Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-013

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, 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 November 16, 2023:

DOC Health Services

- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director Quality Systems
- Deborah Roberts, Program Manager
- MaryBeth Flygare, Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Director Correctional Services
- Rochelle Stephens, Project Manager
- Deborah Jo Wofford, Deputy Assistant Secretary
- Jeri Boe, Superintendent CBCC
- Eric Jackson, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Community Corrections Division

- Dell-Autumn Witten, Administrator
- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Centers

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

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

Year of Birth: 1991

Date of Incarceration: May 2022

Date of Death: August 2023

At the time of his death, this incarcerated individual was housed in a prison facility and was classified as close custody. The cause of death was the result of methamphetamine toxicity. The manner of death was accidental.

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

Hours prior to death	Event
14:16 hours	• Incarcerated individual (I/I) begins visit with approved visitor.
15:12 hours - 15:14 hours	• Visitor approaches game cabinet and reaches into her shirt. • Visitor places balloon in game box. • I/I places balloon into his mouth.
15:45 hours – 15:51 hours	• Visitor leaves. • I/I is strip searched at the end of his visit. • I/I arrives in his cell.
17:56 hours	• Medical emergency called. • I/I found unconscious, not moving, not breathing and had no pulse.
17:57 hours – 18:15 hours	• CPR started. • 911 called. Ambulance enroute. • AED was placed but no shock was advised. • Narcan dosage delivered 5 times. • Pulse returned and shallow breathing noted. • AED advised delivering a shock and shock was delivered. Within seconds he became pulseless again. • Resuscitation efforts continue. • Narcan delivered a sixth time.
18:34 hours	• Ambulance arrives.
18:40 hours	• Emergency Medical services assumes care.
19:21 hours	• Time of death pronounced.

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 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. The incarcerated individual was diagnosed with polysubstance use disorder, depression, anxiety, and post-traumatic stress disorder.
        b. He was found unresponsive in his cell and died despite full resuscitation efforts.
        c. Toxicology report showed high levels of methamphetamine which were incompatible with life.
        d. His cause of death was acute methamphetamine toxicity.
        e. There were no meaningful gaps in his primary or psychiatric care.
        f. The emergency response was appropriate.
        g. He needed substance use care that was not available at the facility.
    2. The MRC recommended:
        a. DOC explore the expansion of addiction recovery services via telemedicine.

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.
    1. The CIR root cause analysis found:
        a. During his approved visit he was given a balloon containing illegal drugs.
        b. The approved visitor was able to conceal the illegal narcotics in a manner that defeats contraband detection practices.
        c. Current security practices only allow for pat searches, metal detectors and scanning of allowable items approved for visitors prior to entering the visiting room.
        d. The drugs were carried into the living unit via ingestion by the incarcerated individual.
        e. The incarcerated individual was in his assigned cell when he began showing symptoms of distress and was not observed by staff or reported by the incarcerated individual's cellmate who witnessed the symptoms.
        f. Staff did not observe the contraband exchange.
    2. The CIR root cause analysis recommended:
        a. DOC create a communication to be placed in visiting rooms, sent out via kiosk, and given to visitors prior to visitation which identifies the danger of ingesting drugs,

recent deaths after ingesting drugs, and the likelihood of people involved in the introductions of drugs to be prosecuted for introduction and death of an individual.

C. The Department of Health (DOH) representative supported both the use of telehealth by DOC to expand substance use treatment and creating informational flyers for the incarcerated population and their visitors.

   1. DOH asked what overdose education training DOC provides to staff.

   Note: DOC requires all staff to complete a Fentanyl and Safety Awareness Training and First Aid/CPR, both of which cover signs of overdose and response. Staff in the living units are taught to report any signs of an incarcerated individual being off their baseline and summon immediate assistance. In this case, the cellmate knew the individual had ingested contraband and that he was becoming ill and chose not to report until it was too late.

D. The Health Care Authority (HCA) Representative stated that the medical response was appropriate, and the first response is to give Narcan. The toxicology report showed the incarcerated individual had five times the lethal level of methamphetamine in his system and there was nothing medically that could be done to assist him by the time staff were notified.

   1. HCA concurred with the educational information being distributed and advised that most individuals who have a substance use disorder also have experienced significant trauma during their lifetime. Research demonstrates that providing trauma-informed therapy along with the substance use treatment has better outcomes than substance use treatment alone. They stated there are many telehealth programs that offer this type of treatment approach, and they encourage the Department to offer co-occurring treatment when appropriate.

E. The Office of the Corrections Ombuds (OCO) submitted the following for UFR committee discussion:

   1. The OCO noted that the incarcerated individual had an extensive history of substance use and questions why he was housed in a facility that did not have the treatment resources needed to assist with his addiction.

   Note: The incarcerated individual was transferred to this facility due to his recent custody demotion and DOC concerns for his safety due to his security threat group affiliation and associated threat concerns from other incarcerated individuals. In this case the individual chose to ingest the drugs in an attempt to introduce them into the facility. We cannot know if the individual would have sought treatment if it were available or if he intended to use the drugs himself. Based on the investigation, including recorded phone calls, it appears the reason for the contraband introduction was monetary.

   2. The OCO encourages the Department to continue to explore options to expand substance use treatment services to include requesting additional funding.

Committee Findings

The manner of the incarcerated individual's death was accidental. The cause of death was acute methamphetamine toxicity.

Committee Recommendations

DOC create and distribute an informational flyer highlighting the risk of overdose, recent deaths involving illegal drug use in the facilities and the prosecution risk for visitors introducing drugs into a facility.

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

The UFR Committee recommended DOC explore telehealth options to expand current substance use disorder treatment and seek additional funding to support the expansion of services.