City of Portland Risk Management 6/12/2024

KB PLOP 2850 / 2852+2856+2858 🗸



GENERAL LIABILITY CLAIM AGAINST THE CITY OF PORTLAND

* for damages to persons or property *

File Number:

2023-015407-28



A	claim must be filed with City of Normal business how Claims receive Faxed or emailed cla Please be sure yo Where space is insufficient Completed Risk Management/Liabili	Portland Risk Management within urs: Monday through Friday, 8:00ar ed during regular business hours wi tims received after business hours w our claim is against the City of Por t, please use additional paper and it d forms may be mailed, emailed, fas ty, 1120 S.W. 5 th Ave., Suite 1040, Fax: 503-823-6120 LiabilityClaims(n 180 days after the n to 5:00pm. Closed Il be recorded on th vill be recorded on f tland, not another dentify information ked, or hand-deliver Portland, OR 9720 @portlandoregon.go	occurrence of the occurrence of the on official holi e date received. the next working public entity. by section numb red to: 4-1912, Ph: 503- ov	he incident days. g day. eer and lett -823-5101,	er.		
1. Cla	imant (Circle: Mr. Mrs. Ms Mi	SS Crystal Chadwell		Date of Birt	h REDAC	т		
a.	Address 125 SW 2n	d Street City	Corvallis	StateOR	_Zip	97333		
b.	Home Phone <u>5419054780</u>	Business Telephone		Cell Phone				
c.	Occupationd. Marital Status: Single (x) Married () Divorced or Widowed ()							
d.	If married, name of spouse E-mail address REDACT							
2. If	claim involves a vehicle: a	Year, make and model						
b.	License Plate Number	Driver's Licen	se Number		Sta	te		
c.	At time of accident, were y	you (check all that apply) Ov	vner:Drive	r Passe	nger	N/A		
d.	Name and address of owne	er if different from claimant (1	.Above)					
3. O	ccurrence or event from w	hich the claim arises:						
a.	Date 9/20/24	Time	20:20	Circle A	M PM)		
b.	Place (exact and specific lo	ocation) <u>479 NW Park Aven</u>	ue Lot 102					
c.	Specify the particular occur damage (use additional pap	rrence, event, act, or omission per if necessary): <u>Please</u>	n by the City that see attached no	t you believe te A	caused th	ne injury or		
d.	State how the City of Portla Please see attached note	and or its employees were at f	ault:					
e.	Were you on the job at the If yes, what is the name / p	time of the accident? Yes_ hone number of employer	NoX					

City of Portland Risk Management 6/12/2024

4. **Description:** Describe the injury, property damage or loss so far as is known at the time of this claim. Please see attached note C

]	If you were injured please provide the following: Social Security #:								
l	Medicare/Medicaid Beneficiary? Yes No) <u>x</u>							
	Give the name(s) of the City employee(s) and/or City Bureau causing the damage or injury								
ult <u>n</u>	omah County Chief Medical Examiner Kimberl	y DiLeo, Of	icer Bu	sh Portland Police Bureau, AMR 313 Engine					
N	Name and address of any other person injured <u>Corey Hart</u>								
	125 SW 2nd Street Corvallis, OR 97333								
N	Name and address of the owner of any damaged property if different from claimant								
_									
Ľ	Damages claimed:								
a	. Amount claimed as of this date:		\$						
b	. Estimated amount of future costs:		\$						
c	. Total amount claimed:		\$	1,500,000					
d	d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.):								
Γ	Names, addresses / phone #s of all witnesses								
_									
_									
_	Any additional information that might be hel	pful in con	siderin	g vour claim					
Please find attached the note D									
_	Please find attached the note D								

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM! (ORS 162.085)

I have carefully read the statements made in this claim, including any attached sheets, and I know them to be true of my own knowledge, except as to those matters stated upon information or belief and to such matters I believe the same to be true. I understand and acknowledge that all statements made in this claim are made to a public servant of the City of Portland, and that the statements are in connection with an application for a benefit from the City of Portland.

Date: 6/11/24

Date: <u>6/11/24</u>

 Gydd Gudd

 Claimant's Signature

Crystal Chadwell

Print Name

Note A

According to the medical examiner's report, CPR or any life saving measures were not taken, naloxone was not administered, and The misidentification of the body and prolonged delay notification of death.

The Police identified a body as deceased upon arrival.

EMS also identified the body as deceased upon arrival not more than 15 minutes later.

No efforts were used to revive the body.

No CPR

No Naloxone

No defibrillator

No life saving measures whatsoever.

After identifying the body with a smudged paper id they cremated and sent the remains to the indentified family. Only when this deceased person applied for a birth certificate did they realize they had the wrong name to the body. Then they ran the fingerprints and found the identification of the body was incorrect.

