

# A DEATH IN CUSTODY

## SUMMARY

On Sunday, July 9, 2007, Ryan George, age 22, died, while in an individual medical observation cell at the Sonoma County Main Adult Detention Facility (MADF). As required by state law, a fatal-incident investigation, was initiated by the Sonoma County Sheriff but completed by an independent agency, in this case by the Marin County Sheriff's Department.

It has been reported in the press and was known to MADF staff, that Mr. George had suffered from Sickle Cell Anemia (SCA) for several years. On July 1, 2007, while incarcerated at MADF, Mr. George experienced a medical crisis and was transported to Sutter Medical Center (SMC). On July 3rd, he was returned to the MADF and a subsequent fatal crisis ensued between July 6th and July 9th.

The discharge orders from SMC included the direction that Mr. George receive a physical examination within 24 hours of discharge. The required examination was not performed. Bed checks at MADF, which were supposed to occur throughout the night, failed to discover that Mr. George had expired. Mr. George was found dead on July 9th at approximately 6:00 A.M. while breakfast/medications were being delivered.

## REASON FOR INVESTIGATION

The Grand Jury is authorized by state law to review all officer-involved fatal incidents that occur in Sonoma County. This Grand Jury is also authorized to review inmate jail deaths.

## BACKGROUND

On May 31, 2007, Mr. George self-surrendered on an outstanding warrant and was transferred to the MADF. On July 1, 2007, it was determined by California Forensic Medical Group (CFMG), contractor with the Sheriff's Department for the provision of medical services at MADF, that Mr. George was unresponsive and experiencing a health crisis that required transport to SMC. While at SMC, Mr. George was tested, examined and medically diagnosed as experiencing a SCA crisis. Mr. George had suffered from SCA for many years and had previously received treatment for this condition from Jail medical staff.

At the SMC, numerous metabolic tests and electro-encephalogram, CT scan and lumbar puncture analysis did not reveal determinative deficits or abnormalities except for dilation of pupils. Fundamental treatment for SCA was provided, including; fluids, analgesics and oxygen as needed. Further medical intervention was determined to be unnecessary by SMC and on July 3rd, Mr. George was returned to MADF. Discharge orders dictated that Mr. George receive a physician's evaluation within 24 hours and be returned to the hospital in the event, his condition deteriorated. He did NOT receive that further evaluation and in fact, had no other medical intervention until the time of his death, other than routine staff checks and a Licensed Clinical Social Worker, who made four visits. The LCSW asked for an appointment to be set for Mr. George the following Monday. After Mr. George had returned to the jail, he continued to be verbally "unresponsive" to nurses and jail personnel. This was not a medical determination, but rather it was thought that the lack of response from Mr. George was volitional. That conclusion, later indicated to be errant, led to the label of "malingering"<sup>1</sup>, which followed Mr. George and may have tainted some CFMG and correctional staff in their assessment of him. He was not returned to the hospital despite his continuing deterioration.

CFMG has a contract with the County under which they provide medical oversight and care of the inmates. However, during interviews of CFMG employees, it was determined: 1) There was no physician exam made during the weekend when Mr. George died; 2) The oversight provided by the Correctional Deputies (CD's) and nurses was undermined by poor communication between nurses, doctors and detention staff. The communication and interaction between SMC and the jail, was not sufficient, in that CFMG did not follow the requirements of the hospital's release and medical follow-up of Mr. George.

[1] Malingering is defined as "to pretend incapacity as to avoid duty or work. (Webster's Dictionary)

[2] Although the CFMG physician was responsible on July 3rd when R.G. was returned to the jail and CFMG staff was aware of the discharge orders requiring a physicians examination/evaluation within 24 hrs. of George's return to MADF, no physicians examination was performed.

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From July 6 to July 8, Mr. George exhibited symptoms, which should have resulted in additional hospitalization. He was not re-hospitalized, despite exhibiting symptoms of jaundice, severe dehydration, bone pain, altered level of consciousness and loss of urinary and bowel control. The "malingering" label resulted in an unfortunate interpretation of all symptoms and the assumption that they were imaginary.

