Unexpected Fatality Review Committee Report

2023 Unexpected Fatality Incident #23-06602 Report to the Legislature

As required by Revised Code of Washington 70.48.510

Date of Publication: May 8, 2024,

Contents

Inmate Information

The decedent was a 44-year-old male who was booked into Issaquah Jail on June 7th, 2023, for the charge of Theft in the third degree (Theft 3).

Incident Overview

The decedent was arrested on June 7, 2023, for Theft 3. During a search incident to arrest, police confiscated a number of pills that officers believed to be fentanyl. The decedent was booked into the Issaquah Jail at approximately 1429 hours. The decedent was cooperative during the booking process and completed the booking questions. During questioning, the decedent stated that he had taken Fentanyl the night before at 6pm. No additional drugs were found on his person at the time of booking, nor did his behavior at time of questioning raise suspicions that would necessitate a strip search.

The decedent was assigned to Dorm 2 group housing. He ate dinner at approximately 1700 hours. Lights out for Inmates is at approximately 2200, at which time the decedent would have gone to bed.

At approximately 0800 hours on the morning of June 9th, the decedent woke up, ate breakfast, and laid back down. The decedent did not seem in distress at this time. At approximately 1140 hours, the decedent was found by a corrections officer after other inmates notified the officers that the decedent needed help. The corrections officer entered the dorm and found the decedent unresponsive while lying on the floor near the shower/bathroom wall. Responding officers relocated the decedent into the corridor where they could safely administer resuscitative measures. At this time, Eastside Fire and Rescue was dispatched. They responded at approximately 1148 hours and took over resuscitative measures.

At approximately 1209 hours medics ceased resuscitative measures and declared the individual deceased.

Consistent with standard procedure, the Independent Force Investigations Team (IFIT) was called and responded at approximately 1245 hours.[1]

The City received the King County Medical Examiner's report on October 27, 2023. In the report, dated September 6, 2023, Interim Chief Medical Examiner Micheline Lubin, MD stated the following: "The 43-year-old male was found unresponsive in the 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."

[1] While no use of force was suspected, IFIT responded pursuant to the terms of the participants' interlocal agreement, which provides that IFIT may be called to respond to any in-custody death.

UFR Committee Meeting Information

Meeting date: May 3, 2024

Committee members in attendance

Chief Of Police, Paula Schwan
Jail/Dispatch Commander, Casey Allred
Jail Manager, Roger Enders
King County Public Health, Ben Sanders, M.D.
King County Adult Detention, Jennifer Schneider
City Attorney, Rachel Bender Turpin

Committee Discussion

The potential factors reviewed include:

A. Structural
    a. Risk Factors present in design or environment
    b. Cell 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. Interaction with Health Care Delivery Systems
    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 an open dorm multi-inmate tank. There are several surveillance cameras in the common area, as well as the decedent's dorm (Dorm 2). These cameras are monitored in real time by on duty corrections officers. The Issaquah City Jail is currently in the process of having even more cameras installed to ensure full visual coverage throughout the facility.

Clinical:

The City contracts with Health Care Delivery Systems for provision of jail medical services. Health Care Delivery Systems is on site in the jail Monday through Friday 0700hours to 1700 hours. Saturday and Sundays 0700 hours to 1500 hours and, available on-call the remainder of the time.

On the day the decedent was booked (June 7, 2023), he submitted a medical "kite," requesting to see a nurse "about detox." The "kite" is a paper form that allows inmates to describe symptoms or request assistance for non-emergency medical conditions that they would like to discuss with medical staff. At the time of the incident, Inmate Trustees were retrieving these kites and turning them into the inbox located on the booking counter. Medical staff then collected the kites for review when they came on duty so that any medical issues could be promptly addressed. The kite submitted by the decedent was not seen by nurses until corrections officers coming on shift the next day, June 8, 2024, found it under the medical basket on the booking counter and turned into the medical office at that time. As part of our investigation into this incident, nursing staff from Health Care Delivery Systems were asked about the kite and stated they had not seen it until after it was retrieved from under the medical basket and handed to medical staff on June 8th. Following this incident, we reviewed this practice and determined that a more secure way of delivering the kites to medical to prevent lost or misplaced medical kites. We are currently in the process of implementing such a system.

When the decedent was found unresponsive, not breathing, and without a pulse Corrections staff on duty immediately called for emergency medical assistance and began resuscitative measures while waiting for aid to arrive from Eastside Fire & Rescue. The King County Medical Examiner's autopsy report lists the following pathological diagnosis for the decedent:

1. The manner of death is best certified: Acute combined drug intoxication including fentanyl and methamphetamine.
2. The 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.

Operational:

The area of this incident was fully staffed. However, review of jail video and Spillman records show that not all required security checks leading up to this event were conducted within policy by the staff on duty the night before decedent's passing. Further, there was evidence that these same staff failed to answer call buttons that night. Due to the failure of answering these call buttons requests, a policy review of the call button system will be conducted. The staff on duty the night before decedent's death were separated from employment with the City following this incident. Staff on duty at time of death were found to have acted appropriately and lifesaving measures began promptly.

Committee Recommendations

As discussed above, a medical kite is a written request for medical assistance or treatment submitted by an inmate to medical staff. An inmate who would like to request care uses the form to write down non-emergent or medical conditions that they would like to discuss with medical. At the time of this incident the procedure was that Inmate Workers (Trustees) were retrieving these kites from other inmates and placing them in a basket on the booking counter that is dedicated to correspondence with jail medical staff. When the jail's contract medical providers would arrive in the building, they would retrieve the basket for review then prioritize the kites based on severity and address them as needed. Moving forward, Corrections Officers will be retrieving all medical Kites, officers will screen kits for potentially emergent conditions and respond accordingly. Officers will deliver all non-emergent medical kits directly to medical for processing. In situations where Corrections Officers are unsure whether a condition is urgent, on-call medical providers will be contacted. We will work jointly with our medical providers from Health Care Delivery Systems to fine tune this process to mitigate risk and ensure the best quality health care in the facility.

One of the two officers on duty the evening prior to decedent's death was terminated for not passing probation. The other officer resigned following an investigation into potential policy violations. Policy review and retraining began immediately following the incident and are now scheduled for multiple times per year. Additional trainings has been incorporated regarding security checks, responding to emergency call buttons by inmates, standard operating procedures reviews, and other jail Policies and practices consistent with the findings of the Committee.

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 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.