Running head: UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

CLARK COUNTY WASHINGTON
JAIL SERVICES
clark.wa.gov/jail-services
1300 Franklin Street
PO Box 5000
Vancouver, WA 98666-5000

Unexpected Fatality Review Committee Report

Report to Clark County Manager

2024 Unexpected Fatality CCSO Case # 24-000499 / JMS # 24000115 / ID # 131428

Clark County Department of Jail Services

July 16, 2024

Adult-in-Custody (AIC) Information

Decedent was a forty-seven year old Caucasian male and was booked into our jail on January 9, 2024 at approximately 5:30 PM. During the intake, the decedent denied all medical and mental health concerns. The decedent was charged with fifteen different charges/counts. Most of the charges were sex-offense related. During the medical screening process, the decedent admitted the use of fentanyl. Decedent died on January 19, 2024.

Running head: UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

Primary Purpose

70.48.510 (c) 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 (RCW 70.48.510: Unexpected fatality review—Records—Discovery. (wa.gov)).

Policy / Definition

Policy: 05.02.040 UNEXPECTED FATALITY REVIEW Definition: Unexpected fatality review - Per RCW 70.48.510: means 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 2 cause or causes of the unexpected fatality and create an associated action plan if needed to address identified root causes and recommendations made by the unexpected fatality review team under this section. Purpose: 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. The department shall conduct an unexpected fatality review in any case in which the death of an individual confined in the jail is unexpected. • The department shall convene an Unexpected Fatality Review (UFR) 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 UFR team will be comprised of individuals who had no previous involvement in the case. • The UFR team shall have access to all records and files regarding the person or otherwise relevant to the review that have been produced or retained by the agency. • The UFR team will develop recommendations for the department regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody. • The UFR team will issue a report on the results of the review within 120 days (unless an extension was granted by the county manager) to the director. The director will submit its report to the county manager. The department will post the review on the department of health public website.

Incident Overview

The decedent was discovered by jail staff on January 19, 2024, at approximately 6:39 PM, during a routine safety and security check. Jail staff called a Code-Blue[1]. Officers requested the cell door to be unlocked—the control officer unlocked the door—officers had to use force to open the door. The door was blocked by the decedent's body. Officers asked for additional information to better direct the medical response. After assessing the situation, staff determined the decedent had something around his neck. Staff called a Code-14[2] for the incident location. Staff were required to use a rescue tool to cut off the ligature[3] from around the decedent's neck. Medical staff and officers initiated CPR, first-aid, applied an AED, and called 911.

EMS responded and assumed care of the decedent. EMS personnel pronounced death at 7:14 PM. Officers secured the scene. The Clark County Sheriff's Office Major Crimes Unit

[1] A Code-Blue is a potential urgent/emergent medical situation which requires a response from medical staff.
[2] A Code-14 is a suicide / attempted suicide incident.
[3] Ligature was constructed from piece(s) of decedent's underwear.

(MCU) responded along with the Clark County Medical Examiner's Office (ME) and conducted an investigation. ME staff removed the decedent at 10:05 PM.

Requested Extension

The Department of Jail Service needed an extension to complete the review. A request was sent to County Manager Kathleen Otto on May 10, 2024. Mgr. Otto approved the extension the same day.

Medical Examiner Investigation Findings

As of July 5, 2024, our department had not been notified of the ME's findings. Cdr. Clark called the ME's office for an update. ME staff informed Cdr. Clark that the investigation was complete (i.e., ME Case number: 2024-0214), and their staff recently received the toxicology report. The ME sent us a document which contained the information available to the public on this incident. The ME concluded the following:

1. Manner of death: Suicide
2. Immediate cause of death: Hanging

Unexpected Fatality Review (UFR) Committee Information

Members

1. Alan Melnick, Public Health Director (PHD) / Health Officer, MD, MPH, CPH
2. Marin Fox, Director of Cowlitz County Corrections
3. Ken Clark, Commander
4. Joe Barnett, Deputy Director of Jail Administration

Meeting Dates

1. May 30, 2024:

Meeting conducted via Zoom (telephonic) and was attended by PHD Alan Melnick, Cdr. Clark, and Dep. Dir. Barnett

2. July 9, 2024:

The meeting was originally scheduled via MS Teams. However, due to technical difficulties, the meeting was conducted via telephone. Attendees were Dir. Fox, Cdr. Clark, and Dep. Dir. Barnett.

Subjects Reviewed

Structural

The following items related to facility structure were reviewed by committee members: (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; and (f) camera locations.

Clinical

The following clinical items were reviewed by committee members: (a) relevant decedent health issues/history; (b) interactions with Jail Mental Health staff; (c) interactions with Wellpath[4] staff; and (d) relevant root cause analysis and/or corrective action.

Operational

The following operational items were reviewed by committee members: (a) supervision (e.g., security checks, and inmate request slips); (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 (i.e., first-aid, CPR, and AED); and (j) use of force review.

[4] WellPath is the jails' contract medical and mental health services provider.

