OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-001

DATE OF INSPECTION:	**FEBRUARY 4, 2015**
FACILITY:	**OKLAHOMA COUNTY JAIL** **201 N SHARTEL** **OKLAHOMA CITY, OK 73102**
SHERIFF:	**JOHN WHETSEL**
JAIL ADMINISTRATOR:	**JACK HERRON**
INVESTIGATOR:	**CINDY RICE**
DECEASED:	**CONFIDENTIAL**
DATE OF DEATH: (approx.)	**JANUARY 12, 2015**
TIME OF DEATH: (approx.)	**1624 HOURS**

FACTS DETERMINED BY THE INVESTIGATION: Detention Officer #1 did not notice anything out of the ordinary while conducting routine sight checks. After he had looked into Cell 38 and was in the process of checking Cell 45, he heard a loud "thud" and someone yelling "we need you down here." Detention Officer headed back to Cell 38 to see what was wrong. When he arrived at Cell 38 Inmate #2 and Inmate #3 were pointing at Inmate #1 who was lying on the floor having what appeared to be convulsions. Detention Officer #1 called for assistance, opened the cell door, went into the cell and knelt down beside Inmate #1 who appeared to be having a seizure and was bleeding from the back of his head.

Detention Officer # 2 and the Nurse #1 arrived and Inmate #2 and Inmate #3 were removed from the cell. While Nurse #1 was putting a bandage on Inmate #1's head, Detention Officer #2 noticed a white foamy substance coming from Inmate #1's mouth. Detention Officer #2 asked Inmate #1 what happened and he replied, "I think I fell." Inmate #1 was taken to the medical floor at approximately 0320 hours for observation every 15 minutes. At approximately 0720 hours medical staff determined that Inmate #1 needed to be taken to St. Anthony's Hospital for further treatment. Inmate #1 was placed in an ambulance at 0740 hours and arrived at St. Anthony Hospital at 0748 hours.

The Facility Investigator #1 arrived at St. Anthony Hospital at 0850 hours to take photographs of Inmate #1's injury. While at the hospital, the Investigator was told by medical personnel that due to a massive brain bleed Inmate #1 had suffered, it caused him to pass out. Medical staff stated "the damage was done before he hit the ground." The facility obtained an OR Bond Release to release Inmate #1 from the custody of the facility. Inmate #1 died later after he was released from the jail. Incident Report states that an investigation is still pending into the incident.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-002

DATE OF INVESTIGATION:	**FEBRUARY 25, 2015**
FACILITY:	**DAVID L. MOSS** **CRIMINAL JUSTICE CENTER** **300 N. DENVER** **TULSA, OK 74013**
SHERIFF:	**STANLEY GLANZ**
JAIL ADMINISTRATOR:	**MAJOR SHANNON CLARK**
INVESTIGATOR:	**ALAN COFFEE**
DATE OF DEATH:	**JANUARY 18, 2015**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was booked into jail on November 7, 2014, and died January 18, 2015. The Investigations Sergeant provided me with copies of Inmate #1's booking documentation. According to the intake health screening and mental health screening forms, Inmate #1 told jail staff that she lived in a mental health home and had mental health issues and was bipolar and schizophrenic. The police officer who brought her to the jail stated she has the mentality of a young child and was hit by a car at age 3.

I was escorted me to the medical ward where I spoke to the Armor Health Administrator. According to her medical charts, Inmate #1 had blood sugar issues and her blood sugar had been checked six (6) different times from December 10, 2014 to December 28, 2014. The reading ranged from 67 to 108. The report stated Inmate #1 had been complaining about tummy pain for a few weeks and had been given Pepto Bismol and she seemed fine.

Inmate #1 was found unresponsive in her cell on January 18, 2015, at 11:45 am, when lunch was being served to the inmates. She was observed sitting with her back against the wall between the bunk and door. She had a blank stare on her face and was not moving. Inmate #1's right arm was on her bunk, her left arm was in her lap, and she was partially dressed. A medical emergency was called and the cell door was opened and CPR was started but Inmate #1 was unresponsive.

According to the supplemental investigation report, Inmate #1 cell had a large amount of feces underneath her bed and in the corners of her cell. The toilet in her cell was clogged with feces and toilet paper. According to a report from the Medical Examiner, there was no clear evidence

of any cardiopulmonary illness. A toxicology report has not been seen yet and the apparent cause of death was probably natural causes, likely sudden cardiac arrhythmia which may or may not be able to be proved pathologically.

DISPOSITION: No further action required.

