Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-028

Report to the Legislature

As required by RCW 72.09.770

December 13, 2022

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, substance use information was not disclosed unless the next of kin authorized release.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on November 17, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Director Health Services
- Rae Simpson, Chief Quality Officer
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Richard Fall, Corrections Specialist – Substance Abuse Recovery Unit
- Mary Beth Flygare, Program Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Director
- Jeri Boe, Superintendent CBCC

DOC Reentry Centers

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator

DOC Graduated Reentry – Community Corrections

- Kristine Skipworth

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Policy Advisor

Department of Health (DOH)

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1986 (36-years-old)

Date of Incarceration: December 2021

Date of Death: August 2022

The incarcerated individual was a 36-year-old man who was incarcerated for the second time in December 2021. He had a history of polysubstance abuse including heroin and methamphetamines. At the time of his death, he was participating in the Graduated Reentry program, living in a DOC Reentry Center while working at a restaurant in the community. His death was the result of toxic effects of fentanyl. The manner of his death was accidental.

He was readmitted to prison in December 2021. His risk and needs assessments were completed correctly with priority goals being employment and housing. During his intake physical exam, he reported past use of heroin with chemical dependency treatment in 2015. During orientation, he answered no to all eight questions on the self-report opioid use screening questionnaire, indicating he did not believe he had a risk for opioid abuse. He was referred for programming and jobs. He transferred to the reentry center three weeks after arriving at his parent facility.

While at the reentry center he tested positive for methamphetamines and fentanyl during a urine drug screen. The Community Corrections Officer managing his case directed the contract reentry center staff to administer daily urine drug screens until he tested negative. The drug screens remained positive for methamphetamine on three consecutive days and fentanyl on seven consecutive days. He participated in an administrative hearing with a negotiated sanction. He lost ten days of good conduct time and was retained at the reentry center.

Approximately three months after the last positive urine drug screen, the incarcerated individual was found unresponsive and without a pulse on the bathroom floor of his workplace. A call to 911 was made and emergency medical services were able to regain a pulse. He was transported to a community hospital, stabilized, and admitted to the critical care unit with a poor prognosis. Testing confirmed he had suffered irreversible brain damage due to lack of oxygen. Hospital staff consulted with his family, and he was removed from life support and transitioned to comfort care. He died approximately 48 hours after he was admitted to the hospital.

A brief timeline of events prior to his death:

Day 1	Event
2111 hours	Reentry staff received a phone call from the incarcerated individual's sister notifying them that he had been taken from his work location to the hospital.
2115 hours	DOC staff left a voicemail at his jobsite requesting information.
2125 hours	His sister called back with additional information. She stated he was found unresponsive and without a pulse in the restroom at work.
2145 hours	Reentry center staff received a call from the emergency room nurse manager who informed them he was in critical condition and being admitted to the critical care unit.
Day 2	**Event**
0018 hours	Reentry center staff called the hospital for a status update. The nurse reported he was still unresponsive.
2052 hours	His sister called and reported the doctors did not believe he would ever leave the hospital and the family would make a decision about removing life support in 3-5 days.
Day 3	**Event**
1040 hours	When contacted, hospital staff reported that testing confirmed he had no brain activity.
2115 hours	He was pronounced deceased by hospital staff.

Committee Discussion

A. The DOC mortality review committee reviewed his health record, the circumstances of his death and presented the following for UFR committee consideration:

1. The incarcerated individual did not request treatment or sobriety support and was not referred for a substance use disorder assessment during his prison incarceration or after his transfer to the reentry center.

2. He had no court ordered conditions for substance use treatment or evaluation.

3. During his final hospital admission, he was found to have an irreversible brain injury from lack of oxygen. Testing confirmed he had no brain activity. After consulting with his family, he was declared deceased by hospital staff.

4. The current opioid crisis is magnified by the probability of overdose with the first fentanyl use. This drives a more inclusive response to counseling and prevention efforts.

5. DOC plans to bring a universal inclusion approach (anyone reporting a history of opioid use) to the interagency fentanyl taskforce for discussion.

B. Independent of the mortality review, the 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. The CIR found:

1. The incarcerated individual had positive urine drug screen results for seven consecutive days. Only one positive test result was addressed. He was sanctioned and kept at the reentry center.
2. Reentry center staff assumed the consecutive positive urine drug screens were a result of the same drug ingestion.
3. Reentry Center staff mistakenly believed individuals could not be returned to full custody for their first positive urine drug screen.
4. A supervisory review of search logs was not being conducted and the computer system used to generate randomized search lists and log results was not operational.
5. Staff were not checking hours worked with the individual's pay stubs to verify appropriate work attendance. They were relying on the employee to report deviations from their approved schedule.
6. DOC staff did not complete required job site visits and were unaware that his family members were visiting him at his work site.
7. The jobsite did not notify DOC when the incarcerated individual was transported to the hospital.
8. The reentry center emergency response plan did not include contact information for all individuals who need to be notified when an incarcerated individual dies.

C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. The OCO appreciates the use of consecutive drug screens for monitoring but recommend that incarcerated individuals in reentry centers who have one positive fentanyl result receive a referral for a substance use disorder assessment and development of a person-centered plan for individual support.

D. The Health Care Authority (HCA) and the Department of Health (DOH) representatives concurred with the findings and did not offer additional recommendations.

Committee Findings

1. DOC staff sanctioned the incarcerated individual but did not pursue a person-centered response to his fentanyl positive urine drug screens.
2. DOC does not distribute Narcan kits or provide overdose education to all individuals transferring to a reentry center.
3. There is no clear process for staff to follow when an individual has a positive drug screen while housed in a reentry center.

4. The incarcerated individual was not referred for a substance use disorder assessment or offered sobriety support services.

5. Current DOC medical and case management processes lack clear direction for when to refer an individual for a substance use disorder assessment.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. Review and refine the current substance use disorder referral process to provide clear direction for staff to follow when assisting an individual who reports a history of illicit substance use in maintaining their sobriety.
2. The case plan for incarcerated individuals who receive a positive drug screen while living in a reentry center should be reviewed with the supervisor as soon as possible and the plan documented.