In-Custody Death of Shannon Burrage

Kent Police Department, #23-10622

King County Prosecuting Attorney
Public Integrity Team

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DECLINE MEMORANDUM

In-Custody Death of Shannon Burrage

WARNING – This memorandum contains images and descriptions of violence that may be offensive and disturbing to some readers. The images and descriptions are included to provide the reader with the most accurate information regarding the topic of this memorandum.

I. INTRODUCTION

On August 12, 2023, at approximately noon, inmate Shannon Burrage (41) died in her sleep at the South Correctional Entity (SCORE) Jail due to hypertensive cardiovascular disease.

The King County Prosecuting Attorney's (KCPAO) role is to ensure that the in-custody death investigation is thorough and complete, determine whether sufficient admissible evidence exists to support filing criminal charges, and inform the King County Executive whether an inquest should be initiated.[1] An inquest is required when "an action, decision or possible failure to offer the appropriate care by a member of any law enforcement agency might have contributed to an individual's death."[2]

The KCPAO's determination if the police action was justified or if there was a criminal action such that criminal charges should be filed is based entirely on the investigation materials provided to the KCPAO, relevant criminal laws, rules of evidence governing criminal proceedings, the applicable burden of proof, and the KCPAO's Filing and Disposition Standards. This determination is not intended to address matters outside the scope of this memorandum including, but not limited to, an administrative action by the involved agency or any other civil action. The KCPAO expresses no opinion regarding the propriety or likely outcome of any such actions.

The Public Integrity Team has determined that the investigation of the August 12, 2023, in-custody death is complete at this time. Based on a thorough review, the Team has concluded that the evidence is insufficient to support criminal charges against any Corrections Officers (CO) or jail staff. As a result, the KCPAO declines to file criminal charges.

Additionally, after a careful review of these materials, pursuant to Executive Order PHL-7-1-5-EO, the PAO does not recommend that an inquest be initiated because the role of law enforcement was *de minimis* and did not contribute in any discernable way to a person's death.

[1] Executive Order PHL 7-1-5 EO.
[2] King County Charter Section 895.

II. EVIDENCE REVIEWED

- Police Reports: Kent PD 23-10622, Des Moines PD 23- 5884, SCORE
- Booking Records
- Jail Medical Records
- Inmate Check Log Entry
- Kent PD CAD
- Des Moines PD CAD
- Fire Dept. CAD
- Municipal Court Records
- Jail Surveillance Video
- Photographs of Scene
- Medical Examiner's Office Photographs
- Autopsy Report
- Toxicology Report

III. INVESTIGATION

1. CALL-OUT

The Valley Independent Investigation Team (VIIT) performed an independent investigation into the death of Ms. Burrage. Kent Police Department detectives were the lead investigators.

2. FACTUAL SUMMARY

At approximately 10:00 AM on August 6, 2023, Shannon Burrage was arrested by SeaTac Police and booked into SCORE jail on multiple misdemeanor warrants. The deputy who arrested Burrage reported to the jail that the inmate threatened to cut herself, hit her head against the patrol car partition and stated she considers killing herself every day. On the booking paperwork she reported a past history of suicide, high blood pressure, and that she was actively withdrawing from Fentanyl. She was placed in medical observation housing instead of general population for detox and suicide watch. On August 9, 2023, she was removed from mental health observations, but detox protocols remained. She had been incarcerated and isolated for approximately 6 days prior to her death, but had regular contact with staff, showered, and ate.

Jail records show that staff conducted cell checks roughly every fifteen minutes when she was on suicide watch and every thirty minutes when she was not.

On August 12, 2023, at 12:12 PM, COs discovered Ms. Burrage lying in her bed deceased.

Earlier that day at 9:06 AM, video footage shows Burrage entering her cell. She organizes her belongings and appears well. Shortly after entering, she can be seen communicating with a female subject in the cell next to her as she exits for her designated hour out of her cell. It is believed that she had written a note which was later discovered and read, "Please wake me up for lunch and meds." Burrage then sat down on her bunk located on the lower left side and began performing grooming acts such as brushing her hair and placing lotion on her lower legs and feet before putting on socks.

At 9:12 AM, Burrage picks up a cup from the small table inside the cell and walks over to the sink where she appears to fill the cup with some water. She then places a smaller Dixie type cup up to her mouth and tilts her head back as if to make sure she completely emptied the cup of its contents.

At 9:27 AM, Burrage lies down on her left side in her bunk and shows no signs of being in distress.

At 9:28 AM, the video stops recording for lack of motion in the cell.

At 9:45 AM Burrage sits up and picks up the cup sitting next to the bunk. She then stands up and walks toward the cell door where she looks out the window and communicates with the nursing staff who are standing at the door. It appears that she is administered medication at this time.

At 9:47 AM, Burrage lays back down on her bunk.

At 10:07 AM, Burrage briefly sits up and then pulls a blanket that was at her feet over her.

