# Unexpected Fatality Review

Pierce County Sheriff's Department

## 2022 Unexpected Fatality Incident 2212202228

### Report to the Legislature

**As required by RCW 70.48.510**

**Date of Critical Incident Review May 18, 2022**

## Date of Publication April 10, 2023


**Chief P. Jackson – Corrections Bureau**
patti.jackson@piercecountywa.gov

**Leslie Medved – UFR Coordinator – Corrections Bureau**
leslie.medved@piercecountywa.gov

Table of Contents

**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: May 18, 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
- Karen Bier, MA, LMHC, PC Corrections Bureau MH Manager

PCSD Corrections Bureau Command Staff

- Steven Jones, A/Chief of Corrections
- Brian Sutherlin, Captain

PCSD Corrections Bureau Operations Leadership

- Administration Lieutenant, Gayle Pero
- Facility Lieutenant, Stacie Woodley
- Facility Sergeant, Brian Conuel
- Facility Sergeant, Kendal Lincoln

PCSD Corrections Bureau Operations

- Corrections Deputy, Jeremie Duffy
- Corrections Deputy, Randolph Frye
- Corrections Deputy, Kailee Laliberte
- Corrections Deputy, Mark Ramos
- Corrections Deputy, Jason Smith

**FATALITY SUMMARY**

DATE OF BIRTH: JULY 6, 1998 (23-YEARS-OLD)

DATE OF INCARCERATION: APRIL 29, 2022

DATE OF DEATH: MAY 2, 2022

The deceased individual was a 23-year-old male with no known significant medical history. He was booked into the Pierce County Jail by the Tacoma Police Department at 1503 hours on April 29, 2022. The defendant was being held on 2 counts of Rape 1; 2 counts of Robbery 1; 1 count of Aslt 2; and 1 count of Ind Lib with a total bail amount set at $1,000,000.

The defendant was cooperative during the intake/booking process and did not report any medical problems or concerns. A Corrections Deputy assigned to our Classifications team alerted our Mental Health (MH) unit of a suicide attempt on April 7, 2022, during his prior incarceration with us (4.6.22-4.8.22). He actively participated in a MH assessment with a licensed member of our MH team on April 30, 2022, to determine appropriate care and housing while in our facility. When asked about previous attempt to self-harm, he said he was caught off guard with initial serious charges but was now prepared to fight them. MH described the deceased as "future oriented" and stated he did not present with acute MH symptoms. Finding no evidence of significant MH issues, he was assigned to housing appropriate to his classification level of 1 (High Maximum Security).

**INCIDENT OVERVIEW**

At approximately 2155 hours on May 2, 2022, a uniformed Corrections Deputy (C/Dep) was conducting a welfare and security check when he observed the subject in some type of medical distress in his assigned cell.

The subject was observed positioned on his back with his hands and feet in the air while laying on his cell floor. The C/Dep attempted to gain the subjects attention by calling his name and striking the metal door with his keys. He utilized the cell door cuff/food port in attempt to gain better sight and sound and observed what appeared to be sock(s) tied around his lower neck.

A radio call for a "medical emergency" was made to alert Jail Health Services and operations supervisory team of need for assistance. Multiple responders arrived on location within seconds. A rescue knife was used to successfully cut and remove the sock from the individual's neck. As he was not responsive, chest compressions were initiated until JHS arrived with their "crash cart" and assisted with lifesaving efforts. An Automated External Defibrillator (AED) was used – indicating "No shock recommended" so CPR was continued until the Tacoma Fire Department (TFD) arrived at approximately 2209 and took over resuscitation measures. TFD discontinued CPR efforts and subject was pronounced deceased at 2219.

A PCSD Detective arrived at 2328 followed a Forensics technician and the Medical Examiner's (ME) office to investigate this in-custody death. The ME departed the facility with the subject at approximately 0105 on May 3, 2022.

The Pierce County Medical Examiner's Office autopsy report certifies the cause of death as asphyxia due to ligature about the neck. Based on the findings of the investigation and autopsy, the manner of death is certified as suicide.

## 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. Staffing levels
    d. Known self-harm statements
    e. Review of inmate communications (phone calls/video visits)
    f. Life saving measures taken
    g. Training recommendations

## 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 single-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.

## COMMITTEE FINDINGS – CLINICAL

Did not disclose any significant medical/mental health issues at time of booking. Denied current suicidal ideation during the primary MH assessment/evaluation. The individual has been incarcerated in the Pierce County Jail a total of 5 times between the years of 2017 through his last booking when he completed suicide.

Jail MH Team completed an initial assessment due to seriousness of charges and alert from Classifications Deputy MH assessed the individual within 2 hours after receipt of report from classifications on April 30, 2022. The subject was cooperative during the assessment process and stated he was prepared to fight the charges he was facing. He said the right things and presented with appropriate demeanor so the suggestion was made to house per classification level.

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.

## COMMITTEE FINDINGS – OPERATIONS

The area of this incident was fully staffed – to include a deputy assigned to light duty status to remain in staff booth and operate computer and locking mechanisms. It is reported 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.

The Classifications Deputy did an excellent job in alerting MH to the individuals return to custody as well as reminding of recent and prior attempt at suicide.

## COMMITTEE RECOMMENDATIONS

As with all reviews of critical incidents in our facility, the following recommendations were made in effort to strengthen measures to maintain a safe, secure, and constitutional facility.

- It was discovered this was the second attempt to complete suicide using jail issued knee high length "tube socks".

**ACTION**: All knee length tube socks were replaced with ankle length socks.

- It was discovered the magnetic window coverings used to cover cell windows of other inmates assigned in the same housing units were not easily located. The window coverings have a significant role during critical incidents.

**ACTION:** Ensure window coverings are in place for units as designed. Order more if needed.