Sheriff Mark C. Brown
Post Office Box 5000
Coupeville, WA 98239-5000
360-678-4422, 629-4523 x7310, 321-5113 x7310
Fax 360-679-7371 MarkB@co.island.wa.us

Island County Sheriff's Office

Island County Sheriff Releases Investigation Report
Concerning Death of Inmate Keaton Farris

Coupeville, WA June 17, 2015 – Sheriff Mark Brown made public today the investigation report on the death of Island County inmate Keaton Farris. Mr. Farris was being held in the Island County Jail on a felony arrest warrant out of San Juan County. He arrived at the Island County Jail on March 26 from Skagit County Jail. Farris was found dead in his cell on April 8, 2015. According to the Coroner's report, the cause of death was dehydration and a contributing factor of malnutrition.

"I am truly sorry for this tragic death. Mr. Farris did not receive the attention and care he needed. Our highest priority is the safety and well-being of our inmates and staff and this report describes a systematic breakdown of policies, procedures and communication that led to this tragedy," stated Sheriff Mark Brown.

"My role as Sheriff is to maintain the trust of the community in the day-to-day operations of the jail. I have already made some policy and personnel changes to correct these problems. We are actively working to establish better supervisory oversight and better chain of command control in the jail to ensure tasks are completed. For example, we have created packets that are posted outside of each safety cell with the appropriate logs for accurate and regular observation and reporting. We have prioritized work with our health department and jail medical officer to determine what steps can be taken between the jail and medical personnel to make sure everyone serving the jail understands their role and authority to properly see and treat inmates," continued Brown

"Members of my jail staff are being held accountable for their lack of leadership and supervision. As a result, effective today, Chief De Dennis has been suspended for 30 days without pay, and will return conditioned upon the review and recommendations of an outside expert who will be hired to provide a review and recommendations of our jail operations, including policies and personnel. During this time, Sgt. Chris Garden will be placed in charge of jail operations. Pending a disciplinary review, Lt. Pam McCarty has been put on paid administrative leave. The two corrections deputies that had been placed on administrative leave for policy violations have since resigned," Brown stated.

"We are determined to do everything possible to minimize the chances of this kind of a tragedy from occurring in our jail ever again. I have met with Mr. Farris senior to personally express our sincere condolences. We are all truly sorry for their loss," concluded Brown.

###

Mr. Keaton Farris Timeline

Chronology based on Investigative Report

March 20, 2015

1755 hours, Keaton FARRIS contacted and taken into custody by Lynnwood Police Department.

2040 hours, FARRIS booked into Lynwood County Jail.

March 21, 2015

0348 hours, FARRIS booked into Snohomish County Jail pending transport to Skagit County.

March 24, 2015

1440 hours, FARRIS transferred from Snohomish County Jail to Skagit County Jail.

March 26, 2015

1015 hours, FARRIS transported to Island County Jail by San Juan County.

1135 hours, FARRIS arrives at Island County Jail and placed in the blue padded safety cell.

March 30, 2015

1552 hours, FARRIS is moved from the safety cell to cell D-1.

Unknown time, Water in cell D-1 turned off due to FARRIS putting pillow in toilet, water to be turned on only at meal times.

April 1, 2015

0800 hours, FARRIS transported to San Juan County for court appearance.

1600 hours (approximately), FARRIS arrives back at Island County Jail and placed back into cell D-1.

April 4, 2015

1615 hours, FARRIS flooded cell D-1 and is moved upstairs into cell H-2 with the water turned off.

April 5, 2015

1600 hours, Safety Cell procedures started for FARRIS in cell H-2.

April 6, 2015

0930 hours, Jail nurse evaluates FARRIS through cell door.

1030 hours, Mental Health Doctors evaluates FARRIS through cell door.

April 7, 2015

Various times, multiple checks not conducted on FARRIS while in safety cell.

April 8, 2015

0030 hours, FARRIS found deceased in cell H-2.

FACILITY SUMMARY

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

Facility Summary Island County Jail

The Island County jail is a 58 bed (61 bed maximum habitable capacity) indirect supervision jail built in 1983 and occupied in 1984, located at 503 North Main Street in Coupeville Washington. An indirect supervision jail does not have the Correction Deputies stationed in the block with the inmates. Since being built the facility has gone through several technological upgrades and a remodel allowing a secure walkway to the Island County Law and Justice building.

The Island County Jail has three general use levels (floors) and a basement/mechanical room that requires an additional key or control room authorization for access. Floor one is the location of the garage sally port, breathalyzer room, kitchen and laundry facilities. Floor 1H (housing) contains cell blocks as outlined below. Floor 2 is the "main" floor of the facility containing cell blocks, the facility control room, a holding cell, administrative offices, interview rooms, visitation rooms, medical treatment room, booking station, shower room, storage room, a multipurpose room and a deck station.

Floor 1H:

"A" Block is an open dorm style block consisting of five beds a common area and shower where the inmate workers (trustees) are housed.

"B" Block is an open dorm style block with 5 beds primarily a common area and shower used to house female inmates.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

"C" Block is a block of three individual cells and a common area with a shower. One cell has the capability to house two inmates. "C" block shares a common sally port with "D" Block.

"D" Block is a block of two individual cells with one bed each. There is a common area with a shower. "D" block shares a common sally port with "C" Block.

FLOOR 2:

"E" Block is an open dorm style block consisting of 8 beds, a common area and a shower. "E" Block is housing for minimum security male inmates. "E" Block shares a common sally port area with "F" block.

"F" Block is an open dorm style block consisting of 8 beds, a common area and a shower. "F" Block is housing for minimum to medium security inmates. "F" Blocks shares a common sally port area with "E" Block.

"G" Block is a block of three individual cells and a common area. One of the cells has the capability to house two inmates. "G" block is for special needs or medical segregation of inmates. "G" block shares a common sally port that contains a shower with "H" block.

"H" block is a block of two individual cells and a common area. "H" block is for special needs or medical segregation of inmates. "H" block shares a common sally port that contains a shower with "G" block.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

"I" Block is a block of 10 individual cells, 5 cells on an upper tier, 5 cells on a lower tier with a common area and a shower. "I" Block is designated for medium to maximum security inmates. "I" block shares a common sally port area with "J" Block.

"J" Block is a block of 10 individual cells, 5 cells on an upper tier, 5 cells on a lower tier with a common area and a shower. "J" Block is designated for minimum to medium security inmates. "J" block shares a common sally port area with "I" Block.

The deck station is the common work area near the sally port for "G/H" Blocks where the daily log, pass down log, inmate books and employee mail boxes are. Corrections Deputies are able to access the Spillman database from this location and monitor the security cameras.

Interview rooms "A" and "B" are two rooms designated for interviews and attorney visits. They both have two doors, one that accesses from inside the secure area of the facility the other from the lobby area. Interview "A" has a large glass window on one side where the control room can observe the occupants.

Visitation rooms 1 through 5 are segregated, no contact visitation through a glass window speaking over a phone, the inmate enters the room through the secure side of the facility, the visitor through the lobby side. The conversations in these rooms are recorded.

The booking area is where new inmates are booked and current inmates released. There are two computers that allow access to the Spillman database along with a computer that displays a housing roster.

I certify under penalty of perjury under the laws of the state of Washington, that the foregoing is true and correct (RCW 9A.72.085)

Name	*Personnel Number*	*Location*	*Date*	
	1067	Coupville	6/9/15	

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

To the right of the booking area is the shower area where inmates shower and change from street clothes into jail uniforms. Attached to the shower area is a storage room where clean laundry is kept along with the inmate's street clothing and large personal items (until they are released).

Across from the booking station is the medical office where sick call is conducted and the nurse sees patients when she is in the facility. Next to this office is the blue padded cell, also referred to as the behavior modification module or "blue" room where inmates that pose a danger to themselves or staff are held. This cell has padded walls, no furniture or fixtures (sink or toilet). Next to this cell is the holding cell where inmates are placed pending booking, release or movement within the facility. This cell has a bench and sink/toilet fixture, no bed.

The multipurpose room or "library" is a common area where the inmate workers can take breaks and the general population does bible study and views movies on the weekends.

The administrative offices are the individual offices used by Chief DENNIS, Lt. McCARTY and the acting supervisor. Correction deputies have access to these areas as well.

The control room controls all entry and exit for the secure area in the facility via electronic locks and cameras. The Corrections Deputies carry keys that allow access into the sally ports, blocks, cells and other areas of the facility but not outside the secure area (an emergency key can be provided by the control room that allows manual entry and

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

exit). The control room also has the ability to electronically open the sally port, block and cell doors. The opening and closing of the doors is not logged. Each cell and common area in the blocks has an emergency button that alerts in the control room and allows two way voice communications. Each corrections deputy also carries a portable radio that allows communication with the control room. The Corrections Deputy in the control room has the ability to monitor and play back the various surveillance cameras.

In addition to monitoring the doors, cameras and alarms, the corrections deputy in the control room also has the responsibility of answering the phones, confirming arrest warrants, clearing the incoming visitors and assisting the public in the lobby.

As of April 7, 2015, there were 18 total employees (The Jail Chief, Jail Lieutenant and 16 corrections deputies) in the corrections division responsible for 24 hour a day 7 day a week operations. On that same date there were 52 inmates held in the facility.

DETECTIVE WALLACE REPORT

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

I am commissioned by the Sheriff of Island County to enforce the laws of the state of Washington and the County of Island. At the time of this incident I was working as a Detective for the investigations division of the Island County Sheriff's Office. I am certified by the Department of Treasury/Homeland Security as a Seized Computer Evidence Recovery Specialist (S.C.E.R.S.), the Department of Homeland Security as a Mobile Device Investigator, the Cellebrite Corporation as a Physical Analyst and the Paraben Corporation as a Handheld Examiner (PDA, cell/mobile phone and Hybrid devices).

On 04/08/2015 at approximately 0040 hour Corrections Deputy BOONE reported finding an inmate non responsive in "H" block, cell H2 of the Island County Jail. Patrol Deputies MIRBAL and ADAMS responded along with Medic and Aid units. I was called out as the duty Detective at 0048 hours.

I arrived at the jail at approximately 0114 hours and contacted BOONE, MIRABAL, ADAMS, and Corrections Deputy LIND; the Medic/Aid units had left prior to my arrival. BOONE advised that inmate Keaton FARRIS was in segregation in cell H2 due to behavior issues and was subject to hourly checks. When BOONE checked on FARRIS at approximately 0030 hours he found FARRIS sitting naked on the floor with his back to the corner of the door. BOONE stated this wasn't uncommon for FARRIS based on his past contacts with him. From his position BOONE couldn't see any signs of movement or breathing. BOONE opened the handcuff/feeding port (a smaller secure door in the main door) and attempted to get a verbal response from FARRIS as well as a physical response by using his baton to push FARRIS (BOONE did not initially open the main door due to FARRIS's prior assault attempts on officers in the facility).

When FARRIS still didn't respond BOONE opened the door (LIND was also present) and tried to wake him. BOONE stated that FARRIS's body was rigid, his color didn't look right and his eyes were open. BOONE stated he advised Corrections Deputy

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

SHARMA who was working in the control room to contact the dispatch center and send medical units. (SEE ATTACHED REPORT BY BOONE). As BOONE was providing the information, Doctor BISHOP, the Island County Coroner arrived.

BISHOP and I entered the cell block and I observed FARRIS sitting with his back to the lock side of the door to cell H2 (the door opens outward and to the right). FARRIS was naked and had EKG pads from the medical response on his arms and legs. His eyes were open and I noted discoloration of the skin on his left hand that appeared to be lividity, I noted no obvious signs of injury or trauma. The interior of the cell was littered with food scraps and I observed FARRIS's jail smock under the built in ledge next to the bed. All of my observations were made from the doorway of the cell; the cell was not entered until BISHOP had finished his initial photographs and video recording.

While BISHOP was taking photographs and video, I retrieved FARRIS's inmate book from the booking station along with the handwritten observation logs. I scanned the book to have an immediate digital copy then returned to take the original documents later.

