



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-024 Report to the Legislature

As required by RCW 72.09.770

April 25, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Table of Contents

Table of Contents	1
Legislative Directive and Governance.....	2
Disclosure of Protected Health Information.....	2
UFR Committee Members	3
Fatality Summary.....	4
UFR Committee Discussion.....	5
Committee Findings.....	7
Committee Recommendations	7
Consultative remarks that do not directly correlate to cause of death, but should be considered for review by the Department of Corrections:	7

Unexpected Fatality Review Committee Report

UFR-23-024 Report to the Legislature–600-SR001

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 21, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Rae Simpson, MSN Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Patty Paterson, MSN, Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Chuck Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Michelle Eller-Doughty, Correction Specialist 4

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, MSN Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director
- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1978 (45-years-old)

Date of Incarceration: October 2022

Date of Death: December 2023

At the time of his death, the incarcerated individual was participating in the Graduated Reentry (GRE) program on electronic home monitoring.

His cause of death was acute buprenorphine, fentanyl, methamphetamine, and xylazine toxicity. The manner of his death was accidental.

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

Approximate Weeks Prior to Death	Event
28 weeks prior	<ul style="list-style-type: none"> Completed a substance use disorder (SUD) assessment through the DOC Health Services Substance Abuse Recovery Unit.
23 weeks prior	<ul style="list-style-type: none"> Transferred to Graduated Reentry (GRE) with initial housing for inpatient SUD treatment.
13 weeks prior	<ul style="list-style-type: none"> Successfully completed inpatient SUD treatment. Transported to approved residence. Seen at community clinic for continuation of medication assisted treatment after discharge from inpatient treatment.
12 weeks prior - 1 day prior	<ul style="list-style-type: none"> Completed required check ins with GRE case manager. All drug screens were negative for non-prescribed substances. He secured and engaged in employment. He reported that everything at his job and home was going well. He continued with outpatient treatment support and had no known sobriety lapses.
Day 0	<ul style="list-style-type: none"> Review of monitor report showed no movement alert, and he did not respond to text messages. Transitional house staff called DOC to inform that he may be deceased and 911 was on the way. Community fire department arrived and found him deceased.

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. They did not identify any additional recommendations to prevent a similar fatality in the future.

1. The MRC found:

- a. He transferred from a prison facility directly to an inpatient admission in a community treatment program for substance use.
- b. After successfully completing the treatment program, he continued with community aftercare and support while participating in the graduated reentry (GRE) program.
- c. He appeared to be successfully managing his disease prior to the fatal overdose.
- d. Contracted community substance-use disorder treatment providers do not directly connect with DOC Health Services to leverage additional sobriety support as the current staffing does not include Health Services staff in GRE.
- e. Because he was directly admitted to a community substance use treatment facility, Health Services Reentry team did not provide additional post-prison outreach to him.
- f. There is a potential opportunity for expansion of Health Services Reentry or development of more collaborative community partnerships to enable enhanced sobriety support assistance for people transitioning into the community from prisons.

2. The MRC recommended:

- a. A referral to the UFR committee.
- b. Exploring opportunities to partner with community corrections reentry staff and community partners to assist people transitioning into the community.
- c. Continuing to implement the 1115 Medicaid waiver to enable connection to community resources 90 days prior to transition from prison.
- d. Continuing to pursue necessary funding to expand the use of medications for opioid use disorder (MOUD) treatment to ensure each individual who needs care has access.
- e. Offering an annual primary care visit to all incarcerated individuals to foster a trusting

relationship between DOC primary care teams and the persons in their care, thereby potentially increasing the lines of support for persons who are struggling.

C. 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 found:

- a. All electronic home monitoring (EHM) and drug testing was conducted within the parameters of the GRE program.
- b. There were missing and late administrative documentation entries noted in the electronic and field case supervision files.
- c. A needs reassessment was not completed by the GRE case manager.

2. The CIR recommendations did not directly correlate to the case of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing critical incidents.

D. The UFR committee reviewed the unexpected fatality and discussed the following topics related to the fatality:

1. Substance use treatment in prison facilities:

The committee discussed the lack of resources to provide medications for treatment of opioid use disorder (MOUD) for all incarcerated individuals who need treatment continually during their incarceration. The current access is for three months at the beginning and end of incarceration for those whose sentence exceeds 6 months. Those with a six month or shorter sentence are maintained on their existing MOUD. Concerns were expressed that when people are tapered from MOUD during their incarceration, the science suggests that it may destabilize their recovery and impair their future ability to remain sober. The committee members support continuing to advocate for funding that support uninterrupted access to MOUD throughout incarceration.

2. Graduated Reentry (GRE) participation:

The committee discussed the criteria and process for transferring into the Graduated Reentry program. This incarcerated individual's substance use assessment determined he needed inpatient substance use disorder (SUD) treatment prior to residing on his own in the community. From the prison facility, he was transported to a contracted community SUD treatment facility. After successfully completing treatment, he resided in a transitional sober living house to complete the GRE program.

During his admission to the SUD treatment facility, he was prescribed medications to treat opioid use disorder and continued the medications while participating in the GRE program. He was given Narcan by his GRE case manager and overdose prevention education. Narcan was also provided to the transitional housing vendor.

The incarcerated individual had two DOC reentry staff members supporting his transition from prison through treatment and into the community transitional housing. They offered resources, assistance, and accountability to support his successful reintegration into the community. He was considered a model GRE participant. He was employed, in treatment, had family support and was doing well overall.

Committee Findings

He died as a result of acute buprenorphine, fentanyl, methamphetamine, and xylazine toxicity. The manner of his death was accidental.

Committee Recommendations

DOC should request funding of substance use disorder treatment services to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy during their incarceration.

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

1. As funding allows, DOC should continue to expand options for incarcerated individuals with a diagnosis of opioid use disorder to receive medication assisted therapy prior to reentering the community.
2. DOC Health Services should explore the possibility of utilizing the Behavioral Health-Administrative Services Organization recovery navigators to offer additional sobriety support for GRE participants.