Clallam County Sheriff's Office

WASPC Accredited Agency

Brian King
Sheriff

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-24172

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

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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 occurred. A review must include an analysis of the root cause or causes of the unexpected 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.

(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.

UFR Committee Meeting Dates and Location

Relevant documents disseminated to committee members for review: 04/10/2023

Meeting date: 04/19/2023

Location: Human Resources Meeting Room, Clallam County Courthouse
223 E 4th Street, Port Angeles, WA 98362

Committee Members

Medical/Mental Health Team

- Wendy Sisk, L.M.H.C. – Peninsula Behavioral Health (CEO)
- Linsey Monaghan, M.D. – North Olympic Healthcare Network and CCCF Physician
- Alicia Long, RN – Wellpath Facility Nurse
- Tamara Vanover, M.S. – CCCF Mental Health Case Manager

Clallam County Team

- Rich Meier – Board of County Commissioners Analyst and Retired Lieutenant for Orange County Sheriff's Office and Corrections

Port Angeles Police Department

- Jason Viada – Deputy Chief of Police

Clallam County Sheriff's Office

- Alicia Newhouse – Corrections Sergeant
- Don Wenzl – Chief Corrections Deputy (Facilitator)

Inmate Information

The decedent was a 39-year-old male, post-9/11 combat veteran with PTSD disability. He was booked into the Clallam County Correction Facility in Port Angeles by a Clallam County Sheriff's Deputy on 07/21/2022 at 1341 hours. His charges were Assault 1st degree and a Gray's Harbor felony warrant. A Violation of a Domestic Violence Temporary Protection Order was added on 07/27/2022.

Incident Overview

At booking on 07/21/2022, the arresting deputy indicated on the Authorization for Confinement that the inmate had a Taser application and attempted suicide at the time of arrest. He was cleared for incarceration by Olympic Medical Center. On 07/22/2023, he was assessed and cleared from the crisis cell by the Mental Health Case manager, who used the Columbia-Suicide Severity Rating Scale (C-SSRS).
On 12/23/2022 at approximately 0032 hours, uniformed correction deputies arrived in C tank to conduct the first welfare check/headcount of the shift. The deputy noticed the inmate appeared to be sitting against the wall and unconscious. After calling out to the inmate and getting no response, the door was opened and both deputies entered the cell (C-3).
The inmate was found with a strip of blanket wrapped around his neck. The other end of the blanket was jammed into the frame of the window. Staff removed the ligature from the window and laid the inmate on the floor. Staff called on the radio for assistance and the ALS aid car.
Unable to find a pulse or breathing, one deputy immediately began lifesaving measures with chest compressions at approximately 0033 hours. The second deputy ran to retrieve the AED from our medical area. The AED was hooked up to the inmate and activated. The AED's instructions only recommended rescue, no shock. Chest compressions and rescue breathing continued for a total of eleven minutes until medics arrived. A LUCAS device was placed on the inmate at approximately 0044 hours.
After getting a pulse on the inmate, the medics transported the inmate to Olympic Medical Center. The inmate was pronounced dead on 12/23/2022 at 2046 hours by the attending physician.

Cause of Death

The final Coroner's report and Pathologist autopsy report find the cause of death was classified as a suicide by "Self-Inflicted" "Ligature Strangulation".

Committee Review & Discussion

Each committee member was provided OneDrive access containing the following information for review:

- Inmate’s complete booking file
- Photo and video evidence
- Inmate’s medical records
- Corrections Deputies’ incident reports
- Corrections Deputy welfare check logs relating to the incident
- Corrections Facility 24-hour log relating to the incident
- Inmate’s personal communication (phone calls, video visits, and emails)
- Investigation and evidence reports
- Coroner’s reports, autopsy results, and toxicology results.
- Relevant CCSO Correction policies

The committee discussed potential factors including:

A. Structural
    a. Risk factors in design or environment
    b. Broken or altered fixtures or furnishings
    c. Security measures compromised or circumvented
    d. Lighting
    e. Camera
B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with jail health services
    c. Relevant root cause analysis and/or corrective action sought
C. Operational
    a. Supervision (welfare checks/observation)
    b. Classification/Housing
    c. Staffing levels
    d. Training recommendations
    e. Phone call and visitation review
    f. Known self-harm
    g. Lifesaving measures taken

Committee Findings

The Committee determined that the response and management to this unfortunate event which led to the loss of a life was conducted in a professional and appropriate manner. Every available tool and resource was utilized in the attempt to save this individual's life.

