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March 29, 2021

Michael Steen
Chief Investigator
Criminal Division
Office of the Attorney General
P.O. Box 83720
Boise, ID 83720

Re: Office of the Attorney General Case #20-71455

Dear Mr. Steen:

I have concluded my review of the detailed report prepared by you in relation to the death of Lance Quick, including reports prepared by other agencies, and videos from the Bannock County Jail.[1] Thank you for the extensive work you did in completing the investigation, including interviews conducted at my request. There are numerous facts in your extensive report that I have considered but did not include below. I have concluded that the conduct of Bannock County Sheriff's Office employees contributed in significant ways to the death of Mr. Quick. However, I decline to pursue criminal charges in the matter because there was insufficient evidence of criminal conduct.

In reaching this conclusion, I have only considered evidence regarding Mr. Quick's incarceration after being arrested on December 8, 2018. In evaluating this matter, there are certain things I did not consider. The Sheriff's Office's contact with Lance Quick prior to December 8, 2018 is not relevant. Mr. Quick's physical condition at the time he was arrested is irrelevant as the Sheriff's Office was responsible for his care regardless of his physical condition on December 8. Also not relevant is whether or not Sheriff Nielsen offered to call a judge to get Lance Quick out of jail, or if the offer was made, whether Kim and/or Shawna Quick refused that offer. The fact that some of the contract medical staff were relatively new to the jail was considered only to the extent it contributed to poor communication between jail staff and medical staff. Frustration expressed by

[1] All references to "Mr. Quick" relate to Lance Quick.

the Sheriff's Office regarding bed spaces for mental health inmates was not considered. Changes in the Sheriff's Office policies after Mr. Quick's death were not considered.

Your report indicates that Mr. Quick was arrested in the late afternoon on December 8 for driving under the influence by Officer Bloxham of the Pocatello Police Department. Mr. Quick denied drinking alcohol, and later was tested and had a blood alcohol content of .00. He admitted that he took Lithium and Lamictal for a bipolar disorder, and a subsequent blood test showed the presence of THC.

Mr. Quick was taken to the Bannock County Jail. He was not booked in because he was reported to have been uncooperative during the booking process. At 7:02 p.m. a nurse was called to evaluate Mr. Quick, and he was cleared medically. He was partially booked in and then placed in Holding Cell 6. Mr. Quick stayed in Holding Cell 6 until 4:37 a.m. on Monday, December 10. At that time he was moved to Holding Cell 8 until his death on the following Thursday. Activities in Holding Cell 8 can be monitored by video and are recorded. In Cell 8 there is a hole in the floor intended to be used as a toilet, and beneath the hole is a container holding water that can be flushed from just outside the cell to carry away urine and feces from an inmate.

During his incarceration, Mr. Quick sometimes ate meals. The first time he did not accept a meal was at 6:41 a.m. on Sunday, December 9. The rest of the day appears to have passed without significant incident.

On Monday, December 10 Mr. Quick is moving constantly, which occurs off and on during his incarceration. After receiving breakfast, he wipes hardboiled eggs on himself. He later "washes" himself with other food. He alternates between being clothed and being naked. In the afternoon he retrieves his own feces from the hole in the cell floor and tosses it on the floor and later into an empty milk carton.

Phone calls were reported to have been made to the jail by Jodi Carlson and Shauna Quick after Lance Quick's arrest. Kim Quick, who was the Bannock County Coroner at the time, called Sheriff Nielsen in the evening on Monday, December 11, to let Sheriff Nielsen know of Lance Quick's arrest and to let Sheriff Nielsen know that Lance Quick needed his medications. Sheriff Nielsen said he called Kim Quick back to tell him that they were working with the Idaho Department of Health and Welfare regarding Lance Quick.

Command staff for the Bannock County Sheriff's Office, including Sheriff Lorin Nielsen, Chief Deputy Jim Dalley, Captain Tad Bybee, and Lieutenants Lyle Thurgood and Kasey Johnson, were at a conference during the first part of the week following Mr. Quick's arrest. Therefore, there were no higher-ranking supervisors in Pocatello above the jail sergeants who supervised jailers in 12-hour blocks.

