Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2024 Unexpected Fatality Incident 24-1792

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: March 18, 2025

Contents

Inmate Information

The in-custody subject was a 44-year-old female who was booked into the Snohomish County Jail on July 22, 2024, at 2124 hrs. The subject was booked on possession of a controlled substance, carrying firearms, prisoner drug in county or local institution, and driving while license suspended 3. Due to drugs and paraphernalia found at the time of arrest and during booking, a strip search was conducted with no additional contraband found. The subject was sent to the hospital by the arresting agency for a clear to book after anomalies were found on the body scanner; additionally, it was reported that the subject dropped a bag of white substance (suspected methamphetamine) during the hospital transport. Upon return to the jail another strip search was conducted with nothing additional found. A urinalysis (UA) test was conducted which detected the presence of methamphetamine. The subject was assessed by medical, and she was placed on a medical detox watch at the time of booking.

Incident Overview

At approximately 1111 hours on July 24, 2024, the female subject was housed in a single occupancy cell located in the jail's maximum security female housing unit. At that time the corrections deputy assigned to this housing unit was serving the lunch meal, when he became aware that the subject was unresponsive. The deputy immediately called a medical emergency over his portable radio. Corrections deputies and medical staff immediately responded to assist and began life saving efforts including the application of an AED and administering Narcan. At 1113 hrs 911 was called for fire and aid to respond. At 1120 hrs Fire and aid (Everett Fire Dept.) arrived and took over lifesaving efforts. EFD continued life saving measures until 1130 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 1219 hours. SCSO deputies contacted the Major Crimes Unit (MCU), who responded at approximately 1238 hours to initiate an investigation.

The Snohomish County Medical Examiner's Office autopsy report, received on March 3, 2025, lists the cause of death to be "undetermined" and lists the manner of death as "undetermined." The Medical Examiner reported that the subject's toxicology showed the presence of methamphetamine and fentanyl. The Medical Examiner concluded that "there are multiple possible causes of death": (1) Sudden cardiac death (2) acute fentanyl and methamphetamine intoxication (3) withdrawal-related complications or (4) any combination of (1), (2), or (3).

UFR Committee Meeting Information

Meeting date: March 12, 2025

Committee members in attendance

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

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

County Risk Management
- Sheila Barker
- Matt Erickson
- 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 administered

Committee Findings

Structural

The incident took place in a single occupancy cell style housing unit on the E-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 methamphetamine in her system at the time of booking. The module deputy called a medical emergency immediately upon becoming aware of the subject being unresponsive. Corrections medical staff responded to the module immediately to evaluate and provide medical care, administered Narcan and applied an AED. Everett Fire Department medics arrived and took over lifesaving efforts. Despite continued interventions, the subject was pronounced deceased at 1130 hours. The medical examiner determined as indicated in the autopsy report, that the cause of death was "undetermined."

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. However, after review of facility logs and video, it was found that there were discrepancies between the safety checks logged by the assigned deputy and the safety checks actually performed by the deputy. An internal investigation was conducted which identified that SCSO Corrections Bureau policies were violated. This investigation and findings resulted in personnel actions being taken against the deputy.

Responding SCJ staff acted within policy. Adequate SCJ uniformed staff and jail medical staff were present to perform life-saving efforts (CPR, rescue breathing). Everett Fire Department medics responded timely and performed lifesaving efforts.

<u>Committee Recommendations</u>

None

<u>Additional information</u>

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.

Refresher training/acknowledgement of safety checks expectations and policies was issued by the jail training unit for all uniformed personnel in the SCSO Corrections Bureau.

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.