Unexpected Fatality Review

Pierce County Sheriff's Office

2024 Unexpected Fatality Incident # 2419301923

Report to the Legislature

As required by RCW 70.48.510

Date of Critical Incident 7/11/2024

Date of Publication 6/2/2025

Chief D. Watkins – Corrections Bureau
douglas.watkins@piercecountywa.gov

theresa stiltner – UFR Coordinator – Corrections Bureau
theresa.stiltner@piercecountywa.gov

Table of Contents

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 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.

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.

UFR COMMITTEE MEETING INFORMATION (CRITICAL INCIDENT REVIEW)

Meeting date: 7/31/2024

COMMITTEE MEMBERS IN ATTENDANCE

Coordinator		
Leslie Medved	(Former) Assistant to the Chief	Corrections Bureau
Medical / Mental Health Team		
Dr. Miguel Balderrama	Medical Director	Corrections Bureau
Karen Bier	Mental Health Manager	Corrections Bureau
Jon Slothower	RN, Health Services Administrator	Everhealth
Angela Valencia	RN, Director of Nursing	Everhealth
Ashley Valencia	RN	Everhealth
Command Staff		
Kevin Roberts	(Former) Chief	Corrections Bureau
Steve Jones	(Former) Major	Corrections Bureau
Brian Sutherlin	(Former) Captain	Corrections Bureau
Matt Dobson	(Former) Captain	Corrections Bureau
Operations Leadership		
Michele Graham	Administrative Lieutenant	Corrections Bureau
Russ Allen	Facility Lieutenant	Corrections Bureau
Nick Johnson	Facility Sergeant	Corrections Bureau
Operations Deputies		
Keila Medero	Corrections Deputy	Corrections Bureau
Mark Ramos	Corrections Deputy	Corrections Bureau
Michael Wagoner	Corrections Deputy	Corrections Bureau
Orett Watson	Corrections Deputy	Corrections Bureau
Ho Youn	Corrections Deputy	Corrections Bureau
Asif Ahmed	Corrections Deputy	Corrections Bureau

FATALITY SUMMARY

AGE: 56-YEARS OLD

DATE OF INCARCERATION: 7/10/2024

DATE OF DEATH: 7/11/2024

The deceased individual was a 56-year old man who disclosed during his initial medical screening that he was suicidal and admitted to using substances. He was booked into the Pierce County Jail by the Tacoma Police Department at 1939 hours on July 10, 2024. The defendant was booked on the charges of Criminal Trespass and LPDA (Loitering with the intent of engaging in drug-related activity). He was released by the courts on his own personal recognizance, however, prior to his release, he admitted to being suicidal and described his plans to follow through upon his release. Because of these statements, the Mental Health Manager called the Designated Crisis Responders (DCR) to assess him for involuntary detainment. Unfortunately, the individual died prior to their arrival.

INCIDENT OVERVIEW

At 1605 hours on July 11, 2024, the Unit Deputy was delivering meals when the individual came to the door, unclothed, to retrieve his tray. The individual was on suicide watch, so he did not have an issued jail uniform, however, he was asked to cover up himself up with his smock as he returned to his bed to eat. At approximately 1627, the Corrections Deputy returned to collect the meal tray and when arriving at his cell door, he was seen on his back, naked and his eyes were open. The Corrections Deputy knocked on the door several times and instructed him to move to confirm he was okay. At approximately 1629, and after no response, the Corrections Deputy called out to their partner to open the door and call a "medical emergency" on the radio. The Unit Deputies safely secured the trustees in a room and multiple responders arrived within seconds, to include the Jail Health Services (JHS) team.

The Corrections and JHS teams immediately started lifesaving measures and administered Narcan, CPR, and rescue breaths. The JHS team simultaneously applied the AED, which delivered two shocks with no change in status. Emergency response was requested at 1631 while life saving measures continued until EMS and Tacoma Fire Department (TFD) arrived at 1637. A second TFD vehicle arrived at 1639 and at this time, they replaced the jail's AED with their own. One shock was delivered but there was no change. They continued lifesaving measures until the individual was pronounced dead at 1703.

The PCSD Investigations Bureau On-Call Detective was notified of the in-custody death at approximately 1801 hours. The On-Call Detective and Forensics Specialist arrived at the jail at 1910 to begin the investigation. The Medical Examiner arrived at approximately 1923 to examine the scene. It was noted by the Medical Examiner that after a brief review of the individual's medical history that he had medical issues. The On-Call Detective, Forensics Specialist, and Medical Examiner departed with the deceased at 2009 hours.

COMMITTEE DISCUSSION

THE SCOPE OF REVIEW INCLUDED:

- Defendants complete booking file
- Defendants current and historical jail medical records
- Facility logs related to the defendant and/or incident
- All internal reports and noted related to the incident
- Detectives investigative report
- Medical Examiner's report and autopsy results

THE POTENTIAL FACTORS REVIEWED INCLUDE:

A. Structural
    a. Risk factors present in design or environment
    b. Broken or altered fixtures or furnishings

B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with Jail Health Services (JHS)
    c. Relevant root cause analysis and/or corrective action
    d. After action response

C. Operational
    a. Supervision (e.g., security checks, kite requests)
    b. Classification and housing
    c. Staffing levels
    d. Known self-harm statements
    e. Review of inmate communications (phone calls/video visits)
    f. Life saving measures taken
    g. Training recommendations

COMMITTEE FINDINGS

The committee found the overall response and handling of this unfortunate incident resulting in the loss of life was both appropriate and professional. All the tools and resources available were utilized in the efforts to preserve the life of this individual.

STRUCTURAL FINDINGS

The incident took place in a single-occupant observation cell on the 3rd floor of the Pierce County Jail. The cell had adequate lighting from the cell window, which was not covered, as well as from the ceiling light. All fixtures in this housing cell, including the emergency call button, were functional.

COMMITTEE FINDINGS – CLINICAL

At the time of the incident, this individual was under observation for suicide precautions with ongoing contact with jail mental health staff. This individual was under the care of JHS for detox protocols and did not appear to exhibit detox symptoms. Postmortem Examination Report shows Acute fentanyl and methamphetamine toxicity; Hypertensive and atherosclerotic cardiovascular disease; and Cholelithiasis. As far as the actions in response to the Medical Emergency, the JHS team did not identify issues or failure to follow policies/procedures, training, supervision or management, personnel, culture or other variables.

COMMITTEE FINDINGS – OPERATIONS

The area of this incident was fully staffed. It is reported all responding PCSD Corrections Bureau staff acted within policy. Uniformed PCSD Corrections Deputies immediately began CPR and continued its application until relieved first by Everhealth Medical Staff, then by Tacoma Fire Department medics. Review of unit logs for this housing unit was completed, and it shows welfare and security checks were done in accordance with policy.

COMMITTEE RECOMMENDATIONS

As with all reviews of critical incidents in our facility, the following requests/recommendations were made in effort to strengthen measures to maintain a safe, secure, and constitutional facility. Although we have a contract for 24/7 on-sight JHS, some of our custody staff are asking for additional CPR/1st Aid Training. ACTION: CPR Training is scheduled for 2025 for all Jail Staff. As the opiate crisis is felt across the nation, our medical team is seeing a pattern of patients coming to the facility with history of Fentanyl addiction. Fentanyl withdrawals are seemingly worse than withdrawals from heroin. ACTION: We have provided training and issued Narcan to all staff members on our Bureau.