Later in the evening on December 10 Mr. Quick began wiping feces on the floor and walls of his cell. Just before midnight and at 2:49 a.m. the next morning, Mr. Quick receives and drinks cups of water. A few minutes later Mr. Quick is allowed to shower and is provided clean jail clothing. Mr. Quick is placed in Holding Cell 7 while a trustee cleaned Cell 8, which was described as having urine and feces "everywhere." The trustee, Savana Howerton, reported later that she believed Mr. Quick had been neglected physically and mentally by jail staff.

At 4:54 a.m. on Tuesday December 12, Deputy Ranere had a discussion with Mr. Quick and concluded he could not get Mr. Quick booked into the jail. Although Deputy Ranere said he notified the nurse of Mr. Quick suffering from withdrawal, there were no corroborating evidence of the notification.

That morning Cpl. Luce prepared an affidavit in support of detention without a hearing. In anticipation of preparing the affidavit, Cpl. Luce asked Nurse Melanie Sparrow to medically assess Mr. Quick, but they could not conduct the assessment because Mr. Quick "bolted for the door," and so they withdrew without doing the assessment. The nurse on shift after Ms. Sparrow was not made aware of Lance Quick's status. At 4:25 p.m., Judge Murray signed a Temporary Custody Order finding Mr. Quick to be "gravely disabled due to mental illness," ordering him to be held, and requiring an examination by a designated examiner within 24 hours.

On the same morning, Sheriff Nielsen called Kim and Shannon Quick, during which Kim Quick emphasized Lance Quick's medication needs. Sheriff Nielsen was reported by Kim Quick to have indicated that a designated examiner was with Lance Quick and reassured Mr. Quick that Lance Quick would be released in 12 hours.

In the evening Mr. Quick's conduct continues to deteriorate. Recordings show Mr. Quick dunking his underwear into the hole five times and wringing the water into his mouth. His skin tone is bright red in his lower legs, buttocks and hands. At 11:18 p.m., Mr. Quick is given three cups of water, and he drinks two and pours one on his mattress. Between 12:00 a.m. and 1:00 a.m. on Wednesday, December 12, Mr. Quick is offered a cup of water and he took one sip and poured the rest on his mat.

At 6:39 a.m. on December 12, Mr. Quick is provided a meal but he pours it into the cell hole. This is the first in a series of meals Mr. Quick declines or does not eat. Before and after Mr. Quick puts the food in the hole, deputies were flushing the hole in his cell.

At 10:27 a.m. deputies attempt to remove Mr. Quick from Cell 8 to clean the cell. They could not do it because Mr. Quick was aggressive towards deputies.

Designated Examiner Marty Cooke arrives to evaluate Mr. Quick at 2:21 p.m. after being notified to do so by the Department of Health and Welfare. Mr. Cooke finds Mr. Quick to be mentally ill, gravely disabled and lacking capacity to make informed decisions about treatment. Based on Mr. Cooke's findings, the Bannock County Prosecutor's Office files paperwork with the court and schedules a hearing the next day to determine if Mr. Quick should be committed.

At 7:40 p.m., Dep. Topliff contacted Portneuf Medical Center and was told that while Mr. Quick could be medically cleared, no bed in the mental health unit was available for him. Dep. Topliff was told to call back the following day after 9:30 a.m. to see if placement is possible. Dep. Topliff did not contact other placement options because he was told they were on "divert" status.

During cell checks that evening, Mr. Quick is offered cups of water, but he either does not get the water or dumps it out. The next morning at 4:01 a.m. a cup of water was left for Mr. Quick but he does not take it. At 6:42 a.m. on Thursday, December 13, Mr. Quick doesn't take offered food, which is the fourth consecutive meal he missed.

At the scheduled time for Mr. Quick's commitment hearing, Mr. Cooke was told that the jail could not transport Mr. Quick and that the hearing would be held the next morning at the jail. At a meeting that morning at Portneuf Medical Center ("PMC"), he was told PMC had current open bed space and was willing to take Mr. Quick. However, because Mr. Quick had recently assaulted nursing staff in PMC's emergency room, BHAT wanted law enforcement presence during intake. DE Cooke said he immediately notified the jail of the open bed space, willingness of PMC to take Quick, and the request to have law enforcement present, but does not remember the name of the person with whom he spoke. That day, Designated Examiner Verena M. Roberts found Mr. Quick to be gravel disabled, lacking the capacity to make informed decisions about treatment, and classified his mental illness as "psychosis, unspecified."