When BISHOP completed his documentation we entered the cell. I observed what appeared to be paper plates and food scraps in the "sink" along with additional food scraps in the toilet bowl. I also noted that there was no water in the toilet bowl and the food scraps were dry. When I asked about the water, BOONE advised that the water in the cell had been shut off because FARRIS had flooded his previous cell.

BISHOP conducted a temputure check at approximately 0150 hours and determined that FARRIS's core body temputure was 89 degrees Fahrenheit. BISHOP's initial assessment was that FARRIS's time of death was prior to 2030 hours. I assisted BISHOP in removing FARRIS from the cell and noted additional lividity that appeared to be fixed and that his body was in full rigor. FARRIS was released to BISHOP and I sealed the door to cell H2 with evidence tape. After releasing FARRIS I contacted the inmate in cell H1 ([redacted] [redacted] advised that he had been asleep and everyone

coming into the cell block woke him up. [redacted] didn't recall hearing any unusual or any noise coming from H2.

H block in the Island County Jail is a segregation block that contains two individual cells, H1 and H2. The cells share a small common area that isn't accessible to the inmates when the cell doors are locked. H block shares a common entry area/sally port with G block where the single shower for both blocks is located. H block and G block are separated from this common area by locked doors and this common area is separated from the jail hallway by another locked door.

While we were moving FARRIS, the jail supervisor (Lt. McCARTY) arrived. I requested that McCARTY have the on duty jail staff write reports about the incident and have them to me as soon as possible. I also requested that any staff that had contact with FARRIS in the past 24 hours provide a report and that cell H2 would remained sealed until I advised otherwise.

Follow-up:

On the morning 04/08/2015 I began reviewing FARRIS's inmate book and observation logs. FARRIS's final observation log goes from April 7, 2015 at 0715 hours until April 8, 2015 at 0030 hours. The log has an area for how often the subject will be observed and provides the option of every 15 min, 30 min or hourly, with hourly being the option circled in FARRIS's log. The log has observations documented from 0715 hours, 0920 hours, 1017 hours and 1130 hours. There are no documented observations for 3.5 hours then they start again showing 1500 hours, 1600 hours, 1635 hours, 1730 hours, 1845 hours, 1945 hours, 2030 hours, 2230 hours, 2330 hours and the final entry of 0030 hours where FARRIS was found not breathing.

I contacted McCARTY and requested that she pull the jail surveillance videos so I could confirm the times on the log and determine if there were any checks made that

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

weren't logged. Reviewing the videos, it was obvious that the activities being shown, such as meal times, were not accurately reflected using the date/time stamp shown on the recordings (the recordings appeared to be at least two hours ahead of actual time). I requested that McCARTY provide a facility schedule for the evening events (meals, medication etc.) as well as a chronological history for FARRIS's stay in the facility (See attached).

To determine the amount of discrepancy between actual time and the time displayed on the recordings I wrote the current date and time, 4/8/15 @1534 hours (based on the date/time provided from the AT&T network on my cell phone) and held it up in front of one of the jail cameras. I download the video file and determined that the recordings were showing the correct date but the time displayed was 2 hours and 51 minutes ahead of actual time. (See attached video from DVR_17-32 Camera 17). Using that offset the corresponding activities appeared to match.

Camera 18 and Camera 27 are positioned at opposite ends of the long hallway that runs in front of the sally port entry into G/H block. Camera 18 is on the east end of the hall facing west, camera 27 is on the west end of the hall facing east. The video quality is poor but clear enough to see when the G/H block door is opened and someone enters/exits. The sally port door for G/H block is almost directly across from the work/deck station area where the inmate books are kept.

Using the video, I compared the entries on the log to actual checks physical checks into G/H block between 1500 hours on April 7, 2015 to 0030 hours on April 8, 2015 (the approximate window of death provided BISHOP initially). With the videos I can only confirm someone entered the sally port area but no activity past that.

I confirmed that entry was made into the block during the logged 1500, 1600, 1635 and 1730 checks. With the exception of the 1730 check, the actual times of the check were

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

within a few minutes of the logged times, the 1730 check (meal pickup) actually occurred at 1702.

There were two checks logged by personnel number 1105 (MOFFIT) at 1845 and 1945 hours but no one entered the block at those times or until 2037 (actual time) hours when the 2030 check was logged by MOFFIT. The next logged checks are at 2230 and 2330 by personnel number 1136 (LIND) but there is no entry into to the block at those times, or at all until FARRIS is found deceased.

Between 2053 and 2054 hours actual time (2334 and 2335 hours recorded time) a corrections deputy, who appears to be MOFFIT, stops at the block door and appears to be writing on the log but does not enter the block. Also, two deputies enter the block at 2100 hours actual time (2351 hours recorded time) but no entry is made in the log. Based on the video recordings between 1702 hours actual time and the time FARRIS was located there were blocks of several hours where he was not being checked/observed, 1702 to 2037 hours actual time and 2100 to 0040 hours actual time. (See Attached Timeline). This was an initial review of the logs, a full review of all the logs and any video documentation will be conducted. An internal investigation into the falsified log entries was initiated and being conducted by Detective FELICI.

On this date I also requested that the ICOM dispatch center provide copies of the recordings of the initial call from the jail as well as the radio traffic associated with the call. These were submitted for transcription.

In addition to the radio logs I requested Spillman System logs (syslog) for any access into or modification of FARRIS's records, along with the syslog entries for McCARTY, HIATT, PIECHOWSKI, PRENDERGAST, REED, MOFFITT, LIND, SHARMA and BOONE showing Spillman activity from April 7, 2015 at 0001 hours to April 8, 2015 at 0300 hours.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

Initial timeline in the facility, provided by McCARTY:

03/26/2015 at 1135 hours FARRIS arrived at the Island County Jail by San Juan County deputies and was placed into the padded safety cell.

03/30/2015 at 1550 hours FARRIS is moved to Cell Block D, cell D-2.

04/01/2015 at 0800 hours San Juan County Deputies pick up FARRIS for court in San Juan County.

04/01/2015 at 1600 FARRIS is returned to ICSO jail by San Juan County Deputies, placed back in D-2.

04/04/2015 at 1615 hours FARRIS is moved back into padded safety cell after flooding cell D-2.

04/04/2015 at 1630 hours is moved to H Block, cell H-2.

04/05/2015 at 1600 hours safety cell procedures are started for FARRIS in H-2.

After receiving the initial timeline from McCARTY, I requested all videos the Island County Jail had showing FARRIS or his housing areas from 03/26/2015 until 04/08/2015 at 0300 hours. In addition to the previously described cameras showing the door to H Block, this request would include the jail vehicle sally port and entrances, the jail elevator, and the deck camera pointing in the direction of the visiting rooms (the camera I conducted the time confirmation test on). The facility does not have cameras showing the door or area around the padded safety cell or D block; however, there is a camera in an adjacent hallway that should show people approaching D block but not necessarily entering the block.

On 04/09/2015 I e-mailed requests to the Snohomish County Sheriff's Office and the Skagit County Sheriff's Office for their records concerning FARRIS.

On 04/14/2015 I provided access to cell H-2 for San Juan County Prosecutor/Coroner Randy GAYLORD and Sheriff Ron KREBS to examine. GAYLORD entered the cell to

get a better view of the interior but did not move or touch anything. When he finished the door was sealed again. At this time I requested that Sheriff KREBS provide me any reports he had regarding his agency's contact with FARRIS. Those reports arrived the following day via e-mail.

On 04/16/2015 I provided access to cell H-2 for Rebecca ROE and Kathy GOATER, attorneys for Schroeter Goldmark & Bender who represent the FARRIS family along with their investigator Kathy LEODLER, also present was Lt. McCARTY. LOEDER took photographs of cell H-2 along with the additional photographs in various locations in the facility. When they completed their documentation I released cell H-2 for cleaning. Prior to H-2 being placed back into service I took measurements and tested the call buttons in the cell and common area of H block. Both buttons worked properly, sounding an alert in the control room and allowing voice communications back and forth.

FARRIS Timeline:

Lynwood PD:

FARRIS was contacted by the Lynwood Police department on 03/20/2015 at 1759 hours when the officer responded to a report of suspicious male at the Union Bank on SR 99 (Case number 15-02160). The officer (KOONCE) contacted a subject matching the description given and identified him as FARRIS. When asked what he was doing at the bank FARRIS advised KOONCE "I was projecting my thoughts at the people inside". FARRIS also stated "I'm off my meds and I'm pretty anxious right now but your badge is calming me down". KOONCE ran a check on FARRIS and determined that he had a valid felony arrest warrant out of San Juan County. FARRIS was taken into custody and transported to the Lynwood Jail for booking.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

FARRIS was booked at the Lynnwood jail on 03/20/2015 at 2040 hours by officer HODGINS. He was photographed and it is indicating that his weight at the time was 175 LBS. I contacted the jail who advised me that FARRIS was not actually weighed; they either estimated his weight or took it of his Department of Licensing records. FARRIS property was inventoried on the Lynwood Jail form, but on the line where the inmate was supposed to sign, "FTC/220" is written. The jail advised me that FTC stands for Failure to Comply and the 220 is a code for mental health issues. The property inventory also indicates that he came into the facility with medication of some sort. I was advised that they also had medical information and observation notes regarding FARRIS but due to HIPAA could not provide the information to me without a court order or family consent. FARRIS's father provided consent for the release of the records and they were provided.

The additional records consisted of medical screening conducted during booking (dated 03/20/2015 at 2040 hours) and a medication list. "Yes" answers on the screening include, #5 Is the person cooperative, #11 Does this person have any medication or pills (Lorazepam), #12, #13, #14 Currently taking any medication, any medication with you, taken any medication in the last 48 hours (all indicate back to #11 Lorazepam), #18 Are you sick, ill, injured (yes, Panic Attacks with a comment of Anxiety), #19 Do you have or have you ever been treated for: (yes, mental illness) and #26 Do you have medical, dental or vision insurance. FARRIS answered "No" to all the suicide related questions. The line where the inmate is supposed to sign contains "FTC/220". These records also contained a prescription medication record showing that FARRIS came in the facility with 4 Lorazepam .05 tablets and left with the same amount indicating that none were given to him while he was at the facility.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

Snohomish County:

On 03/21/2015 FARRIS was transported to the Snohomish county jail where he was booked at 0348 hours and held pending transport to Skagit County. FARRIS was moved multiple times while in the Snohomish County Jail and was released on 03/24/2015 at 1358 hours for transport to the Skagit County Jail.

I reviewed the documents provided by Snohomish County during FARRIS's booking screening. These documents noted that Bipolar 2 and Asthma were listed under chronic health conditions. In an entry under chronological notes dated 03/22/2015, at 0956 hours it was noted that FARRIS was moved to the "OU" due to his mental status and was unfit for "MHU" (Medical Housing) and seems to have mental health issues. The officer noted that when he approached the cell FARRIS was housed he saw that FARRIS was wearing a pair of nitrile (rubber) gloves. FARRIS was directed to remove them, which he did. When FARRIS failed to explain where he had gotten the gloves the officer placed him in lockdown status in cell 9. When FARRIS entered the cell 9 he jumped like he was startled. When asked a second time where he got the gloves FARRIS admitted that he had taken them off the desk but stated that "someone" had told him he could have them. The officer commented "it must have been the voices in your head" and FARRIS agreed. As the officer was documenting this exchange, FARRIS pulled the towel off his cellmates head and almost started a fight, that's when FARRIS was moved to "OU". A response to this information was posted on the same date at 1000 hours stating an MHP (mental health professional) will follow up on 3/22/2015. There is also a Mental Health Memorandum/Inmate release information for FARRIS that has the "Do not release" and the "gravely disabled" blocks checked stating that the inmate will need a jail mental health evaluation prior to leaving the jail. There is also an entry on this form that says "I/M is unwilling or unable to communicate verbally. He is presenting symptoms consistent with psychosis. An MHP will need to evaluate I/M upon release in order to

determine if a DMHP should be called for an ITA." This form is dated 03/22/2015 and signed by MHP HOOVER.

