Pend Oreille County Jail

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

The decedent was a 57-year-old male with a moderate history of depression and anxiety.

The decedent was booked into the Pend Oreille County Jail on 08/01/2022, on one count of Murder 2nd Degree for the Killing of his wife.
During intake decedent was screened and noted to be Alcohol/Drug intoxicated.
Decedent was found fit for incarceration.

Incident Overview

On 08/03/2022 the decedent was transported to the Newport Community Hospital for medication review and medical evaluation. Upon return from medical the decedent was housed in cell 16.

At approximately 0930 the two Corrections Officers on duty went to the booking area of the jail to work on booking a couple individuals for court bookings.

At approximately 0930 the decedent can be seen on camera checking the phone in his cell and then at approximately 0931 the decedent can be seen sticking his head thru the phone cord while it is hung up and then adjusting the cord to get it where he wants it on his neck.

At approximately 1010 once the booking was completed a corrections officer looked at the cameras and noticed that the decedent was hanging in his cell and rushed to render aid.

At approximately 1010 a corrections officer arrived at cell 16 and got the decedent down from the phone cord and called for EMS. The officer then went to get medical equipment including an AED. Another Corrections officer arrived to help at that time, and they started CPR and hooked up the AED. They were advised by the AED to administer a shock. They then continued CPR until paramedics arrived at approximately 1017.

At approximately 1030 the Pend Oreille County paramedics declared the decedent dead.

Spokane County Office of the Medical examiner Autopsy report lists the following:

1. Cause of Death: Asphyxia via Ligature hanging

Washington State Patrol Seattle Toxicology Laboratory Report lists the following:

1. Positive Findings: Delta-9 THC

UFR Committee Meeting Information

Meeting date: August 23, 2023

Meeting Location: Pend Oreille County Jail

Committee Members:

Stevens County Chief of Corrections

Chief Shawn Davis

Newport Chief of Police

Wade Nelson

Retired Newport Chief of Police

Mark Duxbury

Committee Discussion

The potential factors reviewed include:

A. Structural

a. Risk factors present in design or environment.
b. Broken or altered fixtures or furnishings.
c. Security/Security measures circumvented or compromised.
d. Lighting
e. Layout of incident location
f. Camera Locations

B. Clinical

a. Relevant decedent health issues/history
b. Interactions with Jail Medical / Mental Health
c. Relevant root cause analysis and/or corrective action

C. Operational

a. Supervision (e.g., security checks, kite requests)
b. Classification and housing
c. Staffing levels
d. Video review if applicable
e. Presence of contraband
f. Training recommendations
g. Inmate phone call and video visit review
h. Known self-harm statements.
i. Life saving measures taken.
j. Use of Force Review

Committee Findings

Structural

Cell 16 is a cell that shares a small dayroom with one other cell.

- General Population cells have either a single bunk or a bunk bed, a stainless- steel sink and toilet, an overhead light/nightlight with a light switch.

There were no known issues with the cell the decedent was housed in.

Cell 16 has 1 camera covering the inside of the cell.

Clinical

Decedent was screened during booking about medical issues past and present along with mental health issues past and present. Decedent admitted to having received mental health counseling in the past. Decedent also admitted to having had thoughts about committing suicide but denied thinking about it currently. Decedent did not provide any further details.

Decedent was put under medical evaluation.

Decedent was taken to the Newport Hospital Emergency center to see a Dr. on 08/03/2022 for medical clearance for incarceration and medication management. During the visit with the Dr. the Decedent denied being depressed. The Decedent was cleared for incarceration.

Operational

Decedent was put under medical observation.

The decedent was searched at intake.

Hourly rounds and checks were completed thru the use of CCTV, Rounds were not done in person with eyes on.

The jail only has two portable radios and only one that can reach dispatch from cell 16.

The Pend Oreille County dispatch center has the ability to monitor all jail cameras but did not have any cameras up that would have allowed them to witness what the Decedent was doing.

The jail was short staffed and only had two Officers on duty during the day.

The booking area in the jail did not have any monitors to allow for officers to possibly monitor any of the cameras while conducting a booking.

Life saving measures were performed by Corrections Staff, and Pend Oreille Ambulance

Life Saving efforts were within policy.

No use of force was reported or observed during the investigation.

Committee Recommendations

- Place all emergency medical equipment in easy to find locations and make sure staff are trained on where those locations and proper use of all equipment.
- Have all new staff receive CPR, first aid and AED training as part of the FTO process.
- Remove any phones from inside any cells and relocate to communal day rooms.
- Purchase new portable radios so that there are enough for all officers and if necessary install repeaters so that officers can communicate with dispatch via radio from anywhere in or around the jail.
- Install video monitors in the booking area so that officers can still have access to video feeds when not in the main control room.
- Look at the policy to make sure that all hourly rounds are being done in person with actual eyes on all inmates to get an accurate account of all inmates.
- Possible policy around dispatch helping to viewing cameras when Corrections officers are away from the monitors especially any inmates that may be considered at risk or high risk.

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