



GONE BUT NOT FORGOTTEN

The Untold Stories of Jail Deaths
in Washington



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Dedication

This report is dedicated to the men and women who have died in Washington's jails and the family and friends who continue to grieve for them.

It contains graphic descriptions of terrible suffering and death. It includes statistics and numbers that chronicle those deaths in arithmetical terms. We have struggled with how to present this information in an informative and compelling way that also properly respects the real men and women who died while in custody. They were too often people whom society had ignored and thrown away, people fighting addiction, homelessness, mental illness, ill health, and poverty.

Yet each was also a husband, wife, father, mother, son, daughter, brother, sister, aunt or uncle, who ended up behind bars. Each of their lives was unique and special, but collectively their deaths demonstrate serious flaws in our carceral system: A punitive and inequitable model that holds people who have not been convicted of any crime simply because they cannot afford bail; a model that condemns people fighting mental illness and cognitive disabilities to serve days, weeks, or months for behaviors associated with their disabilities; a model compounded by chronically inadequate health care both in the community and in jails; a model that only provides housing to people when they finally end up behind bars; and a model deeply infected with systemic racism and classism. We hope that we honor the people whose lives were lost by shining a light on the institutions and systems that led to their deaths.

Acknowledgements

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Executive Summary

Only 22 years-old, Lindsay Kronberger, a four-sport athlete while in high school, battled drug addiction and ended up in jail, booked into the Snohomish County jail on January 3, 2014.¹ Upon booking, she admitted to having recently taken heroin and that she was feeling the early stages of withdrawal. Over the next several days, Lindsay suffered terribly from severe nausea, vomiting and diarrhea.

Weighing only 95 pounds at booking and appearing “emaciated,” Lindsay proceeded to lose another eight pounds while locked up. Medical professionals in the jail noted that her blood pressure fluctuated dramatically during the nine days she spent there. Desperate because of the severity of her symptoms, she begged to be taken to the hospital, but reports indicate that the jail’s staff did not feel it was necessary and so she remained in the Snohomish County jail. At one point, Lindsay was so weak that she was not able to walk even a few feet from her cell. A federal judge would later note that “more intensive therapies could have been initiated to improve her hydration and reverse the deadly spiral of vomiting and diarrhea that resulted in severe dehydration and electrolyte imbalance.”² Nine days after being booked into jail, Lindsay was found face down in her cell’s toilet - dead from dehydration-triggered cardiac arrest.

Lindsay’s untimely death is unfortunately not an isolated incident. Every day many people suffering like her are booked into jails throughout Washington. Some, like Lindsay, die there. Many of these deaths are entirely avoidable, caused in part by society’s failure to properly care for the many people with mental illness, traumatic brain injuries, cognitive disabilities, and substance use disorders who end up behind bars. Faced with the chronic failure of federal, state, and local governments to properly fund essential services, jails struggle to maintain order and treat all people humanely, respectfully, and safely.

On any given night, roughly 12,500 men and women sleep behind the walls of county and local jails in Washington. Most of them have not been convicted of a crime and are there simply because they cannot afford the bail that a court has set.³ Those who have been convicted are generally serving short sentences for low-level crimes or minor probation violations. The majority are indigent, and many battle substance use disorders and symptoms of severe mental illness, traumatic brain injuries or cognitive disabilities.⁴ Others come to jail suffering from complicated, chronic, and poorly managed medical conditions, such as diabetes, coronary heart disease, high blood pressure, and asthma. People locked up in jails are our friends and family members. Over half of all adults in the United States have an immediate family member who has been incarcerated.⁵



Source: <https://www.seattlepi.com/local/crime/article/Claim-Jailers-mocked-dying-young-woman-during-9121704.php>

Unfortunately, society has abdicated its responsibility to provide humane, cost-effective, community-based housing and treatment services for people with serious medical, mental, and behavioral health needs. Instead we spend millions of dollars a year warehousing people in our jails - institutions ill-equipped to provide appropriate and adequate care.⁶ Far too many die behind bars as a result.

Jails operate without public transparency or outside supervision. As a result, policy makers and the public are largely unaware of the true costs of incarceration.

Jail deaths are merely the most egregious examples of the systemic failures that injure thousands of people locked up in Washington every year. The misdirection of resources to Washington's jails and away from other more effective and humane, community-based alternatives has caused unnecessary suffering and death. In this report we review deaths in Washington jails in the hope of spurring reform to ensure that no person needlessly dies behind bars.

Locking people up in jail is not cheap. Washington counties and localities spend hundreds of millions of dollars a year holding people in jail. King County will spend over \$320 million in the next two years to operate its jails.⁷ Spokane County spends over \$43,000 per detainee per year in its jails.⁸ By comparison, Spokane Public Schools spends under \$12,000 per student each year.⁹

*Each year Spokane County spends **\$43,000 per detainee**. By contrast, the Spokane Public Schools spends under **\$11,700 per student**.*

Moreover, the allocation of millions of dollars to jails is not effective, as medical and mental health care remain seriously deficient in many jails.¹⁰ As Disability Rights Washington has noted: "while mental health treatment may prevent inmate deterioration and enhance protection from self-harm and suicidal or homicidal ideation, jails are ill-equipped to respond appropriately to the needs of individuals with mental illness seeking mental treatment."¹¹

This report takes a deep look at available information regarding deaths that occurred in Washington jails between January 2005 and June 2016.¹² On average, 17 people died every year while locked up during this period. Though a small percentage of the total population, these events highlight larger issues within the jail system, as many other people suffer severe non-deadly harms as a result of our carceral system.

Our analysis of the available data on jail deaths reveals the following:

- Most jail deaths occur within the first days following booking.
- Drugs or alcohol played a significant role in many of the deaths, and these deaths are by and large avoidable.
- Few jails appear to have effective policies and practices in place to avoid deaths caused by overdose or withdrawal from drugs or alcohol.

- Suicide, particularly suicide by hanging, makes up a large percentage of deaths, and current practices in many jails may be increasing the likelihood of suicide.
- Use of force or neglect by jail officers played a contributing role in a significant number of deaths.

People will continue to needlessly die in jails until adequate resources are put into cheaper, community-based programs and treatment. A few relatively inexpensive reforms can reduce or eliminate deaths in Washington's jails. These reforms include:

1. Reducing the number of people living with mental illness, cognitive disabilities, or substance use disorders in jails by increasing diversion programs, eliminating the use of cash bail, and improving community-based treatment and housing options.
2. Increasing oversight and transparency by establishing reporting requirements and introducing statewide standards and monitoring of jails.
3. Implementing an adequate and timely medical, mental health, and substance use intake process in every jail that includes a thorough health examination of each person detained for more than a few days.
4. Using evidence-based overdose and withdrawal protocols in every jail that include appropriate medications and other vital medical, mental health, and substance use disorder interventions.
5. Instituting comprehensive suicide prevention policies and practices that treat all people with dignity and eliminate isolation as a method of responding to people who threaten suicide.
6. Training all staff on how to manage people in crisis, utilize effective de-escalation techniques, and only use force when absolutely necessary.
7. Providing sufficient financial resources to ensure that all jails employ enough staff to properly supervise and care for every person locked behind bars.
8. Requiring that every jail perform a comprehensive and detailed, serious incident administrative review and prepare a written report which is shared with the Washington State Department of Health or another appropriate agency and the public.

Implementing these relatively few reforms will dramatically reduce the number of people injured, disabled, or killed in our jails.

Lack of Transparency Limits Available Information on Jail Deaths and Keeps Major Problems Hidden from View

Washington is one of 17 states that lack any type of state oversight of jail operations or conditions.¹³ Though jails house thousands of people every year and have become the primary health care provider for many Washingtonians, local governments have no obligation to provide information to any state agency or the public regarding conditions within their jails. Information that jails voluntarily provide to the federal government and the Washington Association of Sheriffs and Police Chiefs (WASPC) is extremely narrow in scope and divulges very little about what is actually happening behind jail walls.¹⁴

The information in this report comes from a review of documents we received from jails regarding any person who died while in custody between January 1, 2005, and June 15, 2016. We received thousands of pages of documents from 54 jails based on our Public Records Act requests to each of the 59 county, local, and joint-jurisdictional jails in Washington. While many jails provided significant documentation, several jails provided nothing or very little documentation. We supplemented the review of jail-provided documents with WASPC and federally published data, media reports, and other publicly available information to gain as complete a picture of each death as possible. However, in a number of cases we had difficulty determining the facts because of limited disclosures and severely redacted documents.

State law protects jails from having to disclose dangerous conditions or serious events to state government or the public. RCW 70.48.100 contains a broad exemption from Washington's otherwise expansive Public Records Act. This provision generally bans disclosure of "records of a person

confined in a jail" to all parties but law enforcement.¹⁵

As we discovered during the investigation for this report, jails interpret the bounds of this exemption differently. A number refused to provide any information at all - not even the names of people who died in their custody. Others provided basic information regarding the death itself, but withheld information regarding contributing factors that may have played a role in the death.

Illustration 1, below, is an example of the heavily redacted documents that counties and cities typically provided in response to our Public Records Act requests.

Undoubtedly, it is important to protect the confidentiality of some jail records. However, a legitimate need to maintain the privacy of detainees should not allow jails to keep bad practices and unfortunate events hidden from view. Absent legislative changes to mandate some level of oversight and reporting, jails will continue to operate without transparency or real accountability.¹⁶



Illustration 1

Photo Credit: Alex Bergstrom

Information about Washington's Jails and the People Locked Up Inside Them

There are 59 county, local, and joint-jurisdictional jails in Washington. Combined, these jails are designed to hold 14,819 people.¹⁷ The number of people locked up in each jail differs dramatically, from a reported average of seven people per night in the Oak Harbor city jail to almost 2,000 people per night in the two King County jails. The top five largest jails in Washington house roughly half of all people detained in the state, while the 44 smallest jails hold less than a quarter of all people.

