In-Custody Death Investigation

Kevin Wiley

Kirkland Police Department, Incident #23-20150

King County Prosecuting Attorney
Public Integrity Team

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DECLINE MEMORANDUM

In-Custody Death of Kevin Wiley

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 June 9, 2023, inmate Kevin Wiley died at the Issaquah Jail due to acute combined drug intoxication including fentanyl and methamphetamine.

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. (Executive Order PHL 7-1-5 EO). An inquest is required when any action by law enforcement might have contributed to an individual's death. (King County Charter Section 895).

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 June 9, 2023 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 Issaquah Police Department Jail Corrections Officers (CO) or jail staff. Although Mr. Wiley's medical condition should have been apparent to someone in the jail during the three days he was an inmate, there is insufficient evidence to prove that any one employee by themselves was criminally negligent. As a result, the King County Prosecuting Attorney's Office declines to file criminal charges.

Additionally, after a careful review of these materials, pursuant to Executive Order PHL-7-1-5-EO, we recommend an inquest be initiated.

II. EVIDENCE REVIEWED

- KCME Autopsy Report
- Toxicology Test Report
- KCME Investigator's Report
- Scene Photographs
- 3D Scan of Jail
- Jail Videos
- Medical Kite
- Interviews
- Booking Paperwork
- Jail Call
- Jail Logs
- Jail Check Logs
- House Dorm Report
- Historical Inmate Location Report
- Crime Scene Log
- Paperwork Related to Issaquah Municipal Court Case # 3A0313571
- Jail's Custodial Care Standard
- Jail's Classification and Segregation Policy
- Kirkland PD Report(s)
- CAD
- Issaquah PD Police Reports
- Clyde Hill PD Police Report(s)
- WSP Police Report(s)
- Eastside Fire and Rescue Report(s)
- AED Data
- CJTC Notices of Hire
- CJTC Notices of Officer Separation

III. INVESTIGATION

1. Call-Out

Issaquah Police Department, a member agency of the Independent Force Investigation Team – King County (IFIT-KC), requested that IFIT-KC conduct an independent investigation into the death of Kevin Wiley at its jail. Kirkland Police Department (KPD) was assigned as the lead investigating agency. KPD Lieutenant 1, Detective 1, and Detective 2 were the lead investigators. Washington State Patrol and Clyde Hill Police Department assisted KPD in its investigation.

2. Factual Summary

On June 7, 2023, at approximately 2:30 PM, Kevin Wiley (Wiley) was booked at the Issaquah Police Department Jail on a theft related misdemeanor. Search incident to arrest, Issaquah PD Officer 1 found Wiley in possession of twenty-eight M-30 fentanyl tablets. However, he failed to note that on the jail booking form, which asked if the officer recovered any dangerous drugs on the arrestee, or if he possessed any information which might assist in the care of the arrestee. Officer 1 also wrote that he was not aware that the arrestee had consumed a potentially dangerous level of drugs.

On the jail intake form Wiley reported last using fentanyl at 6:00 PM the prior day but did not claim to currently be experiencing any medical condition. The jail video of Wiley's dormitory shows his medical condition deteriorating over the next three days. He appeared agitated, could not sleep, and vomited multiple times. At around 2:00 AM on June 9, 2023, he had another inmate fill out a medical kite stating that Wiley needed to be seen by a nurse to detox. It is unclear from the evidence whether any guard reviewed or received the kite. However, at 4:25 AM another inmate reported to the corrections officer on duty, Corrections Officer 1, that Wiley was throwing up bad and needed help. This communication was not recorded. CO 1 told the inmate that she could not aid until her partner, Corrections Officer 2, returned from his break. When he returned from his break neither CO provided Wiley with medical assistance. They also failed to perform their hourly checks of Wiley's dorm, Dorm 2, between 10:04 PM and 6:00 AM. Because of their failure to perform their job duties, CO 1 and CO 2 were unaware of how serious Wiley's medical condition was.

The morning shift officers relieved CO 1 and CO 2 around 6:00 AM. There is no evidence that CO 1 or CO 2 updated them on Wiley's condition. At around 6:14 AM, dayshift CO 3 let a dormmate of Wiley's retrieve a mop to clean up Wiley's vomit. It appears that CO 3 walked over or past the medical kite filled out for Wiley. However, whether the piece of paper in the video was Wiley's kite could not be verified by investigators. Wiley then moved his mattress from his top bunk to the floor near the bathroom and vomited again.

According to jail Nurse 1, the jail only employs a nurse during daytime hours. When she began her shift at 7:00 AM the day Wiley died, she was not notified of Wiley's medical condition, nor was she given his medical kite to read. Between 9:45 AM and 10:22 AM, jail records show that officers and the jail nurse were attending to an inmate in another dorm who was experiencing alcohol withdrawals and needed to be sent to the hospital. At around 10:55 AM, jail footage of Dorm 2 shows Wiley apparently suffering cardiac arrest while lying on his mattress. It took approximately 25 to 30 minutes before inmates realized that Wiley may have stopped breathing. Inmates then notified jail staff. The nurse, corrections officers, and later, fire department personnel, attempted to provide lifesaving treatment to Wiley, but were unsuccessful and Wiley died.

The medical examiner ruled the death an accident caused by acute combined drug intoxication including fentanyl and methamphetamine. Atherosclerotic cardiovascular disease was a contributing factor.

3. Photographs/3D Scan of Jail

The jail was 3D scanned by IFIT-KC. Past the entrance area and metal detector, the jail has a booking desk where there is a workstation for two corrections officers. To the left of the booking desk is the "soft side" where the dormitories are located, including Dormitory 2, where Wiley was housed. To the right of the booking desk is the "hard side" where individual cells are located.