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ALAN COFFEE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-003

DATE OF INVESTIGATION:	**MARCH 10, 2015**
FACILITY:	**ARKOMA POLICE DEPT.** **P. O. BOX 277** **ARKOMA, OK 74901**
CHIEF:	**THOMAS LENARD**
JAIL ADMINISTRATOR:	**THOMAS LENARD**
INVESTIGATOR:	**ALICIA DICKERSON**
DATE OF DEATH:	**JANUARY 18, 2015**

FACTS DETERMINED BY THE INVESTIGATION: At approximately 1407 pm, a Reserve Police Officer placed Inmate #1 into Cell #1 and then went to the book-in room to work on his report. At 1450 pm the officer returned to Cell #1 to get some additional information from Inmate #1. When he arrived at the cell, he observed Inmate #1 hanging by his neck from the top rail of the bunk with his belt around his neck. The officer ran to the dispatch office, got the jail keys and unlocked the cell door. He then entered the cell and removed the belt from Inmate #1's neck, laid him down on the floor and began performing CPR until EMS and the first responders arrived.

EMS arrived at the jail at 1520 pm and pronounced the inmate deceased. The Medical Examiner arrived at 1820 pm. Mallory Funeral Home also arrived at the jail and transported the body to the Oklahoma City Medical Examiner's office.

DISPOSITION: No further action required.

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ALICIA DICKERSON, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-004

DATE OF INSPECTION:	**MAY 5, 2015**
FACILITY:	**PAYNE COUNTY JAIL** **606 S HUSBAND** **STILLWATER, OK 74074**
SHERIFF:	**R.B. HAUF**
JAIL ADMINISTRATOR:	**REESE LANE**
INVESTIGATOR:	**CINDY RICE**
DECEASED:	[redacted]
DATE OF DEATH:	**FEBRUARY 14, 2015**
TIME OF DEATH:	**1555 HOURS**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was booked into the facility on February 13, 2015. During booking he told jail staff that he had a CPAP machine when completing the medical questionnaire. He was housed in the lower isolation cell.

On February 14, 2015, at approximately 1147 hours, Detention Officer #1 was picking up serving trays from the inmates. He made verbal contact with Inmate #1 who verbally acknowledged Detention Officer #1 and physically handed his tray to the detention officer. At that time Detention Officer #1 noticed that Inmate #1's CPAP machine was turned on.

At approximately 1515 hours, Detention Officer #1 returned to collect the cleaning supplies from Inmate #1 and noticed that his CPAP machine was off. Detention Officer #1 attempted to make verbal contact with Inmate #1 and got no response. He knocked on the cell door several times and still got no response. Detention Officer #1 then opened the cell door and attempted to use verbal commands and physical touch to get a response. After no response, Detention Officer #1 began checking for a pulse and was unable to find a pulse. He radioed for assistance and started life saving measures.

Emergency personnel arrived at approximately 1525 hours. Emergency responders took over life saving measures until 1555 hours. Life Net responders advised that Inmate #1 was deceased.

FINDINGS: The Medical Examiner ruled the death "complications of heart disease."

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-005

DATE OF INVESTIGATION:	**APRIL 10, 2015**
FACILITY:	**CHEROKEE COUNTY JAIL** **213 W DELAWARE** **TAHLEQUAH, OK 74464**
SHERIFF:	**NORMAN FISHER**
JAIL ADMINISTRATOR:	**TJ GIRDNER**
INVESTIGATOR:	**ALAN COFFEE**
DATE OF DEATH:	**APRIL 6, 2015**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was booked into jail on March 11, 2015, and the Jail Administrator gave me copies of the booking report and medical questionnaire completed at booking. I was also provided with video surveillance of the cell that Inmate #1 was in when he died. It was documented on the medical questionnaire that Inmate #1 tried to commit suicide in 1982 by taking pills and had heart surgery in 1989. Inmate #1 reported that he suffers from anxiety, depression and has a psychiatric disorder and hears voices. He had recently been treated by a doctor for a cut on his wrist and was currently thinking about suicide. Inmate #1 was placed in Cell A6 which is directly in front of the booking desk and has windows that have covers that can be raised to look into the cell and camera surveillance.

I reviewed the video surveillance of Cell A6 on April 5, 2015, and Inmate #1 could be seen sitting nude and on the toilet in the back of the cell. He had placed his mat directly in front of the toilet lengthwise against the wall. Inmate #1 was making hand gestures like he was catching things and shooting with his fingers while talking to himself. At 9:42:00 pm Inmate #1 falls forward on his knees, his head resting on the mat in front of the toilet. At 9:43:00 pm he falls over on his left side and his body was shaking. At 9:43:40 pm he stops shaking and he appeared to be breathing slowly and sporadically. It appeared that Inmate #1 took his last breath at 9:56:20 pm. Inmate #1 no longer moved after that.

