



Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2022 Unexpected Fatality Incident 22-00730
Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

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Inmate Information

The decedent was a 63-year-old male with no known significant medical or mental health history. He weighed 263 lbs and was 5 feet 11 inches in height.

Incident Overview

On April 19, 2022, according to Seattle Police Department (SPD) records, SPD officers responded to a call about individuals refusing to leave the lobby of a downtown Seattle hotel until they were given food or the police arrived; the individuals appeared intoxicated. Around 0218 hours, SPD officers arrived at the hotel and observed the decedent sitting on a couch, his behavior was erratic and elevated. He was yelling at hotel staff and at SPD officers and his answers were nonsensical; he made comments about being a dragon and a lion. The decedent was also aggressively holding on to a second individual by his jacket who informed SPD officers that he did not want to be there and did not know the decedent.

Shortly thereafter, at approximately 0219 hours and in the presence of the SPD officers, the decedent slapped the face of the individual whom he was holding. Three SPD officers moved in to take the decedent into custody. The decedent actively resisted by tensing his arms and pulling away. Three officers took the decedent to the floor. The decedent continued to resist as additional SPD officers arrived on scene. It took additional officers to control, restrain and keep the decedent in a prone position on the floor. All the while, the decedent was actively pulling away. While on his stomach, the decedent repeatedly lifted his head and forcibly slammed it into the floor. It took several officers to control his legs and head in order to protect him from further injuring himself.

SPD called American Medical Response (AMR) for transport to jail by way of ambulance because of his large stature and his combative behavior. Because the decedent continued to actively pull away and not listen to officer commands, several SPD officers had to hold him on the ground until AMR arrived. He continued to resist and thrash around as several officers and AMR staff placed him on the ambulance stretcher. Officers had to use force to control the decedent for approximately 15 minutes from the time that he was first taken to the floor to the time that he was restrained on the AMR stretcher. Once restrained on the stretcher, he began spitting at officers; a spit hood was placed on his head.

AMR and SPD transported the decedent to the King County Correctional Facility (KCCF) in Seattle. When he entered the booking area, around 0300 hours, he was on an AMR ambulance gurney and in four-point restraints. The arresting SPD officer described him to jail staff as assaultive, however no medical concerns pertaining to the decedent were shared with DAJD. It is very rare for arrested individual to be transported to the King County jail on a stretcher for non-medical reasons.

Jail Health Services (JHS) attempted to conduct a medical screening of the decedent but he made numerous threats to bite and physically assault medical and

uniformed staff. JHS staff did notice bandages on the decedent's lower extremities, but it was not felt to be an immediate medical concern.

For the safety and security of all staff and inmates inside the jail, anyone who is booked into jail must be searched and must change into jail-issued clothing. The searching of arrestees is typically conducted by way of a pat search, metal detector and/or body scanner. Because the decedent was wearing multiple layers of clothing, because he was threatening staff and not cooperating, and because he was on a gurney, a routine search was not possible. For the same reasons, and to ascertain that the decedent did not have weapons or other contraband on his person that could be used to harm either himself or others, an immediate dress-out was deemed necessary.

When asked if he would change his clothing on his own, the decedent continued to threaten violence. The decedent refused to cooperate, attempted to headbutt and bite staff, and was clinging to the railing of the gurney. At approximately 0314 hours, several officers attempted to sit the decedent up on the stretcher, remove the gurney's restraint system and place the decedent into two sets of connecting handcuffs. The decedent remained non-compliant.

At approximately 0316 hours, jail staff stood the decedent up from the gurney to begin the dress-out process and he dropped to the floor outside of the holding cell, refusing to walk. Two uniformed staff pulled the decedent by his upper arms and the back of his jacket, as he remained in a sitting position on the floor, and moved him into a holding cell. The decedent continued to thrash around and attempted to kick staff throughout this process. Officers placed him in a prone position, held his extremities, and changed his pants. Subsequently, his handcuffs were removed and his remaining articles of clothing were exchanged for jail clothing. The decedent physically resisted staff during the entire dress-out process. The only statements made by the decedent during the dress-out were obscenities and threats directed at staff.