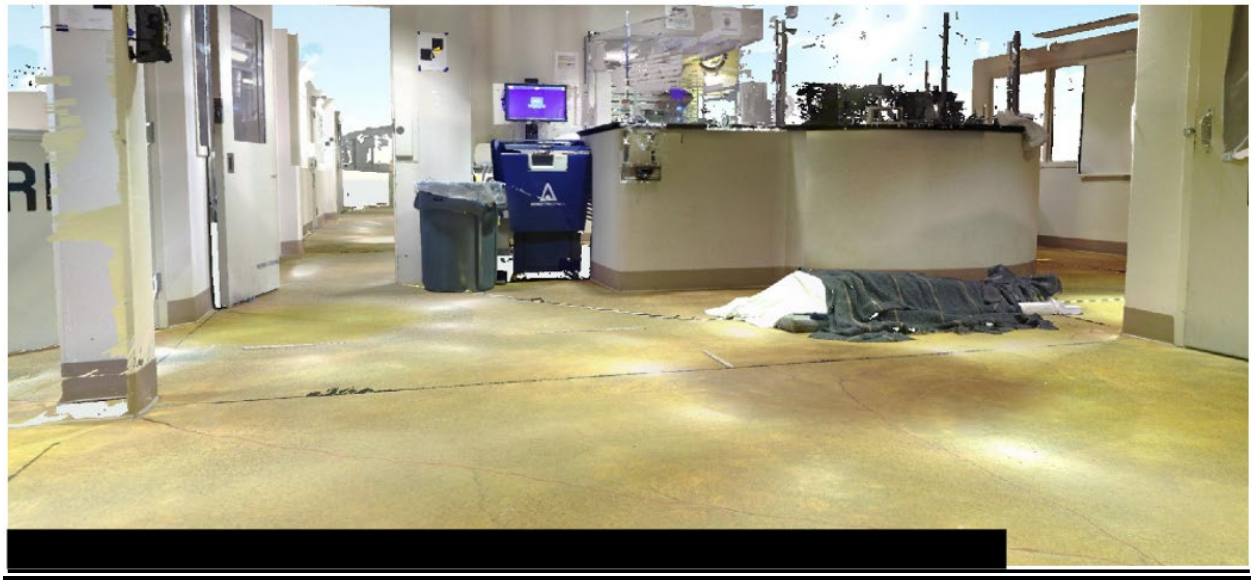

Figure 1: 3D scan of jail showing the booking desk. The "soft side" is the hallway to the left of the booking desk. Dorm 2 is down this hallway on the lefthand side. The "hard side" is to the right and behind the booking desk. Wiley was taken out of Dorm 2 and treated by medical personnel in front of the booking desk. His body is pictured here in front of the booking desk.

Figure 2: 3D scan of jail showing the "soft side." The booking desk is at the top left of the image blocked by the partition where the yellow trashcan is located. Dorm 2, where Wiley was housed, is at the bottom right of the image. Wiley's bunkbed is the left most bunkbed pictured at the top of Dorm 2.

4. <u>Interviews</u>

a. <u>Corrections Officers -</u>

All correction officers declined to provide statements to investigators.

b. <u>Nurse 1 –</u>

Nurse 1's regular work hours are Tuesday through Friday, 7:00 AM to 5:00 PM. Only one nurse works at the facility at a time. On the day of Wiley's death, Nurse 1 started work at 7:00 AM. The day shift COs start work one hour before her at 6:00 AM. They typically give her medical updates, including any updates that the night shift COs have provided. Nurse 1 said she was not given any information about Wiley, and because of that she did not provide him medical assistance. Nurse 1 further said the previous night's log also did not have medical notes on it for Wiley, and usually the log would mention if someone needed medical help. A few hours before Wiley died, just as she started her shift, she did provide medical assistance to another inmate in a different dorm who was withdrawing from alcohol. She was notified by COs that the person arrived at 2:00 AM and now needed help. He was transported to the hospital.

At 11:20 AM, 2-3 hours later, she was working in her office when a CO notified her that Wiley was not breathing. This is the first time she heard about Wiley needing medical assistance. She and CO 4 provided CPR and Narcan. AED was applied by CO 5, but no rhythm was located so no shock was advised. She said during booking Wiley did not claim to be on narcotics. Nurse 1 said that had Wiley self-reported at booking that he was under the influence of drugs, he would

have been taken to the hospital before even being booked. Nurse 1 also explained that she typically does not go into dorms. If inmates need medical attention, they come out of their dorm to be examined. As such, she never had contact with Wiley prior to providing lifesaving care.

