In-Custody Death Investigation

Damaris Rodriguez

Des Moines Police Department, #2018-0024

King County Prosecuting Attorney

Public Integrity Team

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DECLINE MEMORANDUM

IN-CUSTODY DEATH OF DAMARIS RODRIGUEZ

WARNING – This memorandum contains images and descriptions of violence that may be offensive and disturbing to some readers. The images and descriptions are included to provide the reader with the most accurate information regarding the topic of this memorandum.

I. INTRODUCTION

On January 4, 2018, South Correctional Entity (SCORE) inmate Damaris Rodriguez died unexpectedly of natural causes in her cell.

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.

The Public Integrity Team has determined that the investigation of the January 4, 2018, 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 Rodriguez's death.

II. EVIDENCE REVIEWED

- Des Moines Police Reports, Incident # 2018-0024
- Jail Records
- SCORE Jail Video
- CAD # DP180000136
- Scene Photos
- Autopsy and Toxicology reports

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

III. INVESTIGATION

1. CALL-OUT

The lead investigator into Ms. Rodriguez's death was Investigator 1 of Des Moines Police Department.

2. FACTUAL SUMMARY

On December 30, 2017, subject, Damaris Rodriguez's husband, Civilian Witness 1, called 911 to report that Rodriguez punched him in the face without any provocation or warning. He later told police that he walked into the couple's bedroom for something as she was resting on the bed. Without warning or conversation, she jumped up calling him the "devil" and punched him in the left side of his face with a closed fist with both her fists. When officers arrived to arrest her, she began spit at and attempt to punch officers. She was ultimately transported to SCORE Jail.

Civilian Witness 1 later told officers that Rodriguez had been diagnosed with bipolar disorder and paranoia, two years ago, when they lived in New York. He stated she was put on medication, at that time, after she had a similar breakdown, to the one which caused her to be recently incarcerated. He said that she was not on any medication.

Rodriguez was booked at SCORE jail at 2:50 PM. The next day, December 31, 2017, a mental health professional assessed the subject during booking. She was kept in booking for over one day due to her erratic behavior. She was naked and refused to cooperate with the booking process, where she sang and danced. She also refused to speak with jail staff anything other than making noises and sticking her tongue out. Medical staff recommended she be placed in mental health housing instead of in the jail's general population.

On January 2, 2018, the subject spoke with a mental health professional again and this time she was in stable condition. She provided a urine sample and was placed then in the general population. No narcotics were found in the urinalysis. However, after being placed in the jail's general population, she refused to stay dressed. She was also seen overdrinking water and vomiting in the toilet.

On January 3, 2017, at 7:06 PM, Rodriguez was noted as attempting to induce vomiting several times, yelling in Spanish and defecating on floor. Rodriguez was observed vomiting large quantity of water, so was moved to dry cell. The jail's mental health director wrote,

> IM [inmate] has been agitated today. MHP [Mental Health Professional] was able to get her to put on a uniform this morning. She refused to go to court. This afternoon, about 2:30, MHP witnessed her throwing up copious amounts of water- just water. No food or color to it at all. She was self-inducing the vomiting by choking herself and coughing. RN and CO reported she ate lunch but vomited it up. There was a foul smell coming from her cell. MHP requested that IM be placed in dry cell and be given water on schedule so her intake can be monitored. Charge RN got vital signs. Medical NP and Psych ARNP were alerted to potential water intoxication. When being moved, IM became agitated and cussed the COs out in Spanish. Since IM has stable VS, is eating and drinking, there are no grounds for an ITA [Involuntary Treatment Act] referral at this time. Will continue to monitor.

Prior to her death, last cell check/water check a CO performed was at 10:57 PM, approximately 50 minutes before her death,

On January 3, 2017, at 11:46 PM, the subject did not respond to Corrections Officer 1's (CO 1) offer of water. CO 1 noticed the subject was lying face down on her bed. When she did not respond to additional questions, CO 1 and a nurse entered the cell and noticed she was ashen and blue. She did not have a pulse. COs and jail staff immediately began CPR and called for additional aid. The staff administered numerous rounds of CPR and attempted AED, but were advised "no shock" because the subject's heartbeat was not in rhythm. The firefighters and medics arrived 8 minutes later and took over lifesaving care.

The investigators obtained jail video surveillance of Rodriguez's cell. The video shows three officers escorting Rodriguez into her cell at 2:46 PM. Below is a summary of what transpired on video over the nine hours immediately preceding her death:

- 2:53 PM: Rodriguez sits up, on her knees, with her head over the side of the bunk and appears to be dry vomiting.
- 3:03 PM: Rodriguez lies on her left side, in a fetal position.
- 3:20 PM: Rodriguez moves back to a fetal position on her knees.
- 3:44 PM: Rodriguez lies back on her left side, still in a fetal position.
- 3:47 PM: Rodriguez moves back to a fetal position, holding her stomach.
- 3:51 PM: Rodriguez sits up, holding her stomach.
- 3:53 PM: Rodriguez lies back down on her left side, in a fetal position.
- 3:54 PM: Rodriguez sits up and places her feet on the floor with her head between her knees.
- 3:55 PM: Rodriguez lays on her left side with her feet still on the floor.
- 3:56 PM: Rodriguez sits upright.
- 3:57 PM: Rodriguez lies on her back.

- 3:58: Rodriguez sits back upright.
- 3:59: Rodriguez lies on her stomach with her head resting on her right arm. She stays in this position, with minor movements for approximately 6 hours and 4 minutes.
- 10:03: Rodriguez breathing appears to become shallower.
- 10:04: Rodriguez's breathing stops.
- 10:06: Agonal breathing.
- 10:12: Slight upper body movement.
- 11:47: Flash of light seen in cell, coming from hallway.
- 11:48: Officer and nurse enter cell and begin life-saving efforts.

3. AUTOPSY REPORT

An autopsy on Rodriguez's body was performed by then King County Chief Medical Examiner Doctor 1. He concluded, "The cause of death of this 43-year-old woman who died suddenly after several days of exhibited manic behavior in a correction facility is certified "sudden death in excited delirium". Hyponatremia and ketonemia are metabolic manifestations of her excited delirium. No injuries caused or contributed to her death. The manner of death is natural." According to Doctor 1, very high ketone levels (ketoacidosis) can cause heart arrhythmias and other problems, which may lead to death.

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]

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

V. ANALYSIS AND CONCLUSION

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 SCORE jail or the medical staff it employs was a gross deviation from the standard of care that a reasonable person would exercise, which is necessary for a manslaughter charge. As a result, the KCPAO declines to file criminal charges.

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.