Thurston County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report Incident #24- 003724

Report to the Legislature

as required by RCW 70.48.510

Date of Publication: June 13, 2025

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Unexpected Fatality Review Committee Report

Inmate information

The deceased inmate was a Hispanic 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 Thursday August 15, 2024, at approximately 2320 hours. The inmate was booked on Thurston County warrants for the charges of Escape 2nd, Disorderly Conduct, and two charges of Assault 4th.

Upon being processed into the correctional facility, the deceased male indicated to corrections booking staff that he had struggled with Depression, PTSD, and other mental health and medical issues. Also, during the booking process, he indicated he had attempted suicide three times within the last two years. The deceased identified Methamphetamine and Fentanyl as his daily street drugs.

Incident Overview

On Friday August 30, 2024, the deceased male inmate was housed alone in maximum custody cell CD26. Prior to being housed in CD 26, he was housed in cell CE-11 on close observation watch. Prior to being removed from close observation, the deceased male was seen by contract Mental Health Providers and cleared from close observation status on Friday August 23, 2024.

At approximately 1233 hours on August 30th, the deceased inmate accepted his lunch tray and returned the tray to corrections staff at approximately 1256 hours of the same day. At approximately 1335 hours, classification deputies entered CD Unit to conduct classification moves within the unit. Once classification staff arrived at cell CD26, they observed the deceased with a blanket around his neck hanging from an upper bunk. The deceased was unconscious when discovered by classification staff. Once staff discovered the unconscious inmate, a code call for assistance from jail medical staff and additional corrections staff was made. Once correctional and contract medical staff were on scene, they immediately removed the blanket from the neck of the unconscious inmate and began life saving measures. These life saving measures included CPR and the use of an AED. Dispatch was contacted at approximately 1338 hours and Tumwater Fire responded on scene at approximately 1347 hours. Tumwater Fire took over life saving measures on the unconscious inmate and were able to gain a pulse. Once a pulse was obtained, the inmate was transported to St. Peters Hospital in Olympia, Washington.

Upon arriving at St. Peters Hospital, the inmate was placed on life support while additional testing and other life-saving efforts were conducted. On Sunday September 1, 2024, at 1020 hours, the inmate was pronounced dead.

Cause of death

On September 3, 2024, the Thurston County Coroner's Office conducted an external examination of the deceased. After careful review of medical records, examination of the autopsy findings and toxicology results, the Coroner's Office concluded cause of death is attributed to ligature hanging. The manner of death is determined to be suicide.

Committee Meeting Information

Documents disseminated to committee members for review: Friday June 13, 2025

Review of information and suggestions by: June 25, 2025

Committee Members

Healthcare Delivery Systems (HDS) – Thurston County Correctional Facility Medical Provider.

- Shannon Slack – Medical Director
- Mary Fiest

Thurston County Human Resources

- Brian Bishop – Risk and Safety

Olympic Health Recovery Services

- Joe Avalos
- Alexandria Francis

Thurston County Corrections Facility Administration

- Jenny Hovda, Chief Deputy of Corrections
- Todd Thoma, Corrections Support Services
- Andre Muldrew, Corrections Operations
- Shawn Ball, Corrections Programs
- Patrick Robbins, Administrative Lieutenant

Committee Review and discussion

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

Committee Findings

Upon review of this in custody death, the committee found the response from corrections and contract medical staff was appropriate. The response of corrections and medical staff provided all available tools and resources to the scene while attempting to preserve the life of the deceased inmate.

The committee also found that classifications staff and medical staff were not provided with complete mental health information concerning the inmate at the time his housing placement was being determined.

Committee Recommendations

The committee's review and discussion of potential changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody led the committee to identify areas to improve the sharing of information among corrections staff, contract mental health staff, and contract medical staff.

First, moving forward the committee recommends the intake/booking deputy provide both medical and mental health staff with copies of the initial intake Mental health screening questionnaire of inmates. Shift supervisor will ensure copies are distributed.

Second, if an individual is brought into custody and not able or willing to participate with the booking process within 2 hours, a Mental Health Screening Referral will be created in the Jail management system to alert mental health staff of a possible need for their assessment. Inmates will not be moved to housing areas prior to a mental health screening being conducted.

Third, the committee recommends that Medical and Mental Health staff have more direct communication and cooperation to capture times, events and treatment.

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.