IDAHO DEPARTMENT OF CORRECTION
Serious Incident Review (SIR) Report

Date: 10/8/2017 Facility/District: ISCI Incident Location: Unit 11

Type of Incident: Offender Death/Aggravated Battery/Homicide

Time and date of incident: 0056 hours on 9/22/2017

Offenders Involved:

Name:	[redacted]	IDOC#:	[redacted]
Name:	[redacted]	IDOC#:	[redacted]

Staff Involved:

Name:	Lieutenant Nathaniel Jones	Associate #:	0246
Name:	Deputy Warden Garrett Coburn	Associate #:	0455
Name:	Officer Christopher Bennetch	Associate #:	0117
Name:	Officer Charles Bartlett	Associate #:	1422
Name:	Officer Jerry Madrid	Associate #:	A220
Name:	Officer Amanda Kornish-Messer	Associate #:	B724
Name:	Sergeant Daniel Case	Associate #:	8508
Name:	Sergeant Darryl Blanchard	Associate #:	8958
Name:	Officer Jonathan Rigsbee	Associate #:	8492
Name:	Corporal David Elliott	Associate #:	1608
Name:	Officer Jeremy Fugge	Associate #:	B583
Name:	Case Manager Jasmine Avita	Associate #:	0287

(Add additional rows if necessary)

Others Involved:

Name: Kassidee Barney #B240
Name: LPN Tammy McCall #A150
Name: LPN John Shaffer #C401
Name: Jared Berryman #C222
Name: Ada County Paramedics
Name: Ada County Sheriff Deputy Ryan Hart
Name: Ada County Detective Jared Watson #4745
Name: Ada County Detective Jared Lloyd #4464
Name: Ada County Detective Shellie Strolberg #4259
Name: Ada County Detective Kelly Brown
Name: Ada County Coroner

(Add additional rows if necessary)

Was force used? Yes ☐ No ☒

Did all involved staff members completed information reports? Yes ☐ No ☒

If reports were not completed, explain why:

Reports for the incident on 9/17/2017 were not completed by Officer Rigsbee or Corporal Elliott.

Name and job title of the shift commander (correctional facility) or supervisor (community corrections) at the time of the incident:

Lieutenant Nathaniel Jones #0246

Describe the shift commander/supervisor's involvement:

When the emergency was called, Lt. Jones assumed incident command. He directed resources and made

Describe the shift commander/supervisor's involvement:

a notification of the incident to the Facility Duty Officer, Deputy Warden Coburn. He then notified ISCI investigations and had Ada County Paramedics, Sheriff's Deputies, and the coroner respond.

If applicable, the name and title (if available) of any medical personnel involved:

LPN Kassidee Barney #B240, LPN Tammy McCall #A150, CMS John Shaffer #C401, and CMS Jared Berryman #C222

Describe in general, any medical care given:

Lifesaving efforts in the form of CPR and the use of the AED. Ada County Paramedics took over medical care upon arrival at 0136hours.

What department policies, SOPs, FMs, post orders, living guides, etc. govern the incident?

SOP 105.02.01.001 Reporting and Investigation of Major Incidents
ISCI FM 105.02.01.002 Administrative Duty Officer
SOP 116.02.01.001 Custody of Evidence
SOP 125 investigation of Escapes, Serious Crimes, Serious Injury, or Deaths
SOP 312.02.01.001 Death of an Offender
SOP 401.06.03.007 Emergency Medical Response Plans
SOP 401.06.03.041 Emergency Services
SOP 504.02.01.001 Investigations and Intelligence Program
ISCI Post Order- Housing Units 9,10,11
ISCI Post Order- Shift Commander

Were policies, SOPs, FMs, post orders, living guides, etc. followed?

No

Based on the professional opinions of the SIR board, did the staff respond properly?

The board finds the line staff and supervisors on shift responded professionally and appropriately. ISCI investigations responded appropriately and conducted an independent investigation from Ada County Sheriff, while not compromising the criminal case.

[redacted]

What, if anything, can be done to reduce the risk of a similar incident in the future?

The board was unable to determine if the [redacted] injury to [redacted] was related to the 9/22/2017 homicide. The alleged [redacted] and subsequent injuries were never reported or documented by the unit staff.

Results, findings, and recommendations on the following:

Commendation or disciplinary action:

Officer Bartlett, Kornish, Bennetch, and Sgt. Case should be recommended for the silver cross.
Lt. Jones and Officer Madrid should be considered for letters of accommodation

[redacted]

Staffing:

[redacted]. This is to ensure tier checks are being performed on time and allow for staff safety.

