Dave Young
District Attorney

17th Judicial District
Adams & Broomfield Counties
District Attorney's Office

October 16, 2015

Michael McIntosh, Adams County Sheriff
Adams County Sheriff's Office
1901 East Bridge Street
Brighton, CO 80601

Re: The investigation of the death of Tyler Ray Tabor at the Adams County Detention Facility at 150 N. 19th Avenue, Brighton, Colorado on May 17, 2015.

Dear Sheriff McIntosh:

The investigation and legal analysis of the death of Tyler Ray Tabor, while in-custody at the Adams County Detention Facility (ACDF) on May 17, 2015, has been completed. Detective James McKenzie of the Adams County Sheriff's Office led the investigation and presented his reports, video recordings, photos and other documents to the office of the Seventeenth Judicial District Attorney for our review for any potential criminal charges. Chief Trial District Attorney Joseph Pacyga also met with Dr. Michael Arnall, the forensic pathologist. Mr. Pacyga and an investigator with the District Attorney's Office also conducted an interview with Dr. Benjamin Clower. Based on this evidence, Mr. Tabor died of dehydration due to withdrawal from a controlled substance (heroin). Your investigation and the evidence demonstrate that the manner of death was natural causes. Therefore, no criminal charges will be filed against anyone in this matter.

STATEMENT OF INVESTIGATION

On May 14, 2015 at approximately 3:07 p.m., Tyler Ray Tabor was booked into the Adams County Detention Facility (ACDF) on warrants out of Larimer County.

Prior to his arrest, Mr. Tabor was contacted by a Thornton Police Officer regarding an investigation involving illegal controlled substances. However, Mr. Tabor was not charged with or arrested for any crimes relating to controlled substances by the Thornton officer. During the course of this contact, the Thornton officer became aware of two outstanding Larimer County warrants for Mr. Tabor. Mr. Tabor had a warrant for failure to comply with probation on a harassment (misdemeanor) conviction and a warrant for failure to appear on charges of driving under restraint (a misdemeanor) and speeding (a traffic offense). The total bond for both warrants was $300. Thus, Mr. Tabor was taken into custody only on the two warrants out of Larimer County.

Per protocol at the Adams County Detention Facility, Mr. Tabor was processed prior to being housed. Mr. Tabor received a medical screen. This medical screen is a standard screen given to all inmates upon intake, and it was performed by Duffy Sturgeon, a Licensed Practical Nurse. During the screening, Mr. Tabor disclosed that he was a heroin user, that he used heroin on a daily basis, and that he had used one gram of heroin earlier that day, May 14, 2015. Nurse Sturgeon placed Tyler Tabor on an opiate withdrawal protocol.

During his initial hours at the detention facility, Mr. Tabor was kept in the intake unit. On May 14, 2015 at about 6:30 p.m., he was moved from intake to be housed in the medical unit. He was placed in cell I-102. This placement was made so that he could receive treatment in accordance with Corizon Health's opiate withdrawal program. Mr. Tabor remained housed in the medical unit until his death on May 17, 2015.

Mr. Tabor was formally advised of the warrants by a judge on the morning of May 15, 2015, and he was told that he could be released if he posted the $300 bond. Since Mr. Tabor did not post the $300 bond set by the Larimer County Court, he had to remain in custody at the ACDF until Larimer County could arrange to take custody of him and transport him to their detention facility. Larimer County did not pick him up prior to his death.

Medical services at the Adams County Detention Facility are provided by Corizon, also known as "Corizon Medical Services," "CMS," and "Corizon Health." Corizon is the largest privately held health care contractor for detention centers and prisons in the country. It provides health care and pharmacy services for over 107 agencies, including 530 state prisons, jails, and other facilities.

Following the death of Mr. Tabor, Det. McKenzie spoke with Amanda Day, Health Services Administrator for Corizon, about their "Opiate/Benzo Protocol." This opiate withdrawal program is utilized nationwide by Corizon, and it was specifically followed with Mr. Tabor. Ms. Day said that the protocol is set by national standards by individuals that study withdrawal. Ms. Day stated that as part of the protocol, the inmate is regularly assessed using the "Clinical Opiate Withdrawal Scale" or "COWS." These assessment results are entered digitally into the inmate's medical records. A copy of the COWS assessment tool was provided as part of this review. In summary, the inmate or patient is assessed in eleven different areas. Each area is scored. Some areas can receive up to four points and others may receive up to five points.[1] Another portion of the COWS assessment tool provides guidance to the nurses at the ACDF. If an inmate/patient scores 25 to 48 points, emergency medical services should be called immediately. Lower, but significant scores, trigger a call to the supervising doctor.

