DETENTION SERVICES

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 2023-21899 Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Contents

Inmate Information

Decedent was a 34 year old male with a history of suicidal ideation and suicide attempts. Decedent denied suicidal ideation during intake.

Decedent was booked into Spokane County Jail on July 08, 2023 for 1 count Public Officer (Obstruct), Public Officer (Resist Arrest). He was also booked on a Fugitive charge from Montana for Burglary.

On June 08, 2023, prior to being booked into jail, decedent was "medically cleared to discharge to police custody". He was seen for an unknown head injury.

During intake decedent self-admitted fentanyl and meth use and was started on Clinical Opiate Withdrawal Scale (COWS) protocol for opioid withdrawal treatment

Decedent did not request mental health care while in custody.

It was discovered during the investigation that decedent spoke to an individual on the telephone the day of the incident. Decedent told the individual he had a "piece of rope tied up" and was going to hang himself. During the phone call the individual also told the decedent about the death of someone due to drug overdose. Decedent was distraught by the news and began crying.

Received information from SCSO Detective that during an interview SCSO discovered decedent had 2 prior suicide attempts. One as a teen and one during COVID. It was reported he has been suicidal most of his life.

Incident Overview

Decedent was cleared from COWS on June 13, 2023.

Decedent was classified minimum security and moved from 4 West classification housing to 5 West on June 13, 2023. At the time of the incident he did not have a cellmate. Decedent had no interactions or medical requests outside of his COWS protocol. Decedent did not request any mental health care while in custody.

On June 24, 2023 at approximately 2234 hours, an officer conducting rounds found decedent hanging from the upper bunk. He had twisted clothing tightly around his neck. Decedent was removed from the cell and life saving measures were performed by Detention Services staff, Naphcare, Spokane Fire Department and AMR personnel.

Fire personnel were able to get a pulse back. Decedent was taken to the hospital.

Spokane County Sheriff's Office was notified and investigated.

Decedent had brain death days prior to being pronounced deceased June 29, 2023 at the hospital.

On June 30, 2023, Spokane County Medical Examiner performed an autopsy. Spokane County Medical Examiner completed their investigation with the conclusion:

- Cause of Death: **Due to complication of ligature hanging.**
- Manner of Death: **Suicide**

UFR Committee Meeting Information

Meeting date: October 31, 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
Lieutenant 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

5 West is a general population housing unit with 46 cells.

Decedent was housed alone on the mezzanine in cell 45 located at the far east end of the mezzanine. There is no camera coverage on the 5 West mezzanine. By design, there is no camera coverage in the cells.

There was no known lighting or fixture issues with cell 5 West 45.

Clinical

Decedent was started on Clinical Opiate Withdrawal Scale (COWS) protocol for opioid withdrawal treatment.

Decedent was cleared from COWS on 06/13/2023.

Naphcare had no interactions with decedent outside of his COWS protocol.

Decedent did not request any mental health care while in custody.

Operational

Rounds were conducted within policy.

Decedent was housed appropriately for minimum security classification.

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

Between June 08, 2023 and June 24, 2023 decedent attempted 261 phone calls with 42 completed.

No known self-harm statements prior to post-incident investigation phone call review.

He had no visits.

Incident video was retained.

Life saving measures taken were within policy.

Committee Recommendations:

Complete installation of 360° cameral on all modules.

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