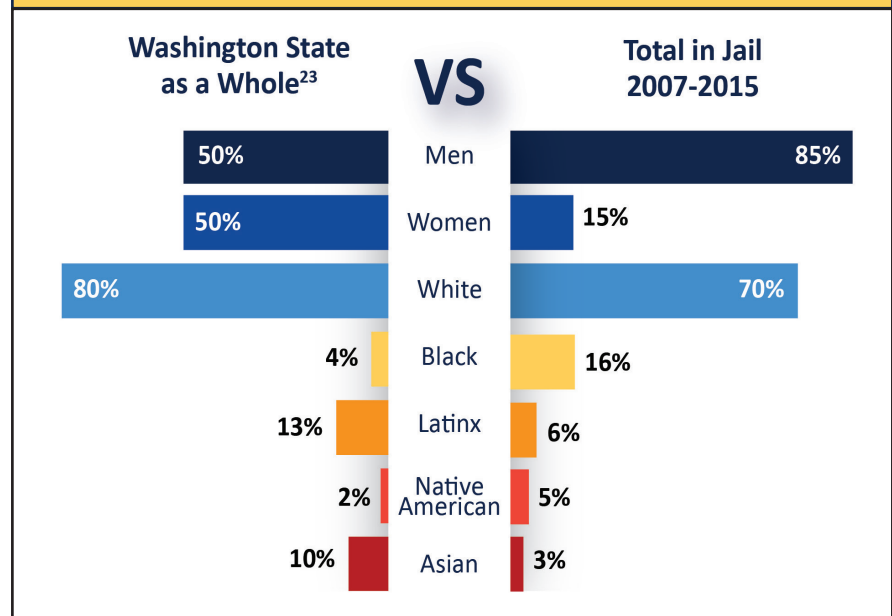
The cost to incarcerate people also varies by jurisdiction, from a low average daily bed rate of \$31 per night per detainee in Adams County to more than \$100 per night in a number of larger jails.²⁰ In 2017, Snohomish County spent almost \$92,000 a day to keep people locked up every night inside its jail.²¹

In total, Washington jails are designed to hold almost 15,000 people. Between 12,000 and 12,500 people sleep in jail on an average night, meaning that Washington has at least 2,500 more jail beds than it currently needs.¹⁸ Nonetheless, some jails are significantly overcrowded, including Clark, Spokane, and Whatcom County jails.¹⁹

Demographics of the people locked up in Washington's jails.

The gender, racial, and ethnic breakdown of people held in jail between 2007 to 2015 is set out in Figure 1. Men made up more than 85% of the jail population during that period.²² People of color are also disproportionately represented in Washington's jails. Black Washingtonians are just over 4% of the state population, but represent 16% of people incarcerated in our jails. Similarly, Native Americans make up less than 2% of the state population, but 4.5% of people in jail.

Figure 1: People in Washington's jails



The average jail stay is 16 days, but most people booked into jails stay for only a few days - 40% for fewer than 24 hours. However, many people remain in jail for months or even years.²⁴

People entering into jail tend to have more significant behavioral health needs than the general public.²⁵ One study indicates that as many as 60% of people entering Washington jails may have either a substance use disorder or a mental health need, and over 40% have co-occurring disorder indicators.²⁶ These local numbers are similar to national averages.²⁷

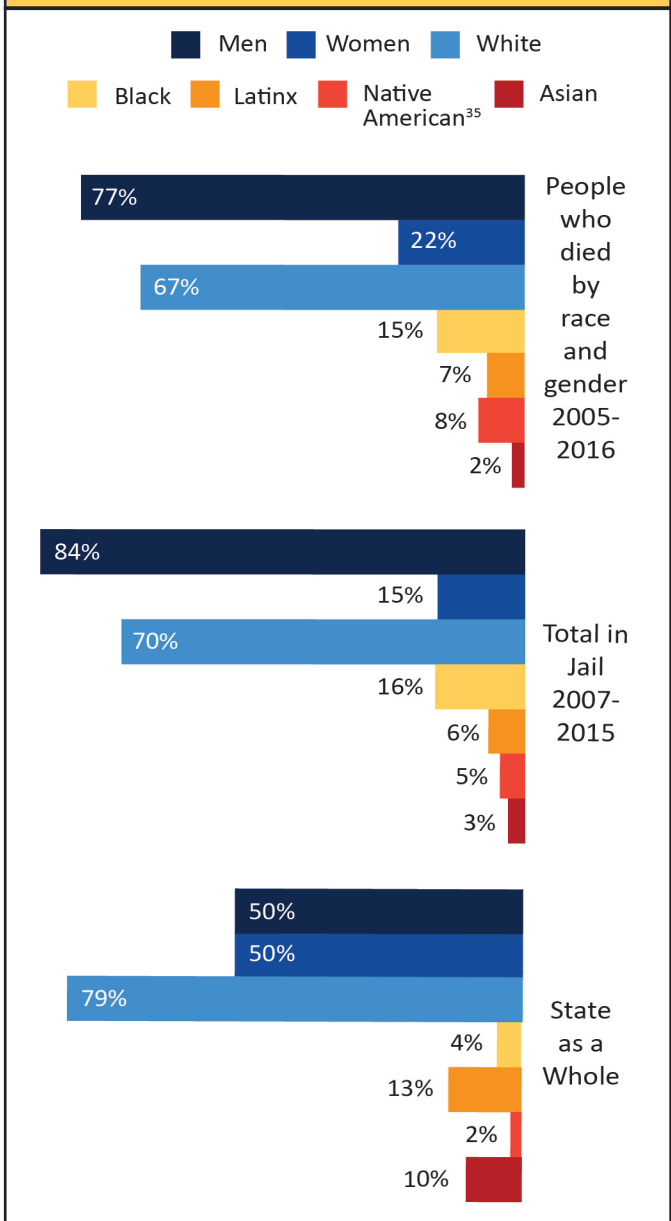
In addition, many people arrive with other complicated and poorly managed medical needs. People detained in jails are nearly two times more likely than the general public to experience high blood pressure, asthma, or diabetes.²⁸ Nationally, over half of jail detainees report having experienced a chronic medical or mental health condition at some point in their lives, and three-quarters were experiencing that condition upon admission to jail.²⁹ The incidence of chronic conditions is greater among women than men.³⁰ Not surprisingly, the older the person, the more likely she will suffer from a chronic medical condition.³¹ Moreover, the rates of chronic medical conditions among people in jail are increasing at a dramatic clip.³² Available data indicate that local conditions reflect these national trends.³³

Roughly two thirds of people sitting in Washington jails are awaiting trial, none of whom have been found guilty of the crime with which they have been charged. Most languish there because they cannot afford the cash bail that courts routinely require. The remaining one-third of people in jail are serving low-level, mostly misdemeanor sentences of less than a year or are being held for short stays for violations of Department of Corrections community custody conditions.

Demographics of people who died in Washington's jails.

We reviewed records of 210 people who died while in the custody of Washington jails between January 1, 2005, and June 15, 2016.³⁴ The gender and racial or ethnic breakdown of the people who died is set out in Figure 2.

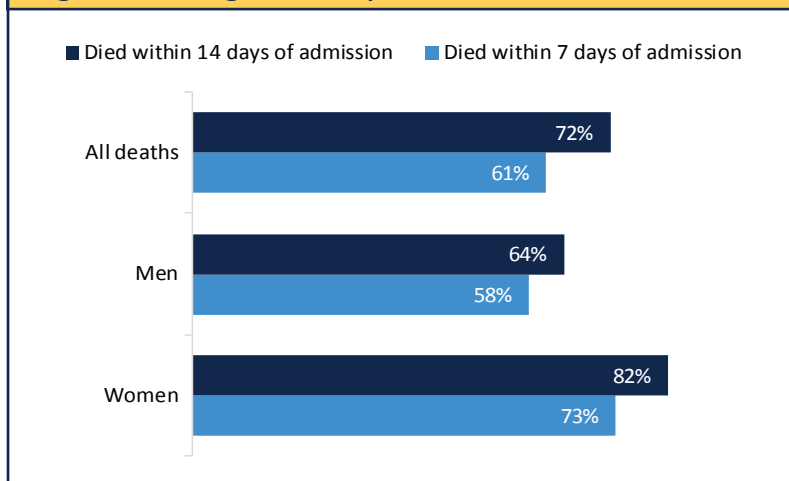
Figure 2: People who died in Washington's jails



The ages of people who died ranged from the youngest, who was 18, to an 82-year-old man. The average age of people who died was 40.

Most deaths occurred within days of booking. Over 72% of all deaths occurred within 14 days, and most occurred within the first seven days.³⁶ The numbers are particularly stark for women. 82% of all women who died did so within 14 days of booking, with 73% dying in the first seven days. See Figure 3.

Figure 3: Length of stay before deaths



The vast majority of early deaths involved alcohol, drugs, or suicide. Substance use-related deaths and suicides made up 85% of the deaths that occurred within the first 72 hours of admission.³⁷ Figure 4 identifies the number and percentage of deaths that involved drugs or alcohol within the first week and after eight days.

Charge or conviction³⁸

47% of the men who died were charged or convicted of a violent offense, including domestic violence, while 62% of women were charged or serving a sentence for a property, driving, or drug crime or were serving time on an outstanding warrant or DOC violation.

Figure 4: Deaths related to drugs or alcohol by time period

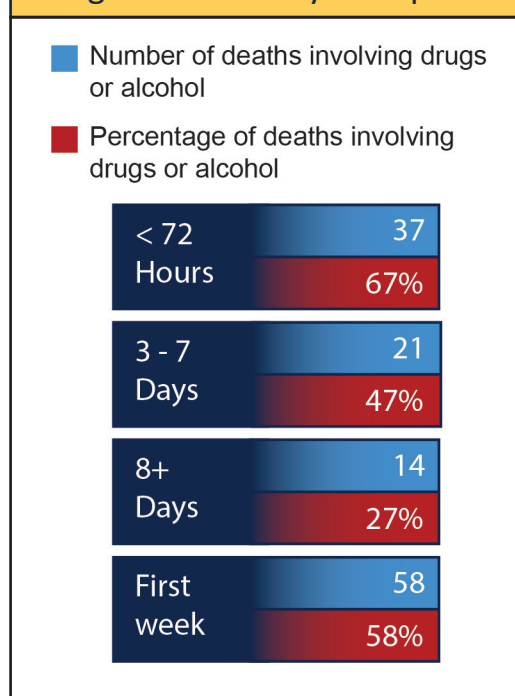
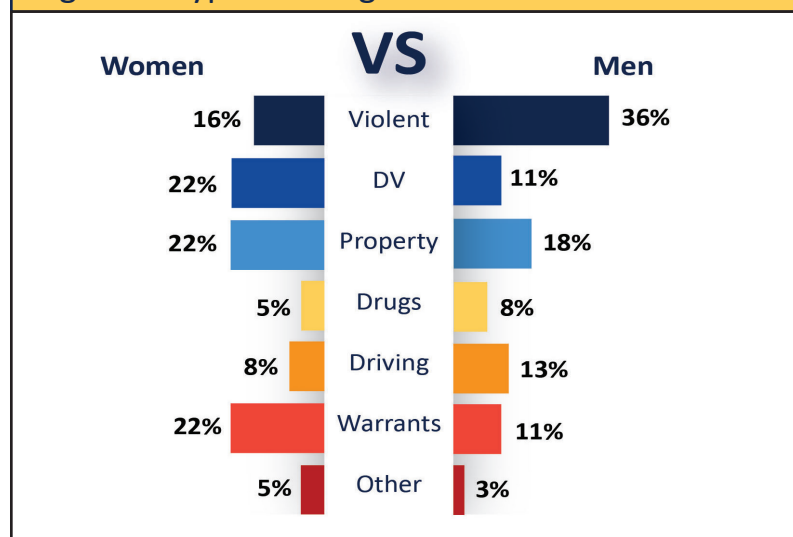


Figure 5: Type of charge



Cause of death

Suicide is the leading cause of death among both women and men in Washington jails, causing over 42% of all deaths and over 45% of deaths of men. A disproportionately greater number of women - almost 20% - died as result of withdrawal from drugs or alcohol. Eleven men died as a result of homicide, accident, or use of force. Moreover, uses of force may have played a role in at least ten other deaths. No women died as a result of one of these three categories.

