED] last dialysis on August 26th. On August 30th, [REDACTED] vital signs were normal and [REDACTED] showed no indication of pain. Morphine and Versed were not ordered nor administered.

The autopsy showed moderate decomposition and severe arteriosclerotic heart disease. Toxicology showed the presence of morphine and Versed.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the hospital records and autopsy and toxicology reports that I have reviewed and the circumstances of death, that the cause of [REDACTED] death is acute morphine and Versed poisoning and that the manner of [REDACTED] death is homicide.

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██████████ was a █████ year old █████ admitted to Life Care from Memorial Medical Center on August 8, 2005 for decubitus ulcers, dehydration and malnutrition. █████ received morphine on August 22nd and that order for morphine was discontinued on August 24th. █████ had orders for fentanyl containing Durgesic patches and Demerol for pain. █████ last received morphine nine days before she died. On August 30th █████ vital signs were normal and Demerol was given for pain. At 8 p.m. █████ temperature was 106.4° and █████ breathing was described as agonal. There was a physician's order for "Disaster Evacuation Discharge." No order was given for morphine or Versed. Autopsy showed severe arteriosclerotic heart disease. Toxicology showed the presence of fentanyl and Demerol, which were ordered, and morphine, which was not ordered and not indicated. The presence of morphine in liver, brain, muscle and purge fluids demonstrates that █████ heart was beating and █████ was alive when that injection was given.

It is my opinion, to a reasonable degree of medical certainty, on the bases of the hospital records that I have reviewed, the autopsy and toxicology findings and the circumstances of death, that although █████ was quite ill and near to dying from █████ natural diseases, the administration of morphine did shorten █████ life. It is, therefore, my opinion that the immediate cause of █████ death is acute morphine poisoning and that the manner of █████ death is homicide.

**Dr. Frank Brescia, Oncologist / Palliative Care
Specialist**

“It is my opinion that these patients were terribly ill, with some very close to death. The external circumstances were horrific, i.e. no water, toilets, electricity, air conditioning- which I expect contributed, to some extent, to hastening their dying. However, after studying the charts carefully, I feel that the manner of death in these individuals, especially in four cases (██████████, ██████████), obligates the legal process to consider them as homicides.”

MUSC

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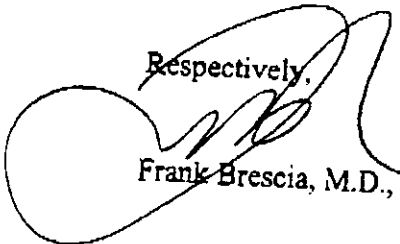
Re: Deaths at Memorial Medical Center

Dear Dr. Minyard,

Enclosed are my conclusions on the nine patient deaths you asked me to review. I thank you for your invitation to examine and comment on these records. I've enclosed brief notations on each individual case, comments, and a conclusion. I have also enclosed articles on palliative care, the principles of double effect, and on treatment considerations near end of life.

It is my opinion that these patients were terribly ill, with some very close to death. The external circumstances were horrific, i.e. no water, toilets, electricity, air conditioning- which I expect contributed, to some extent, to hastening their dying. However, after studying the charts carefully, I feel that the manner of death in these individuals, especially in four cases, obligates the legal process to consider them as homicides.

Respectively,



Frank Brescia, M.D., M.A.

I was asked to review the records of nine chronically ill patients who died during the days surrounding the evacuation and devastation of Hurricane Katrina in New Orleans, late summer of 2005. These nine individuals had a variety of chronic, multiple, complex clinical problems and presentations. Indeed, the average age of these patients was 80.5 years with 5 patients over 89 years. (Range 61-91). There were [REDACTED] and [REDACTED] all hospitalized in a floor of the same facility. Of interest, the average age of the women (85.8 years) was almost 12 years senior to the men. (74 years). All patients had autopsies and toxicology studies of multiple tissue specimens demonstrating suspiciously high values of morphine, and in some cases, morphine and midazolam. (Two patients [REDACTED] only morphine discovered). The review of the records, examining the last days of 4 patients ([REDACTED], [REDACTED], [REDACTED], [REDACTED]) were the most difficult to comprehend because the documentation available shows these patients to be stable, without and immediate or obvious threat of dying. Many of the patients appeared to be both chronically and acutely ill with a serious, progressive, and life-threatening process occurring, where death could be expected, even if there were competent and timely intervention. ([REDACTED], [REDACTED], [REDACTED], [REDACTED]). The deaths of the remaining 4 patients ([REDACTED], [REDACTED], [REDACTED], [REDACTED]) should be regarded as suspicious. I recommend allowing the legal process to investigate them as homicides. The conditions of care described in the documentation of these patients were horrific, extraordinary, and worsening – no electricity, air-conditioning, toilets, water. Documentation was scanty, inadequate, incomplete, below normal standards, or non-