An e-mail from records technician SHANNON to MHP HOOVER was sent on this date at 1718 hours indicating that FARRIS had a pink slip (this appears to be the Mental Health Memorandum) and he was due to be transferred to San Juan County tomorrow (3/23/2015) on the Cooperative Transport. At 1753 hours MHP HOOVER replied that I/M Keaton is ok to transport.

On 03/23/2015 at 0807 hours it was noted that Per MHP HOOVER, start 30 minute behavior watch. No restrictions and 1 hour medical/detox watch remains. At 0917 hours it was noted to continue 30 minute behavior watch. There are no other notes referencing FARRIS's condition or behavior; however I was advised that there is additional medical information that could not be released to me due to HIPAA concerns.

On 03/24/2015 at 1358 hours the final jail release for FARRIS was done. It should also be noted that none of the blocks on the paperwork where the inmate is supposed to sign were filled out, indicating that FARRIS was unwilling or unable to sign. "Who?" is written on the inmate block for the form authorizing people to pick up property or clothing.

Skagit County:

On 03/24/2015 FARRIS arrived at the Skagit County Jail via the prisoner transport shuttle. A jail incident report dated 03/25/2015 at 0531 hours states that FARRIS arrived at the Skagit County Jail in a restraint chair and would not speak. It was also noted in the pass down document that FARRIS had mental health problems. The shuttle staff advised the Skagit jail staff that FARRIS had been Tasered at the Snohomish County Jail the previous day (03/23/2015) and the shuttle staff had initially declined to transport FARRIS due to his actions and not having the appropriate transport vehicle.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

On 03/24/2015 when the shuttle returned, FARRIS was brought out to the shuttle staff in a restraint chair and was being described as passive aggressive. FARRIS was placed in a secure section of the transport bus and the shuttle staff reported that there were no issues with him during the transport to Skagit County.

When he was brought into the facility, FARRIS walked on his own and complied with commands but would only stare and not respond verbally. When it was determined that Island County could not pick him up immediately, FARRIS was housed in "Gry 9" (an observation cell near the booking station where inmates can be easily observed by the corrections staff) due to his lack of communication, behavior, and the limited information Skagit County had regarding him.

Skagit County contacted Lt. McCARTY and she advised that Island County would pick FARRIS up in the morning. Deputy FADDIS (Skagit County) advised her that she should send two officers to transport FARRIS due to the information they had been given and his unpredictable behavior.

On 03/25/2015 Island County Corrections Deputy BOONE arrived to pick up FARRIS and two other inmates. FADDIS told BOONE that based on their observations of FARRIS he had recommended (to McCARTY) that they send two people to transport him. BOONE advised that information had not been passed down but managed to arrange a way to transport all three subject if FARRIS did not cause any problems.

The first two inmates were prepared for transport without issue but FARRIS immediately began struggling when they tried to place him in restraints (transport restraints are a leather belt that goes around the waist and locked in the back with a set of handcuffs in the front along with a set of leg restraints which allow the inmate to walk but not run). FARRIS continued to actively resist and attempted to bite one of the Skagit correction deputies. FARRIS was eventually placed in restraints but could not be transported by just one corrections deputy (BOONE). BOONE took the other two

inmates and advised Island County would try and make arrangements to get FARRIS later.

At 0645 FADDIS called Island County to see if they had a plan to transport. FADDIS was advised that McCARTY would not be in until 0700 hours and that she would call him when she arrived. At 0746 hours McCARTY called FADDIS and advised that she intended to have San Juan County pick FARRIS up and transport him to Island County and was waiting for a call back to verify the arrangements. McCARTY also advised that if she couldn't arrange it with them she would get two Island County deputies to pick him up and transport.

FADDIS advised McCARTY that something needed to be figured out because FARRIS was still sitting in restraints and FADDIS was not comfortable with him sitting in restraints that long. A short time later FADDIS received a call from San Juan County advising that they were waiting for permission from their Sheriff to transport FARRIS. FADDIS contacted the Skagit Jail Nurse (BAERG) and requested that she check FARRIS to see if remaining in restraints would cause any issues.

At 0800 hours BAERG attempted to examine FARRIS but was only able to determine that he was breathing fine and he legs were fine but she could not examine his arms because he would lunge at the staff when they tried to examine him. BAERG's medical notes stated, seen in gray (cell location), able to visualize feet, toes pink +swelling, unable to see hands, handcuffed in back. The notes also indicated that FARRIS refused his Lorazepam at 1120 hours. The lower part of the medical slip has a portion dated 3/21/2015 (the time FARRIS would have been at Snohomish County) that indicated +benzos, +amphet, +THC (positive for drug usage) and MHP (mental health), Bipolar, observation unit @sno (Snohomish County), disorganized, bizarre thought content.

After BAERG left, FADDIS indicated that FARRIS got up on his own and began pacing the cell. Deputy LaQUET attempted to speak with him but got no response. At

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

approximately 0910 hours FADDIS received a call from Lt. SEATON of the San Juan County Jail who requested that Skagit County Contact mental health services (CDMHP/DCR Certified Designated Mental Health Provider/Dedicated Crisis Responder) about FARRIS. SEATON also advised that the San Juan County public defender and prosecutor's office were going to attempt to have a competency hearing for FARRIS.

Since they were still trying to coordinate what to do with FARRIS, at 0920 hours FADDIS directed the jail staff to remove his restraints. The staff attempted to get FARRIS to voluntarily comply, but he refused and had to be taken to the ground to remove them. A call was made for a DCR to respond to the jail to speak with FARRIS. At 0945 CDMHP/DCR CANNIFFE called back and after being advised of the situation declined to respond at this time due to the vagueness of the nature of the request and the jurisdictional issues. FADDIS provided this information to SEATON who advised he would contact his administration. FADDIS attempted to contact McCARTY but received a voicemail that she was out of the office and unavailable. At 1125 hours FADDIS contacted SEATON again and was advised that they were trying to work out some sort of Competency hearing for FARRIS. At approximately 1200 hours SEATON called back stating that Island County would pick FARRIS up the following morning (3/26/2015). At 1550 hours SEATON advised that San Juan County would pick FARRIS up at approximately 0800 hours on 3/26/2015.

On 03/26/2015 at approximately 1015 hours San Juan County arrived to transport FARRIS to Island County. FARRIS was still housed in grey 9 and was lying on the floor with his against the cell door. FARRIS would not respond to verbal commands when asked to stand up and began to ramble. After several attempts to get him to comply Deputy HINES reached down to lift FARRIS off the floor so he could be restrained for transport. FARRIS stated "you cannot touch me" and pulled away from HINES. Deputy

SHULER assisted and they picked FARRIS up by the arms and escorted him out of the cell. FARRIS was passively resistive to being placed into restraints and stiffened (tensed) his muscles requiring the deputies to force his arms behind his back. When they attempted to place leg restraints on FARRIS he kicked at one of the deputies. FARRIS continued to be resistive as he was escorted to the vehicle for transport.

Additional medical records/notes provided by Skagit County show that FARRIS arrived with 4 tablets of .5mg Lorazepam provided by Swedish Hospital in Edmonds. An entry on the inmate medical history dated 3/25/2015 at 0032 hours states "Subject brought in on the day shift from Sno County. Subject arrived in a restraint chair. Subject would not speak to anyone. Subject was housed in Sno County's mental health ward. Leaving for San Juan County in AM. Unable to screen. DCF"

Island County:

On 03/26/2015 at approximately 1135 hours FARRIS arrived at the Island County Jail and was placed directly into the blue padded safety cell. A handwritten record of restraint from his arrival stated "Inmate + Officer Safety. Inmate acting agitated appears distressed due to transport from Skagit County by San Juan County S.O." There is no signature on the form but it listed the names of the San Juan County deputies along with McCARTY and PIECHOWSKI from Island County. There is no additional narrative attached to this form. A safety cell observation log is started at this time.

A hand written entry from the pass down log from this date (no time indicated but it would have been prior to 1135 hours) by 1156 BOON stated "*When I/M FARRIS comes in he is to be a two person movement and remain handcuffed during the movement. Also AD seg.(administrative segregation) for officer safety.*" A booking record was started for FARRIS on this date as well at 1440 hours showing him housed in the BMM. As part of

this booking record the property that FARRIS arrived with was inventoried. There is no indication that he arrived with any of the medication (Lorazepam).

On 03/27/2015 there is another hand written entry from the "pass down log" by 1168 BINGHAM that stated "*Attempted to give cup of water through feed slot on the padded safety cell – FARRIS – FARRIS grabbed Dep. EVANS hand and tried to pull him into the slot. FARRIS splashed water all over us through the door before it was closed. Officer Safety at all times.*" A hand written incident and discipline report was completed by BINGHAM which outlined the incident as well.

On 03/30/2015 at approximately 1505 hours McCARTY allowed FARRIS's Aunt Tamra FRALIC to enter the facility and speak with FARRIS through the door of the padded blue room hoping it would help calm him so he could be moved into a general population cell. At approximately 1552 hours FARRIS was removed from the padded safety cell to cell block D, cell D-1 (downstairs from the deck station) and not placed under safety cell procedures. At an unknown time on the same date there is a handwritten entry in the pass down log by 1155 KELLY that stated "*the water to D-1 inmate FARRIS is off. He has his pillow in the toilet and is playing in the water in his sink. I suggest only turning on the water at meal times.*" There is no other reference to the water being turned off in the cell or documentation to provide FARRIS water/fluid other than at mealtimes.

During his interview Deputy LIND mentioned an incident with FARRIS that would have occurred around this time while he was in cell D-1. LIND stated that Deputy PIECHOSWKI had called him down to D-block stating "you need to take a look at this". When LIND arrived he observed FARRIS naked, face down on his bunk with his head hanging over the edge with some sort of fibrous mass hanging out of his mouth. LIND thought that FARRIS was trying to swallow a cleaning rag and may be choking or gagging on it. Since FARRIS hadn't had a cleaning cart in his cell PIECHOWSKI

thought it was the stuffing from his pillow that he had tried to flush. LIND told PIECHOWSKI that whatever it was FARRIS was choking on it and they needed to get it out of his mouth.

They went upstairs to get gloves and PIECHOWSKI said that since the Lt. (McCARTY) was there he was going to let her know what was going on. LIND followed PIECHOWSKI to McCARTY's office and heard him tell her that they needed to go into the cell because he looked like he was choking on something. LIND advised that McCARTY replied and was specific when she said "Do not open that door. Leave that man alone." LIND stated that he went back to work and wasn't sure if PICHOWSKI went back down to D block to check. This incident is not documented anywhere and PIECHOWSKI did not mention it during his interview.

I contacted PIECHOWSKI a second time and specifically asked about this incident. PIECHOWKSI remembered FARRIS had a white rag or some sort of material over his mouth and was kind of gagging but he wasn't sure if he was gagging on or into the rag. PIECHOWSKI states that he either called LIND or he came down on his own while PECHOWSKI was how to deal with the situation. PIECHOWSKI said they continued on with whatever they had been doing at that time and a short time later mentioned it to McCARTY who was at the deck station. McCARTY decided that it wasn't worth the risk of assault to the deputies or FARRIS to go in and remove a cloth from his room. PIECHOWSKI stated that it was slightly concerning that he had the cloth in his mouth but it didn't appear that he was choking on it (his color was good, he didn't appear in distress).

During her interview I asked McCARTY about this incident. She stated that that it sounded familiar but she doesn't specifically recall it. I outlined what PIECHOWSKI and LIND had told me and that they had possibly asked her permission to go into the cell to take the rag away. McCARTY again said that she didn't remember the incident

specifically but it sounded right. I asked if she remembered telling them not to go into the cell and to leave FARRIS alone or something to that effect and she stated "I don't remember this."

On 03/31/2015 there is a handwritten medical treatment form with a time of 1020 hours on it. Written on the form is "*Father's call, vispealidone (SP?), Lithium. Mr. FARRIS* [redacted] " Based on the logs there is no other documented interaction between FARRIS and anyone, other than meal service until 04/01/2015.

