CITY OF PUYALLUP JAIL

# UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT - 2220100936

REPORT TO THE LEGISLATURE

*pursuant to RCW 70.48.510*

Date of publication: May 9, 2023

# Unexpected Fatality Review

## Introduction – Purpose – Legal Requirements

Pursuant to state law, the Chief of Police of the City of Puyallup is required to conduct "an unexpected fatality review in any case in which the death of an individual confined in the [City's] jail is unexpected." *RCW 70.48.510(1)(a)*. The primary purpose of the review is to develop recommendations to the City of Puyallup and the state legislature "regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody." *RCW 70.48.510(1)(c)*.

In order to conduct the required review, the Chief of Police must select members to comprise the "unexpected fatality review team" ("UFR Team"). The team must include "individuals with appropriate expertise," and may not include anyone who has had "previous involvement in the case." *RCW 70.48.510(1)(b)*.

Once the UFR Team completes its review, the Chief of Police must issue a report on the results of that review. *RCW 70.48.510(1)(d)*. The report must include (1) "an analysis of the root cause or causes of the unexpected fatality," and (2) "an associated corrective plan for the jail to address any root causes and recommendations" made by the UFR Team. *RCW 70.48.510(5)(c)*.

## Current Incident – UFR Team – Investigation

On July 20, 2022, Puyallup Jail an inmate was found deceased in her cell. Because the inmate's death was "unexpected" as defined in RCW 70.48.510(5)(c), I requested the following individuals to comprise the UFR Team for this incident, and to perform the required review:

- John McGrath, former Jail Liaison with Washington Association of Sheriffs and Police Chiefs (WASPC);
- Richard J. Bishop, current Jail Liaison for WASPC[1]
- John DiCorce, Operations Chief for the South Correctional Entity (SCORE); and
- Dr. Mark Stern, Consultant in Correctional Healthcare for WASPC.

Captain Ryan Portmann, who oversees the Puyallup Police Department Corrections Division, including the jail, provided the UFR Team a binder (203) pages containing a variety of records relevant to the incident, including:

- A timeline of events taken from jail logs, CCTV surveillance, and other internal records;
- Arrest report for the inmate;
- Puyallup PD case #2220100963 (death investigation);

[1] Mr. McGrath unexpectedly passed away during this investigation. Mr. Bishop, who took over Mr. McGrath's Jail Liaison position with WASPC, agreed to step in and complete Mr. McGrath's portion of this investigation.

- Crime Response Unit (CRU) case #2220101758;[2]
- Computer Aided Dispatch (CAD) printout of 911 call;
- Statements from Jail Staff;
- Puyallup Jail Report; and
- Pierce County Medical Examiner's Postmortem Examination Report

The UFR Team completed their work in March of 2023 and has since provided me the results of their review. The following constitutes the report regarding that review, as required by RCW 70.48.510(d).

## Facts of Incident

July 18, 2022

On the morning of Monday, July 18, 2022, Puyallup Police officers located a stolen van in the parking lot of the Indian Country Store on River Road in Puyallup. On further investigation, officers found three males and two females sleeping inside the van. Eventually, officers discovered that both females had active warrants for their arrest. Officers arrested both females and transported them to the Puyallup Jail for booking. Both females were booked into the jail just after 8:00 am.

During the booking process, jail staff noted that both females appeared to be under the influence of an unknown substance (alcohol or narcotics). When interviewed by staff, both admitted to using illegal narcotics, including methamphetamine, heroin, and fentanyl. One female claimed to be already feeling the effects of narcotics withdrawal, and the second confirmed she would likely be withdrawing as well. Both also claimed to have COVID-like symptoms, but having refused COVID testing, they were placed together in a holding cell (H-2) near the booking counter for a 72-hour COVID hold.

At approximately 11:40 am, jail staff placed a pitcher of Gatorade in H-2 to help combat the drug withdrawals that both appeared to be experiencing. At that time, both females were sleeping. For the remainder of the day, both women appeared tired and sluggish, often huddling under blankets on their beds. Based on the training and experience of jail staff, both females appeared to be experiencing typical symptoms of narcotics withdrawal, something jail staff sees on a regular basis: chills, lethargy, diarrhea, etc. During the remainder of that day and evening, neither female expressed any complaints or asked for any assistance from jail staff.

