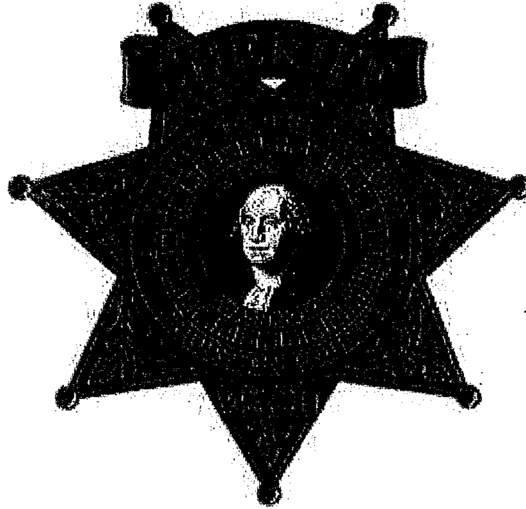

Thurston County Sheriff's Office

Corrections Bureau

Unexpected Fatality Review Committee Report

Report to the Legislature
As required by Engrossed Senate Bill 5119 (2021)

Date of Publication: December 20, 2024

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Unexpected Fatality Review Committee Report

Inmate information

The deceased inmate was a 60-year-old male who was incarcerated at the Thurston County Correctional Facility located in Tumwater Washington. The deceased male was booked into the Thurston County Correctional Facility on Tuesday September 13, 2022, at approximately 0440 hours. The deceased was being held on probable cause charges out of Thurston County for Residential Burglary Domestic Violence and Violation of a No Contact Order. He was also being held on out of county warrants for Assault 2 (DV), Harassment, and Possession of a Stolen Vehicle/Attempted.

Upon being processed into the Thurston County Correctional Facility, the deceased male did not disclose any medical or chemical abuse issues. However, during his incarceration at the Thurston County Jail, he was prescribed Lisinopril, Amitriptyline, and Hydroxyzine at different points during his incarceration.

Incident Overview

On Thursday January 18, 2024, the deceased was housed in a general population area of the Thurston County Jail. This area houses up to 68 inmates in an open dorm style of living which means most individuals within the dorm can see each other. The deceased had been housed in this area since January 7, 2024. At approximately 1845 hours on January 18, 2024, the deceased was up and received his evening medications and returned to his bunk. There was a shift change upcoming in the dorm area at 1930 hours and all occupants of the dorm were on their bunks at 1900 hours while a corrections staff member accounted for all occupants. At 2230 hours, the occupants of the dorm returned to their bunks for the night as the dorm was shut down until morning breakfast which was scheduled for 0500 hours. While the occupants of the dorm slept, corrections staff conducted hourly welfare checks throughout the night.

On Friday January 19, 2024, at approximately 0510 hours, the section of the dorm in which the deceased was located was called up for their breakfast meal. After several attempts to awake the deceased by voice and sound, the dorm deputy walked over and shook the shoulder of the deceased. The dorm deputy immediately felt the deceased body temperature was cold and stiff to the touch. At that time, jail contract medical staff was called to respond. Upon the arrival of jail contract medical staff, it was determined that the deceased could not be revived. The deceased was pronounced dead at 0530 hours once Tumwater Fire and Emergency Medical Services arrived on scene.

Prior to the discovery of the deceased being dead, welfare checks were conducted hourly by the assigned dorm deputy. When the deceased was found unresponsive, the body was in the fetal position turned away from view facing a wall which was next to their bunk. The face of the body was partially covered by a T -shirt which was folded and covering the eyes of the deceased. This is common practice in the jail setting to keep light out of one's eyes.

At approximately 0550 hours, Thurston County Law Enforcement Officers arrived on scene and shortly after, the coroner arrives. Upon review of the area and body of the deceased, it was determined there was no signs of trauma. Due to the state of the body and circumstances leading up to the deceased body being discovered, it was initially believed that the deceased died of natural causes. However, a precautionary search of the dorm and bunk area by corrections staff was conducted. The dorm and bunk area search were conducted with the assistance of the Thurston County Jail Drug Detection K-9. The search was conducted and at the conclusion resulted with negative findings.

Cause of Death

On January 19, 2024, an autopsy was conducted on the deceased by the Thurston County Coroner's Office. The Coroner's Office concluded that the cause of death is attributed to acute Fentanyl intoxication. The manner of death was best classified as an accident.

Committee Meeting Information

Documents disseminated to committee members for review: **Friday December 20, 2024**

Review of information and suggestions by: **Wednesday January 18, 2024**

Committee Members

Health Care Delivery Systems (HDS) – Thurston County Correctional Facility Medical Provider.

- Shannon Slack – Medical Director

Thurston County Human Resources

- Brian Bishop – Risk and Safety Manager

Thurston County Corrections Facility Administration

- Jenny Hovda, Chief Deputy of Corrections
- Todd Thoma, Corrections Support Services Captain

- Andre Muldrew, Corrections Operations Captain
- Shawn Ball, Corrections Programs Lieutenant
- Patrick Robbins, Corrections Administrative Lieutenant

<u>Committee Review and discussion</u>

- Defendants booking file.
- Defendants current and historical medical jail records
- Photos/ Video evidence mad available upon request
- Facility logs related to the incident and relevant training records of staff involved.
- Life saving measures.
- Detective investigation report
- Coroner's report and autopsy results
- Independent Medical Expert post mortality review and subsequent report

<u>Committee Findings</u>

After reviewing the information and actions of staff, the committee found the response to the deceased inmate was appropriate. With the deceased being found stiff, and cold to the touch, life saving measures were not applicable. The committee found that welfare checks were conducted per policy. However, there was no indication or documentation that staff looked for signs of life while conducting their checks.

Since the deceased had their head turned away from view and their face was partially covered, it was difficult for staff to see skin color.

Since the deceased had been in custody since September of 2022, it was clear that harmful Fentanyl that led to the death of the deceased had been smuggled into the secure area of the Thurston County Jail.

In an effort to prevent tragic events of this nature, the Thurston County Jail has introduced several safeguards and tools in an attempt to prevent these events. Some of those safeguards and tools are a Narcotics detection K-9. Before inmates are housed in the secure area of the jail, each inmate goes through the TEK-84 Body Scanner once they are booked into custody. We also have a MX-908 Drug Detection Device which identifies harmful narcotics. No personal property or mail is taken from outside entities and given to individuals in custody.

Committee Recommendations

Upon review of staff actions during dorm welfare checks, it is recommended that staff look for signs of life by observing breathing either by vision or hearing and or movement. This is particularly crucial when the face of an inmate is partially covered. Being more attentive to individuals that are assumed to be sleeping, could prove to be valuable in saving a life and getting medical attention for an individual in a timely manner.

Continue using available tools that have been acquired to detect and identify harmful drugs prior to them getting into the secure area of the jail. These tools will be used in addition to Pat down and Strip searches of individuals that come into custody.

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.

Disclosure of information

(c) 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. A person is not unavailable as a witness

merely because the person has been interviewed by, or has provided a statement for, an unexpected fatality review, but if the person is called as a witness, the person may not be examined regarding the person's interactions with the unexpected fatality review including, without limitation, whether the person was interviewed during such review, the questions that were asked during such review, and the answers that the person provided during such review. This section may not be construed as restricting the person from testifying fully in any proceeding regarding his or her knowledge of the incident under review.