OFFICE OF THE LEWIS COUNTY
SHERIFF

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"Public Safety through Professional Service"

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Special Services Chief

Review Panel: WASPC Unexpected Fatality Review (UFR) Team
Decedent: 47 year old male
Location of Death: Centralia Providence Hospital
Date/Time: September 3, 2022 at 0228hrs

PURPOSE

The Washington Association of Sheriffs and Police Chiefs (WASPC) in accordance with R.C.W. 70.48.510, conducted a review of an in-custody death that occurred on September 3, 2022, involving a 47 year old male. The male died at Centralia Providence Hospital hours after being transported from the Lewis County Sheriff's Office (LCSO) Jail.

Review Panel

On November 10, 2022, the WASPC review team:

- Dr. Marc Stern
- Dr. Radha Sadacharan
- Lieutenant Ren Emerson (City of Olympia)
- Captain Ryan Barrett (SCORE Facility)
- WASPC Representative Ric Bishop (Former Clark County Jail Chief)

LCSO Corrections Bureau administration providing information for the onsite review and present:

- Chief Chris Sweet
- Captain Chris Tawes

NaphCare medical personnel providing information for onsite UFR review via phone:

- NaphCare Chief Medical Officer Dr. Jeffrey Alvarez
- NaphCare Executive Vice President & Chief Legal Officer Bradley Cain

The UFR was conducted onsite, in person, and at the Lewis County Sheriff's Office Jail.

SUMMARY OF FINDINGS

In review of the unexpected fatality that occurred on September 2, 2022, the Washington Association of Sheriffs and Police Chiefs (WASPC) Corrections Liaison John McGrath formed a committee of individuals to conduct the independent review for the Lewis County Sheriff's Office. The team reviewed all reports, housing unit surveillance video, and interviewed Corrections Bureau Administrators.

This review team experienced an unforeseen delay in the review process, due to the unfortunate passing of WASPC Corrections Liaison John McGrath. The unexpected passing delayed this entire review process, causing the LCSO Corrections Chief to extend the 120-day requirement per RCW 70.48.510.

The following is a summary of events leading up to the decedent's death at Centralia Providence Hospital:

The decedent was booked into the Lewis County Jail on July 24, 2022. Decedent indicated no medical or mental health issues at time of booking. During his incarceration at the LCSO Jail, Decedent did not have any disciplinary actions and no medical call history.

Decedent eventually requested inmate worker status and on August 8, 2022, he was assigned to the Work Ethic Restitution Center (WERC) area as a kitchen worker. It was while performing his kitchen duties on September 1, 2022 when the decedent started to complain of back pain. He submitted a medical kite to medical staff. Decedent was seen by medical staff and treated for back pain. Due to the decedent's complaints of back pain and medical treatment, decedent was temporarily removed from his WERC responsibilities and assigned a single occupant housing unit.

On September 2, 2022, while LCSO custody staff were conducting required housing checks, the decedent was found unresponsive sitting on the toilet in his housing unit. Custody staff immediately began rendering aid to the decedent and radioed for medical response. Within approximately two minutes of the initial radio call for assistance, medical staff arrived with additional custody staff and assisted with life saving measures. The decedent was unresponsive, gurgling from the mouth, with little to no pulse. The staff immediately initiated CPR and continued to triage the medical situation. An automated external defibrillator (AED) was applied to the decedent's chest. Emergency Medical Services were dispatched and responded to the jail. Members from American Medical Response (AMR) and Chehalis Fire Department arrived and took over treatment of the decedent. Aid personnel were able to determine that the decedent had a pulse and transported to Centralia Providence Hospital by AMR ambulance.

At approximately 2359hrs, the AMR ambulance arrived at Centralia Providence.

At approximately 0228hrs on September 3, 2022, the hospital pronounced the 47 year old male deceased.

Lewis County Sheriff's Office conducted a death investigation review under Case #22C11399. Detective Mike Mohr was assigned lead detective and submitted the following report:

SUPPLEMENTAL/M. Mohr/10-03-2022

EVIDENCE: Lewis County Jail records, NaphCare records, Centralia Providence Hospital records, and surveillance video of Unit A2 from 09/02/2022 1800 hours to 09/03/2022 0600 hours.