Officer #1 opened the cell door at 3:30:56 am on April 6, 2015, and looked in on Inmate #1. At 3:31:16 am Officer #1 entered the cell again and stood looking at Inmate #1 but did not touch him and walked out and closed the door. At 4:43:35 am the cell door was opened and someone entered the cell and touched Inmate #1. He left the cell and a few minutes later a couple of jail

staff entered the cell and took pictures. The Medical Examiner arrived at 6:08:40 am and picked up the body and it was taken to the medical examiner's office.

OAC310:670-5-2(3) Security and control
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(3) There shall be at least one (1) visual sight check every hour which shall include all areas of each cell, and such sight checks shall be documented.

DEFICIENCY: Sight checks were not conducted as required by the jail standards.

DISPOSITION: A follow-up will be conducted after sixty (60) days.

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ALAN COFFEE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-006

DATE OF INSPECTION:	**JUNE 4, 2015**
FACILITY:	**COMANCHE COUNTY JAIL** **315 SW 5th** **LAWTON, OK 73501**
CHAIRMAN:	**GALE TURNER**
JAIL ADMINISTRATOR:	**WILLIAM HOBBS**
INVESTIGATOR:`	**CINDY RICE**
DECEASED:	[redacted]
DATE OF DEATH:	**MAY 24, 2015**
TIME OF DEATH:	**0530 HRS**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was booked into the facility on alcohol related charges on May 23, 2015, at approximately 0920 hours. Inmate #1 was known by most of the facility staff and had suffered from known alcoholism and had a history of seizures.

At approximately 0435 hours on May 24, 2015, Detention Officer #1 noticed that Inmate #1 had fallen in his cell. He was lying face down on the floor with blood coming from his head. Staff was able to find a pulse and noticed air bubbles on Inmate #1's face. He was unresponsive and jail staff called for an ambulance at approximately 0441 hours. The ambulance arrived at the facility at approximately 0450 hours and began performing emergency medical procedures on Inmate #1. At approximately 0519 hours, Inmate #1 was transported to Comanche County Hospital where he was pronounced dead by Dr. James Williams at 0530 hours.

FINDINGS: Inmate #1 had a history of alcoholism and seizures. It appears that he fell in his holding cell and suffered a head injury. Facility staff was able to find a pulse on Inmate #1 and called for emergency medical staff.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-007

DATE OF INSPECTION: **JANUARY 25, 2016**

FACILITY: **GRADY COUNTY**

FACTS DETERMINED BY THE INVESTIGATION: I interviewed the Jail Administrator and he provided me with statements from the jailers involved. The book in for Inmate #1 documented that she was booked into the facility on July 5, 2015, around 1740 hours. I reviewed the statement from Detention Officer #1 who stated that Inmate #1 was in holding cell 127. At approximately 1900 hours Detention Officer #1 performed a visible assessment while Inmate #1 was in the cell and saw Inmate #1 on the floor picking up paint chips and eating them. At approximately 2000 hours the Detention Officer #1 did a visible assessment on Inmate #1 and found her asleep on the floor and snoring. Detention Officer #1 left his station to assist with an issue on the East Unit.

Detention Officer #2 stated that she gave Inmate #1 a sandwich to eat at approximately 1820 hours. The officer unwrapped the sandwich for Inmate #1 and left the cell. At an unknown time Detention Officer #2 stated that she was in book in area after she gave Inmate #1 a sandwich and saw Inmate #1 face down in the southeast corner of the cell. Detention Officer #2 ran to holding cell 127 and opened the door and called out “ma’am”, twice and did not get an answer. She entered the cell and reached for the inmate’s right wrist and startled the inmate and Inmate #1 said to her “I’m sorry” and started picking at the wall. Detention Officer #2 checked on the inmate again and saw her body rise and fall and heard the inmate snoring loudly. Detention Officer #2 left her station because she received a call to assist in the East Unit with a disturbance.

Central Control Operator #1 came on duty and saw Inmate #1 on camera and turned on the speaker intercom and heard Inmate #1 snoring. Central Control Operator #1 was checking on the inmate every 15 minutes via camera and speaker monitor. At 2115 hours the operator left central control to assist with an issue on the East Unit. Central Control Operator #2 took over the operation of the camera and speaker monitors. At 2133 hours he saw Inmate #1 move her feet. The operator stated that he did a visual check on Inmate #1 every 15 minutes until Central Control Operator #1 returned.

Detention Officers #1, #2 and Central Control Operator #1 returned to their stations at approximately 2240 hours. Detention Officer #1 saw on the camera that Inmate #1 was in the same position that he had last seen her. The officer turned on the speaker monitor and did not hear any noise. He went to holding cell 127 to check on the inmate. Detention Officer #1 entered the cell and felt Inmate #1 was cold to the touch and he didn’t find a pulse. He immediately

called for help and Detention Officer #2 and Nurse #1 arrived. Nurse #1 evaluated Inmate #1 and did not find any vital signs. Detention Officer #2 called for emergency personnel.

