Unexpected Fatality Review

Pierce County Sheriff's Department

2022 Unexpected Fatality Incident 2218001565

Report to the Legislature

As required by RCW 70.48.510

Date of Critical Incident Review July 21, 2022

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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: July 21, 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
- RN Angela Valencia, Naphcare Director of Nursing
- LPN Cameron Carrillo, Naphcare Jail Health Services
- RN Genevive Orosco, Naphcare Jail Health Services
- Karen Bier, MA, LMHC, PC Corrections Bureau MH Manager

PCSD Corrections Bureau Command Staff

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

PCSD Corrections Bureau Operations Leadership

- Administration Lieutenant, Gayle Pero
- Facility Lieutenant, A. Russ Allen
- Facility Sergeant, Brian Blowers

PCSD Corrections Bureau Operations

- Corrections Deputy, Jeremie Duffy
- Corrections Deputy, Angela Kim
- Corrections Deputy, Roger Miller

FATALITY SUMMARY

DATE OF BIRTH: MARCH 2, 1992 (30-YEARS OLD)

DATE OF INCARCERATION: JUNE 20, 2022

DATE OF DEATH: JUNE 30, 2022

The deceased individual was a 30-year-old male with no known significant medical history; but did report significant history of opiate use. He was booked into the Pierce County Jail by the Puyallup Police Department at 2252 hours on June 20, 2022. The defendant was being held on Poss of Stolen Vehicle; 3 counts of Theft 2; and 2 counts of Theft 3 with a total bail imposed at $30,500.

The defendant was cooperative during the intake/booking process, and he was initially assigned to our intake unit awaiting arraignment and housing once cleared. A Corrections Deputy observed behaviors from subject what appeared to be indicative of drug withdrawals and reported same to medical staff. The Jail Health Services (JHS) team initiated the Clinical Opiate Withdrawal Scale (COWS) protocol upon learning individual was withdrawing from Fentanyl. Withdrawal symptoms appeared to be improving and he was moved to general population housing per classification.

INCIDENT OVERVIEW

At approximately 1632 hours on June 29, 2022, a uniformed Corrections Deputy as performing tasks associated with oversight of our general population housing units. The Deputy had just completed meal service and was alerted the occupant of one of the housing units was experiencing some type of medical distress in his assigned cell. The deputy responded to the cell and observed the individual in a kneeling position with his upper body leaning against the sink/toilet combo. An attempt was made to gain the individuals attention and when determined he appeared unresponsive and observed what looked like a dark bruise on his neck, the deputy completed a radio call for a "medical emergency" to alert Jail Health Services (JHS) and operations supervisory team of need for assistance. Multiple responders to include members from the JHS team with their "crash cart" arrived at the incident location within seconds. Direction was given to call 9-1-1 to request community emergency medical services (EMS) response from Tacoma Fire Department (TFD).

The individual was quickly relocated to a space with more room, and upon confirming he was unresponsive, initiated efforts to resuscitate up to and including use of an Automated External Defibrillator (AED). The TFD Advanced Life Support team arrived at our facility at approximately 1639 and took over life saving measures. TFD reported a pulse at 1710 hours and departed our facility with the patient at 1715 to receive medical care at local trauma hospital.

A PCSD Detective arrived with a member of the Forensics team and initiated an initial investigation at 1741 hours. The detective and forensics technician departed the facility at 1805 after processing the scene.

We were notified the individual was compassionately extubated due to poor prognosis and passed away on June 30, 2022.

The Pierce County Medical Examiner's Office autopsy report certifies the cause of death as anoxic encephalopathy due to hanging. 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 4th 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

Although it was later discovered this individual had prior attempt of self-harm while in the community in 2021, he did not initially disclose significant health or mental health issues. The individual has been incarcerated in the Pierce County Jail a total of 11 times from 2010 through his last booking when he completed suicide. Individual did not request / report need for MH intervention during any of his stays with us.

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. 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.

COMMITTEE RECOMMENDATIONS

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

- Although we have a contract for 24/7 on-sight Jail Health Services, some of our custody staff are asking for additional CPR/1st Aid Training

  ACTION: With a current staffing crisis, it is difficult at best to take staff off-line from primary work assignments of oversight of the individuals entrusted to our care. We are continuing to work to find a way that will allow us to provide additional training.

- As the opiate crisis is felt across the nation, our medical team is seeing a pattern of patients coming to the facility with history of Fentanyl addiction. Fentanyl withdrawals are seemingly worse than withdrawals from heroin. Suicide ideation, attempts, and successful completion is largely due to withdrawing. This case was not an acute withdrawal as it was 9 days after booking – but we are finding patients are still detoxing for multiple days.

- Individuals continue to experience poor impulse control and decision-making abilities and often present as very "out of it" with no hope. The depression is lasting much longer and is harder to manage.

  ACTION: We have provided training and issued Narcan to all staff members on our Bureau.