NARRATIVE: While within the boundaries of Lewis County on 09/03/2022 at approximately 0854 hours I, Detective M. Mohr, received a phone call from

Detective Sergeant Stull requesting I respond to the Lewis County Jail to assist with investigating an in-custody death of an inmate. Sergeant Stull advised Deputy Teitzel did the initial part of the investigation but several inmates still needed to be contacted and interviewed. Further Sergeant Stull advised the inmate had been found unresponsive on the toilet, corrections staff began CPR, and the inmate was transported to Centralia Providence Hospital where he was later pronounced deceased. Sergeant Stull advised there was no indications of foul play or controlled substances at that time. I advised I would get ready and respond as soon as I could.

I later arrived at the Lewis County Sheriff's Office at approximately 1007 hours and was able to review Deputy Teitzel's report and photos. I learned the deceased inmate was 47 year old [redacted]. Deputy Teitzel had been at the Lewis County Jail on a separate matter the previous evening when he observed emergency vehicles parked outside of the sally port. Deputy Teitzel was directed to inquire about the incident and see if any assistance was needed, as an inmate was being transported to Centralia Providence Hospital. Deputy Teitzel talked with corrections staff and learned [redacted] complained of stomach pains earlier in the evening and was located slouched over in his cell by Corrections Deputy Yost. Corrections Deputies began life saving measures including CPR until medics arrived, and medics had located a pulse on [redacted] before transporting him to the hospital. Deputy Teitzel was also shown [redacted] cell, A2-D4, which he took initial photographs of. Deputy Teitzel requested [redacted] cell be left alone pending the outcome of his current status.

Deputy Teitzel learned later in his shift that [redacted] had passed away at the hospital. Deputy Teitzel returned to the Lewis County Jail and took more extensive photographs of the unit [redacted] cell was located in, along with [redacted] cell and personal affects within. Deputy Teitzel searched [redacted] cell, finding nothing remarkable. I reviewed the photographs taken by Deputy Teitzel and found them adequate in coverage and quantity, as [redacted] did not have many personal affects in his cell. [redacted] cell was only occupied by [redacted] himself.

I then went over to the Lewis County Jail and asked to speak with the other inmates housed in unit A2. I was provided a roster of the current inmates which included the following inmates and their respective cell numbers:

A2-D1 [redacted]
A2-D2
A2-D3
A2-U2
A2-U3
A2-U4

I then had a corrections deputy check with all of the inmates to see if they were willing to speak with me. Most of the inmates in unit A2 either stated they were sleeping or did not want to speak with me except for [redacted]. [redacted] and I went to a separate room and I advised him I would be recording our conversation with my body worn camera. I advised [redacted] that [redacted] had passed away earlier in the morning. I asked [redacted] what he observed.

[redacted] *told me he woke up to them doing CPR on* [redacted] *and observed the firefighters and paramedics come into the unit.* [redacted] *watched until* [redacted] *was taken away by emergency personnel.*

I then asked [redacted] *if he saw or heard* [redacted] *complaining about anything to do with his body and he said no.* [redacted] *had no reason to believe* [redacted] *was suffering nor had he ever spoken to him before.* [redacted] *told me he only knew* [redacted] *was detoxing, but* [redacted] *seemed to get around normally. Please see body camera recording for further information.*

As no other inmates from unit A2 wanted to speak with me I activated my body worn camera and went to each inmate housed in the unit to clarify what I was doing and to ask further questions. I explained to each inmate I was not conducting a criminal investigation and just wanted to know if they noticed anything off with [redacted] *while he was housed in their unit.* [redacted] *stated he slept through the incident and didn't notice anything unusual about* [redacted] *while he was housed there.* [redacted] *refused to listen and kept repeating he did not care when I tried to talk to him.* [redacted] *stated he was sleeping through the incident and did not notice anything about* [redacted] *as he just got to the unit the previous evening.* [redacted] *stated he was sleeping through the incident and did not hear any complaints or see anything concerning since he got to the unit the previous Thursday.* [redacted] *would not wake up when I addressed him and corrections staff stated he was heavily detoxing and had been sick and vomiting.*

I then went and spoke with Kitchen staff as I was told [redacted] *previously worked in the kitchen. I spoke with* [redacted] *who told me she had not seen* [redacted] *since last Sunday and he seemed fine and had no complaints.* [redacted] *stated she asked about* [redacted] *when she returned to work on Thursday and she was told he was having back pain. I also spoke with* [redacted] *who works in the kitchen but she did not recall* [redacted].

