State of Alaska
Ombudsman

Investigative Report

Ombudsman Complaint A2005-0122
(Final Report – Public Version)

(Edited to remove information that would identify the complainant or infringe on privacy rights of those involved)
December 9, 2005

In February of 2005, a Southeast resident phoned the Office of the Ombudsman to report that her boyfriend had died on July 24, 2004 while serving a sentence at Ketchikan Correctional Center (KCC). Although state authorities ruled that his death was of natural causes, she said she had received word to the contrary from an inmate present at the time of his death. This inmate witness indicated that the dead man had been hog-tied and beaten by correctional officers the night he died. The witness also said that he had a list of other inmates who could corroborate his story.

The ombudsman later received a call from the dead inmate's mother, who said she also had questions about the treatment her son received while in KCC. In addition, another inmate contacted the ombudsman directly with a similar report but was unable to provide specific first-hand information.

The ombudsman opened an ombudsman initiated investigation to determine whether the inmate had been mistreated while in the custody of the Department of Corrections (Corrections). Assistant Ombudsman Mark Kissel investigated the complaint and mailed DOC Commissioner Marc Antrim notice of investigation on February 3, 2005. The Ombudsman opened a complaint file with the following allegation, stated in terms that conform with AS 24.55.150, which authorizes the ombudsman to investigate complaints about administrative acts of state agencies:

Contrary to law: KCC staff assaulted an inmate which resulted in the inmate's death.

Following investigation, the ombudsman concluded that the allegation is ***not supported*** by the evidence.

INVESTIGATION

The deceased inmate was a 31-year-old man who had turned himself in at KCC on July 20, 2005 to serve a week-long sentence for a probation violation. He displayed symptoms of alcohol withdrawal during his incarceration. At approximately 3:08 a.m. on July 24, he was found dead in his cell. Emergency medical personnel were summoned, but they could not revive him.

KCC officials summoned Alaska State Troopers (AST) who arrived at KCC at about 3:55 a.m. on July 24 to begin their investigation.[1] According to their report, troopers saw no evidence of a crime. That morning, a trooper sergeant viewed the video recording from a camera in the inmate's cell. AST then closed its investigation pending additional information from an autopsy.

On August 8, 2004, troopers received two phone calls requesting that they re-investigate the death based on information from inmates at KCC. In response, troopers interviewed two inmates who were incarcerated at KCC the morning of the death. The inmates told troopers that they heard another inmate yelling for medication, possibly insulin. One inmate said that he heard bumping and crying from that inmate's cell. Both thought the inmate had a cellmate at the time of his death. Troopers reported that the bumping and crying most likely came from another inmate, a combative drunk who was brought to the prison at about 11:30 p.m. on July 23. Troopers reported that the log sheets showed that the loud drunken inmate was never in the same cell with the inmate who died and that the deceased inmate was alone in the hours before his death.

Autopsy

The inmate's body was sent to the Office of the State Medical Examiner for autopsy. Deputy Medical Examiner Dr. Susan Klingler performed the autopsy on July 26. Upon request, the Medical Examiner provided the ombudsman investigator a copy of the autopsy report. Dr. Klingler reported the manner of death as "natural." She noted no internal injuries and no signs that the dead man had been restrained by force. [2] The ombudsman investigator also communicated with Dr. Frank Fallico, the state Medical Examiner who further explained the autopsy

Inmate Interview

The ombudsman investigator interviewed an inmate witness via telephone from Spring Creek Correctional Center, Seward, where he had been transferred. The inmate witness said he was at KCC from May through October of 2004 and was there on July 24, the

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[1] DOC Policy and Procedure Manual #808.17 B (3) and #808.17 D (1) (c) direct that DOC notify the Alaska State Troopers "as appropriate" when a prisoner dies in custody. The manual does not define appropriate circumstances.

[2] Because of state and federal confidentiality laws regarding medical information as confidential by statute, the ombudsman has statutory access to specific information gathered from the medical examiner but is not authorized to release that information without court order.

morning of the death. The inmates were in adjacent cells, but they did not converse because the other inmate was “not in a right state of mind.”

The inmate witness said the other inmate was hallucinating. He said the inmate yelled that part of his toilet was on fire and that there were fish in the bowl. The witness said the inmate had three cell mates at different times during his incarceration. Two of them complained about his behavior until guards moved them to the witness’s cell. The witness said another prisoner, who arrived late on July 23, was placed with the inmate who died and remained with him until his death.

