King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident 25-00697

Report to the Legislature

As required by RCW 70.48.510

Date of Publication: June 24, 2025

Contents

Resident Information

The decedent was a 69-year-old with medical history including high blood pressure, high cholesterol, chronic inflammatory arthritis, and past transient ischemic attacks (TIAs) or "mini strokes".

On March 3, 2025, at about 1024 the decedent was booked into the King County Correctional Facility (KCCF) after self-reporting for a 90-day commitment with an anticipated release date of April 26, 2025. The decedent was processed into KCCF per standard practice. A medical prescreening was conducted. The decedent was seen by Jail Health Staff (JHS) and orders were placed for blood pressure and cholesterol-lowering medications as well as an immune system suppressant for ongoing control of inflammation and arthritis.

Based on DAJD Classification staff's assessment the decedent was initially housed in Protective Custody on S07LC19 in the KCCF from March 3, 2025, until March 10. 2025.

On March 10, 2025, at about 0924 the decedent was assigned to Droplet Precaution Isolation housing after being seen by JHS for "cold/flu" symptoms. The decedent's vital signs were normal. JHS ordered nasal swab testing for respiratory viruses (SARS-CoV-2, influenza A and B, and RSV). Results of testing were evaluated on March 12, 2025, which confirmed the decedent had influenza A infection, with other tests negative. Plans were made for follow-up by a medical provider within a few days for evaluation for release from Droplet Precaution Isolation housing if symptoms had resolved.

Incident Overview

On March 14, 2025, staff found the decedent in their cell awake but the decedent did not respond to staff when they asked them to come to the door for a scheduled vital sign check. The decedent was not wearing pants and there was feces in various places in the room. The decedent was looking at staff and following some instructions but seemed to not be fully aware of their surroundings. The deck officer and JHS collaborated and started a medical assessment to obtain the decedent's vital signs. JHS determined additional medical follow up was required and the decedent was escorted to the KCCF 6th floor Clinic, where a medical provider could continue follow up care.

On March 14, 2025, at about 1045 the decedent was being seen by JHS in the KCCF 6th floor Clinic. JHS determined that the decedent required further medical intervention at Harborview Medical Center (HMC). An emergency medical response was initiated. Seattle Fire Department (SFD) arrived at about 1056 to assess the decedent. SFD called for American Medical Response (AMR) to transport the decedent to HMC at about 1103. AMR transported the decedent to HMC at about 1107. The

decedent was admitted to HMC for shortness of breath, further classified as acute hypoxemic respiratory failure . Vital signs showed low blood pressure and low oxygen levels by pulse oximetry, chest x-ray showed bilateral opacities which were felt consistent with pneumonia, lab work showed signs of significant infection, and the decedent was admitted to the medical intensive care unit (MICU) for "septic shock likely secondary to superimposed bacterial pneumonia".

On March 16, 2025, at about 1644 HMC staff informed DAJD staff that the decedent had passed away. HMC doctors stated their preliminary cause of death was "Influenza A and bacterial pneumonia which caused sepsis and eventual cardiac arrest".

DAJD staff called the Seattle Police Department (SPD) to inform them of the in-custody death and to request an investigation. An SPD Officer and Sergeant arrived at HMC and drew a case number (SPD 25-70990). They advised the SPD Force Investigation Team (FIT). SPD FIT deferred to DAJD for the administrative death investigation. SPD closed their investigation as they did not feel further investigation was needed due to the manner of death being medical related and the event did not involve a use of force or criminal conduct.

On March 17, 2025, a DAJD Special Investigation Unit Sergeant contacted the King County Medical Examiner's Office (KCME) to obtain records concerning the decedent's death. KCME advised they had assigned the decedent KCME case number 25-834.

On June 24, 2025, DAJD received the KCME final autopsy report. The KCME determined the manner of death was natural causes. They further state the cause of death was septic shock and pneumonia due to influenza A infection. Contributing factors were cardiovascular disease and renal necrosis.

<u>UFR Committee Meeting Information</u>

Meeting dates: March 18, 2025, via virtual conference

<u>Committee members in attendance</u>

Department of Seattle-King County Public Health, Jail Health Services Division
- Dr. Ben Sanders, Medical Director
- Dr. John Rose, Managing Psychiatrist

DAJD Administration
- Allen Nance, Director
- Steve Larsen, Deputy Director

DAJD Facility Command Staff
- Lisaye Manning, Facility Commander
- Michael Taylor, Operations Major

DAJD Investigations Unit
- Jennifer Schneider, IIU Commander
- Mark Hanning, SIU Sergeant

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. Safety/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.
    j. Use of Force review.

Committee Findings

Structural

The incident took place at an outside medical facility. There were no internal DAJD structural components deemed to be factors in the death.

Clinical

Jail Health Services identified systemic issues including lack of a medical record "flag" for patients with immune system suppression related to medications and lack of easy way to evaluate persons with influenza-like-illness for higher risk for complications from influenza infection (an indication per clinical practice guidelines to order treatment with oseltamivir [Tamiflu]). Jail Health Services did not identify issues or problems with training, supervision/management, personnel, or culture in JHS specifically related to this incident.

Operational

The area of the medical event prior to the incident was fully staffed. Reviewed video and JMS records show that security checks leading up to this event were conducted within policy.

Committee Recommendations

Recommendations for Jail Health Services included development of a health record tool to readily assess for increased risk for complications from respiratory infections, as well as a procedure for "flagging" records of patients receiving immune system suppressing medications.

Legislative Directive
Per RCW 70.48.510

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.