While being escorted throughout the jail by Corrections Deputy Schultz, he advised [redacted] *complained of having trouble breathing the previous day. Deputy Schultz advised he opened* [redacted] *cuff port, which he explained was a common practice when inmates are feeling claustrophobic, and passed the information onto night shift deputies.*

After speaking with the inmates and kitchen staff at the jail, I sent an email request to the Lewis County Jail Administrative Secretary C. Breen requesting video of the A2 unit from 1800 hours until 2359 hours, 2359 hours to 0600 hours, Incident reports from corrections staff, cell check logs, control tower logs, the incident report regarding [redacted] *having back pain and being moved to unit A2, and associated medical reports.*

On 09/06/2022 I had an envelope in my inbox from Jail Administrative Secretary Breen which included a thumb drive containing the records I had requested. I was also contacted by Chief Sweet who advised there was a bag containing [redacted] *clothing left at Secretary Breen's desk. There was some confusion as to where exactly the clothing came from and who placed it there, as* [redacted] *clothing had been collected from the hospital by Deputy Schlecht on 09/03/2022*

and he transported the clothing to the Lewis County Sheriff's Office evidence facility where they were placed in a drying station. I later retrieved the bag of clothing from Secretary Breen's office, and when doing so, she provided me with 2 thumb drives of the surveillance footage I had requested. I also collected [redacted] personal property from the jail and transported the clothing and property to the Lewis County Sheriff's Office evidence facility. Before submitting the bag of clothing I opened the bag and photographed the contents which included a pair of socks and two pairs of underwear.

I later reviewed the records and video provided by Secretary Breen. [redacted] was booked into the Lewis County Jail on 07/24/2022 at 0150 hours on an outstanding Escape Community Custody warrant and Department of Corrections hold. [redacted] was in possession of suspected methamphetamine at the time of his arrest according to Centralia PD Officer Jacobo's report. On [redacted] intake assessment he indicated methamphetamine use but no other health related problems, earning a medical clearance by NaphCare with no restrictions. [redacted] volunteered to participate in the Lewis County Jail WERC (Work Ethics and Restitution Center) Program on 08/08/2022 and was assigned to the kitchen, laundry, maintenance, outside WERC, and POD worker. [redacted] Judgement and Sentence stated he was sentenced on 08/31/2022 to 2 months of confinement with credit for 36 days already served.

[redacted] submitted a medical request on 08/30/2022 at 1837 hours stating he hurt his back in the kitchen, and has never hurt it like that before and could feel it twitch with his hand. [redacted] submitted an additional medical request on 08/31/2022 at 0614 hours asking to please hurry and that he was in severe pain and could not sleep. On 09/01/2022 at 0218 hours an Inmate Status Form log indicated [redacted] was moved from E5 to A2-D4 due to disrupting others and being placed on medical observation.

Correction's Deputy K. Williams noted in an incident report dated 09/01/2022 that [redacted] kept coming to the E5 door requesting to speak with medical and could be heard moaning from the WERC desk. [redacted] refused an icepack when seen by the nurse and was moved to A2-D4. During the move [redacted] stated he could not carry his things or walk, and [redacted] was moved in a wheelchair.

Correction's Deputy Schultz noted in an incident report dated 09/03/2022 that on 09/02/2022 at approximately 1730 hours he picked up [redacted] dinner tray when [redacted] said he was having difficulty breathing. CD Schultz noticed [redacted] had only eaten half of his dinner, and asked if he used any breathing aids, which [redacted] stated he did not. CD Shultz offered to leave the cuff port open and notify other staff to check on [redacted], and [redacted] agreed to such. On the shift report dated 09/02/2022 for dayshift, the supervisor notes stated [redacted] cuff port was left open for air and after speaking with staff he was doing better.

