Snohomish County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 2022-3811

Report to the Snohomish County Council

As required by RCW 70.48.510

Date of Publication: April 3, 2023

Contents

Inmate Information

The inmate was a 32-year-old male with a history of chronic fentanyl and methamphetamine use. He was booked into the Snohomish County Jail (SCJ) at 1211 hours on December 10, 2022 by Edmonds Police for Assault 4. Prior to being booked into the jail, he was medically cleared for booking at Swedish Edmonds Hospital for an open wound on his leg.

On the date of the incident, the inmate was housed in one of the SCJ's inmate detox housing units under medical supervision for opioid withdrawal and his leg wound.

Incident Overview

At approximately 1547 hours on December 11, 2022, the subject was found unresponsive inside a single occupancy cell. The male was housed in the jail's male detox housing unit. As medical staff were conducting routine vital checks escorted by a corrections deputy, the male was found to be unresponsive within his cell as the lone occupant. SCJ staff immediately began administering lifesaving measures (CPR), and the facility called for a medical response from 911.

At approximately 1558 hours, Everett Fire Department arrived and continued lifesaving measures after relieving SCJ staff. At approximately 1614 hours, the aid crew, in consultation with a Providence Medical Center physician, ceased resuscitation efforts and declared the inmate deceased. All aid crew members left the housing area at approximately 1617 hours. The scene was preserved pending an investigation.

The Snohomish County Sheriff's Office (SCSO) was called to the scene, which is standard for any in-custody death. SCSO deputies arrived in the housing unit at 1626 hours. SCSO then called their Major Crimes Unit (MCU), who responded and began an investigation. MCU conducts investigations of all in custody deaths which occur at the SCJ.

The Snohomish County Medical Examiner's Office (ME) autopsy report lists the manner of death as "natural." The ME cited the cause of death to be "complications of chronic fentanyl and methamphetamine use." While the ME found fentanyl and methamphetamine in the inmate's system, the levels were

not consistent with overdose and likely remained in his system from use prior to being booked into jail the day prior. At booking, he was found to have fentanyl and methamphetamine in his system pursuant to a urinalysis conducted by SCJ medical staff in accordance with jail protocols.

UFR Committee Meeting Information

Meeting date: March 23, 2023

Committee members in attendance

Snohomish County Corrections Bureau Command Staff
- Jamie Kane, Bureau Chief
- Alonzo Downing, Major
- David Hall, Detention Captain

SCJ Medical, Jail Health Services
- Debbie Bellinger, Acting Health Service Administrator

Snohomish County Risk Management
- Sheila Barker
- Matt Erickson

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 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 take

Committee Findings

Structural

The incident took place in a single occupant cell within a housing unit on the E-floor of the SCJ. The unit had adequate lighting, a functioning emergency call button within the cell, and no known or reported broken or altered fixtures.

There are several surveillance cameras which capture the booking, processing, movement through the facility and eventual housing of the subject in the detox housing unit. However, there are not surveillance cameras located within the cells of the detox unit, only the communal areas. As a result of this, there is not a recording of the inmate's activities within the cell prior to the medical emergency.

It is noted that 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, with no contraband or other items located.

Clinical

A registered nurse (RN) was in the module at the time of the incident. The nurse was conducting routine vital checks. Once the inmate was found unresponsive, a medical emergency was declared over the institutional radio communications system. SCJ's Medical Director overheard the radio traffic from her office, and responded immediately once retrieving the "crash cart," which holds life saving

equipment and medical supplies. The subject was unresponsive, not breathing, and without a detectable pulse. Autopsy report confirms that the subject died from natural causes due to complications of chronic fentanyl and methamphetamine use.

Jail Health Services (JHS) did not identify issues or problems with policies/procedures, training, facilities/equipment, supervision/management, personnel, culture, or other variables 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 medical staff were present when the subject was discovered not breathing and without a pulse. Lifesaving measures commenced immediately by SCJ staff and continued until they were relieved by Everett Fire Department medics. Inmate welfare checks were conducted timely and in accordance with policy.

<u>Committee Recommendations</u>

- Explore the feasibility of emerging Bio-Sensor Monitoring technology for inmates in our medical/detox units. A Bio-Sensor Monitoring device could alert staff in real time if there are readings outside of an established range.

- Train and outfit all detention staff (medical and custody) with Narcan on their person in a temperature controlled (insulated) case. This will ensure an adequate amount of Narcan is on scene regardless of which staff respond to a potential overdose event. This is a change/expansion from only medical staff having it on their person.

Legislative Directive
Per ESSB 5119 (2021)

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