Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-014

Report to the Legislature

As required by RCW 72.09.770

December 21, 2023

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on October 19, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dawn Williams, Program Administrator, Substance Abuse Recovery Unit
- Patty Paterson, Director of Nursing
- Mary Beth Flygare, Project Manager
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Program Manager
- Rae Simpson, Director, Quality Systems

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Jason Bennett, Superintendent
- Lorne Spooner, Correctional Operations Program Manager

DOC Women's Prison Division

- Jeannie Darneille, Assistant Secretary
- Deborah Jo Wofford, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary - Reentry
- Scott Russell, Deputy Assistant Secretary - Reentry
- Susan Leavell, Senior Administrator - Reentry
- Carrie Stanley, Reentry Center Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Year of Birth: 1972 (51-years-old)

Date of Incarceration: June 2023

Date of Death: August 2023

At the time of his death, the incarcerated individual was on escape status from a DOC Reentry Center operated by a contracted vendor. Cause of death was the result of acute combined drug intoxication including fentanyl and methamphetamine. Manner of death was accidental.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Weeks prior to death	Event
10 weeks	• Readmitted to prison.
5 weeks	• Transferred to parent facility.
2 weeks	• Transferred to reentry center.
1 week	• Escaped from reentry center.
Day prior to death	**Event**
Day of death	• Reentry center employees received phone call from the parent of the incarcerated individual informing them of his death from apparent overdose. • County Medical Examiner was contacted by reentry center staff to confirm his death.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee members considered the information from both reviews in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

a. The incarcerated individual had a known history of methamphetamine use.

b. No significant safety or quality issues were identified with his medical care during his short period of incarceration.

c. He was seen twice for problem focused medical care prior to transferring to the reentry center.

d. He did not report a history of opioid use and as a result DOC Health Services did not have an opportunity to assess and initiate medications for opioid use treatment prior to his transfer.

e. He died of a combined fentanyl and methamphetamine overdose while on escape status from a reentry center.

2. The Mortality Review Committee did not identify any additional recommendations to prevent a similar fatality in the future.

B. Independent of the mortality review, DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

1. The CIR found:

a. While the incarcerated individual was housed in a reentry center, he was issued a point-to-point community pass. When he returned to the facility late in the afternoon, he tested positive for methamphetamines. He was placed on total restriction in the facility until his case could be reviewed in the morning with the multidisciplinary team to determine next steps in his case management.

b. The decision was made to return him to full confinement for his safety. Before he could be detained, he exited out of the emergency exit side door of the facility without authorization. He was placed on escape status and a case was opened with the DOC Community Response Unit.

c. One week later, a family member notified the reentry center that the incarcerated individual was found deceased in the community.

2. The CIR recommended:

a. Adding escape response checklist training to the Reentry Center Academy.

b. Update the On-the-Job training checklist which identifies standard actions and response timeframes in the event of an escape from a reentry center.

c. Update DOC Safety Program form 03-474 to include reentry center site specific information indicating primary and secondary arrest and detain locations within their facility for staff orientation purposes.

C. The Department of Health (DOH) representative offered resources for training and asked about reentry center orientation for the residents related to overdose risk after a period of abstinence and the process to return a person to full confinement from a reentry center.

Note: Incarcerated individuals receive an orientation during the first 48 hours after transitioning to the reentry center. Orientation includes a DOH education video on overdose

risk. All residents are offered a Narcan kit and are also able to access emergency Narcan kits throughout the facility without needing staff permission.

Incarcerated individuals may be returned to full confinement if they are not following reentry center participation requirements that place their own or others safety at risk.

D. The Health Care Authority (HCA) representative asked a) if the case managers are notified when a new resident is at risk due to a history of substance use, b) whether Narcan is offered, c) whether it is possible to offer Narcan to incarcerated individuals prior to them leaving the reentry center and d) whether there were indications of mental health concerns for this individual.

Note: DOC indicated that reentry center employees have access to an incarcerated individual's needs assessment which includes past substance use. In this situation, the individual never disclosed he had a history of opiate addiction. Additionally no mental health concerns were identified or disclosed by the individual. All residents are offered a Narcan kit and educated on its use when they transfer to the reentry center. They are allowed to carry the kit with them at all times. There are several dispensing boxes located throughout the facility. Residents are encouraged to take and use Narcan anytime without permission.

E. The Office of the Corrections Ombuds (OCO) asked whether there are standard procedures for a contracted reentry center employee to follow when there is an escape. The OCO also asked about opportunities to respond differently to SUD treatment needs vs return to total confinement, and how to improve systems to address treatment needs not identified via self-reported.

- *Note: DOC provides staff education for responding to an escape. As a general practice, reentry center employees are taught not to pursue an individual who escapes from partial confinement for the safety of the employee, the incarcerated individual, and members of the community.*
- *DOC attempts to conduct a multidisciplinary team meeting prior to any decisions being made about treatment versus return to total confinement. Each individual situation is unique and needs to be reviewed in the moment.*
- *Reentry center staff are working with HS to investigate options to expand SUD treatment services in reentry centers. Currently all individuals receive a substance use disorder assessment prior to transferring to a reentry center. As DOC moves forward with expanding treatment services, the goal is to have a larger presence in the reentry centers to provide support and additional resources for case managers and residents.*

Committee Findings

The manner of the incarcerated individual's death was accidental. His cause of death was acute combined drug intoxication including fentanyl and methamphetamine.

Committee Recommendations

1. DOC Substance Abuse Recovery (SARU) staff should continue to partner with reentry centers to support and expand substance use disorder treatment services as resources permit.

Consultative remarks that do not correlate to the casue of death but shoud be considered for review by the Department of Corrections

1. DOC should look for opportunities to seek alternatives for sobriety support instead of returning the individual to full confinement until appropriate substance use treatment can be arranged.
2. DOC should continue to pursue opportunities and strategies to reduce prohibited substances from entering the facilities as resources permit.