EMSA arrived at approximately at 2255 hours. The medical examiner arrived at approximately 0140 hours and the medical examiner transport arrived at 0221 hours. At 0227 hours the medical examiner and transport examiner left the facility.

DEFICIENCY #1: Detention officers did not perform a visual sight check every hour.

OAC 310:670-5-2(3)
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(3) There shall be at least one (1) visual sight check every hour which shall include all areas of each cell and such sight checks shall be documented.

FINDINGS: I found evidence in the statements from the Detention Officers and Central Control Operators that they were watching the cameras and using the speaker monitors to do their hourly and 15 minute sight checks and were not seeing all areas of the cell.

DEFICIENCY #2: Detention Officer #2 opened a cell door without backup assistance from another detention officer.

OAC 310:670-5-2(5)
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(5) No one person shall be permitted to enter a prisoner's cell or other area in which a prisoner is confined, past the last locked door, without backup assistance. Prior to breaching the last locked/secure door, central control or another staff member who can provide assistance will be notified. Documentation shall reflect the reason for the decision to enter a cell without backup assistance and a permanent record of the event shall be maintained.

FINDINGS: I did not find any documentation on the jail log as to why Detention Officer #2 entered a cell without backup assistance.

DISPOSITION: A follow-up will be conducted after sixty (60) days.

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ALICIA DICKERSON, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-008

DATE OF INVESTIGATION: **JULY 31, 2015**

FACILITY: **MCCURTAIN COUNTY JAIL**

FACTS DETERMINED BY THE INVESTIGATION:

FINDINGS: According to statements provided by detention officers at the time of this incident, Inmate #1 was booked into the facility on February 12, 2015, at 1555 hours and released from the jail on February 12, 2015, at 2131 hours. The jail administrator assistant stated that this inmate has a history of fighting with the detention officers when he comes in the jail. When the inmate was brought into the jail, several detention officers were available to assist the book in officers if Inmate #1 became agitated.

Detention Officer's #1, #2 and #3 walked Inmate #1 into the book-in/exam room for the book-in process. After the process was done, Detention Officer #4 tried to get Inmate #1 up from the book in chair to go to the shower for the delousing process and remove his street clothing to be put in the jail clothing. Inmate #1 refused to comply.

At approximately 1654 hours, Detention Officer #6 brought the restraint chair into the booking area and Detention Officer #3 told the inmate to sit down in the chair. The inmate complied and was taken to the isolation cell where the jail staff could watch the inmate on the camera until he calmed down.

At approximately 1808 hours, Detention Officers #3, #4 and #5 entered the isolation cell and had Inmate #1 stand up from the restraint chair. Detention Officer #4 asked Inmate #1 if he would like to dress out and Inmate #1 said that he would like to sit back down in the restraint chair. The officers complied with Inmate #1's request and placed him back in the restraint chair.

At approximately 1947 hours the detention officers returned to the isolation cell and released the inmate from the restraint chair and walked him into the exam room to change his clothes. Officer #1 and #3 assisted Inmate #1 with taking his clothing off. Detention Officer #2 told Inmate #1 to put on the jail's jumpsuit. The inmate refused to comply and Officer #2 took the inmate's arm and the inmate started resisting. Detention Officers #1, #2, #3 started to restrain the inmate and dry stunned the inmate on the left leg above the knee. The inmate pushed the stun gun off of his leg and then the detention officers got the inmate on the floor, but the inmate was resisting hard.

Detention Officer #4 dry stunned the inmate two more times but it did not do any good. The inmate kept fighting with the officers.

At 1955 the women's control officer was notified to call for any available officers to come and assist them with the inmate. Officers #1 and #2 arrived at the jail to assist the jailers with Inmate #1. At approximately 2007, the officers got the inmate under control and placed him in the restraint chair and Detention Officer #4 rolled the restraint chair into the isolation cell. The officer then assists the inmate and checked the inmates pulse and it felt faint. At approximately 2010 the detention officer notified the women's control to call for EMS. At 2015 CPR was started by Detention Officer #4. At 2023 EMS arrived and took over the doing CPR.

At 2027 EMS transported the inmate to McCurtain Memorial Hospital. Detention Officer #7 stated that the inmate was treated at the hospital and later transported to St. Michael's Hospital in Texarkana, Arkansas.

