Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-034

Report to the Legislature

As required by RCW 72.09.770-

April 7, 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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 March 9, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Janell Simpkins, Facility Medical Director
- Rae Simpson, Chief Quality Officer
- Nancy Fernelius, Chief Nursing Officer
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Reentry Administrator
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Deborah Wofford, Deputy Assistant Secretary
- Ronald Haynes, Superintendent

DOC Reentry Centers

- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator
- Carrie Stanley, Administrator

DOC Graduated Reentry – Community Corrections

- Danielle Armbruster, Assistant Secretary
- Kelly Miller, Administrator
- Donta Harper, Regional Administrator

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. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1992 (30-years-old)

Date of Incarceration: June 2022

Date of Death: December 2022

The incarcerated individual was a 30-year-old man who has been involved with the justice system since 2017. He was readmitted to prison in June 2022 for failure to follow requirements of his Drug Offender Sentence Alternative (DOSA). He received a substance abuse assessment in July 2022 and was diagnosed with opioid dependence. He did not have enough time to complete chemical dependency treatment with DOC prior to his earned release date. He was transferred to a DOC reentry center in September 2022. His cause of death was toxic effects of Fentanyl. The manner of his death was accidental.

A brief timeline of events prior to the incarcerated individual's death.

Day(s)	Event
Day 1	• He transferred to the reentry center.
Day 4	• He was hired by a local restaurant.
Day 7	• He was directed by his Community Corrections Officer (CCO) to obtain a substance abuse assessment.
Day 26	• He was infracted for being unable to produce a urine sample for drug screening and returning late to the reentry center.
Day 35	• He received a substance abuse assessment that recommended intensive outpatient treatment and Narcotics Anonymous (NA) meetings.
Day 70	• He was found non-responsive in his room during a security check. Resuscitation efforts are unsuccessful, and his was pronounced deceased by emergency medical personnel.

Committee Discussion

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

   1. The incarcerated individual was a 30-year-old man with a past medical history of high blood pressure and substance use disorder including alcohol, opioids (IV and smoking heroin), and methamphetamines.

2. He reported successfully completing chemical dependency treatment in 2018.
3. His intake screening exams and assessments were completed, and he had no need for ongoing medical care.
4. He was not identified on the high needs list for continuity of care services utilized by the prison facility Psychiatric Social Worker (PSW) to aid in connecting individuals with medical services in the community.
5. He qualified for services from the Health Services Reentry Care Navigator (HS - RCN) through the State Opioid Response (SOR) grant.
    a. The HS - RCN contacted the prison facility PSW two days prior to the incarcerated individual's transfer to the reentry center.
    b. The PSW was not able to see the incarcerated individual prior to his transfer to offer services.
6. The HS - RCN reached out to reentry center staff post transfer to offer services and did not receive a response.
    a. No care navigation services were provided to the incarcerated individual.
7. Since the time of this death, the Health Services Reentry Care Navigators have updated their process to include making multiple attempts to contact the incarcerated individual and assist them with connecting to substance use disorder treatment and support.
    a. The expectation for the HS - RCN team is to make a warm handoff and speak with someone at the reentry center. If the incarcerated individual does not respond to an outreach attempt from the HS - RCN team, the team will contact the responsible Community Corrections Officer (CCO) or Community Corrections Supervisor (CCS).
    b. If there is no response from the CCO or CCS, the attempt is documented, and the HS - RCN will contact the Reentry Center Administrator for assistance contacting the incarcerated individual.
8. Members of the DOC Mortality Review Committee did not identify additional opportunities for improvement.

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 completed his orientation and intake within one week of transferring to the reentry center.
2. DOC Policy 420.380 Drug/Alcohol Testing was not followed by staff.
    a. He received a stipulated agreement after returning to the reentry center late and being

unable to produce a urine sample for drug screening within the required timeframe.

- He agreed to enroll in substance abuse treatment, attend Narcotics Anonymous meetings and,
- Provide weekly urine samples for drug testing.

b. DOC staff did not enforce these sanctions.

- Weekly drug screens stopped two weeks prior to his death and,
- There is no documentation that he enrolled in substance abuse treatment or attended Narcotics Anonymous meetings.