On 04/01/2015 at approximately 0800 hours SEATON and URNACH arrived at the Island County Jail to transport FARRIS to San Juan County by car and ferry for court (inmates are normally flown between the locations). When the deputies attempted to restrain FARRIS for transport he resisted and had to be taken forcibly to the ground. FARRIS did not communicate with the deputies during the transport. When they arrived at San Juan County FARRIS was placed in a restraint chair where he remained until his transport back to Island County.

FARRIS's attorney was escorted back to see him but he refused to answer any questions or communicate with her. At approximately 1230 hours FARRIS's mother was escorted in to see him. When she walked into the room FARRIS looked up and said "hey mom" but he refused to engage her or answer any of her questions. At approximately 1345 hours FARRIS was moved out of the cell and showed no sign of resistance. He allowed them to place him in a transport belt (hands in front) and he was transported back to the Island County Jail and placed back into his cell without incident.

On 04/4/2015 there is handwritten entry in the pass down log by 1150 BECKER that stated "*Moved FARRIS to H-2, water is turned off, nothing in cell*". A handwritten record of restraint form along with a typewritten narrative indicated that FARRIS had flooded his cell in D-block and was found laying on the floor making swimming motions and dunking his head completely in the toilet. FARRIS would not respond to verbal

instructions and had to be escorted upstairs to the intake shower so he could be warmed up and the cell mopped. After the shower, FARRIS was placed in the blue padded cell while the water in cell H-2 was turned off and the toilet drained. The report indicates that WHESTEL, BECKER and BINGHAM were the corrections deputies. There is also an e-mail from BINGHAM to Chief DENNIS and McCARTY the outlined the earlier issue with FARRIS to include his concern about him being wet and cold and FARRIS being locked down in cell H-2 with the water turned off. The daily activity worksheet also showed that FARRIS was showered, given drinking water and moved to H-2 with the water turned off. The safety cell procedures/logging was not started at this time. Based on the logs there is no other documented interaction with FARRIS other than meal service until 04/05/2015.

On 04/05/2015 at approximately 1600 the safety cell procedures are started on FARRIS in cell H-2. This is also noted on the daily activity worksheet along with and entry under the sick call block "*Farris-Staff as per safety cell regs*" which indicated that the staff requested he see the nurse/medical staff as per the safety cell procedure. There is no indication that FARRIS saw medical staff on 04/05/2015.

On 04/06/2015 under the sick call block on the daily activity worksheet is another entry that stated "*FARRIS-as per safety cell regs*" along with others stating "*FARRIS-safety cell procedures started*" and "*FARRIS-moved to H-2 water shut off*". At 0930 hours on this date FARRIS saw the jail nurse (BARKER). BARKER entered under the notes "*Responded to the safety cell to observe Mr. FARRIS this morning. He is lying on the floor with his elevated on the wall with his feet elevated on the toilet. His color is good. Respirations regular at 16/min. He responded to my questions with appropriate answers. D.YOUNG PA-C notified/NB.*" BARKER does not mention in her medical notes, but later advised in her statement that FARRIS stated something to the effect of

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

"oh good a medical professional" or "I need a medical professional" when she introduced herself and answered "not good" when she asked how he was doing.

At 1030 hours Doctor HENDRICKSON from Western State Hospital attempted to interview FARRIS for his court ordered competency examination. In his report HENDRICKSON states [redacted] During my attempts to speak with him, he lay naked on the floor of his cell, talking continuously to himself, as if he were speaking to a person in the cell". Based on his report it does not appear that HENDRICKSON made any recommendations to the jail staff regarding FARRIS's condition after his interview.

HENDRICKSON also stated as part of his report that he had interviewed FARRIS's father, [redacted]

FRALIC indicated that FARRIS had first exhibited [redacted]

Fred FARRIS indicated that FARRIS first exhibited indications of [redacted]

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

[redacted]

HENDRICKSON's report was completed on 04/08/2015 the day after FARRIS died. I contacted HENDRIKSON by phone and asked how he was allowed to interact with FARRIS during his interview. HENDRICKSON stated that he attempted to do his interview through the feeding slot on the closed cell door.

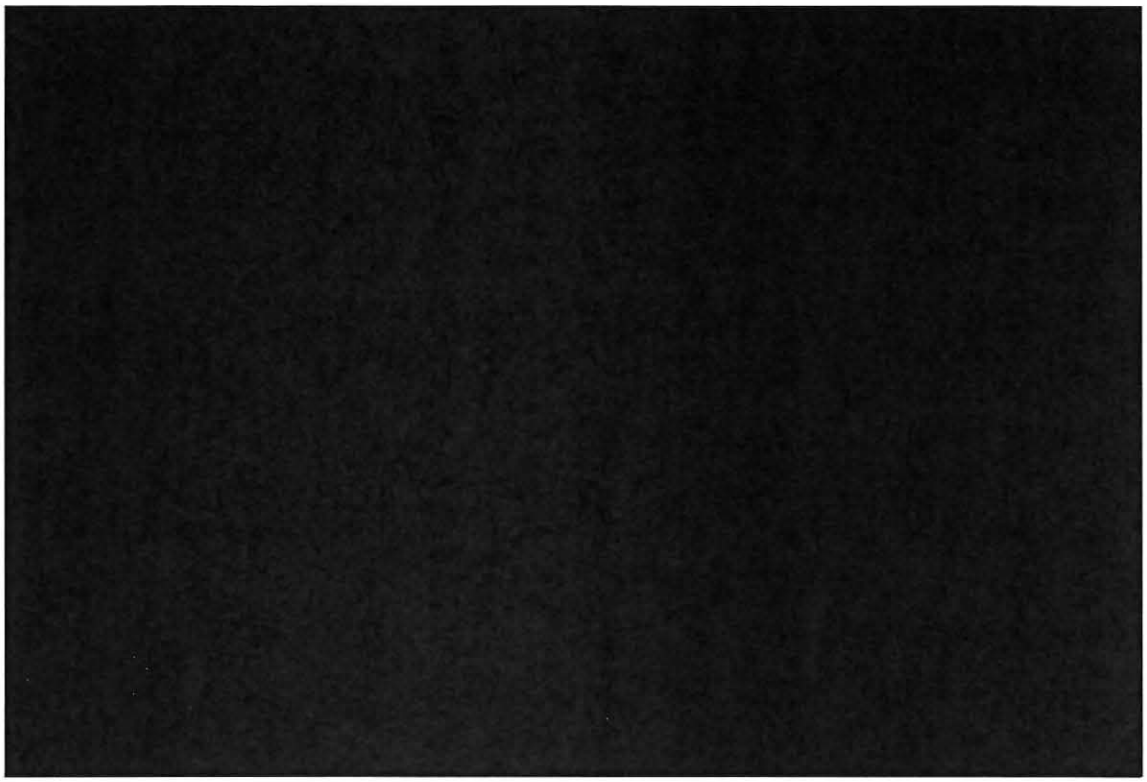
On 04/07/2015 the daily activity worksheet indicates "*H-2 FARRIS-Safety cell procedures started/water shut off*". This is also the date where there are documented multiple gaps where the hourly checks were not being conducted and several documented checks were determined not to have been done. According to the observation log, the 0800, 1200, 1300 and 1400 hours checks were not conducted at all and as stated earlier we were able to determine that several checks that were logged were not conducted, to include the check logged at 2330 hours approximately one hour before FARRIS was found deceased.

Coroner/Pathologist reports:

[redacted]

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352



Water/Fluid Intake:

The Island County Jail uses number 77 wax paper Dixie cups to provide water/fluids to inmates that are not receiving standard meal/tray service. Using a syringe I determined that these cups hold 7 ounces of fluid total (to the very top of the rim) but most likely contained an average of 5 ounces of fluid when provided to an inmate (allowing space for movement so the fluid doesn't spill).

FARRIS was placed directly into the blue padded safety cell when he arrived at the Island county jail where he would not have had the ability to obtain his own water/fluids. Using the Safety cell observation logs as a guide to when he would have been provided fluids, between March 26, 2015 at 1135 hours and March 30, 2015, 1550 hours it appears that FARRIS took water 15 times. Assuming FARRIS drank all the water that was

offered (and the logs do indicate that he spilled some) that is at most 75 ounces of fluids during an approximate 100 hour period. As a guide line, the Institute of Medicine determined that an adequate intake (AI) for men in FARRIS's age group is roughly about 3.7 Liters (125.11 ounces) of total fluids a day; this is both from foods and fluid intake (referenced from the attached chart via the Institute of Medicine). Using this standard FARRIS should have taken in 521 ounces of fluid during the same period for it to be considered adequate intake. FEMA recommends an intake of 64 ounces of water per day for survival, using this standard FARRIS should have taken in 266.24 ounces of water/fluids.

FARRIS was moved to D block on March 30, 2015 at 1550 hours. An entry in the hand written pass down log, dated March 30, 2015, by Deputy KELLY states that the water to cell D-1 (FARRIS) is turned off due to his pillow being in the toilet and playing in the water. KELLY suggests that the water only be turned on during meal times. (KELLY confirmed this in his interview). FERRIS was moved out of D block on April 4, 2015, at 1615 hours and placed in the padded safety cell after flooding his D block cell.

Since FARRIS was not placed under safety cell procedures in D block there are no logged checks so, to determine fluid intake I have to base estimates on the daily facility log (typewriter log) to determine if he took his meals/fluids or not using the same 5 ounce estimate.

FARRIS took 10 meals during his time in D block (approximately 120 hours), for an approximate total of 50 ounces of fluid. Based on the NIH chart his intake during that time period should have been 625.2 ounces, based on the FEMA standard his intake should have been 312 ounces. If the logs are correct and the water in his D Block cell was turned on during meal periods, there is a possibility that he may have consumed additional water on his own during those times. Additionally, FARRIS was in the custody of the San Juan County Sheriff's Office on April 1, 2015 between approximately

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

0800 and 1600 hours for court. There is no documentation but there is a possibility of additional fluid intake at that time.

On April 4, 2015 at 1630 hours, FARRIS was placed into H block, cell H2 with the water turned off, however, safety cell procedures were not started on him until April 5, 2015 at 1600 hours (23.5 hours later). There are no logged checks for that 23.5 hour time frame so, to determine fluid intake I have to base estimates on the daily facility log (typewriter log) to determine if he took his meals/fluids or not using the same 5 ounce estimate. FARRIS took 3 meals during that time period for a total of 15 ounces of fluid. Based on the NIH chart his intake during that period should have been slightly less than 125 ounces based on the FEMA standard his intake should have been slightly less than 64 ounces.

On April 5, 2015 at 1600 hours the safety cell observations began on FARRIS in cell H2. Using the logs FARRIS took water/meals 9 times for a total of 45 ounces in the 56.5 hours between the time the observations were started until he was found deceased. Based on the NIH chart his intake during that period should have been approximately 292 ounces, based on the FEMA standard his intake should have been approximately 149 ounces.

Compiling the results, based on the instances that we have documented where FARRIS was provided water/fluids, his total intake for the time he was in the Island County Jail appears to be approximately 185 ounces. This number could be lower since we cannot confirm that he consumed all the water/fluids provided; it could higher as well since there were windows of opportunity where he would have been able to provide himself water.

Using the NIH chart as a guideline, FARRIS's total intake should have been approximately 1563.2 ounces of water/fluids to be considered adequate during his time in

the facility. Using the FEMA guidelines FARRIS's total intake should have been approximately 791.24 ounces for survival situations.

It should be noted that the water intake outlined are estimates based on documentation available and the NIH/FEMA amounts are provided are for comparison. I cannot determine what state of dehydration/malnutrition FARRIS may have been in when he arrived at the Island County Jail.

Safety Cell Policy/Procedures:

The Island County Jail has a policy regarding the use of safety and sobering cells, this policy is 538, specifically subsections 538.1, 538.2, 538.3 and 538.4 from the Lexipol Custody Services Manual. Even though this policy is marked with "DRAFT" in the footer, it is attached to a memo from Chief DENNIS indicating that it is in effect. This memo and policy were retrieved from a book at the deck station with a cover sheet/memo titled Safety Cell Documentation dated 11/04/2014. The memo states that the chief is attempting to make the transition to Safety Cells as painless as possible and that most important part of the procedure is documentation, followed by a statement saying "We have been lax in documenting what we did and why we did it." There is no indication in any of the documentation that would lead me to believe that policy 538 is only out for review and not the current policy in place.

