South Correctional Entity
Unexpected Fatality Review

Unexpected Fatality
Incident 5884

Report to the Legislature
As required by RCW 70.48.510

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Foreword

This report summarizes an unexpected fatality that occurred at the South Correctional Entity (SCORE). It offers a summary of facts understood through the careful review of events, physical layout, and response to the incident. These reviews are intended to identify any actions, policies, and/or circumstances that can be improved.

This report cannot adequately convey the level of respect, concern, and commitment that SCORE has for the deceased individual and their family. SCORE extends its condolences to the decedent's loved ones. SCORE is committed to thoroughly review and follow through with identified any action items noted in this report.

Background Legislation

RCW 70.48.510

(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.

(2) In any review of an unexpected fatality, the city or county department of corrections or chief law enforcement officer and the unexpected fatality review team shall have access to all records and files regarding the person or otherwise relevant to the review that have been produced or retained by the agency.

(3)(a) An unexpected fatality review completed pursuant to this section is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to this section.

(b) An employee of a city or county department of corrections or law enforcement employee responsible for conducting an unexpected fatality review, or member of an unexpected fatality review team, may not be examined in a civil or administrative proceeding regarding: (i) The work of the unexpected fatality review team; (ii) the incident under review; (iii) his or her statements, deliberations, thoughts, analyses, or impressions relating to the work of the unexpected fatality review team or the incident under review; or (iv) the statements, deliberations, thoughts, analyses, or impressions of any other member of the unexpected fatality review team, or any person who provided information to the unexpected fatality review team relating to the work of the unexpected fatality review team or the incident under review.

(c) Documents prepared by or for an unexpected fatality review team are inadmissible and may not be used in a civil or administrative proceeding, except that any document that exists before its use or consideration in an unexpected fatality review, or that is created independently of such review, does not become inadmissible merely because it is reviewed or used by an unexpected fatality review team. A person is not unavailable as a witness merely because the person has been interviewed by, or has provided a statement for, an unexpected fatality review, but if the person is called as a witness, the person may not be examined regarding the person's interactions with the unexpected fatality review including, without limitation, whether the person was interviewed during such review, the questions that were asked during such review, and the answers that the person provided during such review. This section may not be construed as restricting the person from testifying fully in any proceeding regarding his or her knowledge of the incident under review.

(d) The restrictions set forth in this section do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with an unexpected fatality reviewed by an unexpected fatality review team.

(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

(5) For the purposes of this section:

(a) "City or county department of corrections" means a department of corrections created by a city or county to be in charge of the jail and all persons confined in the jail pursuant to RCW 70.48.090.

(b) "Chief law enforcement officer" means the chief law enforcement officer who is in charge of the jail and all persons confined in the jail if no department of corrections was created by a city or county pursuant to RCW 70.48.090.

(c) "Unexpected fatality review" means 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 actually 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 under this section.

Extension Criteria

In response to the new legislation regarding the reporting responsibility of jails related to unexpected fatalities of incarcerated individuals, the South Correctional Entity (SCORE) worked with the Washington Association of Sheriffs and Police Chiefs (WASPC) Corrections Liaison to receive proper training and to form a committee of individuals to conduct independent reviews of unexpected fatalities for SCORE. While we worked to complete that process, WASPC suffered the unfortunate passing of the Corrections Liaison, which created a longer delay causing the SCORE Executive Director to extend the 120-day requirement (per RCW 70.48.510) to complete this report.

Additionally, the autopsy report related to this fatality was not available to SCORE until June 13, 2024, more than 120 days following the incident, which was an additional reason for the extension.

