Thurston County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report Incident #23- 060603

Report to the Legislature

as required by Engrossed Senate Bill 5119 (2021)

Date of Publication: May 29, 2024

Contents

Unexpected Fatality Review Committee Report

Inmate Information

The deceased inmate was a 36 - year old male who was incarcerated at the Thurston County Correctional Facility located in Tumwater Washington. The deceased male was booked into the Thurston County Correctional Facility on Tuesday January 24, 2023 at approximately 0925 hours for the charges of Burglary 2nd, Possession of Drug Paraphernalia and Making/Possession of Burglary Tools. The deceased male was also being held on a Washington State Department of Corrections warrant for Escape of Community Custody/ Assault 3rd and Violation of Protection Order Violation.

Upon being processed into custody, the deceased male disclosed he had a history of regular Methamphetamine use up until time of intake but denied having any medical issues that needed addressing.

Incident Overview

On Tuesday March 14, 2023 at approximately 0035 hours corrections staff working at the Thurston County Corrections Facility find two inmates unconscious while conducting welfare checks of jail cells. Upon finding the inmates corrections staff immediately begin life saving measures on the two inmates. The deceased inmate was found lying on the cell floor facing the wall while the second inmate was found sitting on the cell floor with his back against the bottom bunk. Both inmates were being housed in a maximum - security cell area of the jail.

As more corrections and on - site medical staff arrived, life saving measures such as CPR, Narcan deployment, and the use of an AED continued until Tumwater Fire and Medic One arrived on scene. The cellmate of the deceased inmate regained consciousness after several doses of Narcan and rounds CPR. The deceased inmate never regained consciousness after being given the same medical attention while at the jail. He was eventually transported to Providence St. Peters Hospital in Olympia Washington for further medical assistance.

The next day of Wednesday March 15, 2023 hours, the inmate was pronounced deceased while at Providence St. Peters Hospital.

Cause of Death

On March 17, 2023 an autopsy was conducted on the deceased inmate by the Thurston County Coroners' Office. The Coroner's Office concluded that the cause of death is attributed to acute Fentanyl intoxication. Manner of death is determined to be accident.

Committee Meeting information

Relevant documents disseminated to committee members for review: Tuesday May 14, 2024

Meeting Date: Tuesday May 28, 2024

Location: Thurston County Corrections Facility

3491 Ferguson Street SW Olympia, Washington 98512

Committee Members

Health Care Delivery Systems (HDS) – Thurston County Corrections Facility contract medical provider.

- Shannon Slack – Medical Director

Thurston County Human Resources.

- Brian Bishop – Risk and Safety Manager

Thurston County Corrections Facility Administration.

- Trevor Davis, Chief Deputy of Corrections
- Todd Thoma, Corrections Support Services Captain
- Andre Muldrew, Corrections operations Captain
- Shawn Ball, Corrections Programs Lieutenant
- Patrick Robbins, Corrections Administrative Lieutenant

Committee Review and Discussion

- Defendants complete booking file
- Defendants current and historical jail medical records
- Photos/video evidence made available upon request.
- Facility logs (electronic/written) related to the incident and relevant training records of staff involved.
- Life saving measures taken
- Detectives investigation report
- Coroner's report and autopsy results
- Independent Medical Expert post mortality review and subsequent report

Committee Findings

The committee found the overall response and handling of this incident was appropriate. All available tools and resources were utilized in the efforts to preserve the life of the inmate.

The committee also found that good documentation and communication was present during the incident by both corrections and medical staff.

The committee found that harmful narcotics were smuggled into the secure housing areas of the facility by another incarcerated inmate housed in the corrections facility. The harmful narcotics that led to the death of the deceased were undetected by corrections staff.

The deceased inmate went through the jail TEK 84 Body Scanner upon incarceration which yielded no signs of contraband on their person.

Committee Recommendations

The Thurston County Correctional Facility has acquired and implemented a Drug detection canine program for our jail. This program was implemented after several Fentanyl overdoses and deaths within the facility to detect and mitigate harmful drugs from getting into the secure area of the jail.

The Thurston County Correctional Facility also acquired a MX- 908 drug detection device that identifies several narcotics that could be harmful to those working in the facility as well as those that are incarcerated in the facility.

LEGISLATIVE DIRECTIVE RCW 70.48.510

Unexpected fatality review--Records—Discovery

(1)(a) A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail shall conduct an unexpected fatality review in any case in which the death of an individual confined in the jail is unexpected.

(b) The city or county department of corrections or chief law enforcement officer shall convene an unexpected fatality review team and determine the membership of the review team. The team shall comprise of individuals with appropriate expertise including, but not limited to, individuals whose professional expertise is pertinent to the dynamics of the case. The city or county department of corrections or chief law enforcement officer shall ensure that the unexpected fatality review team is made up of individuals who had no previous involvement in the case.

(c) The primary purpose of the unexpected fatality review shall be the development of recommendations to the governing unit with primary responsibility for the operation of the jail and

legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody.

(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 Page 5 of 5 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.

DISCLOSURE OF INFORMATION

RCW 70.48.510(3)(c) Unexpected fatality review--Records—Discovery

Documents prepared by or for an unexpected fatality review team are inadmissible and may not be used in a civil or administrative proceeding, except that any document that exists before its use or consideration in an unexpected fatality review, or that is created independently of such review, does not become inadmissible merely because it is reviewed or used by an unexpected fatality review team.