Correction's Deputy Sabin noted in a supplemental report dated 09/03/2022 that on 09/02/2022 at approximately 1820 hours he spoke with [redacted] during inspections. [redacted] cuff port had been left open and [redacted] asked if it felt muggy in his cell. CD Sabin entered the cell and told [redacted] it felt similar to the dayroom, maybe slightly warmer. [redacted] indicated

everything in his cell was working properly.

Correction's Deputy Snaza noted in his incident report supplemental dated 09/03/2022 that on 09/02/2022 at approximately 2056 hours she was on standby for Nurse Perry during medication pass when they were giving medication [redacted] CD Snaza stated [redacted] was looking very tired and she reported to Nurse Perry that [redacted] did not look very good and seemed very out of it. Nurse Perry stated he would bring [redacted] to the clinic later and check up on him.

Corrections Deputy Yost noted in his incident report dated 09/03/2022 that during the 2300 hourly checks on 09/02/2022, he was doing checks in Unit A2 and looked in [redacted] cell and first believed [redacted] was using the restroom. CD Yost then noticed [redacted] wasn't wearing clothes and was slouched over to the right with his head and hands hanging down. [redacted] would not respond to CD Yost's several prompts, and CD Yost entered the cell and found [redacted] cold to the touch. CD Yost radioed for medical staff to respond and tried to sit [redacted] upright. CD Yost did not see any signs of breathing and [redacted] body was completely limp. Nurse Perry arrived shortly thereafter and CPR was started along with the application of an AED device. Life saving measures continued to be attempted by Nurse Perry and corrections staff until medics and fire personnel arrived and transported [redacted]

I reviewed all incident reports, cell checks, medical requests, and surveillance video and found them to be consistent with what had been reported and documented. In the video recordings of Unit A2 I was able to observe various cell checks and med passes as documented. I also observed on 09/02/2022 at 2132 hours [redacted] cell light comes on, and is then turned off at 2208 hours. There is a cell check at 2209 hours, and then CD Yosts's cell check at 2304 hours when [redacted] is discovered unconscious. After medical personnel arrive and transport [redacted], Deputy Teitzel can be seen at 0004 hours on 09/03/2022 reviewing and photographing [redacted] Cell. [redacted] cell is then closed and left closed until Deputy Teitzel returned at 0415 hours to search and document further after [redacted] is pronounced deceased at the hospital.

I did find while reviewing the inmate check logs for the 09/02/2022 2300 hour check that there was "no problem noted" and the headcount remained at 7. As the "problem" was obvious and addressed appropriately by responding corrections and medical staff, the logs still should have reflected a problem to ensure the system of checks and balances that are in place are followed appropriately in all circumstances.

Also on 09/06/2022 Dr. Lacsina performed an autopsy on [redacted], the official results of which are still pending. I did speak with Lewis County Chief Deputy Coroner D. Tucker afterwards and learned [redacted] had no obvious signs of trauma, preliminary toxicology results were negative, he has a familial history of heart disease, and his death appears to be natural due to coronary arterial sclerosis resulting in a probable acute myocardial infarction. Once I receive the final results from the autopsy and toxicology analysis I will add them to the case file with a supplemental report.

At this time I request this case remain active.

End of report.

Detective M. Mohr 2D3
Lewis County Sheriff's Office

This report is intended to be a summary of events. It may contain paraphrased conversations and may not be in the exact sequence of events. For any exact quotes and specific sequencing of events, please refer to my body-worn camera recording if activated at the time of the incident.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT AND I AM ENTERING MY AUTHORIZED USER ID AND PASSWORD TO AUTHENTICATE IT.
Electronically Signed: Yes Signature: Detective M. Mohr
Chehalis/Lewis/Washington Date: Mon Oct 03 14:54:10 PDT 2022

