South Correctional Entity Unexpected Fatality Review

Unexpected Fatality Incident 6416

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 Valley Medical Center. 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

The Executive Director granted a brief extension to the 120-day requirement (per RCW 70.48.510) to complete this report. The autopsy report related to this fatality was not available to SCORE until July 30, 2024.

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:

- June 7, 2024
- June 27, 2024
- August 13, 2024
- September 26, 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 (June 7, June 27, Sept 26)
- Rita Whitman, ARNP (June 27 and Sept 26)
- Mary Broadbent, Director of Nursing (June 7)
- Amy Mason, Registered Nurse (Sept 26)

SCORE Command Staff

- Devon Schrum, Executive Director
- Lucinda Gibbon, Human Resources Director/Risk Manager (June 27 and Aug 13)
- Marilyn Hood, Executive Assistant/Records Manager (June 7, June 27, and Sept 26)
- Nicole Summers, Accreditation Manager

SCORE Operations Leadership

- Al Ervin, Captain (June 7, June 27, and Sept 26)
- Richard Grub, Operations Lieutenant (June 7)
- Josh Burgess, Special Services Lieutenant (June 7 and Aug 13)

- Jeff Gepner, Programs Lieutenant (June 7 and Aug 13)

Decedent Information

Date of Incarceration: May 9, 2024
Date of Unexpected Fatality: May 11, 2024

The deceased individual was a 60-year-old female. The decedent was booked by the City of Federal Way for a warrant. The decedent also had a valid warrant for the City of SeaTac.

The decedent was booked on the following charges: Criminal Trespass and Possession of Drug Paraphernalia. The decedent had 6 previous incarcerations at SCORE.

Unexpected Fatality Summary

On May 9, 2024, at approximately 1304, the decedent was booked in to SCORE. The decedent was pat searched and provided jail clothes to change into, walked through the metal detector and received a body scan. The searches did not yield any contraband. The decedent was medically screened by a Registered Nurse prior to acceptance. The decedent reported incontinence and intermittent rectal bleeding. The decedent had sores on her legs and appeared intoxicated. The decedent initially denied drug use but later acknowledged drug use.

The decedent was placed in a booking cell with a sink and a toilet. At 0330, the decedent was evaluated by a Booking Nurse. The decedent was placed on Detox Protocols and assigned to the medical unit.

The decedent was housed in a single cell in the Medical Unit with a sink, toilet, and shower during her entire stay.

On May 11, 2024, at 0026, the decedent appeared to move from the bed to the floor. At 0028, the clinic officer responded to the decedent's cell with the Clinic Nurse. The Clinic Nurse attempted to communicate with the decedent through the cell door and then entered the cell at 0035. The Clinic Nurse checked decedent's vital signs and reported that the decedent was interacting and talking to her.

At 0043 the Clinic Nurse exited the cell to consult with the Booking Nurse. The Clinic Nurse returned to the cell at 0103 and found the decedent to be non-responsive and began life saving measures. An immediate request for outside assistance was also initiated. CPR and use of an AED were initiated by responding corrections officers and medical staff at 0106.

At 0113, Puget Sound Fire Medic One arrived and assumed lifesaving efforts. The decedent received CPR and AED until 0137 when she was pronounced deceased.

Cause of Death

An autopsy was performed on May 13, 2024. Per the King County Medical Examiner's Report:

- Manner of Death: accident
- Cause of Death: acute combined fentanyl and methamphetamine intoxication

Committee Review and Discussion

The committee met on four 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 assigned cell in Medical had a functional 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 gave conflicting statements regarding drug use.
- Decedent was placed on Clinical Opiate Withdrawal (COWs) protocols.
- Decedent was ambulatory but was provided wheelchair escort to Medical Unit.
- Decedent was small statured weighing 114 pounds.
- Discussed appropriate entry of detox checks into system.
- Discussed use of onsite nursing staff for medical consults.
- Discussed providing additional training on electronic vital sign monitoring equipment.
- Discussed additional training on gathering actual weight vs. self-report.
- Discussed CPR protocols.
- Discussed assisting patients from floor to bed and/or providing floor bed when patients appear unsteady.

Operations

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

Issues discussed:

- Decedent interacted with nurse less than 30 minutes prior to incident.
- Effective use of cut down tool to remove shirt to assist with AED pad placement.
- Discussed use of portable beds for patients unable to safely use elevated bunk in single medical cells.
- Discussed Clinic Nurse's previous experience working with decedent in the community.
- Discussed not using a wheelchair for escorts when patients are ambulatory.
- Discussed piloting use of technology to monitor vital signs or alert staff when vital signs change suddenly.

Committee Recommendations and Actions

- Research and pilot use of life safety technology to assist with vital sign monitoring.
    - SCORE will be piloting two different forms of medical monitoring equipment. Equipment for both systems (passive and wearable) has been ordered.
- Advance medication timelines for persons with low BMI.
    - Protocol is currently being reviewed for implementation this year.
- Provide additional training on detox checks and documentation of checks and/or refusals.
    - This has been completed.
- Remind nursing staff of the expectation to weigh individuals during medical intake.
    - This has been completed.

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.