King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-00311

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 47-year-old male with a history of mental health issues. He was booked into the King County Correctional Facility (KCCF) in Seattle by the Seattle Police Department (SPD) at 0510 hours on February 13, 2022.

Incident Overview

While conducting a security check at about 0212 hours on February 20, 2022, uniformed staff working the 10th floor of KCCF found the subject partially suspended by a ligature tied around his neck and secured to the unoccupied upper bunk of his housing cell.

A medical emergency was called, and uniformed staff used safety scissors to cut the bedsheet being used as a ligature and lower the subject to the floor. Responding uniformed and Jail Health Services staff began CPR and continued to administer lifesaving measures until relieved by Seattle Fire Department staff at about 0222 hours.

Seattle Fire Department and Medic One personnel continued CPR until the subject was pronounced dead at 0243 hours.

Seattle Police Department (SPD) was called to respond to the in-custody death and the first units arrived at 0301 hours.

At the time of this report, SPD has not notified the Department of Adult and Juvenile Detention (DAJD)of their completed investigation.

At the time of this report, the King County Medical Examiner's Office has not released their autopsy report.

UFR Committee Meeting Information

Meeting date: March 21, 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
- Dr. Ryan Quirk, Psychiatric & Social Services Manager

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

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 single occupant cell on the 10th floor of the King County Correctional Facility without blind spots. The cell had adequate lighting from the cell window which was not covered as well as the ceiling light. The only camera with recording capabilities in this housing area shows only the core area of the unit and does not capture the living unit the incident occurred in. All fixtures in the cell including the emergency call button were functional.

The method used to anchor the ligature was a loop created by tying a bedsheet laterally around the unoccupied top bunk of the cell. Another section of bedsheet was then used as a ligature around the subject's neck and tied to the loop.

Clinical

Patient was actively engaged in health care services during most recent booking and denied recent Suicide Attempts/Suicidal Ideation when questioned by Jail Health Services (JHS) staff at booking. Based on interactions with patient, there were no clear signs or indications of current, active suicidality.

Jail Health Services did not identify issues or problems with policies/procedures, training, facilities/equipment, supervision/management, personnel, culture, or other variables.

Operational

The area of this incident was fully staffed and all responding DAJD staff acted within policy. Lifesaving equipment (safety scissors) was present and was used to cut the ligature. DAJD uniformed staff immediately began CPR and continued its application until joined by Jail Health Services staff, then relieved by Seattle Fire Department staff.

Prior to the arrival of the Seattle Police Department, a DAJD Sergeant observed and photographed several handwritten pages in the decedent's cell, including what appeared to be suicide notes and instructions for disposition of his property.

Review of the core area video camera footage shows the housing unit officer conducting a previous security check between the hours of 0111 and 0120 hours.

Committee Recommendations

The method for affixing the ligature to the top bunk was determined to be possible due to the open space between the top bunk and the exterior wall of the cell. This space allows a sheet or other material to be passed around the bunk and tied to itself creating a complete loop. The gap between the wall and upper bunk has been identified as a potential risk and a largescale facility infill project to enclose these gaps is underway.

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.