THURSTON COUNTY SHERIFF'S OFFICE

WASHINGTON
SINCE 1852

JOHN D. SNAZA
Sheriff

2000 Lakeridge Drive SW • Olympia, Washington 98502-6045 • (360) 786-5500

RAY BRADY
Undersheriff

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-002258

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Date of Publication: November 21, 2022

Contents

Defendant Information

The deceased defendant, a 22 year old male, was arrested on May 3, 2022 at 2225 hours and booked into the Thurston County Corrections Facility (TCCF) at 2326 hours. The defendant was being held on three (3) Probable Cause Felony charges as well as a Department of Corrections no bail Warrant.

During the intake process the defendant reported that he had no medical problems and that he was a daily marijuana user.

Incident Overview

On May 5, 2022, records show that correctional staff had conducted welfare checks of the housing areas at 1956 hours and again at 2032 hours. At 2036 hours, correctional staff were alerted via intercom by the defendant housed with the deceased defendant that his cellmate was not moving. Correctional staff responded to the cell within one minute.

Staff found the deceased defendant unresponsive and slumped over.

At 2038 hours, correctional staff called a medical emergency and immediately began chest compressions. TCCF medical staff arrived shortly after chest compressions had begun.

At 2039 hours, 911 was contacted requesting medics respond to TCCF. At 2044 hours, Fire/Medics had arrived. Life saving efforts continued to include the administration of two doses of Narcan and two (2) Automatic External Defibrillator (AED) evaluations. Both evaluations did not recommend shocking. Fire/Medics were able to obtain a faint pulse.

At 2108 hours, Fire/Medics and corrections staff left the facility in route to Providence St. Peter Hospital for continued care. On May 6, 2022, St. Peter Hospital reported that the defendant was deceased.

As per TCCF policy, the following actions were immediately taken or were taken in the days following the incident.

- Thurston County Detectives were immediately called in to evaluate/investigate the scene and subsequent death. No criminal behaviors were identified.

- Thurston County Coroner's investigation was initiated. Final report indicated the cause of death to be attributed to acute fentanyl intoxication

- A comprehensive internal review of the incident was conducted by the TCCF Administrative Lieutenant. This review found that staff followed Policy and Procedures and provided an excellent response.

- In accordance with TCCF policy, an independent medical professional was contracted to perform a post mortality review. That review indicated that the *"care delivered by both custody and healthcare staff members was appropriate and well documented"*

Unexpected Fatality Review Dates

Relevant documents disseminated to committee members for review: Nov 7th, 2022

Meeting date: November 21, 2022

Location: Thurston County Corrections Facility

3491 Ferguson St. SW Olympia, Washington

Committee members

Health Care Delivery Systems (HDS) *-Thurston County Corrections Facility's contract medical provider.*

- Shannon Slack MSN, CCHP- President/CEO/Medical Director

Thurston County Human Resources.

- Tammy Devlin, Risk Manager

Thurston County Corrections Facility Administration.

- Todd Thoma, Chief Deputy
- Andre Muldrew, Operations Captain
- Shawn Ball, Support Services Captain
- Jenny Hovda, Administrative Lieutenant

Committee Review & Discussion

Scope of review:

- Defendants complete booking file
- Defendants current and historical jail medical records
- Photos/video evidence if any
- Facility logs (electronic or written) related to the defendant and or incident
- All internal reports and notes related to the incident and relevant training records of staff involved
- Detectives investigation report
- Coroners report and autopsy results
- Independent Medical Expert post mortality review and subsequent report

Committee Findings

The committee found the overall response and handling of this unfortunate incident was professional and appropriate. All available tools and resources were utilized in the efforts to preserve the life of this defendant.

Cause of Death

The final Coroners report states:

"Cause of death is attributed to acute fentanyl intoxication".

Committee Recommendations

- Although all documentation existed and was available to investigators, Identifying a central person or persons responsible to scribe the events as they unfolded would have been preferred.

- The investigation indicated that staff were unclear about proper handling of the Automatic External Defibrillator (AED) post deployment. Post use care training is recommended.

- Note: Due to time required to receive the final toxicology report and independent post mortality review, two 60-day final report extensions were requested and granted by the chief law enforcement officer.

Legislative Directive Per ESSB 5119 (2021)

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 Page | 9 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.