c. Inmate 1 –

Inmate 1 was an inmate at the jail for approximately two weeks prior to Wiley's death. He explained he had been in Dorm 2 for the last several days. Normally there were approximately 10 inmates in the room at a time. They were a tightknit group except for a couple of people. Inmate 1 stated that Wiley came into the jail pod approximately 3 days prior. He explained that no one was close to Wiley. He described Wiley as a fly on the wall and kept to himself. He also said that Wiley had a large cyst on his neck (noted in Wiley's booking paperwork). Inmate 1 said that Wiley was sleeping on the first top bunk to the left as you come into the room, and Inmate 1 was on the rollout bed directly to the right as you come into the room. When Wiley first arrived, Inmate 1 asked if Wiley had been in before. Wiley confirmed he had been to jail before, and he was there for a theft charge. Wiley was very quiet and mainly slept on his bunk. He did not eat the meals when they were served. Inmate 1 assumed Wiley was "dope sick" because that is how Inmate 1 acts when he is "dope sick." At one point Inmate 1 did ask Wiley if he was coming down from something. Wiley admitted he was coming down from methamphetamine and fentanyl. Inmate 1 explained he thought maybe Wiley had something on him but that was just a theory. The night before Wiley died, he said that Wiley ate some chips. Wiley went to the toilet and threw up around midnight. Inmate 1 described Wiley just throwing up water. Inmate 1 went back to his bunk and someone asked Wiley if he was okay. Wiley stated he was not okay. That inmate got Wiley some water. One of the inmates hit the buzzer to get the CO because Wiley was throwing up. The CO (CO 1) explained she was the only one available and it would have to wait until there was another CO (video surveillance confirms this fact). An hour later Wiley threw up again. Some of the throw up went onto the floor next to his bunk before he made it to the toilet. A request was made by an inmate to a CO to get a mop and bucket to clean up the throw up. Nothing was brought to the inmates at that time. An hour later Wiley threw up again. Inmate 1 told Wiley he would help him. Inmate 1 moved Wiley's mat next to the toilet stall and gave him a sack to throw up in. An older inmate (later identified as Inmate 2) was sleeping under Wiley during the night and saw a CO walk by (CO 3). Inmate 2 began pounding on the window asking for a mop and bucket which he could see in the hallway. The CO allowed

Inmate 2 out. (Video surveillance shows this occurred after CO 1 and CO 2's shift ended - around 6:00 AM). Inmate 2 got the mop and bucket, and cleaned up the throw up. In the morning, breakfast was served from approximately 7:00 AM to 8:00 AM. Wiley got up, got some food, and sat down in a chair. Wiley tried to take a bite of the food however, he threw up again within 10 seconds. At the time, Wiley was responsive and still talking. Inmate 1 said everyone, for the most part, went back to sleep. While Inmate 1 was laying in his bed, Wiley got up, went to the toilet stall, closed the door, and sat down without pulling his pants down. After 3 to 4 minutes Wiley got up, walked out of the stall, did not flush, and did not wash his hands. Approximately 20 minutes later Wiley was dead. Others tried to get Wiley to wake up. They called for the COs. The COs came in and helped drag Wiley out of the dorm. The COs had the inmates clear out of the room. Inmate 1 stated there were no drugs in the unit.

d. Inmate 2 -

Inmate 2 explained he had been in the Issaquah Jail for approximately two weeks. He had been assigned to Dorm 2. When Wiley arrived in Dorm 2 approximately three days prior, Inmate 2 explained he could tell Wiley was coming down from being on drugs. Inmate 2 described Wiley's skin color as gray. Wiley did not talk to anyone. Wiley was in the same bunk as Inmate 2. Inmate 2 was on the bottom and Wiley was on the top. Inmate 2 observed Wiley was not eating and had been giving his food to others. Inmate 2 saw Wiley eat a sandwich at one point. During the morning of June 9th at approximately 2:30 AM Wiley went to the door and pushed the button to talk to the CO. He requested some help. The female CO (CO 1) explained she was alone at the moment, and he would have to wait until her partner was back from his break. Another inmate got on the intercom and stated he had Covid. The CO again stated they would have to wait. Inmate 2 stated Wiley began throwing up and at one point had thrown up off the top of the bed and onto the floor next to him. Wiley had his bed moved to the floor next to the bathroom. Inmate 2 got the attention of one of the COs. Inmate 2 asked for a mop and a bucket to clean up the throw up. Eventually Inmate 2 was given permission to get the bucket and clean up the throw up.

In the morning when breakfast was served, Inmate 1 told Wiley that he should give some of his food to Inmate 2 because Inmate 2 had to clean up the throw up. Inmate 2 declined the breakfast and told Wiley he needed to eat. Inmate 2 went back to his bunk and laid down. There

was a commotion in the room and Inmate 2 heard someone say that Wiley was dead. Inmate 2 observed Wiley was rigid on the floor and appeared to be dead. Inmate 2 pushed the intercom to the corrections staff to come help. A correction officer came in and Inmate 2 helped drag Wiley out of the room. Inmate 2 stated there were no drugs of any kind that he knew of.

e. Inmate 3 –

Inmate 3 said that he noticed last night that Wiley started coughing a lot. Inmate 3 said that Wiley seemed fine earlier in the night, but that later in the night after dinner, Wiley started to vomit. Inmate 3 described Wiley as coughing which prompted him to ask Wiley if he was coming off of drugs. Inmate 3 told investigators that Wiley said that he was on fentanyl. Inmate 3 said that he asked Wiley about taking suboxone, to which Wiley said, "I don't know how." Inmate 3 said that one of the inmates filled out a kite on Wiley's behalf. Inmate 3 said that the kite was then passed under the cell door at approximately 2:00 AM on June 9th. Inmate 3 said that in his experience, the kites are typically then picked up by a corrections officer or a trustee (inmate entrusted with extra privileges). Inmate 3 told investigators that after this, Wiley was "up and down puking." Inmate 3 said that he was sleeping when Wiley was discovered deceased.