14:53:14 10/03/2022 Mohr M
3 SUPPLEMENTAL/M. Mohr/11-15-2022

SUPPLEMENTAL/M. Mohr/11-15-2022

NARRATIVE: On 11/10/2022 at 2029 hours I, Detective M. Mohr, received an email from Chief Sweet with a toxicology report and letter from the Lewis County Coroner attached. I reviewed the toxicology report which indicated [redacted] *blood tested positive for ethanol with a result of 14 mg/dL. Further, the report reflected* [redacted] *Blood Alcohol Concentration (BAC) as 0.014 g/100mL. I then reviewed the letter from Coroner McLeod to Captain Tawes which stated Dr. Lacsina was provided the toxicology results and concluded* [redacted] *cause of death was due to cardiac disease and the manner of death has been determined to be natural. The letter further stated Dr. Lacsina's final autopsy report was still pending, and would be provided once received. Both documents have been attached to this case file. Once the final autopsy report is received it will be added to the case file.*

At this time I request this case be cleared as [redacted] *death appears to be natural.*

End of report.

Detective M. Mohr 2D3
Lewis County Sheriff's Office

Procedure Review from the UFR Team:

Custody:

It was determined by the review team that custody staff acted appropriately with no indication of any policy/procedure violations.

Medical:

Dr. Marc Stern and Dr. Radha Sadacharan reviewed medical procedures and events leading up to custody staff finding the decedent unresponsive, the initial life saving measures performed by medical staff and custody staff, and the AMR response.

On January 26, 2023, Dr. Radha Sadacharan submitted the following summary:

As per Washington State RCW 70.48.510, the following is the culminating medical assessment of the unexpected fatality review. This review should serve as a method of identifying opportunities to strengthen safety and health protections for inmates in custody.

The jail resident was a male in his late 40s who passed away in the local emergency room in late summer 2022. On admission to the jail, he reported no medical or mental health issues and was screened for such. He did later request to be evaluated for alcohol abuse assessment/treatment.

A little over a month into his stay, he submitted an initial kite to medical for hurting his back during work. This kite was followed up the next morning by a second kite, noting he was in severe pain and could not sleep. Both of these health service requests were reviewed that night, with a note of sick call being scheduled, and a few hours later he was evaluated by an LPN for severe musculoskeletal pain. His vital signs were normal, with a blood pressure of 90/74 noted. He was prescribed ibuprofen 400mg twice a day for seven days, and acetaminophen 650 mg twice a day for seven days by an off-site provider approving the LPN's request and sick call assessment.

Three evenings after his initial kite was submitted for back pain, a deputy radioed to medical for an unresponsive inmate. Within two minutes, the LPN and another deputy responded from booking, during which time staff radioed for crash bag and AED to be brought down to the single cell from medical. Chest compressions were quickly initiated. AMR arrived within ten minutes and took over life saving measures from the medical/security team after requesting that patient be relocated to day room. He received 6 rounds of epinephrine. The EMS team recovered a slight pulse and advised it was time to transport patient to the ER. In the ER, CT angio chest/abdomen/pelvis were without evidence of acute aortic syndrome/aneurysm, and no significant liver or lung findings to explain previous symptoms. The patient had two more episodes of cardiac arrest in the emergency room, and in the context of a CT head with diffuse anoxic injury, patient being completely unresponsive, elevated troponins and not being a catheterization lab candidate, further treatment and resuscitation was deemed futile.

The likely cause of death was myocardial infarction leading to cardiac arrest.

Findings:

1. *Medical services is contracted out to a large correctional health vendor with many other contracts of similar size and need. For this specific jail, there is an LPN who administers medications, responds to emergencies, and staffs sick call. An on-site provider is present twice a week. A provider is available by phone 24-7.*
2. *For any prescriptions entered for sick call, an off-site provider that is likely not familiar with the jail, or the patient, reviews the chart and either signs off on the medications requested or declines the prescription.*

3. *Emergency response bags, upon examination, had multiples of some items, and in some cases, none of a necessary item. For example, 4 1L bags of saline were in one bag. No oropharyngeal airways were in the same bag.*
4. *An oxygen tank is not co-located with either of the emergency response bags.*

Root Cause Analysis

1) *Scope of practice: In this case the LPN made an assessment of a patient who likely should have been evaluated by at least an NP/PA-level provider. It is possible that if the patient were evaluated by an NP, PA or physician, they would have completed a review of systems and obtained an EKG, leading to a different diagnosis at the time of initial evaluation, and a potentially different patient outcome. We don't know what we don't know. The absence of higher level healthcare providers is a constant struggle in rural areas across the United States. Add on the extra difficulty of recruiting in corrections, and it's no wonder that an LPN is performing the jobs of RNs, NPs, PAs, and physicians.*

