DETENTION SERVICES

Unexpected Fatality Review Committee Report

2024 Unexpected Fatality Incident Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

The decedent was booked into Jail on February 17, 2024, at 1006 hours on a DOC hold (Poss of Stolen Prop).
The decedent's initial booking drug screen indicated he was positive for Fentanyl, MDMA, Methamphetamine and THC.
The decedent was placed on Clinical Opioid Withdrawal Treatment (COWS) and after the initial booking assessment, the decedent was seen by medical at 1619 hours on 2/17/24 and at 0745 and 1706 hours on 2/18/24.
The decedent didn't disclose he was prescribed any medications and denied self-harm thoughts.
The decedent declined his suboxone taper dose on 2/18/24.
The decedent was found unresponsive on February 19, 2024, at 0610 hours.
An investigation revealed that decedent used a substance in his cell between February 17th and 18th, 2024.

Incident Overview

On February 19, 2024, at approximately 0610 hours, the decedent was found unresponsive in his cell. Medical assistance was requested and staff responded and began life saving measures including CPR and AED assessment.
Nasal Narcan was administered and CPR continued.
An IV was attempted but was not successful.
IM Narcan administered at approximately 0613 and 0615 hours.
Fire and AMR arrived on scene at approximately 0629 and 0632 hours respectively.
Paramedic called time of death at 0634 hours.

UFR Committee Meeting Information

Meeting date: September 25, 2024 @ 0900 Hours

Meeting Location: SCJ Conference Room

Committee Members:

Spokane County Detention Services Administration

Chief Don Hooper

Spokane County Detention Services Command Staff

Lieutenant Darren Lehman

Lieutenant Jason Robison
Lieutenant Aaron Anderton

Detention Services Office of Professional Standards

Lieutenant Lewis Wirth

Spokane County Detention Services Mental Health

Kristina Ray Mental Health Professional Manager

Spokane County Attorney

Haley Day

NaphCare

Richae Nelson Health Services Administrator
Danielle Fosjord Director of Nursing
Marsha Hanna Director of Operations
Seetal Tejura Naphcare Attorney

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
Incident occurred in 4 West 04. The cell has adequate lighting and camera coverage. The cell is in working condition with no known mechanical or maintenance issues.

Clinical
The decedent provided a positive urinalysis upon intake. Witness testimony confirmed substance use while in custody. The decedent declined mental health services. The decedent was seen by medical at intake and on scheduled medical checks on clinical opioid withdrawal treatment (COWS).

Operational
The jail was adequately staffed. Rounds were completed and documented. The decedent was not classified and was housed appropriately. The decedent did not make any phone calls or have any visits. The decedent did not make any self-harm statements. No contraband was found and there was no use of force. Lifesaving efforts were within policy and training. Video was retained.

Committee Recommendations
The Narcan administration protocol was updated. Round standards were updated to include audits by Sergeants and Lieutenant. Suboxone refusals will be investigated to determine the reason for refusal.

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.