DETENTION SERVICES

Unexpected Fatality Review Committee Report

2021 Unexpected Fatality Incident 2023-21735 Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

The decedent was a 63 year old male with reported history of alcohol, methamphetamine and marijuana usage.

The decedent was diagnosed with a hernia prior to being booked in Spokane County Jail.

At the time of death the decedent was housed as a Medium Sex Offender in Cell H15 in the Jail Annex. He was housed with 2 inmates at the time of his death.

The decedent was booked into Spokane County Jail February 23, 2023. He was booked in for one count 1st Degree Murder (Premeditated) and one count 1st Degree Murder(w/Robbery).

The decedent had no history of suicidal ideation. However, on February 23, 2023 he was placed on suicide watch due to the severity of his charges. His arrest received significant media coverage due to the charges being from a 1982 cold case. On February 24, 2023 decedent was removed from the suicide watch, classified, and moved into general population. He was housed in general population in the Jail Annex H14 then H15 for a total of 85 days until the time of death.

Incident Overview

The May 19, 2023 video footage showed the decedent exit his cell to retrieve his breakfast at approximately 05:58.

At approximately 07:10 hours, cellmates of the decedent observed the decedent having seizure like activity and activated their emergency alarm. Staff responded and found the decedent unresponsive. Life saving measures were performed by Detention Services staff as well as responding Fire and AMR personnel. Lifesaving efforts were unsuccessful and he was pronounced deceased at approximately 08:11 hours.

07:12 Annex Officers responded and opened the cell door and entered the cell.
07:13 Medical Escort Officer arrived. The decedents's cellmates were removed from the cell.
07:14 NaphCare Nurse arrived.
07:14 Two Shift Sergeants arrived with responding officers from Booking.
07:15 Additional NaphCare Nurse arrived.
07:15 Classification arrived.
07:16 NaphCare Health Services Administrator arrived.
07:18 Officer arrived with the red medical bag.
07:18 Additional NaphCare Nurse arrived with a medical cart.
07:20 Additional NaphCare Nurse arrived.
07:20 Custody Lieutenant arrived.
07:27 Fire Department arrived on scene and took over life saving measures.
07:29 Additional Naphcare Nurse arrived.
07:31 AMR (American Medical Response) ambulance arrived.

07:54 Detention Services Chief arrived.
08:11 Decedent pronounced deceased.
08:17 Mental Health Supervisor arrived.
08:28 Fire Department and AMR departed from the Annex.
08:45 Detention Services Chief and Custody Lieutenant departed.
08:58 NaphCare Nurse and Escort Officer arrived for medication pass.
09:03 Spokane County Forensic Unit arrived in Booking.
09:07 Spokane County Forensic Unit and Sheriff's Deputy arrived on scene in the Annex.
09:08 Custody Leiutenant arrived.
09:21 Detention Services Chief arrived.
09:46 Detention Services Chief departed.
10:19 Transport Agency arrived.
10:25 Transport Agency departed with decedent.
10:34 All remaining personnel departed and the scene was cleared.

The decedent's property was boxed and placed in the Custody Lieutantant's office for next of kin to pick up.

On May 19, 2023 Spokane County Medical Examiner performed an autopsy. Per the Spokane County Medical Examiner's autopsy report:

1. Cause of Death: **Bilateral Pulmonary Thromboemboli**
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

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 happened in the Jail Annex H15. Cell H15 is a portion of the Jail which has the original linear, bar style doors. By design, there are no cameras in the cells. The camera in the hallway is mounted on the south end of the hallway facing north. The decedents cell was located at the north end of the hallway.

There was sufficient lighting at the time of the incident.

Clinical

The decedent had submitted medical kites and been seen in the Jail medical clinic by an RN, for complaints of hernia related symptoms, chest pain, and shortness of breath in the days prior to his death.

Operational

Safety/Security checks were conducted within policy.

Decedent was appropriately housed in Jail Annex H15 with two cellmates.

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

The last telephone call the decedent made was May 15, 2023 at 10:49. He made two telephone calls while in custody. Neither call was accepted by the party called.

The decedent had no video visits.

Lfe saving measures taken were within policy.

Committee Recommendations

It was discovered a nurse said she responded to a medical kite from decedent on May 16, 2023, but she did not. She was terminated for not responding to the kite per policy.

Change medical kite collection process. The medical kite boxes will be removed and nurses will collect kites directly from inmates.

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