The body of my brother Matthew Alexander Taylor was cremated and sent to the incorrect family.

Matthews remains were not dealt with the way the family desired.

The family had a very long delay in notification of the death.

An additional long delay in gaining identification of the body and information in regards to Matthew's passing making it impossible for the family to grieve.

Site : https://pubmed.ncbi.nlm.nih.gov/19913979/

Abstract

Introduction: Naloxone's use in cardiac arrest has been of recent interest, stimulated by conflicting results in both human case reports and animal studies demonstrating antiarrhythmic and positive ionotropic effects. We hypothesized that naloxone administration during cardiac arrest, in suspected opioid overdosed patients, is associated with a change in cardiac rhythm.

Methods: From a database of 32,544 advanced life support (ALS) emergency medical dispatches between January 2003 and December 2007, a retrospective chart review was completed of patients receiving naloxone in cardiac arrest. Forty-two patients in non-traumatic cardiac arrest were identified. Each patient received naloxone because of suspicion by a paramedic of acute opioid use.

Results: Fifteen of the 36 (42%) (95% confidence interval [CI]: 2658) patients in cardiac arrest who received naloxone in the pre-hospital setting had an improvement in electrocardiogram (EKG) rhythm. Of the participants who responded to naloxone, 47% (95% CI: 2172) (19% [95% CI: 732] of all study subjects) demonstrated EKG rhythm changes immediately following the administration of naloxone.

Discussion: Although we cannot support the routine use of naloxone during cardiac arrest, we recommend its administration with any suspicion o f opioid use. Due to low rates of return of spontaneous circulation and survival during cardiac arrest, any potential intervention leading to rhythm improvement is a reasonable treatment modality.

Site: https://www.emra.org/emresident/article/naloxone -in-cardiac-arrest

The main approach to combating this overwhelming rise in mortality has been through needle exchange programs, health departments, and even hospital emergency departments and EMS distributing naloxone to people at greatest risk of witnessing or experiencing an opioid OD.6,7 Previously a medication only available in the medical setting, increasing naloxone availability has complicated Good Samaritan resuscitation for the layperson rescuer when faced with an unresponsive patient.

The 2015 American Heart Association (AHA) Emergency Cardiac Care (ECC) guidelines address this complexity directly, recommending that despite a lack of evidence that "administration of naloxone will help a patient in cardiac arrest...empiric administration of IM or IN naloxone to all unresponsive opioid-associated resuscitative emergency patients" may be a reasonable adjunct to standard first aid and non-healthcare provider basic life support protocols, but that "CPR should take precedence over naloxone administration as patients without a palpable pulse may be in cardiac arrest or may have an undetected weak or slow pulse."8

While instructive for the layperson rescuer, this guideline references a historical conundrum surrounding naloxone use in patients suff ering cardiac arrest secondary to opioid OD. For professional rescuers in either the prehospital or hospital settings, naloxone remains a constituent of the AHA Advanced Cardiac Life Support (ACLS) Algorithm and is found in the list of interventions to correct reversible causes of cardiac arrest as an adjunct to correct the hypercarbic respiratory failure caused by opioid OD. Although naloxone's efficacy in treating respiratory depression in patients with a pulse is well established, its utility in cardiacarrest remains controversial.

History of Naloxone in Cardiac Arrest

Prior to the advent of EMS equipped with ventilatory equipment and naloxone, respiratory failure in the out of hospital setting frequently resulted in death <code>p</code>-opioid receptor agonists such as morphine, heroin, and fentanyl induce significant respiratory depression, responsible for the toxicity of opioid OD. Naloxone was developed in 1961 and has played a varying role in the resuscitation of opioid OD victims once the drug became availablea decade later.10 Heroin and other opiates were responsible for significant morbidity and mortality in the first half of the 20th century.11However, the earliest iterations of ACLS referenced naloxone only

for use in the resuscitation of neonates with respiratory depression "induced by narcotics given to the mother before delivery."9.12 It was not until the 2000 ECC guidelines that opioid OD was recognized in ACLS as a "pre-arrest poison" with the recommendation to "try to reverse respiratory insufficiency with naloxone before inserting an endotracheal tube."13 In the years since, an epidemic of opioid OD has overtaken the United States, making naloxone one of the most important drugs in the prehospital pharmacopeia.