At 10:28 AM, there is slight movement in Burrage's legs.

At 10:37 AM, Burrage has slight movement in her arms and legs over the next minute with one of her legs coming to rest as it is slightly hanging off of the bunk. She then becomes still again and does not move again before being discovered unresponsive by staff.

At 11:41 AM, a CO appears to open up the cuff ports on the cell doors in preparation for

lunch but does not open the port on Burrage's cell.

At 11:46 AM, an inmate is seen providing lunch trays for the cells with the open cuff ports, so bypasses Burrage's cell whose bypass is closed.

At 12:06 AM, an inmate collects the lunch trays and again passes by Burrage's cell.

At 12:12 PM, Corrections Officer 1 (CO 1) was securing handcuff ports on the southside of the third floor after lunch when she observed that inmate Burrage in cell S3 Mezzanine 11 was laying in a similar position that she observed during her last inmate check at 11:41 AM.

CO 1 wrote that she observed the subject's elbow sticking out from under the blanket and noticed some skin discoloration. This appeared unusual to CO 1, so she opened the cell door and called out the subject's name. The subject did not respond, and CO 1 did not see the subject move. She then entered the cell and began to shake inmate Burrage's leg in order to wake her up. As she was shaking her leg, she did not observe any reaction from Burrage. As she looked at Burrage's face she immediately saw that Burrage's eyes and mouth were open. Burrage had discoloration to her skin and appeared to be unresponsive. CO 1 immediately radioed for help stating, "Code medical South 3. Inmate unresponsive". She and Student Officer 1 carried Burrage off of the bed and onto the floor of the cell in order to give them more room to assist Burrage. Corrections Officer 2 (CO 2) also assisted with moving Burrage onto the floor.

CO 2 asked if Burrage had a pulse, but she did not. CO 2 administered Narcan via the inmate's left nostril and checked for a pulse. No pulse was detected, so CO 2 began CPR at approximately 12:13 PM. Student Officer 2 arrived at 12:13 PM with the AED defibrillator. Student Officer 2 opened the AED and turned it on. The Medical Director arrived and took over the preparation of the AED. The AED cycled and recommended CPR which the COs again performed. Firefighters then arrived and requested jail personnel assist with relocating Burrage out of the cell and onto the upper tier walkway which they did. Firefighters performed CPR again. Medic-One also arrived. They provided care. They declared the subject deceased at 12:37 PM.

3. AUTOPSY REPORT

On August 13, 2023, an autopsy of Burrage’s body was performed by the King County Assistant Medical Examiner, Doctor 1. He concluded the cause of death to be hypertensive

cardiovascular disease. Recent PCP use and obesity were contributing factors in the death. The manner of death was ruled accidental. Toxicology testing showed the presence of 51ng/ml of PCP in the decedent's blood, which is well below the range and median amount for overdose.[3]

IV. LAW

KCPAO's Filing and Disposition Standards state, "Crimes against persons will be filed if sufficient admissible evidence exists, which, when considered with the most plausible, reasonably foreseeable defense that could be raised under the evidence, would justify conviction by a reasonable and objective fact-finder."

A person commits Criminally Negligent Second-Degree Manslaughter if they engaged in conduct of criminal negligence and the decedent died as a result of their negligent acts.[4]

A person is criminally negligent or acts with criminal negligence when he or she fails to be aware of a substantial risk that death may occur, and this failure constitutes a gross deviation from the standard of care that a reasonable person would exercise in the same situation.[5]

V. ANALYSIS AND CONCLUSION

KCPAO declines to file any criminal charges in relation to Ms. Burrage's death. Based on the evidence admissible in a criminal case and the applicable legal standards, we have determined that there is insufficient evidence to prove beyond a reasonable doubt that the care SCORE provided to Ms. Burrage was a gross deviation from the standard of care that a reasonable person would exercise, which is necessary for a manslaughter charge. The jail appropriately screened Ms. Burrage when she entered the facility, and her drug withdrawal and mental health problems were diagnosed. As a result, she was appropriately placed into medical observation housing instead of with the jail's general population and checked on regularly. Additionally, there is insufficient evidence for a manslaughter charge or introducing contraband into a correctional facility charge based on the PCP Ms. Burrage consumed. While the possible presence of PCP in a correctional facility is concerning, there is a lack of evidence suggesting who provided the PCP to Ms. Burrage and under what circumstances it was provided to Ms.

[3] Investigators were not able to determine how Burrage obtained PCP or when she administered it.
[4] RCW 9A.32.070 & WPIC 28.06.
[5] WPIC 10.04.

Burrage and consumed. As a result, no charges are appropriate.

VI. RECOMMENDATION FOR INQUEST

Pursuant to Executive Order PHL-7-1-5-EO, we recommend an inquest not be initiated because the role of law enforcement was *de minimis* and did not contribute in any discernable way to a person's death.