UNEXPECTED FATALITY REVIEW

Walla Walla County Jail

Incident Date: December 27, 2024
Team convened: February 3, 2025

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.

Fatality Review Team

Commander Scotty Anderson, Whitman County Jail
Sergeant Dirk Kivi, Kittitas County Jail
Coroner Annie Pillers, Whitman County

The incident involves an inmate who died of asphyxia due to hanging by ligature. The selected members of the team have expertise that is pertinent to a death by ligature death.

The selected members of the team have expertise with:

- Death by ligature
- Death by suicide
- Emergency response/medical interventions
- First-line supervision of corrections officers
- Jail operations
- Jail policies and procedures

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:

Changes in practices or policies

Create a policy or post order to cover how officers should respond to emergency buttons.

Create a policy or post order about approved methods to stop people from misusing the emergency button.

Update the inmate handbook to cover methods to contact an officer about immediate needs that are non-emergent (i.e. PIN issues).

Walla Walla updated a practice to enter each unit during every round. With this change inmates will have more immediate access to corrections officers for handling routine, non-emergency communication issues and other problems. This also allows corrections officers to better check each unit for safety and security concerns. In addition, jail administration also enters each unit at least once each week which allows inmates direct unfiltered access to jail administration.

Prevent fatalities

Provide inmates with suicide prevention resources, such as access to 9-8-8. Walla Walla County has started on this process by offering their inmate handbook on all kiosks and tablets. This allows quick access to some of the resources available to inmates.

Utilize shorter cords on telephone and kiosk systems. This change was made by Walla Walla County immediately after the event. This change will remove the probability that someone uses a cord as a ligature.

Strengthen safety and health protections

Make sure inmates are instructed that officers and medical staff are trained and available to assist inmates in crisis.

Provide inmates an anonymous way of reporting concerns of fellow inmates who have expressed suicidal ideation.

Make it a practice that officers report safety issues to maintenance by submitting work orders.

Walla Walla should ensure all corrections officers have current CPR and AED training. Walla Walla County has already completed this recommendation holding training sessions with all employees of the jail this year.

Walla Walla provided the corrections officers with a peer support team from the Walla Walla state penitentiary who provided resiliency support to the corrections officers. This is a crucial step with helping them process this traumatic event.

Report, Timing, and Distribution:

Report

Decedent Information

The decedent was a 23-year-old female who had a history of substance abuse most recently self-reported fentanyl use. She was arrested on Walla Walla warrants in the neighboring county of Benton on 12/22/24 and booked into the Benton County Corrections Facility. On 12/23/24 at approximately 2225 hours there was a disciplinary incident with an officer assault, at which time the decedent made a statement "I feel like I want to kill myself". She was then transferred to Walla Walla County Jail the next afternoon and booked in.

Incident Overview

On 12/24/24 at approximately 1336 hours the decedent was transferred to Walla Walla County Jail on two felony warrants for failing to appear in court. She was escorted from the transport vehicle into the facility and processed for booking. Interactions with booking officers were similar to prior incarcerations at the Walla Walla corrections facility and she was compliant throughout the process. At that time, she exhibited no self-harming behavior and denied having any thoughts of killing herself or anyone else. There appears to be no reporting to the Walla Walla County corrections officers, of the statement made during the disciplinary incident that took place at the Benton County correction facility. The booking process was completed, and she was moved to female housing within the facility on the second floor at approximately 1728 hours.

Over the course of the following days of 12/25/24 and 12/26/24 the decedent had several other females housed within the same unit.

On 12/27/24 between approximately 1945 hours and 2105 hours, the decedent was the only inmate house in the unit. The decedent utilized the call light button four times. Officers reset the button three times - at approximately 1955 hours, 2029 hours, and 2105 hours. This is a button when pressed alerts officers on the floor with an audible noise and flashing light that can be observed in the hallway of the second floor. At the same time an alert is signaled in the facility control room. Having this button provides the inmate with the ability to alert officers of an emergency. It should be noted that the audible alert noise for the women's housing unit (C Block) was not functioning at this time according to 0fficers when interviews were conducted on site.

Contact was made by the second-floor officer with the decedent stating that she was having issues with her phone pin. The pin is used in the facility phone system to allow inmates to make individual calls under their specific account. Officers attempted to reset and reopen her account to help with the issue. It should be noted that officers observed her using the phone system earlier in the day and had logged calls of conversation made via their phone provider for the facility. When she had used the phone earlier, she was observed in a seated position, directly beneath the kiosk phone conversing. This was observed by the on-duty sergeant who was working in the control room.

