In-Custody Death of
Michael Clinard

Seattle Police Department, Force Investigation Team, #2017FIT-0013

King County Prosecuting Attorney

Public Integrity Team

October 21, 2024

LEESA MANION (she/her)
PROSECUTING ATTORNEY

King County

Office of the Prosecuting Attorney
CRIMINAL DIVISION
W554 King County Courthouse
516 Third Avenue
Seattle, Washington 98104
(206) 296-9000

DECLINE MEMORANDUM

IN-CUSTODY DEATH OF MICHAEL CLINARD

I. INTRODUCTION

The King County Prosecuting Attorney's role is to ensure that the in-custody death investigation is thorough and complete, determine whether sufficient admissible evidence exists to support filing criminal charges, and advise the King County Executive "whether an inquest should be initiated pursuant to the King County Charter." (Executive Order PHL 7-1-5 EO). "An inquest shall be held to investigate the causes and circumstances of any death where an action, decision or possible failure to offer the appropriate care by a member of any law enforcement agency might have contributed to an individual's death." (King County Charter Section 895).

The Public Integrity Team has determined that the investigation of July 3, 2017 in-custody death of Michael Clinard is complete at this time. Based on a thorough review, the Team has concluded that the evidence is insufficient to support criminal charges. Accordingly, the KCPAO is declining to file criminal charges in this matter based on the evidence presently available.

Furthermore, pursuant to Executive Order PHL-7-1-2-EO, we recommend an inquest be initiated because we have not identified any factors or circumstances under §6.2, or any other reasons that indicate that an inquest is not warranted.

II. INVESTIGATIVE MATERIALS

The KCPAO has reviewed law enforcement reports, witness interviews, booking records, jail records, medical records, Medical Examiner records, photos of the death scene, jail call transcript, radio traffic, CAD/MDT, and 911 call.

III. FACTS

On July 3, 2017, Michael Clinard, while an inmate at King County Jail, committed suicide by hanging.

On June 12, 2017, Mr. Clinard was remanded into custody during a Bothell Municipal Court proceeding and later booked into the King County Jail on investigation of Third-Degree Assault after he allegedly assaulting the police officers who assisted in remanding him into custody. When the court told him that he was being remanded into custody, Mr. Clinard threatened to commit suicide.

Jail records show that during the booking process the arresting officer made jail staff aware that earlier that day the subject threatened suicide at his hearing at Bothell Municipal Court. Jail staff asked the subject if he was currently suicidal or had been suicidal within the past 12 months. He responded “no” to both questions. As a result, Nurse 1 met with the subject and assessed the patient's emotional state, mood and behavior. The nurse did not observe the subject to have any apparent distress. The subject did complain of some situational anxiety which was related to this incarceration. The nurse noted that the subject has complex psychological issues that were being treated with medication. He was informed by the nurse of jail health services available to him, and he was ultimately medical cleared by the jail. Jail Health Services (JHS) scheduled a psychological follow-up appointment for Mr. Clinard 30 days later, scheduled for July 12, 2017.

According to jail records, the medications Mr. Clinard was taking as of June 12, 2017, were: Lithium, Zoloft, Lorazepam, and Adderall. According to the records, the Lorazepam and Adderall were not administered per King County Jail policy. These medications were verified by

Doctor 1 (Clinard's personal doctor) on June 13th. Doctor 1 informed JHS that Clinard was diagnosed bipolar and had a history of taking Depakote and Vraylar.

On June 21, 2017, Clinard reported mental health symptoms to JHS. Clinard requested to be put on Prazosin for PTSD. Clinard denied any suicidal ideations at that time. The progress notes in his file specified that he had a history of mental illness and that the appropriate follow-up was in place stating, "No additional treatment plan changes are needed based on exam and interview."

On June 24, 2017, Clinard reported to triage that he did not feel he was receiving the correct dose of Lithium. Clinard told the nursing staff that he was going through a divorce. He felt stable now but admitted to anger issues. Clinard once again denied any suicidal ideations, though he requested a psychological appointment and that the amount of Lithium prescribed be increased. Nursing staff discussed with him the possibility of entering psychological housing unit but he declined stating, "I like the people I am with." The plan discussed by the nursing staff was to keep hydrated and read/write/art/exercise as a technique for coping. Clinard agreed to request immediate medical attention if he felt like harming himself. The notes stated: "Based on review of the chart, the following action is taken regarding the patient's medication needs: Medications will be continued at current doses until patient can be seen by a provider for f/u. Based on review of the chart, the following action is taken regarding the patient's psychiatric follow-up. Already has follow-up scheduled and will be seen accordingly."