Employee Interviews:

As part of this investigation employees who interacted with FARRIS while in the Island County Jail were interviewed being asked the same general questions then specific questions regarding their interactions with FARRIS. These interviews were recorded and transcribed.

When asked, the correction deputies stated in various ways the basic parameters of the safety cell policy, and indicated that the current policy was the one that had been

implemented by Chief DENNIS via memo (some knew it was a Lexipol Policy). None stated they had any formal training in the policy. The deputies stated that they knew safety cell checks were mandatory and the majority thought they could be disciplined for not conducting them. They also stated that the safety cell checks should be one of the highest priorities of their duties. The deputies summarized in various ways how they conduct a safety cell check, some stated that they looked for signs of movement or breathing, others stated that they would attempt to elicit a response from the inmate. Several off the deputies indicated that FARRIS was aggressive/risk to staff but only a few could indicate why he was deemed that or tell me of an incident (grabbing deputy EVANS) where he acted aggressively towards staff other than struggling while being put in restraints or being passive aggressive. None of the deputies indicated that there was a policy or procedure in place on how to deal with an inmate who was refusing to drink fluids.

The following are summaries from specific interviews in regards to this investigation.

HIATT:

Deputy HIATT was on shift the day that FARRIS died and based on the estimated time of death would have been one of the last deputies, along with deputy MOFFITT to check on FARRIS prior to his death. HIATT was also present when Nurse BARKER did her evaluation of FARRIS. HIATT stated that during each check of FARRIS he would offer him water; this was correct up until the logs on 4/7/2015 where many of his logged do not indicate FARRIS was offered water. HIATT also stated that there was an order in place not to open FARRIS's cell door without a minimum number of deputies present.

In regards to the medical evaluation by BARKER, HIATT states he was there with another deputy but can't remember who. BARKER saw FARRIS based on a staff request

to see him. HIATT stated that BARKER observed FARRIS through the cell door and he wouldn't respond to her. HIATT remembers FARRIS moving while she was observing him and BARKER saying "his color looks good". HIATT did not open the cell door and stated that BARKER did not ask for the door to be opened to examine FARRIS.

Breaking down the checks conducted on 4/7/2015, HIATT stated that FARRIS took his food at 1130 and he conducted a check at approximately 1210 hours that he didn't log. During the dinner meal pickup at approximately 1730, HIATT described observing FARRIS sitting in what sounded like the position he in when he was found deceased. HIATT states that he was in the cell block with deputy MOFFITT and observed FARRIS sitting with his back to the left of the cell door with his feet pointed towards the center of the room. HIATT stated that he tapped on the door with his keys and asked if he wanted water. HIATT observed FARRIS raise his hand then put it back down but FARRIS did not respond.

HIATT and MOFFITT left the block and the next time HIATT entered the block was at approximately 2030 hours (2037 actual time) for evening medication drop off. HIATT was providing medication to the inmate ([redacted] in the cell next to FARRIS and he observed MOFFITT looking into FARRIS's cell. After completing [redacted], HIATT stopped to look into FARRIS's cell. HIATT said he tapped on the door with his keys but didn't get a response. HIATT tapped again and MOFFIT said something to the effect of "he was moving when I look in" or some other comment about FARRIS moving so HIATT walked out and continued his rounds. *This is now in the window of time provided by BISHOP for FARRIS's death. It was also determined that the solo safety checks that MOFFITT logged at 1845 and 1945 hours were not conducted so the last time that it can be confirmed that FARRIS was alive was during the 1730 hours check where HIATT observed him raise his hand.*

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

There is another period between the 2030 hour check and a logged 2230 check that no checks were conducted on FARRIS. HIATT states that it was the end of a 17 hour shift for him and he forgot to do the other checks. HIATT indicated that there were other deputies on the deck at this time, but they did not do the checks either. *The investigation determined that even though there were additional checks logged, NO checks were conducted on FARRIS after 2030 hours until he was found deceased at approximately 0030 hours. Given the totality of the information available, including his lack of reaction to HIATT tapping on the door, it is more likely than not that FARRIS was deceased at 2030 hours*

MOFFITT:

At the time MOFFIT provided this statement he was on administrative leave, under internal investigation for falsifying FARRIS's safety cell check logs 04/07/2015.

Deputy MOFFITT was on shift the day that FARRIS died and based on the estimated time of death would have been one of the last deputies, along with deputy HIATT to check on FARRIS prior to his death. In his statement MOFFIT outlined his understanding of the safety cell policy and he was told that McCARTY had ordered FARRIS's cell door not be opened for any reason. MOFFIT reviewed the safety cell logs and admitted that he falsified the log at 1845 hours and 1945 hours and did not do the checks. In regards to the check at 2030 hours, MOFFIT stated that he was in H block while HIATT was providing medication for the other inmate. MOFFIT remembers HIATT asking if FARRIS had been checked and MOFFIT advised him that he had checked FARRIS.

MOFFIT described FARRIS as lying on the floor in front of the door almost in a prone position with his hands across his chest or stomach and his head in the corner. MOFFIT thought FARRIS was sleeping and that he may have seen one of his fingers twitch.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

LIND:

At the time LIND provided this statement he was on administrative leave, under internal investigation for falsifying FARRIS's safety cell check logs 04/07/2015.

Deputy LIND was working mid shift the day that FARRIS died and was working when Deputy BOONE located FARRIS deceased. In his statement LIND outlined his understanding of the safety cell policy and that there was an order in place that FARRIS cell door not be opened. In regards to the cell door, LIND stated that there was an order in place that the cell door not be opened with less than two people, then another order passed down from McCARTY that the cell door not be opened at all and advised of the incident regarding the rag described earlier in this report.

LIND admitted that he falsified the check log and did not actually conduct the checks listed at 2230 and 2330 hours. LIND also admitted that those checks along with the check logged at 0030 hours were all written down after they had found FARRIS deceased.

BOONE:

Deputy BOONE was working mid shift with Deputy LIND the day that FARRIS died and was the deputy that found him deceased. BOONE was also the deputy who initially responded to Skagit Count to transport FARRIS to Island County. In his statement BOONE outlines his understanding of the safety cell policy and that there was a standing order that FARRIS's cell door not be opened unless there were two people present. BOONE also believes that there was verbal pass down to try and get FARRIS to drink water.

In regards to the incidents at Skagit County, BOONE stated that FARRIS began actively fighting and resisting when they tried to handcuff him for transport and while

doing that, attempted to bite one of the Skagit Deputies and wrapped his legs around the Skagit Deputy's legs so they couldn't put leg restraints on him. BOONE stated that he did not know of any incidents of FARRIS doing anything to, or acting out with Island County corrections staff.

BOONE stated that on the night of the 7th, morning of the 8th at approximately 0020 hours he entered H block to do his checks. BOONE observed FARRIS down by the door of his cell then walked over to H-1 to check. The inmate in cell H-1 ([redacted] was awake either reading or writing something. *When I contacted* [redacted] *the night FARRIS was found deceased, he advised me that he had been asleep and the commotion of everyone coming in woke him up.* BOONE returned to cell H-2 and checked again because he did not see any movement from FARRIS the first time.

BOONE stated that due to the way FARRIS was situated against the door or in the corner he couldn't see any movements that would indicate that FARRIS was breathing. BOONE called LIND over to see if he could see anything. When LIND didn't notice any movement, BOONE opened the cuff port, incase FARRIS was "playing possum" (acting like he was asleep) and attempted to talk to him or get a response. FARRIS didn't respond so BOONE used his expandable baton (not wanting to reach his arm inside the cell) and pushed on him to try and initiate a response. When FARRIS didn't respond to that, BOONE reached in, felt his head and tried to shake him to wake him up.

When he touched FARRIS, BOONE stated his head and neck were very ridged. They opened the cell door and BOONE observed the FARRIS's color was completely gone and that he was stiff/rigid. BOONE radioed the control room and had them call for a medical response. Deputy MIRIBAL arrived first with an Automated External Defibrillator (AED) and elected not to use it due to the state FARRIS was in. Medical arrived a short time later and ran a heart monitor which detected no signs of life.

When asked about the log entries that LIND admitted weren't done, BOONE didn't know if LIND conducted the checks but stated he saw LIND writing on the log sheet after they had located FARRIS.

BARKER:

BARKER is a registered nurse employed by the Island County Health Department that provides medical/sick call services on Monday, Wednesday, Thursday and Fridays dividing time between the Island County Jail and the Island County Juvenile Detention Facility.

BARKER stated that FARRIS was initially brought into the facility while she was on vacation, and that she did not see FARRIS until a staff initiated sick call on the morning of 04/06/2015. As stated earlier in the report, BARKER observed FARRIS through the window in the cell door. She stated that his color looked good, his respirations were fine, and he was moving.

When BARKER introduced herself as "Nancy the Nurse" FARRIS mumbled something to the effect of "medical professional" or "I need a medical professional". When BARKER asked how FARRIS was doing he stated "not good". When she asked where he was, FARRIS stated "jail". After this brief interaction (she estimates about 2 minutes) BARKER stated she was escorted back to the medical office and that she did not have a hands on encounter with FARRIS. BARKER did not ask for the cell door to be opened because she had heard the staff talking about him being violent, disruptive and uncooperative.

After meeting with FARRIS, BARKER completed the facility sick call then entered her notes/observations into the Spillman system. Concluding the interview BARKER stated that she did not believe she was allowed enough time to properly evaluate FARRIS but doesn't feel that should could have told the staff to open the door so she could

conduct a proper evaluation (in a second recorded statement BARKER outlined how she would have liked to do the evaluation). BARKER stated that FARRIS arrived at the facility with no medical history or indications that he was taking any medications.

McCARTY:

Lieutenant McCARTY is the jail supervisor and currently the only civil service supervisor in the jail. The other jail Lieutenant is an acting position that is rotated monthly between the correction deputies. McCarty outlined her understanding of the safety cell policy and indicated that the current policy is the one that was put out in November (2014). McCARTY believes that it is the policy from Lexipol.

When asked what the priority of the safety cell checks (facility wide) should be, McCARTY stated that normally the priority would be the check but there are times when people get busy and forget. McCARTY also stated that there was no mandate in place to watch FARRIS eat or drink. McCARTY outlined FARRIS's movement from the "blue room" downstairs to D block and eventually up into H block.

We discussed the water being turned off in D block and why that was done. I asked McCARTY where the water being shut off was documented and she stated, "we just did it" and that she wasn't aware of it being documented in any log. *The water being shut off in cell D-1 was documented in the pass down book by KELLY on 03/30/2015.* McCARTY also stated that FARRIS was not under safety cell protocols while he was in cell D-1.

When FARRIS was moved from D-1 to H-2 McCARTY stated that she didn't think FARRIS was under safety cell protocols initially because he was moved on Saturday and they didn't initiate the protocol until Sunday even though the water was turned off in the cell. McCARTY stated that the water being turned off in H-2 was documented in the

pass down book. We discussed the multiple log books, and activity sheets the staff keeps and the purpose of each.

McCARTY stated that there was no protocol in place to watch FARRIS eat or drink but he was considered a two man movement and his cell door was not to be opened without two people present due to his resistive nature. When asked if she knew of any instances of FARRIS being aggressive towards Island County staff, she stated "only when we'd go to move him" then clarified that he was resistive toward the end (of the move) and that she heard he threw water. I asked specifically if she knew about FARRIS grabbing any of the corrections officers. McCARTY stated that she didn't recall, she just recalled the water incident, but it should have probably just been documented in the pass down (book) or the safety cell sheet. *FARRIS's inmate book at the deck station contained an Incident and Discipline report dated 03/27/2015 that states FARRIS reached out and grabbed Deputy EVANS by the hand. It also states "Officer Safety Issue" and "Two officer response".*

I provided McCARTY the safety cell logs and had her review them for her entries. McCARTY explained why she allowed FARRIS's aunt to visit him in the padded safety cell (an attempt to get his cooperation), McCARTY said after the visit they were eventually able to move FARRIS to D block, which went easier than his previous move, but he was still not following verbal commands and sat on the ground, crawled out a little bit, and was eating the food crumbs off the floor. McCARTY's described it at as "getting pretty sad".

