King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-00207

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Date of Publication: June 24, 2022

Contents

Inmate Information

The inmate was a 34-year-old male with a history of diabetes. He was transferred to the King County Correctional Facility (KCCF) in Seattle from the South Correctional Entity (SCORE) Jail at 0035 hours on February 4, 2022. The charges he was booked on did not allow for a strip search to be conducted.

Incident Overview

At approximately 0519 hours on February 4, 2022, the subject was observed having what appeared to be a seizure while in the restroom area of his housing unit. A medical emergency was announced, and Jail Health Services (JHS) staff began evaluation. Shortly thereafter, the subject appeared to lose consciousness and stopped breathing. Uniformed staff immediately began administering lifesaving measures (CPR), and the facility called for medical response from 911.

At 0545 hours Seattle Fire Department (SFD)/Medic One arrived and continued lifesaving measures including attaching an AED unit which reported "no shock advised." Multiple SFD units continued lifesaving measures until the subject was pronounced dead by paramedics at 0615 hours. All personnel then left the housing area, and the unit was declared frozen pending police investigation.

The Seattle Police Department (SPD) was called to the scene, which is standard for any in-custody death. SPD patrol officers arrived to the housing unit at 0656 hours. SPD then called their Force Investigation Team (FIT), who responded and began an investigation. It is noted that at the time of this report, SPD/FIT has not notified DAJD of their completed investigation.

The King County Medical Examiner's Office autopsy report lists the cause of death as acute drug intoxication including methamphetamine and the manner of death as accident.

UFR Committee Meeting Information

Meeting date: March 15, 2022 via virtual conference

Committee members in attendance

Department of Seattle-King County Public Health, Jail Health Services Division
- Danotra McBride, Director
- Dr. Ben Sanders, Medical Director

DAJD Administration
- John Diaz, Director
- Hikari Tamura, Deputy Director

DAJD Facility Command Staff
- Facility Commander Todd Clark
- Major Troy Bacon

DAJD Investigations Unit
- Captain Michael Taylor
- Sergeant Benjamin Frary

Committee Discussion

The potential factors reviewed include:

A. Structural
    a. Risk factors present in design or environment
    b. Broken or altered fixtures or furnishings
    c. Security/Security measures circumvented or compromised
    d. Lighting
    e. Layout of incident location
    f. Camera locations

B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with Jail Health Services (JHS)
    c. Relevant root cause analysis and/or corrective action needed

C. Operational
    a. Supervision (e.g. security checks, kite requests)
    b. Classification and housing
    c. Staffing levels
    d. Video review if applicable
    e. Presence of contraband
    f. Training recommendations
    g. Inmate phone call and video visit review
    h. Known self-harm statements
    i. Life saving measures taken

Committee Findings

Structural

The incident took place in a group "dormitory" style housing unit on the 9th floor of the King County Correctional Facility. The unit had adequate lighting, a functioning emergency call button and no known or reported broken or altered fixtures.

There are several surveillance cameras that capture the booking, processing, movement through the facility and eventually housing of the subject during the approximate 5 hours that elapsed between arrival and the beginning of the medical emergency.

It is noted that the KCCF booking area is equipped with a body scanner which can be used to scan incoming inmates, even in cases where strip searches are not permissible by law. It could not be determined if that scanner was functional or if it was used to scan the subject in this incident.

Clinical

Jail Health Services (JHS) was notified by the housing unit officer that other inmates had reported possible methamphetamine ingestion by this inmate, to which a registered nurse (RN) responded. While enroute to the housing unit to see the patient, a medical emergency overhead announcement occurred as the RN was in the elevator heading to the housing unit. After initial responsiveness and vital sign assessment, the patient collapsed and was noted to stop breathing and have no pulse. Autopsy report confirms that the patient died as a result of methamphetamine intoxication, by accidental overdose.

Jail Health Services did not identify issues or problems with policies/procedures, training, facilities/equipment, supervision/management, personnel, culture, or other variable in JHS related to the death.

Operational

The area of this incident was fully staffed and all responding DAJD staff acted within policy. DAJD uniformed staff and Jail Medical staff were present when the subject lost consciousness and immediately began CPR. Lifesaving measures continued until staff were relieved by Seattle Fire Department medics. Security checks were conducted timely and in accordance with policy.

Officer reports generated during this incident note that other inmates housed in the same area notified uniformed staff the subject may have "taken meth."

Committee Recommendations

That DAJD establish a method for documenting when a body scanner is not used.

Legislative Directive
Per ESSB 5119 (2021)

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

Disclosure of Information
RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create

a public website where all unexpected fatality review reports required under this section must be posted and maintained. An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(2)(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.