Unexpected Fatality Review

Pierce County Sheriff's Department

2022 Unexpected Fatality Incident 2200700711

Report to the Legislature

As required by RCW 70.48.510

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Chief P. Jackson – Corrections Bureau

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LEGISLATIVE DIRECTIVE PER ESSB 5119 (2021)

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

DISCLOSURE OF INFORMATION RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained.

An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(2)(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

UFR COMMITTEE MEETING INFORMATION (CRITICAL INCIDENT REVIEW)

Meeting date: February 22, 2022.

In response to the new legislative ruling regarding jails responsibility surrounding unexpected fatalities of incarcerated individuals, the Pierce County Sheriff's Department Corrections Bureau was working with the Washington Association of Sheriff's and Police Chiefs (WASPC) Corrections Liaison to receive proper training and to form a committee of individuals to conduct independent reviews for the PCSD. While we worked to complete that process, WASPC suffered the unfortunate passing of the Corrections Liaison which created a longer delay causing the PCSD Corrections Chief to extend the 120-day requirement (per RCW 70.48.510) to upload this report. This extension was also supported by the Pierce County Executive. Although previously informed we were only required to post information POST May of 2022, the PCSD is posting all relevant incidents throughout the 2022 year. There were no unexpected fatalities in the Pierce County Jail throughout the 2021 year.

COMMITTEE MEMBERS IN ATTENDANCE

Facilitator/Coordinator

- Leslie Medved, Assistant to the Chief of Corrections

Medical/Mental Health Team

- Dr. Miguel Balderrama, PC Corrections Bureau Medical Director
- ARNP Mariena Mears, Naphcare
- RN Jon Slothower, Naphcare Health Services Administrator
- RN Angela Valencia, Naphcare Director of Nursing
- Karen Bier, MA, LMHC, PC Corrections Bureau MH Manager

PCSD Corrections Bureau Command Staff

- Brian Sutherlin, Captain
- Tony Genga, Captain

PCSD Corrections Bureau Operations Leadership

- Facility Lieutenant, Matthew Dobson
- Administration Lieutenant, Gayle Pero
- Facility Sergeant, Anthony Mastandrea

PCSD Corrections Bureau Operations

- Corrections Deputy, Keith Volk
- Corrections Deputy, Chris Hall

FATALITY SUMMARY

DATE OF BIRTH: JULY 3, 1993 (28-YEARS-OLD)

DATE OF INCARCERATION: JANUARY 4, 2022

DATE OF DEATH: JANUARY 7, 2022

The deceased individual was a 28-year-old male with no known significant medical or mental health (MH) history. He was booked into the Pierce County Jail by the Pierce County Sheriff's Department (PCSD) at 1636 hours on January 4, 2022. He was being held on 1 count of Murder 1; 1 count of Kidnapping 2; 1 count of UPCS; 1 count of UPFA 2; 4 counts of Aslt 2/DV; 1 count of Fel Vio NC Ord/DV; and 1 count of Fel Harass-DV, DV- Threats/Death Threats with a total bail amount set at $1,100,000.

The defendant was cooperative during the intake/booking process and did not report any medical problems or concerns. He actively participated in an initial MH assessment with a licensed member of our MH team on January 6, 2022, to determine appropriate housing in our facility. He stated he could cope with charges and agreed to notify unit deputy if difficulties arose. Finding no evidence of significant MH issues, he was assigned to housing appropriate to his classification level of 2 (Maximum Security).

INCIDENT OVERVIEW

At approximately 0938 hours on January 7, 2022, three (3) uniformed corrections deputies were conducting meal service when one of the deputies observed the subject in some type of medical distress in his assigned housing cell.

A radio call for a medical emergency was made to alert Jail Health Services (JHS) and operations supervisory team of need for assistance. The uniformed deputies entered his cell and discovered the subject had tied his blanket "like a hammock" from one end of the top bunk to the other in a two-person cell and was lying face forward on the blanket at his neck level. The individual was nonresponsive so uniformed staff lowered him to the floor and initiated chest compressions. A uniformed Sergeant arrived at approximately 0940 and upon recognizing that CPR was in progress directed our Central Control Room Deputy to call 9-1-1 for community emergency medical services (EMS) response.

JHS arrived with their "crash cart" which included an AED unit at approximately 0941 and initiated additional lifesaving attempts – to include bagging subject with mask connected to an oxygen tank, administering Narcan intranasally (@0944; 0947; and 0950), testing blood sugar, and attaching the AED unit to the subject. No shock was advised so medical staff continued lifesaving efforts until relieved by responding medics.