existent during the last days of evacuation. These were not normal circumstances, and the obvious deviations in standards of good clinical care need to be looked upon in this context, (eg: what is reasonable, permissible, minimal measures and what is not? How does the medical community particularly in the state of Louisiana's medical licensing board and medical society, review the documented care and outcome of these nine patients in such unusual circumstances?) There are also important questions related to the informed consent of these patients, some of whom were demented, critically ill, vulnerable, and without capacity for decision-making. What was reasonable for patients and family members to be told regarding their medical condition, prognosis, and treatment options? Was there any attempt to understand either the patient or family wishes for end of life care? What is the place for minimal documentation by health care providers, particularly physicians and nurses during such a situation of responsibility and accountability? There is no clarity in any of the documentation regarding the decision-making process during those final days, i.e. how morphine and midazolam got into patients' tissues nor the reason, dosage, time, response. What was the intention of the caregivers? Was the intent to deliver a dose that was expected to be lethal, rather than a dose that was expected to relieve only discomfort (pain, anxiety, shortness of breath) and titrated for effectiveness? The principle of double effect would be a useful moral guidepost here, (eg: the intention was only to comfort, while accepting the fact that the

medication could hasten death.) The intent should not be to ~~end life~~. Finally, should there not have been an obligation of some professional help to stay behind with these frail, very ill, vulnerable, needy individuals? Is this abandonment, negligence of professional duty?

Palliative care means simply to reduce the intensity of discomfort a patient is feeling —pain, nausea, shortness of breath. It is a philosophy of care- active, compassionate therapies to comfort and support both the patient and families who are living with a life- threatening illness and meeting the physical, social, psychological, spiritual expectations and needs. The terminology often is used for patients, whose disease is not responsive to curative treatment, thus having a goal to maximize quality of life. It is always appropriate to give palliative care and often is used in patients not actively dying to reduce the burden of symptoms caused by the treatment rather than the disease, (eg: chemotherapy nausea, pain, fatigue.) Often the terms “supportive” or ‘continuum of care’ are used in these situations. In this case, there are twin goals occurring simultaneously: cure or treat illness (enhance survival) as well as reduce symptoms (palliate). When illness no longer is curable or treatable and death is expected, the primary goal of comfort becomes the dominant objective. Thus, planning for the end of life and making certain that death happens with minimum of pain and suffering and in a manner that is consistent with both the wishes and values of the patient and family, are fundamental pillars of this form of care. There is always a moral imperative to comfort. Palliative care does not necessarily aim to postpone death or hasten death. Patients who cannot eat are not necessarily artificially fed, while patients with pain are given opioids,

which may cause drowsiness, decrease eating, that potentially hasten death. The dose of pain medication, particularly opioids, is the dose that works to relieve symptoms. Obviously, a patient in severe pain requires a bigger dose than someone with only minimal discomfort. Dosage is further titrated for effectiveness and side effects. The principle of double-effect (enclosed article) has given moral guidance to clinicians who commonly prescribe high-dose opioids for the pain in terminally ill.

End of life care

Individual Cases: Notations and Comment

#1 [REDACTED]
Admitted 7/1/05
Sepsis, GI bleeds, DNR

Dx. Organic brain syndrome
Dementia
Tardive Dyskinesia
Colostomy

8/5/05. Restraints, PEG, debridemet
8/7/05. Penile cellulitis
Ativan 1-2 mg glh agitation
104.8 Temperature
8/26/05. "Outlook poor... hospice not unreasonable"
No orders for hospice. No documentation with family
8/27/05 last entry by MD "quiet vs. stable. Antibiotics"
8/31/05. MS 1-4 mg IVP/ Im glh for agitation last seen alive
9/1/05. No lights, water, toilet, air, electricity
T 102(squared) sponge bath
Autopsy report reviewed
Toxicology report reviewed
Pyelonephritis
Lower lobe pneumonia

Comments: seriously ill, fever, sepsis. Multiple problems in an environment where care is less than optimal. No diagnostic ability Death with or without competent timely intervention not surprising

[REDACTED]
[REDACTED]
Dx. Decubitus ulcer, dementia, pacemaker, anemia, peripheral vascular disease, old CVA, depression

Chair and bed bound

Oriented to person only

[REDACTED] left hip debridement and skin flap

Tolerated well

[REDACTED] right hip debridement and skin flap

Tolerated well

[REDACTED] BKA @ amputation

No documented use morphine, versed, ativan

No documentation to show deterioration

Autopsy @ bronchopneumonia

Mild nephrosclerosis

Toxicology = morphine, versed

Comment: unclear documentation does not explain death nor findings of toxicology report.

