KITSAP COUNTY SHERIFF'S OFFICE JAIL

UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT B21-006426

REPORT TO THE LEGISLATURE

Pursuant to RCW 70.48.510

Date of Publication: April 29, 2023

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1. INMATE INFORMATION

The inmate was a 40-year-old white female with a history of drug use and recent suicide ideations. She was arrested on December 9, 2021, outside her residence on an outstanding warrant for controlled substance homicide and booked into the Kitsap County Sheriff's Office Jail (Jail) by Port Orchard Police Officers at approximately 2254.

2. INCIDENT OVERVIEW

During the intake booking process, the inmate was screened by medical staff and advised that she had gastric bypass and knee surgery five years ago but identified no concerns regarding the procedures. She also expressed suicidal ideations and was initially placed in a crisis cell and was later moved to South Pod A1 a designated housing unit for inmates requiring special attention. The special management unit provides face-to-face safety checks by corrections staff with 30-minute interval checks on an irregular schedule.

During the late evening on 12/12/2021, the inmate pushed the emergency call button in her cell and advised medical that she could not move. When medical responded, the inmate was moving, but her hands were rigid and she reported that she had slurred speech and reported that she did not feel well, although she did not complain of any specific pain. The inmate advised that she was tired and possibly withdrawing from pain medications. Medical advised that the inmate's vitals were fine, and the inmate's overall condition improved during the evaluation. The nurse requested a urine sample so that she could be placed on the detox protocol.

On 12/13/2023, at approximately 0520, the inmate advised a corrections officer that she had a stomachache. As she did not appear to be in serious distress, the corrections officer asked if she was able to wait about one hour until medical staff conducts their normal rotation. The inmate advised that she could. At 0615, the same corrections officer again made contact with the inmate. He noted that she did not appear in distress and advised that she again advised that she could wait for medical. A nurse responded to the inmate at 0630 to dispense medication and temperature check. The nurse reported that the inmate's temperature was normal, she appeared fine and made no complaints regarding stomach discomfort.

Regular safety checks were conducted on the inmate at 0718, 0745, 0804, 0821, 0856, and 0929. At approximately 0929, jail staff found the inmate unresponsive in her cell. Medical staff commenced CPR and continued until South Kitsap Fire and Rescue responded to take over. Medics transported the inmate to St Michael Medical Hospital in Silverdale where she was pronounced dead at 1121.

3. CAUSE OF DEATH

On December 15, 2021, Kitsap County Forensic Pathologist Lindsey Harle conducted the

autopsy and discovered that the deceased had ruptured staples from gastric bypass surgery in the stomach and colon. The pathologist concluded the cause of death was acute peritonitis due to gastric and colonic perforation due to dehiscence of gastric bypass surgical site. The manner of death was natural.

4. COMMITTEE MEETING INFORMATION

March 16 , 2023 and March 23, 2023, via Teams.

5. COMMITTEE MEMBERS IN ATTENDANCE

Kitsap County Risk Management
- Tim Perez

Kitsap County Sheriff's Office Corrections
- Penelope Sapp
- Keith Hall

Kitsap County Jail Health Care Services
- Alanna Sandack
- Autumn Denesha

6. COMMITTEE RECORDS

Scope of review includes, but is not limited to, the following records and/or topics:

A. Kitsap Critical Incident Response Team Investigation
B. Various custody policies
C. Involved agency reports
D. Interview transcripts
E. Crime scene reports and diagrams
F. Crime scene photographs
G. Coroner reports and photographs
H. Inmate profile
I. Jail logs
J. Medical records
K. Booking documents
L. Fire and EMS Records
M. Property reports
N. 911 calls, radio, and cad logs
O. Jail audio and video recordings
P. Supervision (e.g., security checks, kite requests)
Q. Classification and housing
R. Staffing levels

S. Life saving measures taken

7. COMMITTEE FINDINGS

The committee found the overall response and handling of this tragic incident was both appropriate and professional. All available tools and resources were utilized in the efforts to preserve the life of this inmate.

8. COMMITTEE RECOMMENDATIONS

Although completely unrelated to the inmate's death, the committee did find areas that could be improved.

Clocks. The clocks in the jail are synchronized, and the system was not working properly causing the clocks on the wall not to match the time on jail video. This issue has been resolved.

Nursing. During the course of the investigation, it was discovered that one of the nurses was not charting in an appropriate timeframe, and there were errors in her charting. This discovery required she be moved to another shift for retraining.

9. LEGISLATIVE DIRECTIVE

RCW 70.48.510 Unexpected fatality review--Records—Discovery

(1)(a) A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail shall conduct an unexpected fatality review in any case in which the death of an individual confined in the jail is unexpected.

(b) The city or county department of corrections or chief law enforcement officer shall convene an unexpected fatality review team and determine the membership of the review team. The team shall comprise of individuals with appropriate expertise including, but not limited to, individuals whose professional expertise is pertinent to the dynamics of the case. The city or county department of corrections or chief law enforcement officer shall ensure that the unexpected fatality review team is made up of individuals who had no previous involvement in the case.

(c) The primary purpose of the unexpected fatality review shall be the development of recommendations to the governing unit with primary responsibility for the operation of the jail and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for individuals in custody.

(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.

10. DISCLOSURE OF INFORMATION

RCW 70.48.510(3)(c) Unexpected fatality review--Records—Discovery

Documents prepared by or for an unexpected fatality review team are inadmissible and may not be used in a civil or administrative proceeding, except that any document that exists before its use or consideration in an unexpected fatality review, or that is created independently of such review, does not become inadmissible merely because it is reviewed or used by an unexpected fatality review team.