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: May 14, 2024

Incident Date: December 11, 2023

1. COMMITTEE MEETING INFORMATION

April 17, 2023, via Teams.
April 23, 2024, via Teams.

2. COMMITTEE MEMBERS IN ATTENDANCE

- 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

- Elliot Wade, MD
  Regional Corporate Medical Director
  Everhealth Heath, LLC

- Rebecca Villacorta
  Director of Operations
  Everhealth Heath, LLC

- Elizabeth Starlight
  Health Services Administrator
  Everhealth Heath, LLC

- Tim Perez
  Risk Manager
  Kitsap County Risk Management

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

3. COMMITTEE RECORDS

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

- Medical Examiner reports and photographs
- Inmate profile and file
- Jail booking and assessments
- Jail logs and internal reports
- Medical records
- Fire and EMS Records
- Law enforcement reports

- Supervision (e.g., security checks, kite requests)
- Classification and housing
- Staffing levels and schedules
- Life saving measures taken
- Jail and medical policies and processes
- Everhealth mortality review

4. INMATE INFORMATION

On December 5, 2023, at 11:54 am, multiple officers responded to call of a subject chasing the 911 caller with a knife. The subject, a 48-year-old Filipino male, was taken into custody by Port Orchard police officers and booked in the Kitsap County Sheriff's Office Jail ("Jail") for Assault in the Second degree (deadly weapon plus substantial bodily harm) at 1:01 pm. The inmate appeared in court on December 6, 2023, at which time the court appointed counsel and ordered a competency evaluation of the inmate.

5. INCIDENT OVERVIEW

The inmate was booked into the Jail on December 5, 2023, and a medical intake was completed. The inmate was being held in a single occupant cell in the Jail due to safety and security concerns. While he reported no issues on intake. He appeared to have mental health issues with multiple outbursts while incarcerated (e.g. screaming and banging and kicking the door to his cell). Due to the continued noise, the inmate was moved to a crisis cell on December 10, 2023. The inmate was cooperative during the move and no force was used. Corrections officers conducted 30-minute check on the inmate. During the crisis checks, the inmate appeared fine and no issues of concern were reported.

On December 11, 2023, staff reported that the inmate was fine. At 1:00 pm, the inmate was out of his cell for approximately 30 minutes and appeared fine. At 4:00 pm, the inmate was observed in his cell standing in front of a mirror looking at himself. At appropriate 4:23 pm, others reported hearing a loud crash coming from the cell where the inmate was being housed, and summoned help. Corrections officers responded and found the inmate unresponsive on the floor. A corrections officer commenced CPR and called for medical to respond. South Kitsap Fire and Rescue (EMS) was also summoned to respond.

Medical staff arrived quickly after being notified. Medical staff utilized the AED multiple times, provided oxygen, and administered multiple doses of Narcan intranasally with no response. CPR was continued until South Kitsap Fire and Rescue (EMS) responded to take over. When EMS arrived, they moved the inmate out of the cell and attempted additional live saving measures in an attempt to revive him without success. EMS called time of death at 4:51 pm.

6. CAUSE OF DEATH

Kitsap County Medical Examiner, Lindsey Harle, MD, conducted the autopsy. The Medical Examiner concluded the cause of death was atherosclerotic and hypertensive cardiovascular disease with remote myocardial infarct listed as a contributing factor. The manner of death was natural.

7. COMMITTEE RECOMMENDATIONS

Although unrelated to the cause of death, the following committee recommendations have been made and are being implemented.

Collaborative Training. It would be beneficial for healthcare and corrections staff to participate collaboratively in annual tabletop exercises to promote communication.

Refresher Training. Annual training for healthcare and corrections staff should include refresher training in the use of the AED, emergency triage, and report writing.

Medical forms. Medical forms should be modified to include a narrative section.

8. 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…….

Proposed Changes

- NaphCare receiving form to be modified and clarified
- Modify the medical portion of the pre-booking process
- Medical refusals – the nurses did put this patient on the provider list and the provider should have gone to see him. A provider should have follow-up –
- He did take his blood pressure medication on the day of death. Yes,
- There needs to be a better process for communicating to the provider the fact that the competency evaluation was requested. Court order would have been handed to custody, then it goes to medical
- Policy for how a court order for competency should be handled –
- Mechanism for review of documents that are scanned -

Custody and medical working together, need to involve