[REDACTED]
[REDACTED]
Dx? Impaction (mega colon) CUA diabetes mellitus, Bilateral lower extremity paralysis, Hepatic encephalopathy (past) Hepatitis C, anemia, chronic ileus

[REDACTED] Ativan for anxiety 1mg q 4h

[REDACTED] "alert cooperative"

[REDACTED] "feels good" "stable, improved"

[REDACTED] "calm, WNL, breathing NI

[REDACTED] "stable"

Statements ok by nurses

Awake, aware, knew what was going on

"Too heavy to move" "I'm hot"

Autopsy: cirrhosis of liver
Cardiomegaly
Obesity
Coronary artery disease
Toxicology: morphine/versed

Comments: stable, but multiple chronic serious conditions with obesity and paraplegia. At risk for sudden acute change in status with potential sepsis, embolism. However no indication from documentation that death imminent.

[REDACTED]
[REDACTED]
Dx: congestive heart failure, dementia
Hypertension, GI bleeds, Ileus
Depression, renal failure (on dialysis)

Oxygen 2 liters per minute
PEG, Foley Coded during dialysis [REDACTED]
Dialysis m-w-f last [REDACTED]
[REDACTED] "tolerated fluid removal well"
Last note, "quiet vs. stable"
Last nursing note 8/30/05
BP 128/56, 69, 22 awake, no distress

NI breathing no pain
No orders morphine or versed
Autopsy- right coronary 100% thrombosis
Toxicology report: morphine, versed

Comment: chronically ill with multiple serious problems, extremely frail, but stable at time of documentations. Overall prognosis obviously grim.
Toxicology reports need to be explained

[REDACTED]
[REDACTED]
Dx: pneumonia. Decubiti, old CUA
(L) Hemi paresis, @ hemiplegia
Dementia, scabies, hypertension, COPD
Peripheral vascular disease, anemia, depression, hyperlipidemia

Receiving daily wound care
Oxygen, 2liters/min, Foley, incontinent

[REDACTED] awake, responds simple commands

[REDACTED] ate 100%, smiling today
afebrile vs. stable

[REDACTED] confused, general weakness
On o2 no pain, no orders for
morphine or versed

Water towels to keep cool

Autopsy- moderate C.A.D.

Left ventricle hypertrophy

Aortic valve calcific stevosis

Note: lexapro and paxil - why both?

Documentation scanty

Blood work ok

Toxicology: morphine and versed

Comment: [REDACTED] chronically and seriously ill patient. Documentation scanty. One can project, especially with conditions of heat; this patient was becoming progressively more gravely ill? Dehydration. Despite "stable" documentation, suspect more seriously ill not recognized because of dementia. Toxicology needs explanation

[REDACTED]
[REDACTED]
Dx: urinary tract infection

Sacral decubitus

Anemia, leukocytosis

Rectal cancer, colostomy

OBS, Hx CUA

[REDACTED] 2 units blood

Hx debridement decubitus

2003.11

██████████ bilateral DVT
Greenfield filter
PEG, Foley
VRE wounds

██████████ osteomyelitis @ pubic bones
marked destruction

██████████ ms, ativan ordered

██████████ 104 fever, uncomfortable
daughter refuses surgery

██████████ T 103 ° ? sepsis

██████████ pain. Vicodan given Hot
thick secretions
yelling out- ativan
no order morphine
Doctor gave something to make "feel better"
x3 doses

autopsy" severe ASHD
toxicology: morphine, versed

Comments: suspect death was imminent especially in circumstance of heat could explain why there was use of morphine and comfort measures. Toxicology report needs explanation as to amount discovered.

██
██

Dx: dehydration, decubitus ulcer, CAD, CHF, pacemaker

PEG
Foley
Wounds to left lower leg

██████████ M.S discontinued
demerol 12.5-25mg q 2h
last dose M.S 8/25/05
stable reg. rate lungs clean
abdomen negative
comfortable

[REDACTED]
8pm agonal breathings
autopsy: severe ASHD
Nephrosclerosis
80% narrowing circumflex
toxicology: morphine, no versed

Comments: critically ill, could have expected death in this patient soon. Morphine would be appropriate to give for comfort measures, however no documentation.