At approximately 0321 hours, all jail staff exited the cell, leaving the decedent unrestrained and lying prone on the floor. The duty sergeant remained at the cell window and continued to observe the decedent; medical staff also observed him through the cell window. The sergeant reported seeing the rise and fall of the decedent breathing. At approximately 0323 hours, the sergeant noted that the decedent had stopped moving. The cell door was re-opened, and uniformed staff entered to evaluate his condition. A pulse could not be found and lifesaving measures were initiated. A medical emergency was announced at 0326 hours, and Seattle Fire Department (SFD)/Medic One was called to the scene.

SFD arrived at 0332 hours and took over lifesaving measures. They were able to find a pulse and the decedent was taken to Harborview Medical Center (HMC) at 0411 hours. The decedent was pronounced dead by HMC staff at 0457 hours.

The shift commander called SPD to inform them of the in-custody death and to request an investigation. The first SPD officer arrived to KCCF at 0557 hours, and

the investigation was passed from patrol to the SPD Force Investigation Team (FIT).

An autopsy was performed on April 20, 2022. Per the King County Medical Examiner's autopsy report:

1. The manner of death is best certified undetermined;
2. The cause of death is sudden death during physical restraint;
3. Hypertension and atherosclerotic cardiovascular disease, obesity, and acutely agitated state with manifestations of acute psychosis are contributory conditions; and
4. It is unclear to what extent restraint and cardiovascular disease contributed to the death;

UFR Committee Meeting Information

Meeting dates: May 10, 2022 and August 22, 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
- Allen Nance, Director Designee
- Hikari Tamura, Deputy Director

DAJD Facility Command Staff

- Facility Commander Troy Bacon

DAJD Investigations Unit

- Captain Michael Taylor
- Sergeant Fred Graves

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 single-occupant cell in the booking area of the King County Correctional Facility. There are several surveillance cameras in the booking area, however none are directed at holding cells including the one in which this incident occurred. There are no known contributing structural factors in this incident.

Clinical

The decedent was very briefly in custody at the King County Correctional Facility (approximately 14 minutes) when a medical emergency was called due to medical concerns. He had not yet been given a receiving screening by a JHS nurse. DAJD called JHS nursing due to a possible medical issue and concern about non-responsiveness to verbal commands. It was quickly determined that the decedent was not breathing, did not have a pulse, and a medical emergency was called at 0326 hrs. Resuscitative measures (CPR, rescue breathing) were undertaken and AED was applied, and no shock was advised. Paramedics arrived and continued resuscitative measures, and ACLS interventions were added, leading to ROSC (return of spontaneous circulation) in transit to Harborview Medical Center Emergency Department (HMC ED). Despite continued interventions, the decedent was pronounced dead at 0457 hrs.

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 and based on all available evidence, DAJD staff acted within policy. Lifesaving measures (CPR) began promptly and continued until staff were properly relieved by Seattle Fire Department medics.

The decedent arrived at the jail facility on an ambulance gurney. He had been arrested for assault, was reportedly combative with the arresting officers and made continuous threats to all personnel present. He continued to be non-cooperative and combative with jail staff during the dress-out and pat searching/intake procedures. Because of his behavior, physical force was used by SPD officers during his arrest and by jail officers during his booking. During the entire process, the decedent repeatedly attempted to bite, headbutt and kick at staff while making numerous verbal threats. The physical force used in this incident and the decision

to conduct an immediate dress-out were reviewed by divisional command staff and found to be reasonable and necessary under the circumstances.

Committee Recommendations

Although the Committee concurs that the use of force and decision to conduct a dress-out were reasonable and necessary, the Committee recommends that all dress-outs where force is used be video recorded.

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.