South Correctional Entity
Unexpected Fatality Review

Unexpected Fatality
Incident 6949

Report to the Legislature
As required by RCW 70.48.510

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Table of Contents

Foreword 2

Background Legislation 2

Unexpected Fatality Review Training Schedule 4

SCORE Unexpected Fatality Review (UFR) Committee 4

Decedent Information 4

Unexpected Fatality Summary 5

Cause of Death 5

Committee Review and Discussion 5

Committee Findings 5

- Structural 5
- Clinical 6
- Operations 6

Committee Recommendations and Actions 6

Conclusion 6

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:

- December 4, 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
- Lauren Seaton, PSYCH ARNP
- Patricia Fray, PSYCH ARNP
- Jordan Boulder, Regional Director of Nursing
- Saige Rodgers, RN

SCORE Command Staff

- Devon Schrum, Executive Director
- Dan White, Jail Services Chief
- Lucinda Gibbon, Human Resources Director/Risk Manager
- Nicole Summers, Accreditation Manager

SCORE Operations Leadership

- Josh Burgess, Special Services Lieutenant
- Richard Grub, Lieutenant
- Al Ervin, Captain

Decedent Information

Date of Incarceration: November 1, 2024
Date of Unexpected Fatality: November 1, 2024

The deceased individual was a 30-year-old male. The decedent was booked by the City of Auburn.

The decedent was booked on the following charges: SODA Violation and Criminal Trespass 1nd Degree. The decedent had 8 previous incarcerations at SCORE.

Unexpected Fatality Summary

On November 1, 2024, at approximately 1821, the decedent was booked in to SCORE. The decedent was pat searched and 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 at 1830. At 1834, the Booking Nurse checks decedent's vital signs and provided a cup of Gatorade, which the decedent drank. At 1844, the decedent was provided and drank a second cup of Gatorade. At 1849, the Booking Nurse checked the decedent's vital signs. The decedent's vital signs were low. At 1855, a nurse checked the decedent's blood sugar and consulted with the Director of Nursing. The decedent complained that his body hurt. The decedent stated that he had not taken suboxone in the last 5 days and admitted to huffing between 8 and 15 12 oz. cans of computer dust cleaner daily. SCORE contacted Tri Med to transport the decedent to the hospital for low blood pressure and further evaluation. Tri Med advised SCORE to call Fire/EMS. SCORE contacted FIRE/EMS. While waiting for FIRE/EMS to arrive, the decedent used the toiled and moved from sitting to lying down. Puget Sound Fire arrived at 1934 and assessed decedent. Decedent was talking and participated in the medical assessment. Puget Sound Fire provided oxygen to decedent. Tri Med arrived at 1941. Medic One arrived at 1950. The decedent continued to participate in the medical assessment until 1954 when he became non-responsive. Medic One provided extensive life saving measures including CPR. CPR continued until 2039. Death was pronounced at 2040 by Medic One.

Cause of Death

An autopsy was performed on November 4, 2024. Per the King County Medical Examiner's Report:

- Manner of Death: accident
- Cause of Death: difluoroethane induced cardiomyopathy

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:

- The differences between Tri Med and Fire EMS and the criteria for each.
- The use of Narcan.
- The blood pressure parameters for booking.

Operations

The Booking and Housing areas were adequately staffed.

Issues discussed:

- The quick reaction of the Sergeant in summoning medical to evaluate decedent for off baseline behavior.
- The EMS contact process.
- Updating current intake forms to include more specific questions regarding recent drug use including the use of inhalants.

Committee Recommendations and Actions

- Research and pilot use of life safety technology to assist with vital sign monitoring.
    - SCORE is now piloting two different forms of medical monitoring equipment. Equipment for both systems (passive and wearable).
- Any call for EMS in Booking will be via 911.
- Intake form was revised to provide SCORE more specific information regarding the use of drugs including recency and type by arresting agencies.

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.

This unexpected fatality occurred within one hour of booking.