[REDACTED]
Dx: CUA, renal insufficiency, hypertension
Hypoxia, hyperkalemia
Admitted with wheezing, Rx antibiotics and bronchodilators

Duragesic pain patch 8/28/05
Pain noted only once (darvocet)
[REDACTED] renal failure improving
[REDACTED] "resting comfortably"
VS Good
[REDACTED] discharge
no documentation of morphine/versed
[REDACTED] stable, calm, breathing ok
[REDACTED] ok receiving morning meds
Kristy Johnson in room when SLR receives injections "it burns"
Autopsy: circumflex 80% occluded
Toxicology: morphine alone

Comments: elderly women with obvious serious medical problems, but stable by documentation. Toxicology report needs explanation. Unexplained death. Case bothersome.

[REDACTED]
Dx: dementia, multiple decubitus ulcers, PVD, CUA, contractures, anemia, DUT, osteoarthritis
PEGm Foley
Did not verbalize

Bed and chair bound

Total care for all activities

██████████ plan = amputation

no consent from family

██████████ consent given

██████████ await surgery stable

██████████ temp. 105° increase RR

tachycardia (123/min) crackles

? aspiration pneumonia Code called

Oxygen and antibiotics

no pain

autopsy: cerebral atrophy

gangrene of toes

toxicology: morphine and versed

Comment: acute, critically ill. In view of environment, I would not expect ██████████ to survive. Autopsy not helpful. Death was imminent however. Suspect even with timely, competent intervention, ██████████ would have succumbed.

Professor Arthur Caplan, Bioethicist

“In reviewing the facts and opinions my conclusion is that the deaths of the nine persons at Memorial Medical Center in New Orleans are all cases of active euthanasia. Each person died with massive doses of narcotic drugs in their bodies. There is no evidence of consent. There is no documentation or record of any request on the part of any patient for assistance in dying.”

**Report for New Orleans, Coronor's
Office, Dr. Frank Minyard, State of
Louisiana**

I am writing this report in response to a request by Dr. Frank Minyard, Coronor, City of New Orleans, to evaluate the materials supplied to me by that office describing the deaths of nine persons. All of these persons died in a New Orleans hospital, Memorial Medical Center, during the days following the landfall of hurricane Katrina in New Orleans, Louisiana August 29, 2005.

Qualifications

Caplan

My qualifications for evaluating key features of the reports supplied to me derive from my training, background, research and policy work in bioethics. I am the chair of the Department of Medical Ethics and the Director of the Center for Bioethics at the University of Pennsylvania. I am also the Emanuel and Robert Hart Professor of Bioethics at Penn. I have been at Penn for eleven years. Prior to that I held similar positions at the University of Minnesota, the University of Pittsburgh and Columbia University. I have served as the Associate Director of the Hastings Center, one of the nation's leading think tanks devoted to bioethics.

I teach courses on medical ethics and clinical ethics to medical students at Penn, to students in Penn's Masters of

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Bioethics program, to undergraduates and to students in our schools of Nursing, Dentistry, Law and Business.

I have published over 500 articles in peer-reviewed journals and more than 25 books many of which examine issues around palliative care, assisted suicide, end-of-life care, euthanasia, and the use of medications to control pain and suffering.

I have been invited to lecture at hundreds of institutions in the United States and around the world on topics in bioethics often on issues regarding end-of-life care. I have served on many panels and professional society task forces looking at end-of-life care issues concerning the elderly, children, the disabled, newborns and the mentally ill. I have testified before the United States Congress, House and

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Senate and many state legislatures a number of times on matters pertaining to bioethics and specifically about end-of-life care issues and palliative care.

My opinions draw on my training in philosophy and my experience in medical ethics. I have tried to base my opinion on standards of ethics and standards of care as I understand them to have prevailed in the practice of medicine and end-of-life care in the United States in the year 2005. The reports pertaining to the nine cases you forwarded to me including hospital notes, medication records, toxicology reports, autopsy reports, and reports from coroners and experts are obviously foundational for this report.

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A Framework for Analyzing Actions regarding End-of-life care.

It is obvious from reading these reports that serious questions exist about the manner and cause of death of all nine persons. All of the reports from outside experts and coroners conclude that at least four of the cases ought to be classified as homicides. In eight patients there were high levels of morphine and Versed in the systems of the deceased with no prior complaints of pain and no documentation of pain medicine being ordered in the clinical records. In one patient there appears to have been a large amount of morphine present.

