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Neglect, Recklessness, and Deliberate Indifference in the Face of a Serious Neurosurgical Pathology: Lessons From the Tragic Fate of Prisoner Elliot Earl Williams

Lawson E. Spence, BS,* Kathleen S. Botterbush, BS,* Justin K. Zhang, MD, MSCI,† Todd A. Berger, JD,‡ Philippe A. Mercier, MD, PhD,* and Tobias A. Mattei, MD, FACS*

Abstract: The US prison system, which houses nearly 2 million people, depends on its healthcare agents to provide the first line of diagnosis and treatment for any medical needs that arise during incarceration. Given the high rates of illness and injuries in this population, there is a pressing need for high-quality medical care. However, surgeons often observe that the system frequently fails to provide adequate healthcare services to incarcerated individuals. This study examines an instance of neglect, recklessness, and deliberate indifference in the facet of a serious acute traumatic spinal pathology, which made it to the lay press headlines several years ago. This case involves a prisoner who suffered a cervical spine trauma and, because of delayed diagnosis and treatment, ultimately progressed to quadriplegia and death. Through an analysis of the case's background, legal context, and outcomes, alongside a review of the formal legal complaint filed with the US District Court for the Northern District of Oklahoma, this article provides a detailed root-cause analysis of the systemic failures which led to this unfortunate outcome. Ultimately, the tragic case of US Veteran Elliott Earl Williams serves as a unique learning opportunity for surgeons, physicians, healthcare workers, correctional staff, and facility administrators so that the healthcare system for inmates can be improved to prevent future similar cases.

Key Words: medical malpractice, negligence, spinal cord injury, spine trauma

INTRODUCTION

In 2011, Elliott Earl Williams, a US Army veteran, was arrested during a mental health crisis. Just 6 days later, he was found dead in his jail cell, a victim of a neglect so egregious that it defies comprehension. During those final days, paralyzed and unable to move, he was left to starve and die of thirst. The prison's medical staff observed him multiple times and had live video surveillance of his suffering, yet they failed to act. This preventable tragedy underscores the systemic failures that, unfortunately, are common place across prisons in the United States. Drawing on primary sources, including court testimony and investigative reports, this article reconstructs the harrowing final days of Mr Elliott Williams. His case serves as a stark lens through which to examine the deep-seated inequities in prison healthcare and to propose actionable reforms to prevent such injustices in the future.

*From the *Division of Neurological Surgery, Saint Louis University School of Medicine, Saint Louis, MO; †Department of Neurosurgery, University of Utah Health Clinical Neurosciences Center, Salt Lake City, UT; and ‡Syracuse University College of Law, Syracuse, NY.*

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Reprints: Tobias A. Mattei, MD, FACS, Division of Neurological Surgery, Department of Surgery, Saint Louis University School of Medicine, 1402 S. Grand Blvd, St. Louis, MO 63104. Email: tobias.mattei@health.slu.edu.

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CHALLENGES IN PRISON HEALTHCARE

The United States has the highest prison population in the world, with over 5.4 million people in custody. In 2021, nearly 1.8 million individuals were incarcerated in state or federal prisons, or local jails.[1,2] The inmate population represents a particularly challenging patient group due to significantly higher-than-average rates of chronic and infectious diseases. It has been demonstrated that approximately 40% of incarcerated individuals have at least one chronic medical condition.[3,4] These conditions commonly include tuberculosis, HIV, hepatitis, sexually transmitted infections, asthma, hypertension, substance use disorders, diabetes, and psychiatric illnesses.[3] Among incarcerated individuals with psychiatric illnesses, a majority were found not to be receiving their prescribed treatments upon arrest.[4]

Healthcare providers often encounter significant obstacles in delivering prompt and high-quality care for inmates, including safety concerns, suspicions of feigned illnesses, and delays in appointments as well as surgery authorization. At least, some of these logistical challenges can be traced to the practice of outsourcing inmate healthcare to private companies. After receiving a fixed financial allocation from the government, these companies are often incentivized to minimize costs while bearing little liability for any suboptimal care they may provide.[5,6] Another significant obstacle to effective healthcare delivery within the prison population is the entrenched staff culture in correctional facilities, which frequently prioritizes security over rehabilitation and inmate well-being.[7] This culture permeates the healthcare services in such institutions, where maintaining order often takes precedence over addressing prisoners' health needs. Consequently, healthcare delivery may become underprioritized, access to medical services restricted, and inmates' complaints dismissed or inadequately addressed. This security-first approach undermines patient-centered care, hampers rehabilitative practices, and negatively affects the overall health outcomes and future reintegration of incarcerated individuals into society.

