Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-006

Report to the Legislature

As required by RCW 72.09.770

September 22, 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. 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 August 24, 2023:

DOC Health Services

- Dr Frank Longano, Chief Medical Information Officer
- Mark Eliason, Deputy Assistant Secretary, Health Services
- Dr. Tracy Drake, Chief of Psychology – MCC
- Danielle Moe, Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Community Corrections Division

- Kristine Skipworth, Regional Administrator – E. Region
- Kelly Miller, Administrator – E. Region

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3 – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Dan Lessler, Associate Medical Director

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

Fatality Summary

Date of Birth: 1988 (34-years-old)

Date of Incarceration: August 2022

Date of Death: May 2023

At the time of his death, this incarcerated individual was participating in the Graduated Reentry (GRE) Program. His cause of death was combined fentanyl and methamphetamine toxicity. The manner of his death was an accident.

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

Days Prior to Death	Event
11 weeks before death	• He was approved to reside at a sober living transition house.
9 weeks before death	• He met with a Reentry Navigator and a Corrections Specialist to get assistance applying for benefits in the community.
5 weeks before death	• A pre-transfer urine drug screen was conducted with negative results.
5 weeks before death	• He participated in the GRE intake before being transported to his approved residence: ○ An electronic home ankle monitor was placed. ○ An intake drug screen was completed with negative results. ○ He was informed of the program participation requirements including: • Obtaining a substance use assessment and following any treatment recommendations; • Attending two self-help meetings per week; • Completing the Thinking for Change program; • Obtaining employment and; • Completing other programming assigned.
The month prior to death	• He remained compliant with all check-in and drug screening requirements with the following exceptions: ○ He did not obtain a substance use assessment prior to his death, and ○ An oral swab for drug screen was collected which was positive for methamphetamine. The results were not received until after his death.
Three days after death	• The transition house reported that the incarcerated individual passed away 3 days earlier.

UFR Committee Discussion

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 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 that the incarcerated individual did not choose to engage significantly with the DOC primary care team. The committee members felt that having an established primary care rapport may have been beneficial.
   2. The committee recommended transitional housing keep a stock of naloxone readily available for use and that all individuals releasing to the community are offered naloxone kits.

B. Independent of the mortality review, 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.

   A. The Critical Incident Review found:

      a. Face-to-Face visits occurred per DOC policy 390.590 Graduated Reentry (GRE), and
      b. Drug tests were collected per DOC policy 390.590. Of note, fentanyl testing required additional steps on the requisition form.
      c. The incarcerated individual had not completed a substance use assessment, attended support group meetings, or enrolled in the Thinking for Change program prior to his death as required for GRE program participation.
      d. There was no documentation that he was provided a Narcan kit or overdose education upon transferring to the GRE program.
      e. The transition house where he was residing had Narcan but there is no evidence it was used prior to emergency medical services' arrival.

   B. The Critical Incident Review had the following recommendations:

      a. The Corrections Specialist should establish a short timeline for individuals to obtain a substance abuse evaluation upon transfer to GRE.
      b. Reentry staff should ensure that transition houses have Narcan and that all residents know the location and use of Narcan.
      c. DOC should work with the contracted lab to obtain timely drug screen test results or pursue other options for lab testing.

C. The Department of Health (DOH) representative made the following observations, inquiries, and recommendations:

1. The DOH representative shared that incarcerated individuals reentering the community are at increased risk of overdose due to decreased tolerance and being in a stressful environment that may have easier access to drugs.

2. DOH observed that the incarcerated individual in this case was working closely with a reentry care navigator. DOH asked whether reentry kits provided to incarcerated individuals could include overdose education and a naloxone kit.

   Note: DOC stated that initially a naloxone kit was only provided to individuals with a history of opioid use. Now that more resources have become available, GRE is providing naloxone kits to all individuals upon transfer to GRE.

3. DOH recommended that DOC staff and individuals under their care should receive naloxone training and know where naloxone kits are located. They also requested that overdose education and substance abuse education be offered and or provided for the transition house managers to support and assist them to address possible relapses in GRE participants.

   Note: DOC stated that all staff are trained on naloxone use, and DOC is providing naloxone training to individuals at the time of their transfer into the GRE program. DOC also stated they can work with the corrections specialist for the transition houses to increase SUD and overdose awareness. Additionally, DOC has initiated an interagency task force to address fentanyl overdoses.

4. The DOH representative expressed concern that the transition house manager did not feel comfortable talking to the individual about his possible relapse.

   Note: The DOC GRE Administrator responded that GRE staff will explore options to provide more information to DOC housing vendors.

5. The DOH representative also offered support and resources for DOC related to SUD, overdose, and training on trauma informed care.

D. The Health Care Authority (HCA) representative made the following inquiries and recommendations:

1. HCA asked if the conditions of GRE participation required no substance use, and why random drug screens are conducted.

   Note: The DOC GRE Administrator explained that all participants are prohibited from using illicit substances. If an individual has a positive drug screen, DOC offers the individual two options, in-patient substance use treatment or a return to full prison incarceration.

2. HCA asked what the DOC follow-up has been with the lab vendor that did not supply test results in a timely manner.

Note: The DOC GRE Administrator advised the committee that the forensic lab testing department had relocated to another state which negatively impacted receipt of test results. DOC has been working with the lab vendor to obtain timely results and will terminate the contract if the issue is not resolved.

E. The Office of the Corrections Ombuds (OCO) representative offered the following discussion and recommendations:

1. The OCO Director continued the conversation regarding timely lab results by requesting DOC explore the possibility of moving the lab services contract under health services instead of custody.
2. The OCO representative asked if DOC would update the lab requisition form to ensure we do not have to take additional steps to test for fentanyl.

   Note: The DOC GRE Administrator said the form request has been submitted and new forms should be received soon.
3. The OCO asked whether a substance use disorder assessment was completed prior to this individual's death?

   Note: The DOC GRE Administrator indicated that the corrections specialist assigned to his case did not give a timeframe for completing the assessment and did not follow up with the incarcerated individual as required. –This issue was addressed with the corrections specialist.

Committee Findings

The incarcerated individual died due to combined fentanyl and methamphetamine toxicity. The manner of his death was accidental overdose.

Committee Recommendations

Table 1. UFR Committee Recommendations
1. GRE case managers should establish a deadline for participants to obtain a substance use assessment upon transfer to the GRE program and follow-up to ensure completion.
2. GRE case managers should provide naloxone kits to all GRE participants.
3. DOC should enforce contract requirement for lab vendors to provide lab results.

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

DOC should investigate partnering with DOH to enhance overdose education support for contracted transitional housing staff.