In trying to assess what happened and draw a conclusion about the ethical conduct of those involved in the care of these nine patients it may be helpful to have at hand a

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taxonomy of the concepts used in the literature of bioethics, in professional society guidelines and codes of ethics, and in various interdisciplinary task force reports to describe end-of-life care. This taxonomy should make it possible to see where the deaths of the nine persons at Memorial fall given the facts and expert opinions made available to me.

In medicine death can occur as a result of disease or injury. It may also occur as a result of actions initiated or not initiated by health care professionals. Some of these actions fall within the domain of ethically acceptable professional behavior. Others do not.

Euthanasia is a term that is often applied to situations in which patients die as a result of an action or lack of action on the part of a doctor, nurse or other health care

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professional. Euthanasia has a specific meaning in bioethics. It refers to either killing of a patient by a health care professional without the patients consent or the consent of a surrogate. Euthanasia can involve active steps such as giving a lethal dose of a drug to cause death in which case it is referred to as 'active' euthanasia.

Euthanasia can involve withholding or withdrawing life-supporting treatments in which case it is referred to as 'passive' euthanasia.

In all cases of euthanasia what is distinctive is that there is no consent or request to die from the patient. This can be as a result of the fact that the patient is incapable of communicating consent due to disability or impairment or, because of a lack of the mental ability to have the autonomy and competence requisite to initiate a request,

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i.e. the severely demented elderly, infants, newborns, the severely mentally retarded, the comatose. In cases of euthanasia, both active and passive, there is no ability to ascertain a patient's wishes, to gain their consent and there is no third party who is available to act as a surrogate to offer some form of consent.

Euthanasia may not be the moral equivalent of murder.

There are instances in which doctors or nurses kill their patients for reasons having nothing to do with their health or their pain and suffering. What is characteristic of euthanasia, both active and passive, is that it is undertaken from a motive of mercy, to help relieve pain and suffering that appear to be beyond any other means of palliation.

Euthanasia is not legal in any jurisdiction of the United States.

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Euthanasia is the deliberate involuntary killing of a patient by a health care professional. It may be undertaken from motives of trying to help a patient or to relieve their pain and suffering seen as not remediable in any other way.

In cases of suicide a person acts to take their own life. This can involve the use of medicines or drugs or other means.

Suicide may involve a competent person although there is a minority opinion prevalent in psychiatry that there is not such thing as a 'rational' suicide.

Assisted suicide refers to situations in which a person requests assistance in killing themselves. The request can be made to a health care professional or it might be made to a family member or friend. Assisted suicide always

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involves deliberate, intentional action on the part of the person providing assistance—giving pills, supplying instructions, etc. and on the part of the person seeking to end their life—swallowing pills, injecting themselves, etc.

One state, Oregon, has legalized assisted suicide for terminally ill persons involving physicians. Assisted suicide is legal in Oregon if a very strict set of rules and steps are followed including a waiting period, assessment of competency and reporting of all cases to state authorities. No state has legalized suicide. Ethically, some physicians and nurses believe that assisted suicide is moral if it has been requested by a mentally competent, terminally ill patient who has no other options. This is a minority position within health care and is not one endorsed by any

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major medical, nursing or health organization, society or group.

Assisted suicide is very different although sometimes confused with actions involving withdrawing, forgoing or withholding established medical treatments. Treatment can be withdrawn or withheld for a variety of reasons and motives. Sometimes physicians determine that the continuation of a treatment is simply futile—say efforts at cardiopulmonary resuscitation in a person who is not responding in anyway. Sometimes treatments are withdrawn or withheld because in the eyes of the physician and the patient or the patient's family the treatment is too burdensome relative to the benefit provided—say deciding not to operate on a patient with many, metastized tumors. Sometimes treatment is withdrawn or foregone simply

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because a patient directs that it not be used or given—say a blood transfusion for a competent, adult Jehovah's witness.

Treatment withdrawal can also be undertaken with the goal of determining whether the treatment or treatments themselves are causing unwanted side-effects or iatrogenic problems. Treatment withdrawal—weaning someone for a respirator for example, can be a key part of the strategy for dealing with a patient who appears to be improving or stabilizing.

Withholding, foregoing or withdrawing treatment is almost never done without the consent of the patient or the patient's surrogate. The only exceptions to the requirement for patient consent are situations where physicians

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determine that the continuation or initiation of treatment would be absolutely futile.

Palliative care is a key aspect of end-of-life care as well as the provision of all medical care. Palliative care involves the active use of therapies to control pain and suffering. In end-of-life care it should be although it is not always an essential aspect of health care. Patients and their families do not wish to suffer as a part of dying and it is well understood in medicine and has been for many years that it is important to attend to the psychological and emotional aspects of providing comfort to the dying even when the use of drugs or treatments may risk hastening the death of the patient.