Corizon's protocol for opiate withdrawal called for, among other things, regular administration of medications, steady intake of water and electrolytes (Gatorade), and regular (every six hours) taking of vital signs. Medications prescribed for Mr. Tabor included Clondine, Hydoxyzine (Vistaril), Acetaminophen (Tylenol), Pepto Bismal, Loperamide (Imodium), and Promethazine (phenegran). He was also prescribed an optional medication, Buprenorphine (Suboxone), if needed. It should be noted that the protocol was structured to deal with dehydration through the steady intake of water and electrolytes plus medications to control or minimize vomiting and diarrhea.

During his stay in the medical unit, Mr. Tabor was housed with at least one other inmate, and he frequently was housed with two other inmates. Some of these individuals were also undergoing opiate withdrawals and were also treated pursuant to the same opiate/benzo withdrawal protocol. It should be noted that it is the practice of the ACDF to avoid housing inmates alone. This is a safety procedure to assist in preventing suicides and other mishaps associated with housing inmates alone.

Video surveillance equipment was installed in the cell housing Mr. Tabor. Electronic copies of this surveillance have been provided by Det. McKenzie for review as part of the investigation. It should be noted that the video recording system in the jail is not performing as it should. [This has been a problem for over a year, and the entire electronic surveillance system is scheduled for replacement in the near future.] The

[1] In this tool, low scores are good, higher scores are bad.

malfunction causes the video recorded in the jail to be broken up and stored as short clips varying from seconds to minutes. The recorded video files also lack a time stamp, so watching a video does not reveal the time it was recorded. Fortunately, the video files are created and stored consecutively, so it is possible to view the clips in order. Unfortunately, due to the large number of short or very short video files, it is difficult to determine whether there are gaps in the recording.

The following is a chronology of the events leading up to Tyler Tabor's death:

May 14, 2015 and May 15, 2015

Overall, during this period, nothing remarkable occurs. Tyler Tabor appeared to be restless; however, he is regularly given his medications and he appears to eat food and drink fluids. Tyler Tabor did report to the medical staff that he felt nausea, and he throws up on more than one occasion. On May 15, 2015 at around 7:30 a.m., he is allowed into dayspace.[2] While in Dayspace, Mr. Tabor attempted to place four phone calls, but none of the calls connected with a recipient.

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At approximately 2:29 a.m., Nurse Gordon took Tyler Tabors vital signs. The nurse documented that Mr. Tabor had an upset stomach and was not eating much.

At about 4:45 a.m., Tyler Tabor received his breakfast tray; he drank his milk and ate a little of the food before giving the remainder to his cellmate.

At about 9:17 a.m., Tyler Tabor was seen by RN Stephanie Ostrom, who noted that Tyler Tabor had nausea, was vomiting, and felt weak. Nurse Ostrom gave Tyler Tabor Gatorade and sent him back to his cell.

At about 10:00 a.m., Tyler Tabor was let out of his cell for dayspace. Tyler Tabor made a phone call. This call – and all outgoing inmate calls at the jail – was recorded. The ACDF utilizes a software service to monitor inmate calls. The call was made to 303-827-8461, and the software identified the recipient of the call as Ms. Bridget Buesgens in Berthoud, Colorado. During the call, Tyler Tabor told Ms. Buesgens that he hadn't slept for two days[3] and that he was throwing up. Tyler Tabor and Bridget Buesgens discussed bonding Mr. Tabor out of jail and obtaining money to do that. Ms. Buesgens told Mr. Tabor that she had been arrested on felony drug possession charges, and she stated that they (her and Mr. Tabor) were going to be charged with what was in the car.

After his time in dayspace, Tyler Tabor lay down in his cell and until he got up to take his medications. At 11:10 a.m., lunch was served. After eating some of his lunch, Tyler Tabor again laid down in his bed. Tyler Tabor continued to drink fluids, sit on the toilet, and throw up for much of the day. On a couple of occasions Tyler Tabor sat on the cell sink and put his feet on the toilet.

At about 4:00 p.m., Tyler Tabor received his medications, which he took with fluids. Tyler Tabor received his sack dinner, but he only looked into the bag and did not eat any of the contents.

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[2] "Dayspace" is a common area for inmates where they can socialize, watch TV, use a phone, etc.

