Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-012

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.

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 December 12, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director - Quality Systems
- Brooke Amyx, Health Services Reentry Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

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

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division

- Sarah Sytsma, Deputy Assistant Secretary - Reentry
- Michelle Eller-Doughty, Reentry Center Operations Administrator

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds - Investigations
- Madison Vinson, Assistant Corrections Ombuds – Policy

Department of Health (DOH)

- Ellie Navidson, Nursing 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

Year of Birth: 1988 (36-years-old)

Date of Incarceration: February 2024

Date of Death: July 2024

At the time of death, this incarcerated individual was housed in a community reentry center. His death occurred at his place of employment.

His cause of death was acute fentanyl intoxication. The manner of his death was accidental.

A brief timeline of events prior to the incarcerated individual's death:

Days Prior to Death	Event
41 days prior	• He was transferred to a community reentry center.
Day of Death	**Event**
0 days	• Employer notified the reentry center that he was found unresponsive and pronounced deceased by community emergency services.

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:

    a. He resided in a prison setting for approximately three months prior to transfer.

    b. He did not have substance use disorder (SUD) treatment as a court ordered condition of his sentence and did not receive a substance use assessment prior to transfer.

    c. Documentation demonstrated he provided contradictory medical history related to previous diagnoses and treatment.

    d. He did not engage in supportive medical care and chose not to continue his previously

prescribed medications.

e. He declined assistance with establishing a primary provider in the community and obtaining appointments for medications for opioid use disorder (MOUD) and follow-up of self-reported health conditions.

f. He was provided a copy of his DOC Community Provider Continuity of Care Report prior to transfer.

g. He was covered by Apple Health.

2. The committee did not identify any additional recommendations to prevent a similar fatality in the future.

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 found:

a. Case management focused on his employment and residential needs areas and the substance use and mental health needs were not addressed.

b. There was no documentation that he received a urinalysis the month prior to his death.

2. The CIR recommended:

a. Case management should prioritize mental health and substance use disorder treatment and programming needs before employment searches.

b. Case management should direct individuals to get appointments for treatment with a due date, and to follow up with the resident on or about the due date and document follow-up in the electronic record.

c. Reentry leadership should review standard practice for the number of drug tests required and ensure written directive of the minimum standards per resident is provided statewide.

C. The committee reviewed the unexpected fatality, and the following topics were discussed.

1. Addiction care screening and treatment:

DOC discussed planned updates to the addiction care screening tool to encourage incarcerated individuals to accurately report their substance use history. The committee members supported revising the tool.

The committee discussed the current medication administration process including communication requirements for discontinuing a medication.

DOC also discussed the additional staffing resources for the Health Services reentry team to support individuals with substance use disorder (SUD) during the reentry period.

The committee discussed addiction recovery support for individuals residing in a DOC Reentry center.

- Based on a resident's assessed needs, they will be referred to a community provider for assessment and recommended treatment.
- Reentry Centers accept and support residents who have been prescribed medications per section 5 of Policy 610.300 Health Services for Work Release Offenders.
- The Health Services reentry team coordinates with Apple Health and the community pharmacy to obtain medication prior authorization when needed.
- Reentry center staff follow the DOC Pharmaceutical Management and Formulary Manual to determine if a medication is allowed to be kept by the incarcerated individual.
- Prior to his death, this individual declined SUD treatment.

Committee Findings

The incarcerated individual died as a result of acute fentanyl intoxication. The manner of death was accidental.

Committee Recommendations

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