King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2024 Unexpected Fatality Incident 24-00559

Report to the Legislature

As required by RCW 70.48.510

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Resident Information

The decedent was a 28-year-old with medical history including perennial allergic rhinitis, acid reflux, hypothyroidism, and substance use disorders including opioids (reportedly fentanyl), cannabis, and stimulants (amphetamine class). There was also some past history of possible glaucoma of both eyes. The decedent also reported mental health problems including bipolar disorder, schizophrenia, and attention deficit disorder, not receiving community treatment.

On January 4, 2024, at about 0830 the decedent was released from the King County Correctional Facility (KCCF) on a Temporary Release to ABHS for inpatient treatment. At about 1025 the same day ABHS staff called KCCF and informed them that the decedent had walked away from treatment. The decedent returned to KCCF at about 2311 to turn themself in for the Temporary Release violation. The decedent was processed into KCCF per standard practice.

Based on JHS's medical assessment the decedent was initially housed in the KCCF Infirmary for "ingestion". Based on a JHS medical assessment, the decedent was released from Infirmary housing on January 5, 2024, and transferred to general population on 8-South.

On January 6, 2024, the decedent was found in possession of drug contraband. The decedent was transferred to various locations for housing. On February 1, 2024, the decedent was transferred to restrictive housing for behavior issues, this is a single person housing area. On February 4, 2024, the decedent was infracted for possession of drug contraband.

Incident Overview

On March 21, 2024, at about 1726 an Officer conducting security checks observed the decedent unresponsive on the bed inside their room. The Officer entered the room to check on the decedent when the decedent did not respond to their called name. The Officer observed the decedent laying on the bed, the decedent's face was blueish in color and a nasal spray bottle was protruding from one nostril. Officers called for an emergency response. Additional Officers and Supervisors responded, and medical staff arrived to assess the decedent's status. The decedent was moved to the larger common area directly outside the room so that responding medical staff could provide aid. Officers responded with the Automated External Defibrillator (AED) and Narcan. Officers administered two doses of Narcan. Jail Health Staff (JHS) applied the AED pads to the decedent. JHS started CPR. At about 1732 CPR was paused for a shock from the AED, JHS continued CPR following the AED shock.

At about 1733 Seattle Fire Department (SFD) and Medic One staff arrived to continue medical aid. CPR was continued by SFD Medics. At about 1736 a second SFD Medics

team arrived. At about 1740 a third SFD Medics team arrived. CPR was continued by SFD Medics, CPR was paused at about 1736, 1743, and 1745 for AED administered shocks. At about 1811 SFD Medics announced they had obtained a pulse and blood pressure. SFD Medics transported the decedent to Harborview Medical Center (HMC).

The decedent received medical care at HMC until March 25, 2024, at about 1606, when he was declared deceased by HMC doctors four days after he was admitted to the hospital.

DAJD staff called SPD to inform them of the in-custody death and to request an investigation. An SPD officer arrived at KCCF and drew a case number and referred the case to SPD Homicide who deferred to the SPD Force Investigation Team (FIT). SPD FIT deferred to DAJD for the death investigation.

On March 22, 2024, DAJD Special Investigation Unit sergeants processed the incident scene and collected evidence. The medication bottles were sent to the Washington State Crime Laboratory for analysis to screen for illegal or contraband substances. The Washington State Crime Laboratory report is pending.

The autopsy report by the King County Medical Examiner was received on July 12, 2024. The Medical Examiner found the cause of death is "probable combined fentanyl, cocaine, and methamphetamine intoxication. Obesity WHO Class III are contributory. The manner of death is certified accident."

<u>UFR Committee Meeting Information</u>

Meeting dates: March 18, 2024, 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
- Michael Kilbourne, Program Manager

DAJD Administration
- Steve Larsen, Deputy Director

DAJD Facility Command Staff
- Facility Commander Troy Bacon

DAJD Investigations Unit
- Captain Jennifer Schneider

- Sergeant Ernesto Vazquez

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. Safety/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 a Restrictive Housing area of the King County Correctional Facility. There is one surveillance camera showing the Officer's staff station area, however the camera does not show a view inside the housing areas. There are no known contributing structural factors in this incident.

Clinical

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

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

Although there were no specific, direct issues concerning this incident, as part of a continuing improvement practice DAJD and JHS made the following changes:

The resident commissary list was amended to remove items with potential for misuse including spray bottles and capsule medication or supplements.

JHS providers have been advised to avoid ordering nasal spray medications when possible due to signals of misuse of spray devices.

Reinforced with JHS nursing staff that urine drug screening processes and documentation includes separate orders and result panels for fentanyl and other drugs.

Legislative Directive
Per RCW 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.