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 33-year-old female with medical history of methamphetamine abuse and chronic congestive heart failure.

The decedent was booked into Spokane County Jail on 09/09/2023 at approximately 1100 hours on a Federal probation Violation. She became uncooperative towards the end of the booking process. She was handcuffed and escorted to a holding cell in the booking area. The Decedent had an intial medical screening in the law enforcement lobby.

Incident Overview

At approximately 1515 hours on 09/10/2023, the decedent was moved into holding cell 1 west 08. Naphcare completed her medical intake. The decedent's urinalysis was positive for methamphetamine, amphetamine, fentanyl, and MDMA. The decedent was started on Clinical Opiate Withdrawal Scale (COWS) protocol for opioid withdrawal treatment at approximately 1532 hours. The decedent's booking process was finished, and she returned to 1 West 08.

Corrections staff and the booking nurse completed security round checks on the decedent during her stay in booking.

At approximately 1654 hours, the decedent was given a sack lunch to eat.

At approximaely 1908 hours, staff attempted to send the decedent to 2 West for classification housing. The decedent was found unresponsive. Life saving measures were performed by Detention Services staff, Medical, Spokane Fire and AMR. She was pronounced deceased at 2000 hours.

Spokane County Sheriff's Office and Spokane County Medical Examiners Office were notified and investigated the incident.

On 09/11/2023, Spokane County Medical Examiner performed an autopsy with the following conclusion:

1. Cause of Death: Toxic effects of methamphetamine and fentanyl.
2. Manner of Death: Accident

UFR Committee Meeting Information

Meeting date: October 31, 2023
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

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 1 West 08. This cell had adequate lighting and camera coverage. The cell is in working condition with no known mechanical or maintenance issues.

Clinical
Urine Analysis was positive for methamphetamine, amphetamine, fentanyl and MDMA. Clinical Opiate Withdrawal Scale (COWS) protocol was initiated. The decedent did not request mental health services. Medical rounds will be completed and documented every two hours. A vital check was not documented at 0332 hours.

Operational
The staffing levels at the jail was normal. Two rounds were completed, but not documented at 1513 hours and 1739 hours. The rounds were verified via video review. Physical searches and two body scans were completed on the decedent upon intake, no contraband was found. The decedent was not classified and was housed appropriately.

Decedent did not have visits or make any phone calls, did not make any self-harm statements, there was no use of force.

Life saving efforts were within policy and training. Video was retained.

Committee Recommendations

Round reviews were updated to include documenting rounds in 1 West 07, 08 and 09.

Ensure signs of life are visible in booking holding cells during rounds.

Conduct a visual inspection of the holding cells prior to placing new inmates in the cell.

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