Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-017

Report to the Legislature

As required by RCW 72.09.770

September 19, 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 August 18, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Ronna Cole, Deputy Director Health Services
- Paul Clark, Administrator
- Mark Eliason, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Donald Holbrook, Deputy Assistant Secretary

DOC Reentry Division

- Scott Russell, Deputy Assistant Secretary
- Dave Ganas, Administrator

DOC Community Corrections Division

- Mac Pevey, Assistant Secretary
- Kristine Skipworth, Regional Administrator East
- Dell-Autumn Witten, Administrator
- Donta Harper, Regional Administrator Northwest

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Emily Transue, Associate Medical Director

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

Fatality Summary

Date of Birth: 1996 (26-years-old)

Date of Incarceration: April 2017

Date of Death: May 2022

The incarcerated individual was a 26-year-old male incarcerated with DOC from April 2017 until his transfer to a DOC reentry center in April 2022. Twenty-seven (27) days after his arrival at the reentry center, he escaped through an emergency exit and obtained a gun. He is suspected by community law enforcement of using the gun to kill a woman and later shooting himself. His cause of death was a contact gunshot wound of the head. The manner of his death was suicide.

Brief timeline of post escape events:

> Day 0 - At approximately 2300 the incarcerated individual left the reentry center via an emergency exit without authorization and a Secretary's warrant was issued for his arrest.
>
> Day 1 - The Corrections Specialist (CS) sent a referral to the Community Response Unit regarding his escape and reached out to the incarcerated individual's contacts including his girlfriend. That afternoon his girlfriend returned the call and informed the CS that she had broken up with him the previous day and was concerned he may be suicidal based on previous statements he had made to her.
>
> Day 2 - Per police detective, the incarcerated individual had been identified as the primary suspect in the homicide of an adult female who was found deceased after being shot at a motel in the community. Security camera footage showed the incarcerated individual fleeing the scene.
>
> Day 4 – The incarcerated individual was found deceased from a self-inflicted gunshot wound to the head in the yard of a private residence in a neighboring community.

A review of his records showed that he was not taking any medications at the time of his transfer to the reentry center and that he had no current medical or mental health treatment needs. During his stay at the reentry center, staff noted that he was polite. He completed the reentry center orientation upon arrival. A drug test was conducted which was negative. He was employed in the community and had an approved sponsor to transport him to and from work. He did not have any infractions or negative interactions with staff during his stay. Reentry center staff did not observe any behavior that suggested he was struggling or experiencing mental health issues.

Committee Discussion

A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:

   1. His medical history was notable for increased cholesterol for which he was provided lifestyle counseling.

   2. He was previously diagnosed with antisocial personality and bipolar disorders. His record documented past episodes of impulsive behavior and poor decision making leading to his incarcerations.

   3. Several years ago, he participated in a brief period of mental health treatment (approximately 9 months) including medication. He reported to his primary therapist that he was doing well and would no longer be taking the mental health medication.

   4. He had no history of suicidal thinking or behaviors that were known.

   5. He had people in the community who cared about him and his continued success.

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. He met with a social worker prior to his transfer to a reentry center, and the social worker documented no need for community mental health services.

   2. On the day of the escape, reentry center staff responded quickly to the sound of the alarm and followed procedures when an incarcerated individual escapes from a partial confinement setting.

   3. Following the escape, a referral was appropriately made to the Community Response Unit. It was not updated when reentry staff learned of the possibility the incarcerated individual may be suicidal.

C. The Office of the Corrections Ombuds, Department of Health and Health Care Authority representatives participated in the committee discussion and did not offer additional recommendations.

Committee Findings

The incarcerated individual had a history of impulsive behavior, making poor decisions, and that his intent to die was likely an impulsive act as there is no evidence for previous thoughts of suicide until the final moments of his life. While correlation does not imply causation, the break-up with his girlfriend,

escaping the work release facility, obtaining a gun, and being suspected of homicide seems to point to these as precipitating events to his decision to end his life.

Committee Recommendations

The UFR committee did not offer any recommendations for corrective action.

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

1. Referrals to the Community Response Unit should be updated when any pertinent safety concerns arise.