2) *EMR checkboxes designed to streamline: On review of sick call note, there is a box to consult provider immediately for 'gross deformity, any possible fracture, or disproportional amount of pain to type of injury.' In this patient's case, the severe pain was not consistent with the method of injury, so a provider should have been consulted. From the electronic health record perspective, while the tactic of building a differential/ruling out scary problems is theoretically ideal in a place where medical staffing runs lean, the tool is only as skilled as the wielder. This point is intimately related to the previous one of scope of practice; it should not be expected that an LPN knows a mechanism of injury and how it could produce a certain level/type of pain.*

3) *The crash bags did not have the necessary resources to attend to a medical emergency. It is unclear who played a role in putting the crash bags together, or whose responsibility it is to check them regularly, or if they are checked regularly, at what interval.*

4) *The above points are all related: the healthcare workforce runs too lean, not just in this jail but in most rural jails. The cost of providing the level of care (for both health and rehabilitation) needed for inmates in custody is significantly higher than most correctional settings can currently budget for.*

Recommendations:

1) *Standardization of resources: The crash bags should be evaluated by the medical team, including a physician and the HSA, and it may be worthwhile approaching local AMR to get their perspective on useful tools to have on hand. As the acuity and complexity of the jail population increases, medical needs will continue to rise.*

2) *Regularly scheduled review of crash bags: Like the regular oil change for a car, crash bag contents must be updated and checked with regularity. Just like checking a fire extinguisher, there should be a sheet attached to each crash bag noting the last time it had been checked, and by whom. Oxygen must also be accessible either in crash bag or very close.*

3) *A registered nurse is on site 24/7.*

4) *An on-call provider is local and able to come in (or by telehealth services) to evaluate a patient at any time.*

5) *A thorough review of all sick call note types in the EHR to ensure that there are safe ways for nursing staff to assess patients, and that there is always a referral to a provider if there are any questions or data points that do not align.*

Dr. Marc Stern interviewed the contract medical provider's Chief Medical Doctor, Dr. Jeffrey Alvarez.

Dr. Alvarez reviewed the medical treatment of the decedent and determined the medical staff on-duty acted appropriately and per NaphCare protocols. The following information was provided by NaphCare, as examples, regarding nursing assessment protocols and procedure examples:

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Health Care Policy & Procedure Manual

E-08 Nursing Assessment Protocols And Procedures

Section E: Patient Care and Treatment

Effective Date: 09/05/2014

Policy Revised: 02/24/2022

NCCHC Standard: E-08

NCCHC Opioid Standard: Nursing Assessment Protocols (O-E-08)

NCCHC MH Standard: Nonemergency Mental Health Care Requests and Services (MH-E-05)

ACA Standard: Continuity of Care (4-ALDF-4C-04)

Purpose

To ensure that nurses who provide clinical services are trained and do so under specific guidelines.

Policy

Nursing assessment protocols shall be used by nursing staff when providing clinical care, to the extent possible. Nurses shall comply with relevant state practice acts and conduct data gathering and treatments appropriate to the level of competency and preparation of the nurses who will carry them out.

Procedure

1) NaphCare has developed Nursing Assessment Protocols that have been approved by and reviewed annually by the Nursing Administrator, and responsible physician based on the level of care provided in the facility.
2) All nursing assessment protocols are accessible to nursing staff in TechCare and limited by role.
3) Documentation of nurses' training in protocol use exists, including:
    a) Evidence that all new nursing staff are trained and demonstrate knowledge and competency for the protocols and procedures that are applicable to their scope of practice;
    b) Evidence of annual review of skills/competency; and,
    c) Evidence of training when new protocols are introduced or reviewed.
4) Nursing assessment protocols do not include the use of prescription medications, except for those covering emergency, life-threatening situations.
    a) Protocols with emergency prescription medications on them are listed in TechCare as Emergency Response Orders (ERO's).
    b) Emergency administration of these medications requires a provider's order before or immediately after administration.
    c) Standing orders are not allowed, and all prescription medications require a provider order.
5) If mental health protocols are used onsite, qualified mental health professionals make timely assessments based on these protocols approved by the responsible mental health clinician.