July 19, 2022

The following morning, July 19, 2022, jail staff noted H-2 was extremely dirty and unkept. There were paper plates and food-related trash – the remains of the breakfast the pair had been given – strewn around the cell, and the toilet appeared to be clogged with fecal matter. Again, the

[2] The CRU is a multijurisdictional team comprised of officers from various cities in the area, for the purpose of conducting third-party investigations into major incidents involving member cities. Following the incustody death, Puyallup requested CRU to perform an independent investigation into the circumstances, which they did.

staff noted the condition of the cell was typical of inmates experiencing symptoms of narcotics withdrawal, and neither female expressed any particular complaints.

Just before 7:00 am that morning, jail staff received permission from the jail-assigned ARNP to provide standard withdrawal medications to both females. Around 11:30 am, jail staff provided each inmate one tablet of Promethazine (25 mg), and one tablet of Loperamide (2 mg), standard withdrawal medication that is kept on hand at the jail. Each inmate appeared to swallow the tablets provided. At approximately 5:00 pm that evening, jail staff provided each inmate a second dose of each medication. Again, both appeared to swallow the medication provided. Both females declined lunch and dinner service, which is again typical of individuals experiencing withdrawal.

Later that evening, jail staff had both inmates leave the holding cell so it could be cleaned. At that time, female 1 (The subject of this report) had removed her jail clothing, and left the cell wrapped only in a blanket. She agreed to take a COVID test and tested negative. Because both female inmates had now tested negative for COVID (the second female had agreed to be tested earlier in the day), staff moved the pair into Cell 1, a standard cell in the main housing portion of the jail, with access to a jail room, a shower, and other amenities.

When staff escorted female 1 into Cell 1, she sat on the floor of the dayroom area to wait for the shower, which was occupied at the time. When staff returned later with mattresses, bedding, clothing, and towels for the pair, she was still on the floor of the dayroom waiting for the shower. Staff specifically inquired if she was ok, and she indicated that she was, and was just waiting for the shower. A staff member reminded both females to notify jail staff if they needed anything or felt like their symptoms were worsening. Staff later confirmed via CCTV that female 1 was standing near the shower unclothed.

Shortly after the female inmates were transferred to Cell 1, the trustee cleaning H-2 notified staff he had found a small metal cylinder. Jail staff opened the cylinder, which was consistent with the type of container typically used to carry narcotics, and found it contained two blue pills. Based on their training and experience, staff concluded they were likely fentanyl pills. A female officer questioned the females about the drugs, and both denied they had brought the container or the drugs into the facility. Both inmates also denied they had any drugs in their possession, or that they had ingested any drugs since being booked into the jail.

<u>July 20, 2022</u>

The following morning, July 20, 2022, both inmates refused breakfast, and declined to take their scheduled dose of withdrawal medication. Staff noted that both behaviors, refusal of meals and refusal to take withdrawal medications, are typical of individuals suffering withdrawal symptoms, particularly during the early-morning breakfast service. Throughout the morning of July 20, 2022, jail staff performed standard cell checks approximately every 30 minutes. During these checks, officers visually look into each cell to confirm all inmates are present and accounted for, and that nothing appears out of the ordinary.

At approximately 9:30 am, an officer performed a visual check of Cell 1, and noticed that female 1 was tossing and turning on her bed. According to staff, tossing and turning on jail mattresses is typical behavior for inmates, as the beds are not particularly comfortable. Female 1 sounded like she was moaning, again a typical behavior for someone experiencing withdrawals, which inmates will often describe as similar to having the flu. She did not request any attention, and none of the other females in the cell with her expressed any concern.

At approximately 10:45 am, jail staff announced to the female inmates in Cell 1 that their medications were available. Staff reported that none of the female inmates came out for medication. Shortly after 11:00 am, staff provided the inmates in Cell 1 a bucket to begin cleaning the cell, as it was dirty from multiple inmates detoxing. Staff warned the inmates in Cell 1 that if they did not begin cleaning, they could lose their tv privileges in the day room. A few minutes later, an inmate in Cell 1 requested a cup from an officer. When the officer returned with the cup, he overheard an inmate say something to the effect of "I don't think she's doing too well," in apparent reference to another inmate.

