South Correctional Entity
Unexpected Fatality Review

Unexpected Fatality
Incident 5628

Report to the Legislature
As required by RCW 70.48.510

Devon Schrum, Executive Director

John DiCroce, Operations Chief/UFR Coordinator

Published February 6, 2024

Table of Contents

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 SCORE has for the deceased individual and their family. SCORE extends its condolences to the decedent's loved ones. SCORE also commits to thoroughly review and follow through with identified 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.

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:

- August 24, 2023

UFR Committee Members:

Facilitator/Coordinator

• John Di Croce, Operations Chief

Medical/Mental Health Team

• Dr. Michael Grabinski

• Tela Sigsworth, LPN, Health Services Administrator

• Rita Whitman, ARNP

• Elizabeth Kremer, MCJ, MSW, LSWAIC

• Lance Briggs, Psychiatric Nurse Practitioner•

SCORE Command Staff

• Devon Schrum, Executive Director

• Lucinda Gibbon, Human Resources Director/Risk Manager

• Nicole Summers, Project Specialist

SCORE Operations Leadership

• Al Ervin, Captain

• Richard Grub, Operations Lieutenant

• Jeffrey Gepner, Programs Lieutenant

• Sean Gannon, Sergeant

Decedent Information

Date of Incarceration: March 19, 2023
Date of Unexpected Fatality: March 25, 2023

The deceased individual was a 65-year-old male. Upon medical screening, he reported being a daily user of fentanyl, methamphetamines, and buprenorphine. He was booked into SCORE by the Port of Seattle Police Department on outstanding warrants for the City of Auburn.

Unexpected Fatality Summary

On March 19, 2023, at 0718, the decedent arrived at SCORE and received a body scan.The decedent met briefly with a nurse shortly after arrival and was placed on Clinical Opiate Withdrawal Scale (COWS) protocols. The decedent was placed in a general population housing unit.

Between March 19 and March 24, 2023, the decedent's activities were unremarkable. Decedent was observed eating, socializing with others, and responding to jail expectations. Decedent was participating in COWS assessments.

On March 25, 2023, at 1839, the decedent walked from his bunk to the toilet and began to fall but caught himself by grabbing the fencing. Inmates rushed to his aid and rolled him onto his side and summoned help. Two corrections officers responded and assessed the situation and called for a nurse to respond to the unit. The decedent reported to officers that he believed he just stood up too fast. Shortly thereafter nurses and additional custody staff arrived on scene and continued to assess decedent who was conscious and talking. The decedent was placed in a wheelchair and moved to Medical for additional assessments and evaluation. During the movement to Medical, nurses asked for emergency services to be contacted.

In Medical, the decedent was placed on the exam table and complained of shortness of breath. He was provided a nitro pill. A few minutes later, King County Medic One and Fire Rescue arrived onsite and began assessing the decedent, who was communicating with them. Approximately 15 minutes later, the decedent became unresponsive and Medic One began lifesaving measures. The lifesaving measures continued for approximately 45 minutes, at which point they were discontinued. SCORE notified outside law enforcement about the unexpected fatality. Detectives from Kent Police Department were assigned to investigate. On June 13, 2023, the autopsy report was provided to SCORE.

Cause of Death

An autopsy was performed on March 27, 2023. Autopsy report is dated June 1, 2023. Per the King County Medical Examiner's Report:

- Manner of Death: natural
- Cause of Death: hypertensive and atherosclerotic cardiovascular disease

Committee Review and Discussion

The committee met on August 24, 2023, 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 decedent was found to have been housed appropriately.

Clinical

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

Issues discussed:

- The decedent was found to have been screened and treated appropriately.

Operations

The Booking and Medical Areas were fully staffed. There was nursing coverage for both Booking and Medical areas.

Issues discussed:

- The Decedent interacted with staff and inmates regularly and with no concerns noted.

Committee Recommendations and Actions

No additional actions taken.

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.