Rafael Padilla
Chief of Police

City of Kent Police Department
Corrections Division

WASPC Accredited Agency

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality, Incident #25-439

Report to the Legislature
As required by RCW 70.48.510

Michael Armstrong, Corrections Commander

Date of Publication: 08/15/2025

CONTENTS

Legislative Directive

RCW 70.48.510

During its 2021 legislative session, the State Legislature adopted Engrossed Substitute Senate Bill 5110, which requires a city or county department of corrections or chief law enforcement officer responsible for the operation of a jail to conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

An unexpected fatality review is defined under the law 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 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.

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.

Disclosure of Information

RCW 70.48.510

As state law directs, the state Department of Health created a public website where reports generated during an unexpected fatality review are posted and maintained. Unexpected fatality review 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 the legislation requires a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Foreword

This report summarizes an unexpected fatality that occurred at The City of Kent Corrections Facility. It offers a summary of the facts as they were understood through a careful review of events, physical layout, and response to the incident. These reviews are intended to identify any actions, policies, and/or circumstances where improvement may be able to be achieved.

This report cannot adequately convey the level of respect, concern, and commitment that the City of Kent Corrections Facility has for the deceased individual and their family. The City of Kent Corrections Facility extends its condolences to the decedent's loved ones. The City of Kent Corrections Facility is committed to thoroughly reviewing the incident and exploring the action items identified in this report and evaluating their reasonableness in implementing to the extent they may help prevent fatalities and strengthen safety and health protections for those in custody. .

Unexpected Fatality Review Committee Meeting Dates and Location

Meeting date: 07/01/2025

Facilitator/Coordinator: Michael Armstrong Corrections Commander

Location: City of Kent Corrections Facility Annex Building Conference Room
8323 S 259th St. Kent, WA 98032

Committee Members

Medical Team

- Shannon Slack, ARNP – Health Care Delivery Systems (CEO)
- Karen Santiago, RN – Health Care Delivery Systems Facility Nurse

Kent Police Department

- Eric Hemmen – Assistant Chief

City of Kent Corrections Facility

- Rick Armstrong – Corrections Sergeant
- Michael D Armstrong – Corrections Commander

Decedent Information

Date of Incarceration: April 19, 2025
Date of Unexpected Fatality: April 22, 2025

The decedent was a 45-year-old female who was booked into the City of Kent Corrections Facility in Kent, WA by a City of Kent Police Officer on Saturday, April 19, 2025, at approximately 2203 hours.

The decedent was booked on misdemeanor warrants issued by the Kent Municipal Court for outstanding charges related to violations of the Kent City Code related to using controlled substances in public, and criminal trespass in the 2nd degree.

The decedent had 5 previous incarcerations at the City of Kent Corrections Facility between the years of 2012 and 2025.

Unexpected Fatality Summary

On Saturday April 19, 2025, the decedent was booked into the City of Kent Corrections Facility. The decedent was pat searched, and that search did not yield any contraband.

The decedent was placed in a holding cell at approximately 2203 hours on April 19, 2025. Corrections Staff completed welfare checks/cell checks at 2222 hours and 2311 hours on April 19, 2025, and at 0020 hours on April 20, 2025.

At approximately 0020 hours on Sunday, April 20, 2025, the decedent was brought out of the holding cell and the booking process was completed. During the booking process the decedent was cooperative and responsive.

As part of the booking process, Corrections Staff completed an intake booking medical sheet. The decedent stated that she had used fentanyl and methamphetamines but did not state the last time she had used them. The decedent was asked if she had suffered from drug withdrawals in the past, and she stated that she was currently feeling the symptoms of drug withdrawals, but did not give specific symptoms.

Once the booking process was finished, the decedent was provided jail clothes to change into and was moved to the female living unit. The decedent was place in the E-unit and specifically assigned to cell E-23 with a sink and a toilet.

On Sunday April 20, 2025, at approximately 0930 hours, medical staff contacted the Corrections Officer within the Central Control Room and requested that the decedent report to Medical to be assessed. Approximately 10 to 15 minutes later, medical contacted the Control Room Officer again and they called into the decedent's cell and asked if she wanted to go to medical, the decedent responded with a "Yes" but failed to go to medical as requested. Despite the Corrections Officer directing the decedent to report to Medical several times between approximately 0930 hours and 1030 hours, the decedent failed to report to the medical office as requested.

