



Pacific County

JAIL SERVICES

300 Memorial Drive | P O Box 47 | South Bend, WA 98586
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Unexpected Fatality Review Committee Report

Unexpected Fatality Incident PCJS Case # 24-021264

Report to the Legislature

Pursuant to RCW 70.48.510

Date of Publication: 10/30/2025



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1) Adult-in-Custody (AIC) Information

Decedent was a 42-year-old Caucasian male booked into Pacific County Jail on 09/30/2024 at approximately 1545 hours. During intake, the decedent denied all medical and mental health concerns. The decedent was charged with Malicious Mischief 2nd and 3rd degree and Fail to Comply (DUI). During the medical screening process, the decedent denied the use of substances or having medical needs. Decedent dies on October 7th, 2024.

2) Incident Overview

The decedent was discovered by jail staff on October 7th, 2025 at approximately 1700 hours, after being alerted by a cellmate who activated the intercom that connects to jail control. Officers requested the cell door to be unlocked – the control officer unlocked the door. Upon entry into the cell staff discovered a male subject hanging from a ligature made from towels tied around his neck. Staff removed the ligature from the neck and began immediate CPR and requested 911 be called. CPR was performed until EMS arrived at 1711 hours.

EMS responded and assumed care of the decedent. EMS personnel pronounced death at 1736 hours. Officers secured the scene. The Pacific County Sheriff's Office Major Crimes Unit (MCU) responded along with the Pacific County Medical Examiner's Office (ME) and conducted an investigation.

3) Medical Examiner Investigation Findings/Cause of Death

The ME concluded the following:

- a. Manner of death: Suicide
- b. Immediate cause of death: Hanging

4) Unexpected Fatality Review (UFR) Committee Information

Marc Stern, MD, MPH

James A. Byrd, Director of Pacific County Jail Services

Meeting Date. 1. October 8, 2025



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5) Scope of Review

A. 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.

POD 5 is a 4 cell, medium-security housing area with metal doors which have electric solenoid-type (i.e., clicker) locks. The decedent was housed alone in cell 5B. This cell is designed to house up to 2 individuals.

The cells in POD 5 contain two-way emergency speaker systems which are directly connected to the housing officer's control room. There is camera coverage of the dayroom area but not inside the sleeping area. It was noted that there is a structural design flaw with the window in the back of the cell. The window has metal bars across it and there was a gap just large enough to thread the towels through it and allow it to be tied off. This has since been remedied.

B. Clinical

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

Pacific County Jail staff responded quickly and provided emergency medical 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.

C. 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



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statements; (i) life saving measures taken (i.e., first-aid, CPR, and AED); and (j) use of force review.

At the time of incident corrections and medical staffing levels were not appropriate to operate facility. Corrections staff provided first aid and life saving measures within policy. Hourly Inmate Safety Checks were not being conducted in accordance with Policy 505. Decedent had made a suicidal statement prior that was not taken seriously nor was it acted upon appropriately. The information was not logged or passed on to any other staff members. Decedent was in possession of two towels when only one towel should be issued at a time.

6) Committee Findings and Recommendations

In accordance with RCW 70.48.510, James Byrd, Director Pacific County Jail Services ("Jail") convened an unexpected fatality review (UFR) team to review the October 7, 2024 death. The team (Director Byrd and Marc F. Stern, MD, MPH) met on October 8, 2025 to complete the review. One or both members of the team reviewed all necessary documents. This report contains all recommendations from the UFR.

Based on a root cause analysis of systems errors discovered in the death the team generated the following Findings and Recommendations for needed sustainable system changes.

Findings

- A. The Pacific County Resolution No. 2024-056 adopted on December 26, 2024 creating a Pacific County Jail Services should be amended to indicate that the jail operation was moved from the sheriff to a county service under the Board of Commissioners as a result of analysis of jail operations that led to the death.

The rationale for this recommendation is that without the amendment, the organizational memory of the reason for the change may be lost over time. This increases the risk that a future Board that was not familiar with that history might – in good faith, because jails traditionally operate under a sheriff – reverse the restructuring.



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- B. The amendment above should also direct that the Jail Director must be an individual with at least 5-years of experience as a correctional administrator.
- C. The Jail Policies and Procedures should be amended to require that jail custody staff document the details of all communications with health care personnel that concern the health condition of an incarcerated individual. If that documentation is made in the jail management records, a copy must also appear in the patient's medical record.
- D. The Jail Policies and Procedures regarding the grievance process should be amended to require that formal health-related grievances are addressed and responded to by the head of the entity providing health care services. Appeals to those grievances are addressed by the jail director who, as needed, will seek clinical input from a resource other than the entity providing health care services.
- E. The Jail Policies and Procedures should be amended to require (and the County should fund) the jail director to engage the services of a physician, other than the entity providing health care services to the jail, to review the quality of health care provided to incarcerated individuals. Such review should be conducted no less frequently than quarterly.
- F. Generally, officers should never fail to fulfill a task asked of them by a licensed health care professional for the care of an incarcerated individual. However, the Jail Policies and Procedures and corresponding initial and annual training curricula for officers should be amended to empower officers to do *more* than what is requested of them by a health care professional if, in the reasonable lay judgement of that officer, such action is necessary in the best interest of the incarcerated individual. If time permits, the officer should escalate the proposed action through the appropriate chain of command. However, if time is of the essence, any officer should be empowered to take action to provide necessary care. Commonly, the action at hand is evacuation of the patient to a hospital. The training curricula should include table-top exercises that simulate scenarios in which officers must make such decisions.



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- G. The Jail Policies and Procedures and corresponding initial and annual training curricula for officers should be amended to require officers to conduct timely checks on the welfare of incarcerated individuals.
- H. The Jail Director has already made the maximum degree of improvements to the system of health care delivery that existed at the time of the death given the current budget and operational structure of the jail. Additional improvements or changes to the operation of the jail, however, are required to ensure *a minimal level of patient safety to prevent future deaths*. In other words, the current improvements are necessary, but not sufficient.

Recommendations

Option 1: Presence of a registered nurse (RN) at the jail 24/7; presence of a medical practitioner at the jail 5 days per week; availability of a medical practitioner on-call at all other times; presence of a licensed mental health professional (masters-level or higher) on site 5 days per week as needed and available on-call at all other times. Availability of a mental health prescriber (psychiatrist, mental health nurse practitioner, mental health physician assistant) on-call 24/7.

Option 2: Immediate transport (upon booking or when they meet the following criteria) of any incarcerated individual who has the potential to develop, or has developed, any medical or mental health problems, to another jail with the resources to safely care for the individual or to the hospital, as appropriate.

Option 3: Cease jail operations and contract to house Pacific County arrestees in a regional or other county jail with the resources to safely care for incarcerated individuals.

7) Legislative Directive

RCW 70.48.510 Unexpected fatality review--Records—Discovery



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- 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



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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.