Business 509-773-4455

Jail 509-773-3666

Non Emergency Dispatch
509-773-4545

Fax 509-773-6575

Sheriff Bob Songer
509-773-2377

Undersheriff
Tim Neher
509 773 2476

Chief Civil/Jail Deputy
Carmen Knopes
509 773-2314

Chief Civil Clerk/
Budget Manager
Karen Elings
509 773-2380

Klickitat County Sheriff
205 South Columbus Avenue
Room 108
Goldendale, Washington • 98620-9291

KLICKITAT COUNTY SHERIFF'S OFFICE WASHINGTON

2023 Unexpected Fatality Review Committee Report

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Date of publication: July 21, 2023

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Inmate Information

The deceased inmate, a 24-year-old male, was arrested on 5/15/23 on a Department of Corrections Warrant and Resisting Arrest. Inmate booking interview revealed no concerns for self-harm. He was booked into the Klickitat County Jail at 1608 hours. On 5/16/23 he plead guilty to resisting arrest and was sentenced to 90 days with 75 days suspended.

Incident Overview

On 5/20/23 while doing cell checks, a Corrections Deputy saw the inmate hanging from a bed sheet tied to the air vent inside the inmate's cell. The staff member immediately entered the cell and lifted the inmate by the legs to relieve pressure on the inmate's neck and called for backup. Seconds later another Corrections Deputy entered the cell and cut the sheet, both Deputies lowered the inmate to the cell floor. CPR was started as soon as the inmate was placed on the floor. EMS was requested.

Officers from Goldendale Police, Klickitat County Sheriff's Office and Washington State Patrol responded to the cell and took over CPR. Medics arrived to the cell and took over life saving measures. A pulse was detected and the inmate was taken by ambulance to the local hospital where he was life flighted by helicopter to Kadlec Regional Medical Center in Richland WA. The cell was secured and locked down. A detective from Skamania County was requested and arrived later that evening and conducted an investigation. No criminal behaviors were identified. On 5/23/23 at 1305 hours the inmate passed away.

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Cause of Death

From the Coroner's Report:

"Ligature hanging resulting in asphyxia"

Following Actions

The following actions were immediately taken or were taken following this incident:

- A Skamania County Detective was requested and arrived to do an investigation.
- Jail Chief and Klickitat County Detective did in-person notification to family of the inmate.
- Critical incident counseling was made available to staff.
- Sheets were removed and banned from this facility.
- Coroner's report completed.
- An Unexpected Fatality Review Committee was formed.
- More in-depth mental health intake questionnaires are being implemented.
- At all times possible, cell checks are done with teams of two Corrections Deputies.

Committee Meeting Information

Unexpected Fatality Review Committee met on 7/20/23, relevant documents were disseminated approximately 10 days prior to the meeting.

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Committee Members

Brian Bea – Physician Assistant (Contract Medical Provider)

Erinn Quinn – Klickitat County Public Health Department Director

Karen Elings – Klickitat County Chief Civil Deputy

Jeff King – Klickitat County Emergency Management Director

Loren Culp - Klickitat County Chief Jail Deputy

Committee Review and Discussions

Inmate booking file

Inmate medical file

Facility Logs

Coroner's report

Independent Investigators Report

Facility Structure

Cameras/Video

Cell Doors

Emergency Codes

Medical/Mental Health Screenings

Officer Reports & Jail Forms

Cell heating/cooling vents

Staff and outside agency response

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Committee Findings and Recommendations

- The committee found the response and handling of this unexpected and unfortunate incident was appropriate. The efforts of everyone responding to this incident to try to preserve the life of this inmate, from the first Deputy to find the inmate to the last one in the door, were all professional.

- The committee recommended finding alternative covers for the air vents in the cells that would prevent an anchor point.

- The committee recommended reviewing the possibility of replacing the solid cell doors with doors that would allow better visual observation into the cells.

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Legislative Directive –

Per Revised Code of Washington 70.48.510

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.

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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.