When prisoners do receive the medical treatment they require, the outcomes often fail to meet the standards for the general

population. Research suggests that poor healthcare delivery in correctional settings may contribute to significant psychological trauma, including heightened fear of severe illness, death, or mistreatment by correctional staff.[8,9] In addition, objective surgical outcomes for incarcerated individuals are demonstrably worse. For example, a 2023 study found that prisoners had 9.62× higher odds of nonunion after spinal fusion surgery, compared with similarly situated non-incarcerated individuals, even after controlling for confounding factors such as smoking, body mass index, chronic steroid use, diabetes, previous surgeries, and levels fused.[10] The COVID-19 pandemic further exacerbated the already dire conditions of prison healthcare.[11]

Ultimately, these systemic issues contribute to a pervasive experience of inadequate care among inmates, ultimately eroding trust in the justice system. The quality of healthcare within correctional institutions directly influences prisoner satisfaction, as evidenced by its correlation with a facility's overall social climate, including perceptions of safety, fairness, and responsiveness to vulnerable populations.[12] Improvement in the quality of healthcare services can benefit prisoners and staff alike, as inmates who feel that their healthcare needs are being managed appropriately are less likely to create disturbances or pose security risks.[12]

The Eighth Amendment of the US Constitution guarantees that "excessive bail shall not be required, excessive fines imposed, or cruel and unusual punishments inflicted."[13] In addition, the Fourteenth Amendment's due process clause protects pretrial detainees from intentional disregard in the face of severe medical conditions. Despite these constitutional safeguards, many incarcerated individuals experience a degree of indifference that violates their fundamental human rights.[14] Prison healthcare remains one of the most neglected aspects of the US healthcare system, reflecting broader systemic challenges in meeting inmates' basic needs.[15,16] Neglect often manifests in the setting of trauma.[17,18] These injuries frequently lead to significant long-term disability and morbidity, including cognitive deficits, neurological impairments, and even death. Studies have shown that head and spinal injuries not only occur more frequently among incarcerated individuals but also result in significantly worse outcomes compared with similar injuries in the civilian population, revealing a compounding impact of neglect upon the outcomes of patients in this vulnerable group.[19,20]

Analyzing specific egregious instances of past systemic failure and neglect can provide valuable insights into ways to address the root causes of inadequate care and ultimately improve healthcare delivery, reduce long-term costs, and mitigate unnecessary litigation.[21,22] This historical analysis presents the first comprehensive medical review of the case of Elliot Earl Williams, a US veteran whose story of neglect garnered national attention in 2013 from outlets such as *The New York Times* and *Bloomberg Law* (Fig. 1).[23–26] These reports exposed the extent of neglect and deliberate indifference toward a severe neurosurgical pathology requiring emergent care.[27,28] This analysis seeks to draw important lessons from this tragic case, shedding light on systemic shortcomings and hopefully reducing the chances of similar events in the future.

HISTORY OF INMATE HEALTHCARE RIGHTS IN THE UNITED STATES

Before the 1960s, state prisons were solely responsible for inmate healthcare as there was virtually no federal oversight due to the federal government's "hands-off" doctrine. This doctrine asserted that the federal government lacked legal standing to intervene in the operations of state institutions.[29] The 1976 Supreme Court ruling in *Estelle v. Gamble,* which established that the denial of medical care to inmates could constitute cruel and unusual punishment, constituted a turning point in terms of prison healthcare reform.[30–33] Four months later, in the case *Bowring v. Godwin*, the US Supreme Court extended this precedent, ruling that the denial of psychiatric treatment also violated the Eighth Amendment.[34] This decision acknowledged that inmates are entitled to comprehensive healthcare, including mental health services. In 1993, the Supreme Court decision in *Helling v. McKinney* further broadened the implications of *Estelle v. Gamble* by holding that the Eighth Amendment not only mandates treatment for current health conditions but also requires protection against potential future health risks, including environmental hazards such as exposure to tobacco smoke.[35]

FIGURE 1. Portrait of Elliot Earl Williams. The use of this photograph is claimed as fair use based on 17 United States Code § 107 (Copyright Act).

