In-Custody Death of
Matthew Wilson

Seattle Police Department,
Force Investigation Team, #2017FIT-0018

King County Prosecuting Attorney
Public Integrity Team

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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 MATTHEW WILSON

I. INTRODUCTION

On September 26, 2017, King County Jail (KCJ) inmate Matthew Wilson (Wilson) who was being detained on investigation of attempted robbery hanged himself in his single cell shortly after finding out that criminal charges were filed against him. He died at Harborview Medical Center (HMC) the following day.

The King County Prosecuting Attorney's (KCPAO) 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 inform the King County Executive whether an inquest should be initiated.[1] An inquest is required when any action by law enforcement might have contributed to an individual's death.[2]

The KCPAO's determination if the police action was justified or if there was a criminal action such that criminal charges should be filed is based entirely on the investigation materials provided to the KCPAO, relevant criminal laws, rules of evidence governing criminal proceedings, the applicable burden of proof, and the KCPAO's Filing and Disposition Standards. This determination is not intended to address matters outside the scope of this memorandum including, but not limited to, an administrative action by the involved agency or any other civil action. The KCPAO expresses no opinion regarding the propriety or likely outcome of any such actions.

[1] Executive Order PHL 7-1-5 EO.
[2] King County Charter Section 895.

The Public Integrity Team has determined that the investigation of the September 27, 2017 in-custody death is complete at this time. Based on a thorough review, the Team has concluded that the evidence is insufficient to support criminal charges against any Corrections Officers (CO) or jail staff. As a result, the KCPAO declines to file criminal charges.

Additionally, after a careful review of these materials, pursuant to Executive Order PHL-7-1-5-EO, the PAO does not recommend that an inquest be initiated because the role of law enforcement was *de minimis* and did not contribute in any discernable way to Wilson's death.

II. EVIDENCE REVIEWED

- SPD Reports 2017-359763/2017-0018
- Case Investigation Report
- General Offense Report 2017-352672
- General Offense Report 2017-364299
- Major Investigation Summary
- Force Investigation Report
- Interview Transcripts
- Subject's Criminal History
- Booking Packet
- Jail Video Surveillance Footage
- Rule Infraction Report
- Hospital Log Sheets
- King County Jail Reports
- Other Materials
- Weekly Check Ins
- Scene Photos
- Audio Interviews
- Jail Call Recordings
- MDTs
- CADs
- NICE 911 Report
- NICE Radio Report
- Radio Traffic
- 911 Calls
- Jail Records
- Housing History for Subject
- Inmate List
- Log Book
- Inmate Roster
- Roster Notes
- Surveillance Log
- Rollout Checklist
- KCCF Blueprint 11E
- Classification Information
- KCMEO Photographs
- Autopsy Report
- Toxicology Report
- SFD Patient Care Record
- Jail Medical Records

III. INVESTIGATION

A. CALL-OUT

On September 27, 2017, at 11:40 AM, KCJ Sergeant 1 asked Seattle PD's Force Investigation Team to investigate this incident, stating that an inmate attempted suicide the night before and it appeared that he was not going to live.

B. FACTUAL SUMMARY

On September 22, 2017, at approximately 2:00 AM, Matthew Wilson was arrested on 3rd Ave. and Pine St. in Seattle for investigation of robbery. During transport to the precinct Wilson appeared calm and cooperative. While in the precinct holding cell, Wilson attempted to get out of his handcuffs. When officers attempted to escort him into the transport wagon, he became uncooperative. It took five officers to carry Wilson to the transport wagon in the Sally Port. At approximately 3:05 AM, Wilson was transported to the King County Jail where the transport officer requested assistance from King County Jail Staff.

At 3:08 AM King County Corrections Officer 1 (CO 1) was working in intake and release when Wilson was booked. CO 1 completed a Behavior Modification Report stating that Wilson was infracted for "Physical Resistance" and "Causing a Supervisor's Response." Due to these actions upon intake, Wilson was not placed into general population, but was assigned to 11E, lower B, cell 3. Wilson resided there the entire time he was an inmate at KCJ.

