Pend Oreille County Jail

Unexpected Fatality Review Committee Report

2024 Unexpected Fatality Incident Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

The decedent was a 29-year-old male with a history of mental health issues and delusions. The decedent was booked into the Pend Oreille County Jail on 02-06-2022, on one count of Murder 2nd Degree domestic violence for killing his mother. He attempted suicide by strangulation in his cell at the Pend Oreille County Jail using his underwear on 02-07-2022. The decedent was evaluated at Eastern state hospital after that incident, and it was noted under provisional diagnoses during his psychological evaluation that he suffered from an "unspecified psychological disorder".

Incident Overview

Due to low blood sugar readings the decedent had been taken to the Newport hospital for evaluation on 04-02-2023 and 04-04-2023. Corrections Officers reported that the decedent had been refusing to take medications and had been refusing to eat or eating very little since 03-30-2023. He had plead guilty for Murder 2nd degree that day. Additionally, the decedent had tested positive for COVID on March 29, 2023.

On 04-02-2023 the decedent was transported to the Newport Hospital Emergency Room due to very low blood sugar readings. The reason for his visit was documented on the ER visit summary as weakness and the diagnosis was hypoglycemia (low blood sugar). When he returned from the hospital he was moved to a holding cell for observation.

On 04-04-2023 at approximately 0618 hours the decedent tested his blood sugars and showed a reading of 77. He refused multiple requests to retest throughout the morning and was transported to Newport Hospital ER at approximately 1420 hours after complaining about not feeling well but not giving any specific complaint. The reason for the visit on the ER visit summary was noted as "medical problems" and the diagnosis was "encounter for medical screening examination". His blood glucose level was checked at the hospital and showed a reading of 119.

The decedent returned to the Pend Oreille County Jail at approximately 1617 hours. Jail records indicate that at approximately 2145 hours the decedent tested his blood sugar and had a reading of 124. This information was documented by a Corrections Sergeant. It was further documented that the decedent was given 25 units of Lantus at that time as prescribed.

At 2200 hours the Decedent was observed on camera moving around a lot in his cell which was not unusual for him. The decedent then knelt down by his bed and laid his upper body face down on the bed with his hands under him. This was all considered normal behavior for him. Corrections officers advised that the decedent had not slept in his bed in a week. He said he had seen him laying on the floor in the fetal position, on the toilet leaning forward, and laying on his back on the floor.

Review of jail video showed that the decedent knelt by the bed at approximately 2225 hours. Surveillance video showed the decedent still moving until approximately 2245 hours. No movement was observed after that time. The decedent was found unresponsive in a kneeling position in his cell on 04-05-2024 at 0332 hours and CPR was administered. Emergency Medical units responded to the jail and the decedent was pronounced dead at 0347 hours.

I reviewed the autopsy report which stated the cause of death as complications of Diabetes Mellitus. The autopsy report showed the decedent's vitreous fluid glucose to be less than 4.

I asked POC corrections officers about how inmates receive their insulin and other medications, and was told that there are no medical personnel on staff at the Pend Oreille County Jail. He explained to me that medications including insulin are provided per prescription instructions to inmates at specified times throughout the day. In the case of insulin, the medication is not in pill form and is administered via subcutaneous injection using a multi dose pen. There is a plunger that dials up the number of units to be dosed and the plunger is then depressed releasing the specified amount of insulin. The corrections officer administering the medication uses the sliding scale prescribed by the doctor to determine how many units insulin needs to be administered based on the subject's blood sugar levels. The officer then dials up the dosage and hands the insulin pen to the inmate who injects the insulin his or her self.

It should be noted that on two occasions the decedent was caught trying to dial up the amount of insulin while injecting himself. Those incidents occurred on 05-04-2022 and 05-05-2022 respectively. Both times the decedent tried to dose himself with extra Lantus and was stopped by the officer who was observing him inject the insulin.

I asked how inmate's insulin is stored and was told that the decedent's medication was stored in the refrigerator. He told me that the decedent's insulin was still in the refrigerator as we spoke. He showed me the insulin which was in a gallon plastic bag on the door shelf inside the refrigerator.

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

1. Cause of Death: Complications from Diabetes Mellitus type 1

UFR Committee Meeting Information

Meeting date: November 1, 2024
Meeting Location: Pend Oreille County Jail

Committee Members:

Travis Stigall, Investigator, Pend Oreille County Sheriff's Office
James Cotter: Retired Sergeant Bonner County Sheriff's Office

Wade Engelson: Former Police Officer, Fresno PD, retired Deputy Chief of Police, Vacaville CA

Dr. Clayton Kersting M.D.

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
There were no known issues with the cell the decedent was housed in.
There was an active camera monitoring the cell.

Clinical
Decedent received mental health counseling in the past. Decedent was taken to the Newport Hospital Emergency center to see a Dr. on 04-04-2023 due to an unknown complaint. The Decedent was cleared for incarceration.

The decedent was a Type 1 diabetic, insulin dependent. The Pend Oreille County Jail does not have any medical person on staff; therefore, corrections officers are required to dispense medications. In the case of a Type 1 diabetic this is not optimal due to the chronic nature of the condition.

In addition, the decedent had severe mental illness with psychotic delusions.

Operational

Decedent was receiving medications and was being held in a holding cell for closer observation.

Hourly rounds and checks were completed thru the use of CCTV, Rounds were also done in person but visibility within cells is limited due to lighting and the way some cells are constructed. With this being the case, eyes on contact is resigned to CCTV during the night. Corrections officers use their senses of hearing and smell at night after lights out to make certain that there are no issues within the jail.

The jail was staffed with two Officers on duty at the time of the incident. On most nights there is only one officer on duty in the facility through out the night. This is due to staffing numbers and is the practice when the facility is fully staffed. Per policy, when a single corrections officer is on duty, they are not allowed to open any cell door unless they are accompanied by another officer or deputy. Effectively, if there is some sort of altercation or medical emergency, and only one officer is on duty, then that officer either calls a deputy who is on duty, or a corrections officer is called from home to respond to the facility to assist.

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

• Create a position to allow for a medical professional (PAC, Nurse, etc.) to be on staff at the jail to conduct any and all medical screenings and administer and oversee any prescription drugs ingestion or injections. The decedent was a unique case due to his mental illness and psychosis. In unique and complicated cases of chronic conditions and/or severe mental illness, the agency could examine options of a secured corrections facility to contract with to house inmates. Any determination of this sort of case could be more clearly determined with onsite medical staffing that could properly triage and evaluate incoming subjects.

• Consider increasing staffing to allow for more than one corrections officer to be on duty at all times.

• In the case of insulin, separate long acting and short acting insulins, clearly marking each container with the name, purpose and dosage

• Install video monitors in the booking area so that officers can still have access to video feeds when not in the main control room.

• 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.

• 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 done in person with actual eyes on all inmates to get an accurate account of all inmates.

• Possible policy around dispatch helping to view 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