South Correctional Entity
Unexpected Fatality Review

Unexpected Fatality
Incident 5708

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 until August 22, 2023, more than 120 days following the incident, which was an additional reason for the extension. The Unexpected Fatality Review Committee commenced meeting following receipt of the autopsy 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
- September 6, 2023
- September 20, 2023
- October 12, 2023
- October 30, 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
- Megan Leinen, MBA, BSN-RN, CCHP (Sept 30 meeting only)

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: May 16, 2023
Date of Unexpected Fatality: May 19, 2023

The deceased individual was a 43-year-old female with a significant medical history. She was booked into SCORE by the Auburn Police Department. The decedent was being held on new charges of Criminal Trespass 2nd degree and Theft in the 3rd degree. In addition, the decedent was also being held for two (2) Stay Out of Drug Areas (SODA) Order violations, Possession of Drug Paraphernalia, and Criminal Trespass 2nd degree warrants with a total bail amount set at $9,600.00.

Unexpected Fatality Summary

On May 16, 2023, at 1608, the decedent arrived at SCORE. Shortly thereafter, the decedent was searched and discovered to have sores on her legs. The decedent then met briefly with a nurse and walked through the body scanner. The decedent was placed in a Booking cell with a toilet. The decedent was provided a meal at 1650, and again the following morning at 0648.

On May 17, 2023, at 0812, Corrections Officers attempted to complete the booking of decedent. Decedent refused to leave the booking cell to complete booking. The decedent refused to be further assessed by a nurse. The decedent continued to lay down on the floor of the booking cell with a blanket. Decedent was provided a meal at 1139 and again at 1648. On May 18, 2023, at 0109, the decedent used the toilet and then laid down. At 0646 on May 18th, the decedent was provided a meal, and at 1032, the decedent was provided additional fluids (Gatorade), with a nurse observing. At 1135, decedent received another meal. At approximately 1302, the decedent soiled herself and corrections officers and a nurse responded to decedent's cell and assisted with cleaning up and changing the decedent's uniform. At this point, decedent was moved from Booking to Medical and was provided with additional fluids.

In Medical, the decedent was provided a meal at 1619, which the officer moved from the cuff port to inside the cell at 1645. At 1946, the decedent was provided additional fluids by the officer with the nurse present. On May 19, at 0708, the decedent was provided another meal. At 1130, the medical

officer tried to speak with the decedent and he noted that she was breathing and appeared to be sleeping. At 1134, the decedent was provided another meal. At 1420, the medical officer entered the cell with the nurse to check on the decedent. The decedent was not responsive. The medical officer immediately called for assistance and began lifesaving measures. A request for outside assistance was also immediately initiated.

On May 19, 2023, at 1432, 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. On August 22, 2023, the autopsy report was provided to the VIIT Investigator.

Cause of Death

An autopsy was performed on May 20, 2023. Per the King County Medical Examiner's Report:

- Manner of Death: accident
- Cause of Death: dehydration with hypernatremia and evidence of acute renal failure
- Other Conditions Contributing to Death: acute methamphetamine intoxication, severe protein calorie malnutrition, and chronic drug abuse
- Place of Injury: jail
- Description of Injury: toxic use of a drug

Committee Review and Discussion

The committee met on five separate occasions 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 decedent had access to drinking water and was given Gatorade on several separate occasions.
- The cell in Medical had functional emergency call buttons.
- The cells in Booking and Medical had working surveillance/security cameras. Cameras only record movement activity, so periods of inactivity are not recorded.
- The booking cells were constructed with a partial privacy wall obscuring the view of the toilet and sink from the Booking hallway. This partial wall prevented staff from seeing that the decedent was lying on the floor in a state of undress. Staff entering the cell noticed the decedent in this state and took action to check on her and provide her with clean clothing.

- The body scanner in Booking was functioning and used to scan the decedent upon booking. No items of contraband were discovered in the body scan or pat search.

Clinical

SCORE contracts with a vendor for medical and mental health services. There were several areas of improvement identified during the course of this review.

Issues discussed:

- A urinalysis was not collected from the decedent upon booking due to the decedent's refusal to complete intake.
- Medical charting was only partially completed while decedent was in the Booking and Medical areas.
- Detox protocol was not started upon initial intake.
- Meals were provided regularly but not consumed.

Operations

The Booking and Medical areas were fully staffed. There was nursing coverage for both Booking and Medical areas. Corrections Officers regularly interacted with the decedent and routinely attempted to complete intake, which includes a screening for healthcare concerns by the Booking Nurse, but Decedent consistently refused to complete intake.

Issues discussed:

- Decedent was well known to SCORE Officers. Decedent had been booked 27 times previously without detox complications. Over familiarity with the decedent and previous detox experiences were discussed as possible issues.
- Decedent was given meals upon arrival and at each scheduled mealtime. Meal sacks were not removed at the time a new meal was served. This made it difficult for Corrections Officers to assess how much food was being consumed.
- Decedent was allowed to continue to refuse screening and completion of intake without a medical assessment occurring.

Committee Recommendations and Actions

Many of the below recommended actions were put into place immediately after this incident. As a result, the committee also reviewed the effectiveness of the immediate actions and developed additional recommendations. At the time of this writing all recommended actions have been completed.

- Nursing walkthroughs will occur in Booking every 4 hours. These walkthroughs will be documented in the jail management system and be charted on by nursing staff.
- Detox protocols will be started upon initial booking and before the completion of intake (in the event of a delayed intake).

- Nurses will be trained to look at previous chart notes to find detox or drug use history.
- Any new patients admitted to Medical must be screened immediately by a Medical Charge Nurse or Medical Provider and charted on.
- The Medication for Opioid Use Disorder (MOUD) Team will speak with patients in Booking after two refusals to cooperate with medical screening.
- A Medical Provider must see a patient after three refusals to cooperate with the medical screening.
- Mental Health staff will also check on patients who are detoxing on days 3 and 5.
- Real time booking information is now available to Booking and Medical staff via strategically located monitors in those areas.
- The Charge Nurse has been relocated from the general nursing station to the in-patient nursing station.
- The Shift Lieutenant will share reports of anyone that is in Booking for more than 8 hours. The Lieutenant will document a current (same shift) medical check and state who performed the check. This report will be shared with Medical and Jail Command Staff.

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.