WHATCOM COUNTY
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WHATCOM COUNTY SHERIFF'S OFFICE JAIL

UNEXPECTED FATALITY REVIEW

COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT WCSO RB-25-63514

REPORT TO THE LEGISLATURE

Pursuant to RCW 70.48.510

Date of Publication: March 3, 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 the Blaine Police Department on September 24, 2024, at about 15:53 hours for DUI, Pursuit Eluding and Malicious Mischief.

2) INCIDENT OVERVIEW

On Friday, January 17, 2025 at about 09:53 hours deputies called for Jail Medical Staff (JMS) to inmate housing unit 2B. Upon arrival at 2B, JMS spoke to the detainee who reported that they were in bad pain in their lower extremity. The detainee denied any acute injury or falling. Deputies assisted moving the detainee to 1st floor for medical observation. At about 11:28 hours, after consulting with the jail MD, JMS directed jail deputies to transport the detainee to the PeachHealth St. Joseph's Medical Center Emergency Department (ED) for evaluation of this pain. They were discharged from the ED and returned to the WCJ at about 14:52 hours. Upon return from the ED, the detainee was housed in cell 128.

On Sunday, January 19, 2025 at about 21:15 hours a deputy was conducting security checks on the first-floor cells of the WCJ. When the deputy looked into cell 128 he saw the detainee with a bed sheet tied around their neck and noted their skin was pale. After calling for back up, the deputy opened the door and cut the sheet from the detainee's neck. By that time, other deputies had arrived with an AED to assist. The deputies carried the detainee out of the cell and placed him on the floor and immediately started first aid and CPR. As the deputies continued first aid and CPR, a jail sergeant called 911 to request Bellingham Fire Department (EMS) to respond to the jail.

At about 21:17 hours, the AED unit was turned on and applied to the detainee but no shock was advised. Deputies continued CPR until EMS arrived at about 21:23 hours and took over CPR efforts.

At about 21:40 hours, after regaining a pulse on the detainee, EMS transported them to the local hospital emergency department (ED).

A jail sergeant assigned a deputy to accompany the detainee at the ED.

At about 23:35 hours, the sergeant contacted the deputy at the ED and told him that he had faxed a temporary release (TR) of the detainee to the ED. The deputy was directed to verify the ED had a copy of the TR and then return to the WCJ.

The detainee was admitted to the hospital and housed in the ICU in grave condition. He died on January 22, 2025.

3) CAUSE OF DEATH

On January 27, 2025, Whatcom County Chief Medical Examiner Dr. Aldo Fusaro conducted the autopsy. The autopsy report, signed on February 5, 2025, reported the primary cause of death as Anoxic Brain Injury due to Asphyxia due to Ligature Hanging. The manner of death was listed as Suicide.

4) COMMITTEE MEMBERS

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

5) COMMITTEE SCOPE OF REVIEW

A. Structural

- **Risk factors in design or environment**
  - At the time of this incident, there was only one AED in service at the WCJ.

- **Broken or altered fixtures or furnishings**
  - Following the incident, WCJ staff discovered missing concrete grout between bunk and wall. This allowed a fixed point to attach a ligature.
  - It is unknown if the call light in 2B09 was used or functioned properly on the night of January 17, 2025.

- **Security measures compromised or circumvented**
  - The countdown clock to signal walk-throughs to staff was visible for some of the cells of the WCJ 1st floor.

- **Lighting**
  - No issued discovered.

- **Cameras**
  - The main jail does not have camera's inside any individual cells.
  - The camera's covering the 1st floor passageway are inadequate and do not provide visual coverage of the cell door where this incident occurred.

B. Clinical

- **Relevant decedent health issues and history**
  - The detainee had a history of contracting with MH for help when needed.
  - Detainee was offered and used a journal to write down his thoughts as part of his therapy.
  - MHP had no concerns with self-harm. It was mentioned that he was remarkably stable during this incarceration period.

- Pain management was consistent with standards of care considering symptoms displayed.
- The consultation with the jail MD and subsequent decision to send the detainee to the ER for a 2nd opinion regarding pain management was reasonable considering the jail MD was not on site that day and would not return for 4 days.

- **Interactions with jail health services**
  - The response to 2nd floor, move to 1st floor and the consult with the jail MD were all appropriate.

C. **Operationa**l

- **Supervision: (welfare checks/observation)**
  - Jail logs and available video reviewed. Even though video footage documents that welfare checks were completed on time and within limits on the day of the incident there is no specific video showing welfare checks of the cell in question.
  - The detainee was scheduled for a medical visit on 1/16 but was not transported to the clinic due to a scheduling conflict with court. Although JMS requested that he be brought to the clinic after court, he was not taken.
  - There are no log entries made by jail staff from 0400-1000 on 1/17/2025. However, video evidence shows that at about 0416 hours and 0631 hours deputies conducting security checks stopped and talked to the detainee for about 1 minute each time.

- **Classification and Housing**
  - No issues discovered.

- **Staffing levels**
  - Jail was staffed appropriately.

- **Training**
  - Documentation of staff training is incomplete.

- **Lifesaving measures taken**
  - Jail staff and JMS followed proper lifesaving measures.

6) COMMITTEE FINDINGS AND RECOMMENDATIONS

Relevant root cause analysis and/or corrective action sought

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**
  - Purchase and deploy additional AED's in the WCJ. Recommend 1/floor and additional unit in the medical clinic.

        - Purchased and deployed as of March 25, 2025
    - Investigate, report and create repair work orders for any area of the jail that has areas that may be missing grout.
        - Completed
    - Verify that call lights are operating correctly.
        - Completed
    - Submit work orders for camera installation, focusing on common areas where coverage is inadequate.
        - In progress

- **Clinical**
    - Continue to work closely with jail staff to improve the coordination of care of inmates when overlapping needs limit the availability of inmates to make it to medical clinics for care.

- **Operational**
    - Review log entry procedures with jail staff to improve documentation
        - In progress- This will be covered extensively during shift briefs, in training bulletins and annual block training.
    - Improve staff training and staff training documentation
        - In progress.
    - Improve communication between jail staff and JMS to minimize situations where an inmate may miss a medical appointment.
        - Jail and JMS meet regularly to discuss challenges and ways to improve communication. In progress and ongoing.

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.