King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-01498

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Date of Publication: 12/29/2022

(updated - originally published 11/29/22)

Contents

Inmate Information

The decedent was a 59-year-old male with a history of alcohol use disorder and opioid use disorder. He was booked into the King County Correctional Facility (KCCF) in Seattle by Burien Police (a King County Sheriff's Office contract city) at 2053 hours on July 22, 2022, for Investigation of Felony Stolen Property and a Burglary warrant. On the date of the incident, he was housed in the Infirmary area of the KCCF for medical treatment of alcohol withdrawal syndrome.

Incident Overview

At 1327 hours on July 28, 2022, a medical emergency was called in the Infirmary area of KCCF after an inmate pounded on his cell window to notify staff that his cellmate was actively attempting suicide by hanging. The housing unit officer responded immediately, opened the cell door, and lowered the decedent to the floor. Staff removed a ligature that had been made from strips of a torn bedsheet from around the decedent's neck (with the other end tied around the conduit box of a emergency call button, which was used as a ligature point) and checked for vital signs but could not find a pulse. Responding Jail Health Services (JHS) staff began lifesaving measures (CPR), and the facility called 911 for a medical response. An Automated External Defibrillator (AED) was applied, and the device reported "no shock advised."

JHS and uniformed DAJD staff continued lifesaving measures until they were relieved by the Seattle Fire Department (SFD) at 1333 hours.

Additional SFD and Medic One personnel arrived, and lifesaving measures continued. Paramedic interventions resulted in return of spontaneous circulation (ROSC), and the inmate was taken to Harborview Medical Center (HMC) Emergency Room for continued treatment at approximately 1351 hours.

The Seattle Police Department (SPD) was notified that an inmate had attempted to hang himself in a cell while in the presence of another inmate, and that the victim was on life support at HMC. SPD assigned the investigation to its Force Investigation Team (FIT).

On August 2, 2022, the decedent passed away while at HMC. On October 20, 2022, the King County Medical Examiner released its autopsy report to SPD. The Medical Examiner determined the cause of death was anoxic encephalopathy due to asphyxia. The manner of asphyxia was ligature hanging.

During the emergency response, a DAJD "Service Request Kite," (the form incarcerated individuals use to request services from the jail) with the decedent's name on it was found on the cell floor. The kite, which had not been submitted to Jail staff for review or response, was dated July 28, 2022. It stated, "I need to talk w/Sgt. ? A.S.A.P. very important Emergency."

The incident took place in a dormitory-style housing cell which was occupied by the decedent and a second inmate. The second inmate in the cell (referred to in this report as "witness") was interviewed by DAJD and reported that the decedent had been very upset upon finding out that he would be charged with additional crimes and had been yelling at his attorney about it on a telephone call.

The witness stated that he watched as the decedent created a noose out of his bedsheet. The witness stated that he had not called for help earlier because the decedent had threatened that if he said anything to alert staff, he would "make [his] life hell in the penitentiary."

The witness reported that after the ligature was made, he saw an officer and a nurse walk by their cell (doing a security check), that he did not attempt to notify them because of the threat made by the decedent, and that the decedent proceeded to hang himself after they had walked out of sight by securing the ligature to an electrical box mounted on the wall. The witness stated that after "about 15 minutes," he began banging on the glass to notify staff of the incident.

Additional information gathered from the witness by JHS staff immediately following this incident was consistent with the information, described above, that the witness had provided to DAJD staff. The witness went on to report to JHS staff that he had woken up to the sounds of the decedent tearing a blanket into strips. The witness repeated that it had been at this point that the decedent had made the above-described threats to the witness. The witness reported that he then observed the decedent tie one end of the torn sheets to the metal call box and the other around his neck. The witness reported that the sheets had broken twice in response to the decedent's body weight. The witness reported that during the third attempt the sheet did not break and the decedent "lost color in their face." This additional information was shared with SPD by DAJD.

On August 16, 2022, following a meeting between DAJD staff and the witness, JHS staff were informed that the witness had informed DAJD staff that the decedent had suicidal ideation and intent leading up to the incident, contrary to the witness' previous reporting. In response, on August 17, 2022, JHS staff met again with the witness. On this occasion, the witness reported that he and the decedent had discussed both attempting suicide on the same day and had been making plans to both do so. The witness reported that he did not know how to make a noose, so he requested assistance from the decedent. The witness reported that he participated in the tearing of bedding sheets for the purpose of making nooses, which the witness reported had been made by the decedent. The witness reported that two nooses were made, not three. The witness reported that the decedent first

attempted suicide via a noose that the decedent had made. Once that noose broke, the decedent then used a noose that had been intended for the witness. The witness repeated that the decedent had made the threats that he had described to DAJD and JHS staff previously.