In *Miltier v. Beorn*, the United States Court of Appeals for the Fourth Circuit established that for an action to violate the Eighth Amendment's prohibition against cruel and unusual punishment, there must be a demonstration of deliberate indifference to the victim's rights. Specifically, the treatment, or lack thereof, must be deemed "grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness."[36] Since the landmark *Estelle v. Gamble* decision, approximately 13,000 cases between 1985 and 2022 have cited it as a legal precedent. However, this figure only represents incarcerated people who successfully filed lawsuits (Fig. 2), likely a small proportion of those who experienced deliberate indifference in their healthcare.[4]

Title II of the Americans With Disabilities Act (ADA) of 1990 provides that "no qualified individual with a disability shall... be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity."[37] The US Supreme Court reinforced this provision in the *Pennsylvania Department of Corrections v. Yeskey* decision in 1998, clarifying that Title II applies to individuals in state correctional facilities. This ruling recognized that incarcerated individuals with disabilities are "qualified individuals" under the ADA and that correctional medical care falls under the definition of "services" provided by a public entity.[4,37] The decision emphasized the need

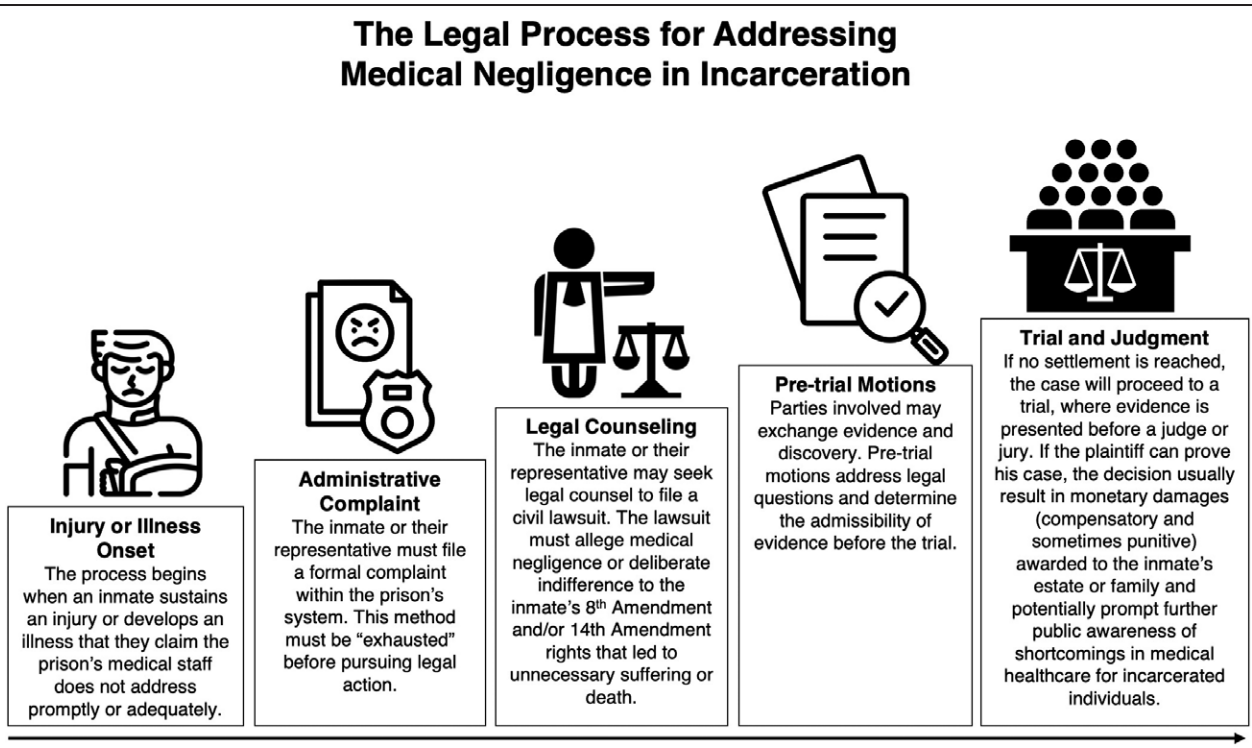

FIGURE 2. The legal process for addressing medical negligence in incarceration.

for the ADA to be broadly construed to prevent discrimination and to ensure that incarcerated individuals with disabilities can access necessary services and programs.

