



Department of Adult and Juvenile Detention

# Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-00546  
Report to the Legislature

*As required by Engrossed Substitute Senate Bill 5119 (2021)*

Date of Publication: July 13, 2022

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### Inmate Information

The deceased inmate was a 53-year-old male with no significant medical history. He was booked into the King County Correctional Facility (KCCF) in Seattle by the King County Sheriff's Office at 1153 hours on March 25, 2022.

### Incident Overview

At approximately 1309 hours on March 27, 2022, a uniformed officer was conducting a security check on the 8<sup>th</sup> floor of KCCF when he discovered the subject hanging from a ligature made from a bedsheet secured over the top of the cell door.

A medical emergency was called immediately, and uniformed staff used a rescue knife to cut the ligature then lower the subject to the floor. Staff began CPR and continued lifesaving attempts which included application of an AED, which reported "unable to analyze". At approximately 1311 hours, Jail Health Services nurses arrived with their crash cart which also included an AED unit. That AED was applied but reported that the inmate was not treatable by shock. CPR continued until DAJD and JHS staff were relieved by responding medics.

Seattle Fire Department (SFD)/Medic One arrived at 1320 hours and continued lifesaving operations. The subject was pronounced deceased by Medic One personnel at 1358 hours.

The Seattle Police Department (SPD) was called to investigate this in-custody death, and the first officers arrived on scene at 1440 hours. At the time of this report, SPD has not completed their investigation.

The King County Medical Examiner's Office autopsy report lists the cause of death as asphyxia due to ligature hanging and the manner as suicide.

## UFR Committee Meeting Information

Meeting date: April 21, 2022 via virtual conference

### Committee members in attendance

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

- Danotra McBride, Director
- Dr. Ben Sanders, Medical Director
- Dr. Ryan Quirk, Psychiatric & Social Services Manager

DAJD Administration

- John Diaz, Director
- Hikari Tamura, Deputy Director

DAJD Facility Command Staff

- Facility Commander Todd Clark
- Major Troy Bacon

DAJD Investigations Unit

- Captain Michael Taylor
- Sergeant Fred Graves

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## 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

## Committee Findings

### Structural

The incident took place in a single-occupant cell on the 8th floor of the King County Correctional Facility. The cell had adequate lighting from the cell window, which was not covered, as well as from the ceiling light. All fixtures in this housing cell, including the emergency call button, were functional.

The only camera with recording capabilities in this housing area shows only the core area of the unit and does not capture the living unit the incident occurred in.

The AED first used in this incident is kept on the housing floor, near the living units. When applied, it read "unable to analyze," which can be the result of mechanical failure of the unit or improper application. DAJD Maintenance performs monthly function testing, and records show this unit was fully functional when inspected in March 2022.

The AED unit first used in this incident was sent to SFD/Medic One for data collection. Because no usage log could be found, the cause for the inability to analyze could not be determined.

The method used to anchor the ligature was to make a knot in the loose end of the bedsheet, placing that knot around the top of, and outside the cell door, and closing the door with the remaining sheet inside the cell. The doors in this housing unit are not controlled mechanically and must be closed manually.

### Clinical

Patient denied any psychiatric history or suicidal ideation during the booking process, no prior bookings in King County.

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 and all responding DAJD staff acted within policy. DAJD uniformed staff immediately began CPR and continued its application until relieved first by JHS, then by Seattle Fire Department medics.

There is video of this housing wing, and it shows security checks being done in accordance with policy.

### Committee Recommendations

Tracking numbers should be affixed to all AEDs in use within DAJD and Jail Health Services to allow for better tracking of individual units.

Policy/practice changes should be made both within DAJD and JHS to ensure AEDs used in lifesaving events are sent out of the facility with responding medics for data collection.

AED training for DAJD staff should be updated to include these changes.

## Legislative Directive

Per ESSB 5119 (2021)

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.