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Again it is important that palliative care be undertaken and managed with the consent of the patient or the patient's surrogate. In lieu of such consent be possible to obtain—say in an emergency room setting or for incompetent persons who lack family or friends—physicians must exercise prudent judgment about the management of pain and suffering. They may risk the death of a patient but not make the death of the patient the goal of care in carrying out palliative tasks. A key factor in determining the soundness of a palliative care strategy is to see whether pain and suffering are assessed and how a gradual response sensitive to the risk of causing death is carried out. The use of a massive dose of a lethal agent all at once

Fitting the Nine Deaths at Memorial into this framework

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It is clear from the reports submitted by various experts who analyzed the medical records and autopsy reports for these persons that all of them died with massive doses of narcotic drugs such as morphine or Versed present in their bodies. It is also clear that none of these patients went through any documented gradual palliative care approach prior to their deaths. It is further obvious that at least for some of these persons it is not clear that they were terminally ill. All were very sick and very frail but not all were at risk of imminent death upon admission to Memorial.

It is also clear that no consent was involved on the part of any of these patients in the direction of the care. Nor is it evident that any surrogate or person with legal authority participated in the direction of their medical care. Those

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providing care did so according to their determination of what was required medically.

In reviewing the facts and opinions my conclusion is that the deaths of the nine persons at Memorial Medical Center in New Orleans are all cases of active euthanasia. Each person died with massive doses of narcotic drugs in their bodies. There is no evidence of consent. There is no documentation or record of any request on the part of any patient for assistance in dying.

Without consent none of these cases represent instances of assisted suicide. Without competency and given the frailty of the patients involved, none of these cases represent examples of suicide. None of the cases involve the withdrawal of withholding of treatments that might have

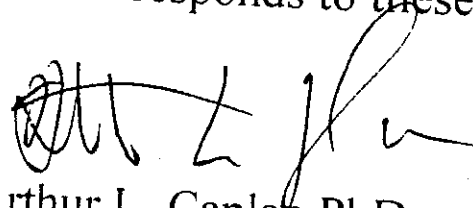
Caplan

kept one of the patients alive. And none of the cases involve examples of palliative care since the amount of drugs involved and the mode of their administration—rapid with no prior use according to the expert opinions—is not consistent with the ethical standards of palliative care that prevail in the United States last year and currently.

The active administration of large amounts of drugs known to be lethal without any pattern of gradual prior use with no consent from the patient or a surrogate, particularly in patients not at risk of imminent death, must be described as active euthanasia. It is not clear that there was no other path to relieving pain or suffering these patients might have felt except to kill them.

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I take no position as to whether the euthanasia of these patients in the circumstances in which they died was ethical since I do not have all the facts surrounding the circumstances of their deaths. But, I do believe that there is more than sufficient evidence to classify the deaths as instances of active euthanasia and that this classification must guide the District Attorney's Office or all other prosecutors in deciding how the state responds to these nine deaths.

A handwritten signature in black ink, appearing to read 'Arthur L. Caplan', written in a cursive style.

Arthur L. Caplan PhD
January 26, 2007

Dr. Cyril Wecht, Forensic Pathologist

“The primary and immediate cause of death for each of these patients was acute combined drug toxicity, specifically, morphine and versed.”

“.....the manner of death would be classified as homicide.”

CYRIL H. WECHT, M.D., J.D.

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FORENSIC PATHOLOGY
LEGAL MEDICINE

October 3, 2006

Arthur Schafer, Deputy Attorney General
Office of the Attorney General
P.O. Box 9005
Baton Rouge, Louisiana 708-9005

Re: Memorial Hospital Deaths

Dear Mr. Schafer:

I have completed my review and analysis of the Lifecare (Memorial Hospital) records of the following patients, all of whom reportedly died sometime on Thursday, September 1st, 2005, when they were patients on the seventh floor of that facility:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Based upon my examination of all the materials and information pertaining to these patients that have been submitted to me, I am prepared to offer the following conclusions and opinions, all which are set forth with a reasonable degree of medical certainty.

1. The primary and immediate cause of death for each of these patients was acute combined drug toxicity, specifically, morphine and versed.
2. Neither morphine nor versed had been properly and officially ordered by an attending physician for [REDACTED] or [REDACTED].

Morphine had been previously ordered for [REDACTED], but it had been discontinued on August 24th.

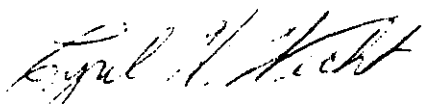
Arthur Schafer, Esquire
October 3, 2006
Page 2

Morphine in an appropriate therapeutic level had been ordered for [REDACTED]. However, there is nothing in the record to indicate that it was ever administered.