Despite these legal milestones, as well as the establishment of guidelines by the American Public Health Association and the creation of the National Commission on Correctional Health Care (NCCHC), significant systemic challenges persist within the US prison healthcare system.[38] Limited access to justice and legal counsel, combined with the restrictions imposed by the Prisoner Litigation Reform Act, often prevents incarcerated individuals from securing even the minimal relief prescribed under the existing legal framework. These barriers highlight the need for continued reform to address persistent gaps in the quality and accessibility of healthcare by inmates.

THE TRAGIC CASE OF US ARMY VETERAN ELLIOT EARL WILLIAMS

The sequence of events leading to Mr Williams' tragic death is outlined in Figure 3. On October 21, 2011, Owasso Police Department officers responded to a call reporting disruptive behavior by Mr Williams at a Marriott hotel. The staff had called the police after Mr Williams appeared to have had a mental breakdown in the hotel lobby. Arrested for misdemeanor obstruction, Mr Williams was taken to the Owasso jail. The booking report noted that officers believed he was "suicidal." Early the next day, he was transferred to the custody of the Tulsa County Sheriff's Office and booked into jail.

Upon his arrival on October 22, 2011, Mr Williams refused to change clothes and was forcefully taken to a holding cell. While in solitary confinement, he struck his head against the cell door, collapsing to the ground. Nurse Kimberly Hughes and Mary Hudson observed him lying face-up, complaining of neck pain and stating, "I can't move." Despite his complaints, nurse Hughes claimed "nothing was wrong" with his neck, provided no treatment, and did not order any imaging. Hudson tested his reflexes with a pen, observing some leg movement, and suggested he might be faking paralysis. Neither nurse provided any treatment, nor even for pain. Later, detention officers placed Mr Williams on a gurney and took him to the shower after he defecated on himself. They left him there for an hour, during which he became hypothermic and was heard screaming, "Help me." His skin turned purple, and officers noted, "Something's wrong with Williams."[39]

No medical evaluation was conducted on October 23. Nurse Stiles documented on October 24 that Mr Williams stated he could not walk. The same day, Dr Stephen Harnish, the jail's psychiatrist, ordered that Mr Williams be placed in a video-monitored cell for observation. Video footage showed that shortly after Dr Harnish's visit, a detention officer threw a food container out of reach into Mr Williams's cell. It remained untouched for 2 days as Mr Williams unsuccessfully attempted to lift a water cup and access the food container that landed nearby. Dr Harnish acknowledged being aware of possible paralysis.

On October 25, detention officers dragged Mr Williams naked on a blanket to a medical cell, leaving a water cup at his feet. By October 26, staff noted that Mr Williams was "muttering," with white residue visible on his lips. Nurse Devorsha Stewart documented that he was lying on the floor, shaking, and partially covered by a blanket. Despite his deteriorating condition, no medical treatment was provided.

On October 27, breakfast was delivered at 5:15 a.m. and officers recorded that Mr Williams could feed himself. However, video footage contradicted this, showing the food container untouched, even hours later. By this time, Mr Williams had gone without food or water for over 2 days despite repeated requests. At 11:30 a.m., Dr Limbu conducted the first medical examination since Mr Williams's arrest. He recommended imaging studies to rule out significant injuries, reporting to Dr Phillip Washburn, the jail's medical director. Dr Washburn, however, failed to follow up on these recommendations.

At approximately 11:30 a.m. that day, the jail staff found Mr Williams unresponsive. Nurses attempted CPR, but a review of the resuscitation efforts revealed significant delays and interruptions. Effective chest compressions were performed for only 1 minute and 34 seconds within the first 8 minutes of the response. Paramedics arrived, but efforts to