3. DOC Policy 300.550 Monitoring of Graduated Community Access was not followed by staff.
    a. There was no work compliance check done in November.
    b. Neither the employer nor the incarcerated individual reported when there was a schedule change, and he was released from work early.
4. The Correctional Officer who found the incarcerated individual unresponsive was unable to administer Narcan immediately.
    a. Narcan was only kept in the control booth and,
    b. There were only two staff on shift, and one was providing access to community emergency responders.

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

1. The OCO asked if the incarcerated individual had access to Apple Health benefits?
    a. The incarcerated individual was enrolled in Apple Health and had coverage from the first day of the month prior to his transfer which would have provided coverage for substance abuse assessment and treatment.
2. The OCO asked for clarification regarding incarcerated individuals who have a Drug Offender Sentencing Alternative (DOSA) and need substance abuse treatment being approved for transfer to a reentry center prior to receiving treatment or being connected to community services.
    a. DOC has a screening process for individuals transferring from a prison facility into a partial confinement program (DOC reentry center or electronic home monitoring). Screening resources differ between the partial confinement programs. DOC plans to establish a centralized screening team to improve the consistency between partial confinement programs.
    b. In this case, the incarcerated individual was serving the remaining length of a DOSA sentence and was unable to obtain treatment in DOC because he did not have enough

time left in his sentence (level 3 treatment takes 8 months) prior to his earned release date and he only had seven months of his sentence left to serve.

c. His substance use assessment date was available to prison classification and community corrections staff, but the diagnosis and level of treatment needed are not available to without a signed release of information from the incarcerated individual due to federal confidentiality laws.

3. The OCO recommends DOC develop a process as part of the reentry partial confinement program eligibility screening to verify the incarcerated individual's substance use disorder assessment and treatment status needs prior to transfer.

4. The OCO asked what expectations and course corrections are for reentry center employees regarding policy compliance.

    a. The following corrective actions have already been taken.

        - A review of the reentry center facility staffing model,
        - A review of the reentry center facility processes to include searches and drug testing,
        - Updated forms to clarify drug testing expectations,
        - A memo was sent to all reentry center staff and residents by the Reentry Center Administrator requiring all residents who have a positive drug screen be discussed with a supervisor for consideration of return to total confinement for their safety.
        - Logs for drug screening and searches have been updated and are reviewed monthly by a supervisor.
        - Narcan is offered to individuals leaving total confinement and offered to residents during reentry center orientation.
        - Reentry center staff now carry Narcan on their duty belts. AEDs and Narcan kits have been installed on each floor for easy access.

D. The Health Care Authority (HCA) representative asked if the incarcerated individual received a Narcan kit prior to transferring and if the reentry center staff are prepared with multiple doses of Narcan and the ability to support an individual's breathing until emergency medical services arrive.

    a. The incarcerated individual was not provided a Narcan kit prior to transfer.

    b. Reentry Centers are expanding their staff training to include use of Narcan and masks with larger barriers to provide rescue breathing more effectively.

    c. Additional Narcan has been allocated to the reentry centers to provide multiple doses when

needed and is now available to residents without restriction.

E. The Department of Health (DOH) representative concurred with the discussion and did not offer additional recommendations.

Committee Findings

1. The reentry center staff did not follow DOC Policy 420.380 Drug/Alcohol Testing by not enforcing the stipulated agreement sanctions and DOC Policy 300.550 Monitoring of Graduated Community Access when a monthly work compliance check was not conducted.
2. The reentry center staff was not prepared to effectively respond to the medical emergency (Narcan was not readily available on the resident's floor).
3. The incarcerated individual did not receive Narcan prior to transferring.
4. The current DOC screening process does not include verification of a diagnosis of substance use disorder or the treatment level needed for incarcerated individuals transferring from a prison facility into a DOC reentry partial confinement program (DOC reentry center or electronic home monitoring).

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. Reentry centers should conduct emergency response drills, table-top exercises, safety discussions and planning with all staff.
2. Reentry centers should review and discuss DOC policies related to substance use, searches, employment checks, and requirements for DOSA participants with staff.
3. DOC should develop a process as part of the reentry partial confinement program eligibility screening with the Substance Abuse Recovery Unit to verify the incarcerated individual's substance use disorder assessment and treatment needs prior to approval for transfer.

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

1. DOC should continue to explore and when possible, expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy prior to reentering the community. For example, adopting the use of Sublocade injections to provide a bridge for

individuals who need to access services in the community.