Department of Adult and Juvenile Detention

Unexpected Fatality Review Committee Report

2021 Unexpected Fatality Incident 21-00788

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

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Inmate Information

The inmate was a 27-year-old transgender female without significant medical history. She was booked into the King County Correctional Facility (KCCF) in Seattle by Renton Police Department on December 18, 2021, at 2138 hours.

Incident Overview

While conducting a routine security check at 1456 hours on December 19, 2021, Department of Adult and Juvenile Detention (DAJD) staff found the subject partially suspended by a ligature made from a bedsheet which was tied to a loop around the top bunk of the cell. A medical emergency was called, and lifesaving measures were initiated by Jail Health Services (JHS) and DAJD staff. At 1506 hours Seattle Fire Department (SFD) arrived and took control of the scene. SFD announced a pulse had been found and the individual was taken to Harborview Medical Center for further treatment.

On December 20, 2021, while still at Harborview Medical Center (HMC), Renton Police Department released their hold, and the subject was released from DAJD custody.

On December 26, 2021, the subject passed away while at HMC. The Medical Examiner lists the cause of death as ligature hanging and the manner as suicide.

UFR Committee Meeting Information

Meeting date: May 25, 2022 via virtual conference

Committee members in attendance

Public Health – Seattle & King County, Jail Health Services Division
- Danotra McBride, Director
- Dr. Ben Sanders, Medical Director
- Dr. Ryan Quirk, Psychiatric & Social 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

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 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. Lifesaving equipment (rescue knife) was present and was used to cut the ligature. DAJD uniformed staff immediately began CPR and continued its application until relieved first by jail medical staff then Seattle Fire Department medics. There is video of this housing unit which was reviewed and showed security checks being done in accordance with policy.

Structural

The incident took place in a single-occupant cell on the 9th 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. There is a surveillance camera located in the subject's housing area which shows the outside of the cell door but does not show inside the cell. All fixtures in the cell including the emergency call button were functional.

The method used to anchor the ligature was a loop created by tying a bedsheet laterally around the unoccupied top bunk of the cell. Another section of bedsheet was then used as a ligature around the subject's neck and tied to the loop. The presence of such an accessible tie-off point with which to secure a ligature represents a structural issue.

Clinical

Prior to booking, the inmate had two recent visits to the Hospital Emergency Department related to reports of being the victim of sexual assault. During the booking process, the inmate denied being suicidal and denied having any suicide attempts in the past 12 months. The inmate was also seen by a Psychiatric Evaluation Specialist while in custody and denied suicidal ideation soon after booking.

JHS did not identify issues or problems with policies/procedures, training, supervision/management, personnel, culture, or other variable relevant to the period of death.

Committee Recommendations

The method for affixing the ligature to the top bunk was determined to be possible due to the open space between the top bunk and the exterior wall of the cell. This space allows a sheet or other material to be passed around the bunk and tied to itself creating a complete loop. The gap between the wall and upper bunk has been identified as a potential risk and a large-scale facility infill project to enclose these gaps is underway.

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 occurred. A review must include an analysis of the root cause or causes of the unexpected 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.

(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.