f. Inmate 4 -

Inmate 4 (now deceased) described Wiley as "coming down hard and should have gone to the detox tank." Inmate 4 said that Wiley got in contact with a friend to let the friend know Wiley was in custody and "something with his car." Inmate 4 said that he had gone to court with Wiley on June 8th, the day before he died. Inmate 4 said that he and some of the other inmates who were familiar with opiates and fentanyl asked Wiley if he was okay, and at first, he said that he was. Inmate 4 said that the night Wiley died, Wiley said that he was not alright. Inmate 4 said that the emergency button was pressed but "nothing happened from that." Inmate 4 said that he was experienced with opiates and in his personal opinion, he believed that Wiley was likely using a half gram to a gram of fentanyl a day. Inmate 4 described Issaquah Jail as one of the better jails he had been committed to but said that he felt they needed to bring back their "subutex and suboxone" program because of the problem with people "coming down," getting sick and having epileptic seizures while detoxing in his presence. Inmate 4 did not think that this was Wiley's first time detoxing based on how he carried himself and "didn't bitch," even though he was "clearly going through it." Inmate 4 did not know who pushed the emergency button on

Wiley's behalf, but was not aware of any action taken to resolve the issue. Inmate 4 recalled hearing Wiley "choke," which he also described as "aspirating," but did not realize Wiley was not breathing and did not check on him further. It was 15 to 20 mins later that another inmate realized he was not breathing. He ended the interview stating that withdrawal should be taken more seriously by Issaquah jail.

g. Inmate 5 –

Inmate 5 said Wiley did not look "dope sick" when he came in, but got progressively worse. He observed Wiley breathing heavily and was agitated while sleeping. Inmate 5 said Wiley's death could have been prevented. He felt like after booking jail staff forgets inmates are there. Inmate 5 said on the morning Wiley died, he pressed the emergency button because one inmate (Inmate 8) said he had Covid and that Wiley was "throwing up, and like, throwing up bad." Inmate 5 said that he did so after asking Wiley if he wanted him to press the button. Inmate 5 asked Wiley if he was ok. Wiley said no. Inmate 5 told investigators that Wiley was "throwing up and 'dope sick.'" Inmate 5 said that corrections staff pulled out Inmate 8 who allegedly had Covid but not Wiley. Inmate 5 said jail staff should have helped Wiley, but they did not help him. Inmate 5 said Wiley later ate breakfast when it was served to the dorm, but he vomited it up. Inmate 5 said Wiley was making moaning sounds and breathing heavy during the night as he was constantly sitting up and laying down in his bed. Inmate 5 recognized Wiley as being "dope sick." Inmate 5 said that he woke up when somebody said that Wiley was not breathing. Inmate 5 said he woke up and saw Wiley and knew from personal experience and his appearance that Wiley was deceased.

h. Inmate 6 -

Inmate 6 said he had used the button for toilet paper and found that the COs were responsive to his request. Inmate 6 said that he had no interactions with Wiley other than just passing by each other. He said they did not talk, but Wiley did look sick from the time he got booked in. Inmate 6 said "yesterday" Wiley had been puking and "they" pressed the button and suggested he was looked at. Inmate 6 said there was no response for Wiley's needs that he was aware of. Inmate 6 said breakfast came on the morning of June 9th and that Wiley "puked it out." He said that he gave Wiley some bread and another inmate gave him an orange. While watching TV, Inmate 6 noticed Wiley was breathing weird, he later said heavily. Heavy breathing stopped,

so Inmate 6 continued watching TV. Ten to fifteen minutes later other inmates asked him to check if Wiley was breathing. Wiley's hands were up in the air.

i. Inmate 7 –

Inmate 7's bed was located on the other side of the dorm from Wiley's near the bathroom. He had been in the Issaquah Jail since February 15, 2023 and had been in Dorm 2 the entire time. He confirmed that Wiley came into the jail approximately 2 to 3 days prior. He described Wiley as quiet and kept to himself. Inmate 7 observed Wiley eat a couple of meals. Inmate 7 described Wiley as looking loaded on the first day in jail. Wiley looked like he was coming off of something; Wiley nodded off and could not keep his eyes open. He said that he could tell Wiley was "going through it," meaning that he was detoxing. He was yawning, sleeping, and restless. At midnight when they got back from the rec room, Inmate 7 asked Wiley if he needed anything because he could tell that Wiley was hurting. The night before he died Wiley later confirmed to Inmate 7 he was coming down off fentanyl. Wiley was not doing well and filled out a medical kite, stating he needed to see the nurse. Inmate 7 slid it under the door for Wiley on June 9, 2023 at approximately midnight. He said that he did not give it directly to a nurse. He just slid it under the door. Typically, the corrections officers collect the medical kites and gave them to the nurse. Inmate 7 went to bed around 2:30 AM and later woke up to Wiley going to the bathroom and throwing up 3 to 4 times. Eventually Wiley moved his mattress next to the bathroom, which allowed Inmate 7 to see Wiley a lot better. When breakfast was served Wiley ate a little but could not keep it down. Inmate 7 gave Wiley an orange thinking the Vitamin C would help. Inmate 7 fell back asleep and woke up to someone hitting the button stating Wiley was unresponsive. A correctional officer (CO 6) then came into the room, checked Wiley’s pulse, and helped drag Wiley out on the mat. Inmate 7 and the other inmates were moved into the rec room.

j. Inmate 8 –

Inmate 8 was assigned the top bunk next to Wiley. He said Wiley looked sick from the time he entered the jail. Wiley slept the whole time. Wiley threw up on June 8th and June 9th. Just prior to Wiley dying, Inmate 8 said he was using the bathroom stall next to where Wiley placed his mattress on the floor and was laying down. Inmate 8 said he could hear that Wiley's breathing was labored. He said, had Wiley been given help sooner, he thinks he would have lived.

