WHATCOM COUNTY
SHERIFF'S OFFICE
DONNELL "TANK" TANKSLEY
SHERIFF

PUBLIC SAFETY BUILDING
311 Grand Avenue
Bellingham, WA 98225-4038
(360) 778-6600

WHATCOM COUNTY SHERIFF'S OFFICE JAIL

UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT WCSO RB-22-55665

REPORT TO THE LEGISLATURE

Pursuant to RCW 70.48.510

Date of Publication: January 9, 2025

Table of Contents

1) DETAINEE INFORMATION

The detainee was a 40-year-old white male. He was booked into the Whatcom County Jail (WCJ) by a Lummi Nation Police Department Officer on November 11, 2022 @ 2240 PM. For Felony Fail to Register as an SO, Burglary 2nd and Theft 3rd.

2) INCIDENT OVERVIEW

On Monday, November 14, 2022, at approximately 1245 hours, the jail Sergeant notified the transport deputies of pending medical transport. Jail nursing staff informed the transport deputy that the detainee was not being transported by aid car.

Transport deputies assisted him into a wheel chair and subsequently loaded him into the jail transport vehicle and he was taken to St. Joseph's Hospital Emergency Room(ER) for care. Once checked in, the deputy escorted the detainee to their assigned space in the ER. While at the ER, the detainee was assisted to the restroom. Once there, the deputy left the room for privacy reasons. A short time later, when the deputy checked on the detainee he was found unconscious. The detainee was moved to trauma room 1 for care.

Later the same date, a jail sergeant secured paperwork from the courts, releasing any holds on the detainee. The paperwork was faxed to the ER when he was released from custody and the deputy returned to the jail.

On 11/15/2022 at 2235 hours, a RN with PeaceHealth St Joseph, reported the death of the detainee.

3) CAUSE OF DEATH

On November 16, 2022, Whatcom County Chief Medical Examiner Dr. Allison Hunt performed an autopsy and determined the cause of death as acute bilateral bronchopneumonia of undetermined etiology. Other significant conditions include sepsis, ischemic small bowel, acute rental failure and acute methamphetamine intoxication. The manner of death is accident.

4) COMMITTEE MEMBERS

- Caleb Erickson, Chief of Corrections
- Dr. Tyson Hawkins, MD
- Emily Blake, RN
- Steve Harris, Undersheriff WCSO
- Barry Lovell, Lt. Corrections
- Darrell Smith, Lt. Corrections
- Lamont Bos, Lt. Corrections

5) COMMITTEE SCOPE OF REVIEW

A. Structural
   1. Risk factors in design or environment
   2. Broken or altered fixtures or furnishings
   3. Security measures compromised or circumvented
   4. Lighting
   5. Camera

B. Clinical
   1. Relevant detainee health issues/history
   2. Interactions with jail health services
   3. Relevant root cause analysis and/or corrective action sought

C. Operational
   1. Supervision (welfare checks/observation)
   2. Classification/Housing
   3. Staffing levels
   4. Training recommendations
   5. Lifesaving measures take

6) COMMITTEE FINDINGS AND RECOMMENDATIONS

Considering the common elements involved in these types of incidents, jails must continuously seek ways to mitigate negative outcomes. WCJ determined key components for minimizing such incidents in the future include the following:

- Structural
    - At the time of death, the detainee had been admitted at St. Joseph's Hospital for greater than 24 hours and the Committee finds that there were no structural factors that contributed to the detainee's death.

- Clinical
    - Jail Medical Services (JMS) did not identify any violations of policy or procedure, training, supervision/management, personnel, culture, or other variables in JMS specifically related to this incident.

- Operational
    - Although it would not have affected the outcome of this incident, the Committee recommends transporting a detainee with similar symptoms via EMS.

7) LEGISLATIVE DIRECTIVE

RCW 70.48.510 Unexpected fatality review--Records—Discovery

i) A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail shall conduct an unexpected fatality review in any case in which the death of an individual confined in the jail is unexpected.

ii) The city or county department of corrections or chief law enforcement officer shall convene an unexpected fatality review team and determine the membership of the review team. The team shall comprise of individuals with appropriate expertise including, but not limited to, individuals whose professional expertise is pertinent to the dynamics of the case. The city or county department of corrections or chief law enforcement officer shall ensure that the unexpected fatality review team is made up of individuals who had no previous involvement in the case.

iii) The primary purpose of the unexpected fatality review shall be the development of recommendations to the governing unit with primary responsibility for the operation of the jail and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody.

iv) 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.

8) DISCLOSURE OF INFORMATION

RCW 70.48.510(3)(c) Unexpected fatality review--Records—Discovery

i) Documents prepared by or for an unexpected fatality review team are inadmissible and may not be used in a civil or administrative proceeding, except that any document that exists before its use or consideration in an unexpected fatality review, or that is created independently of such review, does not become inadmissible merely because it is reviewed or used by an unexpected fatality review team.