At 9:47 AM Wilson was evaluated by Jail Health Services (JHS) Nurse 1. During this initial evaluation, Nurse 1 noted that Wilson appeared angry and was irritable. Wilson refused to let nursing staff take his vitals and claimed he was diagnosed with cancer two days prior, but would not give further information. He stated, “Let them do their 72-hour investigation, then I can move on.” When asked if he was suicidal, he responded, "Why do you guys ask such stupid questions? No I am not suicidal. I want to go to court"

On September 24, 2017 at 11:44 AM, Wilson was seen by Nurse 2. During this visit, Wilson stated that he had Post Traumatic Stress Disorder (PTSD) very bad and needed medications. He told the nurse that he usually medicated with THC. He was diagnosed at that time as being depressed but still was negative for any suicidal ideations. The nurse however, noted in the assessment and plan that a request would be sent to the Psychiatric Unit, as that appeared to be the underlying issue of that day's visit. On September 25th, 2017, Wilson was scheduled for a psychiatric follow-up.

On September 26, 2017, at approximately 7:20PM, Wilson called CO 2 using the intercom and asked if criminal charges had been filed against him. CO 2 checked on his

computer and told Wilson that charges had indeed been filed. Wilson thanked him for the information. Just a few minutes later at 7:23 PM, CO 2 and Nurse 3 began their security check of the inmates where Nurse 3 also provided inmates with their prescription medication. The second cell they checked was Wilson's. At 7:27 PM CO 2 found Wilson "hanging by his brown sheets." The bed sheet was wrapped around his neck tied to the opposite side of the bed. His body lay in a prone position facing the ground with his shoulder against bed, his head resting on mattress and blood on his face. CO 2 immediately used his radio to call a medical status III. Nurse 4 handed CO 2 trauma scissors. CO 3 assisted CO 2 with cutting the sheet from around Wilson's neck. Multiple staff from JHS responded to the emergency call and moved Wilson's body to the day room area of 11E, lower B so they had more area to work. Nurse 5 started CPR with Nurse 6 relieving him. They applied AED pads but were advised "no shock."

At 7:32 PM, Seattle Fire Department (SFD) Firefighters 1 and 2 took over CPR from JHS staff. Medic One arrived right after and medics ran IV lines, hooked up their AED machine, and administered epinephrine and sodium bicarb. The AED advised "no shock." SFD Engine 10 with Captain 1 and Firefighters 3, 4 and 5 arrived. Firefighters 3 and 5 jumped into the rotation of doing compressions of CPR while Captain 1 tracked the CPR rounds.

At 7:51 PM, paramedics were successful at getting a pulse and Wilson was prepped for transport to HMC. The ambulance left KCJ at 7:58 PM and arrived at HMC at 8:03 PM. HMC staff took over Wilson's medical care. On September 27, 2017, Wilson passed away after being taken off life support

Later, investigators located a handwritten note in Wilson's cell on the floor directly below the toilet that read, "I love you Yelena you were the greatest thing to happen to me."

C. AUTOPSY REPORT

An autopsy on Wilson's body was performed by King County Associate Medical Examiner Doctor 1. He concluded, "The cause of death of this 34-year-old man who died in hospital is anoxic encephalopathy due to ligature hanging, which reportedly occurred in the King County jail. The manner of death is classified suicide."

IV. LAW

KCPAO's Filing and Disposition Standards state, "Crimes against persons will be filed if sufficient admissible evidence exists, which, when considered with the most plausible, reasonably foreseeable defense that could be raised under the evidence, would justify conviction by a reasonable and objective fact-finder."

A person commits Criminally Negligent Second-Degree Manslaughter if they engaged in conduct of criminal negligence and the decedent died as a result of their negligent acts.[3]

A person is criminally negligent or acts with criminal negligence when he or she 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.[4]

V. ANALYSIS AND CONCLUSION

KCPAO will not file criminal charges in relation to Mr. Wilson's death. Based on the evidence admissible in a criminal case and the applicable legal standards, we have determined that there is insufficient evidence to prove beyond a reasonable doubt that the care provided by any King County Jail or Jail Health Services staff was a gross deviation from the standard of care that a reasonable person would exercise, which is necessary for a manslaughter charge.

VI. RECOMMENDATION FOR INQUEST

Pursuant to Executive Order PHL-7-1-5-EO, we recommend an inquest not be initiated because the role of law enforcement was *de minimis* and did not contribute in any discernable way to a person's death.

[3] RCW 9A.32.070 & WPIC 28.06.
[4] WPIC 10.04.