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

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WHATCOM COUNTY SHERIFF'S OFFICE JAIL

I. UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT WCSO RB-23-59700

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 detainee, was a 37-year-old white male. He was booked into the Whatcom County Jail (WCJ) by a Whatcom County Sheriff's Office Deputy on October 26, 2023, at 15:47 hours for a DOC detainer and a number of other felony and misdemeanor violations.

2) INCIDENT OVERVIEW

On November 11, 2023, at about 08:33 hours the detainee's cellmate yelled out of housing unit 2B meal hatch that he could not wake up his cellmate. Multiple deputies responded to 2B and locked the rest of the detainees in 2B down and responded to cell 2B09.

When deputies arrived at 2B09, they found the detainee unresponsive, his body cold to the touch with blood coming out of his mouth. He also appeared to not have a pulse and was not breathing. Staff at the scene reported on the radio these findings and coordinated to move the detainee to the 2nd floor hallway for safety and security reasons. Once in the 2nd floor hallway, CPR was started and Emergency Medical Services (EMS) was requested. Correctional staff applied the AED and no shock was advised.

EMS arrived at the jail at about 08:41 hours and took over lifesaving efforts. At about 08:45 hours, the detainee was declared deceased by EMS.

3) CAUSE OF DEATH

On November 11, 2023, Whatcom County Chief Medical Examiner Dr. Allison Hunt conducted the autopsy and reported that the cause of death as atherosclerotic cardiovascular disease. The manner of death as natural.

4) COMMITTEE MEMBERS

- Caleb Erickson, Chief Corrections Deputy
- Tyson Hawkins, MD
- Emily Blake, RN
- Steve Harris, Undersheriff WCSO
- Barry Lovell, Corrections Lieutenant
- Darrell Smith, Corrections Lieutenant

- Lamont Bos, Corrections Lieutenant

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. Cameras

B. Clinical
   1. Relevant decedent health issues and 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 and Housing
   3. Staffing levels
   4. Training recommendations
   5. Lifesaving measures taken

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
  - The incident took place in a double-occupant cell in a Restrictive Housing area of the Whatcom County Jail. The two surveillance cameras views of the housing unit common area, however the cameras do not show a view inside the individual cells. It is unknown if lighting was a contributing factor in this incident however WCJ historically has issues with detainees putting paper in light fixtures to darken their cells.
  - Call buttons were checked and functional.

- Clinical
    - Jail Medical Services (JMS) did not identify issues or problems with policies/procedures, training, supervision/management, personnel, culture, or other variables in JMS specifically related to this incident.

- Operational
    - The area of this incident was staffed by a single floor deputy. Reviewed video and JMS records show that security checks leading up to this event were conducted. Lifesaving measures (CPR) began promptly and continued until staff were properly relieved by JMS and responding 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.