Relevant Forms

References

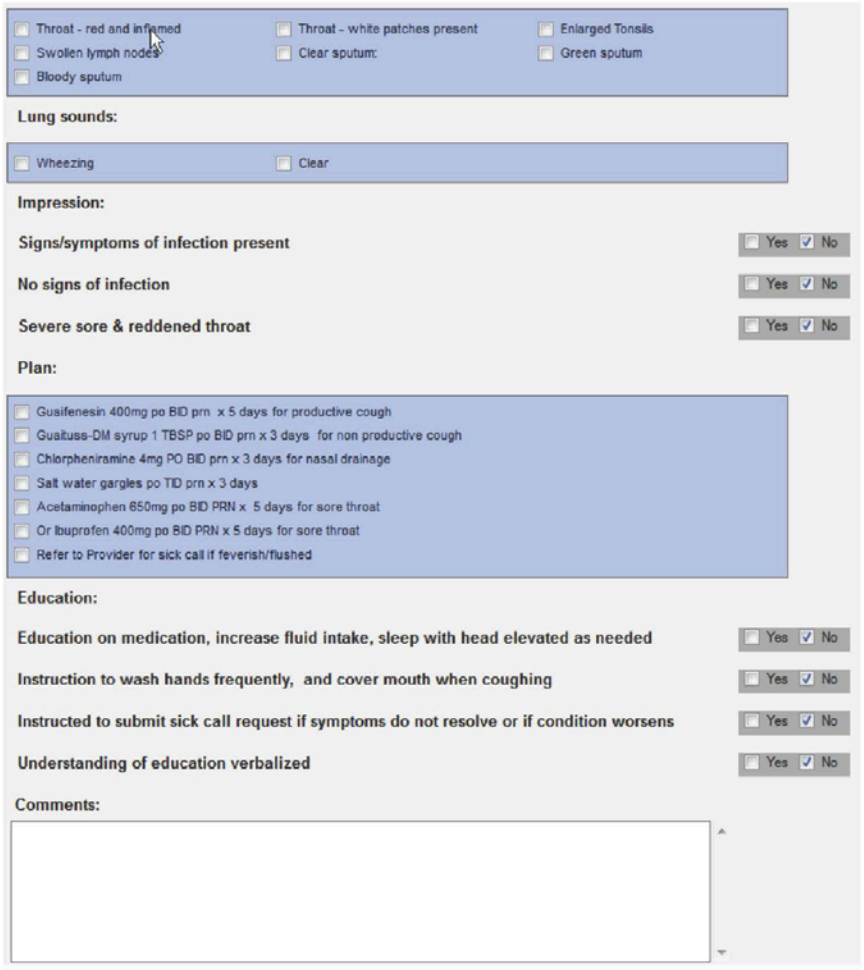

Figure: This TechCare screenshot shows an example of a nursing assessment protocol form.

No relevant forms for this policy.

Nursing Assessment Protocols and Procedures (J-E-10). National Commission on Correctional Health Care: Standards for Health Services in Jails, 2018.

Nursing Assessment Protocols and Procedures (P-E-10). National Commission on Correctional Health Care: Standards for Health Services in Prisons, 2018.

Nursing Assessment Protocols (O-E-08). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.

Nonemergency Mental Health Care Requests and Services (MH-E-05). National Commission on Correctional Health Care: Standards for Mental Health Services in Correctional Facilities, 2015.

Continuity of Care (4-ALDF-4C-04). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

American Correctional Association: Standards Supplement, 2016.