The witness said that he could not see into the deceased’s cell, but he could hear what was going on there. He said that there was some disturbance in that cell and correctional officers went in and beat both inmates. The witness said he heard thumps, as if the men were being beaten, and he heard both men screaming and crying. He said this began between midnight and 12:30 a.m. and lasted for about 30-45 minutes. When it was over, he said, the correctional officers took the other inmate to the glass observation room and dragged a body into the hallway in front of the witness’s cell. He said he could see that the inmate was dead.

The witness said that the two inmates who shared a cell with him that night would be able to verify his account. However, he said both of them had since left the United States, and he did not know how to reach them.

The ombudsman investigator requested from Corrections a copy of the video recording from the camera in the inmate’s cell the morning he died. The video had a time counter, which shows on the playback software. The video showed an inmate alone in his cell from 12:30 a.m. until 3:30 a.m. on July 24. At 12:30 a.m. the inmate appeared to be restless but otherwise well. He was seated on a bunk. He moved his head and upper body often. The video has no audio, so a viewer cannot tell whether the inmate was speaking. At about 12:50 a.m., the inmate stood and walked to the toilet. Then he lay on the floor, his feet nearly behind the toilet and his head at the opposite wall. The inmate changed his position several times, from laying on the floor to sitting with his back against the wall. At about 1:15 a.m., the inmate settled into a sitting position on the floor leaning against the wall. His movements became gradually less discernable. By about 1:30 a.m., the inmate was sitting still. It appeared as though he had fallen asleep.

Shortly after 3 a.m., a shadow fell across the cell door slot, as if someone were looking into the cell from the hallway. A few minutes later the cell door opened. One uniformed man, presumably a correctional officer, entered the cell, stepped over the inmate’s legs, and appeared to move the mattress from the bunk to the floor. Other uniformed people were standing at the cell door. One of them placed his hand on the inmate’s chest. Then the officers left for a few moments, partially closing the door. When the door reopened, an officer picked up a blanket that had been on or next to the inmate. He appeared to spread the blanket outside the cell and pulled the inmate by his upper body until he was on the blanket. Only the inmate's lower legs remained in the cell. At about 3:17 a.m., other uniformed people arrived and examined the inmate.

The cell video contradicts the witness's story. The deceased was in his cell alone the two hours preceding the discovery of his death. No one beat him or abused him during this time. He was pulled into the hallway after 3 a.m., about two hours later than the witness recalled. If the witness was sincere in his interpretation of what he heard, then the conclusion of the troopers, that he heard staff dealing with a combative drunk in the booking area, seems the simplest explanation.

An incident report filed by Correctional Officer II Sharri Davis after the inmate death provided additional descriptions of the inmate's final hours. C.O. Davis said she watched the inmate via the camera in his cell. She wrote:

> During the course of shift I observed inmate…in the camera. He was climbing on the bunk, scratching on the walls and doors. He kept walking around the cell like he was trying to find something. He had fallen a few times as well. Sgt. Henderson went back to check on him and told him to lay on the bunk and try to sleep.
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> I also observed subject stuffing something in his mouth and informed Sgt. Henderson. Sgt. Henderson, Officer Irizarry and Officer Murray went to his cell. They opened the door and removed the extra mattress, toilet paper and some of the clothing from his cell. He had one blanket, his shirt and underwear remaining with him. Before they left his cell, Officer Irizarry had to clean it. He mopped the floor and left the area when done.

The video corresponds with reports written by the correctional officers on duty the morning the inmate died. The guards stated that they went into the cell shortly after 3 a.m. to move the inmate from the floor to a mattress "so he'd be more comfortable." Sgt. Henderson instructed the officers to place the mattress on the floor so the inmate would not fall off the bunk. This explains why the video shows a correctional officer entering the cell, stepping over the inmate, and moving the mattress to the floor. It was at this time that the correctional officers noticed that the inmate was not breathing and that his skin had a mottled appearance.

KCC Medical Care

The ombudsman investigator received a copy of the medical progress notes and criminal remand health screening forms for the deceased inmate. These had been filled out by the KCC nurse, Linda Monticello. Her notes show that she conducted a health screening of the inmate at 1:50 p.m. on July 21, the day after he turned himself in at the jail. The notes indicate a concern about alcohol withdrawal, noting a mild hand tremor. She wrote on the form: "observe for DT" [delirium tremens]. She noted that the inmate denied suffering hallucinations, that he appeared normal in speech, thought processes, and orientation, and that his attitude was cooperative.