Information about individual jails

Larger jails experienced a higher rate of death than smaller jails. While some jails had no deaths during the period reviewed, a number of jails had multiple deaths.³⁹ For example, 22 people died, 16 by suicide, in the Clark

Figure 6: Cause of death

	Women	Percentage of women deaths	Men	Percentage of men deaths	Percentage of total deaths
Accident	0	0%	3	2%	1%
Withdrawal	8	18%	5	3%	6%
Cardiac event	6	13%	12	7%	9%
Homicide	0	0%	2	1%	1%
Illness	10	22%	40	24%	24%
Overdose	2	4%	9	5%	5%
Suicide	15	33%	74	45%	42%
Unknown	4	9%	14	8%	9%
Use of force	0	0%	6	4%	3%
TOTALS	45	100%	165	100%	100%

County jail between January 2005 and June 2016. Other jails that have experienced disproportionately greater rates of death include the Cowlitz County, Okanogan County, Whatcom County, and Spokane County jails. A number of these jails also appear to house many more people than their facilities are designed to detain, indicating significant overcrowding. Specific information for deaths by jail is included in the Appendix at the end of this report.

Suicide

Suicide is a leading cause of death in jails both nationally and in Washington. Recent high-profile incidents, including the deaths of Sandra Bland and Aaron Hernandez, have raised public awareness of the issue around the country, and at an important time. After falling steadily for two decades, suicide rates in jails have been rising nationally since 2009.⁴⁰ Yet despite the risk and the increased

incidence of suicide in jails, nationally, only 20% of jails have written policies that encompass all the important components of suicide prevention.⁴¹ A jail that fails to take active, appropriate, evidence-based steps to prevent suicides is operating illegally and faces significant risk of liability.⁴² Factors that make jails a particularly high-risk environment include the large proportion of inmates who

have mental illness, the high rate of enforced withdrawal from alcohol and drugs, and the traumatic effect that criminal conviction and incarceration have on an inmate's personal life.⁴³

Experts generally agree on the factors in a jail setting that increase the risk of death by suicide and on the contents of a "gold standard," comprehensive, suicide prevention program.

A comprehensive prevention policy must consider who is at risk, when they are at risk, and how that risk manifests into self-harm.

General Risk Factors

There are a collection of general and individual risk factors for suicide that converge uniquely in jail settings. Unfortunately, many Washington jails utilize suicide prevention practices or have design flaws that increase the likelihood of suicide and place people at risk. Inadequate staffing, protocols that provide for isolating potentially suicidal detainees and cells or other physical structures that enable hanging are particularly dangerous. Over 80% of jail suicides in Washington occurred as a result of hanging, many occurring in single occupancy cells or in other spaces where detainees were alone, like showers.⁴⁴ A few examples demonstrate how too few staff, isolation, and jail design are contributing factors in many suicides.

*"[I]solation escalates a sense of alienation and further removes the individual from proper staff supervision. Whenever possible, suicidal inmates should be housed in the general population unit, mental health unit, or medical infirmary, and should be located close to facility staff."*⁴⁵

- A.G.A. died as a result of suicide in the Chelan County jail after being isolated for "mental health problems" and violence toward jail staff. There were many indications that A.G.A. was at risk of suicide, including a history of attempts and concerns expressed by his wife. Unfortunately, instead of being monitored in a medical setting, A.G.A. was housed alone with two hours between wellness checks. He was found hanging in his cell and pronounced dead soon thereafter at a local hospital.
- After being booked into the Yakima County jail, S.K. was moved to solitary confinement for "anti-social behavior." She was placed in isolation even though her medical records indicate that she had previously attempted suicide and struggled with mental health issues. S.K. repeatedly activated the emergency button in her cell during the night and early morning before her death, imploring jail officers to let her out of solitary confinement. Later that morning, another inmate found her hanging from a sheet in her cell. Paramedics rushed her to the hospital, but she died there a few days later. S.K.

had been scheduled to see a mental health care provider the next day.

- C.S. died in the Franklin County jail from hanging. He had attempted suicide during his last admission at the jail, resulting in a days-long hospital stay. His booking intake indicated that he had a history of suicidality and might be currently suicidal. However, this information was not conveyed to the jail's mental health staff. C.S. was placed in isolation without constant observation and took his own life a few days later.



Photo Credit: Hamilton Medical Products

As a matter of general practice, many jails place people who describe suicidal thoughts or threaten self-harm in solitary confinement, usually without constant, direct observation by staff. This type of “suicide watch” is often humiliating and dehumanizing.

People are generally stripped of all of their clothes and placed naked in a “suicide smock,” a tear-resistant bag with slots for arms and the head. They are often held in “dry” cells, concrete or padded cells without running water or other fixtures, the only toilet a grated hole in the floor. Some may be shackled for hours in a restraint chair or other device that severely limits body movements.

Not only can these practices increase the dangers that someone may take his own life, they also may deter potentially suicidal people from making their intentions known. A number

of people who died from suicide did so without expressing their thoughts because of terrible, dehumanizing experiences they had suffered during a prior placement in isolation as part of a “suicide watch.”



- B.O. was booked into Clark County jail and was placed on suicide watch at one point. His solitary confinement continued after being released from suicide watch. Other detainees apparently informed jail staff that B.O. was not stable. However, no mental health staff was available to evaluate him at the time. B.O. was found hanging from a bed sheet tied to the crossbars of the window frame in his cell the next day. Officers found a suicide note he had written that said in part that he did not want to be forced into a suicide vest again.

Individual Risk Factors

Individual risk factors such as age, length of stay, type of charge, and co-occurring mental health disorders also show strong correlation with the incidence of suicide. In absolute terms, most suicides in jails are committed by men. However, women are at greater risk of suicide than men relative to their numbers in jails.⁴⁶ There is very little research on suicide rates among transgender and gender non-conforming people in jails. Though it is likely

that they also face an increased risk of self-harm because of the unique hardships they face while incarcerated.⁴⁷

At additional risk are the very young or very old; people who have a history of suicide attempts; are intoxicated at the time of incarceration; have an ongoing substance use disorder; have experienced recent personal trauma; are experiencing one or more mental illnesses; or are facing sex offense charges.⁴⁸ These factors were present in a number of the deaths by suicide that we reviewed.

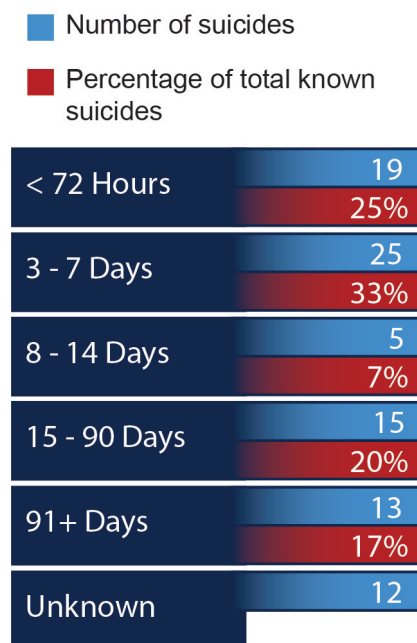
- B.C. was arrested after he drunkenly assaulted a bus driver. He resisted arrest and was clearly severely intoxicated during his arrest and subsequent booking into the Thurston County jail. Because of his condition he was placed alone in a cell and a nurse was called to evaluate him. The nurse decided that he was healthy enough to remain alone. Later that day, he dove head-first from the top bunk of his cell, killing himself.

Generally speaking, suicide attempts are most likely at certain points during a detention.

Most suicides take place within the first days of incarceration. Over half of suicides in Washington jails occurred in the first week of incarceration. However, suicides occur at any stage. 17% occurred after the person had spent more than three months behind bars.

Specific events can also increase the chances of suicide. Negative outcomes in a person's case (conviction or other bad news) and withdrawal from drugs or alcohol make suicide more likely. Other triggering events such as bad news from family on the outside, conflicts with cellmates, or ongoing substance abuse also increase the chances that someone may engage in self-harm.⁴⁹

Figure 7: Deaths by suicide by length of stay



“[H]igh risk periods include immediately upon admission, following new legal problems (e.g., new charges, additional sentences...), after the receipt of bad news regarding self or family..., after suffering humiliation (e.g., sexual assault) or rejection[.]”⁵⁰

Figure 8: Charge faced by people who died from suicide						
	Women	Men	Total	Percentage of women	Percentage of men	Percentage total
Violent	4	26	30	33%	46%	45%
DV	3	8	11	25%	14%	16%
Property	0	10	10	0%	18%	15%
Drugs	0	4	4	0%	7%	6%
Driving	1	3	4	8%	5%	6%
Warrants	3	4	7	25%	7%	10%
Other	1	1	2	8%	2%	3%

Most of these risk factors were apparent in the population of people who died as a result of suicide in Washington's jails. Substance use issues, including active withdrawal or a recent history of substance use disorders, appear to have contributed to many of the suicides. Moreover, at least 19 of the decedents had previous suicide attempts. Most of the men who died were awaiting trial for violent offenses, including domestic violence. Six men facing a sex offense charge died as a result of suicide. In every case but one, the underlying charge involved sexual conduct with a child. Women who died of suicide were more likely to be charged with a violent crime than women facing criminal charges generally.

Importantly, many people who took their own lives made their intentions clear to other people within a few days of their deaths. Records indicate that at least 22 people expressed suicidal intentions to someone, including jail staff, other detainees, or family members before their final suicide attempt. Others had been actively suicidal during their current admission, including at least 13 who had been on suicide watch at some point prior to the attempt that ended in their death. Records indicate the jail had notice of some sort that the person was likely suicidal in at least 30 instances.

- R.M.G. died as a result of suicide in the Skagit County jail, at age 59

following a recent 20-26 year sentence for multiple counts of child rape. After expressing suicidal thoughts to his lawyer and jail staff, he refused food, water, and diabetes medication for days. He died from complications related to his unmanaged diabetes, apparently without the jail taking active steps to intervene and provide him with necessary medical care.

- D.M. was booked into Clark County jail on March 29, 2015. He had a history of mental illness, including hospitalizations and previous suicide attempts. The jail's mental health intake indicated he had mental health needs. Prior to his death, D.M.'s fiancée called the jail to discuss his need for psychotropic medications. A mental health care provider met with D.M., who denied being suicidal or needing medication. However, D.M. spoke with his father on the telephone the day that he died. His father reported that D.M. had not been doing well emotionally when they last spoke. D.M. was in solitary confinement when he hung himself on March 30.

