



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-015 Report to the Legislature

As required by RCW 72.09.770

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Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Table of Contents

Table of Contents	1
Legislative Directive and Governance	2
Disclosure of Protected Health Information	2
UFR Committee Members	3
Fatality Summary.....	4
Committee Discussion	4
Committee Findings.....	6
Committee Recommendations.....	6

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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 June 9, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Command A
- David Flynn, Assistant Secretary
- Ken Taylor, Deputy Director Health Services
- Rae Simpson, Director of Nursing Services
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Psychiatric Social Worker 4

DOC Prisons Division

- Tom Fithian – Senior Director – Correctional Operations
- Jeffrey Uttecht – Deputy Assistant Secretary of Prisons

DOC Reentry Division

- Susan Leavell, Senior Administrator
- Dave Ganas, Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Caitlin Robertson, Director

Department of Health (DOH)

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

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

Fatality Summary

Date of Birth: 1981 (40 years old)

Date of Incarceration: August 2018

Date of Death: February 2022

This individual was a 40-year-old man with a past medical history of hypertension and significant drug use including IV drugs. The individual was incarcerated in a DOC facility from August 2018 to November 2021. He was not in physical custody of the WA DOC at the time of his death.

The individual was screened and approved for Graduated Reentry on electronic home monitoring, during October 2021. The individual transferred directly to the Graduated Reentry Program during November 2021 with an electronic home monitor in his family's home.

The death was determined to be accidental due to toxic effects of fentanyl and methamphetamines.

Committee Discussion

- A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:
1. During his incarceration, it appears the individual had poor continuity of care. A review of his case records did not show that he had made requests or had interest in receiving mental health and/or substance abuse support services that were available to him if requested. This may have been a contributor to the lack of mental health and substance abuse support services that were available to him. He was transferred from prison to the Graduated Reentry Program without a plan for sobriety per records reviewed.
 2. The individual stopped taking his chronic anti-hypertensive medications in July 2019 and requested a restart of medication in 2021. This had not occurred by the time of his transfer in November 2021 when he had the opportunity to identify a community provider for his ongoing support of health care needs.
 3. The individual was assessed for substance use disorder in November 2019 and diagnosed with a severe amphetamine and opioid use disorder. He was recommended for intensive day treatment.
 4. This individual was not on the Substance Use Recovery Unit's list of individuals who have been prioritized as needing substance use disorder treatment during prison incarceration.
 5. Current resource limitations do not support the Department's interest in providing substance use

disorder treatment for all individuals identified with a substance use disorder.

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 individual was compliant with supervision having no disciplinary concerns, no positive tests for substance use and no electronic home monitoring alerts for out of area activities.
2. Face-to-face supervision contacts and drug testing were conducted per Department policy. Drugs tested for were amphetamine, methamphetamine, opiates, THC, oxycodone, cocaine/metabolite, and benzodiazepine. None of the tests indicated a positive result.
3. The individual was not tested for fentanyl, as this is not a drug that could be detected by the opiate assay used by the Graduated Reentry Program.
4. The individual was not referred to substance use disorder treatment, as his risk was assessed as low, based off the Washington One Assessment he completed with his classification counselor.
5. The individual was found unresponsive by family in their home where he was residing. The family contacted emergency services who dispatched law enforcement and emergency medical services (EMS). EMS pronounced his death at the scene.
6. During the emergency response, paramedics found a plastic baggie containing two small blue pills. The officer on the scene reported he believed the pills to be fentanyl.
7. The Graduated Reentry Correction Specialist and his supervisor were new to the program allowing for process gaps during caseload auditing.
8. The Correction Specialist responsible for supervising this individual had a prior personal relationship with him and his family. He reported the prior relationship to his supervisor but required documentation was not completed per policy.
9. When the CIR team requested to review the Correction Specialist's text communications with the supervised individual, the Correction Specialist reported that he deleted the text messages to free up space on his work cell phone.

C. The Office of the Corrections Ombuds (OCO) received summarized notes of the provisional Critical Incident Review (CIR) on June 8, 2022. Prior to an independent review of the provisional CIR, the OCO was unable to provide "OCO Recommendations" for UFR-22-015.

During the case discussion, the OCO representative identified an additional opportunity for the UFR Committee's consideration:

10. Ensure every incarcerated individual transitioning to the Graduated Reentry Program receives an opportunity for a reentry team meeting.

Committee Findings

1. The Department’s WA One risk assessment tool did not identify this individual as needing substance use treatment support, which is contradictory to his documented history.
2. Despite extensive substance use history, there is no documentation this individual was offered treatment from the Substance Use Recovery Unit or medical support for opioid use disorder.
3. This individual did not receive follow-up care. Gaps were identified in the documentation of the individual's care declinations regarding chronic care management including a plan for future care outreach prior to his release.
4. There were gaps in the process of mentoring and caseload audits for the Correction Specialist assigned to supervise this individual.
5. A possibility of ongoing personal relationship between the Graduated Reentry participant and Correction Specialist responsible for his supervision was identified.
6. Random drug testing at the time of the fatality did not include fentanyl for Graduated Reentry participants.
7. Correction Specialist deleted text communications with supervised individual losing documentation of supervisory contacts.
8. The Reentry Navigator assigned to work with this individual failed to conduct a Reentry Team Meeting (RTM) prior to his transfer to the Graduated Reentry Program.

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. Need to review prioritization and hand-off to ensure persons with substance use disorder receive all available treatment as indicated.
2. Ensure that metrics/logic for reports are reviewed to verify all necessary diagnostic codes and key terms are included going forward.
3. Recommend adopting best practices for supervisory caseload audits.
4. Graduated Reentry Division review of DOC 850.030 - Relationships/Contacts with Individuals to:

<ul style="list-style-type: none"> a. Ensure required forms are completed in accordance with policy. b. Document on DOC form 03-039 – Report of Contact Relationship the Appointing Authority’s determination of relationship significance.
5. Test for fentanyl during all random drug testing.
6. Preserve record of communications between DOC staff and Graduated Reentry Program participants.
7. Ensure individuals transferring to Graduated Reentry have an opportunity to have a Reentry Team meeting for case planning.

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

1. The mortality review committee identified gaps in chronic follow up care. Recommend continuing the partnership with the WA Health Care Authority to develop more access to medical care for individuals leaving incarceration and returning to the community. DOC should continue its redesign of care delivery in the Washington DOC to support a patient-centered model with resources for chronic care management and release continuity of care.