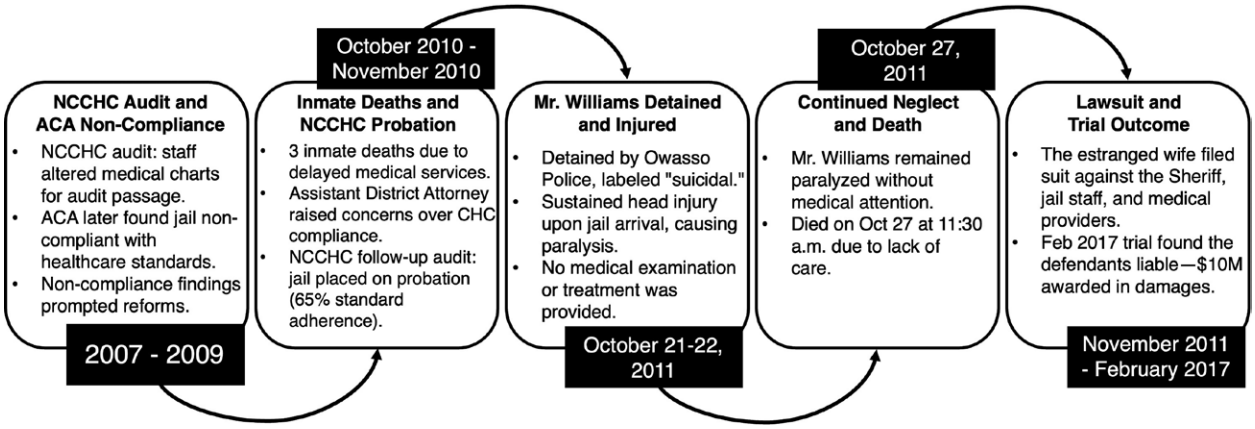

FIGURE 3. Timeline of relevant events regarding Mr Elliot Earl Williams' death and the ensuing litigation.

revive Mr Williams were ultimately unsuccessful. The medical examiner determined that Mr Williams died from "complications of vertebral spinal injuries due to blunt force trauma." Expert testimony indicated that stabilizing Mr Williams's neck and transferring him to an appropriate facility could have prevented his death.

An autopsy examination showed that Mr Williams was dehydrated. Robbie Emery Burke's expert, Dr Zeeshaan Khan, opined that the jail's failure to stabilize Mr Williams's neck caused a hematoma that traveled up his spine and "shut down" his spinal cord, which, in turn, caused Mr Williams's respiratory muscles to stop working. He testified that if the jail had stabilized Mr Williams's neck and referred him to an appropriate medical facility, his death likely would have been avoided.

Robbie Emery Burke, the special administratrix of Mr Williams's estate, filed a complaint under 42 United States Code § 1983, alleging cruel and unusual punishment under the Eighth and Fourteenth Amendments. The lawsuit accused Tulsa County Sheriff Stanley Glanz of deliberate indifference to Mr Williams's serious medical needs and sought damages for civil rights violations. During litigation, Sheriff Glanz resigned, and his successor, Sheriff Vic Regalado, was substituted as a defendant in his official capacity.

In March 2017, a jury awarded $10 million in compensatory damages and $250,000 in punitive damages against Glanz. This case got significant public attention as an epitome of the pervasive systemic failures in jail operations and healthcare delivery, raising questions about the accountability of private medical providers contracted to care for inmates.[39]

The US Court of Appeals for the Tenth Circuit later reviewed an appeal on the case, addressing disputes over evidence and damage calculations. The court remanded the case to the District Court for further proceedings but upheld significant findings against the defendants.[39]

DISCUSSION

Historical Overview and Audits

Investigations conducted by the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association identified numerous deficiencies in the health services of Tulsa County Jail before Williams' death in 2011. In 2007, an NCCHC audit of the jail's health services revealed several deficiencies including delays in addressing health issues flagged during initial screenings and insufficient follow-up for mental health needs. The Health Services Administrator allegedly instructed staff to alter medical charts to pass the audit. As a result of these findings, the NCCHC placed the jail on probation.[39]

In a subsequent 2009 inspection, the American Correctional Association reiterated that the institution fell short in numerous areas, including the health services offered. They specifically cited shortages of medical personnel, inadequate coverage by doctors or physician assistants, lack of oversight and supervision over health services, and the absence of formal training for new health staff, all of which significantly impacted the quality of health care available to inmates. Additional problems included delays in providing necessary medication, improper documentation of delivered health services, failure to conduct timely health appraisals, and 313 health-related grievances in the previous year alone, highlighting widespread dissatisfaction with the jail's healthcare services.

