Leave

Spokane County
WASHINGTON

DETENTION SERVICES

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 2023-21797

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information	3
Incident Overview	3
Committee Meeting Information	4
Committee Members	4
Discussion	5
Findings	6
Recommendations	6
Legislative Directive	7
Disclosure of Information	8

Inmate Information

The decedent was a 37 year old male with an admitted history of methamphetamine and Fentanyl usage. It was later discovered that he had a history of alcohol abuse.

The decedent had history of arrhythmias.

The decedent had a history of suicidal ideation.

Upon intake he was placed on Clinical Opiate Withdrawal Scale (COWS) protocol for opioid withdrawal treatment.

Prior to his death, decedent was unclassified and housed in 4 West Classification Housing with a cellmate.

The decedent was taken to 2 West 15 watch cell. He was housed alone for monitoring seizure activity. He was moved to 2 West approximately 40 minutes prior to being transported to the hospital.

The decedent was booked into Spokane County Jail May 28, 2023 for 1 count Public Officer (Obstruct), 1 count Making False Statement, 1 count Public Officer (Resist Arrest), 1 count Use of Controlled Substance - Public, 1 count Pedestrian or Vehicular Interference.

Incident Overview

On 05/31/2023, at approximately 0930 hours, Jail Officers reported decedent appeared to be having a seizure while being escorted to a visit. NaphCare provided medical care and assessment.

At approximately 1315, NaphCare followed up with decedent. He was taken to the Jail Medical Clinic, treated with IV fluids, and started on Clinical Institute Withdrawal Assessment (CIWA) CIWA protocol to assess and manage the symptoms of alcohol withdrawal. Though decedent had not reported alcohol use, he was displaying symptoms commonly associated with alcohol withdrawal.

At approximately 1430, Jail Officers reported that the decedent appeared to be having another seizure. He had also been displaying agitation and odd behavior in his cell prior to the seizure. Decedent was combative with officers as they attempted to assist him. He was moved to 2 West where he could be monitored closer. NaphCare administered Ativan at that time due to the seizure activity and suspected alcohol withdrawal and remained on scene.

Decedent laid down and appeared to rest. A few moments later he was observed getting up from his bed, walking towards the door, then appeared to faint. Decedent struck his head against the cell door as he fell.

NaphCare and Jail Officers immediately entered the cell. Decedent was unresponsive. Lifesaving measures were started.

Spokane Fire Department and AMR (American Medical Response) personnel responded and provided advanced life support. They were able to re-gain a heartbeat. He was transported to the hospital in this critical condition. The Jail was notified he was pronounced deceased later that day in the hospital.

On June 1, 2023 Spokane County Medical Examiner performed an autopsy. Per the Spokane County Medical Examiner's autopsy report:

1. Cause of Death: **Aspiration pneumonia due to the combined effects of alcohol withdrawal and seizure disorder of unclear 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 Office of Professional Standards
Sgt. GiGi Parker

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

The 2 West 360 and front door cameras provided a good view of the incident. The 360 camera is located in the center of the dayroom. The front door camera is located above the north wall lower shower. The view is facing east toward the module door with a linear view.

No cameras were in the watch cells at the time of the incident.

The lighting was sufficient.

Clinical

Decedent was placed on Clinical Opiate Withdrawal Scale (COWS) and monitored appropriately.

The day of the incident decedent was seen in the medical clinic and treated with IV fluids. The decedent didn't disclosed alcohol usage. However, due to his symptoms he was placed on Clinical Institute Withdrawal Assessment (CIWA) CIWA protocol to assess and manage the symptoms of alcohol withdrawal.

Operational

Safety/Security checks were conducted within policy.

Decedent was appropriately housed in 4 West with once cellmate then moved to 2 West for seizure monitoring.

At the time of death Detention Services staffing was standard for the facility.

Incident video was retained.

The decedent had no phone calls or visits.

Life saving measures taken were within policy.

Committee Recommendations

Decedent last disclosed alcohol abuse in 2020. It is recommended to have an alert in the NaphCare system for previous medical, alcohol and drug usage history.

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