3. There does not appear to have been an appropriate and reasonably necessary clinical basis for either morphine or versed to have been prescribed and administered to any of these patients.
4. It would have been physically and procedurally impossible for any of these patients to have obtained and administered morphine and versed to themselves.
5. Morphine and versed were administered to these patients by one or more third parties.
6. In light of all the above described physical and clinical circumstances relating to these patients at and around the reported times of their respective deaths, the manner of death would be classified as homicide.

Please let me know if you would like to have any additional discussion regarding these Lifecare (Memorial Hospital) deaths.

Very truly yours,


Cyril H. Wecht, M.D., J.D.

CHW/srw
cc.: Hon. Frank Minyard

**Dr. James Young, Chief Coroner of the
Province of Ontario, Canada / Physician**

“I believe each individual case represents a cause of death of *drug toxicity* and a manner of death of *homicide*. All these nine patients survived the adverse events of the previous days and for every patient on a floor to have died in one three and a half hour period with drug toxicity is *beyond coincidence*.”

“I believe that the cause of death for all nine persons is toxicity from morphine or morphine and Versed. I believe the *manner of death in all nine of these cases is homicide*.”

Life Care of New Orleans

OCT 08 2006
DEPARTMENT OF JUSTICE
MEDICAL FORENSIC UNIT

Background

This report is authored by James Young O.Ont, MD. I am a medical doctor licensed to practice in the Province of Ontario, Canada. I am currently the special advisor to the Government of Canada on Emergency Management. I also frequently represent the Canadian Government's forensic interests at international events such as 911, the Bali bombing and the south east Asia tsunami.

For 14 years I was the Chief Coroner of the Province of Ontario. The Office of the Chief coroner investigates approximately 20,000 deaths per year. Ontario coroners are medical doctors who are appointed by government. As Chief Coroner, I supervised and directed a system of more than 300 investigating coroners, ten full time supervising coroners, and approximately 200 pathologists who performed 7,000 autopsies yearly.

I was also the Commissioner of Emergency Management for Ontario and the assistant Deputy Minister of Public Safety. In these roles, I supervised the provincial response to such events as the 1998 Ice Storm, 2003 SARS and 2003 Power Blackout. I had responsibility for Emergency Management Ontario, the Fire Marshal of Ontario and the Centre of Forensic Science. The Centre is a large full service forensic facility which employs 200 scientists and does all the forensic testing for police and coroners in the province.

I have frequently been involved in the investigation of drug administrations in medical settings. These cases have been in Ontario, other provinces of Canada, the United States and Britain. I have also appeared before the Canadian Senate on the topic of euthanasia.

Investigations

I have been asked by the New Orleans Coroner's Office to participate in the expert review of nine deaths in the Life Care of New Orleans in the immediate period around Hurricane Katrina. I have been given medical charts, autopsy reports and toxicology reports to review and have done so carefully.

I believe there are several key questions that should be considered and answered if possible. They include:

- What underlying medical conditions did the person have?
- What medications were they taking?
- In particular were they receiving morphine and Versed? If so, how often and how much?
- What are the autopsy findings?
- What are the toxicology results?
- How stable did the person's condition appear to be based on medical and nursing notes, and records of vitals?
- Was there evidence the person was receiving palliative care?

The information from these questions is used to formulate answers to:

- o The medical cause of death
- o Was the death sudden and unexpected
- o The manner of death (accident, suicide, natural, homicide, undetermined)
- o Is there any logical connection between the deaths or are the deaths random?

In considering these questions it is important to recognize that palliative care is a widely recognized medical act. Palliative care ensures that terminally ill patients are kept comfortable. Often increasingly high doses of analgesics are used for pain management while at the same time aggressive, acute medical care is not pursued. The first step in palliative care is the discussion of the concept with patient and family. The fact the discussion took place and agreement is then documented in the chart. When analgesics are used the need for the drug for pain relief is also documented on the chart. Usually small doses are started first and dosage is titrated upward according to need. The need for higher doses is demonstrated in the charting as levels are increased. Some patients, over time, become tolerant of analgesics, leading to the use of high doses but this tolerance is acquired over time. The purpose of palliative care is to increase patient comfort and quality of life. It is never intended to end life. In palliative care, if high doses of drug contribute to death in some ways this is considered acceptable provided that it can be demonstrated that the intent of the drug was not to end life. On the other hand if the intent of drug use is to hasten death, then this is active euthanasia or some form of homicide. In investigating cases where the issue is whether treatment goes beyond palliative, the documentation in the chart becomes very significant. One expects to see notations indicating consent for palliative care and demonstrations of drug need and titration. As well the drugs used must be appropriate to the patient's conditions and the dose appropriate to need. I have included as Appendix B, a memo I produced for Ontario coroners to assist them in investigating these cases. This memo has been widely circulated within the Ontario medical community and was given to the Canadian Senate during a committee appearance considering legalization of euthanasia.