At approximately 2105 hours the second-floor officer is observed resetting the call light at the unit's control box. Officers stated the reset for each call light button is outside of the cell block where the button was pressed. The only way to reset the call light is by personally responding to that cell block and using a key to perform the reset. After the call light is reset, the notification light is turned off and

the alert sound is silenced. Because the C Block audio alert sound did not produce audio, the reset function only served to turn off the notification light.

The decedent can be observed stepping into her cell then coming back out after the officer is gone. At approximately 2109 hours, the decedent appears to have hit the call light again yelling "Hello". She can be observed banging on the exterior hallway cuff port until the sergeant on duty communicated with her via the intercom from control. She yells something to the effect her phone isn't working on her tablet. She continues to yell towards the intercom stating, "it's not working." From interviewing the sergeant regarding this interaction, it was explained to her that the issue would have to be addressed during business hours by the administrative staff as they had done all they could with the access they had.

Appearing frustrated, the decedent can be seen moving to the unit's regular phones on the shower side of the unit and taking the receiver and banging it repeatedly. She then takes the phone receiver and appears to try and wrap the cord around her neck at approximately 2112 hours. However, the regular phone cord is not long enough. She drops the phone and proceeds to the opposite side of the unit where the kiosk phone unit is mounted on the wall. The kiosk, which has an interactive screen also has a longer cord with the phone receiver. It should be noted that the call light button was still activated even though the initial response had been received by control. The decedent then takes the kiosk phone cord and wraps it around her neck looking out towards the exterior hallway. She then slowly crouches down with the cord still wrapped around her neck at approximately 2113 hours.

Shift change occurred at approximately 2130 hours, and officers began their nightshift head count. This included going through the whole facility and accounting for every inmate. At the start of this the two officers on duty that where conducting the head count knew of the female housing unit call light button being on. Information passed on from the previous shift indicated that the light was activated regarding a PIN issue that had been addressed multiple times already. Reference above the conversation the previous sergeant had via the intercom.

As the officers proceeded to the second floor they were notified via the control room of a second call light on the opposite side of the second floor. Knowing that the other unit had known medical issues officers prioritized the response to this light first before proceeding systematically down the hall arriving at the female unit at approximately 2142 hours.

Officers observe the decedent sitting upright under the kiosk through the mod door window. Opening the door officers see the phone cord wrapped around her neck and reach to remove it. They move the decedent away from the wall, so she is laying flat. They began to attempt to locate vitals, with no vitals found. One officer begins performing CPR while the other is directed to get the AED located on the second floor. Lifesaving efforts continue by officers until EMS arrived at approximately 2147 hours, at which time EMS continued resuscitative measures.

At 2229 hours Paramedics declared the decedent deceased.

Cause of Death

An autopsy was performed on Wednesday 1/1/2025 at the direction of the Walla Walla County Coroner by forensic pathologist Dr. Allison Hunt. The cause of death was asphyxia due to hanging by ligature. The manner was suicide.

Analysis of the Root Cause

1) The act of suicide was made in a very short period of time after the conclusion of the phone call that had an unfortunate outcome. It was an extremely abrupt decision, with a hastily devised plan, and an immediate onset which left no realistic opportunity for officers to intervene.

2) The department's policy manual is very large and challenging for experienced officers to understand. Although it covers a wide variety of subjects, it doesn't have a policy for responding to and handling call lights, leading to varied responses to call buttons by officers

3) Corrections submitted a Repair Order to fix the audible alert for C Unit on September 22, 2022; it was closed on October 3, 2022. No notation was given in the work order. However, the audible tone that is part of the emergency call button system was not operating.

Discussion

Root Cause 1

The decedent placed several phone calls before reaching someone. The conversation lasted several minutes in which the inmate was given a stream of bad news. The inmate spoke to officers via an intercom system and did not ask for any assistance other than wanting help logging in to a tablet device. This, together with previous interactions with officers, did not put any officer on notice that she may have been in serious distress.

Within a short period of time the inmate went from wanting access to login a tablet device to attempting to use a telephone cord as a ligature device. The plan was clearly hasty because the first telephone she attempted to use had a cord that was too short. She then tried another handset and cord attached to the kiosk. Just prior to utilizing the longer phone cord she looked out the windows of the unit.

