King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident 23-00557

Report to the Legislature

As required by Revised Code of Washington 70.48.510

Date of Publication: June 1, 2023

Contents

Resident Information

The decedent was a 58-year-old female with medical history including bipolar disorder and substance use disorder. The decedent had vital sign monitoring and medical and mental health treatment provided by Jail Health Services. The decedent was assigned to single room housing in medical housing for the duration of the booking.

Incident Overview

On March 17, 2023, according to Seattle Police Department (SPD) records, SPD officers responded to a call about an individual allegedly stealing merchandise from a local store. Around 1306 hours, SPD officers arrived at the store and placed the decedent under arrest for Investigation Burglary, Criminal Trespass 1, and Theft. Additionally, the decedent had four warrants for property crimes listed in King County Mental Health Court.

The decedent was initially declined for booking on March 17, 2023, at about 1500 and was transported by SPD to Harborview Medical Center (HMC) to be medically cleared related to possible skin infection. SPD returned to the King County Correctional Facility (KCCF) at about 2140 on March 17, 2023, when the decedent was booked into the facility.

Once the decedent was returned to KCCF they were processed for the charges listed above. Jail Health Services (JHS) clinicians reviewed the emergency department information concerning the treatment that was provided at HMC. JHS clinicians also reviewed the past jail records, which confirmed diagnosis and medication treatment for mental illness. The decedent was transferred to psychiatric housing. Psychiatric providers were also sent notification in the electronic health record for possible prescribing.

For the safety and security of all staff and inmates inside the jail, anyone who is booked into jail must be searched and must change into jail-issued clothing. The decedent was seen by JHS at prebook and escorted to the dress out area. The decedent changed into a Jail uniform without any issue and was escorted to a single occupancy cell to await further processing**.**

The decedent was assigned to psychiatric housing on March 18, 2023. Upon evaluation by a Psychiatric Evaluation Specialist (PES) the decedent was found in soiled clothing, complaining of diarrhea. The PES reviewed health record information from past bookings and found that historically, the decedent was able to be stabilized on medications and be housed in non-psychiatric housing. A psychiatric provider then ordered the decedent's usual medications and Pedialyte for diarrhea. Later that evening the decedent showered, was given a clean uniform and transferred to a clean cell. Vital signs were normal, and the decedent was without fever. Over the next two days the decedent chose not to engage in a second PES visit nor several nurse encounters. The decedent refused all medications. Nevertheless, the decedent said

they were "okay" on March 19, 2023, and accepted Pedialyte on March 20, 2023, in the morning.

On March 21, 2023, at about 0605 an Officer conducting security checks in compliance with policy observed the decedent unresponsive on the floor of their room. Officers working in that housing area called for an emergency response. When the Supervisor arrived, the decedent was moved to the larger common area directly outside the room so that responding medical staff could provide aid. Officers started CPR as JHS medically assessed the decedent. JHS applied an Automated External Defibrillator (AED). The AED displayed "No Shock Advised", indicating that the decedent's heart rhythm could not be treated by shock.

On March 21, 2023, at about 0627 Seattle Fire Department (SFD) and Medic One staff arrived to continue medical aid. At about 0648 Medic One staff ceased life saving measures and declared the individual deceased.

DAJD staff called SPD to inform them of the in-custody death and to request an investigation. The first SPD officer arrived to KCCF at 0711 hours, and the investigation was passed from patrol to the SPD Force Investigation Team (FIT).

An autopsy was performed on March 22, 2023**.** Per the King County Medical Examiner's autopsy report:

1. The manner of death is best certified: **Natural**
2. The cause of death is: **Arrhythmogenic right ventricular dysplasia**

<u>UFR Committee Meeting Information</u>

Meeting dates: April 3, 2023, via virtual conference

<u>Committee members in attendance</u>

Department of Seattle-King County Public Health, Jail Health Services Division

- Danotra McBride, Director
- Dr. Ben Sanders, Medical Director
- Dr. John Rose, Managing Psychiatrist

DAJD Administration

- Allen Nance, Director
- Steve Larsen, Deputy Director

DAJD Facility Command Staff

- Facility Commander Troy Bacon
- Facility Major Michael Taylor

DAJD Investigations Unit
- Captain Jennifer Schneider
- Sergeant Benjamin Frary

Committee Discussion

The potential factors reviewed include:

A. Structural
    a. Risk factors present in design or environment
    b. Broken or altered fixtures or furnishings
    c. Security/Security measures circumvented or compromised
    d. Lighting
    e. Layout of incident location
    f. Camera locations

B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with Jail Health Services (JHS)
    c. Relevant root cause analysis and/or corrective action

C. Operational
    a. Supervision (e.g. security checks, kite requests)
    b. Classification and housing
    c. Staffing levels
    d. Video review if applicable
    e. Presence of contraband
    f. Training recommendations
    g. Inmate phone call and video visit review
    h. Known self-harm statements
    i. Life saving measures taken
    j. Use of Force review

Committee Findings

Structural

The incident took place in a single-occupant cell in the psychiatric housing area of the King County Correctional Facility. There are several surveillance cameras in the common area, however by design, none are directed to view inside housing cells. There are no known contributing structural factors in this incident.

Clinical

The decedent was very briefly in custody at the King County Correctional Facility

Jail Health Services did not identify issues or problems with policies/procedures, training, supervision/management, personnel, culture, or other variables in JHS.

Operational

The area of this incident was fully staffed. Reviewed video and JMS records show that security checks leading up to this event were conducted within policy. Lifesaving measures (CPR) began promptly and continued until staff were properly relieved by JHS and SFD medics.

Committee Recommendations

There are no structural, Clinical or Operational changes identified.

Legislative Directive - Per Revised Code of Washington 70.48.510

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

Disclosure of Information
RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and

maintained. An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(2)(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.