Nurse Monticello noted six additional contacts with the inmate over the next two days. At 2 p.m. on July 22, she evaluated the inmate for possible DT. At the time of this examination, the inmate was very sweaty, had hand tremors, and claimed that he saw objects move on a countertop. Following this evaluation, the nurse phoned Dr. E.B. Meloche, KCC's contract physician. Her notes indicate that Dr. Meloche instructed her to initiate a DT protocol, specifically to administer clorazepate and thiamine. Her notes indicate that she administered a dose of each medication at 2:50 p.m.

The next morning, July 23, Ms. Monticello noted that she observed the inmate in his cell at 6:10 a.m. At 7 a.m. she wrote that she administered another dose of medication. She noted that the inmate still had hand tremors. At 9:30 a.m., the nurse saw the inmate in the examination room. She noted that he was sweaty, hallucinating, but still cooperative. He talked to Ms. Monticello about a new job he would be starting. He drank the fluids that she offered. At 2:10 p.m. Ms. Monticello wrote that she observed the inmate in his cell. She wrote that he was sitting on his bunk. She said she advised him to rest; he nodded and fixed his blankets. Ms. Monticello wrote that she advised Sgt. Ellis to "make certain inmate eats dinner."

Research of medical sites on the internet reveals that alcohol withdrawal presents serious risks. Physicians describe alcohol withdrawal syndrome as the disorder that occurs when people who are physically dependent upon alcohol stop drinking or reduce their alcohol intake. The syndrome is generally divided into four categories:

> **Minor withdrawal**, also called withdrawal tremulousness, occurs within 6-24 hours following the last drink and is characterized by tremor, anxiety, nausea, vomiting, and insomnia.
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> **Major withdrawal**, characterized by hallucinations, occurs 10-72 hours after the last drink. Symptoms include hallucinations, whole body tremor, vomiting, sweating, and elevated blood pressure
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> **Withdrawal seizures**, or rum fits, occur within 6-48 hours of the last drink and are characterized by major seizures. About 30-40% of patients with withdrawal seizures progress to DTs.
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> **Delirium Tremens** is the most severe manifestation of alcohol withdrawal, occurring 3-10 days following the last drink. Symptoms include agitation, confusion, disorientation, hallucinations, fever, and elevated heart rate and blood pressure.

According to an article on the web site e-medicine.com, mortality for patients with DTs ranges from 5 percent to 15 percent, even with appropriate treatment. The most common conditions leading to death in these patients are respiratory failure and cardiac arrhythmias. The article was authored by Drs. Michael Burns, MD, James B Price, MD, and Michael Lekawa, MD. Other sources estimate a lower mortality, but alcohol withdrawal clearly can be fatal.

The seriousness of alcohol withdrawal is highlighted in the Alaska DOC Medical Guideline for Alcohol Withdrawal: "Notify medical provider immediately if patient is markedly dehydrated, fever over 101, severe agitation, seizures, severe DTs, airway problems, or other concerns." The inmate, although hallucinating and agitated at times, did not manifest fever, dehydration, or airway problems, according to the nurse's notes.

On July 22, the nurse notified Dr. Meloche when the inmate's blood pressure increased to 160/104 with a pulse of 160. The day before his blood pressure had been 132/96 and his pulse 87. Dr. Meloche ordered her to initiate an alcohol withdrawal protocol using clorazepate, which is similar to Valium. When the nurse examined the inmate the morning of July 23, his blood pressure had decreased to 115/84 and his pulse to 80.

The Alaska guidelines provide 16 steps of treatment over five days "if patient shows only signs of mild symptoms of withdrawal, tremulousness, irritability, anorexia, nausea, and occasional hallucinations." Some of the steps addressed symptoms that the inmate did not exhibit, such as nausea and vomiting. But it appears from the nurse's records that she adhered to the guidelines as far as was indicated.

The ombudsman lacks the medical expertise to assess the medical treatment that the inmate received while incarcerated. However, a review of internet resources turned up other guidelines for treating alcohol withdrawal that were similar to Correction's guidelines.

FINDING OF RECORD AND CLOSURE

The evidence does not lead the ombudsman to believe that the inmate's death was violent as alleged by at least two other inmates. Consequently, the ombudsman finds the allegation that Correction's staff contributed to the inmate's death ***not supported*** by the facts.

A death in custody is a tragic event for all concerned. Although the ombudsman has no reason to believe the current guidelines for dealing with inmate alcohol withdrawal are inadequate, it is fitting that a death in custody spur a review of the guidelines to make sure they reflect current medical standards and best practices. In that spirit, the ombudsman suggests that Corrections medical experts review its guidelines for care of inmates undergoing alcohol withdrawal.