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WHATCOM COUNTY SHERIFF'S OFFICE JAIL

UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT WCSO RB-23-58228

A. REPORT TO THE LEGISLATURE

Pursuant to RCW 70.48.510

Date of Publication: January 9, 2025

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1) DETAINEE INFORMATION

The decedent was a 36-year-old white male. He was booked into the Whatcom County Jail (WCJ) by a Whatcom County Sheriff's Office Deputy on June 24, 2023, at 2107 hours for Assault 2nd Degree and Felony Harassment Domestic Violence.

2) INCIDENT OVERVIEW

On September 16, 2023 the detainee, with a history of mental illness, drug use and Tourette Syndrome was moved to a first-floor housing cell by himself for observation after exhibiting self-harming behavior.

At approximately 0930 on September 18, 2023 a Jail Medical Service (JMS) staff member observed the detainee lying on the floor of his first-floor cell in the WCJ. The nurse noticed the detainee had redness around his right eye. As the nurse spoke to him, he had difficulty following the instructions of the nurse.

Considering the circumstances of how the detainee was found and not finding any documented incidents or medical chart notes, the nurse called for EMS and he was transported to the ER. Once at the ER, a CT scan was taken of the detainee's head which revealed a right anterior skull base fracture involving the roof of the right orbit.

After his intake at the ER, the detainee was admitted to the hospital and moved to the ICU. At 0130 he became hypertensive and had an emergency CT which revealed significant swelling in his brain, and herniation of the "cerebellar tonsillar."

At 1354 on September 20, 2023 the detainee died.

3) CAUSE OF DEATH

On September 21, 2023, Whatcom County Chief Medical Examiner Dr. Allison Hunt conducted the autopsy and reported that the cause of death as necrotizing suppurative meningoencephalitis with ventriculitis. Other significant conditions include blunt impact injuries of the head. The manner of death as 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 decedent 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. The key components for preventing 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. Prior to being transported to the ER, the detainee was housed on the first floor of WCJ. The jail was recently re-lamped, so lighting was not a factor. Even though the Committee did not find any evidence that the structural make of the physical plant contributed in the detainee's death, it is noteworthy that there is insufficient camera footage of the 1st floor housing to adequately monitor each cell.

- 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
    - The committee did not identify any violations of policy or procedure, training, supervision/management, personnel, culture, or other operationally that related to this incident.

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.