[3] Note: Though Mr. Tabor indicates he has not slept in two days, he is observed sleeping in the ACDF at various times prior to this call.

At about 7:55 p.m., Tyler Tabor met with RN Cheryl Groothuis to have his vital signs taken. Tyler Tabor struggled to stand up, staggered to the door, then sat in the doorway of the cell. After being seen, Tyler Tabor appeared like he was unable to stand, and he scooted over and sat next to the wall. Later, he stood up, walked over, and lay down in his bed. Tyler Tabor tries to stand later, but loses his balance and falls over his cellmate's bed, landing on the floor. Tyler Tabor then sat against the wall for a while before standing up and walking to the toilet to go to the bathroom. Tyler Tabor sat on the toilet for quite a while before going back to his bed.

At around 11:38 p.m., Tyler Tabor was called for his medications. He appears unable to stand on his own, and he was assisted to his feet by his cellmate before going to the cell door. Tyler Tabor staggered to the cell door and received his medication from RN Cheryl Groothuis. While the nurse handed the medications to Mr. Tabor, Tyler Tabors' hands appear to be cramping. Mr. Tabor appears unable to hold his medications, and some or all of them fall to the floor. Deputies are called to the cell, and the dropped medicine is located. Nurse Groothuis then assisted Tyler Tabor in taking his medication by placing the medication into his mouth. As Tyler Tabor stepped back from the nurse, he lost his balance. Deputy Brown grabbed him so that Mr. Tabor would not fall. Tyler Tabor is helped to sit down on the floor and given Gatorade.

During this same time period, the video shows Tyler Tabor being removed from the cell and then returned. Nurse Groothuis had asked that Mr. Tabor be taken to the treatment area of the medical unit to meet with her. While in the treatment area, the nurse checked Mr. Tabors' vitals. Mr. Tabor's blood pressure was low. When she was interviewed on May 17, Nurse Groothuis stated she spoke with Tyler Tabor and Mr. Tabor's conversation made sense, i.e. he was coherent. Nurse Groothuis reported that Tyler Tabor asked about getting an Intravenous (IV) therapy. She told him that they try not to use IV's unless it's absolutely necessary. Nurse Groothuis stated that she had noted that Tyler Tabors hands were bent in when she treated him, and that is entered in her medical notes. Nurse Groothuis made Tyler Tabor drink two pitchers of Gatorade before he went back to his cell. The medical records also show that she took additional readings of Mr. Tabor's blood pressure after each pitcher. In a later interview, Dr. Clower stated that the pitchers in the medical unit hold approximately one liter of fluid.

Nurse Groothuis said she contacted Dr. Clower after meeting with Mr. Tabor. She stated that Dr. Clower advised her to continue to treat Mr. Tabor and to watch him. Dr. Clower confirmed this when he was interviewed by Det. McKenzie on August 11, 2015. Dr. Clower said that he remembered receiving phone calls from RN Cheryl Groothuis in regards to her concerns about Tyler Tabor's blood pressure on the evening May 16, 2015. Dr. Clower said that he told Nurse Groothuis to give Tyler Tabor fluids and continue to watch him.

Upon returning to his cell with Gatorade, Tyler Tabor laid down in his bed. Tyler Tabor appeared restless, moving onto his stomach, his back, his knees, sitting up and then laying down. Mr. Tabor continued to drink Gatorade while in his bed.

At approximately 11:44 p.m., Tyler Tabor struggled out of his bed walked over to the cell door. Once there, Mr. Tabor sat down, removed his shirt, and then lay down on the floor. A short time later, Tyler Tabor crawled back to his bed.

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Just after midnight, Tyler Tabor scooted on his knees, almost falling over, from his bed to the toilet. Tyler Tabor used the sink to pull himself to his feet. Tyler Tabor supported himself with the hand rails by the toilet, pulled his pants down, and then sat on the toilet for about ten minutes. Mr. Tabor stood up and

attempted to pull his pants up, but lost his balance and fell into the wall. After steadying himself, Tyler Tabor again tried to pull up his pants. Mr. Tabor held up his pants, walked to his bed, and fell into his bed.

At about 2:20 a.m., Tyler Tabor is helped from his bed to a wheelchair by Deputy Engel. Mr. Tabor is again taken to see Nurse Groothuis in the treatment area. Nurse Groothuis stated that she had Tyler Tabor brought out to the treatment area so she could assess his progress. Nurse Groothuis said that Tyler Tabor's blood pressure had risen, and she stated that he answered questions for her, i.e. that he was coherent. She had Tyler Tabor returned to his cell.