During the morning hours on December 12, Mr. Quick appears sunburned, and has redness on his hip bones and inner right ankle. He refused lunch and dinner, his fifth and sixth meals missed in a row. Dinner is noted by jail staff as his third missed meal in a row. Three missed meals in a row should have activated the Sheriff's Office's Hunger Strike Policy but that did not happen.

At 5:25 p.m., Sheriff Nielsen had a conversation with Kim Quick, and Sheriff Nielsen expressed frustration that nothing had happened and his concern was that Lance Quick was going to be "damaged." Sheriff Nielsen said he would get on it the next day.

At 10:07 p.m., Dep. Schei goes to the cell with Nurse Chrystal. Nurse Chrystal offers Mr. Quick a cup of Powerade but he refused it. No medical assessment takes place. Nurse Chrystal said she could not do an assessment because jail staff told her Mr. Quick had assaulted jail staff and was violent. Dep. Schei said he would never have stopped medical from doing a medical assessment. During the evening, Mr. Quick continues to be in constant motion, but is on his back or stomach.

Early Friday morning, December 14, Mr. Quick's left leg and thigh are mottled in color. His left foot and toes are purple. Although he does squat, he falls over several times. Checks continue until 9:54 a.m. During that time Mr. Quick's condition continues to deteriorate, showing bruising in different areas, and turning a greyish blue in color. At 10:23 a.m., a deputy radios for assistance and life saving measures were unsuccessfully attempted. The Bingham County Coroner's Office autopsy report cited the causes of death as "Complications of Hypernatremic Dehydration and Ketoacidosis Secondary to Prolonged Period without Food or Water."

I have considered whether the conduct of Sheriff's Office employees individually, or acting together, constitute a crime, and I have concluded they do not. For a person to be found guilty of Involuntary Manslaughter, the state must prove that the conduct was such that an ordinary person would anticipate that death might occur under the circumstances. Further, the conduct must have been committed with reckless disregard of consequences and of the rights of others. Last, the conduct must have produced the death of Mr. Quick.

There is no individual who is solely responsible for Mr. Quick's death. During the course of his incarceration, there was command staff, jail sergeants, deputies and contract medical personnel, all of whom had responsibility for Mr. Quick's safety. Command staff was out of town during a portion of the week, and so information that might have been consolidated with one or more supervisor for better decision-making, was not communicated. There was a lack of communication and documentation between jail personnel regarding Mr. Quick's condition. There was a failure

to have documentation policies in place to track Mr. Quick's incarceration when he was not fully booked in. There was a lack of communication between jail staff and contract medical personnel, in violation of jail policy, which left Mr. Quick without a needed evaluation or treatment.

Miscommunication also played a role in this situation. Direction to medical personnel to check on Mr. Quick on the morning of his death was not obeyed because one nurse told a second nurse that Mr. Quick had already been taken to the hospital.

Information relating to Mr. Quick's condition and necessary medications that was, or could have been, provided by Jodi Carlson and Lance Quick's parents would have been very helpful in stabilizing Mr. Quick. Still, jail personnel are charged with the care of inmates regardless of information provided by outside sources.

There is a lack of communication necessary to prove any individuals conspired to commit a crime. The fact that numerous individuals charged with his care did not perceive that Mr. Quick was physically compromised, as opposed to mentally compromised, argues against a conclusion that a reasonable person would conclude that death might occur under the circumstances. Further, efforts were ongoing to seek a commitment, if appropriate, for Mr. Quick's care.

I also find that there is not proof beyond a reasonable doubt that anyone acted with reckless disregard of consequences. Jailers offered food and water to Mr. Quick on a regular basis. They checked on him frequently, if not every 15 minutes as required. They attempted to have him evaluated medically, though they did not pursue an evaluation as his condition worsened. They initiated commitment proceedings because of concern regarding his mental health.

Please do not construe my decisions to be an endorsement of what happened in this case. A man with compromised mental capacity died while in the care of the Bannock County Sheriff's Office. Reading the reports that related to Mr. Quick's physical and mental deterioration, and watching Mr. Quick's deterioration on video during his incarceration was extremely difficult. My condolences go out to the friends and family of Lance Quick.

Please feel free to contact me with questions.

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Yours very truly,

Barry McHugh

Barry McHugh
Prosecuting Attorney

cc: Stephen Herzog, Bannock County Prosecuting Attorney