Unexpected Fatality Review Training Schedule

- WASPC Sponsored Training - September 7, 2023
- WASPC Sponsored Training – November 7, 2023

SCORE Unexpected Fatality Review (UFR) Committee

UFR Committee Meeting dates:

- February 15, 2024

UFR Committee Members:

Facilitator/Coordinator

- John Di Croce, Operations Chief

Medical/Mental Health Team

- Dr. Michael Grabinski
- Ann Marie Natali, DBe, MBA, MA, Health Services Administrator
- Jason Wiggins, RN, Director of Nursing
- Rita Whitman, ARNP
- Elizabeth Kremer, MCJ, MSW, LSWAIC

SCORE Command Staff

- Devon Schrum, Executive Director
- Lucinda Gibbon, Human Resources Director/Risk Manager
- Nicole Summers, Accreditation Manager

SCORE Operations Leadership

- Al Ervin, Captain
- Josh Burgess, Special Services Lieutenant
- Dan Koidahl, Corrections Sergeant

Decedent Information

Date of Incarceration: August 6, 2023
Date of Unexpected Fatality: August 12, 2023

The deceased individual was a 41 -year-old female. The decedent was booked by the City of SeaTac on new charges of Violation of Protection Order, DV, Assault 3rd Degree – Attempt. She was also booked on warrants for Violation of Protection Order DV, Assault 4th Degree DV x3, and Harassment, and Resisting Arrest. The decedent had 6 previous incarcerations at SCORE.

Unexpected Fatality Summary

On August 6, 2023, at 0955, the decedent arrived at SCORE. The decedent completed the booking process and was placed on enhanced watch at 1016 in Booking. Prior to booking the decedent had made suicidal statements and was hitting her head on the patrol car partition.

On August 7, 2023, at 0214, the decedent was assigned a bed in the clinic where she remained on enhanced watch. At 0916, the decedent was evaluated by Mental Health Staff and placed on Mental Health Observation. The decedent interacted with Mental Health Staff daily. At 1500, the decedent was placed on Detox Protocols.

On August 9, 2023, the decedent was assigned to Housing and removed from Mental Health Observation. She did not share a cell with others. The decedent continued on Detox Protocols.

August 9-12, 2023, the decedent interacted with staff, participated in Detox Protocols, showered, and ate.

On August 12, 2023, the decedent spoke with nursing staff at 0946 and then lay down on her bed and appeared to be sleeping. At 1212, she was discovered to be non-responsive. Lifesaving efforts were initiated by corrections officers and medical staff at 1213. An immediate request for outside assistance was also initiated. Puget Sound Fire arrived at 1220 and took over CPR. King County Medic One arrived at 1224 and assumed lifesaving efforts.

On August 12, 2023, at 1238, the decedent was pronounced deceased by the responding fire and aid unit. Outside law enforcement was notified about the unexpected fatality. The Valley Independent Investigative Team (VIIT) assigned a Detective to investigate.

Cause of Death

An autopsy was performed on August 13, 2023. Per the King County Medical Examiner's Report:

- Manner of Death: accident
- Cause of Death: hypertensive cardiovascular disease
- Contributing Factors: recent phencyclidine use and Obesity WHO Class 1

Committee Review and Discussion

The committee met 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.

Committee Findings

Structural

Issues discussed:

- The cells in Booking, Housing, and Medical had functional toilets and sinks.
- The assigned cell in Housing had a functional emergency call button.
- The cells in Booking, Medical, and Housing had working surveillance/security cameras. Cameras only record movement activity, so periods of inactivity are not recorded.
- The body scanner in Booking was functioning. There is no record of a body scan.

Clinical

SCORE contracts with a vendor for medical and mental health services.

Issues discussed:

- A urinalysis was conducted upon booking. Decedent admitted to recent fentanyl use.
- Decedent was placed on Clinical Opiate Withdrawal (COWs) protocols.
- Decedent was interacting with Officers, Mental Health Staff, and participated in 7 of 12 scheduled Detox Checks.

Operations

The Booking, Medical, and Housing areas were fully staffed. Corrections Officers regularly interacted with the decedent.

Issues discussed:

- Discussed pros and cons of congregant housing for Mental Health Observation. The decedent would not have been a good fit for a cellmate or general population in her current state.

Committee Recommendations and Actions

All recommended actions have been completed.

- 3 refused Detox Checks will result in a provider assessment.

Conclusion

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