Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 23-2794

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: February 15, 2024

Contents

Inmate Information

The inmate was a 38-year-old male booked into the Snohomish County Sheriff's Office Corrections Bureau February 10, 2023, at 0520 hours. The inmate was stripped searched at booking due to having drugs and drug paraphernalia on his person during his arrest. There was nothing found as a result of the strip search. A urinalysis (UA) test was conducted which detected the presence of methamphetamine and cocaine in his system. He was medically assessed by Corrections nursing staff and placed on a medical detox watch.

Incident Overview

At approximately 1110 hours on October 25, 2023, the male subject was alone in his assigned cell located in the jail's F-1 housing unit. As a Corrections deputy was supervising the lunch time meal service, the adult male was located unresponsive inside his cell. Corrections staff immediately called a medical emergency and began lifesaving measures (CPR). Attempts to resuscitate the inmate were unsuccessful.

Everett Fire Department arrived at 1121 hours and continued lifesaving measures. The aid crew pronounced the time of death at 1151 hours. All aid crew members left the housing area at approximately 1152 hours. The scene was preserved pending an investigation by law enforcement. The Snohomish County Sheriff's Office (SCSO) was called to the scene, which is standard for any in-custody death. SCSO deputies arrived in the housing unit at 1218 hours. SCSO deputies contacted Major Crimes Unit (MCU), who responded at approximately 1319 hours to initiate an investigation.

The Snohomish County Medical Examiner's Office autopsy report identified the cause of death to be "Acute fentanyl intoxication" and the manner of death "accident."

UFR Committee Meeting Information

Meeting date: January 18, 2024

Committee members in attendance

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

SCJ Medical, Jail Health Services
- Amanda Ray, Health Services Administrator
- Stuart Andrews, Medical Director
- Debbie Bellinger, Nursing Supervisor

County Risk Management
- Tracie O'Neill

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 taken

Committee Findings

Structural

The incident took place in a double occupancy cell, in the F-1 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 within the housing unit that monitor the common areas. 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. Body scanner training was provided to staff in 2024.

Additionally, the SCSO Corrections Bureau is in the process of acquiring and implementing a drug sniffing canine program for assignment in the jail, as an additional effort to identify and remove harmful drugs from the facility.

Clinical

The subject was positive for the presence of methamphetamine and cocaine in his system at the time of booking. The module deputy found the subject unresponsive and radioed for a medical response. He and responding staff immediately began life saving measures. Additional corrections medical staff responded to the module and assisted with lifesaving measures. An AED was applied, with no shock advised. Everett Fire Department medics arrived and continued resuscitative measures. Despite continued interventions, the subject was pronounced deceased at 1151 hours. The medical examiner autopsy report identified that the subject died of "Acute fentanyl intoxication."

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

Operational

The area of this incident was fully staffed and all responding SCJ staff acted within policy. Corrections Bureau uniformed staff and jail medical staff were present to assist with life-saving measures (CPR, rescue breathing, etc.) after the subject was discovered not breathing and without a pulse. Five (5) doses of Narcan were administered along with the presence of an AED to assist with resuscitative measures. Lifesaving measures continued until staff were relieved by Everett Fire Department medics. Security checks were conducted timely and in accordance with policy.

Committee Recommendations

The SCSO Corrections Bureau is in the process of acquiring and implementing a drug sniffing canine program for assignment in the jail, as an additional effort to identify and remove harmful drugs from the facility.

The SCSO Corrections Bureau has implemented random module and cell searches by utilizing information/resources from the Corrections Bureau Intelligence Unit.

The SCSO Corrections Bureau is researching a notification system called “Custody Protec.” The system is a biometric sensor secured to an inmate’s wrist or ankle which makes notification to medical personnel when a wellness issue is detected.

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