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City of Kent Police Department Corrections Division

WASPC Accredited Agency

Unexpected Fatality Review Committee Report

2025 Unexpected Fatality Incident 25-0551

Report to the Legislature
As required by RCW 70.48.510

Michael Armstrong, Corrections Commander

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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 to the 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 after an individual, while in-custody at the City of Kent Corrections Facility (or "CKCF"), suffered a medical emergency. While in the care of medical providers at Valley Medical Center, the inmate died two days after admission. This report 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 CKCF has for the decedent and their family. The CKCF extends its condolences to the decedent's loved ones. The CKCF is committed to thoroughly reviewing the incident, exploring the action items identified in this report, and evaluating their implementation to the extent they may reasonably help prevent fatalities and strengthen safety and health protections for those in custody.

Extension

On September 3, 2025, the CKCF requested and was granted an extension of the unexpected fatality review deadline related to the circumstances surrounding the decedent's death and the subsequent investigation documented in Kent Police Department's Case #25-5354 and the CKCF Incident #25-551.

Under state law, the unexpected fatality review is to be completed within 120-days from the date of the decedent's death, or by September 11, 2025, with respect to this incident. An extension, however, was necessary due to the City of Kent's delay in receiving the Medical Examiner's final determination of the decedent's cause of death as that determination could not be made until toxicology results were obtained by the Medical Examiner. These results were received and the Medical Examiner's opinion concerning the decedent's official cause of death was issued on December 26, 2025. After those results were received, the Unexpected Fatality Review Committee was convened.

Unexpected Fatality Review Committee Meeting Dates and Location

Meeting date: 01/14/2026

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)

Kent Police Department

- Eric Hemmen – Assistant Police Chief

City of Kent Corrections Facility

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

Decedent Information and Arrest

Date of Incarceration: May 11, 2025

Date of Unexpected Fatality: May 15, 2025

The decedent was a 36-year-old male who was arrested the morning of May 11, 2025. At the time of his arrest, he attempted to swallow several plastic baggies containing suspected drugs. Kent Police officers were able to forcibly remove the baggies from the decedent's mouth at the time of his arrest. The baggies contained a white, powder-like substance.

After his arrest, the decedent was transported by ambulance to the hospital at Valley Medical Center for examination prior to taking him to the CKCF for booking. Medical personnel at the hospital examined and observed the decedent, who released him with the following discharge instructions:

- *"This patient was evaluated in the ED for opioid abuse history. There was no report of ingestion, and he has normal vitals her after 2 hrs. of obs. No Narcan required. He is medically cleared and discharged in stable condition to police custody."*

The (After Visit Summary) was printed on May 11, 2025, at 1115 hours.

After his release from the hospital, the decedent arrived at the CKCF at 1146 hours and was booked.

Unexpected Fatality Summary

On Sunday May 11, 2025, at approximately 1153 hours the decedent was booked into the CKCF on misdemeanor charges of Controlled Substance and Tampering with Evidence out of the City of Kent Municipal Court; the decedent also had a Department of Corrections (DOC) felony warrant.

The decedent was pat searched as part of the booking process, and that search did not yield any contraband.

The decedent has no previous incarcerations at the CKCF.

Pursuant to CKCF policy 16.5, Medical Clearance, the decedent was placed on 15-minute observations for a total of 6-hours from the onset of the event when the decedent attempted to swallow a baggie of white powder-like substance at the time of his arrest. The decedent's 15-minute observations ended at 1645 hours.

The decedent remained in the holding area during his entire incarceration and was placed in a cell with a fully functional toilet and sink. The decedent refused booking on Sunday, May 11, 2025, at approximately 2235 hours.

On Monday, May 12, 2025, the decedent was evaluated by medical staff at the CKCF. He was placed on Detox Protocols, which included taking his vitals, completing a Clinical Opiate Withdrawal (COWS) assessment, and the provision of medication to mitigate withdrawal symptoms. The decedent remained in the holding area to facilitate observation and did not show signs of distress.

Medical staff continued to monitor the decedent on Tuesday, May 13, 2026, which included another vitals check, another COWS assessment at 1800 hours, and additional medications. All medications prescribed and dispensed to the decedent were documented on the decedent's Medical Administration Record (MAR). The decedent's COWS assessment score had gone from a 4 down to a 2.

On Tuesday, May 13, 2025, at approximately 2225 hours, Corrections Staff found the decedent having a seizure. Corrections Staff rolled the decedent into the recovery position to prevent choking and injury. An immediate request for outside medical assistance was initiated.

At approximately 2233 Hours, Puget Sound Regional Fire arrived and started evaluating the decedent. At approximately 2236 Hours Tri-Med arrived, and at approximately 2251 hours, Medic One arrived. Puget Sound Regional Fire started CPR at approximately 2247 hours. They found a pulse and transported the decedent to Valley Medical Center.

CKCF was later advised that, while being treated at the hospital, the decedent was pronounced deceased on Thursday May 15, 2025.

Cause of Death

An autopsy was performed on May 16, 2025, and after the King County Medical Examiner received toxicology results, the Medical Examiner issued their report on December 20, 2025. The Medical Examiner determined the cause of decedent's death was as follows:

- Manner of Death: Natural
- Cause of Death: Complications following seizure and cardiac arrest in the setting of chronic opioid and methamphetamine use disorder.

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 Officers incident reports
- Corrections Officer cell check logs
- Investigation and evidence reports
- Autopsy report, and toxicology results
- Relevant CKCF policies

The committee's 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 4 in Booking had a functional toilet and sink.
- b. Holding cell 4 in Booking had working surveillance/security cameras.
- c. Holding cell 4 in Booking had adequate lighting

B. Clinical

The CKCF contracts with a vendor to provide medical and mental health services.

Issues discussed:

- a. Discussed relevant decedent health issues/history
- b. Decedent was placed on Clinical Opiate Withdrawal (COWs) protocols
- c. Discussed the inmate booking medical sheet not being completed due to refusal by the decedent
- d. Discussed appropriate medical checks on the holding cell check sheets.

C. Operational

The CKCF was fully staffed. Corrections Officers interacted and regularly checked on the decedent.

Issues discussed:

- a. Decedent's interactions with Corrections Staff.
- b. Corrections Staff response to the incident.
- c. Discussed ways to complete the Inmate Booking Medical Sheet despite inmate refusal to cooperate.

Committee Recommendations and Actions

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

- Develop protocols that require Corrections Staff to track each time they attempt to complete the inmate booking medical sheet, if not completed within the first six hours of incarceration.
- Directive 25-03 was implemented on September 12, 2025, which requires the following:
 - Corrections Staff will attempt to complete the Inmate Booking Medical Sheet within the first (6) six hours of an inmate's arrival at the CKCF.
 - If the Inmate Booking Medical Sheet cannot be completed within the first (6) six hours of an inmate's arrival, Corrections Officers will complete an incident report that documents the circumstances that existed to cause the delay, and that incident report will be forwarded as follows:
 - Medical
 - Administration
 - On-Duty Supervisor
 - Inmate File
 - Incident Reader board
 - Thereafter, Corrections Staff will attempt at least (3) three times per shift to interact with an inmate for the purpose of completing the Inmate Booking Medical Sheet and Corrections Staff will document the outcome of each attempt made on the (Inmate Refusing Inmate Medical Questions form) IRIMQ form.
 - If an inmate cooperates and the Inmate Booking Medical Sheet is ultimately completed, it will be documented in a supplemental incident report and on the IRIMQ form. The IRIMQ form will then be placed in the inmate's file.

Conclusion

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