On December 14, 2022, DAJD received the completed administrative investigation from SPD. SPD recommended no criminal referrals for this event.

UFR Committee Meeting Information

Meeting date: August 23, 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
- Allen Nance, Director
- Hikari Tamura, Deputy Director

DAJD Command Staff
- Facility Commander Troy Bacon
- Facility Commander Lisaye Manning
- Corrections Program Administrator Gregg Curtis

DAJD Investigations Unit
- Captain Michael Taylor
- Sergeant Fred Graves
- 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
    j. Use of Force Review

Committee Findings

Structural

The incident took place in a dormitory-style housing cell in the Infirmary. The cell had adequate lighting from the cell window which was not covered as well as the ceiling light. The electrical box which houses the cell's call button was used as an anchor point for the ligature. This is a 4.5 x 2.75-inch metal box mounted externally to the wall 59 inches above the cell floor.

There are no surveillance cameras with recording capabilities in the Infirmary.

Clinical

At intake on July 22, 2022, the decedent self-reported alcohol abuse, angina, right-sided groin hernia, chronic right-sided knee pain, bipolar disorder and schizophrenia. He also reported suicidal ideation. Orders were placed for monitoring for signs of alcohol withdrawal and for placement into psychiatric "red" housing status for reported suicidal ideation. Mental health professional evaluation on July 23, 2022, found no confirmation of current diagnosis of, or treatment for, bipolar disorder or schizophrenia, and the decedent indicated he had not received treatment "for years." He also reported that his report of suicidal ideation at intake was related to wanting to reduce contact with others and get to a single cell, stating that he didn't "...deal with other people too well." During the evaluation, he twice denied ongoing suicidal ideation and any thoughts or intentions to harm or kill himself. His case was discussed by the multidisciplinary "red review" team and the decision was made to move him to non-psychiatric housing on the 7W/Infirmary unit due to the risk of alcohol withdrawal syndrome, since medication treatment of that syndrome is provided in that housing unit. The Mental Health Professional ordered follow-up (with a Mental Health Professional) for the decedent and the expected date was consistent with current standard work.

On July 24, 2022, the decedent was seen by a medical provider in the Infirmary, and he was started on medication treatment for alcohol withdrawal syndrome later on that date based on worsening symptoms. From that date until the date of death, the subject was receiving medication treatment for alcohol withdrawal syndrome and progressing safely through a medication taper. Monitoring during treatment for alcohol withdrawal syndrome included obtaining a set of vital signs and doing assessments using the Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) scoring instrument each shift, or three times a day. Patients receiving medication treatment for alcohol withdrawal syndrome are also seen daily

by a medical provider for adjustments to the treatment plan. The decedent received all scheduled monitoring and provider follow-up visits in the Infirmary.
Medical provider examination confirmed the presence of a right-sided inguinal hernia without apparent signs of complication or any worsening symptoms. Despite the decedent's reported history of knee pain, his gait and functional status did not show signs of impairment, and no medical treatment was needed. The reported "angina" was clarified as chest pain without a defined etiology and no confirmation of cardiovascular disease. But as the decedent reported regular use of low-dose aspirin in the community without problems, this medication was ordered for use during the jail stay.

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. Security checks in this area of the jail are required by policy every 30 minutes. All security checks had been completed. Facility documentation indicates a security check was done at 1303 hours, which also fits with the witness' account of the events. The available evidence indicates all responding DAJD staff acted within policy.

<u>Committee Recommendations</u>

1. That facility improvements are made to eliminate externally mounted electrical/call boxes in cells so they can't be used as tie off points.

    - Facility improvements in the infirmary were implemented in October 2022.

2. Standardization of an evaluation of level of suicide risk for use by JHS Psychiatric Services staff.

3. Explore options for suicide risk mitigation by potentially removing current version of bed sheets or obtaining tear resistant sheets.

    - The elimination of sheets and replacement with additional blankets was implemented in October 2022.

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.