Tacoma Fire Department (TFD) rescue squads arrived at approximately 0948 and 0954. Subject was intubated and responders continued resuscitation efforts but were unsuccessful in reviving him. The individual was reported deceased by TFD personnel at 1017.

The PCSD Investigations Bureau was called to investigate this in-custody death. A PCSD Det. Sgt. arrived at 1024 to begin the investigation. Forensics and the Medical Examiner were requested for response before moving or touching anything. A member of the PC Forensics Unit arrived at approximately 1040 and processed the scene. Members of The PC Medical Examiner's Office arrived at approximately 1120 and departed the scene with the decedent at approximately 1210.

COMMITTEE DISCUSSION

THE SCOPE OF REVIEW INCLUDED:

- Defendants complete booking file
- Defendants current and historical jail medical records
- Facility logs related to the defendant and/or incident
- All internal reports and noted related to the incident
- Detectives investigative report
- Medical Examiner's report and autopsy results

THE POTENTIAL FACTORS REVIEWED INCLUDE:

A. Structural
    a. Risk factors present in design or environment
    b. Broken or altered fixtures or furnishings

B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with Jail Health Services (JHS)
    c. Relevant root cause analysis and/or corrective action
    d. After action response

C. Operational
    a. Supervision (e.g., security checks, kite requests)
    b. Classification and housing
    c. Training recommendations
    d. Known self-harm statements
    e. Life saving measures taken

COMMITTEE FINDINGS

The committee found the overall response and handling of this unfortunate incident resulting in the loss of life was both appropriate and professional. All the tools and resources available were utilized in the efforts to preserve the life of this individual.

STRUCTURAL

The incident took place in a double-occupant cell on the 3rd floor of the Pierce County Jail. The cell had adequate lighting from the cell window, which was not covered, as well as from the ceiling light. All fixtures in this housing cell, including the emergency call button, were functional.

The method used to anchor the ligature was tying his jail issued blanket from one end of the upper bunk in his cell to the other – described as "hammock style".

COMMITTEE FINDINGS – CLINICAL

Denied any psychiatric history or suicidal ideation during the booking process. 1 prior booking in the Pierce County Jail from June 6 – 7, 2021 with no significant issues. The individual was released from custody after a bail bond was posted to cover imposed bail amount of $40,000.

Jail MH Team completed an initial assessment (due to seriousness of charges) on January 6, 2022. No evidence of significant MH issues was found. The subject was cooperative during the assessment process and stated he could cope with the charges he was facing and preferred to be housed around others. Suggestion was made to house per classification level.

Jail Health Services (JHS) initiated the Clinical Opiate Withdrawal Scale (COWS) protocol upon learning individual was withdrawing from Fentanyl. Last COWS assessment was completed at 0800 on January 7, 2022. Subject had a COWS of 13 (moderate withdrawal) on the day he died after scoring a 0 the day prior. LPN was aware of need to report to provider and planned to do so upon doctor's 0900 arrival time. Waiting for results from autopsy to determine more.

As far as the actions in response to the Medical Emergency, the JHS team did not identify issues or failure to follow policies/procedures, training, supervision or management, personnel, culture or other variables. However, the need to evaluate protocol regarding response to COWS scoring was discussed and recommendations were made and described later in this document.

COMMITTEE FINDINGS – OPERATIONS

The area of this incident was fully staffed and all responding PCSD Corrections Bureau staff acted within policy. Uniformed PCSD Corrections Deputies immediately began CPR and continued its application until relieved first by Naphcare Medical Staff, then by Tacoma Fire Department medics.

Review of unit logs for this housing unit was completed, and it shows welfare and security checks were done in accordance with policy.

COMMITTEE RECOMMENDATIONS

All Main Jail (MJ) housing units should be re-evaluated for compromise in space/furnishings that increases ability for individuals to complete suicide.

- Discovered that some of the bunk frames have coin sized "holes" in them that can be used to tie blankets, etc. through.

  ACTION: Facility improvements to plug all the holes on the bunk frames to reduce ability to self-harm has been implemented

- That medications are generally started on individuals at a COWS of 6+ was verbalized. It was determined the JHS protocol to immediately notify provider of high COWS was not precisely followed.

  ACTION: HSA facilitated training to re-educate JHS staff that COWS / CIWA protocol is to ensure individuals with high COWS are brought to the providers attention immediately to start Buprenorphine.