On July 3, 2017, King County Corrections Officer (CO) 1 was working as the desk officer in 8 East at KCJ. At approximately 6:30 pm he performed a security check of the jail cells on 8 East. At approximately 6:46 pm, he was at his station when multiple inmates from 8 East, Upper A made him aware that something appeared wrong with the inmate from 3 house. The inmate, Mr. Clinard, was lying in his cell, face down, with his face in a pool of blood. Upon inspection of Mr. Clinard, CO 1 immediately called over radio for a "Med III" which indicated to all staff that there was a situation rising to the level of possible life saving measures needed.

CO 2 and CO 3 were the first to arrive to 3 house and located Clinard. There was a pool of blood near his head which was positioned left of the toilet. They turned his body over on the right side and saw what they believed to be cloth from the bed linens wrapped multiple times around his neck. Both officers attempted to get the cloth around Clinard's neck loosened, but it was too tight, and they were not having any success. CO 2 asked for a "rescue knife." CO 4 retrieved the knife from the secured location and promptly handed it off to CO 5 who delivered it to CO 2. With the use of the knife, CO Currier was able to cut the cloth from Clinard's neck. Realizing that Clinard had no pulse and CPR needed to be started, the officers opted to bring Clinard to the "Day Room" area where there would be more space to work.

CO 2 immediately started doing chest compressions on Clinard with CO 3. An AED defibrillator from JHS cart was used on scene and advised no shock. CO 2 and CO 3 continued chest compressions until JHS staff nurses, Nurse 2 and Nurse 3 responded and took over CPR. Seattle Fire Department (SFD) received a call of a "Med 7" which indicates CPR in progress. Aid Car 5 with Firefighters McCandless and Hearne arrived at the same time as Medic 1 with Paramedics Martin and Olswang. The group was escorted up the elevator by jail staff to floor 8.

Shortly behind A5 and M1 was Engine 10 with Lieutenant Firefighter 1 and Firefighters 2, 3, and 4. Lieutenant Firefighter 1 kept notes on rounds of CPR and updated the tablet with pertinent patient information. Firefighters 2, 3, 4, and 5 each completed one to two rounds of CPR and prepped oxygen bottles and IV bags as requested by Paramedic 1 who took charge of the scene.

Paramedic 2 successfully intubated Clinard and they were also able to draw an IV line. Clinard received multiple doses of epinephrine and sodium bicarbonate via the IV. The SFD Medic 1 unit hooked up their Lifepack defibrillator to Clinard and were advised no shock. Paramedic Martin's team continued breaths and compressions for approximately twenty minutes at which time she called the doctor at Medic 1 and advised him of the situation. The doctor acknowledged and agreed that all possible life saving measures had been taken. At 7:10 pm Paramedic 1 called off the CPR and Clinard was pronounced deceased. Paramedics stood by and waited until SPD Officers 1 and 2 and Acting Sergeant Officer 3 arrived on scene.

Subsequently, Chief Medical Examiner Dr. 2 conducted an autopsy of Mr. Clinard. The cause of death of this 38-year-old man found in his jail cell with a ligature made from a torn bed sheet wrapped tightly about his neck is asphyxia due to ligature compression of neck. The manner of death is suicide.

IV. ANALYSIS AND CONCLUSION

Manslaughter in the Second Degree with Criminal Negligence occurs when a person fails to be aware of a substantial risk that death may occur, and this failure constitutes a gross deviation from the standard of care that a reasonable person would exercise in the same situation.

Although Mr. Clinard's death is tragic, based on the evidence admissible from the criminal investigation and the applicable criminal legal standards, we have determined that there is insufficient evidence to prove beyond a reasonable doubt that any of the involved individuals acted with criminal negligence. There is insufficient evidence to support a finding beyond a reasonable doubt that there was gross deviation from the standard of care due to Mr. Clinard by any corrections officers, medic, firefighter, or Jail Health Services staff that was the cause of Mr. Clinard's death. As a result, KCPAO declines to file any criminal charges.

V. RECOMMENDATION FOR INQUEST

Pursuant to Executive Order PHL-7-1-5-EO, we recommend an inquest be initiated because we have not identified any factors or circumstances under §6.1, or any other reasons, that indicate that an inquest is not warranted.