Among the records we compiled were stories of people misidentified, misplaced, and mishandled even when properly identified. The use of isolation cells, inattention to

the presentation of risky behavior, lack of communication and monitoring, and dangerous fixtures inside of cells all stand out as common threads through much of our data.

Although each case includes its own unique circumstances, as discussed below, there are comprehensive policies and practices that if implemented will save lives in the future.

Overdose and Withdrawal

It's estimated that more than 47,000 people in Washington regularly use opioids (heroin or prescription pain medications) and over half of them will be incarcerated in a Washington jail at some point in 2019.⁵¹ Nationally, overdose from drugs, particularly opioids, has become the leading cause of death for Americans under 50.⁵² A recent report stressed the need for Washington jails to implement effective and appropriate treatment protocols to avoid needless overdoses or deaths caused by unmanaged withdrawal.⁵³

“Failure to treat opioid use disorder during incarceration has serious consequences, including an extremely high risk of death of overdose death after release, [death or injury] from opioid withdrawal during incarceration, high rates of crime and recidivism, and social and medical consequences of untreated opioid use disorder after release.”⁵⁴

Drugs or alcohol played some part in at least 38% of all of the jail deaths, the percentage being significantly higher for women than men.

Drugs or alcohol were likely at least a contributing factor in 54% of the deaths of women.⁵⁵ Irrespective of gender, most deaths that occurred within the first few days following booking were related to drugs or alcohol. As set out in Figure 4, 60% of the deaths within the first week of admission involved drugs or alcohol. The vast majority of deaths involving drugs or alcohol occurred within the first seven days after booking.

Drug- or alcohol-related deaths included overdoses and alcohol poisonings, deaths caused in part by poorly managed withdrawal, and deaths caused by other serious medical conditions whose symptoms jail staff mistakenly attributed to withdrawal. These deaths highlight what can occur without proper management and supervision of people suffering from substance use disorders or withdrawal from those substances.

Overdose

Many people are arrested under the influence of drugs or alcohol and brought directly to jail. As a result, death or injury from overdose or alcohol toxicity is a significant danger within the first few hours after booking.

- Following his arrest on drug charges, D.D. was taken to the hospital by the arresting officer prior to booking because of concern that he had ingested heroin. He was cleared at the hospital and booked into the King

County jail. Though being monitored in a holding cell, because of concern about his high blood sugar, he died as a result of acute combined heroin and cocaine intoxication.

- T.S. was arrested for DUI and booked into the SCORE jail in Des Moines. During the booking process, jail officers observed him slumping forward in his chair with his eyes rolling back in his head. He was incontinent, had difficulty answering questions, and appeared to lose consciousness at points during the process. At one point, he required medical attention after suffering a seizure. He was placed in a cell and found unresponsive a few hours later on a mattress soaked with urine. Notes indicate that his death was caused by possible withdrawal from alcohol or benzodiazepines.

While most prevalent within the first hours after booking, overdoses can also occur later in a person's incarceration, either through drugs smuggled into the facility or from jail-provided medications that are stored over time and then taken in high doses.

- V.T., a man with serious mental illness, was booked into Clark County jail. During intake he made suicidal statements and was put on suicide watch. After a series of volatile and unpredictable outbursts, V.T. was sent to Western State Hospital for three months for observation and treatment. A week after his return to Clark County Jail, V.T. died of an overdose of the psychotropic medication, fluoxetine, also known as Prozac. Investigators believe that he stored his medications for a period of time and then took a massive amount that ended his life.

Deaths and injuries from overdose are largely



Photo Credit: Adapt Pharma

preventable. Simple medical interventions can mean the difference between life and death for someone experiencing an overdose. Naloxone and other similar medications immediately block the sedative effects of opioids and bring someone experiencing an overdose back from the brink of death.

These medications are easily administered, even in a non-clinical setting. NARCAN, a form of naloxone, can be given via a nasal spray, without the need for needles or any other significant medical procedure. There is no reason why every jail in the state should not have a ready supply of Naloxone and officers trained to administer it when necessary. Eliminating overdoses from opioids in Washington jails is readily attainable, provided jails do their part.

Treatments for severe alcohol poisoning involve more invasive medical procedures that are routinely done in emergency rooms across the country. With proper training, correctional officers can learn to identify when a person is in need of more intensive medical attention as a result of possible alcohol toxicity. Timely action is absolutely essential to avoid an otherwise entirely needless death. People will continue to die of overdoses inside jail walls if jails remain unprepared and their staff untrained.

Withdrawal

A person with an active substance use disorder will likely suffer withdrawal symptoms upon being booked into jail. A range of awful and debilitating symptoms accompany withdrawal from opioids, including severe muscle aches, agitation, sweats, hypertension, fever, nausea, vomiting, diarrhea, abdominal cramps, depression, anxiety, severe drug cravings, and suicidal thoughts.⁵⁶ Symptoms can begin within a few hours of last use and continue for a week or more, depending on the substance and the severity of use.⁵⁷ These symptoms can kill people if not properly treated.

The withdrawal process for someone coming down from alcohol can also be very dangerous or even fatal. Similar to opioid withdrawal, alcohol withdrawal can cause anxiety, muscle aches, nausea, vomiting, high blood pressure, or insomnia. If not properly managed, alcohol withdrawal can also bring on serious hallucinations, and in severe cases, seizures, heart arrhythmias, and death.

“Contrary to commonly held notions, withdrawal is often not only uncomfortable or painful, but also may be harmful to health and even fatal.”⁵⁸

The National Commission on Correctional Health Care (NCCHC) makes clear that “severe withdrawal symptoms must never be managed outside of a hospital. Deaths from acute intoxication or severe withdrawal have occurred in correctional institutions.”⁵⁹ Cases in Washington demonstrate the dangers of poorly managed withdrawal inside of jails.

- S.D. was booked into Cowlitz County jail on August 3, 2013. The next day she sought medical attention for withdrawal from heroin and methamphetamines. She was placed on a withdrawal protocol and her symptoms, including severe “stomach problems,” continued for the next several days. At times, she was unresponsive when contacted by staff. On August 10, a nurse found S.D. slurring her words, and she had difficulty finding her pulse. S.D. went into cardiac arrest and lost consciousness. She was rushed to the hospital, but died shortly after arrival.
- B.B. was taken to the hospital and cleared by staff there before being booked into the King County jail. The next day he was found unresponsive in his cell. Emergency measures were unsuccessful and B.B. died. Other detainees told investigators that B.B. had been seriously ill from vomiting and diarrhea and repeatedly sought the attention of jail staff by ringing the emergency bell for assistance, without success. The coroner’s report found that he died as a result of dehydration from vomiting and diarrhea as a consequence of withdrawal from opioids.

Suffering withdrawal in jail can be incredibly dehumanizing, debilitating, and in some circumstances, fatal. During our work with people incarcerated in jails across the state we have heard numerous stories of people in the midst of severe opioid or alcohol withdrawal being left alone, unsupervised in solitary confinement; condemned to agonizing cramps, nausea and pain while sleeping in their own filth and vomit. Others have described sharing a tiny cell with someone in the grip of withdrawal, heaving into a shared toilet and moaning throughout night.⁶⁰

- G.G. was booked into Okanogan County jail on October 18, 2014, for the delivery of controlled substances including heroin, methamphetamine, mushrooms, and oxycodone. Upon booking, G.G. was severely nauseous and vomiting because of withdrawal. Though provided medications for nausea, he had on-going bouts of vomiting and refused to eat or drink because of his symptoms. On October 21, G.G. begged to be taken to the hospital because of his severe, ongoing withdrawal symptoms. Jail staff refused his request, and later that day, he was found dead in his cell.
- K.J.M. was booked into King County jail on September 15, 2007 after her arrest for selling narcotics. During booking, K.J.M. apparently passed out and fell to the floor, injuring her head in the process. She was taken to Harborview Medical Center for evaluation. After being treated for her head injury, K.J.M. was transported back to the jail where she began exhibiting signs of “dope sickness.” For the next several hours she suffered frequent vomiting and bouts of loose stool, but reportedly

refused medical attention. K.J.M. placed her mattress pad on the floor of her cell to be closer to the toilet. The next morning K.J.M. was unresponsive. Resuscitative efforts failed and she died. King County implemented new protocols for monitoring people experiencing withdrawal after her death.

- D.G. died in custody in Pierce County jail due to severe alcohol withdrawal only a few days after being booked into jail. He had been experiencing extreme withdrawal symptoms, smelled toxic, and had not been eating prior to his death. Jail staff expressed concerns to nursing staff, but since he was able to hold down some water, no other efforts were made to help him. He died alone in his cell.
- M.M., an 18-year-old man battling bipolar disorder and schizophrenia, was booked into the Benton County jail after becoming agitated at a Richland mental health facility. Reports indicate that jail staff provided him with water and food, but did not monitor whether he was actually eating or drinking. M.M. was found dead in his cell eleven days after he arrived. The coroner ruled that he died as a result of an irregular heartbeat and dehydration related to use of synthetic marijuana.



The need for humane medical care for people experiencing withdrawal in jails is particularly important because people admitted to jail are forced to go through withdrawal regardless of whether they are psychologically and emotionally prepared to do

so. Unlike people who seek treatment in the community, withdrawal behind bars occurs without the true consent of the person affected, thereby increasing the chances of depression, anxiety, and immediate relapse upon release from jail.

Medications and proper medical care can greatly reduce the terrible effects of withdrawal and eliminate the chances that someone may die as a result of unmanaged withdrawal.

Medications like methadone, buprenorphine, and naltrexone minimize the suffering that withdrawal causes and help people avoid relapse.⁶¹ Other medications can assist with withdrawal from alcohol and other drugs. Experts therefore stress the need for appropriate medication management of people suffering withdrawal in jail.⁶² All jails should have medications readily available for people who are struggling with substance use disorders.⁶³

A recent report on withdrawal services in Washington jails recommends that jails “[c]losely monitor patients at risk for opioid withdrawal using a validated instrument, and treat withdrawal symptoms with buprenorphine, or methadone, if available.”⁶⁴

A jail that fails to provide these essential medical services is operating in violation of its constitutional and other legal obligations.⁶⁵ Unfortunately, a recent study found that most Washington jails have no protocol for monitoring withdrawal, and fewer than half of the jails surveyed provided any medications to people suffering withdrawal.⁶⁶

Other Serious Medical Conditions Left Untreated

Withdrawal symptoms can also mask, multiply, or replicate symptoms caused by other medical conditions that if left untreated can also prove disabling or even fatal. Sepsis, pneumonia and staph infections, including MRSA infections, are regularly found in people who have been living unsheltered or recently using intravenous drugs. Unless medical professionals are knowledgeable and careful, symptoms of these illnesses can be easily mistaken for symptoms of withdrawal, or withdrawal can mask symptoms of these other potentially life-threatening conditions. Jail staff in a number of cases failed to properly diagnose and treat serious medical conditions because it appears they attributed reported symptoms to withdrawal.