General Notes

Structural

F1 is a fifteen cell, medium-security housing area with metal doors which have electric solenoid-type (i.e., clicker) locks. The decedent was housed alone on the mezzanine level, in the left corner cell. This cell is designated as F1-8. A group of F1 cells were on out-of-cell lock down rotations. F1-8 was in this group.

The cells in F1 contain two-way emergency speaker systems which are directly connected to the housing officer's control room. There is limited camera coverage of the door entrance area for F1-8. By Design, there is no camera coverage inside the cells in F1.

There were no documented lighting issues within F1 housing area, lighting .

Clinical

Clark County Jail staff responded quickly and provided emergency medical aid, Wellpath medical staff responded appropriately and provided emergency aid until relieved by higher level EMS responders. Review of Medical screening and health exams gives no indication of suicidality or request for Mental Health. Health exam was completed on the same day of the event. Wellpath Mortality Administrative Review recommended some system IT updates/changes for ease of access in reading their medical records and adding copy of charges to booking nurse screening for additional referrals.

Operational

At the time of incident corrections and medical staffing levels were appropriate to operate facility. Corrections and Medical staff provided first aid and life saving measures within policy.

Video records from incident were retained. Review of ViaPath[5] records the decedent had not made any calls or had any video visiting from January 9th, 2024, to January 19, 2024. The ligature was crafted from the decedent's own underwear.

Committee Recommendations

1. The PHD recommended adding an additional step when responding to unconscious / unresponsive patients: Jail staff should dose these types of patients with either Narcan or Naloxone due to possible drug overdose.
2. Committee members recommended that the Jail Management System (JMS) be updated to reflect the Adult-in-Custody's (AIC) death (i.e., release from computer system) after the family is notified. This action will remove the decedent's name from the publicly accessible jail roster. The intent of this recommendation is to lessen the potential angst and anguish from family and friends of the decedent.
3. Committee member recommended peer support check in with responders.
4. Committee members considered whether the department will continue to allow AICs to keep underwear. We believe it is unreasonable, and lessons human-dignity, to remove the underwear from all AICs.

Action

The policies and procedures related to these recommendations will be created and distributed within sixty (60) days of the publication of this document.

Distribution

[5] ViaPath is our contracted vendor who provides inmate services like phones, tablets, video, grievances, and request slips.

Per RCW, these findings are being sent to the Clark County Manager and WA State Dept. of Health

Footnotes

1. A Code-Blue is a potential urgent/emergent medical situation which requires a response from medical staff (p. 5).

2. A Code-14 is a suicide / attempted suicide incident (p. 5).

3. Ligature was constructed from piece(s) of decedent's underwear (p. 5).

4. WellPath is the jails' contract medical and mental health services provider (p. 7).

5. ViaPath is our contracted vendor who provides inmate services like phones, tablets, video, grievances, and request slips (p. 9).

Signature Page

_____

David Shook, Director of Jail Services

Appendix A

RCW 70.48.510 - Unexpected fatality review—Records—Discovery. (1)(a) 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. (b) 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. (c) 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. (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. (e) The city or county department of corrections or chief law enforcement officer shall develop and implement procedures to carry out the requirements of this section. (2) In any review of an unexpected fatality, the city or county department of corrections or chief law enforcement officer and the unexpected fatality review team shall have access to all records and files regarding the person or otherwise relevant to the review that have been produced or retained by the agency. (3)(a) An unexpected fatality review completed pursuant to this section is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to this section. (b) An employee of a city or county department of corrections or law enforcement employee responsible for conducting an unexpected fatality review, or member of an unexpected fatality review team, may not be examined in a civil or administrative proceeding regarding: (i) The work of the unexpected fatality review team; (ii) the incident under review; (iii) his or her statements, deliberations, thoughts, analyses, or impressions relating to the work of the unexpected fatality review team or the incident under review; or (iv) the statements, deliberations, thoughts, analyses, or impressions of any other member of the unexpected fatality review team, or any person who provided information to the unexpected fatality review team relating to the work of the unexpected fatality review team or the incident under review. (c) 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. A person is not unavailable as a witness merely because the person has been interviewed by, or has provided a statement for, an unexpected fatality review, but if the person is called as a witness, the person may not be examined regarding the person's interactions with the unexpected fatality review including, without limitation, whether the person was interviewed during such review, the questions that were asked during such review, and the answers that the person provided during such review. This section may not be construed as restricting the person from testifying fully in any proceeding regarding his or her knowledge of the incident under review. (d) The restrictions set forth in this section do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with an unexpected fatality reviewed by an unexpected fatality review team.

(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.

(5) For the purposes of this section: (a) "City or county department of corrections" means a department of corrections created by a city or county to be in charge of the jail and all persons confined in the jail pursuant to RCW 70.48.090. (b) "Chief law enforcement officer" means the chief law enforcement officer who is in charge of the jail and all persons confined in the jail if no department of corrections was created by a city or county pursuant to RCW 70.48.090.

(c) "Unexpected fatality review" means 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 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 under this section (RCW 70.48.510: Unexpected fatality review—Records—Discovery. (wa.gov)).