Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2024 Unexpected Fatality Incident 24-119

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: May 7, 2024

Contents

Inmate Information

The in-custody subject was a 37-year-old male who was booked into the Snohomish County Jail on August 17, 2023, at 1658hrs. The subject was booked on felony and misdemeanor warrants. A strip search was not conducted at booking as it was not automatically permitted due to the type of charge(s). A urinalysis (UA) test was conducted which detected the presence of morphine, fentanyl, methamphetamine, amphetamine and MDMA. The subject was assessed by medical, and he was placed on a medical detox watch at the time of booking.

Incident Overview

At approximately 1109 hours on January 15, 2024, the male subject was housed in a double occupancy cell located in one of the jail's high/medium security housing units. As a corrections deputy was serving the lunch meal, the adult male was located unresponsive inside his cell. The corrections deputy immediately called for a medical emergency response. Deputies and jail medical responded and 911 was called. Corrections deputies and medical staff immediately began lifesaving measures (CPR) and administered ten rounds of CPR and five doses of Narcan; an AED was applied to the subject but did not advise a shock. Attempts to resuscitate the inmate were unsuccessful.

At approximately 1120 hours Everett Fire Department arrived and continued lifesaving measures. The aid crew pronounced the time of death at 1141 hours. 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 1213 hours. SCSO deputies contacted the Major Crimes Unit (MCU), who responded at approximately 1430 hours to initiate an investigation.

The Snohomish County Medical Examiner's Office autopsy report lists the cause of death to be "acute fentanyl intoxication" and lists the manner of death as "accident."

UFR Committee Meeting Information

Meeting date: April 25, 2024

Committee members in attendance

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

SCJ Medical, Jail Health Services
- Amanda Ray, Health Services Administrator
- Stuart Andrews, Medical Director
- Debbie Bellinger, Nursing Supervisor

County Risk Management
- Sheila Barker

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 double occupancy cell style housing unit on the F-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 fentanyl, morphine, methamphetamine, amphetamine and MDMA in his system at the time of booking. The module deputy found the subject unresponsive and radioed for a medical response. Life saving measures were started immediately after the deputy identified the subject as unresponsive. Corrections medical staff responded to the module and assisted with lifesaving measures. An 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 1141 hours. Autopsy report confirms that the subject died from acute fentanyl intoxication.

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 and all responding SCJ staff acted within policy. Adequate 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. Five 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 timely and in accordance with policy.

The subject also had a medical emergency in November 2023, after being found unresponsive due to ingesting "a bag of fentanyl and several Xanax bars." Narcan was administered at that time, he was transported to the hospital, and he fully recovered. The ME report also indicates, that at the hospital, the subject revealed to nurses that he had suicidal ideations due to facing long term confinement.

Committee Recommendations

None

Additional information

SCSO Corrections Bureau has recently acquired a drug sniffing canine along with a handler to assist with identifying and eradicating dangerous drugs from the Snohomish County Jail. The canine has been trained to detect several illicit drugs to include fentanyl.

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.