- L.L. died from a severe lung infection after a stay in the Snohomish County jail. Reports indicate that she had sought treatment for severe breathing problems for a number of days, had a high temperature, elevated heart rate, and low oxygen saturation. Nonetheless, medical staff did not provide her with antibiotics or order a chest x-ray. They did, however, note that they believed that she was “drug seeking.” She died when her chest filled with fluid, collapsing her lungs and suffocating her. Snohomish County agreed to pay L.L.’s estate \$1.5 million in damages as a result of its negligence in her death.
- L.I. was booked into the King County jail on disorderly conduct and drug charges. Two days later, he complained of severe abdominal pain, reporting that it felt like his “liver exploded.” He required a wheelchair to get from his cell to the infirmary because of the pain. Medical staff in the infirmary noted in

his records that he was coming down from heroin and alcohol. He asked to be taken to the hospital because of his pain, but instead medical staff placed him in the medical unit in the jail for observation. He was found unconscious and unresponsive the next morning. An autopsy showed that he died of acute peritonitis (burst appendix). His life could have been saved had he received appropriate treatment promptly upon reporting his symptoms.

People like Lindsay Kronberger have died from

inadequately managed withdrawal, others from overdoses, and still others, because medical professionals mistook symptoms and failed to properly treat other serious medical conditions. These deaths demonstrate that medical professionals operating in jails must provide medications and other appropriate therapies to mitigate the symptoms of withdrawal, and also carefully evaluate the patient in order to determine whether some other serious condition may also be involved. Jails must take active steps to avoid any additional needless deaths from overdose, withdrawal, or other serious medical conditions.

Use of Force and Neglect

A number of deaths have been caused in part or in whole by uses of force committed by jail officers or by outright neglect of the people under their care. A use of force appears to have played a factor in at least 16 deaths reviewed. Most of these deaths occurred following the use of Tasers, restraints, or direct physical takedowns of detainees.⁶⁷ Often they also involved the interplay of excessive alcohol or drug use, mental illness, and poor medical or mental health treatment. A few examples demonstrate how a number of variables including uses of force can come together with tragic consequences.

- B.W. died while being booked into the Snohomish County Jail for shoplifting beer and cigarettes. B.W., a man with a long history of alcoholism, drug dependency, and mental illness, became combative during the booking process, whereupon jail officers wrestled him to the ground and shocked him with a Taser. He began struggling to breathe and turned blue. When he appeared to recover, jail

officers attempted to place him in an isolation cell, but he began to resist again. An officer shot him again with a Taser. Finally, four officers wrestled him into a cell and left him on his stomach with his hands cuffed behind his back. An officer estimated that about a minute later she saw B.W. take two deep breaths and then stop breathing. Officers flipped him onto his back, pulled him out of the cell and began



resuscitation efforts, which proved unsuccessful. B.W. died on the floor of the jail. It later came out that a local mental health provider had warned that B.W. was in the midst of a “psychiatric episode.” However, this information was not conveyed to police or jail staff prior to his death.

- C.P. was a 33-year-old man with diabetes who died in Spokane County jail on February 24, 2013. Earlier that morning he had called 911 claiming he was paranoid, diabetic, and high on methamphetamine. Police officers arrived and discovered C.P. had a warrant for his arrest due to unpaid child support. Instead of taking him to the hospital, he was arrested. While in a holding cell, C.P. began swaying and grasping his head in his hands. He was asked to sit down in the cell, but he did not comply. Jail staff placed him in a headlock, shocked him twice with a Taser, and strapped him into a restraint chair. He lost consciousness, stopped breathing, and died in the hallway of the Spokane County jail. An autopsy ruled his death a homicide, with the cause of death being a methamphetamine overdose “with restraint stress.” His blood sugar was over 2000 when he died, a blood sugar level sufficient to cause hallucinations, abnormal behavior, coma, or death.
- T.S. entered the Asotin County jail in November 2005 on assault charges. His family called and informed jail staff at least twice that he had bipolar disorder and that he had been hospitalized recently. Jail officers used force on T.S., including Tasers and a restraint chair, on at least three occasions before the episode that resulted in his death. On November 25, 2005, staff found him screaming

incomprehensibly and beating his head against the walls of his cell. Officers shot him with a Taser in an effort to subdue him. When he continued to resist, an officer repeatedly hit T.S. with a baton. Other officers then Tased him three or four more times before they were able to handcuff him. They then put T.S. in a restraint chair, where he lost consciousness and subsequently died. An autopsy determined that he died of arrhythmia following multiple blunt force injuries and the use of Tasers. His death was ruled an “accident.” Media reports indicate that a lack of adequate staffing may have contributed to T.S.’s death.

- M.A. was asphyxiated by jail staff during a use of force incident at the Clark County jail. M.A. who had been diagnosed with bi-polar disorder was awaiting transport to Western State Hospital for a mental competency evaluation at the time of his death. By his third day in jail, he reported being suicidal and was placed in a suicide smock in a solitary cell on suicide watch. Witnesses reported that M.A. banged his head almost constantly against his cell walls, the door and a metal grate in the floor used as a toilet. Jail officers placed him in a restraint chair several times before his death. He died during a struggle with the guards who were once again trying to force him into the restraint chair. He was Tased, and when guards couldn’t get him into the chair, they pinned him on the floor where he suffocated. His death was ruled a “homicide by mechanical asphyxia.”

Other deaths demonstrate how jail staff can neglect the needs of detainees by denying them essential medical care or failing to adequately monitor their food and water



intake. A number of cases demonstrated problems with access to necessary medical care. In fact, in 62 of cases there was some indication that the jail's medical or mental health care was deficient. Health care-related inadequacies ranged from failing to conduct a thorough medical intake, failures of communication between staff members, and poor medical decisions or inappropriate treatments. In other instances, staff simply ignored the needs of detainees and failed to ensure that they received proper food, water or medical attention. Again, mental illness or substance use disorders were factors in many of these cases.

- D.B. informed an officer that he was suffering from back pain while being booked into the Cowlitz County jail on January 13, 2014. Two days later he again complained to medical staff of shortness of breath, achy bones, and a sharp pain in his back and was unable to move or lift his arms. On January 16, D.B. reported that he had a chest injury, depression, and anxiety. The clinician dismissed his complaints, recording that they were just manipulative behaviors and that D.B. was "okay." Later that day, jail staff placed him in a

restraint chair in his cell in response to a threat of self-harm. When medical staff arrived, they found him unresponsive and with blood on his face. He responded to ammonia after two attempts. On January 18, D.B. again complained to medical staff that he had chest pain and difficulty breathing when sitting up. He said his chest felt like "pins and needles." Later that night, he was found coughing up blood, sweating profusely and complaining of severe chest pain. The next morning jail staff found him screaming in his cell because of the pain he felt while inhaling. A clinician noted that he had blood in the back of his throat, but nonetheless recommended that staff just continue to monitor him. He was found dead in his cell early in the morning on January 20. The medical examiner determined that he died from bilateral pneumonia and a staph infection, which likely led to sepsis.

- A.N. had been jailed in the Walla Walla County jail for over a week when she died from septic shock. She had complained of chest pain and seen a jail nurse on a couple of occasions. Her autopsy showed an extreme infection in her chest that had "marbled her" chest muscle wall and eaten a quarter size hole in her sternum. Her lungs also showed signs of severe infection.
- K.F., a young man suffering from severe bipolar disorder, was booked into Island County jail. Family members contacted the jail to inform them about his significant mental health needs. He refused food or water for many days due to his severely disturbed condition. Nonetheless, jail officials took no action to intervene, even though they were aware of his condition and his refusal to

eat or drink. K.F. died alone in his cell from dehydration and malnutrition a number of days after admission. Later, a jail officer admitted to falsifying safety check logs in an attempt to hide the horrendous treatment he had received. K.F.'s death has received much attention in the media and resulted in important reforms at the Island County jail.

- J.M. was incarcerated at Kittitas County jail in August 2012 to serve a 270-day sentence for a DUI. He became ill in early February 2013 and on February 8, was seen by a nurse who noted he was feeling sick, could barely talk, had a dry cough, and little appetite. Though it appears a doctor prescribed antibiotics, the medications were either never ordered or not given to him. Early in the morning a few days later, J.M. pressed the emergency button and explained through the intercom that he was having trouble breathing. Jail officers dismissed his concerns as an anxiety attack. He continued struggling for breath and again asked to be taken to the hospital. Staff refused his request. He continued to beg for assistance

throughout the morning before his oxygen levels were finally checked. He was immediately sent to the hospital where he died later that evening. Other detainees who were later interviewed reported that staff repeatedly ignored his requests for assistance, telling him that he would have to wait until Monday to see the doctor. Investigators acknowledged that “all of the inmates who were interviewed expressed concern about [J.M.]’s condition and what they referred to as a lack of concern by jail staff for his care and well-being.”

Abuse and neglect are unfortunate realities inside too many jails. Underpaid, overworked, and undertrained staff react in inappropriate ways or fail to properly monitor the people under their care. While better supervision and training are essential, more importantly, jails must reduce the number of people held within their walls and employ enough properly trained staff to ensure that all people who remain incarcerated are properly monitored and treated humanely. If governments continue to refuse to spend what is necessary to effectively treat these populations, more people will inevitably die.

Recommendations

The medical and mental health needs of people living with these challenges can be much better served outside of jail walls. However, the criminalization of certain behaviors, the routine use of pre-trial incarceration, and the reduction in supports for community-based, mental health, chemical dependency, and medical services has placed the responsibility for care upon jail administrators and their staff. Unfortunately, jails are ill-equipped to meet the need, thereby injuring both the people locked up there and the professionals tasked with keeping them safe and secure.⁶⁸ Though it is likely inevitable that some people will die in jail, there are a number of steps that can be taken to limit the number of deaths and reduce or eliminate preventable deaths.

Reduce the number of people living with mental illness or substance use disorders in jails.

Community-based treatment and supports are much more effective, inexpensive, and humane than are jails in treating people with mental illness or substance use disorders. With the expansion of Medicaid under the Affordable Care Act, many people are now newly eligible for medical, mental health, and substance use treatment. However, Medicaid is not available to people who are currently incarcerated. People must be kept in the community in order to receive the benefits of these significant federally provided health care dollars. In addition to being cost-effective, keeping people in their communities and out of jail is also the option most likely to result in positive health outcomes.⁶⁹ By dramatically increasing the use of pre-arrest and pre-trial diversion programs, eradicating the use of cash bail, and providing community-based alternatives to incarceration, counties and localities will reduce the number of people inside their jails, improve the outcomes that they achieve and save money.

Increase oversight and transparency of what happens inside jails.