5. Video Surveillance

The jail provided video footage of Dorm 2 for the few days leading up to Wiley's death. It also provided footage of the hallway and booking desk for various times, but none for the dayshift on the day Wiley passed away. The cameras are motion-activated so only capture periods when individuals are moving.

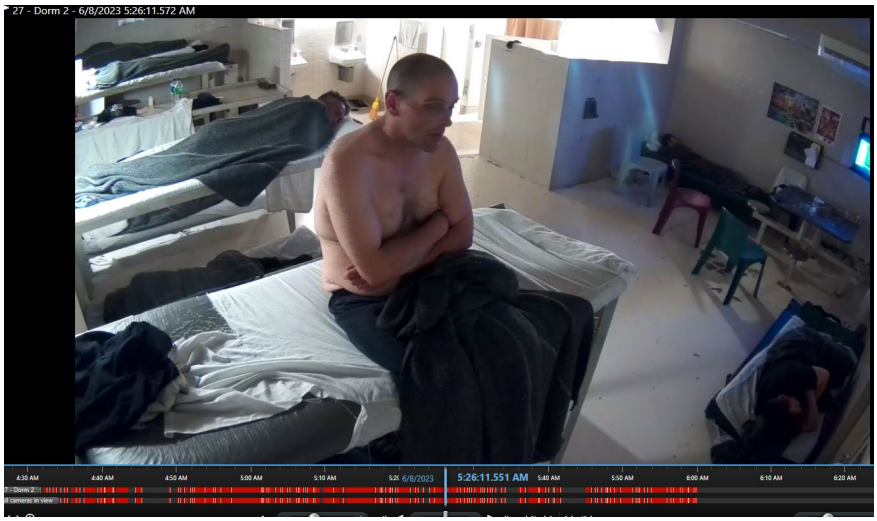

Figure 3: Surveillance footage of Wiley in Dorm 2 the day prior to his death.

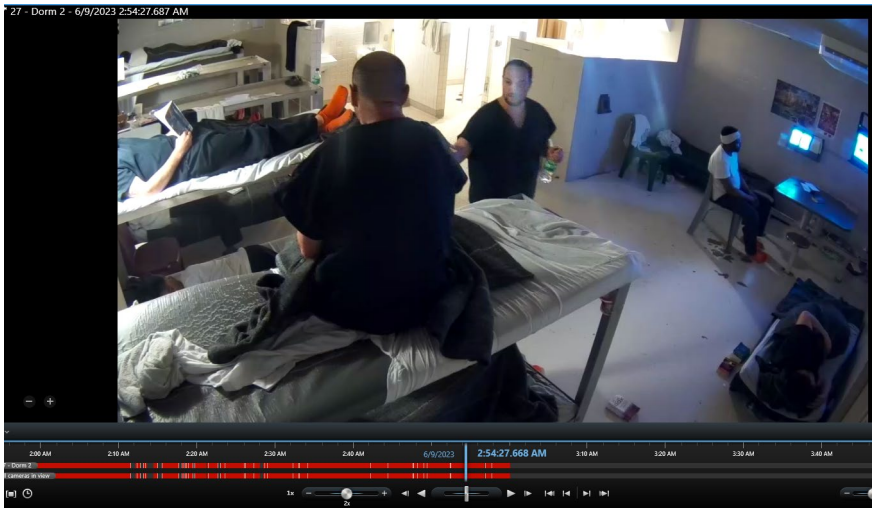

Figure 4: Surveillance footage of Wiley exchanging a medical kite with Inmate 7 at 2:54 AM the morning of his passing.

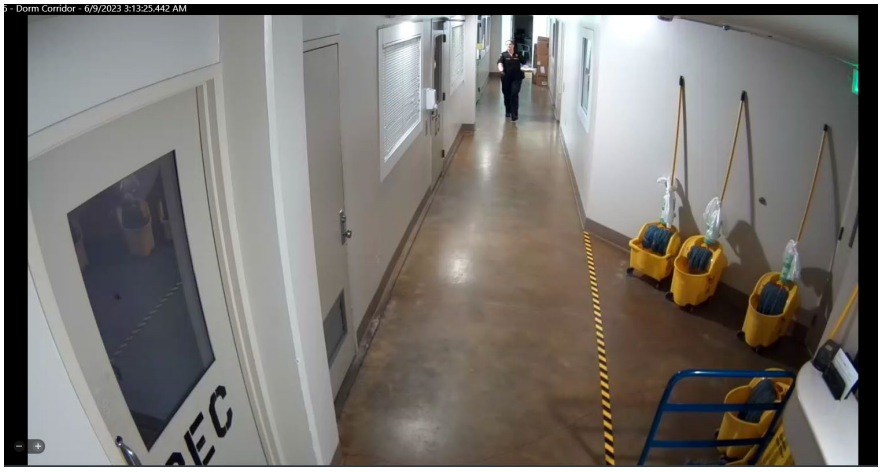

Figure 5: Surveillance footage of the soft side hallway approximately 20 minutes later. CO 1 is walking by Dorm 2 on her way back to the booking desk. The medical kite does not appear to be outside of the door to Dorm 2.

Figure 6: Left, at 4:25 AM, surveillance footage of Inmate 5 using the intercom to inform CO 1 that (1) Inmate 8 believes he has Covid-19 and (2) Wiley, pictured in the bathroom stall on the left, needs medical assistance. Right, surveillance footage of CO 1 talking with Inmate 5 over the intercom. Neither video camera records audio.

