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WHATCOM COUNTY SHERIFF'S OFFICE JAIL

UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT WCSO RB-24-59806

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 28-year-old white male. He was booked into the Whatcom County Jail by a Blaine Police Department Officer on November 5, 2023 @ 0823AM. For Felony Harassment, Felony Assault 4nd Degree and Felony Animal Cruelty 2nd.

2) INCIDENT OVERVIEW

On March 13, 2024 at approximately 1018 AM, Whatcom County Jail Staff responded to housing unit 2A for a distress call. A detainee housed in 2A had hit the emergency call button and reported a medical emergency in the cell next to them. Corrections Officers responded to find two unresponsive males down on the floor of cell 2A-1.
The decedent was found unresponsive and bluish/purple in the face. The cellmate as was also unresponsive. Corrections offices started lifesaving measures were administered with multiple doses of Narcan. Bellingham EMS arrived and continued lifesaving measures to include the use of an automatic external defibrillator. The decedent could not be revived and was pronounced deceased by Bellingham EMS on scene. The cellmate was revived after multiple doses of Narcan and then transported to St. Joseph's Hospital for continued care.

3) CAUSE OF DEATH

On March 14, 2024, Whatcom County Chief Medical Examiner Dr. Allison Hunt conducted the autopsy and reported that the cause of death as acute fentanyl intoxication. 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. WCJ determined key components for minimizing such incidents in the future include the following:

- Structural
  - This incident took place in a double-occupant cell of the WCJ. There are two camera views of the housing unit common area, however the cameras do not show inside the individual cells. The call buttons were used and proved to functioning properly. 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
    - 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. Deputies responded promptly and began lifesaving measures (CPR) and continued until staff were properly relieved by JMS and responding EMS. The amount of time between the detainee's booking and this incident may indicate that there is a inadequate searches and screenings for drugs and paraphernalia. The committee recommends WCJ continue their efforts to have their body scanners replaced as well as developing their K-9 program.

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.