DETENTION SERVICES

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

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Inmate Information

The inmate was a 26-year-old male. He was brought to Spokane County Jail on December 2, 2023, for Unlawful Imprisonment, two counts of 2nd degree Assault, and 4th degree Assault. The decedent was medically refused at booking and was sent to the hospital with the arresting agency. The decedent was cleared at the hospital and booked into Spokane County Jail on December 3, 2023, at approximately 0240 hours. The decedent admitted to fentanyl use resulting in him passing out frequently in the past week and provided he was hit by a car four days prior.

The Decedent was unclassified and was housed in 2 West 12 alone.

Incident Overview

On December 4, 2023, at approximately 1750 hours, an officer responded to a call light at 2 West 12, the decedent was found unresponsive in his single jail cell 2 West 12. The decedent activated the call light at approximately 1745 hours. He appeared to be pale in color and didn't appear to be breathing. Cardiopulmonary Resuscitation (CPR) was started. Nasal Narcan was also administered at approximately 1750 hours.

Naphcare nurses arrived on the floor at approximately 1751 hours. Naphcare staff and Corrections Officers continued CPR and started rescue breathing with a bag valve mask (BVM) and oxygen.

AED pads were applied, and no shock was advised. A Nurse attempted an IV start.

At approximately 1752 hours, a second nasal Narcan was administered, CPR continued and a second IV was attempted and was successful and fluids started. IM Narcan was set up but wasn't administered.

At approximately 1757 hours, Spokane Fire Department (SFD) arrived on scene and at 1801 hours, American Medical Response (AMR) arrived on scene.

At approximately 1805 hours, AMR replaced the AED pads, and a faint pulse was detected. No shock was given. Chest compressions were stopped but rescue breathing continued.

At approximately 1821 hours, the decedent was secured for transport and at 1836 hours AMR departed the Jail to the Emergency Department (ED).

The decedent was declared dead at 1903 hours.

Spokane County Medical Examiner ruled the decedent's death as:

Cause of Death: Pulmonary thromboembolism due to lower extremity deep vein thrombosis

Manner of Death: Natural

UFR Committee Meeting Information

Meeting date: January 24, 2024

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
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
The incident occurred in 2 West 12. The call light notification was silenced with only a visual notification active, which could have resulted in a slower response time to that area of the jail. The cell had adequate lighting and camera coverage. The cell was in working condition with no known mechanical or maintenance issues.

Clinical
The decedent reported he had used fentanyl and was passing out frequently in the past week. He was also hit by a car four days prior to incarceration. Decedent was refused medically and was sent to Deaconess Hospital Emergency Department. Decedent was discharged from Deaconess Hospital with a prescription. Decedent returned to jail and refused his medication on December 3rd and 4th.

Operational
The jail was adequately staffed. The decedent was not classified and was housed appropriately. The decedent did not make any phone calls, he had one professional visit, and did not make any self-harm statements. No contraband was found and there was no use of force.
2 West officer duties were adjusted to improve monitoring and response. Lifesaving efforts were within policy and training. Video was retained.

Committee Recommendations

Improve observation of watch cells by reviewing and adjusting officer duties for better monitoring and response times to emergencies.
A monitor was installed to improve visual observation of watch cells via camera.Initiate site wide order to keep duress alarm audio active.
2 West call light notification was reviewed and improved to include an updated desk light that is more visible and includes an audio alarm.

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.