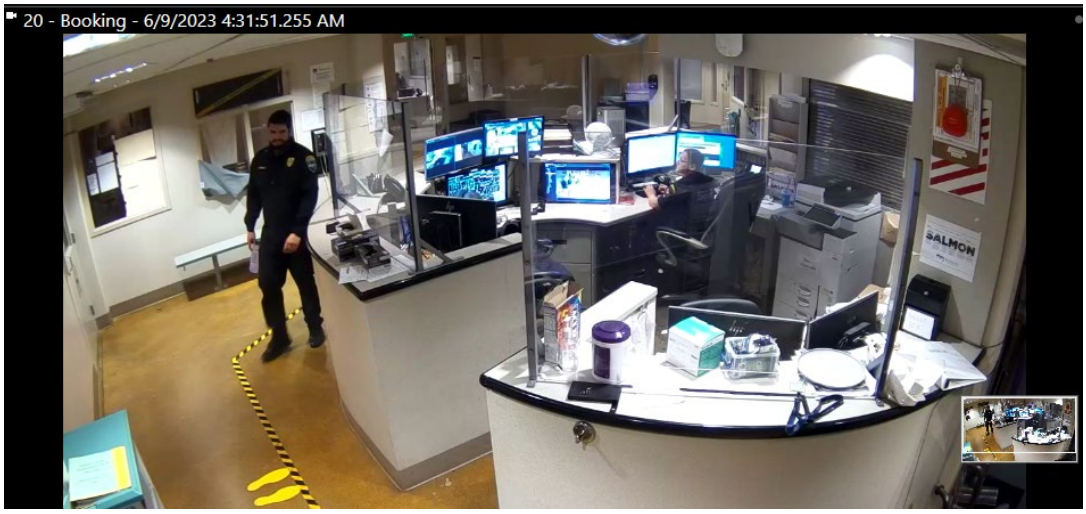

Figure 7: At 4:31 AM, surveillance footage shows CO 2, left, returning to work from his hour-long break. CO 1 is seated at her workstation.

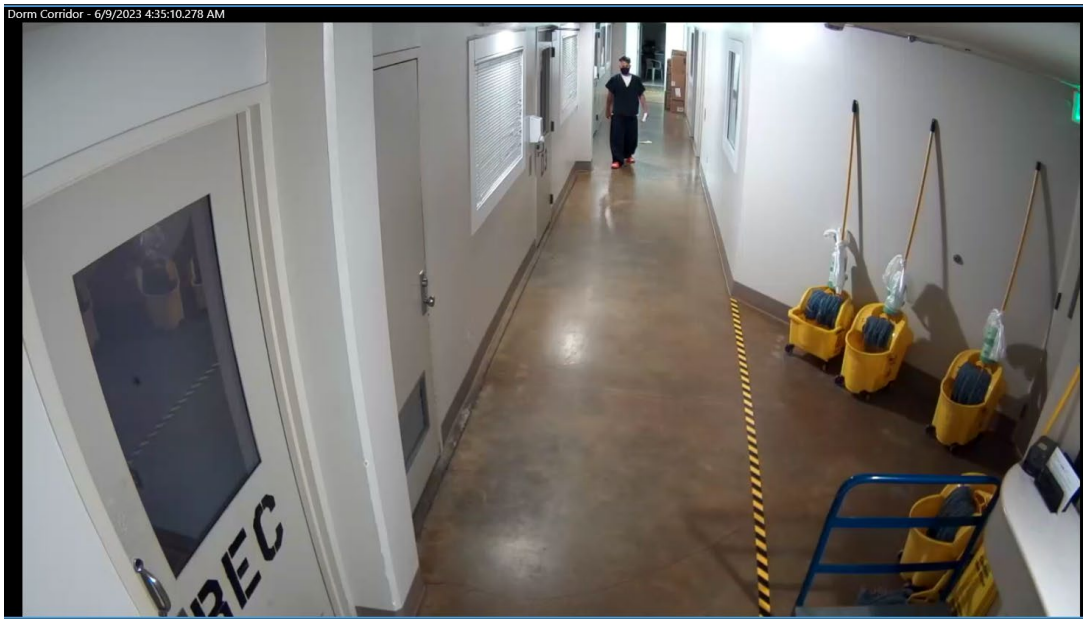

Figure 8: A 4:35 AM, surveillance footage shows Inmate 8 walking down the hall from Dorm 2 to the booking counter to receive a Covid-19 test from CO 1. What could possibly be Wiley's medical kite is pictured on the ground in front of Dorm 2, to Inmate 8's left.

Figure 9: A 5:47 AM, surveillance footage shows Wiley vomiting from his top bunkbed.

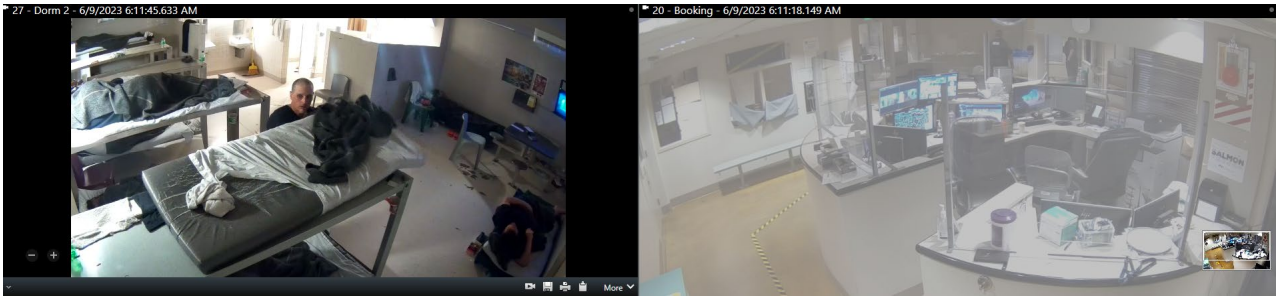

Figure 10: Approximately 25 minutes later, at 6:11 AM, Wiley is captured moving his bed mattress to the ground in front of the bathroom. At that time both corrections officers were away from the monitor performing other jail tasks.