DEFICIENCY #1: Improper use of restraint chair

OAC 310:670-5-2(24) Security and control

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> **(24) Instruments of restraint such as handcuffs, leg irons, restraint chairs, restraint beds and straitjackets, shall not be applied longer than authorized by policy and procedure and equipment manufacturer's specifications. Prisoners placed in restraints shall not be left without required supervision.**

DISPOSITION: A follow-up will be conducted after sixty (60) days.

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-009

DATE OF INSPECTION: **NOVEMBER 18, 2015**

FACILITY: **CARTER COUNTY JAIL**

FACTS DETERMINED BY THE INVESTIGATION: According to statements received from the jail nurse and the detention officers, at approximately 1145 hours Detention Officer #1 was passing out food trays in H block and came to cell 404 and asked central control to open the cell door for her to give Inmate #1 his food. When the cell door was opened the officer asked the inmate if he wanted his tray. The inmate didn't respond and the officer looked up and saw the inmate sitting up against the sink with something tied around his neck and he appeared to be unresponsive. The detention officer immediately called for backup in H block.

The jail nurse went to H Block and asked what happened and was told that Inmate #1 had hung himself. Cell 404's door was opened by central control and the nurse entered and saw the inmate sitting beside the sink with a towel wrapped around his neck. Detention Officer #2 and the nurse untied the towel from the faucet and from the inmate's neck and lifted the inmate up and laid him on the floor and began compressions. The nurse told the other officers to call S.O.A.S. Ambulance Service.

At approximately 1150 hours S.O.A.S. arrived and took over the scene. At 1157 hours S.O.A.S loaded the inmate and took him to Mercy Hospital in Ardmore. The hospital pronounced the inmate deceased at approximately 1215 hours.

DISPOSITION: No further action required

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ALICIA DICKERSON, INSPECTOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-011.1

DATE OF INSPECTION: **MARCH 10, 2016**

FACILITY: **LEFLORE COUNTY JAIL**

FACTS DETERMINED BY THE INVESTIGATION: This was investigated by Investigator #1. According to documentation, Inmate #1 was booked into jail on August 28, 2015. The Oklahoma State Bureau of Investigation was called in for an official investigation. According to the report from the OSBI, at approximately 0050 hours, Inmate #2 notified the jail staff that Inmate #1 had hung himself in the cell. Detention Officer #1 was the first on the scene and notified Detention Officer #2 (also the shift supervisor). Inmate #1 was housed in a cell alone. Detention Officer #1 and other jail staff responded, locked down the pod, checked for signs of life and EMS was notified. According to the report, Inmate #1 used a noose fashioned from a bath towel. Upon arrival, EMS confirmed that Inmate #1 was deceased. The body was released to Evans and Miller Funeral Home for transport to the Medical Examiner's Office. OSBI report stated that according to video footage, there were no other inmates that entered the cell occupied by Inmate #1.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
DEATH INVESTIGATION REPORT D-2015-011

DATE OF INSPECTION:	**AUGUST 11, 2015**
FACILITY:	**OKLAHOMA COUNTY JAIL** **201 N SHARTEL** **OKLAHOMA CITY, OK 73102**
SHERIFF:	**JOHN WHETSEL**
JAIL ADMINISTRATOR:	**JACK HERRON**
INVESTIGATOR:	**CINDY RICE**
DECEASED:	**CONFIDENTIAL**
DATE OF DEATH: (approx.)	**JULY 23, 2015**
TIME OF DEATH: (approx.)	**2140 HRS**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was housed in medical pod. Cellmate called the control center and told them Inmate #1 was having trouble. When staff responded, Inmate #1 was found unresponsive in his bed. Detention Officer #1 performed chest compressions while waiting for medical staff. Upon arrival of medical staff, the Automated External Defibrillator (AED) was applied. AED advised to continue CPR. Staff continued CPR until Fire & EMSA took over lifesaving procedures. Inmate #1 was transported to St. Anthony's Hospital. At approximately 2140 hours, Inmate #1 was pronounced dead. Preliminary report from Medical Examiner stated findings of "previous heart attack, severe cardio vascular disease, two of the three main arteries clogged, no fatal trauma." OSBI was called in for investigation.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-012

