Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 23-2381

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: January 5, 2024

Contents

Inmate Information

The inmate was a 42-year-old male booked into the Snohomish County Sheriff's Office Corrections Bureau on September 8, 2023, at 08:32 hours. The inmate was stripped searched due to the type of charge. There was nothing found. A urinalysis (UA) test was conducted which detected the presence of methamphetamine, morphine, ecstasy, and fentanyl in his system. He was medically assessed by Corrections nursing staff and placed on a medical detox watch.

Incident Overview

On September 11, 2023, the Correction Deputy assigned to module F2 was concerned about an inmate's erratic behavior. Module F2 is a male detox housing unit designed to house 64 inmates but is being used as a single occupant housing unit. The nurse was notified and recommended the inmate be transported to booking for a urinalysis test. At approximately 03:36 hours, the inmate was transported to booking where a urinalysis test was administered. He tested positive for methamphetamine, fentanyl, and cocaine. The detection of cocaine was not present during a urinalysis test in booking on September 8, 2023. The inmate was strip searched and moved to the Observation Unit.

On September 11, 2023, the Corrections Deputy assigned to the Observation Unit (OU) was conducting a routine check when he found an unresponsive inmate lying on the floor inside his cell. The Observation Housing Unit has an inmate capacity of ten with one corrections deputy overseeing the module. At approximately 21:20 hours, the Corrections Deputy went to the inmate's cell and discovered the inmate unresponsive. The deputy immediately called a medical emergency by using a portable radio system and began lifesaving measures; CPR. Narcan was administered. While attempts to resuscitate the inmate were in progress, a call to 9-1-1 was made and aid was requested.

At approximately 21:29 hours the Everett Fire Department arrived and continued lifesaving measures. After thirty-three minutes of life-saving efforts, the aid crew pronounced the time of death at 21:57 hours. All Everett Fire Department aid crew members left the housing area at approximately 22:05 hours. To protect the integrity of the investigation, the scene was preserved pending an investigation from the Snohomish County Sheriff's Office Major Crimes Unit. Snohomish County

Sheriff's Office (SCSO) deputies arrived in the housing unit at 22:49 hours and the Major Crimes Unit (MCU) arrived at approximately 23:25 hours to initiate an investigation.

The Snohomish County Medical Examiner's Office completed their investigation on November 21, 2023, and their autopsy report lists the cause of death as "peritonitis" and lists the manner of death as natural.

UFR Committee Meeting Information

Meeting date: December 7, 2023

Committee members in attendance

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

SCJ Medical, Jail Health Services
- Amanda Ray, Health Service Administrator
- Stuart Andrews, Medical Director
- Debbie Bellinger, Nursing Supervisor
- Kristi Seiders-Werner, ARNP

County Risk Management
- Tracie O'Neill

County Prosecuting Attorney
- Geoff Enns

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, i.e., Layout of incident location
   e. 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
   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 Snohomish County Corrections facility is a seven-story structure capable of housing 1,050 inmates. Currently there are 154 Corrections Deputies on staff. On the day of this incident, there were five hundred fifty-three inmates in the facility. The incident took place in a single cell style housing unit on the D-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. The cell the inmate was housed in lacked any in-cell camera. The Snohomish County Jail (SCJ) is in negotiations with a vendor to upgrade the security system in 2024 which will include a camera in every cell inside the Observation Unit.

The SCJ booking area is equipped with a Tek-84 body scanner which can be used to scan incoming inmates, even in cases where strip searches are not permissible by law. Refresher training on the proper use of the Tek-84 body scanner was provided to staff in the fourth quarter of 2023. The body scanner was functional and used to scan the subject at the time of his booking on September 8, 2023, and again on September 11, 2023.

Clinical

The subject was positive for the presence of methamphetamine, heroin, and fentanyl in his system at the time of booking. The module deputy found the subject unresponsive and radioed for a medical response. He immediately began life saving measures. Corrections and medical staff responded to the module and assisted with lifesaving measures. An onsite 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 21:57 hours. The autopsy report confirms the subject died from a ruptured peptic ulcer.

Jail Health Services (JHS) 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 and all responding SCJ staff acted within policy. SCJ uniformed staff and jail medical staff were present to assist with life-saving measures (CPR, rescue breathing) after the subject was discovered not breathing and without a pulse. All staff carry, on their body, Narcan for use in the case of a suspected opioid overdose. Four 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 on time and in accordance with policy.

Committee Recommendations

-Signed Medical Waiver initiated when an inmate refuse treatment.
-Cameras added inside and outside of the cells in Observation Unit (OU).

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