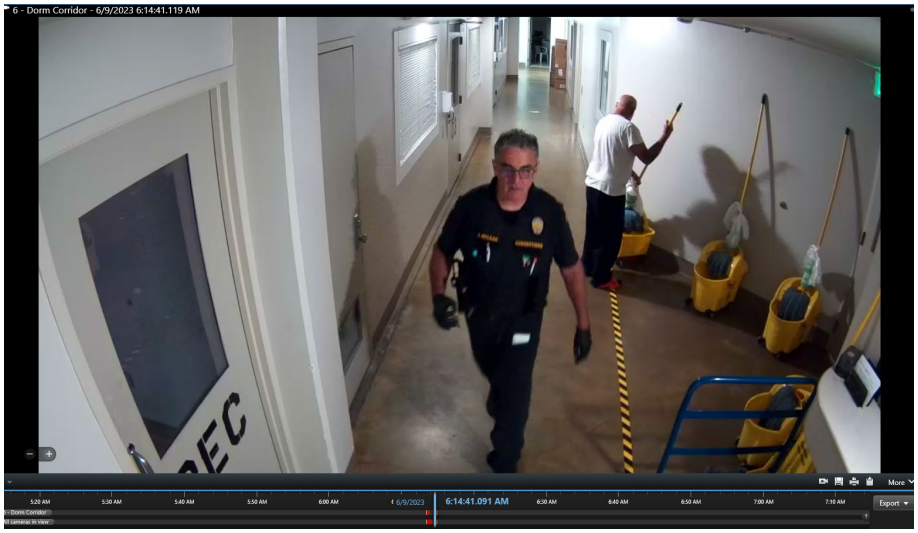

Figure 11: At 6:14 AM, dayshift officer CO 3 (left) permits Inmate 2 (right) to retrieve a mop to clean up Wiley's vomit. What could possibly be Wiley's medical kite is pictured on the ground in front of Dorm 2 at the top of the image.

Figure 12: At 6:20 AM, Inmate 2 cleans up Wiley's vomit. Wiley is seen laying down on the floor to Inmate 2's right.

Figure 13: At 6:40 AM, Wiley is vomiting in a trash bag provided to him by Inmate 2.

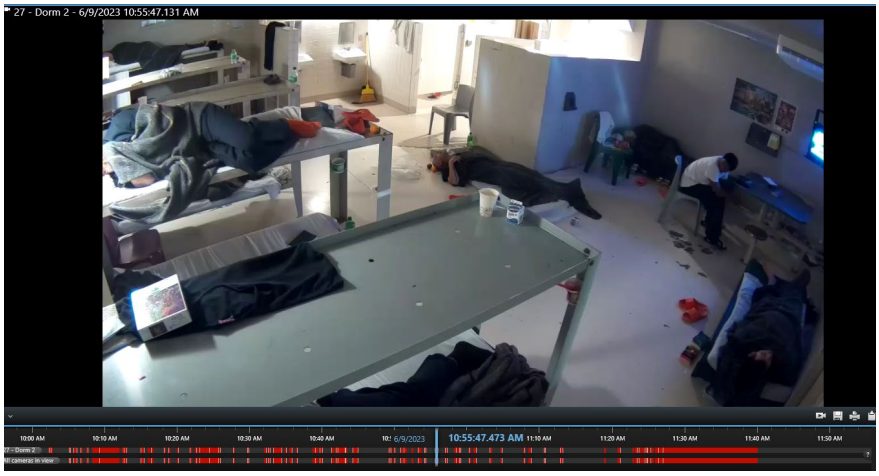

Figure 14: At 10:55 AM, Wiley's hands appear to seize up. No other inmate seems to notice the change in Wiley.

Figure 15: At 11:26 AM, the inmate realize that Wiley is likely not breathing. They inform corrections officers.

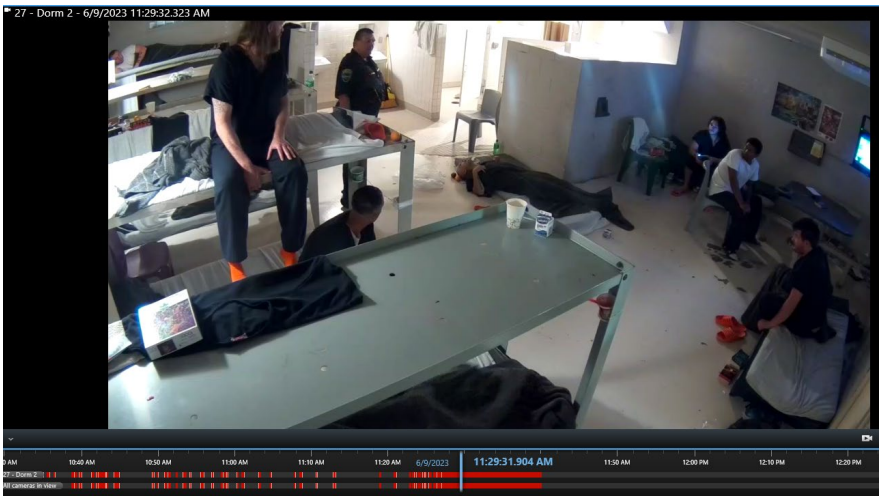

Figure 16: At 11:29 AM, the first CO enters the dorm and sees Wiley is not breathing. He requests medical aid.

