UNEXPECTED FATALITY REVIEW

Walla Walla County Jail

Incident Date: March 24, 2023
Team convened: July 12, 2023

LEGISLATIVE INTENT

RCW 70.48.510 Unexpected Fatality Review (UFR)

Fatality Review Team (Team):

1. Comprised of individuals with appropriate expertise.
2. Individuals whose professional expertise is pertinent to the dynamics of the case.
3. Individuals who had no previous involvement in the case.

Development of Recommendations:

1. Regarding changes in practices or policies
2. Prevent fatalities.
3. Strengthen safety and health protections.

Report, Timing, and Distribution:

1. Analysis of the root cause or causes of the unexpected fatality.
2. Associated corrective action plan that provides recommendations that address the identified root cause.
3. Completed within 120 days unless an extension is granted.
4. Copy provided to:
   a. The governing unit primarily responsible for operation of the jail.
   b. The appropriate committees of the legislature.
   c. The Department of Health's public website after confidential information is redacted consistent with the requirements of applicable state and federal laws.

Records and Documentation:

1. Team shall have access to all records and files regarding the person.
2. Team shall have access to otherwise relevant records and files that have been produced or retained by the Walla Walla County Jail.

Confidential List of Involved (redact page from final report, if permissible)

Decedent – [redacted]
Physician Assistant – Nadean Pulfer, PA Blue Mountain Heart to Heart
Nurse - Esmeralda Reynosa RN
Medical Assistant – Ramona Moreno – Medical Assistant, Walla Walla County Jail
Sergeant – Sgt. Edgar Aguilar, Walla Walla County Jail
Second Floor Officer – Officer Jake Nunan, Walla Walla County Jail
Booth Officer – Officer Jabe Corier, Walla Walla County Jail
Deputy Commander – Deputy Commander Keri Weber, Walla Walla County Jail
Director – Director of Corrections Norrie Gregoire, Walla Walla County Jail
Patrol Officer – Officer Silva, Walla Walla Police Department
Hospital – St. Mary Medical Center (SMMC)

Fatality Review Team

Dr. Radha Sadacharan, Idaho Department of Corrections
Commander Shawn Davis, Stevens County Jail
Commander Scotty Anderson, Whitman County Jail

The incident involves an inmate who died of an overdose within a couple hours of arrival the jail. The selected members of the team have expertise that is pertinent to an overdose death case.

The team brings both understanding and expertise in all aspects of the operation of a corrections facility to include training, policies, and emergency responses. In addition the team has knowledge in emergency medical care, human physiology, and pharmacology. None of the members of the team had any involvement in the case prior to being asked to be members of the Fatality Review Team.

Development of Recommendations:

Training Recommendations:
Develop a standardized field training process for custody staff. It appears each employee had a different training process. Topics relevant to medical emergencies should be included in field training.

Ensure all staff members, custody and medical, participate in emergency medical response drills. If this is possible ensure it is done annually, perhaps in conjunction with First Aid/CPR training, it will allow staff to respond quickly and effectively to emergency medical needs. Simulations should include retrieving and utilizing the AED and other emergency supplies. Emphasis should be placed on starting chest compressions immediately if there is not a palpable pulse or signs of circulation (depending on the CPR training provided).

Equipment Recommendations:
The equipment recommendations below have already been addressed by the facility.

AED location and visibility: After the incident it was ensured that AEDs were visible, and that staff were briefed on their locations.

Naloxone access: It is noted that the first two doses were easily accessible but the location was not known to every employee at the time. After the incident, all staff members started to carry intranasal naloxone on their person. Extra doses of Narcan are available in the medical room and in the emergency medical bags.

Emergency medical supplies: Ensure jump kits contain all necessary patient assessment tools, supplies for airway management, trauma, and personal protective equipment. Ensure the crash cart is appropriately stocked based on the level of medical care that staff are trained to provide. These emergency supplies should be routinely checked and stocked, with a checklist of included supplies available in each resource. Dr. Sadacharan reviewed the equipment during the Team's on-site visit and provided feedback for additional supplies.

Report, Timing, and Distribution:

Report

Decedent Information

The Decedent was a 35-year-old male with a history of polysubstance use disorder, including methamphetamines and opioids, incarcerated at the Walla Walla County Jail.

Event Background

On 032423 at approximately 0622 hours the Decedent was arrested by Walla Walla Police Officer for a felony warrant out of Walla Walls County and was transported to the Walla Walla County Jail. A wound was noted by jail staff and the Decedent was taken to the Hospital for evaluation of the injury by the Patrol Officer. Of note, the decedent had been seen in the same emergency room the night before, and at that visit he was given a RCW 70.02RCW 70.02 in the emergency room and discharged. The timing of administration or dosage of the RCW 70.02 is unclear.

The Hospital treated the injury to the Decedent's toe the morning of March 24th, 2023, noted concern for active substance use in documentation. No labs were obtained at this time. He was medically cleared and released into police custody, and was transported back to the jail at approximately 0750 hours.

Approximately an hour after returning from the Hospital, custody personnel noted the Decedent was having trouble answering basic medical questions. During medical background questioning the Decedent was not answering questions appropriately. One such example includes when the Decedent was asked if he had any head injuries. He responded "Yes, I want a blanket". He was noted as having a difficult time standing still and keeping his balance. During the photographs he was seated in a chair. A couple officers were needed to complete the fingerprints due to his physical limitations at that point in time.