Inmate Deaths and Institutional Response

By June, 3 inmates had died in the Tulsa County jail in 2010 alone. In March 2010, an inmate reported chest pain over a week. He went into cardiac arrest and died of a pulmonary embolus after a 42-minute delay in calling emergency medical services for the inmate. Another inmate committed suicide 8 days after requesting someone to "talk" with him in jail and 2 days after a mental health exam had ruled out suicidal ideation. In June 2010, a second inmate died of cardiac arrest, after which the consultant's report noted "several standard of care issues," including multiple lab results showing an elevated potassium level that "could lead to cardiac arrest." It faulted "inadequate system protocols, and real-time auditing of protocols for treatment, monitoring, [and] referral" and concluded that "Without such protocols, the risk of similar episodes for other inmates in the future is quite high."

On October 28, 2010, Assistant District Attorney Andrea Wyrick wrote an email to the Risk Manager of the Office of the Tulsa County Sheriff's voicing concerns about Correctional Health Care's compliance with its contract. She stated, "This is very serious, especially in light of the 3 cases we have now—what else will be coming?" In November 2010, an NCCHC audit placed the Tulsa County jail on probation after meeting only 65% of so-called essential standards. The NCCHC report highlighted poorly performed clinical mortality reviews, a lack of physician-conducted chart reviews, delays in diagnostic tests and consultations, insufficient training for custody staff, and failure to implement changes in treatment based on clinical justifications. During the trial following the death of Elliott Earl Williams, Sheriff Glanz and the Detention Chief Deputy were unable to identify specific changes made in response to the 2010 audit. In December 2010, another inmate died of cardiac arrest at the jail after not receiving medications for a heart condition. Despite these multiple deaths, the NCCHC renewed the jail's accreditation in March 2011. Subsequently, in 2011, the US

Department of Homeland Security's Office of Civil Rights and Civil Liberties inspected the jail's medical system and found a prevailing attitude of indifference among clinic staff, inadequate nurse training and documentation, and instances of medical neglect, including a diagnosis of an appendix perforation on an inmate, which apparently was missed due to lack of training.[39]

The Case of Elliott Earl Williams

It seems clear that the death of Elliott Earl Williams, a 37-year-old Black US Army veteran who passed away 6 days after his arrest while in custody at the recently accredited Tulsa County jail, was just another manifestation of a recurrent pattern of deliberate indifference and gross neglect regarding inmates healthcare needs in that facility, a problem that had been identified in multiple previous occasions by supervising agencies, but which was ultimately left unaddressed.

Dr Zeeshaan Khan, an orthopedic surgeon, testified in court as Ms. Burke's expert witness that if the jail had stabilized Mr Williams's injury and referred him to an appropriate medical facility, his death likely would have been avoided.[39] The medical expert report from Dr Scott A. Allen, a board-certified internist employed by the Rhode Island Department of Corrections, stated: "This is a very disturbing case. It involves the death of an inmate with clear and compelling severe medical and mental health needs whose needs are entirely neglected. Mr Williams' death was due not only to inadequate medical care but also to deprivation of food and water, all while under the supervision of licensed health professionals. The progression to extreme dehydration and starvation underscores the prolonged neglect that Mr Williams endured before his death. [This case] shines a light on a medical staff more concerned with a quasi-police role than their legitimate role as healers."[38]

It is crucial to recognize that Mr Williams' symptoms warranted a comprehensive evaluation for multiple differential diagnoses and neurological conditions, such as central cord syndrome or seizure activity. Central cord syndrome, for example, often manifests as disproportionate motor impairment in the upper extremities and can be overlooked when paralysis is incorrectly assumed to be psychogenic, especially when movement is observed in the lower limbs. According to the literature, its subtle presentation frequently leads to misdiagnosis as a psychogenic disorder.[40] Similarly, seizures, particularly those occurring in the context of head trauma, can mimic psychogenic symptoms and worsen existing neurological deficits. Seizures that deviate from the typical tonic-clonic epileptic pattern are sometimes mistakenly attributed to psychogenic causes, resulting in misdiagnosis.[41] The failure to investigate these differential diagnosis highlights a significant lack of thoroughness. A more detailed evaluation, including imaging and consultation with a neurologist, could have identified the true underlying pathology and potentially prevented the progression to a fatal outcome.

