Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-019

Report to the Legislature

As required by RCW 72.09.770

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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 September 15, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zainab Ghazal, Administrator - Command A
- Dawn Williams, Program Manager - Substance Abuse Recovery Unit
- Mark Eliason, Program Manager
- Mary Beth Flygare, Project Manager

DOC Women's Prisons Division

- Jeannie Darneille, Assistant Secretary

DOC Reentry Division

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

DOC Community Corrections Division

- Mac Pevey, Assistant Secretary
- Kristine Skipworth, Regional Administrator - East Region
- Steve Johnson, Regional Administrator - SW Region
- Donta Harper, Regional Administrator - NW Region
- Dell Autumn-Witten, Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director
- Dr. Emily Transue, Associate Medical Director

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

Fatality Summary

Date of Birth: 1990 (32 years old)

Date of Incarceration: August 2011

Date of Death: June 2022

This person was a 32-year-old man incarcerated with DOC from August 2011 until his transfer to the Graduated Reentry (GRE) program in November 2021. While residing in the community, he lived with his parents, was gainfully employed as an arborist, and was enrolled in classes to obtain a commercial driver's license. His mother was approved to transport him to and from school and work. He had not been approved to drive his personal vehicles. He died from blunt force injuries sustained in June 2022 when the motorcycle he was driving collided with another vehicle. The manner of his death was accidental.

Committee Discussion

A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:

  1. During his most recent intake exam he reported smoking marijuana and using a pack of tobacco daily for ten years. He had no ongoing medical or mental health conditions requiring treatment prior to his transfer to the GRE program.

  2. The mortality review committee members did not identify any additional recommendations to prevent a similar fatality in the future.

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 Correctional Specialist 3 (CS3) completed all required face to face and collateral contacts.

  2. The CS3 completed all drug screens according to policy. The sample collected 5/10/22 returned a positive result for methamphetamine on 5/23/22. The CS3 met with the incarcerated individual at his home to discuss the positive results. The incarcerated individual denied using any drugs. The CS3 restricted his movements allowing him to only leave his residence for work and medical purposes. The CS3 collected an additional drug screen sample (which also returned a positive result for methamphetamine on 6/6/23 after the death of the incarcerated individual).

  3. The CS3 received a text from the incarcerated individual on 5/26/22 who admitted to smoking

someone else's vape. He reported that his exposure to drugs was unintentional. The CS3 informed him that if the 5/23/22 sample also came back positive he would be required to get a substance use assessment and follow the treatment provider's recommendations to remain in the GRE program.

4. On the day of his death, the incarcerated individual sent a photo from his job site to his CS3 at 2:26 pm stating he was going to the dump, then a text at 2:40 pm saying he was back at the shop followed by a photo of the shop. His last text to the CS3 was at 5:16 pm stating he was going home for the day. The accident occurred at 5:22 pm.

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

1. Recommend DOC conduct a cost analysis of active (real-time) versus passive (activity report from previous 24-hour period) electronic home monitoring while participating in GRE program, and
2. DOC should consider expanding criteria for use of active electronic home monitoring to include when an incarcerated individual has a positive drug screen result.

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

Committee Findings

1. Electronic home monitoring is currently funded to support passive monitoring for GRE participants instead of active monitoring. Expansion of the program to include active monitoring for this population would require additional funding.
2. The CS3 followed all contact and drug testing standards for the case management of the incarcerated individual. The CS3 was in process of referring the incarcerated individual for a substance use evaluation at the time of his death.
3. After having a positive drug screen, the incarcerated individual admitted to using illicit drugs and was operating a motorcycle without authorization at the time of his death.

Committee Recommendations

The UFR Committee did not offer any recommendations for corrective action.

Consultative remarks that do not directly correlate to cause of death, but should be considered for review by the Department of Corrections:

1. Conduct a cost analysis of active (real-time) versus passive (activity report from previous 24-hour period) electronic home monitoring of participants in the GRE program, and
2. Consider using active electronic home monitoring when a GRE participant has a positive drug screen result.