While in Hold Cell 6, video showed the Decedent constantly moving and fidgeting. He did not appear coordinated in his movements and had fallen down on more than one occasion. He also spent time picking at the injury on his toe.

Sergeant later saw Decedent's arms out to their sides and could hear loud breathing. At approximately 0952 hours, Sergeant checked the Decedent when he saw a finger barely moving. Sergeant couldn't find a pulse. He then listened to the Decedent's chest. Sergeant called for medical staff to respond and for an ambulance.

Event Response

At 0954 hours Second Floor Officer heard a radio call from Sergeant to get medical staff and Narcan. Narcan was retrieved and administered. Booth Officer stated there was no reaction to the first spray of Narcan. Additional doses were retrieved and administered. A total of 32mg of naloxone was utilized, and chest compressions were initiated by the RN at the scene. Booth Officer was sent to get a face mask to perform CPR, and had a difficult time locating the shield.

Second Floor Officer went into the Med Room, which is on the second floor of the jail, looking for Narcan. Medical Assistant went with Second Floor Officer to Holding Cell 6 on the first floor. Medical Assistant took over chest compressions from the Nurse who had already started to perform chest compressions. Medical Assistant continued compressions until EMS took over upon their arrival.

EMS continued to perform lifesaving efforts and transported the Decedent to the hospital where he was pronounced dead by an ER physician at 1049 hours.

Autopsy and Toxicology

The autopsy report was reviewed, with positive findings for RCW 68.50.105 [redacted], RCW 68.50.105 [redacted]) in peripheral blood, obtained on March 29th, 2023.

Analysis of the Root Cause

This case highlights the need for comprehensive and timely access to a higher level of care for jail patients, and must include excellent communication.

As jails across the country experience sicker individuals in their custody, in small and rural jails especially, the reliance on a local community health system necessitates direct lines of communication, and definitions of both the care needed for the patient and the care that can be provided in a specific jail setting.

For local hospitals, the term 'medical clearance' may have different meanings to different providers, and is fully dependent on the level of care that the receiving custody setting can accommodate. For this reason, if a request for medical clearance is presented to a local hospital by law enforcement, this request needs to be clearly defined, and informed by the level of care that is available at the receiving custody setting. Definitions may be provided in the form of jail policies, information sent outwith patients to the hospital, and/or through verbal communication between healthcare providers. Additionally, assessing healthcare provider to custody healthcare provider communication should occur in real-time, to relay concerns, confirm care needed, and close the loop.

Finally, with regards to emergency services within the jail: again, as jails across the country experience sicker individuals in their custody, the need for emergency medical response has risen significantly. The facility staff, when it was discovered there was a medical emergency, responded quickly. Narcan was utilized by security, CPR was initiated by medical, and EMS was called. The staff, both security and medical, at Walla Walla County Jail are compassionate and have good training and excellent leadership.

Corrective Action Plan Addressing Identified Root Cause

Realistically speaking, people of all walks of life are incarcerated, including those who are intoxicated. The facility cannot stop people from getting themselves intoxicated while outside of the jail, but staff needs to do what it can to stop additional intoxication from happening after arriving. This means thorough searches of the person and property. Utilizing body scanners can also help reduce concealed drugs from entering the facility. This action plan is not based on any discovered short-coming of the facility or its staff, it is acknowledging the difficulties when balancing incarceration with intoxication.

Foster an environment that allows for better communication between outside medical providers, law enforcement, and corrections officers. Build the rapport and trust between the facility and outside medical providers so that open lines of communication exist. Provide specific concerns to outside medical providers for those inmates being seen. Ensure those specific concerns are addressed in any returning medical documentation.

The facility is actively working to improve communication and cooperation between the outside medical facilities and the facility. I believe the facility will continue to work on strengthening communication.

Consider a policy that treats those with obvious intoxication and impairment, whether drugs or alcohol, as high-risk inmates who need closer supervision while detoxing. This may include use of more frequent observations, in-person welfare checks, and/or technology that will continuously monitor and report vital signs.

Timing and Distribution

The report timeline included two extensions. The first was due to the length of time between the event and gathering information from toxicology and autopsy. The second was to provide time for the Fatality Review Team to review all available information.

The distribution of this report is beyond the scope of the Team. This report will be provided to Walla Walla County Jail administration who will be responsible for distribution of the report to:

a. The governing unit primarily responsible for operation of the jail.
b. The appropriate committees of the legislature.
c. The Department of Health's public website after confidential information is redacted consistent with the requirements of applicable state and federal laws.

Records and Documentation:

The Fatality Review Team was provided access to all records and files regarding the Decedent as well as access to other relevant records and files that have been produced or retained by the Walla Walla County Jail. All requests for records and files were fulfilled by Walla Walla County Jail administration.

Signatures:

The undersigned Unexpected Fatality Review team members concur with the findings within this report. They respectfully submit this report to Director of Corrections Norrie Gregoire, Walla Walla County Jail.

Digitally signed by Radha Sadacharan
Date: 2023.10.20 19:32:05 -06'00'

Dr. Radha Sadacharan, Idaho Department of Corrections — Date

Shawn Davis — 10/23/23

Commander Shawn Davis, Stevens County Jail — Date

102023

Commander Scotty Anderson, Whitman County Jail — Date