Officers immediately entered Cell 1 and found female 1 unconscious, not breathing, and without a pulse. Based on their training and experience, it appeared clear to the officers present that female 1 was deceased at that time. However, jail staff requested fire and aid personnel, began CPR, administered Narcan, and connected female 1 to an Automatic External Defibrillator. Medics arrived a short time later and took over lifesaving attempts, but eventually determined she was deceased.

CRU Investigation and Medical Examiner's Postmortem Examination

Following the death of female 1, Puyallup Police Department personnel contact the Metro Cities Criminal Response Unit, and multijurisdictional team comprised of investigators from regional jurisdictions, to conduct a death investigation. CRU detectives responded to the jail and began their investigation. Over the ensuing days, CRU investigators reviewed records, interviewed witnesses, including jail staff and inmates, and prepared investigative reports.

On July 21, 2022, the day after female 1 passed away, Pierce County Chief Medical Examiner Karen Cline-Parhamovich, conducted a postmortem examination (*i.e.*, an autopsy). Her examination, including toxicological reports, indicated that she had fatal levels of methamphetamine and fentanyl in her system at the time of her death, and concluded that the cause of death was acute methamphetamine and fentanyl toxicity.

## Root Cause – Policy/Practice Recommendations

Based on my review and analysis of the records provided, including jail records, CRU investigative records, the Medical Examiner's Postmortem examination report, and the review performed by the UFR Team, it is clear that the root cause of female 1's death appears to be her use of methamphetamine and fentanyl while in custody at the jail. Notwithstanding that determination, our goal as the City of Puyallup, and in fact our statutory mandate under RCW

70.48.510(1)(b), is to consider any way in which changes to our practices and policies might help to prevent such fatalities and strengthen safety and health protections for individuals in custody.

For that purpose, and in that spirit, the UFR Team identified various policies and practices that may be relevant to the facts and circumstances of female 1's death and recommended that the City consider the extent to which changes to those policies and practices may serve the goals of the health and safety of inmates at our jail. These policies and practices, and my determination as the Chief of Police regarding further consideration of those issues, are as follows:

<u>Medical Screening During Booking Process</u>

As discussed above, our unfortunate experience at the Puyallup Jail is that an increasing number of individuals booked are addicted to narcotics. As many other jails have experienced, a large percentage of those individuals are addicted to opiates in general, and fentanyl in particular. Our experience is that fentanyl abusers may often have specific medical issues, and the length and severity of their withdrawal process is often greater than that associated with other narcotics.

Based on those facts, and the opioid crisis facing our country in general, the concern was raised that our initial medical screening process should be updated to more specifically and explicitly account for the possibility that individuals booked into the jail are habitual opioid users and may require additional medical attention or intervention.

In response to this issue, and without awaiting my decision or order, our corrections staff has proactively updated the medical screening forms, in consultation with our healthcare provider, used for all new bookings at the City of Puyallup Jail. These forms now include specific inquiries designed to elicit more information about possible drug addiction, and specific inquiries that will automatically trigger notification of medical personnel for further review, including individual examination of arrestees in various situations (certain vital signs, certain affirmative responses to questions from jail staff, etc.).

The booking forms have also been updated to require intake officers to make and record additional observations about the appearance and actions of an arrestee during the intake (appearance, speech, loss of consciousness, etc.), and to be more proactive in the notification of medical personnel in various circumstances, with the goal of more accurately assessing the extent to which such individual may be under the influence of a specific narcotic, or may be more likely to experience medical complications during withdrawal. Jail staff have already been trained on the updated policies and practices.

Additionally, our outside medical provider (Health Delivery Systems or "HDS) recommended considering drug screening during the intake/booking process, noting that an early identification of specific narcotics that an inmate may have recently ingested would provide an additional layer of information about potential complications, or particular medical needs the individual may be more likely to have. In response to that recommendation, jail administration has already applied for and received City funding for drug screening during the intake process. Drug screening began in March of 2023.

