Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-027

Report to the Legislature

As required by RCW 72.09.770

December 9, 2022

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 November 17, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Director Health Services
- Rae Simpson, Director Quality Systems
- Richard Fall, Corrections Spec. Substance Abuse Recovery Unit
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager 2

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson – Deputy Director
- Jeri Boe, Superintendent CBCC

DOC Reentry Centers

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

DOC Community Corrections

- Steve Johnson, Regional Administrator, SW

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Policy Advisor

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: 1989 (33-years-old)

Date of Incarceration: August 2021

Date of Death: August 2022

The incarcerated individual was a 33-year-old man who has been involved with the Washington State Department of Corrections since 2008. At the time of his death, he was participating in the DOC Graduated Reentry program on an electronic home ankle monitor and was residing in a community sober living house. His death was the result of combined fentanyl and ethanol intoxication. The manner of his death was accidental.

He was readmitted to prison in August 2021. His risk and needs assessments were completed correctly. During his intake screening he reported a history of social drug and alcohol use. During orientation, he answered affirmatively to 7 out of 8 questions on the self-report opioid use screening questionnaire indicating a risk for opioid abuse. He participated in educational programming and received his high school diploma while incarcerated.

In June 2022, he transferred into the Graduated Reentry Program and was employed in the community working the night shift. After he transferred, he worked with a Reentry Care Navigator to connect with a community medical provider for enrollment in a medication assisted treatment program for opioid use disorder. There were no medication assisted treatment providers in his community. The Reentry Care Navigator referred him to a clinic for a substance use disorder evaluation and treatment in a nearby community that provides services on a walk-in basis. The referral information was also provided to his mother who was his support person for transportation.

A brief timeline of events prior to his death:

Day 1	Event
1300 – 1500 hours	He goes on an approved shopping trip to Walmart before work.
1800 hours	He reports to his worksite as scheduled.
2247 – 2337 hours	He clocks out of work to go on break. He made several phone calls and possibly met someone in person.
Unknown time	A co-worker asks their supervisor to leave work early because the incarcerated individual is reportedly “doing drugs” on the job. This was not conveyed to DOC staff until after the individual’s death.
Day 2	**Event**

0500 hours	He walks back to the sober living facility.
1838 hours	He is found unresponsive in his assigned room by another resident. CPR is initiated and the sober living house manager calls 911.
1845 hours	A county sheriff's deputy and paramedics arrive.
1908 hours	He is pronounced deceased by the county medical examiner.

Committee Discussion

A. The DOC mortality review committee reviewed his health record, the circumstances of his death and presented the following for UFR committee consideration:

1. He had a history of attention deficit hyperactivity disorder and substance use disorder (SUD).
2. He did not appear to request any sobriety support.
3. His intake physical and nursing intrasystem intake screening did not document any additional chronic medical conditions. He declined mental health screening.
4. He had no court ordered conditions mandating an assessment or treatment for SUD.
5. While at the sober living house, he had one infraction for a urine drug screen result that was positive for methamphetamine. He was appropriately sanctioned and kept in the GRE program.
6. The current opioid crisis is magnified by the probability of overdose with the first fentanyl use. This drives a more inclusive response to counseling and prevention efforts.
7. DOC plans to bring a universal inclusion approach (anyone reporting a history of opioid use) to the interagency fentanyl taskforce for discussion.

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 property was released to his mother by the manager at the sober living house prior to the incident review being conducted by DOC staff.
2. Staff at the sober living house did not have an after-hours contact list of DOC staff to provide notification of the incarcerated individual's death.
3. The electronic home ankle monitor bracelets do not connect well with the base unit at the sober living house which generate false alerts.

The CIR recommendations did not directly correlate to the incarcerated individual's cause of death and will be remediated per DOC Policy 400.110 – Reporting and Reviewing Critical Incidents.

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

   1. The incarcerated individual self-selected affirmatively 7/8 questions on the opioid screening questionnaire during orientation. This indicated he had a risk for opioid abuse and a possible need for sobriety support, but he did not receive a referral from staff for a SUD assessment. The department should develop a process for connecting individuals with support services based on self-reported questionnaire responses.

D. The Health Care Authority (HCA) and the Department of Health (DOH) representatives did not offer additional recommendations.

Committee Findings

1. The incarcerated individual was not referred for a SUD assessment or offered sobriety support services while incarcerated.

2. Current DOC medical and case management processes lack clear direction for when to refer an individual for a SUD assessment.

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. Review and refine the current SUD referral process to provide clear direction for staff to follow when assisting an individual who reports a history of illicit substance use in maintaining their sobriety.