# Unexpected Fatality Review Committee Report

## 2023 Unexpected Fatality

## Incident #23-11017

## Report to the Legislature

*As required by Revised Code of Washington 70.48.510*

Date of Publication: May 8, 2024

**Contents**

## Inmate Information

The decedent was a 48-year-old male that was seen by medical and referred to the Hospital by on duty medical staff for medication and further assistance for alcohol withdrawal.

## Incident Overview

On September 16, 2023, the decedent was booked into the Issaquah Jail on September 15, 2023, at about 1500 hours. The decedent was initially uncooperative during the booking process and declining to participate in answering questions. Booking officers were able to communicate and get the decedent through the process and seen by medical staff from Healthcare Delivery Services, the jail's contracted medical provider.

The decedent was assigned to B3 high observation cell where he could be more readily monitored. On September 16th, at approximately 1000 hours the decedent was able to walk out under his own power and be seen by the nurse. He was then given a urine sample which he completed and returned to the nurse. At 1011 hours he was witnessed returning to his cell under his own power and without appearing to be in distress.

At approximately 1030 hours a request from Health Care Delivery Systems to corrections staff was made for the decedent to be medically furloughed to the hospital for medication treatment for his alcohol withdrawal. The decedent did not appear to be in medical distress at the time this recommendation was made. Instead, the recommendation was made because the jail was currently out of the recommended medication. Accordingly, it was planned that the decedent would be temporarily furloughed to the hospital to obtain the recommended medication and then would return to the jail with medication for his continued treatment in custody. At approximately 1200 hours he was asked if he wanted lunch, which he refused. At approximately 1239 hours a request from Corrections staff for approval and medical transport was made.

Eastside Fire responded at approximately 1247 for transport at which point the door was opened and medics determined that decedent was not breathing decedent was moved to the larger common area allowing medics more room to provide aid.

At approximately 1315 hours medics ceased resuscitative measures and declared the individual deceased.

IFIT responded at approximately 1615 hours. At approximately 1830 hours IFIT concluded the on-sight investigation and departed the facility.

1. The manner of death is best certified: Overdose
2. The cause of death is: Acute Fentanyl Intoxication

## UFR Committee Meeting Information

Meeting date: May 3, 2024

## Committee members in attendance

Chief Of Police, Paula Schwan
Jail/Dispatch Commander, Casey Allred
Jail Manager, Roger Enders
King County Public Health, Ben Sanders, M.D.
King County Adult Detention, Jennifer Schneider
City Attorney, Rachel Bender Turpin

## Committee Discussion

The potential factors reviewed include:

A. Structural
    a. Risk Factors present in design or environment
    b. Cell 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. Interaction with Health Care Delivery Systems
    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, high observation cell. There are several surveillance cameras in the common area, however not directly inside the housing unit. There are no known contributing structural factors in this incident.

### Clinical:

The decedent was very briefly in custody at the Issaquah Jail. Health Care Delivery Systems identified detox and recommended he be furloughed to obtain medication for treatment of alcohol withdrawal. The furlough process was completed and Eastside Fire and Rescue was called for transport to the local hospital. Decedent was found unresponsive when medics arrived for transport.

### Operational:

Th area of this incident was fully staffed. Reviewed video and Spillman records show that security and welfare checks leading up to this event were conducted within policy. Resuscitative measures began promptly.

## Committee Recommendations

There are no structural, Clinical or Operational changes identified.

**Legislative Directive** - Per Revised Code of Washington 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.