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SHERIFF

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"Public Safety through Professional Service"

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Review Panel: Unexpected Fatality Review (UFR)
Decedent: 35 year old male
Location of Death: Lewis County Sheriff's Office Jail
Manner of Death: Suicide
Date/Time: July 12, 2023 at 2158hrs

PURPOSE

In accordance with R.C.W. 70.48.510, This report provides a review of an in-custody death that occurred on July 12, 2023, involving a 35 year old male at the Lewis County Sheriff's Office Jail.

Investigation Team

- Lewis County Sheriff's Office Deputies
- Lewis County Sheriff's Office Detective Unit
- Thurston County Sheriff's Office Detective Carrie Nastansky
- Lewis County Prosecuting Attorney's Office

Timeline of Investigation

- July 12, 2023 – Suicide
- July 12,2023 – LCSO Detectives Unit starts in-custody death investigation for alleged suicide.
- July 13, 2023 – LCSO media release of in-custody death.
- August 1, 2023 – TCSO Detective completes independent interview of LCSO Corrections staff.
- August 29, 2023 – LCSO Detective Wallace refers case to Lewis County Prosecutor's Office for review.
- December 21, 2023 – Lewis County Prosecutor's Office completes review with decline letter.

SUMMARY OF FINDINGS

The following is a summary of events leading up to the decedent's death at the Lewis County Sheriff's Office Jail:

Decedent was arrested for Assault 3rd, Harassment, and Disorderly Conduct by Chehalis Police Department. Decedent was arrested in the east parking lot of the Lewis County Law and Justice Building. The decedent was walked into the Lewis County Sheriff's Office Jail for intake procedures by LCSO deputies assisting Chehalis Police Department.

While at intake, the decedent's behavior was agitated and appeared to be under the influence of alcohol and or drugs. At 1859 hours, decedent is medically evaluated by contract medical staff from Everhealth. Corrections staff complete intake questionnaire with no indication of suicide and/or mental health history. Decedent was placed into a holding cell with additional individuals to await the booking process. While in the intake unit, the corrections supervisor on shift determined that the decedent was too disruptive for the other individuals in the cell and transferred the decedent to a single cell to temporarily await the booking process.

Sequence of events prior to suicide discovery:

- 2005hrs - Corrections deputy completes cell checks in decedent's housing unit.
- 2011hrs - The decedent is let out of the housing cell and uses kiosk in the dayroom.
- 2014hrs - Decedent returned to his cell.
- 2055hrs - Decedent is observed on camera in his cell looking through the cell door window.
- 2113hrs - A corrections deputy and an Everhealth nurse enter the housing area to complete medication pass for individuals previously assigned to that unit for housing.
- 2159hrs - A corrections deputy completing hourly cell checks discovers decedent hanging and unresponsive.
- 2201hrs - Contract medical staff arrive and assist corrections deputies with rendering aid to decedent.
- 2205hrs - AMR arrives at jail and immediately escorted to decedent location.
- 2207hrs - Chehalis Fire Department arrives at jail and escorted to decedent location.
- 2211hrs - Additional AMR personnel arrive at jail to assist with life saving measures.
- 2237hrs - Life saving measures are stopped by AMR/Fire and decedent pronounced deceased.

Lewis County Sheriff's Office deputies and detectives respond to start in-custody death investigation under Case #23C8447. Refer to Case #23C8447 for complete investigative reports.

Procedure Review:

Custody:

The intake process was completed correctly, and the individual answered no to suicidal intentions.

It was determined that the actions of the corrections supervisor to transfer the decedent from the other individuals was within protocol to prevent potential escalation between those in the intake unit.

It was discovered during the investigation that the corrections deputy who entered the housing unit at 2113hrs, for medications pass, failed to check the first two housing cells (A2D1 and A2D2). The decedent is seen on camera looking through the cell door window at 2055hrs and the next check for the hour was conducted at 2159hrs when the decedent was found to have committed suicide by a corrections deputy.

Medical:

Everhealth nursing staff on shift responded appropriately and immediately began life saving measures. The notification to outside medical response personnel was conducted properly and the response time for outsider responders was immediate.

RECOMMENDATION

The 2113hrs cell check performed by the corrections deputy was not conducted properly and violated current policy. The corrections deputy communicated to the control room deputy that the medication pass was completed, and the housing area was checked. This was documented by the control room deputy on the iPad device per procedures at time

of incident. However, the deputy logging the housing area check on the iPad did not indicate in the notes that the check was performed by the other deputy. This led to a potential wrongdoing investigation that was conducted independently by an outside agency, Thurston County Sheriff's Office, per the request of the Lewis County Sheriff's Office.

The investigation into this incident resulted in several findings against jail practices at the time of the incident. The findings include:

- The decedent was temporarily housed in the housing unit and the decedent's name was not listed on the occupancy board located at the entry door to the housing unit.
- At the time of this incident, it was normal practice that corrections deputies doing the hourly housing checks would communicate to a partnering deputy who had the iPad to enter the log. However, there were no notes written who the actual corrections deputy was that did the physical checks. The iPad log would only show who was entering the information into the program.

ACTIONS TAKEN/MANAGEMENT'S RESPONSE

As a result of this investigation, the hourly check procedures have changed. Corrections staff are no longer using the iPad for electronic record cell checks. This facility has eliminated the electronic iPad method and reverted to a paper log located at each housing unit within the facility. Corrections deputies who are doing the hourly checks are required to complete the log themselves for better accountability and accuracy. This change in procedure will hopefully mitigate any further errors with the hourly check process and inmate housing accountability, regardless of temporary housing location or permanent housing location.

Point of contact:

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