Ultimately, it seems undeniable that Mr Elliott Earl Williams's death was a tragic, unnecessary, and preventable outcome. As stated by Dr Allen, 'The incorrect diagnosis of faked paralysis is followed by a plan conceived of and deployed by medical professionals: to "catch" him in his alleged "faking." So, he is placed in a video observation cell. And the only thing they "catch" is their own glaring inhumanity and lack of professionalism. We see no medical care provided at all. They have lost sight of their primary responsibility to their patient.'[42]

This case underscores the critical importance of providing emergent medical care, especially when considering traumatic injuries. It has been documented that approximately 21% of inmates have reported experiencing violence while incarcerated, and this statistic does not include the type of accidental injuries like the one experienced by Mr Williams.[43] Ultimately, patients who experience neglect and deliberate indifference in the face of such type of serious neurosurgical pathologies are likely to experience severe morbidity or even fatal consequences.[44–46] Mr Williams' tragic story could have been prevented at various levels and on multiple occasions were it not for the gross neglect, recklessness, and deliberate indifference of prison nurses, physicians, guards, and staff. In this case, the multifaceted nature of such shortcomings illustrate that, in the absence of multiple system safeguards, the unimaginable may occur in front of everyone's eyes, especially in areas with a long-standing culture of carelessness and disregard.

Lessons Learned and Policy Considerations

The tragic fate of Mr Williams highlights some of the systemic failures in prison healthcare, especially the insufficient response to potentially threatening conditions. Regardless of their lack of specialization, prison healthcare providers must be able to identify red-flag symptoms, which suggest the presence of a medical emergency. Medical professional training should also include cultural competence and sensitivity to ensure fair treatment of incarcerated individuals from diverse backgrounds, emphasizing the importance of valuing every patient equally and ensuring that complaints and symptoms are taken seriously, with appropriate diagnostic tests used to rule out underlying pathologies. As illustrated in Figure 4, these measures align with ethical and effective care principles. If Mr Williams had received even minimal attention to his emergent needs, his outcome could have been drastically different.

Healthcare providers in prisons often contend with pressures from correctional administrators motivated by cost-saving measures or rigid security protocols, both of which can substantially interfere with medical autonomy. These constraints create a challenging environment where decisions may be influenced by nonmedical factors and ultimately compromise the quality of care. As one commenter notes, prison administrators may impose "'pressures or excessive supervision" on providers, prioritizing financial or security concerns over appropriate medical care.[47] To address this conflict, providers must receive training to safeguard their clinical independence, while administrators should be educated to respect medical autonomy. Enforceable internal guidelines codifying this independence, combined with a multidisciplinary approach, as outlined in Figure 5, can help improve inmate healthcare. Such reforms may enable adequate collaboration among physicians, nurses, and mental health professionals to meet the unique needs of incarcerated individuals without undue interference.

Comprehensive reforms are necessary to address the widespread inadequacies in prison healthcare. Improved oversight and accreditation standards, integration of medical technologies such as electronic health records, and streamlined communication between correctional and medical staff are critical steps in narrowing the quality-of-care gap illustrated by the tragic case of Mr Elliot Williams. Furthermore, recent policy changes, such as California and Washington's Medicaid waivers, exemplify efforts to extend funding and improve care for marginalized prison populations. Finally, enhanced health surveillance and value-based payment models could better align prison healthcare with community standards. Finally, there is a pressing need of a rehabilitative healthcare model for incarcerated individuals, which addresses not only immediate medical needs but also takes into account long-term physical and mental needs. Such a holistic long-term approach may ensure better outcomes for inmates and further contribute to their successful reintegration into society, ultimately benefiting the communities they return to.

CONCLUSIONS

The tragic fate of US Veteran Elliott Earl Williams constitutes a timely reminder of the need to improve the quality of the healthcare system for incarcerated individuals. In this historical