DATE OF INSPECTION: **FEBRUARY 4, 2016**

FACILITY: **DAVID L. MOSS**

FACTS DETERMINED BY THE INVESTIGATION: This was investigated by Investigator #1. According to the reports and investigation notes, during the intake mental health screening, Inmate #1 admitted to considering killing and/or harming himself in years past, psychosis, and psychiatric illness. Inmate #1 was not placed on suicide watch due to the fact that at the time he stated that he was not considering suicide. On September 19, 2015, during a security check at approximately 1612 hours, Detention Officer #1 stated that there were no IDs in the window of cell M. Detention Officer #1 banged on the window to wake both occupants up. Inmate #2 woke up and showed Detention Officer #1 his ID, Inmate #1 did not move. Detention Officer #1 opened the cell door and shook the pant leg of Inmate #1 to wake him up. Inmate #1 did not respond. Detention Officer #1 stated that Inmate #1's leg was "stiff" and that he noticed spots on his foot. Detention Officer #1 commanded Inmate #2 to exit the cell. Detention Officer then pulled back the blanket from Inmate #1 and at that time, his chest was not moving. Detention Officer #1 called a "medical emergency". Sargent #1, Detention Officer #2, Detention Officer #3 along with Nurse #1and Nurse #2 responded along with other staff to assist. Detention Officer asked Nurses to confirm that Inmate #1 did not have a pulse. Nurse #1 and Nurse #2 both confirmed there was no pulse. Everyone exited the cell and secured it as a crime scene. EMSA was contacted for the official verification of death. Tulsa Fire Department arrived at approximately 1632 hours and EMSA arrived at approximately 1634 hours. Tulsa Fire Department pronounced Inmate #1 deceased at approximately 1651 hours. The body of Inmate #1 was released to the Medical Examiner's Office.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-013

DATE OF INSPECTION: **OCTOBER 29, 2015**

FACILITY: **OKLAHOMA COUNTY JAIL**

FACTS DETERMINED BY THE INVESTIGATION: On September 28, 2015, at approximately 1950 hours, Detention Officer #1 entered 4B pod to feed and at approximately 1956 hours, opened cell 22 when he noticed Inmate #1 hanging from a sheet. Detention Officer #1 stated that the sheet was tied to the top bunk and Inmate #1 was in a sitting position in the back of the cell. Detention Officer #1 radioed for a nurse and gurney and began to attempt to free Inmate #1 from the "noose". Inmates #2, #3, #4 and #5 all attempted to help Detention Officer #1 get Inmate #1 down. Inmates #2, #3, #4 and #5 held Inmate #1 up while Detention Officer loosened the knot. At approximately 1958 hours, Detention Officer #2, Nurse #1, Nurse #2 and Nurse #3 arrived with the gurney. Nurse #1 advised that Inmate #1 did not have a pulse and that they needed to notify EMS immediately. Nurses #1, #2 and #3 began life saving measures until EMSA arrived at approximately 2007 hours and took over CPR. At approximately 2024 hours, EMSA removed Inmate #1 from the pod and transported him to OU Medical Center where he was pronounced dead at 2045 hours.

DISPOSITION: No further action required.

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CINDY RICE, INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-014

DATE OF INSPECTION: **DECEMBER 9, 2015**

FACILITY: **PONTOTOC COUNTY JAIL**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was booked into the Pontotoc County Jail on September 25, 21015. According to the medical questionnaire, Inmate #1 stated she suffered from a heart condition, high blood pressure and psychiatric disorder. Inmate #1 was housed in the holding cell.

According to the incident report, on September 29, 2015, at approximately 0637 hours, Detention Officer #1 went into the holding cell to do a visual sight check on Inmate #1. Detention Officer #1 stated that she walked toward the head of the bunk and reached down to touch Inmate #1's arm when she noticed that Inmate #1 was laying on her stomach with a strip of blanket wrapped around her neck and tied to the corner of the top bunk. Detention Officer #1 called for assistance. Detention Officers #2, #3 and #4 arrived while dispatch contacted 911. Detention Officer #2 removed Inmate #1 from the bunk and she was not breathing. Inmate #1 was placed just outside her cell where Detention Officer #2 and #4 performed CPR. The AED was used and prompted, "shock not advised". Deputy #1 and Mercy EMS arrived and Inmate #1 was pronounced deceased at 0648 hours. The State Medical Examiner was notified and the body was released to Criswells Funeral Home at 0841 hours.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-015