Finally, based on the recommendations of our outside medical provider (HDS), jail administration initiated annual training on jail related medical issues. The first training session occurred in September of 2022 and will occur annually each September.

It is my conclusion that these changes, already implemented by jail staff and administration, are well-considered and thoughtful responses to the health and safety risks posed to our inmates.

Timing and Method of Medication Administration

In the course of its review, the UFR noted three potential ways in which the current policies and practices regarding administration of medication to inmates may be changed to further enhance the safety and security of individuals housed at the Puyallup Jail.

First, the UFR Team noted that morning medications are typically dispensed at 4:30 am. The concern was expressed that this early time, though typical in the correctional industry, may lead to more inmates declining to take medication available to them, *i.e.*, simply choosing to sleep instead of waking up to take their medication. Based on this concern, jail staff and administration have proactively changed the time of morning medication administration to 6:30 am, with the purpose of increasing the likelihood that inmates for whom medication is available may already be awake or may be more willing to wake up and take their medication.

Second, the UFR noted the policy and procedure for administering medication was either to (1) announce via loudspeaker that medications were available and waiting for inmates to exit their cell for their medication, or (2) call out eligible inmates (via loudspeaker) individually by name. Under either method, if an inmate did not respond to the announcement/invitation, jail staff would consider that inmate to have declined his or her medication at that time. Concern was expressed that these methods might make it less likely for any individual inmate to voluntarily comply with his or her medication protocol, and less likely for jail staff to determine why such compliance was refused. Alternatively, the possibility was raised that a more individualized procedure may result in a higher rate of compliance and provide jail staff another opportunity to consider any specific medical problems or concerns an inmate might be having.

Based on these concerns, jail staff and administration have proactively adjusted the policy and practice regarding the administration of medication. The update policy and practice is to call out individual inmates for their approved medication. If an inmate does not respond to such a call, jail staff are required to make direct contact with the inmate to confirm he/she is explicitly declining to take the medication, and to inquire into the reasons for that decision. Any time such contact is made, jail staff are now required to document the circumstances, and record their observations of the inmate and his or her reason for refusing medication.

Third, as discussed more fully below, the UFR Team noted what is a common difficulty for correctional facilities, particularly small local facilities like the Puyallup Jail, the availability and affordability of medical care in general, and the regular medical monitoring of individual inmates with specific concerns. With the aim of partially addressing this issue, jail staff and administration have implemented a policy/practice of requiring jail staff to (1) obtain and record vital signs

anytime medication is provided to an individual inmate who is experiencing withdrawals (temperature, heart rate, blood pressure, etc.), and (2) report immediately to a medical provider if the inmate's vital signs hit certain benchmarks. This adjustment to our policies and practices will help to more regularly monitor the health of our inmates, particularly those whose medical needs may be complicated by habitual narcotics use.

<u>Strip Searches</u>

Based on the length of time between female 1's booking and her death (approx. 51 hours), and the amount of narcotics in her blood at the time of her death, it is apparent that she ingested narcotics while housed in our jail. Similarly, we have noted an increasing amount of narcotics found in our facility during both random and regular cell searches, the tin of suspected fentanyl pills found during the cleaning of the holding cell a prime example. The UFR Team expressed concern that the frequency with which narcotics are discovered may require a re-examination of our policies and practices related to how individuals are searched during the intake process. Specifically, the UFR Team, notes that staff are hesitant to conduct strip searches at intake based on both written policy and general legal considerations.

Washington law has extensive restrictions on the ability of jail staff to conduct strip searches during the booking process. *See RCW 10.79.060-170*. However, given the increased frequency with which narcotics are being found inside our jail, and our ethical and legal obligation to care for the health and welfare of our inmates, it is worthwhile to consider the extent to which our policies and practices might be improved. I am therefore instructing our jail commander, Captain Ryan Portmann, to analyze Policy 514 (Searches) of the Puyallup Custody Manual, analyze the current state of the law regarding in-custody searches, and provide recommendations regarding any potential changes to our policies and practices that might enhance the safety and welfare of our inmates, reduce the frequency with which narcotics are located in our facility, and still comply with both state and federal law protecting the important rights of those in our custody.