At about 4:10 a.m., Nurse Groothuis went to Mr. Tabor's cell for med call. Tyler Tabor had a hard time standing up. Mr. Tabor is handed his medications, but dropped some to the floor. As Tyler Tabor let go of the wall he was holding onto, he fell to the floor. Nurse Groothuis attempted to help him stay on his feet, but she was unsuccessful. Deputy Brown entered the cell and helped find the medication that fell on floor, and then Deputy Brown assisted Tyler Tabor into his bed. Nurse Groothuis gave Tyler Tabor the remainder of his medicine.

At about 4:20 a.m., breakfast was delivered to Mr. Tabor's cell. Tyler Tabor did not come to the door, so Deputy Brown took breakfast to Mr. Tabor in his bed. The Deputy placed the tray on the floor near Tyler Tabors' bed. Mr. Tabor ate a small amount of food off of the tray, drank some Gatorade, and lay back in his bed.

At around 4:50 a.m., Tyler Tabor pressed the cell's distress button. Nurse Gordon answered the call. In her interview on May 17, Nurse Gordon said that she had no contact with Tyler Tabor until he hit his distress button around 5 a.m. Nurse Gordon states that she answered the distress call, but she could not understand what Mr. Tabor was saying over the intercom. Nurse Gordon then went to cell I-102. Through the door, she saw that Tyler Tabor was lying across his bed. She said that Mr. Tabor asked her if he could get a shower. Nurse Gordon states she explained to Mr. Tabor that showers are taken during the dayshift while out in dayspace.

At about 4:59 a.m., Tyler Tabor got out of bed and walked to the cell door. He looked out of the cell window, then lost balance and fell back onto his bed. Tyler Tabor lay on the floor briefly, and then crawled back into his bed.

<u>May 17, 2015 – Events after 5:00 a.m. leading up to the death of Tyler Tabor</u>

At about 5:20 a.m., Tyler Tabor crawled over to the cell door. He stayed on his hands and knees for a period, then lay down on the floor. Mr. Tabor got back on his hands and knees and threw up a small amount of vomit onto the floor. Mr. Tabor then lay on his back in the middle of the cell.

At approximately 5:25 a.m., Deputy Engel observed Mr. Tabor lying in the middle of the cell floor on a video monitor. Deputy Engel went to the cell to check on Mr. Tabor's status. Once in the cell and observing Mr. Tabor, Deputy Engel became concerned that Mr. Tabor appeared to be having some difficulty breathing. He immediately called for medical assistance. Deputy Engel attempted to speak to Mr. Tabor and ask him what was wrong and whether he could speak. Deputy Engel only heard some slight moaning. Deputy Engel gave Mr. Tabor a sternum rub, but Mr. Tabor did not respond. Deputy Brown, who had arrived during this period, shined his flashlight into Mr. Tabor's eyes, but Mr. Tabor did not respond. Sergeant Mykelann Wise, who was in the Medical Unit, also arrived at the cell.

Sgt. Wise advised Nurse Groothuis of the situation. Nurse Groothuis stated that she was treating another inmate for a hand injury when she was advised that the inmate in cell I-102 was unresponsive. Nurse

Groothuis said she went to the cell and did a sternum rub on Tyler Tabor. She reports that Mr. Tabor spoke to her; however, Tyler Tabor did not make sense, i.e. he was not coherent. Nurse Groothuis said she left the cell and went to notify Dr. Clower of Tabor's condition. Nurse Groothuis states she left a message for Dr. Clower, and then proceeded to the treatment area.

Immediately after Nurse Groothuis left the cell, Sgt. Wise, Deputy Engel, and Deputy Brown lifted Tyler Tabor into a wheelchair and pushed him to the treatment area. Tyler Tabor remained unresponsive during the move. Once in the treatment area, Deputy Engel was not able to detect Mr. Tabor's pulse. Tyler Tabor was moved onto the floor so that Nurse Darald Lara and Nurse Staci Gordon could treat him.

