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 decedent was a 42-year-old male and had been booked into Spokane County Jail on 11/16/2023 at 0124 hours. The decedent was placed on Clinical Opiate Withdrawal Scale (COWS) protocol after reporting Methadone use. The decedent also reported having a chest port for dialysis but had not been to dialysis for a while. The decedent reported his last dialysis was done at Deaconess Medical center. The decedent was moved to 2 West around 0341 hours. An alert was entered into Jail Tracker as "OK GP, no MH restrictions" by Classification.

Medical reports indicate that the decedent was in renal failure and was ordered to receive dialysis every M/W/F. The decedent was non-compliant with dialysis. The decedent was PRN for dialysis when he is puffy.

Incident Overview

At approximately 0915 hours on 11/17/2023, assistance was called to 2 West after the decedent attempted to divert his medication during medication pass. Officers attempted to handcuff him and recover the pill, the decedent fought officers and tried to bite an officer. The decedent was taken to the floor and two strikes to the left side back were used to gain compliance and handcuff the decedent. The decedent was escorted back into his cell and unhandcuffed using a cuff retainer through the food slot.

At approximately 1104 hours, assistance was called to 2 West 47 for an unresponsive male. After determining the decedent was not breathing, a dose of Narcan was delivered and CPR began. Additional resources were requested via 911. Detention Services and Naphcare staff performed life saving measures. Spokane Fire and AMR Staff arrived and took over care of the decedent aided by Detention and Naphcare staff. Ultimately, lifesaving efforts were unsuccessful, and the decedent was pronounced deceased at approximately 1144 hours.

UFR Committee Meeting Information

Meeting date: December 14, 2024

Meeting Location: 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

No Representation

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 decedent was housed in a cell located on 2 West mezzanine level on the North wall. There are no known maintenance issues or reports for any cell the decedent was housed in. The cell was recorded by one camera view.

Clinical
The Decedent was in renal failure and non-compliant with dialysis. Mental Health completed an intake screening during decedent's booking, and he was cleared for general population housing. Decedent was on medical protocol (COWS) and was seen regularly during his incarceration.

Operational
The staffing levels at the jail was normal. Rounds were reviewed and within policy. No contraband was found. The decedent was not classified and was housed appropriately.

Decedent did not make any phone calls and had one professional visit. The decedent did not make any self-harm statements. Use of force was reviewed internally and by the Spokane County Prosecutors office and was within policy and state law.

Lifesaving efforts were within policy and training. Video was retained.

Committee Recommendations

No committee Recommendations

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