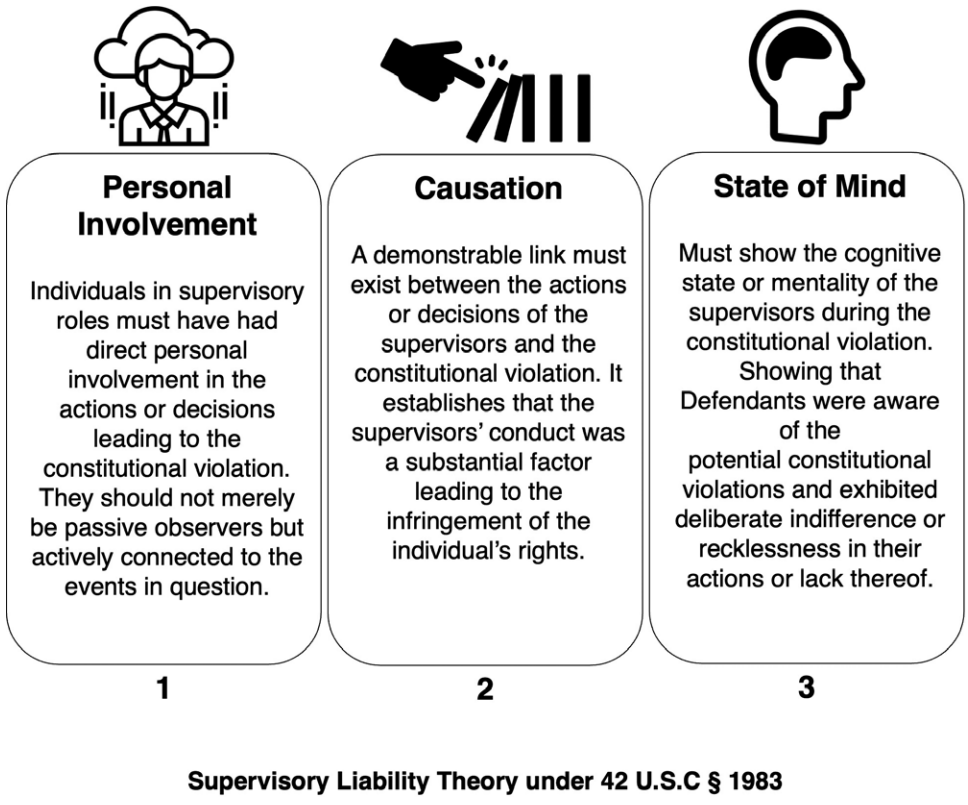

FIGURE 4. Elements of supervisory liability under 42 United States Code § 1983.

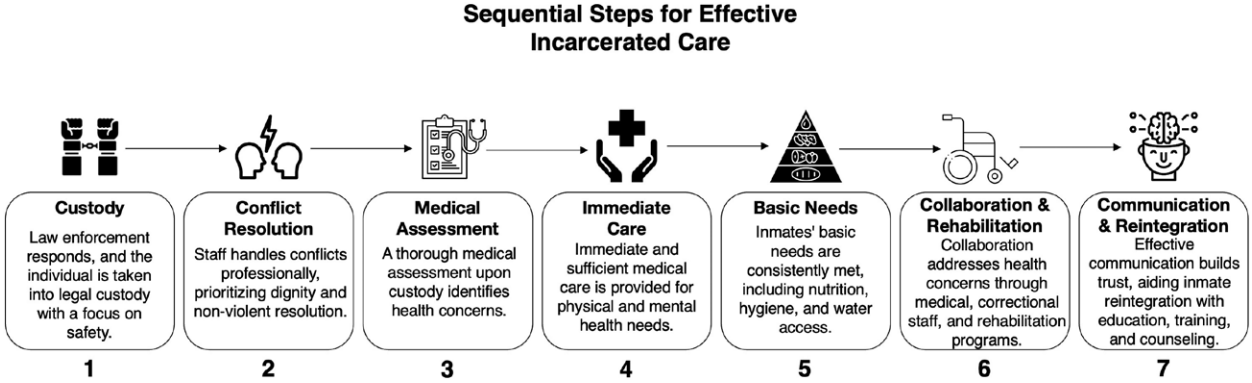

FIGURE 5. Proposed sequential steps for effective care of incarcerated individuals.

vignette, we provide the reader with a comprehensive overview of the factual history of this case as well as a detailed root-cause analysis of the underlying systemic failures responsible for this unfortunate outcome. This review also provides several important insights into healthcare policy and practice reforms that can be implemented to improve the quality of health care for incarcerated individuals, such as enhanced training for healthcare professionals, adopting evidence-based healthcare practices, fostering a culture of respect and care toward a patient which is independent of law enforcement personnel, ensuring accountability through independent oversight, and modernizing healthcare through simple approaches such as the use electronic medical records and access by the inmates to such documents. Such measures would significantly improve the quality of care for incarcerated individuals, better align correctional healthcare with community standards, and prevent future similar tragedies such as that experienced by US Veteran Elliot Earl Williams.

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