Skagit County Community Justice Center

05/15/2023

In-Custody Death Review Summary Report

Purpose of the Report

At the request of Sheriff Don McDermott of the Skagit County Sheriff's Office, Dr. Radha Sadacharan and Chief Jail Administrator Jose Briones reviewed the [redacted] In-Custody Death incident. The purpose of this review was to provide Sheriff McDermott and his Corrections Division with a Root Cause Analysis "RCA" of the incident and to satisfy Revised Code of Washington (RCW) 70.48.510 Unexpected Fatality Review-Records-Discovery. The RCA is a mechanism in which any agency can improve investigations into Unexpected Deaths in Jails. This process takes an in depth look at the incident and helps an agency "get to the why" so that future incidents similar in nature can be mitigated or prevented. The review must include an analysis of the root cause or causes of the unexpected fatality, and associated corrective actions plan for the jail to address identified root causes and recommendations made by the review team. The review team was provided access to all records, policies, procedures, and files regarding the incident along with access to the facility and staff for follow up interviews.

Narrative of incident

On 05/15/2023 a 48-year-old male was booked into the Skagit County Community Justice Center (SCCJC) on a felony charge. At the time of his incarceration, decedent also had two other misdemeanor warrants pending from other jurisdictions. While being held in the SCCJC the Prosecuting Attorney's Office had communicated that they were working with decedent's attorney and had arranged an offer for credit for time served so that decedent could be released. On 12/26/2023, decedent attorney was brought directly to decedent's cell and decedent refused to accept any agreement which would reduce the charges. On 12/27/2023 shortly after dinner trays were passed out, decedent was found unresponsive in his assigned cell during a routine observation check. Attempts to revive decedent were unsuccessful and he was pronounced deceased at the scene by outside medical staff.

During his current incarceration at the SCCJC, decedent had been sent to Western State Hospital (WSH) for a competency assessment from 07/10/2023 - 10/04/2023. Upon his return and due to various medical needs decedent was housed in J Pod. Before the incident, decedent had an undiagnosed medical condition that caused him to lose his balance and fall. To help mitigate fall related injuries decedent was provided a wheelchair and helmet. Because of this undiagnosed medical condition, decedent was being monitored by the medical provider, had been to the hospital numerous times, and requests by the medical provider for additional off-site testing was in the works.

decedent was housed on J Pod, a 24/7 direct supervision setting typically used for inmates with mental health and medical needs who are generally placed on 15 or 30-minute checks. J Pod is also used for

around medical policy, procedure, and standards of care. Looking into the specifics of an event such as this, it is not unique in nature. Jails regularly manage the most medically compromised subjects. Most times, events with almost identical factors do not result in an in-custody death. Jails can do their best to follow all the best-known medical practices such as housing subjects in appropriate medical settings and the event may still result in death.

Considering the elements of death in this incident are common elements, jails must always be looking in how to mitigate negative outcomes. The below bullet points are they key components to mitigating these types of incidents in the future.

- Once inmates are identified to be a risk to themselves, they must be housed in an appropriate environment.
- Medical services and policies should be reviewed by command staff with some level of frequency to ensure compliance.
- A multi-disciplinary team "MDT" approach of medical supervisors and custody supervisors should meet weekly to discuss high risk inmates. This meeting should identify risks and how they are being managed.
- Staff assigned to a Specialized Housing Unit should be veteran staff with the attributes necessary to manage challenging personalities.
- Retrofit J-Pod cells, common areas, program space to the specific needs of the inmates being housed in this location. Some spaces will need to be hardened, while others will need to be updated with safety measures in mind.
- Add additional medical emergency equipment to J-Pod so that staff do not have to retrieve it from other areas of the facility during an emergency.

In closing the SCCJC should continue to assess its operations and adjust course as necessary. Under the current leadership of Chief Marlow several areas in this report are already underway and the facility has undergone several significant changes. This clearly shows that that the Sheriff made the appropriate appointment to lead this facility forward into success.