

**In-Custody Death of  
Derek Hutchinson**

Kent Police Department, #2017-14631



King County Prosecuting Attorney  
Public Integrity Team

April 19, 2023



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## **DECLINE MEMORANDUM**

### In-Custody Death of **Derek Hutchinson**

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#### **I. OVERVIEW**

Subject, Derek Hutchinson was in his jailcell at the Maleng Regional Justice Center jail (MRJC) when he got up to get a drink. As he faced the sink, he fell backward into the middle of room, knocking over a chair. His cellmate asked him if he was okay. Mr. Hutchinson had difficulty responding. A corrections officer responded to the cell. Mr. Hutchinson was not able to respond clearly to him either. He was drooling. The officer asked if he needed medical attention and inmate shook his head yes. He was given lifesaving aid and then transported to Valley Medical Center. He passed away the following day. His cause of death is peritonitis due to a perforated duodenal ulcer. The manner of death is natural.

The King County Prosecuting Attorney's role is to ensure that an in-custody death investigation is thorough and complete, determine whether sufficient admissible evidence exists to support filing criminal charges, and make a recommendation to the King County Executive as to 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 Public Integrity Team has determined that the investigation of the September 25, 2017 in-custody death of Derek Hutchinson is complete. Based on a thorough review, the Team has concluded that the evidence is insufficient to support criminal charges against any King County Department of Adult and Juvenile Detention corrections officer (CO) or jail staff. Accordingly, the KCPAO is declining to file criminal charges in this matter based on the evidence presently

available. Additionally, KCPAO does not recommend an inquest be initiated because based on a review of the investigation, that the role of law enforcement was *de minimis* and did not contribute in any discernable way to a Mr. Hutchinson's death. *Executive Order PHL 7-1-5 EO, §6.1.*

This determination is based entirely on the relevant criminal laws, rules of evidence governing criminal proceedings, and the criminal burden of proof in Washington. Additionally, the current determination that the evidence is insufficient to support criminal charges does not limit administrative action by the involved agency, or any other civil action. The Team expresses no opinion regarding the propriety or likely outcome of any such actions.

## II. INVESTIGATION AND EVIDENCE

### a. Items Reviewed:

- Statement from Corrections Officer Witnesses
- Statement of Cellmate
- Jail Health Records
- KCME Autopsy Report
- Jail Calls
- Photos
- Jail Videos

### b. Timeline:

- 8:15 AM: Mr. Hutchinson requested to be transferred to Harborview. He was transferred to another cell after being cleared by a nurse.
- 7:37 AM: Mr. Hutchinson fell in his cell after experiencing a seizure. Corrections Officer #3 responded to Mr. Hutchinson's cell.
- 7:45 PM: Mr. Hutchinson was placed on AED; "No Shock" was advised.
- 7:50 PM: Kent Fire responded to Mary East Unit.
- 7:52 PM: CPR was started on Mr. Hutchinson
- 7:58 PM: Medic One responded to Mary East Unit.
- 8:01 PM: Tri-Med responded to Mary East Unit.

- 8:12 PM: AED "No Shock" was advised 2 more times. CPR continued. Medics contacted Kent P.D.
- 8:14 PM: Facility lock down announced.
- 8:16 PM: Kent P.D. responded to Mary East Unit.
- 8:32 PM: Mr. Hutchinson regained a slight pulse. Mr. Hutchinson transported to the Intake, Transfer, and Release facility (ITR) by officers and medic staff.
- 8:45 PM: Medical Status 3 cleared.
- 5:33 AM (Sept. 26<sup>th</sup>): Pronounced deceased.

### III. FACTUAL ANALYSIS

At approximately 6:00 PM on September 21, 2017, Derek Duane Hutchinson was booked into the King County Correctional Facility for possession of narcotics and a Department of Corrections (DOC) warrant for escaping from community custody.

Mr. Hutchinson was initially examined at Pre-Book by Jail Health Services (JHS) Nurse #1 for an "Injury." During his exam he claimed to have a history of umbilical hernia for the last 5 years stating that its size never changed and he never sought treatment for the issue. He did not complain to be experiencing pain when he was booked. No current medical problems were observed, so Mr. Hutchinson was cleared to enter the facility, subsequently processed, and transferred to S09LD for housing at about 8:23 PM on September 21, 2017.

On September 22, 2017, at about 3:48 AM, Mr. Hutchinson was transferred to the MRJC jail. He was housed in RME-123L.