DATE OF INSPECTION: **DECEMBER 3, 2015**

FACILITY: **OTTAWA COUNTY**

FACTS DETERMINED BY THE INVESTIGATION: Inmate #1 was booked into Ottawa County Jail on October 10, 2015. At the time of booking, Inmate stated on the medical questionnaire that he suffered from Asthma and took Albuterol for his condition. On October 17, 2015, Nurse #1 received a call from the jail that Inmate #1 was complaining, "I think I broke my back". When Nurse #1 asked what happened, he stated to the jailer that it was from sleeping on a hard bunk. Nurse #1 asked the jailer if Inmate #1 was moving around and the jailer stated, "yes". Nurse #1 instructed the jailer to ask inmate if he had fallen or received any other injuries, Inmate #1 denied either. Nurse #1 instructed the jailer to give Inmate #1 over the counter Ibuprofen and she would check on Inmate #1 on Monday to see if he was still having back pain. On October 19, 2015, Inmate #1 was taken to the nurse's office and was asked about back pain. Inmate #1 stated that the pain was in the middle of his back and that he thought it was possibly kidney stones. Nurse #1 asked Inmate #1 to remove the top portion of his jumpsuit so that she could examine his back. Inmate #1 was asked to lie on his stomach so that Nurse #1 could examine his back. According to the report from Nurse #1, Inmate #1 had tender areas on the left side of his spine at approximately T-3 and T-4 with slight protrusion of T-4. Nurse #1 instructed Inmate #1 that he had what appeared to be a dislocated rib. Nurse #1 allowed Inmate #1 to use the phone to call his grandfather to see if he would pay for an appointment for Inmate #1 to see a chiropractor. Inmate #1 was unable to make contact with his grandfather, but left a message. There was no return response from grandfather. Inmate was given over-the-counter Ibuprofen and was told that when the facility Nurse Practitioner made rounds, that Inmate #1 would be allowed to see her.

On October 21, 2015, at approximately 1630 hours, Nurse #1 received a call from the jail informing her that Inmate #1 was having what appeared to be seizure activity. Nurse #1 advised the Jailer #1 to contact EMS. According to the jailer report, EMS was on the scene at approximately 1641 hours. Inmate #1 was not taken to the Emergency Room. Inmate #1 was placed in Holding Cell 1 on medical watch. According to the EMS run report, when MED 4 arrived at the jail, Inmate #1 was found in his pod lying on his mattress on the floor on his right side. During the initial assessment, the only visible sign of trauma was small bruising on his right ribs which Inmate #1 told them was from a fall approximately one week before. According to the EMS report, Inmate #1 was not having any difficulty breathing and pulse was found to be within normal limits. Inmate #1 told EMS that he had two seizures in which he was awake. Inmate #1's blood pressure was taken and found to be within normal limits. Inmate #1 stated that his ribs

were hurting and he thought that they were broken. EMS told Inmate #1 that if he had broken ribs that the ER would X-ray them and if bad enough, they would wrap them but there was nothing that they could really do for broken ribs. According to the EMS report, a Detention Officer pulled the EMT aside and told her that Inmate #1 had been up walking around all day and that right before his seizure like episode that he had walked up the guard station and told them that he would sue them for not letting him use the phone and for the fall the previous week because of the plumbing. The EMTs then helped Inmate #1 to his feet and took another blood pressure reading. Inmate #1 had a negative orthostatic test. Inmate #1 was moving around without dizziness or complaints of pain. Inmate #1 stated that he was sweating due to the elevated temperature in the pod. Inmate #1 sat on the side of the stretcher and stated that he was dehydrated. Inmate #1 was asked if he had been eating and drinking like normal and he stated that he had been. EMS listened to Inmate #1's lung sounds and they were found to be clear and equal bilaterally. Inmate #1 stated to EMS that he had been seen by the jail nurse and was given Ibuprofen for the rib pain and that the nurse let him call his grandpa to tell him about the fall. Inmate #1 stated that he wanted to call his grandpa and that if he could call his grandpa; he wanted to be left alone. One of the Detention Officers stated that they would place Inmate #1 into a holding cell in view of the guard desk and check every fifteen (15) minutes and that if anything changed, they would contact EMS immediately. Inmate #1 was told by the Detention Officer that he could not call his grandpa and Inmate #1 became visibly agitated, took off the blood pressure cuff and threw it, got up off the stretcher and stated for the Detention Officer to take him to the holding cell "now". Inmate #1 did not sign the refusal paperwork because of being placed in a holding cell.

According to the Nurse's report, on October 22, 2015, at approximately 0945 hours, Inmate #1 was observed lying in the floor on a mattress in holding cell 1 and voiced no complaints to Nurse #1 at this time. Inmate #1 stated that he had eaten breakfast and was asking to go back to the pod. Nurse #1 stated that he was going to be kept in holding cell for a little while longer to see how he was doing. At approximately 1045 hours, Inmate #1 stated that he couldn't move his legs but Nurse #1 witnessed him moving them. At approximately 1345 hours, Assistant Jail Administrator #1 asked Nurse #1 if Inmate #1 could go back to the pod. Nurse #1 instructed the Assistant Jail Administrator to bring Inmate #1 to her office so that she could talk to Inmate #1. According to Nurse #1's report, the Assistant Jail Administrator left her office to go get Inmate #1 and immediately returned and stated to Nurse #1, "you need to come look at inmate". According to the Assistant Jail Administrator's report, when he entered the cell, he noticed a piece of towel tied to a blanket lying on Inmate #1's chest and noticed that Inmate #1's feet and hands were "slightly discolored blue" and that is when he summoned Nurse #1. According to Nurse #1's report, upon entering holding cell #1, Inmate #1 appeared to be in respiratory distress but still responsive and answered when asked what his name was. According to Nurse #1's report, Inmate #1's speech was slightly garbled, eyes were petechial, pupils were pin point, fixed, head and neck were hyperextended. Neck area was red with what looked like may have been ligature marks. Skin was cold to touch. Inmate #1 responded in pain when touched on any