At approximately 1210 hours, Corrections Staff completed formal count and served lunch in the E-Unit. The decedent walked down the stairs and collected her lunch from Corrections Staff and made no comments about going to medical.

Corrections Staff returned to E-Unit at approximately 1211 hours to give the decedent a hygiene bag she had requested and again the decedent made no mention about going to medical.

After medical staff notified the Central Control Room officer that the decedent had not reported to medical after several attempts, Corrections Staff was sent to the living unit at 1430 hours to escort the decedent to a holding cell for closer observation and for medical staff to examine the decedent.

At approximately 1440 hours, the decedent was moved from E-23 to holding cell 5 for closer observation by Corrections Staff based on their observations when contacting her in E-23. The decedent was suffering from drug withdrawal symptoms and had vomited on herself and her mattress. Corrections Staff noted in the incident report when they moved her into the holding cell that the toilet in her housing unit (E-23) also had fecal matter and vomit in it.

After the decedent was moved into holding cell 5, medical staff completed an assessment at approximately 1605 hours. The decedent's vitals were taken at the time of the assessment, and they indicated that the decedent's vitals were as follows; blood pressure 112/44, Pulse 57, Temperature 97.3 and Oxygen Saturation (Sat) 99%. Nothing indicated that the decedent's vitals were abnormal at the time of the assessment.

Between 1440 hours on Sunday, April 20, 2025, and 0736 hours on Tuesday, April 22, 2025, the decedent remained in holding cell 5 with Corrections Staff conducting 60-minute welfare checks in accordance with City of Kent Corrections Facility Policy No. 18.10, Surveillance and Supervision.

Some of the 60-minute welfare checks were conducted late for the following reasons. On Monday, April 21, 2025, between approximately 0205 hours to 0319 hours, the check was approximately 14 minutes late due to Corrections Staff dealing with a fire and aid call at the Corrections Facility for a different inmate. On Monday, April 21, 2025, approximately 1028 hours to 1135 hours, the check was approximately 7 minutes late, due to Corrections Staff assigned to the booking area conducting a strip search on another inmate.

The decedent was given Gatorade on several occasions. It was also noted that the decedent had vomited on Monday April 21, 2025, at approximately 1935 hours and Corrections Staff had the cell cleaned at approximately 2155 hours.

On Monday April 21, 2025, at approximately 1900 hours, Medical notes they saw the decedent and obtained urine in the AM. The decedent was positive for fentanyl, methamphetamines, and MDMA.

Medical staff contacted the ARNP who prescribed Loperamide 2mg to control and relieve the symptoms of acute diarrhea; Promethazine 25mg to manage and treat allergic conditions, nausea and vomiting, motion sickness, and sedation; and Tylenol 325 mg to treat minor aches and pains.

Medical staff also noted the decedent was in her cell for Clinical Opiate Withdrawal (COWs) monitoring throughout the day. Decedent was covered in blankets and refused to shower or participate in vitals checks. Decedent just stated, “I just want my juice”. Corrections Staff was able to get the decedent to have her pulse taken on her finger at Approximately 1831 hours.

Medical staff also noted that the decedent had vomit on the floor of the cell, and it was clear in color. Medical also noted that the decedent’s dinner was half eaten and she had drunk about half a cup of Gatorade. Medical staff also noted that the decedent got up and walked to the cell door for her evening medication and told medical staff she was feeling better.

On Tuesday April 22, 2025, at approximately 0501 hours the decedent was served breakfast. At approximately 0617 hours, Corrections Staff had the decedent come out of holding cell 5, so it could be cleaned and to have the decedent change clothes and shower. The decedent at first wanted to shower and then changed her mind.

The decedent was placed back in holding cell 5 at approximately 0637 hours and was checked on again at approximately 0736 hours.

At approximately 0806 hours, Corrections Staff found the decedent to be non-responsive and began life saving measures. An immediate request for outside assistance was also initiated. CPR and use of an AED were initiated by responding corrections officers and medical staff at approximately 0808 hours.