Corrections Officer #2 stated in a post-incident interview that on September 25, 2017 at about 8:15 AM Mr. Hutchinson approached Corrections Officer #1 at the staff station and "demanded" to go to Harborview Medical Center. Corrections Officer #1 explained the kite system to the inmate. Mr. Hutchinson then asked to see the nurse immediately. Corrections Officer #1 said he would contact the nurse and relay any relevant information. Corrections Officer #2 could see and hear the interaction between Mr. Hutchinson and Corrections Officer #1. Corrections Officer #2 said that Mr. Hutchinson was speaking normally, although somewhat

demanding, and did not show any outward signs of distress. When Mr. Hutchinson became aware that the Corrections Officer #1 would not call the nurse for immediate action Corrections Officer #2 observed Mr. Hutchinson lower his body partially to the floor and then drop a short distance to lay on the floor next to the staff station. At that point the nurse was called to see Mr. Hutchinson for heroin withdrawal and abdomen pain. He denied withdrawing and refused a urine test. He complained of nausea and vomiting. He was cleared after no concerning symptoms were observed by JHS staff.

Corrections Officer #2 stated they decided to move Mr. Hutchinson to a lower tier because they were concerned he may try to create an opportunity for an injury when returning to his cell on the upper tier in order to force JHS to send him to the hospital. The move was made out of an abundance of caution to prevent what officers called any unnecessary hospital transports. Corrections Officer #2 escorted Mr. Hutchinson to his lower tier housing assignment. Mr. Hutchinson walked to his new housing assignment under his own power.

At 7:37 PM, an inmate in the dayroom told Corrections Officer #3 that an inmate in cell M-009 was having a seizure. Corrections Officer #3 responded to the cell and observed Mr. Hutchinson on the floor next to his bunk. He was alert and awake. Corrections Officer #3 asked him if he was okay and if he needed a nurse. Hutchinson replied, "Yes, thank you." Corrections Officer #3 notified Nurse #2 via telephone and she requested that a medical status be called. Corrections Officer #3 notified Central Control via radio and a medical status II was initiated.

Mr. Hutchinson's cellmate, Cellmate #1, later told investigators that Mr. Hutchinson got up to get a drink. While he was facing a sink, he fell backward into middle of room, knocking over a chair. Cellmate #1 asked if he was okay. Mr. Hutchinson was unable to respond. He said an officer responded to the cell. Mr. Hutchinson was not able to respond to him either. Mr. Hutchinson was drooling. The officer asked if he needed medical attention and Mr. Hutchinson shook his head yes.

Additional corrections officers and nurses responded to aid Mr. Hutchinson. They immediately began to render first aid to Hutchinson. At 7:38 PM Nurse #2 requested that 911 be called because the inmate was breathing, but he was unconscious. Nurse #2 also ordered that the

situation be ungraded to a medical status III. After several minutes, they applied an AED and "no shock" was advised several times. Kent Fire arrived at 7:50 PM and at 7:52 PM, they began CPR. At 8:12 PM, anticipating that Hutchinson was not going to be revived, Kent Fire requested that Kent Police Department respond to the facility. The facility was placed on lockdown per Captain #1 at 8:14 PM. CPR was continued for nearly 40 minutes when they finally detected a faint pulse. Hutchinson was placed on a gurney and transported via ambulance to Valley Medical Center escorted by Corrections Officer #4.

On Sept. 26, 2017 at 5:20 AM, Mr. Hutchinson stopped breathing. Hospital medical staff performed CPR, but were unsuccessful. Mr. Hutchinson was pronounced deceased at 5:33 AM.

The medical examiner performed an autopsy and found that this 43-year-old man was an inmate housed at the King County Regional Justice Center when he was witnessed by his cellmate to become unresponsive. He was transported to hospital where he died despite resuscitative efforts. The cause of death is certified as peritonitis due to perforated duodenal ulcer. The manner of death is natural.

#### **IV. 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 any corrections officers or JHS staff played a role in Mr. Hutchinson's death, let alone committed a criminal act that caused his death. As a result, KCPAO will not file any criminal charges.

#### **V. RECOMMENDATION FOR INQUEST**

Because the role of law enforcement was *de minimis* and did not contribute in any discernable way to a Mr. Hutchinson's death an inquest is not recommended. *Executive Order PHL 7-1-5 EO, §6.1.*