



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-020 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

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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, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 May 2, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief Nursing Officer
- Dr. Rae Simpson, Director – Quality Systems
- Paul French, Administrator – Substance Abuse Recovery Unit
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director, Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men’s Prison Project Manager

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

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

Dates of DOC Incarceration: August 2022 – May 2023

Date of Death: November 2023

At the time of death, this incarcerated individual was housed in a federal Bureau of Prisons facility.

The cause of death was due to acute heroin, olanzapine, and mirtazapine intoxication. The manner of death was accidental.

Below is a brief timeline of events leading up to the incarcerated individual’s death:

Weeks prior to death	Event
23 weeks	<ul style="list-style-type: none">• He was transported to a county jail from a DOC prison facility per court order.
10 weeks	<ul style="list-style-type: none">• He was transferred by the county jail to the custody of the U.S. Marshals Service and transported to the federal Bureau of Prisons (BOP) facility.
6 weeks	<ul style="list-style-type: none">• He was hospitalized and returned to the BOP facility.
3 weeks	<ul style="list-style-type: none">• He was hospitalized and returned to the BOP facility.
Day of death	Event
Day of death	<ul style="list-style-type: none">• He was found unresponsive at the BOP facility and emergency treatment was provided.• He was pronounced deceased by community emergency medical services.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombuds, the UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee members considered the information from both reviews in formulating recommendations for corrective action.

- A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.
 1. The committee found:
 - a. He was diagnosed with multiple mental health disorders and co-occurring substance

use disorder.

- b. He tested positive twice in 2022 when screened for illicit drug use by DOC correctional staff.
- c. There was no documentation of a notification to medical staff or a referral to the Substance Use Recovery Unit found in the records reviewed.
- d. He had several facility moves for custody and behavior management reasons during his incarceration.

2. The Mortality Review Committee recommended:

- a. Continuing to work with interagency opioid taskforce to develop a DOC process for tracking and addressing when an incarcerated individual has positive drug screens.
- b. Further evaluation is needed regarding resource and system updates to support increased SUD referrals and treatment coordination needs.

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 the compliance with DOC policies and operational procedures.

1. The CIR found DOC policies and procedures were followed prior to transferring this incarcerated individual to federal custody.

2. The CIR had no recommended actions.

C. Although this incarcerated individual was in BOP custody for approximately 6 months prior to his death, the UFR committee reviewed the case records to identify any learning opportunities for DOC. The following topics were discussed:

1. UFR committee members appreciated the supporting documentation and wanted to thank the Bureau of Prisons for the cooperation with this review.

2. DOC's addiction medicine program and availability of medication for opioid use disorder (MOUD) treatment:

The department is not funded at the level needed to provide the optimum level of support required for all who have opioid use disorder and other substance use needs. The Department of Health representative shared research with committee members showing that for individuals with opioid use disorder, counseling without MOUD treatment was ineffective to support long term sobriety. The committee discussed the importance of expanding MOUD treatment to meet current needs.

DOC is moving forward to align policy and protocol for more effective utilization of existing resources and optimize available treatment. DOC Health Services was recently able to add a clinical staff member to the addiction medicine team to further support these efforts.

3. DOC's management of individuals with co-occurring serious mental illness and substance use disorder.

DOC is aligning resources through integration of the substance use recovery unit into the

behavioral health program. Health Services is working with consultants to support development of the behavioral health and addiction care team with the goal to continue to unify medical and therapeutic addiction treatment services. The committee acknowledged a collaborative co-occurring management program is not available throughout Washington state and DOC is steps ahead by adding a dedicated Addiction Medicine Nurse to the care team.

Committee members recognized in a carceral setting, there are inherent challenges to maintain safety and provide medical treatment. Challenges include contraband introduction and prescription diversion. DOC Health Services and custody have implemented additional safety procedures during MOUD medication administration to decrease diversion opportunities. In an effort to improve care, the committee supported a standard notification to health services if an incarcerated individual has a drug screen result positive for a non-prescribed substance.

4. Transfers for court proceedings.

The committee discussed procedures for transfer of incarcerated individuals to court proceedings including:

- a. The incarcerated individual cannot be notified of the specific date and time of transfer for safety and security reasons.
- b. DOC custody arranges for appropriate transportation to the receiving facility.
- c. DOC Health Services provides a transfer packet that contains a printed care summary, ten (10) days of prescription medication and a copy of the medication administration record.
- d. DOC provides a 24-hour service staffed by registered nurses that can assist the receiving facility with medical information and obtaining any additional medical records.

Committee Findings

The manner of the incarcerated individual's death was accidental. The cause of death was due to acute heroin, olanzapine, and mirtazapine intoxication.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.

Consultative remarks that do not correlate to the cause of death but may be considered for review by the Department of Corrections

1. DOC should identify opportunities that support information sharing between custody and health services.
2. DOC should evaluate feasibility for developing an automated notification to Health Services when an individual tests positive for an illicit substance once an electronic system is implemented.

3. DOC should evaluate projected resource impacts for Health Services to conduct a substance use assessment and identify possible treatment opportunities when an incarcerated individual tests positive for an illicit substance during incarceration.