Nurse Lara was interviewed on May 15, 2015. He stated that he had not treated Mr. Tabor until that morning, though he understood that Mr. Tabor was being treated pursuant to the Opiate/Benzo withdrawal protocol. Nurse Lara said he went to the treatment area and saw a gentleman (who he later learned was Tyler Tabor) slouched down in a wheelchair. Nurse Lara saw Mr. Tabor's body draw up and then go limp, so at first he thought that Tyler Tabor was possibly having a seizure.[4] Nurse Lara said that Tyler Tabor was placed on the floor, where Nurse Lara assessed the situation. Nurse Lara said that he gave Tyler Tabor a sternum rub, and said that Tyler Tabor was not breathing that good. Nurse Lara asked Nurse Gordon to get the oxygen, as he continued to assess Tyler Tabor. Nurse Lara said that he felt a faint pulse, but that Tyler Tabor was not really breathing. Nurse Lara said that he then began CPR. Nurse Lara said that the Automated External Defibrillator (AED) was placed on Mr. Tabor. The AED advised to clear and to shock. Nurse Lara said that the AED cycled and delivered one shock, and then said to continue treatment. Nurse Lara said that CPR continued until EMS arrived.

Nurse Gordon reported that when she arrived in the treatment area, she saw Tyler Tabor in a wheelchair. Tyler Tabor was lowered to the floor. Nurse Gordon said that once Mr. Tabor was on the floor LPN Derald Lara began to assess Tyler Tabor. She said that Nurse Lara sent her for the oxygen bottle. Nurse Gordan stated that when she returned with the oxygen, Nurse Lara instructed her to retrieve the ambu bag and the AED while Nurse Lara began CPR. Nurse Gordon said that she did not notice any breaths or a chest rise when she applied the AED. Nurse Gordon said that she began doing the chest compressions and Nurse Lara continued CPR doing the respirations. Nurse Gordon said that the AED advised them to clear and to shock. Nurse Gordon said that the AED cycled and delivered one shock. The AED then indicated to them to continue treatment. Nurse Gordon said that she and Nurse Lara continued treatment until EMS arrived on scene.

Nurse Groothius states that when she arrived in the treatment area, the other two nurses were performing CPR. She states she left and either requested an ambulance or confirmed with the sergeant that the ambulance was called. Nurse Groothius states she then phoned Platte Valley Medical Center to notify them of this information, and then she got the paperwork for Mr. Tabor's transport to the hospital.

At 5:44 a.m., a Brighton Fire Engine and a Platte Valley Ambulance arrived at the ACDF. A deputy was awaiting them at the entrance to the facility, and the deputy escorted the paramedics and EMT's into the facility and to Tyler Tabor. Medical treatment continued on Tyler Tabor until 6:00 a.m., when Mr. Tabor was pronounced deceased by Rhett Butler, MD of Platte Valley Medical Center. Mr. Tabor was not transported from the ACDF.

[4] Deputy Engel corroborated this incident, stating in his interview that while Tyler Tabor was sitting in the wheelchair, he "cramped up," further describing it as "his head went back," and he shut his eyes.

The two inmates in the cell where Mr. Tabor was housed were moved to other cells, and Cell I-102 was sealed until it could be photographed and processed by investigators from the Crime Lab. The Coroner's Office was notified, and personnel from the Coroner's Office arrived and took custody of Mr. Tabor's body.

In addition to the contacts listed in the above chronology, the deputies assigned to the medical unit conduct "row checks" every half hour. During a row check, a deputy or deputies move through the module or area and look into each cell, confirming that nothing unusual or dangerous is taking place. A row check should have occurred at or around 5:00 a.m. on May 17; however, that row check did not occur. The deputies assigned to the medical unit, who were tasked with the responsibility of doing row checks, were engaged in two other incidents. First, a fight had occurred in another pod, and an inmate who was injured was moved into the medical unit for treatment of an injury. [This was the same inmate being treated by Nurse Groothuis when she was called to Mr. Tabor's cell.] Second, an incident in the Intake unit had required additional personnel to assist in securing an inmate. Thus, there were insufficient deputies available to conduct the 5:00 a.m. row check.

A review of the medical records kept by the jail shows the following vital signs:

		Blood Pressure	Temperature	Respiration	Pulse	Oxygen Level
5/14/15						
	Intake	101 / 60	98.9	18	62	
5/15/15						
	05:11 a.m.	106 / 60	98.1	16	88	98
	09:48 a.m.	120 / 70	97.3	18	52	96
5/16/15						
	02:29 a.m.	110 / 71	97.1	16	56	96
	09:17 a.m.	97 / 70	97.6	18	86	
	11:38 p.m.	82 / 60	98.9	17	110	97
	After 1st Pitcher[5]	90 / 60			110	
	After 2nd Pitcher[6]	95 / 64			108	
5/17/15						
	02:20 am	137 / 99	98.1	16	80	98

Subsequent to Tyler Tabor's death, Det. McKenzie interviewed the two inmates that were housed with Tyler Tabor immediately prior to his death.