Lewis County Correctional Facility
345 NW North St.
Suite 4000
Chehalis, WA 98532

1/30/2023 5:22:26 PM PST

BACK PAIN - Created on 1/30/2023 5:22:27 PM PST

Patient:	Patient, BioReference Test	**#:**	A1234 (A1234)	**Lang:**	
DOB:	7/6/1985 (Age=37)	**Sex:**	Female	**Race:**	White
Housing:		**SSN#:**	**HIDDEN**	**Type:**	
Status:	NOT ACTIVE				

PICTURE NOT AVAILABLE

Current Allergies

Abacavir, Abatacept, Abciximab, Abraxane, Acalabrutinib, Acarbose, Accupril, Acetic Acid, Acetohydroxamic Acid, Acthar, Alcohol, Aspirin, Bees, Diabinese, Elmiron, Emtriva, Factrel, Guaifenesin, Ibuprofen, Lisinopril, Morphine and Related, No Known Environmental Allergy, No Known Food Allergy, No Known Latex Allergy, Nonoxynol 9, Penicillin, Sulfa Antibiotics, Tylenol

Current Medications:

No Medications

Chronic Conditions:

Transplant, Seizure Disorder, Seizure Disorder, PVD, Other Chronic Care, Migraines/Chronic Headaches, Inflammatory Bowel Disease, Hypertension, Hypertension, HIV/AIDS, Hepatitis C, Diabetes, Diabetes, COPD/Emphysema, Bleeding or Coagulation Disorders, Asthma, Anemia

SUBJECTIVE:

☐ New ☐ Old Injury History of back pain/injury:

Mechanism of injury:

Duration of symptoms: Pain Level (0-10)

☐ Numbness

- [ ] Tingling
- [ ] Weakness of Extremities
- [ ] Other

Other:

Any previous treatments/surgeries:

- [ ] Hx of UTI/ Kidney Stones
- [ ] Hx of Weight Loss
- [ ] Hx of IV Drug Use
- [ ] Hx of Night Sweats
- [ ] Abdominal Pain
- [ ] History of Cancer
- [ ] Other

Other:

OBJECTIVE:

- [ ] Patient Refused

BP	Temp	Pulse	Resp	SaO2	BS	Pain	Height(ft)	Height(in)
/							5	9
Weight	**BMI**	**MAP**						

- [ ] Limited Range of Motion
- [ ] Difficulty ambulating

Urinalysis results (presence of hematuria?):

- [ ] Costovertebral angle tenderness
- [ ] Generalized tenderness

- [ ] Point tenderness/location:

- [ ] Able to complete straight leg raises without difficulty

Other:

ASSESSMENT:

◯ Acute Back Pain

◯ Chronic Back Pain

PLAN:
Provider must be contacted for medication orders for any PREGNANT patients

☐ Consult provider for fever greater than or equal to 101; loss of bowel/bladder control; progressing neurological deficits, bilateral weakness or numbness or if patient is pregnant

☐ Back exercises - Select to print handout on stretching exercises

If no contraindication or allergies:

☐ Acetaminophen 325 mg ii tablets bid po prn x 7 days (#30)

☐ Ibuprofen 200mg ii tablets bid prn x 7 days (#30)

☐ Provider contacted

Time:

PATIENT EDUCATION:

☐ Common causes of back pain: poor posture, overweight, stress, and inappropriate lifting

☐ Weight loss (if patient is overweight)

☐ If symptoms are not improved with exercise in thirty days submit request to Health Care Provider

☐ Pain relievers are available through Commissary

☐ Chronic Back Pain is pain that lasts longer than 6 months and it is not easy to find the cause. Chronic pain can begin from previous old injury, irritation, or inflammation to the structures of the lower back or abdomen. Lower back pain is a discomfort that ranges from the bottom of the rib cage to the tailbone.

Comments:

RECOMMENDATION

The 24/7 contract medical services provided by NaphCare has been very successful and extremely beneficial to the Lewis County Sheriff's Office Jail for the last seven years. The medical system in place has saved multiple lives and has elevated the medical treatment to a high standard of medical care for the LCSO Jail. However, the independent recommendation from Dr. Sadacharan recommends that we hire only Registered Nurses and Nurse Practitioners for the 24/7 medical services in our facility.

ACTIONS TAKEN/MANAGEMENT'S RESPONSE

After the feedback from Dr. Sadacharan, NaphCare Chief Medical Officer Dr. Alvarez reviewed the information and the procedures followed by the on-duty nurse the night before the decedent's passing. The conclusion of the review is that the nurse followed NaphCare protocol and procedures and NaphCare has no recommendations for any change to their medical procedures.

Point of contact:

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