Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2024 Unexpected Fatality Incident 24-1130

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: October 18, 2024

Contents

Inmate Information

The in-custody subject was a 51-year-old male who was booked into the Snohomish County Jail on May 17, 2024, at 0731hrs. The subject was booked on protection order violation (assault). A strip search was conducted at booking as he was found in possession of drug paraphernalia at the time of arrest. A urinalysis (UA) test was conducted which detected the presence of fentanyl, methamphetamine, amphetamine and MDMA. The subject was assessed by medical, and he was placed on a medical detox watch at the time of booking.

Incident Overview

At approximately 1450 hours on May 20, 2024, the male subject was housed in a double occupancy ADA cell located in one of the jail's high/medium security housing units. At that time the corrections deputy assigned to this housing unit heard noise coming from the cell the decedent was housed in. The decedent told the deputy that he had fallen. The deputy immediately called for medical to come evaluate the subject. The responding nurse spoke with the decedent and began evaluating him. At approx. 1457hrs the nurse told the deputy to call a medical emergency. Corrections deputies and medical staff immediately responded to assist, and medical staff called 911 for fire and aid to respond. At 1507hrs Fire and aid (Everett Fire Dept.) arrived. As fire and aid were evaluating the subject, he suddenly became un-responsive. Fire and aid applied an AED and at 1509hrs EFD began lifesaving measures (CPR). EFD continued life saving measures until 1544 when they pronounced the subject deceased.

The scene was preserved pending an investigation by law enforcement. The Snohomish County Sheriff's Office (SCSO) patrol division was called to the scene, which is standard for any in-custody deaths. SCSO deputies arrived in the housing unit at 1719 hours. SCSO deputies contacted the Major Crimes Unit (MCU), who responded at approximately 1801 hours to initiate an investigation.

The Snohomish County Medical Examiner's Office autopsy report lists the cause of death to be "post-seizure cardiac arrest" and lists the manner of death as "accident."

UFR Committee Meeting Information

Meeting date: October 9, 2024

Committee members in attendance

Snohomish County Corrections Bureau Command Staff
- Alonzo Downing, Bureau Chief
- David Hall, Major

SCJ Medical, Jail Health Services
- Amanda Ray, Health Services Administrator
- Stuart Andrews, Medical Director
- Robert Wamukoya, ARNP

County Risk Management
- Sheila Barker
- Matt Erickson

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
   e. Layout of incident location
   f. 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 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 statements
    i. Life saving measures administered

Committee Findings

Structural

The incident took place in a double occupancy ADA cell style housing unit on the F-floor of 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. There was no camera located inside the cell.

The SCJ booking area is equipped with a body scanner which can be used to scan incoming inmates, even in cases where strip searches are not permissible by law. The body scanner was functional and was used to scan the subject in this incident at the time of booking.

Clinical

The subject was positive for the presence of fentanyl, methamphetamine, amphetamine and MDMA in his system at the time of booking. The module deputy was alerted by the inmate and called for a medical response. Corrections medical staff responded to the module immediately to evaluate and provide medical care. Everett Fire Department medics arrived and applied an AED. The

subject became un-responsive and EFD began life saving measures. Despite continued interventions, the subject was pronounced deceased at 1544 hours. The medical examiner determined as indicated in the autopsy report, that the cause of death was “post-seizure cardiac arrest.”

Jail Health Services 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. Adequate SCJ uniformed staff and jail medical staff were present to assist with life-saving measures (CPR, rescue breathing) if needed. Everett Fire Department medics responded timely, applied an AED and performed CPR immediately after the subject became unresponsive. Security checks were conducted timely and in accordance with policy.

Committee Recommendations

None

Additional information

This publishing of this report was delayed beyond the required 120 days for it to be completed, due to delays in receiving the autopsy report from the Medical Examiner’s office. Prior to the report being overdue, the appropriate Snohomish County authorities were advised of the delay and agreed to an extension.

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.