We continued to discuss FARRIS's behavior, specifically how he was non-communicative but every once and a while he'd answer with "yes" or "no" or he'd shake or nod his head but wouldn't communicate in full sentences. I asked if she thought it was a mental health issue and McCARTY answered "Yeah I believe so, yeah."

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

We next discussed the possible choking issue with the rag or cloth while FARRIS was in D block. I asked McCARTY if she remembered the incident where PIECHOWSKI and LIND came to her because FARRIS had something in his mouth. McCARTY stated that it sounded familiar but she didn't specifically recall it but it sounds right. She also didn't remember telling PIECHOWSKI or LIND not to go into FARRIS's cell.

We continued with FARRIS being housed in H block. I asked her if the water was time FARRIS was put in H block? McCARTY answered "that's what I was told". When I asked what the delay was in starting the safety cell procedure when placing somebody in a block with no access to water, McCARTY answered "I don't know." "I wasn't there."

We next discussed the jail nurse (BARKER), McCARTY advised that she works approximately 32 hours per week in the jail and is an employee of the Island County Health Department. McCARTY advised that there is no protocol in place for the medical staff to override a lock down so they can be evaluated, but the nurse could let them know what she wanted and they could maybe work from there but lockdown is a "safety thing" so the nurse couldn't have access if that was the case. McCARTY was standing outside H block when BARKER did her evaluation of FARRIS and she confirmed that it was done through the closed door.

I asked why the safety cell protocols weren't started when FARRIS was moved to D block and the water was turned off. At that point in time McCARTY said that FARRIS was in "general population" hoping that might spur some communication from him and they didn't see reason for a safety cell. When I asked if that meant he was allowed out of his cell and into the block day area or if he was still locked in his cell, she confirmed that he was still in a locked cell but he had access to a call button (that rings in the control room).

When I asked about FARRIS's being moved to H Block with the water off and why the safety cell protocols weren't started, McCARTY stated "I don't know". When I asked

McCARTY if the protocols should have been started, she answered, "I would think to be on the safe side yeah" and "I can Monday night quarterback not you know I –I don't know. He wasn't moved because he was a threat to himself at that point". *In the e-mail from Deputy (acting Lieutenant) BINGHAM to DENNIS and McCARTY after the move to H Block, BINGHAM clearly outlines that the move was done for safety. "FARRIS was shaking, his fingers were pruning up and it was evident that he was very cold and naked. Venturing on the side of safety and his health, we once again brought him upstairs and placed him into a warm shower for about 20 mins. After which time he was escorted to H2 and locked down."*

We discussed policy 538.1, the Safety and Sobering cell procedures and whether or not it is the current policy. McCARTY stated that was her understanding that Policy 538.1 is the current policy they should be using, even though it states "Draft" on the bottom.

We then discussed policy 538.3 Safety Cell Procedures section by section. In regards to section "A" placement of inmates into a safety cell, McCARTY defined "shift supervisor" as a lead officer, acting Lieutenant, herself or the Chief (DENNIS). McCARTY explained how the lead officer is selected and that they, along with the acting Lieutenant get paid for being in those roles.

In regards to sections "B" and "C" of the procedure, we discussed the amount of time between checks and that each check shall be documented and a supervisor shall inspect the logs for completeness every two hours and document this action on the log. McCARTY admits that there was no supervisory oversight on any of the logs and when I asked why she stated "Cause I didn't do my job". When asked who else would be responsible for the log checks, she stated the acting Lieutenant, lead officer, and the Chief.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

We continued with section "D", the inmate clothing and the reasons for placing an inmate in a safety (also known as a suicide) smock, why FARRIS was issued one instead of a standard jail uniform and section "E", the inmate shall be offered water and Juices at least hourly and the inmate shall be given sufficient time to drink the fluids before the cup is removed. I provided McCARTY the safety cell logs and asked if that occurred. McCARTY advised that it did not look like (based on the logs) that FARRIS was offered water every hour. McCARTY confirmed that an inmate in a cell with the water turned off has no way to provide themselves water. When I asked how it could be determined that FARRIS was offered water in the first 23 hours he was in H block with the water turned off and no safety cell checks being logged she stated that there was a carafe of water sitting out on the deck with cups and she couldn't imagine the staff would have put a carafe of water out if it wasn't to give an inmate water.

Section "F" states inmates will be provided meals and the meals will be documented on the logs. McCARTY stated that she knew that FARRIS was given water or juice at every meal because that would be part of the meal. Section "G", states that the shift supervisor shall review the appropriateness for continued retention in the safety cell every 8 hours, and the reason for continued retention or removal shall be documented. McCARTY stated that she did not document that, but the lead officer should have because the lead officer is considered the shift supervisor as well "that's why we pay them, to make those decisions".

Section "H", states the requirement for a medical assessment of the inmate in the safety cell shall occur within 12 hours of placement or the next daily sick call whichever is earliest. I asked if that had been completed and McCARTY stated that a medical assessment is doing their (the deputies) best to make sure he's medically ok and that the officers can conduct medical assessments per this policy because they don't have someone (nurse/doctor) available every 12 hours or on the weekends.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Section "H" continues stating that continued assessment of the inmate in the safety cell shall be conducted by a qualified health care professional and shall occur at least every 24 hours thereafter. I pointed out that based on the policy FARRIS was supposed to be evaluated by a medical professional every 24 hours and asked if he was. She stated "NO" and advised that they don't have a medical professional available.

Section "I" states a mental health assessment shall be conducted within 24 hours of an inmate's placement in the safety cell and documented. McCARTY stated that we did not have as assessment done within the first 24 hours and San Juan County was supposed to set one up for FARRIS.

After reviewing the policy with McCARTY I asked her why weren't we following our own policy. In summary, McCARTY stated that it was a new policy with things (duties and requirements) that weren't covered under the old policy and they (the corrections deputies and supervisors) didn't follow it because they were unfamiliar with the new parts at that point in time and they hadn't used the new policy enough to become familiar with it.

We discussed the security cameras in the jail and the fact that many weren't being recorded due to a Digital Video Recorder that had failed. I asked how long that recorder wasn't working and she stated "months". We continued with the safety cell logs on 4/7/2015 and 4/8/2015 and I asked about the period of approximately 3 ½ hours where not checks had been conducted. McCARTY stated that she believed people entered the block and looked at FARRIS during those times but got busy in between and forgot. I provided McCARTY all of the logs, asked her to review them to see if she saw a pattern in the amount of water FARRIS was offered while he was under the safety cell protocols and if she thought that the amount he was provided would be enough to sustain someone that didn't have the access to feed or water themselves. McCARTY examined the logs and answered "NO. "Now that I look back through them it looks like he was given a lot

more water when he was in the padded safety cell up at the booking area. It does not look like took that much water while he was in-he did when he first got to H block but then it looks like he didn't."

I asked McCARTY if she had anything else she'd like to add to her statement and she stated "I don't, no. I'm sorry" and followed up with "I know he took water that day but obviously not enough."

DENNIS:

Chief DENNIS is the Jail Commander, a position appointed by the Sheriff to run the operations in the jail. I asked DENNIS to break down the command structure of the jail and he advised that directly below him is McCARTY who is the Administrative Lieutenant. There was an operations Lieutenant (who retired). DENNIS and McCARTY now split his duties. Below McCARTY is the acting Lieutenant and then the lead officer. DENNIS confirmed that in the absence of a supervisor, the lead officer is the supervisor. We discussed how the lead officers are selected and the fact that they can basically make the decisions of a Lieutenant absent any disciplinary requirement.

I asked if there was a policy regarding safety cell procedures, and DENNIS corrected me stating that policy refers to the Sheriff's Office as a whole, the Jail (corrections division) has procedures with the current (safety cell) procedure being the one dated October 2014 that's at the deck station.

DENNIS provided an overview of the procedure and I asked if this procedure came from the Lexipol manual. DENNIS stated that the majority of it came out of the Lexipol Manual and not just the safety cell procedures. I asked if the safety cell checks were mandatory and DENNIS confirmed that they were and there are consequences for not doing them. He stated that he has reprimanded officers for not doing them, but never put anything in writing. I asked what the priority of the checks are and gave examples of

various duties in the jail occurring when a safety cell check was due. DENNIS advised that the safety check would be a priority and they (the corrections staff) can stop all the other activities (to complete the check) then return to them later.

DENNIS confirmed that there was no mandate in place to watch FARRIS eat or drink. I asked if he knew if the water had been turned off in any of FARRIS's cells and DENNIS advised that there was one time when it was indicated that he was flooding his cell so the water was turned off but DENNIS did not know of any other time that the water was off. When asked where it would be documented if an officer decided to turn off the water in the cell DENNIS stated that they would document it in the pass down log and worksheet, along with a annotation of the cell number and the reason.

DENNIS confirmed that FARRIS was determined to be a two man contact due to one aggressive incident with the staff that labeled him a hostile inmate. DENNIS said there was not an order in place to not open his cell door; it could be opened with at least two people present. We discussed the medical staff (Nurse BARKER/PA YOUNG) and their room in the facility. DENNIS confirmed that both are contract positions not jail employees. DENNIS also confirmed that there is a medical override in place, "If the medical staff said they want them out (the inmate in a cell) we take them out". *This contradicts McCARTY's statement that there is no medical override available.*

During my questions regarding FARRIS's movement from location to location in the facility, DENNIS stated that it was his understanding that FARRIS was under safety cell protocols during his time in D block. I asked if just the water being turned off was enough to initiate safety cell checks and DENNIS replied "If the water's turned off the checks are to be made because he doesn't have access to sufficient amounts of water so on our hourly checks we provide em the opportunity for liquids". DENNIS also stated that he was unaware that safety cell checks were not started for almost 24 hours after FARRIS was placed in H block.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

We continued by going over sections of 538.3 and how it was implemented or not implemented in regards to FARRIS. Section "A" states that the placement of an inmate into a safety cell requires approval of the shift supervisor or medical staff. DENNIS stated that he didn't know if FARRIS's placement was approved by a shift supervisor or medical staff

Section "C" states that direct visual observations shall occur at a minimum of hourly and each check shall be documented. Supervisors shall inspect the logs for completeness every two hours and document this on the safety cell log. DENNIS stated "that won't (happen) and that doesn't always happen because there isn't a supervisor on shift all the time." DENNIS did state that the acting lieutenant could review the logs if he was on the deck but not the lead officer because he was in the control room.

Section "E" states that inmates shall be given the opportunity to have fluids at least hourly and each time an inmate is provided an opportunity to drink it will be documented on the safety cell log. DENNIS stated that to his knowledge this section was being followed and he mentioned the same carafe and cups in front of H block as McCARTY. *The logs show that FARRIS was not being offered water hourly as required.*

Section "G" states the shift supervisor shall review the appropriateness for continued retention in the safety cell at least every eight hours. The reason for continued retention or removal shall be documented on the safety cell log. DENNIS stated that he did not know if FARRIS was evaluated every eight hours or not and, that (the monitoring and evaluations) would have been the responsibility of the supervisor that was on shift. *Evaluations did not occur as per this section.*

Section "H" states that a medical assessment of the inmate in the safety cell shall occur within 12 hours of placement or at the next sick call and continued assessment of the inmate in the safety cell shall be conducted by a qualified health care professional and shall occur every 24 hours thereafter and the medical assessment shall be documented.

DENNIS stated "It's not gonna happen that way cause we don't have a medical staff that's available every you know 24 hours." DENNIS explained they will often take the nurse, doctor or mental health professional down and open the feed slot so they can communicate with them and ask how they are doing, what their needs are and make some observations. DENNIS explained that a true assessment of going down there and actually assessing the inmate is very difficult because that doesn't happen all the time and there is no way it will happen all the time cause some of the inmates are extremely dangerous and "I will not expose the medical staff to that."