6. Jail Call

Wiley made an approximately nine-minute-long call to a bail bondsman the day he was arrested. He sounded coherent, did not speak rapidly, and showed no obvious signs of being under the influence of narcotics.

7. Autopsy Report

On June 12, 2023, an autopsy of Wiley's body was performed by the King County Medical Examiner's Office. The Medical Examiner concluded, "This 43-year-old male was found unresponsive in jail. Cause of death is acute combined drug intoxication including fentanyl and methamphetamine. Atherosclerotic cardiovascular disease is a contributory condition. The manner of death is accident."

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. (RCW 9A.32.070 & WPIC 28.06).

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. (WPIC 10.04).

V. ANALYSIS AND CONCLUSION

There is insufficient evidence to establish beyond a reasonable doubt that Corrections Officer 1 and Corrections Officer 2 should have known that their inaction created a substantial risk of death. Wiley was indeed objectively ill, due to the combined missed opportunities by themselves and other employees at Issaquah Jail, the extent and severity of Wiley's medical condition was not clearly apparent to them, specifically that Wiley was near death. As a result, KCPAO declines to file criminal charges against former Issaquah Corrections Officers CO 1 or CO 2, or any other Issaquah jail staff member.

The missteps that obscured the extent of Wiley's condition were as follows:

First, the extent of Wiley's condition was not made apparent at his booking. On his booking paperwork he stated that he took fentanyl 20 hours prior to his arrest. However, the arresting officer who booked Wiley into jail failed to note on the booking paperwork that Wiley was arrested with approximately twenty-five M-30 pills or whether Wiley was experiencing withdrawal symptoms. The notes on the booking paperwork are relied upon by jail staff throughout the inmates stay. As a result, neither the nurse nor COs were put on notice that Wiley may be experiencing symptoms of withdrawal.

Second, the following day another inmate in Wiley's dorm, Inmate 4 (now deceased), noticed that Wiley looked unwell at his video court appearance. However, Wiley's condition was either not caught or noted by jail corrections officers. Neither CO 1 nor CO 2 was on duty during this timeframe, as they worked the evening shift, so were not privy to this information.

Third, corrections officers on various shifts either did not notice or did not take note of the multiple times Wiley vomited in his dorm room, even though the dorm room is constantly monitored by video camera and Wiley's bunk was in the most prominent position in the frame.

Fourth, hourly checks were not performed by night shift CO 1 or CO 2 the morning Wiley passed away. Had they been performed, the COs would have recovered Wiley's medical kite stating that he needed to see a nurse because he was detoxing. This failure may have been negligent, but CO 1 and CO 2's shift ended at 6:00 AM. Wiley's condition worsened after their

shift ended. He did not die on their shift, but expired approximately 5 ½ hours after they went home.

Fifth, CO 1 did not act on or relay to medical personnel or to the dayshift COs the information about Wiley's medical condition after it was passed onto her via intercom by Inmate 5. Not only did this information not appear in the nightly briefing log filled out by her partner, CO 2, but there is no evidence that it was conveyed by CO 1 or CO 2 to dayshift CO 3 who took over for them at the end of their shift. Nurse 1 later stated that she did not treat Wiley when she started working at 7:00 AM on the morning of his death because neither the briefing log nor the update she received from day shift COs mentioned Wiley being ill.

Sixth, the jail does not employ a nurse during non-business hours, during the time when it became apparent to inmates that Wiley needed medical attention.

Seventh, CO 3 did not check on Wiley's condition or notice Wiley's medical kite on the ground when he let Inmate 2 out of Dorm 2 to obtain a mop to clean up Wiley's vomit.

When analyzing the strength of the evidence against CO 1 and CO 2, it is necessary to point out that although video footage of Dorm 2 shows that Wiley was agitated, could not sleep and was vomiting, unless they were meticulously watching every second of the footage, it was not readily apparent how sick Wiley truly was. COs have job responsibilities that do not permit them to monitor every second of footage like an investigator after the fact, such as booking and releasing inmates, bail outs, checking incoming mail, meal delivery, and general security. As a result, a fact that might appear obvious to the outside viewer may not have been as obvious at the time.

While the conduct of CO 1 and CO 2 may be disappointing, the investigation did not uncover sufficient evidence that would permit a reasonable and objective fact-finder to conclude that CO 1 and CO 2 acted with criminal negligence and are guilty of manslaughter in the second degree. Specifically, there is insufficient evidence to prove that CO 1 and CO 2 were aware of a substantial risk of death to Wiley caused by their inaction. (see WPIC 10.04). This is in part due to how Wiley presented at booking, failures of other jail staff to recognize and report Wiley's worsening condition, and CO 1 and CO 2's failure to perform their basic job duties. Moreover, the intercom communication between Inmate 5 and CO 1 was not recorded and investigators were not able to definitively establish that the paper in the surveillance video was indeed the medical kite filled out for Wiley. Without this evidence, it cannot be proven beyond a reasonable

doubt that CO 1 and CO 2 are guilty of manslaughter in the second degree. As such, the KCPAO declines to file criminal charges against them.[1]

VI. 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.

[1] It should be noted that CO 1 and CO 2 were either fired or resigned from Issaquah Police Department after Mr. Wiley's in-custody death.