The Role of a Coroner

In jurisdictions where death investigation is managed by coroners it is the role of a coroner to establish in law who died, when they died, where they died, the medical cause of death and the manner of death. When death occurred, the cause and manner of death are particularly relevant in this case. In reaching conclusions the coroner is expected to rely on a broad range of sources including medical charts, toxicology, autopsies, and any investigation carried out in relation to the death. The coroner is not empowered to make findings of fault or legal responsibility either civil or criminal. This is particularly important when the coroner decides that the manner of death is homicide. Homicide to a coroner means that the action of one human caused the death of another human. The coroner in such a case is not naming who might have been responsible nor is the coroner judging legal responsibility. This judgment is the role of the courts.

Conclusions of Review

As previously mentioned my review included charts, autopsy reports, toxicology reports, review of some cases by [REDACTED] an internist, and limited investigative information including details of when the deceased were last seen alive and when they were found dead. None of the charts detailed a precise time of death.

I have summarized my findings in chart form which are included as Appendix A. I believe that the deaths of [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED] are sudden and unexpected. The deaths of [REDACTED] and [REDACTED] have been classified by me as probably sudden and unexpected. I believe that there is a high degree of probability that these deaths were sudden and unexpected but the degree of belief for these two cases is lower than the other seven.

As recorded in Appendix A, I believe that the cause of death for all nine persons is toxicity from morphine or morphine and Versed.

I believe the manner of death in all nine of these cases is homicide. Again, I note this is a finding that does not imply culpability.

Discussion

The finding that a death is sudden and unexpected implies that a careful examination of the facts must take place. It may be that with further investigation and after with autopsy results that eventually the death is classified as natural. On the other hand further testing such as toxicology combined with autopsy results and the medical chart may lead to the conclusion that the cause and manner of death may not be natural.

Elderly patients with chronic illness die of their illnesses every day but the key determination in establishing cause and manner of death is what happened at the time of death. Most of these patients had multiple serious medical problems but one has to consider how stable they appeared on the day of death. This plus autopsy and toxicology findings leads me to believe it was the drug toxicity that resulted in these deaths, not the natural disease they suffered from.

The findings of non-documented drugs in all these nine patients and non-prescribed drugs in seven is very significant and must be explained. The levels of the drugs were high enough to cause death and I believe did cause death. In the case of Versed no one had been prescribed this drug.

It is also necessary to explain why the drug was given. One possibility of drug administration is self-administration in suicide. This is highly unlikely in this case given that patients would not have access, they would have to administer by needle and many were not well enough to either contemplate the act or carry it out.

A further possibility is that the drug or drugs were accidentally administered in too high a dose. Many of these patients had no medical indication for these drugs. Large doses of

these drugs were present in patients and the administration of the drug was not documented. Accidental overdoses would need to have occurred nine times between 12 noon and 3:30 p.m. all on the floor to every patient who was left on that floor. Anyone working with geriatric patients is aware of the potential respiratory depression that occurs with morphine use and the danger of combining drugs like Versed and morphine. As well, they would be aware of the need to titrate doses very carefully in the elderly and chronically ill to avoid adverse effects such as respiratory depression. Again it is noted that morphine was not ordered for seven of the patients and Versed was not ordered for any. Therefore it seems highly unlikely that nine patients died on the same floor on the same afternoon of accidental overdose.

If the patients did not die a natural death, suicide or accidental, could these deaths be classified as undetermined? In these circumstances I do not believe they can if the cause of death is drug toxicity. The drugs had to be given by someone and therefore the actions of one human resulted in the death in this case of others. This is homicide.

I also wish to comment on the number of deaths that occurred between noon and 3:30 p.m. on September 1, 2005 on the 7th floor. The facts of each of the cases stand on their own and for the reasons stated I believe each individual case represents a cause of death of drug toxicity and a manner of death of homicide. All these patients survived the adverse events of the previous days and for every patient on a floor to have died in one three and a half hour period with drug toxicity is beyond coincidence. This cluster of deaths reinforces my belief that the individual classification of the cases that I have described is correct.

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