As detailed above, there currently exists no centralized oversight of Washington jails, and jails have no obligation to report information to any state agency after a major event such as a death, suicide attempt, or other serious injury. Laws should be changed to require reporting after serious incidents to a state agency, like the Department of Health, that is empowered to take action to review the incident and address any shortcomings. Mandated reporting following serious events will ensure accountability and provide a mechanism whereby proper reforms can be identified and initiated. Public disclosure laws should be amended to require jails to provide more information to the public regarding deaths and other serious events. Names and other identifying information can be redacted from relevant records to protect the privacy of the people involved.

Every jail must have an adequate and timely medical, mental health, and substance use intake process.

Most jails have some form of intake process to gather some amount of medical, mental health, and substance use information from detainees. However, often the information gathered is insufficient to actually identify and understand the person's current needs. These intakes are generally taken by jail staff without proper health care expertise or training. Important information is missed or ignored. Inadequate intake



procedures and neglected care contributed to a number of the deaths that we investigated.

Thorough intake questionnaires filled out by trained staff and timely communication and follow up with health care staff are absolutely essential initial steps in increasing safety. Each inmate should then have a much more detailed medical, mental health, and substance use examination by a qualified health care professional within a few days of entry into jail.⁷⁰ The failure to identify medical conditions in a timely manner or provide appropriate mental health or withdrawal treatment contributed to a number of the deaths. Early evaluation and treatment would likely have changed the outcome in some of these cases.

Every jail must have overdose and withdrawal protocols and provide medications when appropriate.

As detailed above, overdose and poorly managed withdrawal kill people. However, even when withdrawal does not lead to death, it causes unnecessary torment and trauma to people experiencing it. With proper identification and timely treatment, most, if not all deaths and suffering can be avoided.

The NCCHC has promulgated standards for withdrawal management that should be provided in every jail.⁷¹ Essential practices include:

- Proper training for staff to identify people suffering withdrawal symptoms.
- Protocols that meet current, evidence based, treatment guidelines.
- Intake procedures that ensure that people under the influence of drugs or alcohol are identified immediately upon booking and properly supervised.
- Withdrawal management that is done under the supervision of qualified health care professionals who utilize recognized validated assessments to judge the severity of withdrawal symptoms.⁷²
- Policies mandating the medication management of detainees suffering from withdrawal.

Every jail in Washington must adopt appropriate withdrawal protocols in order to ensure the humane treatment of all people under their care. Staff training and the ready availability of medications like Narcan and Suboxone, which temper the worst aspects of withdrawal and save lives, are essential elements.

Jails must change how they care for people who have expressed suicidal thoughts or may be actively suicidal.

As with overdoses and deaths from withdrawal, jails can take active steps to significantly reduce the number of suicides inside their facilities. Isolation is not an appropriate management tool for someone who is suicidal. It exacerbates symptoms and increases the likelihood that a person considering suicide will take action. Terrible prior experiences with isolation also deter people who may be suicidal from reporting their condition to jail staff. Jails must ensure that people experiencing acute suicidal feelings are constantly and directly monitored by jail staff. To the extent that jails do not have the facilities or staffing to ensure such constant monitoring, detainees must

be transferred to outside facilities that can provide the necessary level of care.

Comprehensive written policies are foundational to a successful suicide prevention program. Jails should also abandon certain common practices that actually increase the likelihood of a suicide attempt, like isolation. Any comprehensive suicide prevention program should include:

“[T]he antiquated mindset that ‘inmate suicides cannot be prevented’ should forever be put to rest.”⁷³

- Regular training for staff, regardless of tenure.
- Identification, referral, and evaluation protocols that properly assess the risk of self-harm and include review of prior incarcerations to identify any history of self-harm. Jails should revisit this risk assessment regularly throughout the person’s incarceration.⁷⁴
- Jails not simply accepting a person’s word that he is not currently suicidal, particularly for a detainee with a history of self-harm.⁷⁵
- Avoidance of solitary confinement or other dehumanizing conditions.
- Appropriate, safe housing in “suicide-proof” cells.
- Constant, direct observation of any person who is actively suicidal.
- An assessment for suicide risk of every person placed in solitary confinement at the outset of their placement and then regularly thereafter during their entire stay in solitary.
- Identification of likely stressors and communication between staff regarding upcoming events that may cause someone to engage in self-harm.
- Development of suicide “profiles” to quickly identify who might be most at risk, and when.⁷⁶
- Jail policies and practices which do not deter a detainee, family, friends or other detainees from reporting suicidal thoughts or actions.
- Avenues of communication that detainees and people on the outside can use to report threats of self-harm.
- Ongoing observation and treatment plans for people identified as vulnerable to suicide.
- Access to emergency response services.
- Administrative review of any suicide attempts to identify opportunities for improvement.

Staff must be trained to manage people in crisis, utilize effective de-escalation techniques, and use force only when absolutely necessary.

Newly passed Initiative 940 requires that all law enforcement officers in Washington complete approved violence de-escalation training and training on how to work with people with mental illness. The new law also requires such training on a regular, annual basis thereafter.⁷⁷ By contrast, current regulations governing mandatory training for jail officers do not include such requirements.⁷⁸ However, jail staff, like law enforcement, should be trained in “de-escalation... and interpersonal communication training, including tactical methods to use time, distance, cover, and concealment, to avoid escalating situations that lead to violence.”⁷⁹ Other relevant requirements include training regarding “implicit and explicit bias, cultural competency, and the historical intersection between race and [the criminal justice system]”; “[s]kills including de-escalation techniques to effectively, safely, and respectfully interact with people with disabilities and/or behavioral health issues”; and

“[a]lternatives to the use of physical or deadly force.”⁸⁰ State law should be changed to require similar training for all jail staff.

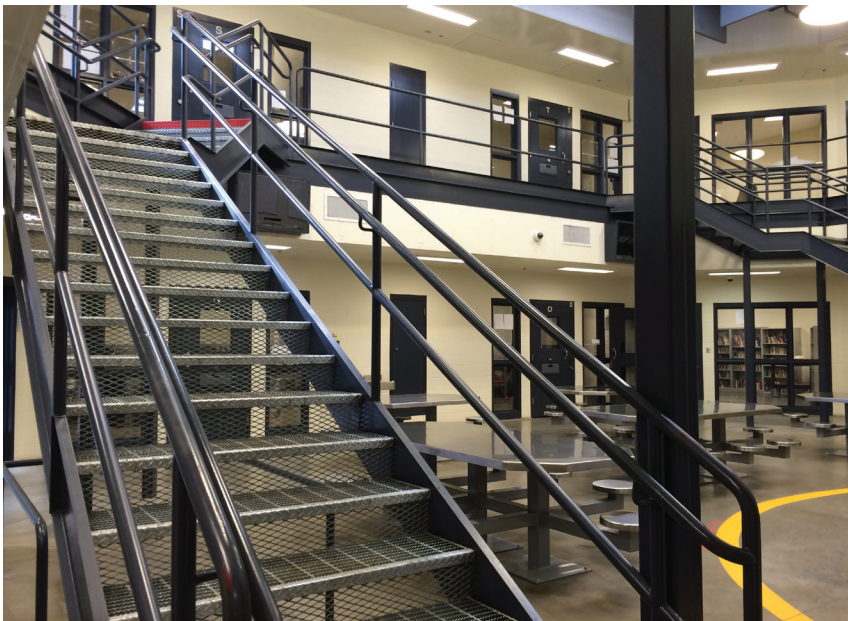
Laws should also be enacted to limit the use of restraint chairs, Tasers, pepper spray, and other weapons deployed within jails. They should be utilized only in appropriate situations involving imminent threat of bodily injury, only after all other non-violent means have failed and then only to the extent necessary to eliminate the immediate danger. The steps that jails must take to ensure the health and safety of the person against whom force was used should also be set out in statute. Finally, each jail should be required to create and maintain records related to any use of force and make them available to an appropriate third party for review on a regular basis.

Each jail must have enough staff to ensure that all people receive appropriate supervision and care.

Inadequate staffing is a perennial problem facing jails short on resources. Shortages of security, medical, and mental health staff lead to myriad problems, including the neglect of detainees, too frequent use of solitary confinement, and poor medical and mental health care. A number of the deaths studied indicated that had more staff been available to provide appropriate supervision for people who were threatening self-harm, deaths would have been avoided. Other deaths we reviewed demonstrate a lack of appropriate attention from medical or mental health care professionals, either because they were not actually present in the jail at relevant periods or because they were inattentive because of the sheer number of other demands on their time.

Both the inability to provide full medical, mental health or substance abuse evaluations for all admitted detainees within a few days and a jail’s failure to provide medically

appropriate supervision of people suffering from withdrawal are the product of too many detainees and too few resources. Jails could provide the appropriate level of care set out in national standards promulgated by organizations like the NCCHC.⁸¹ However, policy makers and the public have required them to house too many people and yet neglected to provide them the resources sufficient to do so. To the extent that society has forced jails to meet the needs of people combatting mental illness, traumatic brain injuries, or substance abuse, we must give them the resources necessary to provide that care in an adequate, safe, humane, and respectful manner. To continue to do less is to ensure that more people will needlessly die behind bars.



Every jail should be required to engage in a full serious incident administrative review and provide that report to appropriate third parties.

The NCCHC standards require that “[a]ll deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.”⁸² These reviews should include three components: an administrative review, a clinical mortality review, and a psychological autopsy that examines the individual’s life “with an emphasis on factors that led up to and may have contributed to the individual’s death.”⁸³ The review’s result should be summarized in a written report that lays out the cause of death, any precipitating factors, and recommendations regarding changes to policy, training, physical structures, medical and mental health services, or other operational practices.⁸⁴ Best practice is to do a review after every serious incident, even incidents that do not result in death.

Many jails appear to engage in some level of review following deaths. However, a number either do nothing, or their reviews are insufficient to identify causes and changes in policy and practice that may be required. Such reviews should be mandated following every serious incident and relevant information made available to appropriate state agencies and the public generally.⁸⁵

Conclusion

This report details deaths that occurred within Washington jails from January 2005 through June 2016. However, people continue to die in Washington’s jails. Eight people have died in the Spokane County Jail alone since June 2016 from a variety of different causes.⁸⁶ In Snohomish County, another man died as a result of a use of force while in the custody of the jail, and a young woman died from meningitis after suffering terribly for days while locked away there.⁸⁷ None of these ten deaths are included in those discussed in this report, but they indicate that serious problems continue.

Without sufficient community-based services and alternative housing options, jails have become the primary medical, mental health, and substance use treatment providers for thousands of people in Washington. The lack of other adequate treatment and housing options means that people fighting mental health and substance use disorders cycle in and out of jails. These realities stress the systems and the people who live and work within them. People die as a result.

However, as detailed in this report, there are many actions that can be taken to reduce the number of deaths inside Washington’s jails. Reducing the jail population, increasing the availability of community-based treatment and housing, requiring greater transparency, and giving jails the resources they need in order to properly care for our friends and family members, are absolutely essential steps that should be taken. Anything less will condemn other men and women to needless injury and death behind bars.

