Thurston County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report Incident #23-0581-03

Report to the Legislature

as required by Engrossed Senate Bill 5119 (2021)

Date of Publication: May 29, 2024

Contents

Unexpected Fatality Review Committee Report

Defendant Information

The deceased inmate was a 28 - year old male who was incarcerated at the Thurston County Jail located in Tumwater Washington. He was booked into custody on Monday February 13, 2023 at 1011 hours. He was being held on a felony warrant with the charge of two counts of Robbery in the 1st Degree while armed with a deadly weapon.

At the time of booking, the inmate denied having any mental health or medical issues as an adult. He also denied any alcohol or drug problems in which he would need care.

Incident Overview

On Thursday March 9, 2023 at approximately 1925 hours, Thurston County Corrections staff were alerted by an inmate that their cellmate was on the cell floor and unconscious located in a maximum - security cell area of the jail. Upon being alerted, corrections staff responded to the occupied cell and found the inmate in a seated position on the floor with his back against his bunk. Corrections and on-site medical staff entered the cell and immediately started life saving measures such as Narcan deployment, CPR, and the use of an AED until medics arrived on scene from Tumwater Fire Department and Medic One.

During the life saving measures by medical personnel a pulse was detected on the inmate. Once a pulse was detected, the inmate was transported to Providence St. Peters Hospital in Olympia, Washington for further care.

After the inmate was transported from the facility, the cell was secured to preserve any evidence that may be located within the cell. A cell search was later conducted by corrections staff which resulted in the discovery of Fentanyl.

On Saturday March 11, 2023 at 2318 hours, the inmate was pronounced deceased while at Providence St. Peters Hospital.

Cause of Death

On March 15, 2023, an autopsy was conducted on the inmate by the Thurston County Coroner's Office. The Coroner's Office concluded that the cause of death was attribute to delayed complications of cardiac arrest(resuscitated) due to acute fentanyl toxicity. Aspiration of gastric contents was considered a contributing factor. Manner of death is best classified as accident.

Committee Meeting information

Relevant documents disseminated to committee members for review: Tuesday May 14, 2024

Meeting Date: Tuesday May 28, 2024

Location: Thurston County Corrections Facility

3491 Ferguson Street SW Olympia, Washington 98512

Committee Members

Health Care Delivery Systems (HDS) – Thurston County Corrections Facility contract medical provider.

- Shannon Slack – Medical Director

Thurston County Human Resources.

- Brian Bishop – Risk and Safety Manager

Thurston County Corrections Facility Administration.

- Trevor Davis, Corrections Chief Deputy
- Todd Thoma, Corrections Support Services Captain
- Andre Muldrew, Corrections Operations Captain
- Shawn Ball, Corrections Programs Lieutenant
- Patrick Robbins, Corrections Administrative Lieutenant

Committee Review and Discussion

- Defendants complete booking file
- Defendants current and historical jail medical records
- Photos/video evidence available upon request
- Facility logs (electronic/written) related to the incident and relevant training records of staff involved.
- Detectives investigation report
- Coroner's report and autopsy results
- Independent Medical Export post mortality review and subsequent report

Committee Findings

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

The committee also found that good documentation and communication was present during the incident by both corrections and medical staff.

The committee found that harmful narcotics were smuggled into the secure housing areas of the facility by another incarcerated inmate housed in the corrections facility. The harmful narcotics that led to the death of the deceased were undetected by corrections staff.

The deceased inmate went through the jail TEK 84 Body Scanner upon incarceration which yielded no signs of contraband on their person.

Committee Recommendations

The Thurston County Correctional Facility has acquired and implemented a Drug detection canine program for our jail. This program was implemented after several Fentanyl overdoses and deaths within the facility to detect and mitigate harmful drugs from getting into the secure area of the jail.

The Thurston County Correctional Facility also acquired a MX- 908 drug detection device that identifies several narcotics that could be harmful to those working in the facility as well as those that are incarcerated in the facility.

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

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.