Rocco Chioda, who had been housed with Tyler Tabor since May 14, 2015, stated that Tyler Tabor was acting weird and had said that he wanted to go to Denver West and burn everybody up. Rocco Chioda said that Tyler Tabor was not eating or drinking the Gatorade he was given, and he described seeing Mr. Tabor's medication falling from his hands when it was given to him. Rocco Chioda said that Tyler Tabor told him he was coming off of heroin and couldn't stay awake. Rocco Chioda said that at breakfast on May 17, 2015, deputies

[5] After the low blood pressure reading at 11:38 p.m., Nurse Groothuis had Mr. Tabor drink two pitchers of Gatorade. After each pitcher, she took additional readings of Mr. Tabor's blood pressure and pulse. An exact time of each reading is not documented.
[6] See the preceding footnote.

tried to get Tyler Tabor to eat but Tyler didn't want to eat. Rocco Chioda said that he didn't hear anything after breakfast because he was asleep.

Robert Allen, who had been housed in I-102 since May 16, 2015, said that Tyler Tabor told him that something was wrong because he was coming off of heroin. Robert Allen said that Tyler Tabor kept telling him "I'm not okay," "I'm not okay," and that he didn't feel good. Robert Allen said that Tyler Tabor told the nurses this, and the nurses told Mr. Tabor that he had to go through it (withdrawals). Robert Allen said that Tyler Tabor was falling down and spilling water in the cell. Robert Allen said that Tyler Tabor's hands appeared to seize up, and the medication given to him would fall to the floor. Robert Allen said that he was also coming off of heroin, that he was in the same boat as Tyler Tabor. Robert Allen observed that you don't eat when you're coming off of heroin, that "heroin is horrible." Robert Allen said he told Tyler Tabor that it gets easier after four to five days. Robert Allen said that Tyler Tabor did not eat while he was in the cell but said that Tyler Tabor was being given Gatorade to drink. Robert Allen said that Tyler Tabor's fingers were crunching up and he couldn't move them. Robert Allen said that deputies came into the cell and helped Tyler Tabor into a wheelchair because he couldn't stand up. Robert Allen said that he remembers Tyler Tabor telling the nurses that he was not okay, and said that Tyler Tabor was lethargic saying some girl's name. Robert Allen said that he thought Tyler Tabor would snap out of it. Robert Allen said that he did not hear anything this morning because he was asleep.

Mr. Chioda and Mr. Allen appear to sleep through the entire period of medical intervention, even sleeping through the period when the two deputies and the nurse are assessing Mr. Tabor and Mr. Tabor is removed from the cell.

On August 11, 2015, Dr. Clower was interviewed at the ACDF. Dr. Clower stated that he had never treated Tyler Tabor in person, but said that the nurses had followed the Corizon Opiate/Benzo withdrawal protocol. Dr. Clower said that according to medical records Tyler Tabor was given the medications and fluids as stated in the protocol.

On May 18, 2015, Dr. Michael Arnall, a board certified forensic pathologist, performed an autopsy on the body of Tyler Tabor. Dr. Arnall concluded that that the **cause of death** of Tyler Tabor was **Hypernatremic Dehydration**, and the **manner of death** was **Natural**.

In a follow-up interview with Dr. Arnall, Dr. Arnall explained how dehydration causes death. Cells, particularly brain cells, need a certain water content to function properly. If the water volume inside the brain cell drops, the brain cell shrinks and shrivels. At some point, when the water content drops far enough, the brain cells cease to function properly and death ensues. Dr. Arnall explained that dehydration typically is due to a lack of water volume in the body.

Because blood volume drops, the dehydrated person's blood pressure typically drops and, since the heart is trying to supply the body with oxygen with a smaller volume of blood, the pulse rate increases. Dr. Arnall stated that the observable symptoms for dehydration and hyponatremic dehydration are the same. The patient will exhibit confusion, then convulsions or seizures. He stated that those are the only outward signs. Dr. Arnall also cautioned that blood pressure and pulse rate are not very reliable indicators of dehydration. He noted as examples that stress or observing a startling event can elevate blood pressure or cause the pulse rate to climb, yet the blood chemistry and the volume of water is unaltered.

