South Correctional Entity
Unexpected Fatality Review

Unexpected Fatality
Incident 6276

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. 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.

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:

- September 6, 2024
- September 26, 2024
- December 12, 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
- Rita Whitman, ARNP
- R.N. Ami Mason, R.N.
- Lauren Seaton, Psych ARNP
- Patricia Fray, Psych ARNP
- Saige Rodgers, RN Director of Nursing
- Jordan Boulder, Wellpath Northwest Regional Director of Nursing

SCORE Command Staff

- Devon Schrum, Executive Director
- Dan White, Jail Services Chief
- Lucinda Gibbon, Human Resources Director/Risk Manager (Sept 6)
- Nicole Summers, Accreditation Manager
- Marilyn Hood, Records Manager

SCORE Operations Leadership

- Josh Burgess, Special Services Lieutenant (Sept 6)
- Jeff Gepner, Lieutenant
- Pedro Santos, Lieutenant
- Richard Grub, Lieutenant
- Al Ervin, Captain

Decedent Information

Date of Incarceration: August 22, 2024,
Date of Unexpected Fatality: August 31, 2024

The deceased individual was a 33-year-old male. The decedent was booked by the City of Covington.

The decedent was booked on the following charges: Washington State Department of Corrections Secretary's Warrant. The decedent had 18 previous incarcerations at SCORE.

Unexpected Fatality Summary

On August 22, 2024, at approximately 2136, the decedent was booked in to SCORE. The decedent was pat and strip searched, provided jail clothes to change into and received a body scan. The searches did not yield any contraband.

The decedent was placed in a booking cell, where he remained until August 23, 2024, at approximately 0200. At approximately 0202 the decedent met with the Booking Nurse, who conducted a receiving screening in the medical office located in the open booking area. Decedent spoke and participated in the medical assessment.

Decedent's medical assessment indicated that the decedent was a daily opioid user and had been for greater than a year. No other medical conditions were stated at the time of the assessment and the decedent was placed on a Clinical Opiate Withdrawal Scale (COWS) and cleared to be housed in general population.

The decedent was housed in general population for one day, when a determination was made by SCORE Medical staff to have him moved to the Medical Clinic for additional observation while going through detox protocols.

On August 27, 2024, the decedent was sent to Saint Anne Hospital following apparent seizure like activity and vomiting. Upon return from Saint Anne's Hospital, the decedent was again housed in the Medical Clinic without further incident until he was cleared from COWS protocols on August 29, 2024.

On August 31, 2024, at approximately 0600 while conducting rounds, SCORE staff observed the decedent had a lack of color to the body parts visible while the decedent laid on his assigned bunk. SCORE staff attempted to wake the decedent and upon no response made entry into the cell. SCORE Staff checked for signs of life and upon observing none, immediately called for medical assistance and began cardiopulmonary resuscitation (CPR). At approximately 0603, the Automated External Defibrillator (AED) pads were applied and the AED indicated "No shock advised" on two separate occasions. CPR continued until 0614, when SeaTac Fire Department arrived and took over care. King County Medic One arrived at 0617 and pronounced the decedent deceased.

Cause of Death

An autopsy was performed on September 1, 2024. Per the King County Medical Examiner's Report:

- Manner of Death: Natural
- Cause of Death: Ruptured cerebral artery aneurysm

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 and Medical had functional toilets and sinks.
- The assigned cell in Housing had a working emergency call button.
- The cells in Booking 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 and used to scan the decedent upon booking. No additional items of contraband were discovered in the body scan image.

Clinical

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

Issues discussed:

- Decedent successfully completed detox protocols.
- Decedent was taken to Saint Anne Hospital on 08/27/2024 for complaints regarding withdrawal from opiates.
- Decedent was evaluated at the hospital and eventually discharged back to jail.

Operations

The Booking and Housing areas were adequately staffed.

Issues discussed:

- Quick reaction of SCORE staff and recognition of medical issue.

Committee Recommendations and Actions

- Research and pilot use of specific housing unit to be used for persons detoxing.

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 monitor a system of Continuous Quality Improvement.