



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-013 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 July 7, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Paul Clark, Administrator
- Ronna Cole, Deputy Director
- Ken Taylor, Deputy Director
- Rae Simpson, Chief Quality Officer
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit

DOC Office of Correctional Operations

- Tom Fithian – Senior Director – Correctional Operations

DOC Prisons Division

- Mike Obenland – Assistant Secretary
- Jeffrey Uttecht – Deputy Assistant Secretary

DOC Reentry Division

- Scott Russell – Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: 1990 (31-years-old)

Date of Incarceration: December 2021

Date of Death: April 2022

The incarcerated individual was a 31-year-old otherwise healthy man with a diagnosed history of substance use disorder (SUD) that included opioid use. Between the years of 2017 and 2022 he was incarcerated on three separate occasions. The third incarceration occurred in December 2021 when his Drug Offender Sentencing Alternative was revoked due to his noncompliance with requirements. Two weeks prior to his death, he transferred to the Graduated Reentry Program (GRE) and was placed in a transitional sober living house on electronic ankle monitoring. His death was a result of acute drug intoxication, including fentanyl. The manner of death was accidental.

A review of the incarcerated individual's records showed he asked to be started on suboxone (medication assisted treatment) prior to his GRE transfer to support his sobriety. He was told that suboxone was not available at the facility, and that he had been referred to the reentry care navigator who would assist him with setting up an appointment for medication assisted treatment in the community. He was transferred to GRE prior to meeting with the reentry care navigator to schedule his community treatment appointment. While participating in GRE, he missed two required telephonic check-ins that were appropriately addressed by his Correctional Specialist (CS). While he was at the sober living house, he submitted three urine drug screens, and all were negative for prohibited substances. The day prior to his death, he met with his CS virtually. He shared that he had overdosed on two previous occasions but felt like he now had his addiction under control. He asked about the possibility of starting on suboxone to support his continued sobriety. After discussing options with his CS, the incarcerated individual agreed he would contact his previous treatment facility and schedule an appointment for an assessment and treatment planning. He reported that he was attending virtual Narcotics Anonymous meetings since he had not yet submitted the required approval paperwork to attend in-person. His CS was scheduled to meet with him on the day of his death to assist him in completing the required paperwork.

On the date of his death, the incarcerated individual had not called in by noon for his required telephonic check-in. His CS attempted to contact him twice. He did not respond to either attempt. The CS reviewed the activity report for his ankle monitor which showed the monitor had not moved for several hours. The CS called the sober living house and requested a physical wellness check on the incarcerated individual. During the wellness check the incarcerated individual was found in his room non-responsive. Emergency Medical Services was called and upon arrival confirmed the incarcerated individual was deceased. Drug paraphernalia and pills were found in his room.

Committee Discussion

- A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:
1. His medical records from his two previous incarcerations were archived and not available during his final intake exam. He did not disclose any opioid use to the practitioner performing the exam. Based on the information he provided, he was diagnosed with severe meth and marijuana dependency. When an individual is reincarcerated, having previous chart records readily available supports accurate diagnosis and treatment planning.
 2. He requested initiation of suboxone for medication assisted treatment for opioid use disorder and was informed that this was not available. He was referred for reentry care navigation to establish medication assisted treatment in the community after his transfer to the GRE program.
 3. Current staffing levels do not support the current level of need for medication assisted treatment for opioid use disorder (OUD). A request for funding has been made to support the expansion of the medication assisted treatment program in all DOC facilities.
- 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's reported that he was attending Narcotics Anonymous meetings virtually. A request to attend these meetings in-person was in process.
- C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:
1. A written protocol is needed for DOC staff to follow when an incarcerated individual requests medication as treatment for OUD.
- D. The Health Care Authority (HCA) representative discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:
1. The treatment of choice for OUD is medication. This is especially critical with the increased potency of fentanyl. All persons with OUD should be offered medication as an option to treat OUD. Medication is the only treatment shown to reduce overdose death risk. Narcotics Anonymous meetings may help support recovery once someone is stable on medication, but they are rarely effective for OUD in the absence of medication.
 - i. The Department should consider requiring all DOC practitioners to complete the federally required training and obtain approval to prescribe medications for treatment of OUD.

- ii. The Department should establish a referral process to partner with community medication assisted treatment clinics to facilitate enrollment and access for incarcerated individuals transferring or releasing from a prison facility with a diagnosis of OUD.
- E. The Department of Health (DOH) representative participated in the committee discussion and did not offer additional recommendations.

Committee Findings

- 1. There is no standard protocol for staff to follow when an incarcerated individual requests medication to treat OUD.
- 2. The incarcerated individual was not receiving medication assisted treatment for OUD prior to his death.

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. Develop and implement a protocol for staff to follow when an incarcerated individual requests medication for the treatment of OUD.
2. Investigate available options to expand medication assisted treatment options for incarcerated individuals with OUD.

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

- 1. Provide education to incarcerated individuals and department employees regarding the dangers of fentanyl and the benefits of medication assisted treatment for OUD.
- 2. Continue progress toward acquiring an electronic health record.