When asked about the muscle cramps that Mr. Tabor was having in his hands, Dr. Arnall stated that muscle cramps (as opposed to seizures) are symptomatic of a potassium deficiency and are not a symptom of dehydration or hypernatremia.

Hypernatremic dehydration can be somewhat different. "Hypernatremic" means that a person has a high level of salt in his blood stream. Cells have semi-permeable membranes. Water passes freely in and out of cells, but not salt and some other chemicals. If the concentration of salt in the blood stream is higher than the concentration in the cells, water will move out of the cells into the bloodstream. [Dr. Arnall pointed out that this is simple chemistry. The salt concentration will balance on both sides of the brain cell's membrane. Since the water can move freely and the salt can't, water will move out of the cells and into the bloodstream.] Hypernatremia can speed the dehydration of the cells. In rare circumstances, if the salt concentration in the blood is high enough, it is possible for the overall body to have a sufficient volume of water, yet have the cells dehydrated.

When specifically asked about Mr. Tabor's high blood pressure at 2:20 a.m. on May 17th and about the consumption of two pitchers of Gatorade, Dr. Arnall stated that it did not affect his finding that Mr. Tabor was dehydrated. While Dr. Arnall stated that it is impossible to determine the volume of water in the living person once the person is deceased, he stated that when you have high salt levels without evidence of a vastly disproportionate consumption of salt, the only medical conclusion is that the deceased was hypovolemic.[7] Moreover, Dr. Arnall stated that the levels of chloride and nitrogen in the vitreous corroborated his conclusion that Mr. Tabor was hypovolemic. In Dr. Arnall's opinion, the blood pressure reading at 2:20 a.m. was likely an anomaly.

Dr. Clower readily agreed to meet with a prosecutor and an investigator from this office. In his interview, Dr. Benjamin Clower indicated that the nursing staff at the detention center followed the Corizon opiate withdrawal protocol with Tyler Tabor. Dr. Clower stated that Nurse Groothuis called him on May 16, 2015 at approximately 11:38 p.m.

When asked about Nurse Groothuis statement about preferring not to use an IV, Dr. Clower stated that it is much better, if the patient is able to hold down fluids, to give the patient fluids orally rather than intravenously. Nurse Groothuis had indicated to him that Mr. Tabor was able to drink fluids. Dr. Clower stated he did not have a discussion with Nurse Groothuis about having the patient drink Gatorade as opposed to giving the patient fluids intravenously. However, giving the patient Gatorade is standard and was preferable to intravenous fluids. Dr. Clower noted that Mr. Tabor was able to drink the two liters of Gatorade and keep it down.

Dr. Clower indicated that neither Nurse Groothuis nor anyone else telephoned him about Mr. Tabor's blood pressure reading at 2:20 a.m. on May 17. He stated that the higher blood pressure indicated that Mr. Tabor's blood pressure had normalized, so he would not expect anyone to call him. When asked if the higher reading was or should have been a cause for alarm because it was higher than Mr. Tabor's other readings, Dr. Clower indicated that it was not a cause for concern. He stated that Mr. Tabor's blood pressure would have to been much higher than it was at 2:20 a.m. before it would have been of concern to him or to the staff.

Dr. Clower volunteered that Nurse Cheryl Groothuis has been a registered nurse for about eighteen years and that he has a lot of trust in her abilities.

[7] "Hypovolemic" means that the person has an insufficient volume of water in his body.

LEGAL ANALYSIS

Criminal liability is established in Colorado when it is proven beyond a reasonable doubt that someone has committed all of the elements of an offense defined by Colorado statutes, and it is proven beyond a reasonable doubt that the offense was committed without any statutorily recognized justification or excuse.

The lowest level of criminal culpability for causing the death of an individual is criminally negligent homicide. "Any person who causes the death of another person by conduct amounting to criminal negligence commits criminally negligent homicide," C.R.S. 18-3-106. The other crimes for causing the death of a person – reckless manslaughter, second degree murder, and first degree murder – require a higher culpable mental state. To commit them, a person must act recklessly, knowingly, or intentionally. In analyzing the case, we must first determine whether any one acted with criminal negligence and caused Mr. Tabor's death.

Pursuant to C.R.S. 18-1-501 (3), "A person acts with criminal negligence when, through a gross deviation from the standard of care that a reasonable person would exercise, he fails to perceive a substantial or unjustifiable risk that a result will occur or that a circumstance exists."