At approximately 0813, Puget Sound Regional Fire Aid and Medic One arrived and assumed lifesaving efforts. The decedent received life saving measures until 0843 hours when she was pronounced deceased.

Cause of Death

An autopsy was performed on April 23, 2025. Per the King County Medical Examiner's Report:

- Manner of Death: Natural
- Cause of Death: Dehydration and Ketoacidosis due to opiate withdrawal

Committee Review & Discussion

The committee met on one occasion to discuss the incident, review materials, and develop action plans for identified issues. The committee specifically reviewed structural, clinical, and operational factors related to the incident.

Each committee member was provided access to the following information for review:

- Decedent's complete booking file
- Photo and video evidence
- Decedent's medical records
- Corrections Officer incident reports
- Corrections Officer cell check logs
- Investigation and evidence reports
- Autopsy report, and toxicology results
- Relevant City of Kent Corrections Facility policies

The committee findings and recommendations:

Considering the common elements involved in these types of incidents, jails must continuously seek ways to mitigate negative outcomes. The key components for preventing such incidents in the future include the following:

A. Structural
   Issues discussed:

a. Holding cell 5 in Booking had a functional toilet and sink.
b. Holding cell 5 in Booking had working surveillance/security cameras.
c. Holding cell 5 in Booking had adequate lighting

B. Clinical

The City of Kent Corrections Facility contracts with a vendor for medical and mental health services.

Issues discussed:

a. Discussed relevant decedent health issues/history
b. Decedent was placed on Clinical Opiate Withdrawal (COWs) protocols. The decedent's COW score was 17, which indicated she was suffering moderate withdrawal symptoms.
c. Decedent was small statured weighing 105 pounds at booking. The autopsy report listed a clinical history of anorexia.
d. Discussed appropriate entry of medical checks on the holding cell check sheets.
e. Discussed Corrections Staff contacting the on-call provider on a more regular basis.
f. Discussed additional training on gathering actual weight vs. self-report weight. The decedent's weight was listed at 105 pounds at booking and the autopsy report listed the decedent's weight at 91 pounds at the time of autopsy.

C. Operational

The City of Kent Corrections Facility was fully staffed. Corrections Officers interacted and regularly checked on the decedent.

Issues discussed:

a. Decedent interacted with Corrections Staff, 96 minutes prior to incident.
b. Discussed the holding cell check sheets and how medical staff should document their checks on inmates housed in the booking area.
c. Discussed adjustments to the holding cell check sheet.
d. Discussed modifying the Inmate Booking Medical Sheet to include the inmates' weight at intake.

Committee Recommendations and Actions

After discussing and evaluating this incident, the Committee provides the following recommendations for consideration:

- Research the use of life safety technology to assist with vital sign monitoring
    - The City of Kent Corrections Facility is in the process of evaluating the possible purchase of new life safety technology to assist Corrections staff with vital sign monitoring.
- Remind Corrections Staff and Medical staff of the expectation to weigh individuals during medical intake.
    - City of Kent Corrections Facility will purchase a scale for the booking area to gather actual weight vs. self-report.
- Advance medication timelines for persons with low BMI.
    - Protocol is currently being reviewed for implementation.
- Provide additional training on detox checks and documentation of checks and/or refusals.
- Modify the holding cell check sheet to include a section for Medical Staff to complete when they see an inmate in a holding cell.
    - Although medical staff make chart notes for inmates, they see in a holding cell, it is not clear to Corrections Staff that the inmate has been seen by medical staff, because Corrections Staff do not have access to those chart notes.
- Require Corrections Staff and Medical Staff to initial the holding cell check sheet when inmates are seen by Medical Staff and document the check clearly.
    - Although medical staff make chart notes for inmates, they see in a holding cell, it is not clear to Corrections Staff that the inmate has been seen by medical staff, because Corrections Staff do not have access to those chart notes.

Conclusion

The City of Kent Corrections Facility is committed to consistently reviewing the effectiveness of these recommendations. The City of Kent Corrections Facility will continue to work closely with its vendor for Medical Services to implement and monitor a system of Continuous Quality Improvement.