WHATCOM COUNTY
SHERIFF'S OFFICE
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WHATCOM COUNTY SHERIFF'S OFFICE JAIL

# UNEXPECTED FATALITY REVIEW

# COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT WCSO RB-25-65658

REPORT TO THE LEGISLATURE

*Pursuant to RCW 70.48.510*

Date of Publication: July 8, 2025

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## 1) DETAINEE INFORMATION

The detainee was a 28 -year-old Native American male. He was booked into the Whatcom County Jail (WCJ) by the Bellingham Police Department (BPD) on March 16, 2025, at about 18:24 hours for Burglary 2nd, Theft 3rd, Violation DV Protection Order and a warrant for FTA Assault 4DV.

## 2) INCIDENT OVERVIEW

On March 20, 2025, at approximately about 0235 hrs., a Deputy initiated a security check on the first floor and observed the detainee in Cell 130 appearing unwell. The detainee was gasping for air, prompting the Deputy to notify the Duty Sergeant and recommend placing the detainee on 30-minute observation checks due to their observed symptoms.

Deputies entered Cell 130 to assess the detainee's condition. The detainee's pupils were dilated, their breathing was labored, and they were cold to the touch. A Deputy administered the first dose of Narcan at about 0240 hrs. Deputies assisted in moving the detainee to a mattress outside their cell to provide more space for medical intervention.

The detainee's oxygen levels were very low, prompting the administration of additional doses of Narcan at about 0241 hrs. and about 0248 hrs. Despite these efforts, the detainee's condition did not improve significantly. Their oxygen levels increased from 31% to 60% after being placed on oxygen at about 0245 hrs.

At about 0250 hrs., the first aid car arrived, and the Duty Sergeant escorted the paramedics into the facility. Paramedics took over medical care at about 0252 hrs. and began chest compressions. Additional paramedic units arrived shortly after, and life-saving measures continued until the detainee was pronounced dead at approximately about 0322 hrs.

**Actions Taken:**

- about 0235 hrs..: A Deputy observed the detainee gasping for air and notified the Duty Sergeant.
- about 0238 hrs.: The Duty Sergeant called for aid.
- about 0239 hrs.: The Duty Sergeant made the call to AID while Narcan was administered.
- about 0240 hrs.: A Deputy administered the first dose of Narcan.
- about 0241 hrs.: Second dose of Narcan administered.
- about 0245 hrs.: The detainee placed on oxygen, oxygen levels increased to 60%.
- about 0246 hrs.: The Duty Sergeant made a second call to AID due to the detainee's critical condition.
- about 0248 hrs.: Third dose of Narcan administered.
- about 0250 hrs.: First aid car arrived, paramedics escorted in.
- about 0252 hrs.: Paramedics began chest compressions.
- about 0322 hrs.: The detainee pronounced dead.

## 3) CAUSE OF DEATH

- Complications of Narcotics Withdrawal
    - Manner of Death- Natural

## 4) COMMITTEE MEMBERS

- Caleb Erickson, Chief Corrections Deputy
- James Triplett, Chief Inspector
- Tyson Hawkins, MD
- Hannah Fisk, MSW, LICSW
- Barry Lovell, Corrections Lieutenant
- Lamont Bos, Corrections Lieutenant

## 5) COMMITTEE SCOPE OF REVIEW

**A. Structural**

- **Risk factors in design or environment**
- **Broken or altered fixtures or furnishings**
- **Security measures compromised or circumvented**
- **Lighting**
- **Cameras**

**B. Clinical**

- **Relevant decedent health issues and history**
- **Interactions with jail health services**

C. **Operationa**l

- **Supervision: (welfare checks/observation)**
- **Classification and Housing**
- **Staffing levels**
- **Training**
- **Lifesaving measures taken**

## 6) COMMITTEE FINDINGS AND RECOMMENDATIONS

***Relevant root cause analysis and/or corrective action sought***

Considering the common elements involved in these types of incidents, jails must continuously seek ways to mitigate negative outcomes. The key components for preventing such incidents in the future include the following:

- **Structural**
  - Identified areas that lack sufficient security camera coverage and submit work orders for camera installation.
    - Supplemental budget request written and submitted to Chain of Command.
      - In process and ongoing.
    - Establish a procedure using comparative triage to move more acutely ill detainees closer to the booking area.
      - In process and ongoing.

- **Clinical**
  - Implement the following changes to medical processes:
    - Macro/micro dosing of MOUD.
    - Ensure level of certification/qualification of medical staff reviewing the inmate's conditions meets standards.
    - Post incident we now supply a 7-day supply of Buprenorphine meds upon release for anyone who is on MOUD protocol.
    - JMS (Jail Medical Staff) contacted to ensure we are using best practices.
    - Consider 24/7 staffed medical/nursing.
      - In process and ongoing.

  - This detainee had one kidney. Did this have any effect on the outcome?
    - According the reviewing physician, based on recent bloodwork within 2 months of this event, his kidney appeared to functioning within normal readings.

  - JMS followed nursing protocol for withdrawal.
    - However, they noted that they had serious concerns with the inmate's medical conditions. Considering this, could/should JMS have done another evaluation prior to JMS leaving for the day?
      - The Chief Corrections Deputy will discuss the implement of process with the JMS.

  - The detainee was appropriately started on symptomatic meds.
    - However, the medication administration history did not include a signature/initial line for who delivered the meds.
      - This change request has already been submitted.

- **Operational**

    - Jail logs and available video reviewed.
        - Even though video footage documents that welfare checks were completed on time and within limits on the day of the incident there is no specific video showing welfare checks of the cell in question.
            - Jail staff has submitted work orders to install additional cameras to ensure they capture the entire booking area.
        - Review log entry procedures with jail staff to improve documentation. This will be covered extensively during shift briefs, in training bulletins and annual block training.
            - In process and ongoing.

    - Improve staff training and staff training documentation
        - Due to recent events and focus on the use of Narcan, did that narrow focus limit the jail staff's ability to recognize the possibility of other possible medical events.
            - In process and ongoing.
        - Develop and implement medical emergency procedure for jail staff.
            - In process and ongoing.
        - Jail staff will ensure staff knows and follows established W/D protocols.
            - In process and ongoing.

    - Improve communication between jail staff and JMS.
        - Was jail staff appropriately aware of the severity of the detainee's conditions.
        - Jail and JMS meet regularly to discuss challenges and ways to improve communication.
            - In process and ongoing.

    - The detainee was housed appropriately based on his classification and medical recommendations, however based on the acute medical needs he should have been housed as close to the booking desk as possible.

    - Jail was staffed appropriately.

    - Jail staff and JMS followed proper lifesaving measures.

## 7) LEGISLATIVE DIRECTIVE

RCW 70.48.510 Unexpected fatality review--Records—Discovery

i) 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.

ii) 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.

iii) 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.

iv) 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.

## 8) DISCLOSURE OF INFORMATION

RCW 70.48.510(3)(c) Unexpected fatality review--Records—Discovery

i) 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.