Root Cause 2

Policies and practices largely go hand in hand, and it is important to recognize and utilize practices in the daily operations of a jail. Policies and Procedures also have an important role within a correctional facility. The policy manual is approximately 547 pages long, not including attachments. No policy was located which covers how officers are expected to respond to call light activations.

Post orders are also available, which help officers prioritize important topics for fulfilling daily duties and tasks. However, the post orders did not include instructions about responding to and handling emergency call lights.

The call light is referred to as both a call light and an emergency call button in the inmate handbook. The practice that call lights are to be treated as an emergency was universally known by each officer who was interviewed. The response, however, to the call light differed between officers and supervisors. Each officer had their own perception of how to respond, the timeliness of the response, and what was expected during the response.

The inmate handbook contains a list of published rules. No rule covers using the call light in a non-emergency situation. The three times the call light/emergency call button is mentioned in the handbook

are in areas instructing the inmate to utilize the button during medical emergencies, in sexual abuse and harassment prevention, and in the section dealing with emergencies.

The inmate handbook describes communication with staff via a list of different kites. It says they will be answered within seven days. There are no instructions to inmates on how to communicate with an officer outside of the call light and using a kite. To use a kite the inmate must be able to get on a kiosk, but if they are not able to login to the kiosk, there isn't a method described in the inmate handbook about how to get information to log into the kiosk. This leaves the inmate with no instructions about how to speak to an officer in a non-emergency situation.

Root Cause 3
At least one attempt was made to fix the emergency button system. It should include both a light and an audible sound. These are not reset until the officer addresses the situation at the cell block. An audible alarm provides a constant reminder to the officer about the call button activation and encourages the officer to respond in order to get it reset.

Corrections submitted the work order. It was not fixed by maintenance. The printout provided from the work order system had no notes explaining why it was not fixed. Any part of an emergency system should be considered a high priority. This work order had a priority of "Low". Although the officer said "We need it fixed", it wasn't.

Corrective Action Plan Addressing Identified Root Cause
Root Cause 1
People are going to get bad news and there is nothing a correctional facility can do to stop various kinds of bad news received by an inmate while communicating with family and friends. Because the time between receiving bad news and potential self-harm may be incredibly short, correctional facilities must help educate all inmates to resources at their disposal prior to making these tragic decisions.

Each jail facility has a number of resources that can be called upon to help inmates in crisis. Examples of such programs at various jails include: corrections officers, inmate peer support groups, chaplain programs, mental health professions, and medical staff to name a few.

We encourage this facility to look at its resources that are available. Once identified, inmates must be made aware that these resources are available and the inmate needs to understand how to obtain help from these resources. This information should be available on postings within the unit as well as in the inmate handbook. Just as individuals on the outside of a facility have the ability to call a suicide helpline such as 9-8-8, the inmates need to know they can reach out for similar help.

The department's policy and procedure manual stated "Any Suicide attempt is a medical emergency". Make sure all inmates know that officers will treat an inmate in a suicidal crisis as an emergency and will provide needed resources to help the inmate.

Root Cause 2
Utilize the policies and procedures, post orders, administrative memo, or some other available option within the facility to define and explain what is expected when a call light is activated and what actions are required to meet those expectations. Rely on the sergeants to ensure officers understand and follow these expectations.

Along with expectations, look for ways to provide some relief to the officers when an inmate causes undue hardship due to improper use of the call light. During interviews, we learned of one method that was utilized.

Root Cause 3
The jail administration should encourage any officer or supervisor to report an emergency system that is not correctly functioning. Provide guidance for completing a work order to include as much detail as possible. Also include why the emergency system is important. The audience of a work order system may not understand how important the system is to a safe and secure jail. Any such request should not be a "low" priority within the work order system.

Timing and Distribution
The report timeline was completed within the 120 day timeframe with no extensions.

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.

Within the records provided by Walla Walla included documentation of an after-action review that included all entities involved in this event. Those entities included the fire department, sheriff's office, administration, coroner's officer, and all corrections officers involved. This process is important and provided a number of takeaways to help with strategies in future events.

Signatures:

The undersigned Unexpected Fatality Review team members concur with the findings within this report. They respectfully submit this report to Commander Steven Barker, Walla Walla County Jail.

Commander Scotty Anderson, Whitman County Jail — Date: 041725

Sergeant Dirk Kivi, Kittitas County Jail — Date: 4/21/25

Coroner Annie Pillers, Whitman County Coroner's Office — Date: 04/21/2025