King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-00418

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Date of Publication: June 24, 2022

Contents

Inmate Information

The subject was a 25-year-old transgender/gender fluid individual with a history of mental health issues and repeated self-harm events, as well as chronic medical problems. They were booked into the King County Correctional Facility (KCCF) in Seattle by the Seattle Police Department at 0916 hours on February 3, 2022.

Incident Overview

At about 1112 hours on March 10, 2022, DAJD uniformed staff were feeding lunch to inmates housed on the 9th floor of the King County Correctional Facility (KCCF). As the officer delivered the meal tray, she observed the subject kneeling in front of the lower cell bunk, with a sheet apparently tied around their neck. The officer attempted to interact with the subject however they were unresponsive. The officer immediately called for a medical emergency, which was announced at 1112 hours.

Responding staff entered the cell and found the subject had a ligature tied around their neck and affixed to the unoccupied upper bunk of the cell. Staff were able to lift the individual up and untie the knot, then begin lifesaving measures including starting CPR and connecting an AED machine, which reported "no shock advised."

Uniformed staff and responding Jail Health staff continued CPR until relieved by Seattle Fire Department (SFD) paramedics at approximately 1122 hours. The subject was taken to Harborview Medical Center (HMC) for further treatment by Medic One, departing KCCF at approximately 1140 hours.

The subject was released from King County/DAJD custody on March 14, 2022, while still at HMC.

On March 15, 2022 the subject passed away while at HMC.

The incident was reported to the Seattle Police Department, who began an investigation. At the time of this report, that investigation is still ongoing.

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

UFR Committee Meeting Information

Meeting date: June 2, 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
- Interim Commander Troy Bacon
- Interim Commander Lisaye Manning
- Corrections Program Administrator Gregg Curtis

DAJD Investigations Unit
- Captain Michael Taylor
- Sergeant Benjamin Frary
- Records Manager Audrey Hoover

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 9th floor of the King County Correctional Facility. The cell had adequate lighting from the cell window which was not covered as well as the ceiling light. There is a surveillance camera located in the subject's housing area which shows the outside of the cell door but does not show inside the cell. All fixtures in the cell including the emergency call button were functional.

The method used to anchor the ligature was a loop created by tying a bedsheet laterally around the unoccupied top bunk of the cell. Another section of bedsheet was then used as a ligature around the subject's neck and tied to the loop.

Clinical

Jail Health Services determined that there was an equipment issue in this case, as the code response cart was not stocked with an Ambu Bag, delaying bag-assisted rescue breathing at the start of the code response. A pocket mask was used for ventilation until the Ambu Bag arrived on scene.

Another issue noted was the delay in a medical provider assuming the role of Code Leader at the code site, despite multiple providers being present at the site. This was identified as a training / procedure issue for medical providers.

Jail Health Services detected that there was apparent confusion regarding court documentation (and associated timeframes), referral to an outside agency for possible civil commitment (and when that assessment could take place), and when the subject was eligible for release to the community, which resulted in the subject remaining in jail custody past the expiration date included on the court documentation.

Operational

The area of this incident was fully staffed and all responding DAJD staff acted within policy. DAJD uniformed staff and responding Jail Health Staff began CPR and continued its application until relieved by the Seattle Fire Department. There is video of this housing unit which was reviewed and showed security checks being done in accordance with policy.

It was reported that the subject had a brief verbal interaction with the housing unit officer at approximately 1045 hours when their cell pass through was being opened for lunch service. That interaction, less than 30 minutes before the individual was found hanging, gave no indication of suicide ideation.

Committee Recommendations

The method for affixing the ligature to the top bunk was determined to be possible due to the open space between the top bunk and the exterior wall of the cell. This space allows a sheet or other material to be passed around the bunk and tied to itself creating a complete loop. The gap between the wall and upper bunk has been identified as a potential risk and a largescale facility infill project to enclose these gaps is underway.

The code cart stocking process was reviewed by JHS nursing leadership, and the code cart restocking process has been improved. The code cart will now standardly have two Ambu Bags on it (continuing to have one in the drawer of the code cart, and an additional one that hangs in a clear bag on the oxygen tank so it is in full view). We have also improved the code cart checks conducted that ensure they are stocked appropriately, and these checks are now conducted by Charge Nurses and integrated as part of their daily work.

The medical provider team discussed the need for a medical provider to promptly assume the Code Leader role as soon as possible in a code response. The Medical Director outlined the role and its importance, as well as the expectation that medical providers assume this role when present, allowing other clinical and correctional staff to assume the direct responder roles for which they are well suited.

JHS Psychiatric Services provided this subject's civil commitment referral information and court documentation to the appropriate outside agency for their awareness. JHS Psychiatric Services will re-consider the housing placement and potential modifications to conditions of confinement for any individual that has been referred for civil commitment (specifically by JHS).

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 unexpected 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.