Mr. Tabor arrived at the Adams County Detention Facility, and he was appropriately screened. This screen was thorough and was successful in revealing that he had recently used heroin and that he had a heroin addiction. Mr. Tabor was not placed into the general population at the detention facility; instead, he was appropriately housed in the medical unit. A medically appropriate treatment program was initiated. The evidence presented indicates that this Corizon's opiate withdrawal program is an evidence based treatment program designed by professionals with expertise in the area of opiate withdrawal. The treatment program prescribed various medications for Tyler Tabor to assist him during his withdrawal. The treatment program also called for monitoring of Mr. Tabor's treatment. His vital signs were to be taken twice a day, and the nurses were to assess him utilizing various tools, especially the COWS. It is reasonable for the medical staff at the Adams County Detention Facility to rely upon the program.

On May 16, 2015, his vitals were taken, and his blood pressure was 82/60. In response to that, Nurse Groothuis – as per the protocol – called Dr. Clower. Nurse Groothuis then took corrective action. She had Mr. Tabor drink two pitchers (two liters) of Gatorade. She took his blood pressure and pulse after each pitcher. After each pitcher, she took his blood pressure. After each pitcher, his blood pressure rose. These were positive signs, and it was reasonable for her to interpret them as improvements in Mr. Tabor's hydration. While it should be noted that Mr. Tabor suggested that he receive an IV, the reliance by the medical staff on Mr. Tabor drinking Gatorade is not unreasonable.

The last assessment of Mr. Tabor utilizing "Clinical Opiate Withdrawal Scale" or "COWS" occurred on April 17, 2015 at about 2:26 a.m. At that time, a few short hours before his death, Mr. Tabor was scored at six points out of a possible 48 points, which indicated that the severity of his withdrawal was mild. While Dr. Arnall, based upon his autopsy, indicates that the 2:26 a.m. blood pressure reading was anomalous, it was reasonable for the medical personnel to rely upon it and interpret it as an improvement in Mr. Tabor's condition.

The investigation supports the fact that he was kept under reasonable observation. As noted in the narrative above, the row check at 5:00 a.m. was not conducted. While this is concerning, a review of the video indicates that – had the row check occurred – nothing was occurring in Mr. Tabor's cell at 5:00 a.m. that would have alerted the deputies that Mr. Tabor was in need of immediate medical assistance.

Dr. Arnall indicated that the outward signs of severe dehydration would be confusion and, later, convulsions or seizures. Mr. Tabor exhibited none of these until after 5:25 a.m. on the 17th. While Mr. Chioda stated that Mr. Tabor had said that he wanted to go to Denver West and burn everybody up, it is not clear that Mr. Tabor was confused or simply angry when he made that statement. More importantly, Mr. Chioda did not relate that to the guards or to any medical personnel. Mr. Tabor does not appear to have a seizure or convulsion in the video of him in his cell. The only behavior that could be characterized as a seizure occurred in the treatment area at about the time an ambulance was called for.

When his medical condition deteriorated at around 5:25 a.m., he was observed laying on his back in the middle of his cell. Deputies immediately responded to his cell, and a nurse was called. Nurse Groothuis went to call the Doctor Clower, and Mr. Tabor was quickly moved to the treatment area. Once there, he was observed to have stopped breathing, and the medical staff immediately took reasonable steps to prevent his death, including calling for an ambulance and EMT's.

In summary, a review of the materials presented does not disclose any abuse, mistreatment, or maltreatment that rises to a level of criminal culpability.

There is not sufficient evidence to prove that anyone caused the death of Tyler Tabor by conduct amounting to criminal negligence.

The evidence demonstrates that on April 17, 2015, Mr. Tabor died as a result of his heroin addiction and dehydration associated with his withdrawal from the illegal use of that substance.

Conclusion

On April 15, 2015, Mr. Tyler Tabor was in the Adams County Detention Facility on warrants out of Larimer County. All of the evidence indicates that Mr. Tabor died as a natural result of heroin withdrawal.

The District Attorney's Office has reviewed the reports, statements, and evidence and applied the relevant law to the evidence. Pursuant to the law and the state statutes cited above, there is insufficient evidence to prove that that either the detention personnel, other inmates in the detention facility, or the medical staff at the detention facility committed a criminal offense in this unfortunate incident. Accordingly, no criminal charges will be filed.

If you have any questions pertaining to this report or findings and conclusions, please contact me.

Sincerely,

Joseph S. Pacyga
Chief Trial District Attorney
Office of the District Attorney, 17th Judicial District