Endnotes

1. We have identified Ms. Lindsay Kronberger by name in this report because her story has been covered extensively in the media. See e.g., Levi Pulkkinen, *Claim: Jailers Mocked Dying Young Woman During Her Last Hours*, Seattle P.I. (August 3, 2016), <http://www.seattlepi.com/local/crime/article/Claim-Jailers-mocked-dy-ing-young-woman-during-9121704.php>; Scott North, *Lawsuit Contends Staff Ignored Inmate's Peril Before She Died*, Everett Herald (August 4, 2016), <https://www.heraldnet.com/news/lawsuit-against-snohomish-county-focus-es-on-inmates-death/>. Most of the other cases we discuss in this report did not receive similar public attention. In all other cases, we refer to people who died solely by their initials in the interest of preserving their identities.
2. *Gohranson v. Snohomish Cty.*, 2018 WL 2411756, at *6 (W.D. Wash. May 29, 2018).
3. “Roughly two-thirds of people sitting in Washington jails are awaiting trial; none of whom have been found guilty of the criminal charge with which they have been accused. Most languish there because they cannot afford the cash bail that courts routinely require.” ACLU, *No Money, No Freedom: The Need For Bail Reform*, 7 (September 2016), <https://www.aclu-wa.org/bail>.
4. National statistics indicate that 60% of people in jails actively exhibit mental health symptoms and 30% of people in jails have a cognitive disability of some type. See Disability Rights Washington, *County Jails, Statewide Problems: A Look at How Our Friends, Family and Neighbors With Disabilities Are Treated in Washington's Jails*, 16 (April 2016), https://www.disabilityrightswa.org/wp-content/uploads/2016/04/CountyJailsStatewideProblems_April2016.pdf.
5. See FWD.us, *Every Second: The Impact of the Incarceration Crisis on America's Families*, 10 (December 2018), <https://everysecond.fwd.us/downloads/EverySecond.fwd.us.pdf>.
6. One study indicates that as many as 76% of people living with severe mental illness who are locked up in jails receive acute psychiatric in-patient treatment solely while in jail and not in community-based, mental health facilities. See H. Richard Lamb et al., *Treatment Prospects for Persons With Severe Mental Illness in an Urban County Jail*, 58 *Psychiatr Serv.* 782, 784-86 (June 2007), <https://www.ncbi.nlm.nih.gov/pubmed/17535937>.
7. King County Executive's Office, *2019-2020 King County Proposed Biennial Budget*, 409, <https://kingcounty.gov/depts/executive/performance-strategy-budget/budget/2019-2020-Proposed-Budget/2019-2020-ProposedBudgetBook.aspx>.
8. Spokane City, *Budget Presentation* (October 16, 2018), <https://www.spokanecounty.org/DocumentCenter/View/23128/2019-Public-Safety-Justice-Presentation>.
9. <https://www.publicschoolreview.com/washington/spokane/5308250-school-district>.
10. See generally Disability Rights Washington, *Lost and Forgotten: Conditions of Confinement While Waiting for Competency Evaluation and Restoration* (January 2013), https://www.disabilityrightswa.org/wp-content/uploads/2017/12/LostandForgotten_January2013.pdf.
11. *Id.* at 7.
12. The authors reviewed all available records for all deaths that occurred in jails between January 1, 2005 and June 15, 2016.
13. Keri-Anne Jetzer, *Jail Bookings in Washington State*, Washington State Statistical Analysis Center, 1 (June 2016), <https://www.ofm.wa.gov/sites/default/files/public/legacy/researchbriefs/2016/brief078.pdf>.
14. The Bureau of Justice Statistics, a division of the federal Department of Justice, does annual surveys of jails across the country. Those surveys ask jails to provide information about average daily populations, the demographics of jail population, and very limited information regarding any jail death that has occurred in the prior year. This information includes the person's gender and very basic information about the cause of death. Jails need not provide any additional explanation or supporting documentation. WASPC asks jails in Washington to provide demographic information about the people detained, but does not request information regarding jail deaths or other serious events. And the data jails provide is often faulty or incomplete. “[T]here is little standardization related to the input or coding of the [WASPC] data being entered by jail staff.” *Id.* at 1.
15. RCW 70.48.100(2)
16. The threat of litigation is not sufficient to compel all jails to implement necessary reforms. Washington law significantly limits financial recoveries in wrongful death cases, particularly those involving people who have limited economic prospects or no dependents. See, e.g., *Otani ex rel. Shigaki v. Broudy*, 151 Wn.2d 750, 760 (2004) (loss of enjoyment of life damages not recoverable as part of wrongful death claim).
17. WASPC, *2015 Washington State Jail Statistics – County, Regional, City and Tribal*, <https://www.waspc.org/crime-statistics-reports>.
18. *Id.* Compare the aggregate average daily

populations for all jails with the design capacities for all jails.

19. See WASPC, *2017 Washington State Jail Statistics – County, Regional, City and Tribal*, <https://www.waspc.org/crime-statistics-reports>).
20. *Id.*
21. *Id.* Compare Average Daily Population for Snohomish County with its Average Daily Bed Rate.
22. This report identifies gender in a binary fashion, “men” and “women.” The authors could not find information regarding people who are transgender, intersex or otherwise gender non-conforming in jails in Washington from any source. The information provided by jails did not include any gender markers other than traditional binary indicators. The authors hope that more precise records and analysis can be conducted in the future in order to understand the impacts that jail life has upon all people.
23. See U.S. Census Bureau, *Statistics for Washington*, <https://www.census.gov/quickfacts/wa>. The information regarding demographics of the jail population from 2005 to 2015 comes from aggregating data from WASPC, *Washington State Jail Statistics – County, Regional, City and Tribal*, <https://www.waspc.org/crime-statistics-reports>.
24. Jetzer Report, *supra* note 13, at 3.
25. A recent study of people in Washington indicates that 58% of people who both receive Medicaid and had at least one stay in jail have significant mental health treatment needs, compared to only 42% of all people who receive Medicaid. In addition, six in ten people entering jail had substance use disorder treatment needs and four in ten had co-occurring disorder indicators. See DSHS Research and Data Analysis Division, *Behavioral Health Needs of Jail Inmates in Washington State*, 1 (January 2016), <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-11-226a.pdf>.
26. *Id.*
27. See Doris J. James & Lauren E. Glaze, *BJS Special Report: Mental Health Problems of Prison and Jail Inmates*, 1 (September 2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>.
28. *Id.* at 3.
29. *Id.* at 10.
30. Roughly two-thirds of women detained in jails reported having had a chronic medical condition, while just under half of men in jail reported the same. *Id.* at 5.
31. *Id.*
32. For example, rates of high blood pressure among detainees increased by nearly 50%, and rates of diabetes doubled between 2004 and 2012. *Id.* at 6-7.
33. See generally DSHS Behavioral Health Needs Study, *supra* note 24; and Disability Rights Washington reports, *supra* notes 4 & 10.
34. We have had difficulty determining the actual number of deaths with precision given the limited information available in many cases. For example, the Bureau of Justice Statistics has reported data on jail deaths only through 2014. The authors attempted to be as precise as possible, but acknowledge that the actual number of deaths may be slightly greater or slightly fewer than 210. Counted deaths include deaths that occurred in a hospital following an event that occurred within a jail. They do not include deaths that occurred while a person was living in the community on work release, furlough, probation, or electronic home monitoring.
35. Our review indicates that jail deaths did not disproportionately impact any particular racial or ethnic group, with one exception: Native people died in jail at a higher rate than the population of Native people in jails. However, the small sample set of Native people who died makes it difficult to draw any conclusion with significant certainty.
36. These percentages are based solely upon those deaths for which a length of stay could be calculated. It was not possible to calculate how long the person had been incarcerated before her death in 48 circumstances because of incomplete available information.
37. Drug or alcohol-related deaths included those in which the person was under the influence at the time of her death, suffering from withdrawal or likely suffering withdrawal at the time of her death. Alcohol or drugs was involved in 67% of deaths within the first 72 hours, while ten suicides that appear unrelated to drugs or alcohol occurred during that same period.
38. The Jetzer Report includes data regarding the charging offenses that people booked into Washington jails face. However, the categories included in that report are not the same as identified here. Jetzer reports that 30% of detainees face gross misdemeanor charges, 21% other types of charges, including violent felonies, 10% other misdemeanors, 13% for violations of community custody or warrants for failure to appear. Jetzer Report, *supra* note 13, at 3.
39. During the period studied, 24 jails reported no deaths, nine reported one death, 17 reported between two and ten deaths and seven reported more than ten deaths. The 33 jails that reported no deaths or only one death are generally very small local or county jails that collectively house only 12% of the total statewide jail population. See Appendix.
40. National Institute of Corrections presentation, *Basics and Beyond: Suicide Prevention in Jails*, slide 6, <https://s3.amazonaws.com/static.nicic.gov/Library/026251.pdf>.
41. Linda Peckel, *Preventing Suicide in Prison Inmates*,