Policy and SOP:

SOP 105.02.01.001 Reporting and Investigation of Major Incidents
"Reporting Major Incidents
The following incidents require (1) a telephone call to the administrative duty officer and the applicable division chief (see section 1), and (2) a 105 Incident Notification Report—often referred to as a '105 Report':
Incident involving an offender or occurring on State of Idaho property that causes death or life-threatening injury of an offender, staff member, or member of the general public"
"The following incidents require a 105 Incident Notification Report—often referred to as a '105 Report':
Accidental injury requiring medical attention (staff member, contractor, visitor, offender, etc.)"
"Information Reports
All staff members involved in or witnessing an incident must immediately report the incident to a supervisor such as a shift commander, CRC manager, district manager, etc. In addition the staff member must complete Information Report, before the end of the workday."
"Internal Incident Review and Serious Incident Review (SIR)
The following events must have a formal review or be investigated: escape/walkaway, serious crime, riot, hostage situation, discharge of a firearm (other than training), and serious injury or death of an inmate, staff member, or member of the public."
"SIR Authorization
The director, deputy director, division chiefs, facility head, or district manager can request a SIR for any serious incident, including staff misconduct. Facility heads and managers can only request a SIR for incidents occurring in their facility, office, work site, or district. The director or deputy director act as the convening authority and upon acceptance of an SIR request, assign an SIR chairperson to the incident and determine if a review panel will be used in compliment to the chairperson"
Findings:
Deputy Warden Coburn was the duty officer. He was notified by Lt. Jones that a crime scene was established, law enforcement and paramedics were responding, and that staff were performing life saving measures on [redacted]

ISCI FM 105.02.01.002 Administrative Duty Officer
"The Warden will be notified of situations involving a serious injury to staff requiring relief of the staff member from duty, fires, death of an inmate or staff, or lock-down of any portion of the facility. If, in the duty officer's judgement, any situation seriously affects the operation of the institution, a courtesy notification call to the warden is advised."
Findings:
Deputy Warden Coburn was the facility duty officer. He was notified by Lt. Jones that a crime scene was established, law enforcement, and paramedics were responding, and that staff were performing life saving measures on [redacted]**.** [redacted]

SOP 116.02.01.001 Custody of Evidence
[redacted]

Policy and SOP:

er.

Policy and SOP:

[redacted]

SOP 125 investigation of Escapes, Serious Crimes, Serious Injury, or Deaths
"Each division administrator will conduct an investigation of every escape, serious crime, death or serious injury and a written report will be completed."
Findings:
There were no areas of concern with this SOP.

SOP 312.02.01.001 Death of an Offender
"Death Appears to be by Other than Natural Cause
Responsible Person 1
Upon finding an offender who appears to be deceased, immediately sound an alert to the emergency situation.
Note: If death is uncertain, begin life saving techniques.
Shift Commander (or Designee) 2
• Secure the scene and contact law enforcement in accordance with SOP 504.02.01.001 Investigations and Intelligence Program;
• Post a staff member at the scene and ensure a staff member remains with the body until it is transported off site; and
• Document actions using appendix A, Shift Commander Worksheet (Death of an Offender).
Note: If any object or potential evidence needs to be removed due to a threat to security or for the safety of staff or offenders, the item(s) will be photographed and diagramed in relation to the rest of the death scene prior to its removal (if practical) and then removed, preferably using plastic gloves and placed in an evidence bag, and secured in an evidence locker or immediately turned over to law enforcement.
Shift Commander (or Designee) 4
Contact the coroner in accordance with MOU.
Shift Commander (or Designee) 5
Contact the facility duty officer by telephone, and skip to step 8.
Facility Duty Officer 6
Contact administrative duty officer
Administrative Duty Officer 7
Contact applicable IDOC Leadership Team members.
Note: The Leadership Team consists of the director of the IDOC, division chiefs, and the director's administrative support manager, and others as designated by the director.
Shift Commander (or Designee) 8
• Identify and document any witnesses of the death; and
• Obtain Information Report(s) from staff (see SOP 105.02.01.001 General Reporting and Investigation of Major Incidents).
Shift Commander (or Designee) 9
Complete a 105 Incident Notification Report in accordance with SOP 105.02.01.001 General Reporting and Investigation of Major Incidents.
Shift Commander (or Designee) 10
Have central control change the deceased offender's status in the Reflections computer system to transit for count purposes.
Shift Commander (or Designee) 11
Once the investigation of the scene has been completed, ensure the deceased is removed and transported

Policy and SOP:

in accordance with the MOU (normally the MOU will require that the coroner takes custody of the body).
Shift Commander (or Designee) 12
Unless law enforcement is not finished with the death scene (and excluding any property that is seized as evidence or for forensic testing), ensure that staff remove, inventory, and secure the deceased offender's property in accordance with SOP 320.02.01.001 Property: State-issued and Offender Personal Property.
Note: Obtain a receipt from law enforcement or document any property or evidence taken."
Findings:
The administrative checklist for death of an offender should be modified to allow for real time chronological timelines. For example, the coroner's report may not be released until well after the SIR report is finalized.
The administrative duty officer was not contacted per step 6 of the SOP.