Once those recommendations are provided, my office will consider those recommendations and, if necessary, work with City, police, and jail personnel to implement any appropriate changes to our polices or practices.

<u>Medical Staff</u>

As briefly discussed above, one of the most difficult issues faced by correctional facilities is obtaining and paying for regular medical care for inmates. Jails, particularly small local jails like ours, are constantly balancing our responsibility for the health and welfare of our inmates with the very real limitations on finances and personnel that are endemic to governmental services in general, and the corrections industry specifically.

Currently, the City of Puyallup contracts with an outside medical vendor, Healthcare Delivery Systems (HDS), for provisions of medical service to our jail population. The contract provides on on-site Nurse Practitioner two days a week (12 hours total), and a Psychiatric Nurse Practitioner one additional day per week. HDS also maintains a 24-hour on-call telephone service for any medical questions or concerns jail staff may have. Emergency medical services are

provided by Central Pierce Fire and Rescue, which has a station next door to the jail. And our jail staff are trained and certified in basic first aid, obtaining vitals, and emergency life-saving measures (CPR, AED, etc.).

While the medical services we provide at our jail are consistent with industry standards and best practices, that fact should not foreclose the possibility that improvements might be made. I am therefore instructing our jail commander, Captain Ryan Portmann, to conduct an analysis of any potential expansion of our medical services, along with the financial impacts of any such expansion, and report his findings and recommendations to me. Such potential expansion of services could, for example, include adding an additional shift for the Nurse Practitioner, or simply redistributing the current 12 hours of weekly coverage among additional days to provide more frequent opportunities for our jail staff to address any questions or concerns.

Once those recommendations are provided, my office will work with City, police, and jail personnel to implement any appropriate changes.

<u>Welfare Checks by Jail Staff</u>

The UFR Team identified potential confusion among jail staff on the specific policy for inmate welfare checks; in particular, the extent to which an officer is required to make direct visual or verbal contact with each inmate during these regular checks. In response to this concern, jail administration has already conducted updated staff training on the policy's specific requirements, and the overall expectations for officers conducting welfare checks. Jail administration has also implemented random spot checks to ensure staff compliance with the policies and practices.

<u>Video Observation of Inmates</u>

All cells and common areas in the Puyallup Jail are subject to video monitoring by a collection of stationary cameras. At the time of female 1's death, however, in an effort to protect the privacy of the inmates, the footage from inside individual cells was not recorded.[3] The UFR Team noted that the absence of recording in the cells was pertinent in several ways to the facts and circumstance of her time in the jail. For example, had the camera inside H-2 been recording, jail staff may have been able to review footage after the suspected fentanyl was found in that cell. That review may have provided important evidence about who brought the pills into the facility, and more importantly, whether either female had consumed any pills or other illicit substances while housed in H-2. Similarly, the availability of recorded footage inside Cell 1 would have allowed jail staff or subsequent investigators to more easily determine female 1's condition in the final hours of her life, her specific time of death, and whether any other foul play occurred while she was in our custody.

While the goal of providing inmates with even a modicum of privacy is an admirable goal, jail administration determined the extent to which recorded footage may materially advance

[3] It is important to note that the City was previously sued for having a policy that allowed recording of footage from inside cells, including the holding cells. *See WAWD Case # 13-5926 RJB*. In that case, the jury found the City was lawfully entitled to record such footage, and that doing so did not violate the inmates' privacy rights. Notwithstanding that verdict, the City nevertheless changed the policy, disallowing the recording of inside the cells.

legitimate law enforcement and penological interests going forward outweighs the marginal privacy benefit offered by not recording the in-cell cameras. In September 2022, jail administration officially changed the policy to allow recording of footage from cameras inside the cells at the Puyallup Jail.

## **Conclusion**

This inmate overdose fatality was unexpected and unfortunate. However, we remain committed to our responsibility for the health and safety of our inmates. And, as outlined above, the City of Puyallup is committed to a full examination of the extent to which changes to jail policies and/or practices could help to prevent such fatalities in the future, or generally strengthen the safety and health protections for individuals in custody.