Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 23-2333

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: January 5, 2024

Contents

Inmate Information

The inmate was a 38-year-old male booked into the Snohomish County Sheriff's Office Corrections Bureau on September 6, 2023, at 03:12 hours. Prior to being booked into the jail, the subject's backpack and belongings were searched by Mukilteo PD. The officer found a small plastic container with a white powdery substance. The substance was NIK tested at the Mukilteo PD and resulted a positive test for fentanyl. The subject was transported to the Snohomish County Sheriff's Office Corrections Bureau. A medical assessment was administered by the jail's medical staff. The inmate was in possession of fentanyl and paraphernalia at the time of arrest, so a strip search was conducted. A medical detox watch was initiated by a nurse.

Incident Overview

On September 7, 2023, the Nurse and Corrections Deputy assigned to the Medical Housing Unit (MHU) were conducting vital checks. The Medical Housing Unit has an inmate capacity of fifty inmates with one Corrections Deputy and a Nurse. At approximately 06:45 hours, the inmate was in his cell and when asked to cooperate with vital checks, he verbalized his refusal to medical staff. There were two additional inmates housed with this inmate. The decision was made to finish vital checks on the rest of the inmates and then return to this inmate and try again. At approximately 07:49 hours, the Corrections Deputy went back to the inmate's cell and discovered the inmate was unresponsive. The Corrections Deputy immediately called for a medical emergency using the portable radio system and began lifesaving measures; (CPR). The nurse administered multiple doses of Narcan. While attempts to resuscitate the inmate were in progress, additional medical and corrections staff arrived, 911 was called and aid requested.

At approximately 08:07 hours Everett Fire Department arrived and continued lifesaving efforts for the next twenty-seven minutes before pronouncing death. The Everett Fire Department aid crew members left the housing unit at approximately 08:34 hours. In order to protect the integrity of the investigation, the scene was preserved pending an investigation from the Snohomish County Sheriff's Office Major Crimes Unit. The Snohomish County Sheriff's Office (SCSO) was called to the scene, which is standard for any in-custody death. Major Crimes Unit (MCU) arrived at approximately 09:15 hours to initiate an investigation.

The Snohomish County Medical Examiner's Office completed their investigation on December 06, 2023, and their autopsy report lists the cause of death as "Arteriosclerotic cardiovascular disease" and lists the manner of death as natural.

UFR Committee Meeting Information

Meeting date: December 14, 2023

Committee members in attendance

Snohomish County Corrections Bureau Command Staff
- John Flood, Bureau Chief
- Alonzo Downing, Major
- David Hall, Detention Captain
- Robert Ogawa, Special Operations Captain

SCJ Medical, Jail Health Services
- Amanda Ray, Health Service Administrator
- Stuart Andrews, Medical Director

County Risk Management
- Matt Erickson

County Prosecuting Attorney
- Geoff Enns

Committee Discussion

The potential factors reviewed include:

A. Structural
   a. Risk factors present in design or environment
   b. Broken or altered fixtures or furnishings
   c. Security/Security measures circumvented or compromised
   d. Lighting i.e., Layout of incident location
   e. Camera locations

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

C. Operational
   a. Supervision (e.g., security checks, kite requests)
   b. Classification and housing
   c. Staffing
   d. Video review if applicable
   e. Presence of contraband
   f. Training recommendations
   g. Inmate phone call and video visit review
   h. Known self-harm statements
   i. Life saving measures taken

Committee Findings

Structural

The Snohomish County Corrections facility is a seven-story structure capable of housing 1,050 inmates. Currently there are 154 Corrections Deputies on staff. On the day of this incident, there were five hundred twenty-eight inmates in the facility. The incident took place in the medical housing unit cell at the Snohomish County Sheriff's Office Corrections Bureau. The unit had adequate lighting, a functioning emergency call button and no known or reported broken or altered fixtures.

There are several surveillance cameras that capture the booking, processing, movement through the facility and eventually housing of the subject. The cell the inmate was housed in lacked any in-cell camera. The Snohomish County Jail (SCJ) is in negotiations with a vendor to upgrade the security system in 2024 which will include a camera in every cell inside the Observation Unit.

It is noted that the SCJ booking area is equipped with a Tek-84 body scanner which can be used to scan incoming inmates, even in cases where strip searches are not permissible by law. Refresher training on the proper use of the Tek-84 body scanner was provided to staff in the fourth quarter of 2023. The body scanner was functional and was used to scan the subject in this incident.

Clinical

A registered nurse (RN) was in the module at the time of the incident. The nurse was conducting routine vital checks. The subject was found unresponsive, not breathing, and without a pulse. The module deputy radioed for a medical emergency and immediately began lifesaving measures. Medical and Corrections staff responded and assisted with lifesaving measures. The inmate had an extensive history of fentanyl, heroin, methamphetamine, and tobacco abuse with multiple past hospitalizations for accidental overdoses and opioid withdrawals. The Medical Examiner's autopsy report lists the subject died from arteriosclerotic cardiovascular disease.

Jail Health Services (JHS) did not identify issues or problems with policies/procedures, training, facilities/equipment, supervision/management, personnel, culture, or other variable in JHS related to the death.

Operational

The area of this incident was fully staffed and all responding SCJ staff acted within policy. SCJ uniformed staff and Jail Medical staff were present when the subject was discovered not breathing and without a pulse. Lifesaving measures continued until staff were relieved by Everett Fire Department medics. Security checks were conducted timely and in accordance with policy.

Committee Recommendations

-Signed Medical Waiver initiated when an inmate refuses treatment.
-Cameras added inside and outside of the cells in Observation Unit (OU).

Legislative Directive
Per RCW 70.48.510

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