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: November 2, 2023

1. INMATE INFORMATION

The decedent was a 46-year-old white female. She was booked into the Kitsap County Sheriff's Office Jail by a Bremerton police officer on June 30, 2023, at 0744 hours for Assault 4th Degree Domestic Violence.

2. INCIDENT OVERVIEW

During booking, the inmate complained of hip and back pain. She was vomiting and tested positive for methamphetamine and THC. The inmate was housed in the East Pod, low security level housing with two per capacity per housing unit and the doors unlocked.

During her stay, the inmate refused her meals, and the vomiting became worse throughout the day. The inmate was provided additional fluids and medicine for the vomiting. The inmate vomited multiple times over the next couple of days.

On 7/3/2023, walk throughs were conducted by corrections officers in the pod where the inmate was housed. The inmate was observed in her cell laying on her side by a corrections officer at 0557, 0653, 0655, and 0748. In compliance with standard protocol, the officer specifically observed what appeared to be the rise and fall of her chest indicating that she was breathing.

At 0800, a corrections officer was alerted to a concern regarding this inmate when multiple inmates came to the unit door yelling that the inmate was dead. A corrections officer responded to the location and observed the inmate laying on her back, unresponsive and not breathing. The corrections officer immediately commenced life saving measures and continued to assist medical staff when they responded. Medical staff continued life saving measures until South Kitsap Fire and Rescue responded on scene at 0811 to take over providing medical aid. Narcan and the AED were administered multiple times. Death was pronounced at 0831. The Port Orchard Police were contacted to respond to investigate the incident.

3. CAUSE OF DEATH

On July 6, 2023, Kitsap County Forensic Pathologist Lindsey Harle conducted the autopsy and discovered that the deceased had extensive subarachnoid hemorrhage centered over the base of the brain consistent with ruptured berry aneurysm. The manner of death was natural.

4. COMMITTEE MEMBERS

Kitsap County Sheriff's Office Corrections

- Penelope Sapp, Chief of Corrections
  Kitsap County Sheriff's Office Corrections
- Marc Stern, MD, MPH
  Affiliate Assistant Professor, School of Public Health,
  University of Washington
  Clinical Professor, School of Public Health
  University of Albany

Consultant in Correctional Health Care

5. COMMITTEE SCOPE OF REVIEW

A. Scope of Review.
   1. Port Orchard investigative report
   2. Shift Assignment
   3. Security/Surveillance logs
   4. Housing Lists-head counts
   5. Involved agency reports
   6. Jail logs
   7. Medical records
   8. Booking documents
   9. Property reports
   10. Autopsy records
   11. Mortality review
   12. Reports subsequent to the incident
   13. Video recordings
   14. Operational response

B. Structural
   1. Risk factors in design or environment
   2. Broken or altered fixtures or furnishings
   3. Security measures compromised or circumvented
   4. Lighting
   5. Camera

C. Clinical
   1. Relevant decedent health issues/history
   2. Interactions with jail health services
   3. Relevant root cause analysis and/or corrective action sought

D. Operational
   1. Supervision (welfare checks/observation)
   2. Classification/Housing
   3. Staffing levels
   4. Training recommendations
   5. Lifesaving measures take

6. COMMITTEE FINDINGS AND RECOMMENDATIONS

A. Structural

The incident took place in a double occupancy low security cell. There was adequate lighting and no known contributing structural factors in this incident. There are surveillance cameras in the area, but the cameras do not show inside the cell for inmate privacy concerns.

B. Clinical

While there was documentation as required by the medical vendor's policy, the committee discussed the need to timely, accurately, thoroughly annotate all medical conditions and care provided. Health care staff could have been more responsive (both in scope and time) to the subjective complaints and physical discomfort of the inmate.

There were no identifiable issues with the emergency medical response by corrections staff and health care staff. The emergency response time was appropriate, facilities and equipment were appropriate, policies and procedures were followed.

C. Operational

The housing unit where the incident occurred was fully staffed. Inmate welfare checks were timely and regularly conducted by corrections staff in compliance with policy. Emergency response and life saving measures were promptly provided and continued until relieved by emergency responders.

7. 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.

8. 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.