Section "I" states a mental health assessment shall be conducted within 24 hours of an inmate's placement of a safety cell and the mental health professionals recommendations shall be documented. DENNIS stated that FARRIS was not evaluated within the 24 hours period and explained "Uh, not everybody put in a safety cell and-and I understand what that says, but that's not necessarily the gospel. Everybody put in a safety cell is not-does not necessitate a CMHP (Certified Mental Health Professional)." DENNIS then goes into an explanation as to why it will not happen.

I also asked if they staff has received any training in treatment of dealing with mental health people (inmates). DENNIS stated that he has had 40 hour critical intervention training and he has provided the staff bullet points to look out for in dealing with someone, but the staff is not qualified to determine mental health. I asked if medical records are provided when an inmate arrives from another facility and DENNIS that they (medical records) do not normally accompany an inmate, "they have to beg, borrow or steal to get them." DENNIS also stated that if they receive an inmate and the inmate has a medical condition or there is a suspicion that the inmate a mental health condition then they will request the records. Nurse BARKER however tries to always send records out, along with medications if an inmate is transferred.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

We went over the safety cell logs and I asked DENNIS to tell me if he could locate any supervisory sign offs or evaluations as per the policy. DENNIS stated that he could see where the supervisors had seen FARRIS but couldn't say if that was the supervisor conducting the overall check. I advised DENNIS that during my interviews, the staff stated if they had offered FARRIS water they would have documented it on the logs, if they had not it would not be there. DENNIS stated that he agreed because the staffs are supposed to document exactly what they did. I asked DENNIS if based on the logs FARRIS was offered water every hour as per the procedure? DENNIS stated that according to the logs he was not. DENNIS also stated that he would have to look to see where FARRIS was at the time and if the water was on because the logs do not say if the water was off. *The logs do not state clearly state the location (cell) FARRIS was in or if the water was turned off in that location.*

I broke down the logs by date and location for DENNIS starting with the March logs when FARRIS was in the padded safety cell. DENNIS confirmed that there is no source of water at all in that cell and he was not offered water hourly as per procedure. From the padded safety cell I advised DENNIS that FARRIS was moved into D block where the water was eventually turned off but no checks were conducted. I asked if that was proper. DENNIS advised that if the water was turned of, it was turned off for a reason, but FARRIS should be checked hourly and he should be receiving or at least offered water hourly and if not, it should be documented. DENNIS also said that it should be documented because an individual who doesn't eat or doesn't take any kind of liquid, they're going to see the nurse or the nurse is coming down to see them and then at that point what that period of time is-we may just transfer them to a hospital from that point right there and say we cannot manage that individual here, he has to go to the hospital.

I continued with FARRIS being moved to H block with the water turned off and no logs being started for almost 24 hours and asked if that was proper. DENNIS advised,

"No, if that water's turned off he's going on safety checks cause the individual cannot be in there even if it's shut off for an hour."

I asked DENNIS to take into account all the logs and the periods of time we could not document FARRIS being offered water. I also asked him to assume in the best case scenario every time FARRIS was offered water he drank the entire cup. I asked DENNIS if he felt that FARRIS was adequately provided water while he was in the facility, based on the above assumptions and records. DENNIS answered "Looking at this log I would say he probably not." DENNIS then explained how he would offer the inmate water and watch them drink and provide them with as much liquid as they wanted.

I asked DENNIS as Chief of the Jail, taking into account all of the records and documentation, would the fact that he was probably not receiving enough water have been caught if the checks were being done by the supervisor? DENNIS answered, "Yeah if the supervisor was aware of the requirement and was doing it, it would have been caught, absolutely." "If we had a supervisor out there then absolutely. He'd come by or she'd come by and look and say, OK needs more water here and I'd give him water and also see if the checks being made because we would notice if the check's not made."

We then discussed not being able to confirm any checks of FARRIS in D block because of the non-functioning DVR. DENNIS stated that he was aware the DVR was not functioning and had not been functioning since approximately February (2014). DENNIS said that he has been trying to get it fixed but due to replacement costs it has not happened.

When I asked if there was anything else he would like to add, DENNIS advised that looking at the sheets and the policy he "somewhat" implemented for our use (*he advised earlier in his stament that it was implemented, not somewhat,)*, he would definitely "tighten it up", which is what he was doing working with Undersheriff MAUCK on the Lexipol manual. He said that the Lexipol manual is "nice" but it is not

fully implemented because a large portion of the manual just does not apply to us (Island County Jail) because they wrote it for facilities much larger than us.
From DENNIS's statement: "They wrote it for facilities much larger than us. They have a medical staff, they have a psychiatric staff um they have other things that we just don't have and so what I'm doin is I'm takin everything that we do have and combining it into a – a usable Lexipol Manual that's why you'll see some "draft". I'll send them out there. I'll ask for comments on em. We'll update it and the staff's doin pretty well. Uh this year and – and this is a tragedy that uh and I – I felt – I don't know if it – what the uh cause of death was. I haven't got that information but I lookin at this I can honestly say that uh uh this inmate probably had some dehydration issues goin and uh had we monitored closely, uh offered him water – we can't watch him drink the water but there has to be some period during the observations when you say you know things just ain't right. Uh he's not drinkin the water. He takes the cup but we don't see him drink it. Bring it to our attention and say this is a type of individual perhaps we might just want to have Doc Young look or um perhaps take him to the hospital. I felt somewhat comfortable and I didn't realize it was an issue of this magnitude now that it's been you know I have access to all the documents cause these were pretty well gone when I got back so I couldn't brief myself but seein something of this magnitude uh I was comfortable in saying well the staff went down to talk to him. They – they observed him back pedalin in his flooded cell. I had Nurse Nancy go down and talk to him. She reported back that he appeared to be OK but when I had Western State Hospital doc go down there who's – I really uh uh trust and put a lot of confidence – a PhD uh uh psychiatrist and MD talk to the individual had no in – indication whatsoever there was something wrong there in that picture other than the fact that yeah he uh needs to come down to Western State. I felt no OK OK. So he's doin alright down there. We'll just give him to Western State as soon as possible. Um the documentation could be better

but looking at it I'm saying yeah it – it reflects a true picture and when I look at this I say "uh-huh OK" and I see mistakes and I see errors and I see room for improvement, definitely. Yeah. There's no excu – there's no excuses here. There's a – a man died and what our party contributed to that I want to know what that was and I want to take ownership in that and I want to correct that and I believe my staff out here does also. Uh I don't think anyone out there would say "Hey we did our job and did it to the best of our ability". I'd say each member out there is probably questioning themselves as long – as well as I sayin what could I have done and uh I could always say more staff, more cameras and etc., but I won't say that because that'd be makin excuses for what happened here. So I – I think we have some ownership in this and I think that should be the message we present to the family that yes uh there was some uh some errors made along the way. A degree of ownership I think it's collective. It – it collects wherever it came from. We should have got information from the time he was picked up, every stop he made along the way. I know there was difficulties in Snohomish County. I know there was difficulties uh you know with his housing and – and what went on there I don't know. It was same – some difficulties in Skagit County. What they were I don't know and I do know that I called San Juan and said "We don't have the manpower to get this individual. You have to go get him. They did and brought him to us."

We concluded the statement by discussing FARRIS's transport to Island County, and DENNIS being able to have Doctor HENDRICKSON do an evaluation and BARKER's medical evaluation. I advised DENNIS that the feed slot on FARRIS's cell door was not opened and BARKER had to do her evaluation through the window of the cell door because the staff were told they could no open the door or the feed slot and asked if that was normal. DENNIS advised "I've seen it happen before uh but to do an assessment uh I think the – the officers were kinda uh the officers should have taken the individual out and brought him up to uh the nurse so the nurse could make an

observation in a well lit area, clean area." I don't know how much observation she could make through there, but her school's a lot different than mine too and what she sees and I see you know."

Additional Information:

At the request of the Attorney for the FARRIS family searches were conducted for telephone calls to/from 360-[redacted] The inmate phone system (SECURUS) only allows outgoing collect or calling card calls. A search between 03/15/2015 and 04/16/2015 located no calls to that number. I also contacted Island County Central Services and requested a system wide check of the county phone system for calls to that number. A search between 03/20/2015 and 04/09/2015 located four calls from that number. Two calls to the extension 7384 (the Superior Court jury information line) one on 3/30/2015 at 1756 hours and another on 04/06/2015 at 1734 hours and two calls to extension 5111 (the main phone trunk/switchboard) on 3/31/3015 at 1011 hours and 1333 hours.

Forensic images were made of the hard drives of the county computers assigned to the jail using FTK imager version 3.4.0.1 and stored. With the exception of the state access terminal in the jail, all of the images were physical images. Since the access terminal could not be taken off line for imaging due to its function in the control room, a logical image was made of that drive. Analysis of the images will be addressed in an additional narrative. Based on the provided Syslogs there is no indication that any information regarding FARRIS in Spillman system was altered after his death.

The information release provided by the FARRIS family attorney was provided to Snohomish County shortly after it was received on 5/8/2015. As of 5/19/2015 I had not received any documents so I emailed again, asked for a status update, and outlined some specific items/information I needed. A short time later I received an e-mail apologizing

for the delay and providing an estimate that I should have the information by the end of the week.

As of 6/8/2015 I still had not received the documents. I requested Sheriff BROWN contact Snohomish County to expedite the process. BROWN was advised that the records would be provided by the afternoon of 6/8/2015. On the morning of 6/9/2015 I received an e-mail containing the documents from Snohomish County. The documents provided were the same documents I had received from them earlier in the investigation and did not contain any of the specific information I requested. I am still trying to obtain the correct documents.

Findings:

The Island County Jail deputies and supervisors failed to follow policy 538.3 in regards to Safety Cell Procedures, specifically:

538.3 (b) A safety cell log shall be initiated every time an inmate is placed in a safety cell and should be maintained the entire time the inmate is housed in the cell. *When FARRIS was moved into cell H-2 with the water turned off for his safety after flooding cell in D-1, safety cell logs were not started for almost 24 hours. According to Chief DENNIS, turning off the water in cell D-1 (or any cell) should have initiated safety cell logging as well.*

538.3 (c) A safety check consisting of direct visual supervision that is sufficient to assess the inmate's well-being and behavior shall occur as indicated on the log but hourly as a minimum. Each safety check of the inmate shall be documented. Supervisors shall inspect the logs for completeness every two hours and document this action on the safety cell log. *In some cases the checks conducted by the staff were not sufficient to assess*

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

FARRIS's well being and hourly checks were not being conducted and documented as required. Supervisors did not inspect the logs as required.

538.3 (e) Inmates in safety cells shall be given the opportunity to have fluids (water, juices) at least hourly. Deputies shall provide the fluids in paper cups. The inmates shall be given sufficient time to drink the fluids prior to the cup being removed. Each time the inmate is provided the opportunity to drink fluids will be documented on the safety cell log. *FARRIS was not offered the opportunity to have fluids hourly while under safety cell procedures.*

538.3 (g) The Shift Supervisor shall review the appropriateness for continued retention in the safety cell at least every eight hours. The reason for continued retention or removal from the safety cell shall be documented on the safety cell log. *No reviews occurred.*

583.3 (h) A medical assessment of the inmate in the safety cell shall occur within 12 hours of the placement or at the next daily sick call, whichever is earliest. Continued assessment of the inmate in the safety cell shall be conducted by a qualified health care professional and shall occur at least every 24 hours thereafter. Medical assessments shall be documented. *FARRIS was not medically evaluated until his eleventh day in custody.*

583.3 (i) A mental health assessment shall be conducted within 24 hours of an inmate's placement in the safety cell. The mental health professional's recommendations shall be documented. *FARRIS did not receive a mental health evaluation until his eleventh day in custody.*

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

The Island County Jail deputies and supervisors failed to follow Island County Corrections Facility Procedures Manual (dated 11/9/12) specifically:

2.02.008 Prisoner's Inability to be Processed: *This procedure appears to be the precursor of policy 583.3 but contains many of the requirement outline in the newer policy.*

If a prisoner's physical condition of behavior prohibits the completion of the admissions process, the following procedures shall be completed.