Structural

The incident took place in a single occupant cell (C-3) within the C-tank housing unit at the Clallam County Correction Facility. The unit had adequate lighting which was not covered. All lighting was operational prior to lockdown and during the emergency. The inner cell had a properly working nightlight in the light fixture during the "lights out" period. The nightlight allowed the deputy to see the inmate sitting against the wall.

The method of anchoring the ligature was done by fishing a ripped portion of the blanket through a window seam less than ¼" wide. This method of anchoring has never been observed in the history of this facility.

Due to PREA privacy requirements, there are no cameras mounted in the inner cells. The camera in C-tank dayroom recorded the lifesaving efforts.

All other fixtures, including the emergency call buttons were operational.

Clinical

Without violating HIPAA issues, the committee reviewed all medical and mental health documentation provided for the UFR and found that policies were followed, clinical notes were well documented, and appropriate treatment was provided.

The decedent refused to continue medical and mental health treatment contrary to providers' recommendations. Although the decedent refused recommended treatment, he was checked on daily by the jail nurses and contacted regularly by the Mental Health Case manager.

Jail services reached out to the state's veterans' support services for assistance but were unable to receive much support. Case managers from REdisCOVERY attempted to coordinate a bed date for treatment but were denied by courts.

Operational

At the time of the incident, the shift had the required staffing level for operation. It was determined that all responding Corrections staff acted within policy. Uniformed Corrections Deputies immediately requested assistance and began CPR. Lifesaving efforts were continued until relieved by Port Angeles Fire Department medics.

The PIPE logs were reviewed and show that welfare and security checks were done in accordance with policy.
The committee reviewed and determined that related staff training (Suicide Prevention, First Aid, and CPR) was appropriate and according to policy.

Committee Recommendations

As with all reviews of critical incidents in our facility, recommendations, although unrelated to the outcome of this incident, were made in effort to strengthen measures to maintain a safe, secure, and constitutional facility.

- Explore options in sealing the thin separation between the window and frame. Agency will coordinate efforts with County maintenance for solutions.
- The AED was discussed, and the committee was informed that two additional AEDs were installed in January at the ends of each deck, allowing quicker retrieval.
- The committee addressed having additional cameras installed in the inner cells. Due to the layout of inner cells and the PREA requirement, "*The facility must demonstrate that its policies, procedures and practices allow inmates to shower, perform bodily functions, and change clothes without being viewed by non-medical staff of the opposite gender except in exigent circumstances or when viewing is incidental to routine cell checks*", the department will research the feasibility of installing inner-cell cameras.
- Concerns for veterans' resources while incarcerated was also discussed as well as the benefits of developing a Veteran's Court. A Veterans Court could assist in diversion or navigation through an individual's court case. Clallam County has the highest percentage per capita of veterans in Washington state. A committee member was able to provide jail services with updated local contact information accessible to veteran inmates and staff. Information will compliment section 30.00.00 Community Resources of the inmate handbook. A flyer provided by the NW Veterans Resource Center was posted on the inmate kiosk and the NWVRC email and phone number was approved for inmate communication.
- The committee brought up the medical department would like to request access to oxygen in the jail for emergent situations. The facility nurse was directed to research pricing and availability to our facility.
- Even though life-saving efforts were properly implemented, a committee member recommended wallet-sized laminate cards with First Aid instructions for various medical emergencies for Corrections Staff.