part of body. Extremities were cold and mottled. Nurse #1 was unable to get blood pressure reading on either arm using a manual cuff and unable to obtain O2stat. Nail beds were cyanotic. EMS was notified at 1345 hours. EMS arrived at approximately 1400 hours. Inmate was still responsive and answered when asked what his name was but his speech was still garbled. Blood pressure reading on monitor showed 120/60. Inmate #1 was picked up by EMS and placed on gurney and taken off the floor at approximately 1415 hours. Inmate was taken by ambulance to Integris Baptist Regional Health Center in Miami and was pronounced dead at approximately 1451 hours. Body was released to the Medical Examiner's Office. According to the Medical Examiner's Report, the probable cause of death was sepsis/septic shock due to acute bronchopneumonia.

DISPOSITION: No further action required.

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CINDY RICE, INSPECTOR/INVESTIGATOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-016

DATE OF INSPECTION: **NOVEMBER 18, 2015**

FACILITY: **CARTER COUNTY JAIL**

FACTS DETERMINED BY THE INVESTIGATION: A review of the inmate's booking sheet shows the Medical Questionnaire is checked "yes" for Diabetes, high blood pressure and psychiatric disorder and inmate is currently under medical treatment prescribed by a doctor.

According to statements received from the Jail Nurse and the detention officers, at approximately 1145 hours, Detention Officer #1 was passing out food trays in H block and came to cell 404 and asked central control to open the cell door for her to give Inmate #1 his food. When the cell door was opened the officer asked the inmate if he wanted his tray. The inmate didn't respond and the officer looked up saw the inmate sitting up against the sink with something tied around his neck and appeared to be unresponsive. Detention Officer #1 immediately called for backup in H block.

The jail nurse went to H Block and asked what happened and was told that Inmate #1 had hung himself. Cell 404's door was opened by central control and the nurse entered and saw the inmate sitting beside the sink with a towel wrapped around his neck. Detention Officer #2 and the nurse untied the towel from the faucet and from the inmate's neck and lifted the inmate up and laid him on the floor and began compressions. The nurse told the other officers to call S.O.A.S. ambulance service. At approximately 1150 hours S.O.A.S. ambulance service arrived and took over the scene. At 1157 hours S.O.A.S ambulance loaded the inmate into the ambulance and took him to Mercy Hospital in Ardmore. The hospital pronounced the inmate deceased.

DISPOSITION: No further action required

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ALICIA DICKERSON, INSPECTOR

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES
JAIL INSPECTION DIVISION
INVESTIGATION REPORT D-2015-017

DATE OF INSPECTION:	**DECEMBER 16, 2015**
FACILITY:	**MUSKOGEE COUNTY JAIL**
INVESTIGATOR:	**CINDY RICE/ALICIA DICKERSON**

FACTS DETERMINED BY THE INVESTIGATION:

FINDING:

The investigator arrived at the jail on December 16, 2015, and informed the jail administrator that she was investigating the death of Inmate #1. The jail administrator provided the investigator with statements from the detention officers on duty at the time of the death.

According to the statements from Detention Officer #1 and #2, they were passing out food trays in the North Detox Unit at approximately 1240 hours. When Detention Officer #2 arrived at cell 135, a blanket covering a person lying on the bench was observed through the window. Detention Officer #1 was called to the cell. Detention Officer #1 entered the cell and observed Inmate #1 lying on the bench with a blanket covering her body and face. Detention Officer #2 removed the blanket from the inmate's face and observed bubbles and saliva coming from her face and nose. Detention Officer #1 rolled the inmate onto her side and called for medical personnel via radio and checked for a pulse on the inmate's neck and wrist. Detention Officer #1 told Detention Officer #2 to retrieve the AED and mask for giving rescue breaths.

EMS was called at 1245 hours. Detention Officer #1 started CPR until EMS arrived. EMS arrived and transported the inmate to Muskogee Regional Medical Center. At 1331 hours the inmate was pronounced deceased by emergency medical personnel at the hospital.

There was no immediate indication of the cause or manner of death, which remains under investigation by the medical examiner.

DISPOSITION: No further action required.

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ALICIA DICKERSON, INSPECTOR