DETENTION SERVICES

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 2023-21826 Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

The decedent was a 23-year-old male with reported history of daily fentanyl use.

The decedent was medically cleared at Sacred Heart Medical Center for a fentanyl overdose prior to being booked into jail. Narcan and IV fluids were administered at the hospital. Uranalysis was positive for methamphetamine and fentanyl.

The decedent was booked into Spokane County Jail on 06/03/2023, on two counts of Unlawful Imprisonment, 2D Mal Mis and Hold Community Custody (DOC).

During intake decedent self-admitted fentanyl use and was started on Clinical Opiate Withdrawal Scale (COWS) protocol for opioid withdrawal treatment.

Incident Overview

On 06/04/2023 the decedent was housed on 2 West. Decedent refused to move to 4 West housing with another inmate. The decedent was moved to 6 East on 06/06/2023. On 06/07/2023 just before midnight, the decedent refused to have a COWS detox check completed and made suicidal statements. The decedent was moved from 6 East back to 2 west on a suicide watch at approximately 0030 hours on 06/08/2023. The decedent complied with a COWS detox check.

The decedent made statements to a Sergeant that he was suicidal and would take drugs to kill himself. The decedent was strip searched prior to being placed on a suicide watch. Nothing was found during the search.

At approximately 0601 hours, staff attempted to wake the decedent up for breakfast. Officers entered his cell and determined he was unresponsive. Life saving measures were started immediately (Narcan, CPR). AMR (American Medical Response) and Spokane Fire were requested and arrived at approximately 0607 and 0611 hours. Life saving measures continued by Detention Services staff, Naphcare, Spokane Fire and AMR personnel. Life-saving efforts were unsuccessful, and he was pronounced deceased at approximately 0628 hours.

Spokane County Sheriff's Office and Spokane County Medical Examiner's Office were notified and investigated the death.

On June 08, 2023, Spokane County Medical Examiner performed an autopsy. On September 27, 2023, Spokane County Medical Examiner completed their investigation with the conclusion:

1. Cause of Death: Sudden cardiac death of uncertain etiology
2. Manner of Death: Natural

UFR Committee Meeting Information

Meeting date: June 28, 2023

Meeting Location: Detention Services Mental Health Conference Room

Committee Members:

Spokane County Detention Services Administration

Chief Don Hooper

Spokane County Detention Services Command Staff

Lieutenant Darren Lehman
Lieutenant Lewis Wirth
Lieutenant Jason Robison

Spokane County Detention Services Mental Health

Kristina Ray Mental Health Professional Manager

NaphCare

Richae Nelson Health Services Administrator
Michelle Johnson Director of Nursing

Committee Discussion

The potential factors reviewed include:

A. Structural

a. Risk factors present in design or environment.
b. Broken or altered fixtures or furnishings.
c. Security/Security measures circumvented or compromised.
d. Lighting
e. Layout of incident location

f. Camera locations

B. Clinical

a. Relevant decedent health issues/history
b. Interactions with Jail Mental Health
c. Interactions with NaphCare
c. Relevant root cause analysis and/or corrective action

C. Operational

a. Supervision (e.g., security checks, kite requests)
b. Classification and housing
c. Staffing levels
d. Video review if applicable
e. Presence of contraband
f. Training recommendations
g. Inmate phone call and video visit review
h. Known self-harm statements.
i. Life saving measures taken.
j. Use of Force Review

Committee Findings

Structural

2 West is a classification unit with 58 cells.

- Watch cells have no bunk, a stainless-steel sink and toilet, an overhead light/nightlight with a light switch and an emergency button.
- General Population cells have either a single bunk or a bunk bed, a desk, a stainless-steel sink and toilet, an overhead light/nightlight with a light switch and an emergency button.

6 East is a maximum-security housing unit with 46 cells.

- Maximum security cells have a single bunk, a desk, a stainless-steel sink and toilet, an overhead light/nightlight with a light switch and an emergency button.

There were no known issues with any cells the decedent was housed in.

2 West has camera coverage on the main floor, mezzanine and a 360-degree camera.
6 East has camera coverage on the main floor and the mezzanine.
By design there is no camera coverage in the cells.

Clinical

Decedent was placed on Clinical Opiate Withdrawal Scale (COWS) protocol for opioid withdrawal treatment, after self-reported drug use to the intake nurse.
A routine Mental health appointment was scheduled by Naphcare staff.
Decedent was seen by medical on the following dates:

06/04/23	4 Times
06/05/23	3 Times
06/06/23	5 Times
06/07/23	4 Times
06/08/23	1 Time

Operational

Decedent was classified as a maximum-security inmate.
Decedent was placed on a suicide watch after making a suicidal state to a Sergeant. Decedent told the Sergeant he would ingest drugs if he had them.
The decedent was strip searched at intake and was strip searched when he was placed on suicide watch.
Module rounds and suicide observation checks were completed. One module round wasn't documented at 0330-0333 hours but was verified with video that it was completed.
Video of the incident was retained.
Spokane County Jail has an Adani body scanner. Inmates are body scanned at intake. The body scanner was inoperable during the decedent's intake on 6/3/2023. The body scanner was inoperable from 5/31/2023 – 6/8/2023.
Decedent made no phone calls and had no visits.
Life saving measures were performed by Detention Services Staff, medical, Spokane Fire and AMR. Life Saving efforts were within policy.
No use of force was reported or observed during the investigation.

Committee Recommendations

- Enter suicide alerts into Jail Tracker and Techcare medical programs.
- Conduct routine checks of emergency equipment.
    - Initial suction device failed, used secondary suction device.

Legislative Directive

Per ESSB 5119 (2021)

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

Disclosure of Information

RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained. An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(2)(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail