King County

Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2021 Unexpected Fatality Incident 21-00429

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

Date of Publication: June 3, 2022

Revised: August 5, 2022

Contents

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.

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.

UFR Committee Meeting Information

Meeting date: May 25, 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 Services Manager

DAJD Administration
- John Diaz, Director
- Hikari Tamura, Deputy Director
- Allen Nance, DAJD Juvenile Division Director

DAJD Facility Command Staff
- Interim Facility Commander Troy Bacon

DAJD Investigations Unit
- Captain Michael Taylor
- Sergeant Benjamin Frary
- Sergeant Katherine Orth

Inmate Information

The inmate was a 48-year-old male without significant health history. He was booked into the King County Correctional Facility in Seattle by the Seattle Police Department on June 19, 2021, at 0247 hours.

Incident Overview

While conducting routine security rounds at 0904 hours October 17, 2021, the inmate was found in his single occupancy housing cell, wedged between the wall and the cell bunk. Staff immediately entered the cell and found the individual unresponsive. A medical emergency was announced and life saving measures were initiated by Jail Health Staff as well as DAJD uniformed staff. An AED was applied and reported "no shock advised." CPR was administered continually by DAJD/JHS staff until they were relieved by Seattle Fire and Medic One. Life saving measures continued, and the inmate was taken by Medic One to Harborview Medical Center for further treatment at 0935 hours. The DAJD officer escorting the inmate to HMC called the facility at 1040 hours to report medical staff had pronounced him dead.

An autopsy performed by the King County Medical Examiner's Office ruled the cause of death to be hypertensive and atherosclerotic cardiovascular disease. The manner of death was determined to be natural.

This in-custody death was investigated by the Seattle Police Department's Force Investigation Team. They completed their review on July 6, 2022 and concur with the determination of a natural death. No referrals for criminal charges were filed.

Committee Discussion

The potential factors reviewed include but may not be limited to;

A. Operational
    a. Policy review
    b. Staffing levels
    c. Video review if applicable
    d. Training recommendations
    e. Inmate phone calls and video visits
    f. Availability and functionality of equipment (rescue knife, AED etc)

B. Structural
    a. Lighting
    b. Layout of incident location
    c. Camera location(s)
    d. Blind spots
    e. Were any supplies or fixtures implemented in the act
    f. Emergency call button functionality
    g. Presence of foreign objects or other contraband

C. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with Jail Health Services (JHS)
    c. Relevant root cause analysis and/or corrective action needed

Committee Findings

Operational

The area of this incident was fully staffed and all responding DAJD staff acted within policy. A previous security check of the area had been performed at 0820 hours, the officer conducting the check noted the subject was sitting on his bunk at that time. Lifesaving equipment (AED) was present and functional. Video of this housing unit does not exist. The decedent did not make any telephone calls or have any visits during this booking.

Structural

The incident took place in a single occupant cell on the 11th floor of the King County Correctional Facility without blind spots. The cell had adequate lighting from the cell window which was not covered as well as the ceiling light. The only video camera on this wing of the facility is a Pan/Tilt/Zoom "PTZ" located at the entrance to the unit and did not capture the incident. All fixtures in the cell including the emergency call button were functional.

Clinical

Jail Health Services did not identify issues or problems with policies/procedures, training, facilities/equipment, training, supervision/management, personnel, culture, or other variables related to the death of Mr. Rand. No suggestions for corrective actions or follow-up.

Committee Recommendations

No recommendations noted for DAJD uniformed staff or Seattle-King County Public Health – Jail Health Services.