SOP 401.06.03.007 Emergency Medical Response Plans
"Healthcare services staff and equipment must be deployed to provide medical care in the event of an emergency in the facility or surrounding community according to the Emergency Medical Response Plan."
Findings:
There were no areas of concern with this SOP.

SOP 401.06.03.041 Emergency Services
"General
• Emergency healthcare services will be available to all individuals at all IDOC facilities on a 24-hour basis. To facilitate these services, man-down kits will be available in designated areas and will be adequately stocked and maintained.
Note: 'Man-down' refers to any individual who is in need of immediate medical intervention and the 'kit' refers to packaged emergency medical response supplies.
• Immediately upon receiving the request for assistance, the qualified health professional (as designated for emergencies) will obtain a man-down kit and, if appropriate, the emergency medication container and proceed to the scene.
Note: A qualified health professional on each shift will have the designated responsibility for emergency medical response. This designation may be combined with other assignments.
• The health status of the individual for whom the emergency assistance was requested will be assessed and the individual's condition stabilized.
• Emergency healthcare conditions may be treated according to directions in specific written nursing protocols.
• If resuscitation measures are initiated, they are to be continued until the individual's care has been transferred to emergency personnel or a physician has made a finding of death."
"Documentation
The emergency response, assessment, and treatment provided must be documented in the inmate's healthcare record, timed, dated, and signed."
Findings:
Medical staff responded in accordance with this SOP for the incident on 9/22/2017, in which [redacted] was pronounced dead.
LPN McCall complied with this SOP for the emergency treatment of [redacted] on [redacted] She also documented the incident in CIS.
[redacted] and [redacted] collaborated in writing their information reports instead of writing independent reports. [redacted] disposed of the original treatment notes from 9/22/2017 after transcribing them to an e-mail. These notes should have been turned in with [redacted] information report as evidence.

SOP 504.02.01.001 Investigations and Intelligence Program
[redacted]

Policy and SOP:

Policy and SOP:

[redacted]

Findings:

[redacted] **was not photographed before he removed his clothing.** [redacted] **This is due to lack of training of line staff and shift supervisors in the required process.**

As of this date, the crime scene and inmate's property has not been processed completely. It appears that the facility investigators were not aware that they needed to complete the processing of the crime scene and property independent of outside law enforcement per SOP 504.

Ada County Sheriff's recovered evidence and did not provide facility investigators a log of what was removed.

[redacted] **This incident was documented using an "internal incident report".**

The board recommends that proper training be conducted for the facility investigators. This training needs to include crime scene investigation, processing of evidence, and reporting requirements.

ISCI Post Order- Housing Units 9,10,11

[redacted]

Policy and SOP:

Findings:
The initial tier check on 9/22/2017, 1st shift was at 2307 hours. **The unit post orders require the shift commander to be notified.**

ISCI Post Order- Shift Commander
"The shift commander may function as the incident commander during emergency situations until relieved by a higher authority."
"The shift commander will keep the institutional duty officer advised of deviation from the norm during their assigned shift on an as-needed basis."
Findings:
Lieutenant Jones, shift commander, made the initial notification of the incident to the facility duty officer.

Operational Issues:

The locking mechanisms of the cell doors are being tampered with by inmates and the staff are not addressing the issue.
Tier checks are not being completed per SOP and the post orders. This is due to the response and escort officer being assigned to other tasks.
Officer Bartlett responded to the initial call light alone, not knowing a potential homicide had taken place. . Staff stated this often leads to tier checks in restrictive housing being late.
The timing and documentation of the facility being placed on secure status/lock down is a concern. The board was unable to verify when the facility was officially secured and released. Testimony of staff interviewed varied on this issue.
The board was unable to determine if the to was related to the 9/22/2017 homicide. The were never reported or documented by the unit staff. We have concerns that stated that attempted to persuade to not pursue the issue of an assault . claims that notified the unit 11 corporal on and expressed concerns with the injury and how it happened. Inmate interviews revealed the same concern and issues with

Training:

The "Basic Crime Scene Preservation and Evidence Handling: Division of Prisons" training on Relias should be made part of the security staff annual training requirements.
The shift commander should have SOPs and checklists available to them in their office for emergency use.

Equipment Issues:

N/A

Other:

N/A

Signatures of review panel:

Warden Randy Blades, Chairperson	Associate #	Date
Deputy Warden Tim Richardson, Panel member	Associate #	Date
Nurse Supervisor Joe Cardona, Panel member	Associate #	Date
Emergency Coordinator Bret Kimmel, Panel member	Associate #	Date

(Add additional rows if necessary)