KITSAP COUNTY SHERIFF'S OFFICE JAIL

UNEXPECTED FATALITY REVIEW COMMITTEE REPORT

UNEXPECTED FATALITY INCIDENT

REPORT TO THE LEGISLATURE

Pursuant to RCW 70.48.510

Release Date: February 9, 2024

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1. INMATE INFORMATION

The inmate was a 58-year-old white male with a self-reported severe alcohol and methamphetamine addiction. He was arrested for Assault-4th degree DV on August 6, 2023, at his residence, at 2:00 pm. Deputies and medics had been called to respond to his residence earlier that same day due to reports of possible overdose from methamphetamines and verbal domestic dispute. The inmate refused medical attention on both occasions and reported that he had not been taking methamphetamines. The inmate advised that he consumes 15 beers per day and is on disability.

The inmate was transported by the Kitsap County Sheriff Deputies to the Kitsap County Sheriff's Office Jail (Jail) by Kitsap County Sheriff Deputies at approximately 2:40 pm.

2. INCIDENT OVERVIEW

The Jail was advised that the inmate was in need of a wheelchair and had one ready for use upon the inmate's arrival. The inmate arrived at the Jail at 1540 pm.

Upon arrival, the inmate advised the medical staff waiting to conduct his assessment, that "I drink 15 beers a day and I am a meth addict."

The inmate was not able to be booked due to being uncooperative. Corrections officers conducted regular security checks and made observations of the inmate at various time intervals consistent with Department policy. The inmate was observed breathing in his cell by corrections officers during their 30-minute interval checks. During the last check he was found unresponsive lying supine on the floor with his head leaning against the bench in the holding intake cell.

A corrections officer commenced CPR and called 911 and medical staff to the scene. Medical staff utilized the AED and administered three doses of Narcan intranasally with no response. CPR was continued until South Kitsap Fire and Rescue (EMS) responded to take over. EMS pronounced the inmate deceased at the scene.

3. CAUSE OF DEATH

On August 6, 2023, Kitsap County Deputy Medical Examiner, James Porter, conducted the autopsy. The Deputy Medical Examiner concluded the cause of death was ketoacidosis due to poorly controlled diabetes and ethanol abuse; with hypertension and obesity as contributing factors. The manner of death was natural.

4. COMMITTEE MEETING INFORMATION

December 19, 2023, via Teams.

5. COMMITTEE MEMBERS IN ATTENDANCE

Medical Professional

- 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

Kitsap County Risk Management
- Tim Perez

Kitsap County Sheriff's Office Corrections
- Penelope Sapp, Chief of Corrections

6. COMMITTEE RECORDS

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

- Kitsap Critical Incident Response Team Investigation
- Various custody policies
- Involved agency reports
- Interview transcripts
- Crime scene reports and diagrams
- Crime scene photographs
- Coroner reports and photographs
- Inmate profile
- Jail logs
- Medical records
- Booking documents
- Fire and EMS Records
- Property reports
- 911 calls, radio, and cad logs
- Jail audio and video recordings
- Supervision (e.g., security checks, kite requests)
- Classification and housing
- Staffing levels
- 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 unrelated to the inmate's death, the committee did find areas that could be improved.

Documentation. 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, DISCLOSURE

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.

(e) The city or county department of corrections or chief law enforcement officer shall develop and implement procedures to carry out the requirements of this section.

(2) In any review of an unexpected fatality, the city or county department of corrections or chief law enforcement officer and the unexpected fatality review team shall have access to all records and files regarding the person or otherwise relevant to the review that have been produced or retained by the agency.

(3)(a) An unexpected fatality review completed pursuant to this section is subject to discovery in a civil or administrative proceeding but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to this section.

(b) An employee of a city or county department of corrections or law enforcement employee responsible for conducting an unexpected fatality review, or member of an unexpected fatality review team, may not be examined in a civil or administrative proceeding regarding: (i) The work of the unexpected fatality review team; (ii) the incident under review; (iii) his or her statements, deliberations, thoughts, analyses, or impressions relating to the work of the unexpected fatality review team or the incident under review; or (iv) the statements, deliberations, thoughts, analyses, or impressions of any other member of the unexpected fatality review team, or any person who provided information to the unexpected fatality review team relating to the work of the unexpected fatality review team or the incident under review.

(c) 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. A person is not unavailable as a witness merely because the person has been interviewed by, or has provided a statement for, an unexpected fatality review, but if the person is called as a witness, the person may not be examined regarding the person's interactions with the unexpected fatality review including, without limitation, whether the person was interviewed during such review, the questions that were asked during such review, and the answers that the person provided during such review. This section may not be construed as restricting the person from testifying fully in any proceeding regarding his or her knowledge of the incident under review.

(d) The restrictions set forth in this section do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed

professional based in whole or in part upon allegations of wrongdoing in connection with an unexpected fatality reviewed by an unexpected fatality review team.

(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.

(5) For the purposes of this section:

(a) "City or county department of corrections" means a department of corrections created by a city or county to be in charge of the jail and all persons confined in the jail pursuant to RCW 70.48.090.

(b) "Chief law enforcement officer" means the chief law enforcement officer who is in charge of the jail and all persons confined in the jail if no department of corrections was created by a city or county pursuant to RCW 70.48.090.

(c) "Unexpected fatality review" means 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 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 under this section.