Many studies and practice guidelines have recommended the use of naloxone in cardiac arrest patients. However, in the 2015 ACLS guidelines, the AHA endorses specific indications for empiric naloxone administration in the peri-arrest setting:

- "It may be reasonable to administer IM or IN naloxone based on the possibility that the patient is not in cardiac arrest. (Class IIb, LOE GEO)
- Standard resuscitative measures should take priority over naloxone administration, with a focus on high -quality CPR (compressions plus ventilation). (Class I, LOE GEO)
- We can make no recommendation regarding the administration of naloxone in confirmed opioid -associated cardiac arrest. Patients with opioid -associated cardiac arrest are managed in accordance with standard ACLS practices." 14

In the absence of a clear recommendation on naloxone in confirmed cardiac arrest patients, physicians are left to the literature base to support decision making when faced with patients in cardiac arrest secondary to presumed or known opioid OD.

Evidence Supporting Naloxone Use in Cardia c Arrest

Naloxone is a potent opioid receptor antagonist with an excellent safety profile and ability to reverse opioid-associated respiratory depression in patients. It can be administered via intravenous, intraosseous, intramuscular, subcutaneous or internasal routes, as well as nebulized for inhalation. There are few adverse events associated with naloxone. The most prominent adverse event is the precipitation of acute withdrawal, with signs and symptoms including agitation, hypertension, tachydysrhythmas, and vomiting15,16Precipitated withdrawal is particularly dangerous in opioid overdoses in the setting of polypharmacy overdose.

Reversal of opioid overdose in the presence of stimulants can trigger unopposed catecholaminergic activity with subsequent demand ischemia. Reversal of overdose in the presence of CNS depressants is particularly dangerous as patients who remain obtunded but with an iatrogenically induced predisposition for emesis are at increased risk for aspiration. Although several reports exist in the literature describing flash non-cardiogenic pulmonary edema occurring following naloxone administration, this phenomenon is rare at a rate of 0.2-3.6% in patients transported to ED following opioid overdose.¹⁷ Documented since the 1970s, the etiology of naloxone associated non-cardiogenic pulmonary edema is still poorly understood and potentially caused by rapidly stimulated ventilatory drive in the presence of a closed glottis or a sequelae of the histaminergic activity of opioid use itself.¹⁸

Theoretically, administration of naloxone prior to ROSC could result in a patient who can protect their own airway upon obtaining a pulse, thereby abrogating the need for aggressive airway management, including intubation.

Several case reports and animal studies describe antiarrhythmic and positive inotropic effects of naloxone in cardiac arrest. 19,20 Likewise, a retrospective chart review of emergency medical dispatches for cardiac arrest in which patients received naloxone found that 42% of patients who received naloxone in the prehospital setting had an improvement in electrocardiogram (EKG). Furthermore, "of the participants who responded to naloxone, 47% demonstrated EKG rhythm changes immediately following the administration of naloxone." These rhythm changes were inconsistent and included sinus tachycardia, accelerated junctional rhythm, PEA, ventricular tachycardia and ventricular fibrillation.21

Two other studies on demographics of out-of-hospital cardiac arrests (OHCA) found that patients in cardiac arrest secondary to a presumed opioid OD had improved odds of survival to ED and survival to hospital discharge. The first found an odds ratio of 1.21 (P=0.66) for survival to ED, while the other found a higher rate of survival to hospital discharge (19% vs. 12%, p=0.014) versus non-overdoses.22,23 These findings support the recommendation to administer naloxone in opioid associated OHCA, because given "low rates of [ROSC] and survival during cardiac arrest, any potential intervention leading to rhythm improvement is a reasonable treatment modality."21 Baseline prognostic factors in cardiac arrest secondary to opioid overdose are poor and outcomes are often dismal. However, this is not an acceptable reason to limit use of a pharmacologic agent with potential mortality benefit: A review of

patients who survived OHCA secondary to OD with or without naloxone found that outcomes were "no worse than after non-OD OHCA, and among survivors a majority had a good neurological outcome."22

Portland Police Bureau officers are trained to provide medical aid, including CPR, under specific circumstances. According to the directives and policies of the Portland Police Bureau, officers are expected to render medical assistance when encountering individuals in medical distress. This includes situations where an individual is found unresponsive and is in need of resuscitation (Portland.gov) (Portland.gov).

The specific procedures for CPR and other medical aid are detailed in their training protocols and emergency response directives. Officers receive training in CPR and are required to maintain their proficiency in this life-saving technique as part of their ongoing professional development (<u>Portland.gov</u>). Furthermore, the Portland Police Bureau has a directive specifically addressing the provision of medical aid, ensuring officers are prepared to act decisively and effectively in emergencies (<u>Portland.gov</u>).

CPR should not be initiated if:

• There are obvious signs of death (e.g., rigor mortis, decapitation, decomposition)

As stated in the medical examiners report no rigor mortis had set in. The body was stated as warm but extremities cool.