Sheriff's Departmental policy requires that each inmate in a medical evaluation module be "checked" every 15 minutes by a correctional deputy (CD). Mr. George should have been "checked" 16 times, between 2:00 A.M., and 6:00 A.M. July 9th, when Mr. George was found to be deceased. The "checks" were ineffective because a determination that Mr. George was alive and stable were not completed. In fact, his death was not discovered until the morning wake-up call. The Sheriff's investigations and the District Attorney's investigations did not address the shortcomings of ineffectual "checks".

Logs, substantiating that CDs looked at Mr. George at 15 minute intervals were NOT available to the Grand Jury and it is not clear whether these were done. As a consequence of an un-noticed computer failure, no RATS logs [3] were available.<sup>3</sup> The CD in charge of these checks, claimed to have looked in to check Mr. George's condition, but did not speak to him or observe any body movements. Therefore, these checks gave a false sense of well-being.

## INVESTIGATIVE PROCEDURES

The Grand Jury interviewed three correction deputies (CDs), two doctors and three nurses, one CFMG Program Director and one social worker. Jurors examined closely the inter-relationship of the individuals interviewed, the function of the jail staff

vis-à-vis the safety and health of the inmates and the adequacy of the health care provided. Jurors also obtained scheduling documents from CFMG, autopsy reports and job descriptions. An attempt to review the RATS logs was made with no success, as the system was nonfunctional at those times.

In the past, the documents provided for the Jury's review were voluminous and complete. In the George case, the documents appear brief and inadequate, affecting the Jury's ability to make findings and recommendations. The death of Mr. George occurred July 9, 2007. The District Attorney's Report was not received until the 2009-10 Grand Jury's term.

#### FINDING

F-1 Sonoma County Sheriff's and CFMG medical staff failed to fully intervene in Mr. George's further deterioration after return from SMC. (7/06/07 – 7/09/07).

F-2 Although Title 15 of the state penal code requires that an inmate receive six hours of uninterrupted sleep, failure by Sonoma County Sheriff's correctional staff and/or medical staff of CFMG, to require proof of life, at each fifteen (15) minute interval, may have contributed to Mr. George's death.

F-3 CFMG staff also failed to provide Mr. George with a physician's examination within 24 hrs of his return to MADF as was required by the discharge orders from SMC.

F-4 A complete medical record of Mr. George was not sent with him to SMC. On 7/01/07. Medical records are essential to accurate diagnosis and treatment.

F-5 CFMG and the Sonoma County Sheriff failed to provide a complete set of requested documents to the Grand Jury including accurate time records and telephone calls.

F-6 The Sonoma County District Attorney's Critical Incident Report was not received until February 2010, although the incident occurred July 2007. The review did not address all salient details; ie., ineffectual bed-checks for proof of life.

[3] RATS Logs are mechanized logs indicating times of inmate surveillance by CDs

#### RECOMMENDATIONS

R-1 That "proof of life" be required at each "check" of an inmate in medical observation cell. Vital signs should be taken at each change of shift and recorded for as long as the inmate is in medical detention.

R-2 That the Sonoma County District Attorney complete the review of the Sonoma County Sheriff's investigation within 90 days.

R-3 CFMG and Sonoma County Sheriff provide complete investigational files to the Grand Jury.

R-4 CFMG be requested to keep complete employee time records, particularly for physicians.

R-5 CFMG medical staff comply with discharge orders for hospitalized inmates and document compliance.

R-6 That CFMG undergo regular, independent peer review of medical care provided to jail facilities.

#### Required Responses to Findings:

Sonoma County Sheriff F-1, F-2, F-3, F-4, F-5

Sonoma County District Attorney F-6

#### Required Responses to Recommendations:

Sonoma County Sheriff R-1, R-3, R-4, R-5, R-6

Sonoma County District Attorney R-2

#### Requested Responses to Findings and Recommendations:

CFMG F-1, F-2, F-3, F-4, F-5 • R-1, R-3, R-4, R-5, R-6