If the inmate is a danger to the corrections deputy or them self the deputy may place the inmate in the BMM (Behavior Modification Module) *BMM is struck out and a note states change all BMM to Safety Cell* or other appropriate temporary housing until the inmate returns to a cooperative state. At such time, the deputy shall resume processing the prisoner.

In the event it should become necessary to place an individual in the BMM (*struck out)* the following procedures will be initiated.

An inmate who will remain in the BMM (*struck out)* for a period exceeding 24hrs will be screened by medical staff. *FARRIS was not seen by medical staff until his eleventh day in custody.*

3.02.000 Supervision and Management of Inmates:

Sight and sound surveillance of all inmates will be maintained. *Sight and sound surveillance (hourly checks) were not maintained on FARRIS.*

I certify ~~under penalty~~ of perjury under the laws of the state of Washington, that the foregoing is true and correct (RCW 9A.72.085)

Name	1067 Personnel Number	Coupeville Location	6/15/15 Date

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

3.02.002 Cell Checks:

The Corrections Deputy shall conduct periodic personal observations of all inmates under his/her supervision. Cell checks will be conducted at least hourly, on an irregular schedule. Special management inmates (i.e. Suicide Risk, Medical, etc.), will be checked at least every 30 minutes *(struck out) and replaced with* hour, more often as necessary. *FARRIS qualified as a special management inmate and required hourly checks were not conducted.*

A copy of policies 538.1.1 Definitions (Safety Cell and Sobering Cell), 538.2 Policy (Safety Cell and Sobering Cell) and 538.4 Sobering cell procedures are part of this manual. There is a line drawn through the page with change all and draft procedure in the deck station for review handwritten on it. There is also a copy of policy 538.3 Safety Cell procedures with "Draft in deck station" handwritten on the bottom. As stated earlier, based on the memos from Chief DENNIS dated 10/30/2014 and 11/04/2014 and his statement these policies were in place and not drafts out for review.

4.04.002 Emergency Mental Health Services:

If a deputy observes an inmate exhibiting signs of emotional instability or psychological distress, the inmate shall *(struck out) and replaced with may*, if the situation dictates be placed in administrative segregation until contacted by a mental health professional. *FARRIS exhibited these sings and was placed in administrative segregation (safety cell).*

The deputy shall describe the inmate's behavior on an Inmate Medical Form then provide the information to the mental health professional responsible for emergency referrals. *Some of FARRIS's behavior was documented in the logs but not on the Inmate Medical form, no emergency referral was made.*

The mental health worker shall interview the inmate then advise the medical staff if it appears that treatment is required. *No emergency referral was made; no interview was conducted with FARRIS.*

In most cases the documentation regarding the safety cell check was not adequate and other documentation regarding FARRIS was scattered between various logs and activity sheets. The supervisory staff failed to properly coordinate the information.

The medical staff (nurse) was not called in to examine FARRIS until one day before his death. Once the nurse was notified she failed to do a proper evaluation of his condition even after FARRIS advised her that he was not doing well. There appears to be no protocol/policy/procedure that would allow the medical staff to override a lockdown to conduct a medical evaluation, so the nurse may not have been able to force the issue to examine FARRIS further, however, she failed to bring any concerns regarding his health to the attention of the deputies or supervisors and she failed to document that she was not allowed to properly examine FARRIS or his statement that he was not doing well.

The records provided show that FARRIS's medication transferred with him from the Lynwood jail, to the Snohomish County jail to the Skagit County Jail but they did not arrive at the Island County Jail with him. Based on the Skagit County documentation, FARRIS was refusing to take his medication so there should have been pills left when he was released from the facility, I cannot locate any indication of the disposition of that the medication. The report from the San Juan County Deputies that transported FARRIS to Island County didn't indicate that they were provided medication for him.

ISLAND COUNTY SHERIFF'S OFFICE
NARRATIVE

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

Island County Jail supervisors and staff violated multiple policies/procedures in regards to Keaton FARRIS's custody. Based on the totality of the information, to include the Coroner's determination [redacted], this investigation is closed as a non-criminal death. This finding is subject to review if additional evidence becomes available.

I certify under penalty of perjury under the laws of the state of Washington, that the foregoing is true and correct (RCW 9A.72.085)

Name	Personnel Number	Location	Date
	1067	Coupeville	6/15/15

ISLAND COUNTY SHERIFF'S OFFICE
SUPPLEMENTAL REPORT

Detective C.E. Wallace Jr. 1067 Case # 15-I05352

I am commissioned by the Sheriff of Island County to enforce the laws of the state of Washington and the County of Island. At the time of this incident I was working as a Detective for the investigations division of the Island County Sheriff's Office. I am certified by the Department of Treasury/Homeland Security as a Seized Computer Evidence Recovery Specialist (S.C.E.R.S.), the Department of Homeland Security as a Mobile Device Investigator, the Cellebrite Corporation as a Physical Analyst and the Paraben Corporation as a Handheld Examiner (PDA, cell/mobile phone and Hybrid devices).

Forensic images were made of the hard drives of the county computers assigned to the jail using FTK imager version 3.4.0.1 and stored. With the exception of the state access terminal in the jail, all of the images were physical images. Since the access terminal could not be taken off line for imaging due to its function in the control room, a logical image was made of that drive. The images are in .E01 format and named as follows (based on their location in the facility), Booking Station, Booking Station 2, Cobra Banking, Control Room, Deck Station, Housing Computer, Jail Access Term, Jail Commander, Jail Nurse, Lt. Office McCarty, Lt. Office East and, Lt. Office West.

Using Internet Evidence Finder (IEF) version 6.6 I scanned the images for files, artifacts and information pertaining to the usage of the computers. Each image was scanned independently and a global date/time filter ran on the results. The filter was set to extract usage information between 04/07/2015 at 0000 hours and 04/08/2015 at 0300 hours. The filtered information was generated into an HTML report for each image. The reports were burned onto a compact disk and added to the case file. The Housing Computer and Jail Access Term contained no information from the specified date/time range so no reports were generated for these images.

I certify under ~~penalty of~~ perjury under the laws of the state of Washington, that the foregoing is true and correct (RCW 9A.72.085)

Name	*Personnel Number*	*Location*	*Date*	
	1067	Coupeville	6/15/15	

Video timeline:

The date on the recordings is correct, the time is 2 hours and 51 minutes ahead of actual time (actual time on test recording is 1534 hours, displayed time on recording is 1825 hours).

April 7 to April 8, 2015. No checks logged between 1130 hours and 1500 hours.

Logged Time:	**Time on Camera:**	**Actual Time:**	**Deputy:**
April 7, 2015			
1500 hours	1750 hours	1459 hours	Moffit
1600 hours	1848 hours	1557 hours	Pendergast
1635 hours (meal)	1925 hours	1634 hours	Moffit
1730 hours (P/U)	1953 hours	1702 hours	Moffit
1845 hours	No check seen	No check seen	Moffit
1945 hours	No check seen	No check seen	Moffit
2030 hours	2328 hours	2037 hours	Moffit
2230 hours	No check seen	No check seen	Lind
2330 hours	No check seen	No check seen	Lind
April 8, 2015			

0030 hours Log states does not appear to be breathing, no initials.

Additional info:

April 7, 2015

2334:06 hours to 2335:48 hours (2053:06 to 2054:48) deputy (possibly Moffit) stops as door, appears to log something, leaves towards the deck station then comes back and appears to log something else, no entry into the block.

2351 hours to 2352 hours two deputies enter H block (2100 hours to 2101 hours actual time) no log entry made.

CW107

Dietary Reference Intakes (DRIs): Recommended Dietary Allowances and Adequate Intakes, Total Water and Macronutrients

Food and Nutrition Board, Institute of Medicine, National Academies

Life Stage Group	*Total* Water[a] (L/d)	Carbohydrate (g/d)	Total Fiber (g/d)	Fat (g/d)	Linoleic Acid (g/d)	α-Linolenic Acid (g/d)	Protein[b] (g/d)
Infants							
0 to 6 mo	0.7*	60*	ND	31*	4.4*	0.5*	9.1*
6 to 12 mo	0.8*	95*	ND	30*	4.6*	0.5*	**11.0**
Children							
1–3 y	1.3*	**130**	19*	ND[c]	7*	0.7*	**13**
4–8 y	1.7*	**130**	25*	ND	10*	0.9*	**19**
Males							
9–13 y	2.4*	**130**	31*	ND	12*	1.2*	**34**
14–18 y	3.3*	**130**	38*	ND	16*	1.6*	**52**
19–30 y	3.7*	**130**	38*	ND	17*	1.6*	**56**
31–50 y	3.7*	**130**	38*	ND	17*	1.6*	**56**
51–70 y	3.7*	**130**	30*	ND	14*	1.6*	**56**
> 70 y	3.7*	**130**	30*	ND	14*	1.6*	**56**
Females							
9–13 y	2.1*	**130**	26*	ND	10*	1.0*	**34**
14–18 y	2.3*	**130**	26*	ND	11*	1.1*	**46**
19–30 y	2.7*	**130**	25*	ND	12*	1.1*	**46**
31–50 y	2.7*	**130**	25*	ND	12*	1.1*	**46**
51–70 y	2.7*	**130**	21*	ND	11*	1.1*	**46**
> 70 y	2.7*	**130**	21*	ND	11*	1.1*	**46**
Pregnancy							
14–18 y	3.0*	**175**	28*	ND	13*	1.4*	**71**
19–30 y	3.0*	**175**	28*	ND	13*	1.4*	**71**
31–50 y	3.0*	**175**	28*	ND	13*	1.4*	**71**
Lactation							
14–18	3.8*	**210**	29*	ND	13*	1.3*	**71**
19–30 y	3.8*	**210**	29*	ND	13*	1.3*	**71**
31–50 y	3.8*	**210**	29*	ND	13*	1.3*	**71**

NOTE: This table (take from the DRI reports, see www.nap.edu) presents Recommended Dietary Allowances (RDA) in **bold type** and Adequate Intakes (AI) in ordinary type followed by an asterisk (*). An RDA is the average daily dietary intake level; sufficient to meet the nutrient requirements of nearly all (97-98 percent) healthy individuals in a group. It is calculated from an Estimated Average Requirement (EAR). If sufficient scientific evidence is not available to establish an EAR, and thus calculate an RDA, an AI is usually developed. For healthy breastfed infants, an AI is the mean intake. The AI for other life stage and gender groups is believed to cover the needs of all healthy individuals in the groups, but lack of data or uncertainty in the data prevent being able to specify with confidence the percentage of individuals covered by this intake.

[a] *Total* water includes all water contained in food, beverages, and drinking water.

[b] Based on g protein per kg of body weight for the reference body weight, e.g., for adults 0.8 g/kg body weight for the reference body weight.

[c] Not determined.

SOURCE: *Dietary Reference Intakes for Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids* (2002/2005) and *Dietary Reference Intakes for Water, Potassium, Sodium, Chloride, and Sulfate* (2005). The report may be accessed via www.nap.edu.

Video Timeline

Death Investigation – Farris

By: Undersheriff Mauck

On 04/13/15 at the request of Detective Wallace I reviewed Jail video footage between the times of 12:00 AM on 04/07/08 through approximately 1130 AM on 04/07/08. The camera from which the footage was recorded shows the hallway that runs in front of H/G blocks. I compared the footage to Keaton Farris's safety cell observation log to verify when/if checks had been made by deputies as documented on the observation log sheet. The actual time is estimated based upon my understanding from Det. Wallace that the camera time is approximately 2 hrs 51 min ahead of the actual time. The results are as follows:

Logged Time	Time on Camera	Actual Time	Deputy
0055	3:47	0056	Boone
0200	4:48	0157	Lind
0300	5:53	0302	Boone
0410	7:14	0423	Lind
0555	8:57	0606	Hiatt
0633	9:23	0632	Hiatt
0715	10:04	0713	Boone
0920	12:18	0927	Hiatt
1017	1:07	1016	Hiatt
1130	2:29	1138	Hiatt