- Psychiatry Advisor (December 2017), <https://www.psychiatryadvisor.com/home/topics/suicide-and-self-harm/preventing-suicide-in-prison-inmates>.
42. See *De Vincenzi v. City of Chico*, 592 F. App'x 632, 634 (9th Cir. 2015) (“the officers’ duty to provide medical care, including suicide prevention, [is] clearly established”) (citation omitted); *Clouthier v. County of Contra Costa*, 591 F.3d 1232, 1244-45 (9th Cir. 2010) (failure to follow appropriate suicide prevention practices can violate constitutional obligations).
 43. J. Richard Goss et al., *Characteristics of Suicide Attempts in a Large Urban Jail System With an Established Suicide Prevention Program*, 53 *Psychiatric Services* 574, 574 (May 2002), <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.5.574>.
 44. Our review indicated that at least 40% of all suicides happened while in solitary confinement. However, the number is likely far greater, because limitations in the records did not allow us to determine the location of each suicide or whether it occurred during a period of isolation.
 45. Lindsay M. Hayes, *National Study of Jail Suicide – 20 Years Later*, 50 (April 2010), <https://s3.amazonaws.com/static.nicic.gov/Library/O24308.pdf>.
 46. See Peckel article, *supra* note 41.
 47. Transgender people who are incarcerated are at very high risk of sexual assault and other forms of violence. In addition, many jails place transgender people in solitary “protective custody”. See National Center on Transgender Equality, *LGBTQ People Behind Bars: A Guide to Understanding the Issues Facing Trans-gender Prisoners and Their Legal Rights*, 13-14 (October 2018), <https://transequality.org/transpeoplebehindbars>. Being a victim of sexual assault and being placed in isolation are two significant risk factors for suicidal thoughts and actions.
 48. See National Institute of Corrections presentation, *supra* note 40, at slides 13-14.
 49. Suicide Prevention Resource Center, *What Corrections Professionals Can Do to Prevent Suicide*, 2 - 3 (October 2017), <https://ubhc.rutgers.edu/tlc/docs/suicideAwareness/SPR/SPRC%20Corrections%20Professionals.pdf>.
 50. National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Jails, Standard J-G-05 Suicide Prevention Program*, 119 (2014).
 51. Lucinda Grande & Marc Stern, *Providing Medication to Treat Opioid Use Disorder in Washington State Jails*, 5 (July 3, 2018), <https://www.waspc.org/assets/docs/opioid%20treatment%20in%20jail%20-%20final%20pdf.pdf>.
 52. Center for Health & Justice at TASC, *Safe Withdrawal in Jail Settings: Preventing Deaths, Reducing Risks to Counties and States*, 1 (January 2018), http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/Safe%20Withdrawal%20in%20Jail_010918.pdf.
 53. Grande Report, *supra* note 51, at 5.
 54. *Id.*
 55. See Appendix.
 56. TASC Report, *supra* note 52, at 2.
 57. While variable between people, major withdrawal symptoms from opioids peak between 24–48 hours after the last dose and subside after about a week. <https://www.drugabuse.gov/publications/research-reports/heroin/what-are-long-term-effects-heroin-use>. Withdrawal from alcohol peaks with 48-72 hours and can last weeks. <https://medlineplus.gov/ency/article/000764.htm>.
 58. TASC Report, *supra* note 52, at 1.
 59. NCCHC Jail Standards, *supra* note 50, *Standard J-G-07 Intoxification and Withdrawal*, at 125.
 60. The author of this report, Columbia Legal Services’ Institutions Project, represents men and women locked up in jails and prisons throughout Washington. In that capacity, we have spoken with hundreds of prisoners from all over the state regarding the conditions they face. Many have shared terrible stories of suffering from withdrawal after being booked into jails.
 61. Grande Report, *supra* note 51, at 5
 62. *Id.*; TASC Report, *supra* note 52, at 2.
 63. Grande Report, *supra* note 51, at 5.
 64. *Id.* at 15.
 65. See e.g., *Pesce v. Coppinger*, 355 F.Supp.3d 35, 45-48 (D. Mass. 2018) (correctional system’s refusal to provide methadone treatment likely violates ADA and 8th Amendment prohibition on cruel and unusual punishment); *Villareal v. County of Monterey*, 254 F.Supp.3d 1168, 1183 (N.D. Cal. 2017) (county sheriff can be held liable for jail’s failure to properly care for woman in withdrawal).
 66. Grande Report, *supra* note 51, at 7 and 13.
 67. One detainee was killed by a correctional officer who shot him during the course of an escape. Other deaths occurred as a result of “excited delirium,” with few other details provided. “Excited delirium” is a condition that occurs suddenly, with symptoms of bizarre and/or aggressive behavior, shouting, paranoia, panic, violence toward others, unexpected physical strength and hyperthermia. Often times the use of stimulants, like methamphetamine or cocaine, and the use of restraints or physical control tactics by law enforcement or correctional officers are correlated with the on-set of fatal episodes of excited delirium. Asia Takeuchi, Terence L. Ahem, Sean O. Henderson, *Excited Delirium*, *West J. Emerg. Med.* (February 2011), <https://www.ncbi>.

- nlm.nih.gov/pmc/articles/PMC3088378/. A death by excited delirium likely involves a number of different factors including “positional asphyxia, hyperthermia, drug toxicity, and/or catecholamine-induced fatal arrhythmias.” Mohammad Otahbachi et al., *Excited Delirium, Restraints, and Unexpected Death: A Review of Pathogenesis*, *Amer. J of Forensic Med. and Pathology* (June 2010).
68. “The physical and mental health needs of inmates can place significant stress on COs, particularly among treatment and medical staff.” Jaime Brower, *Correctional Officer Wellness and Safety Literature Review*, 5 (July 13), <https://s3.amazonaws.com/static.nicic.gov/Public/244831.pdf>.
 69. Community based interventions for people living with mental illness leaving prisons and jails have been shown to reduce recidivism, substance use, suicidality, and psychiatric hospitalizations. See generally E. Fuller Torrey et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, Mental Illness Policy Org. (May 2010), <https://mentalillnesspolicy.org/ngri/jails-vs-hospitals.html>.
 70. The NCCHC recommends that every detainee receive a full medical and mental health evaluation within 14 days of admission. NCCHC Jail Health Standards, *supra* note 50, *Standard J-E-04 Initial Health Assessment*, at 76. However, waiting for 14 days to conduct such evaluations would have had no impact on the vast majority of deaths, 73% of which occurred within the first 14 days of admission.
 71. NCCHC Jail Health Standards, *supra* note 50, *Standard J-G-07 Intoxication and Withdrawal*, at 124-25.
 72. Such validated assessments include the Clinical Opiate Withdrawal Scale or the Objective Opiate Withdrawal Scale and the Clinical Institute Withdrawal Assessment of Alcohol Scale. See *id.*
 73. Hayes Report, *supra* note 45, at xiii.
 74. Each jail must integrate questions regarding suicide risk into their initial intake questionnaires. The Hayes Report sets out a list of questions that all detainees should be asked. *Id.* at 48.
 75. Jails should utilize other available sources of information in order to make these determinations, including records of prior incarcerations that indicate a history of suicidal acts, information from relatives or friends, prior statements the person has made and records from community based health providers. However, care must be taken to ensure that jails do not make assumptions about suicidality based on gender identity or other characteristics that do not have any correlation to suicidal actions.
 76. See RCW 43.101.450 & .452
 77. See Department of Mental Health and Substance Abuse, World Health Organization, *Preventing Suicide In Jails and Prisons*, 14 (2007), https://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf. Such profiles must be based solely upon actions that indicate a potential likelihood for suicide and must be regularly updated to reflect current evidence based thinking. *Id.* at 14. Stereotypes based upon gender identity or other characteristics which do not correlate to suicidality should not be relied upon.
 78. RCW 43.101.455(2)(a)
 79. RCW 43.101.455(2)(b)-(f)
 80. See WAC 139-10-230 Basic Corrections Officer Academy Curriculum.
 81. See NCCHC, *Standards for Health Services in Jail* (2014); also NCCHC, *Standards for Mental Health Services in Correctional Facilities* (2015).
 82. NCCHC Jail Health Standards, *supra* note 50, *Standard J-A-10 Procedure in the Event of an Inmate Death*, at 22.
 83. *Id.*
 84. See Hayes Report, *supra* note 45, at 39. The NCCHC standards require that all deaths are reviewed within 30 days and that such reviews include an administrative review, a clinical mortality review and a psychological autopsy when suicide is the cause. NCCHC Jail Health Standards, *supra* note 50, at 22.
 85. Records from such serious incident reviews and discussions during these reviews could be protected from discovery during litigation. See for example, RCW 70.41.200, which allows hospitals to refuse to disclose certain documents created as part of internal examinations of negative health care outcomes.
 86. Jonathan Glover, *Spokane County Jail Records Eighth Inmate Death in 14 Months*, The Spokesman Review (August 26, 2018), <http://www.spokesman.com/stories/2018/aug/26/spokane-county-jail-records-eighth-inmate-death-in/>.
 87. Zachariah Bryan, *New Documents Shed Light on Fatal Struggle in County Jail*, The Everett Herald (October 18, 2018), <https://www.heraldnet.com/news/new-documents-shed-light-on-fatal-struggle-in-county-jail/>; Sidney Brownstone, *She Was Jailed for Shoplifting. A Month Later She Was Dead*, KUOW (February 7, 2019), <https://www.kuow.org/stories/their-daughter-died-after-being-booked-into-the-snohomish-county-jail-they-want-to-know-why>.

Appendix

	Percentage of Total Bed Space	Percentage of Total Bed Usage	Total Deaths	Total Suicides	Percentage of Total Deaths	Percentage of Suicides
Adams	0.20%	0.24%	0	0	0.00%	0.00%
Asotin	0.16%	0.57%	1	0	0.48%	0.00%
Benton	5.28%	4.95%	13	4	6.19%	4.49%
Chelan	2.74%	2.49%	3	2	1.43%	2.25%
Clallam	0.86%	1.01%	1	1	0.48%	1.12%
Clark	5.86%	6.52%	22	16	10.48%	17.98%
Columbia	0.06%	0.05%	0	0	0.00%	0.00%
Cowlitz	2.55%	2.33%	7	2	3.33%	2.25%
Enumclaw	0.17%	0.17%	1	0	0.48%	0.00%
Ferry	0.32%	0.23%	0	0	0.00%	0.00%
Fife	0.24%	0.20%	1	0	0.48%	0.00%
Franklin	1.64%	1.69%	4	1	1.90%	1.12%
Garfield	0.11%	0.06%	0	0	0.00%	0.00%
Grant	1.32%	1.57%	1	1	0.48%	1.12%
Grays Harbor	0.59%	1.33%	1	0	0.48%	0.00%
Island	0.41%	0.47%	2	0	0.95%	0.00%
Jefferson	0.35%	0.35%	0	0	0.00%	0.00%
Kent	0.84%	1.04%	2	1	0.95%	1.12%
King	18.54%	17.73%	33	9	15.71%	10.11%
Kirkland	0.42%	0.30%	2	1	0.95%	1.12%
Kitsap	3.65%	3.42%	5	4	2.38%	4.49%
Kittitas	1.64%	0.78%	3	1	1.43%	1.12%
Klickitat	0.35%	0.40%	2	2	0.95%	2.25%
Lewis	2.47%	1.59%	3	3	1.43%	3.37%
Lincoln	0.18%	0.21%	0	0	0.00%	0.00%
Mason	0.74%	1.12%	2	2	0.95%	2.25%
Nisqually	0.02%	0.02%	1	0	0.48%	0.00%
Okanogan	1.31%	1.53%	4	2	1.90%	2.25%
Other city jails	3.95%	4.45%	0	0	0.00%	0.00%
Pacific	0.21%	0.35%	0	0	0.00%	0.00%
Pend Oreille	0.27%	0.20%	0	0	0.00%	0.00%
Pierce	12.88%	9.89%	22	9	10.48%	10.11%
San Juan	0.03%	0.02%	0	0	0.00%	0.00%
SCORE	5.74%	5.15%	5	0	2.38%	0.00%
Skagit	0.59%	1.82%	5	3	2.38%	3.37%
Skamania	0.34%	0.24%	0	0	0.00%	0.00%
Snohomish	8.82%	8.60%	15	5	7.14%	5.62%
Spokane	4.81%	7.84%	20	5	9.52%	5.62%
Stevens	0.29%	0.37%	1	0	0.48%	0.00%
Thurston	3.51%	3.78%	3	3	1.43%	3.37%
Wahkiakum	0.10%	0.09%	0	0	0.00%	0.00%
Walla Walla	0.82%	0.62%	2	0	0.95%	0.00%
Whatcom	2.13%	3.18%	7	4	3.33%	4.49%
Whitman	0.24%	0.32%	1	1	0.48%	1.12%
Yakima	7.88%	6.90%	15	7	7.14%	7.87%



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