DETENTION SERVICES

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 2023-22296 Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

Decedent was a 39 year old male with a history methamphetamine and Fentanyl usage. He was initially medically refused to be booked into jail. He received medical clearance from the hospital to be cleared for incarceration on September 14, 2023.

Decedent was booked into Spokane County Jail on September 14, 2023. He was booked on a Community Custody Hold (original charge was Domestic Violence Order Violation).

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

Incident Overview

Decedent had not been classified and was housed in 2West 41 awaiting classification. He was housed with two other inmates.

Decedent was seen by Medical at 09:17 for a Detox check.

At approximately 10:00 decedent complained that he felt pain in his genitals and that he couldn't urinate. Medical staff checked him shortly after 10:00.

Decedent complained to staff 2 more times for the same issue. Medical staff arrived at 2 West 41 at 11:45 to evaluate him again. He walked to his bunk then walked to sit on the toilet for the Nurse to check him.

The Nurse determined he needed to be transported to the hospital. 911 was called.

Decedent was assisted from his cell. As he was walking from the cell, he appeared to collapse into a seated position outside of the cell door. Officers carried him down the stairs to the main floor for treatment.

After being carried downstairs, decedent laid on the floor and complained of feeling faint. He began to vomit. Staff turned him on his side to prevent aspiration.

Decedent stopped moving and no longer had a pulse. Detention Staff immediately began life saving measures.

Spokane Fire Department and American Medical Response (AMR) personnel arrived within minutes of the start of CPR and soon took over all lifesaving efforts.

Decedent was pronounced deceased at 12:30.

The Spokane County Sheriffs' Office and The Spokane County Medical Examiner's Office investigated the cause of death.

On September 18, 2023 Spokane County Medical Examiner conducted an autopsy.

Medical Examiner completed their investigation with the conclusion:

Cause of Death: **Strangulated Small Bowel Obstruction due to a probable congenital adhesion band.**

Manner of Death: **Natural**

UFR Committee Meeting Information

Meeting date: October 31, 2023

Meeting Location: Jail 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
Lieutenant Aaron Anderton

Detention Services Office of Professional Standards

Sergeant GiGi Parker

Spokane County Detention Services Mental Health

Kristina Ray Mental Health Professional Manager

Spokane County Attorney
Haley Day

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

Cell 2 West 41 is located at the top of the stairwell from the first floor of 2 West to the second floor of 2 West directly below the 2 West upper north camera. There was a clear camera view of decedents cell door and the stairwell leading to the first floor of 2 West.

Due to ongoing intermittent camera outages with the vendor, the 360 camera was inoperable at the time of the incident. Therefore, there was no clear camera view of the incident.

There was sufficient lighting.

Clinical

The decedent was medically cleared for incarceration at the hospital on September 14, 2023. Decedent was monitored by medical staff for detox. He was seen by medical for genital pain and inability to urinate.

Operational

Decedent was unclassified and housed with two other inmates.

Video of the incident was retained.

Life saving measures were performed by Detention Services Staff, medical, Spokane Fire and AMR. Life Saving efforts were within policy.

Rounds were conducted within policy.

Decedent had no phone calls or visits.

Committee Recommendations

Camera vendor has been notified to provide a permanent solution to the intermittent camera outages.

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