Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-036

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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Table of Contents

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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 March 23, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Janell Simpkins, Facility Medical Director
- Rae Simpson, Chief Quality Officer
- Brooke Amyx, Reentry Administrator
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Deborah Wofford, Deputy Assistant Secretary
- Ronald Haynes, Superintendent

DOC Graduated Reentry – Reentry Centers

- Danielle Armbruster, Assistant Secretary
- Carrie Stanley, Administrator
- Susan Leavell, Senior Administrator

DOC Graduated Reentry – Community Corrections

- Kristine Skipworth, Regional Administrator
- Kelly Miller, Administrator

DOC Risk Mitigation

- Michael Pettersen, Director

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. Sophie Miller, Medical Officer

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

Fatality Summary

Date of Birth: 1997 (25-years-old)

Date of Incarceration: December 2021

Date of Death: December 2022

Location of Death: Community Residence

The incarcerated individual was a 25-year-old woman who was serving a Residential Drug Offender Sentencing Alternative (DOSA) sentence at the time of her death. She was anticipated to complete her sentence on January 24, 2023. She was admitted to prison in December 2021 for not following the supervision requirements of her DOSA sentence. She transferred into the Graduated Reentry Program (GRE) on electronic home monitoring in June 2022. Her cause of death was toxic effects of fentanyl. The manner of her death was accidental.

A brief timeline of events leading up to the incarcerated individual's death.

Days Prior to Death	Event
159	• She participated in a reentry team meeting where she denied any current medical or mental health issues.
145	• She transferred to the Graduate Reentry (GRE) program.
125	• During a home visit with the Corrections Specialist (CS) and Reentry Navigator (RN), she admitted to using fentanyl and requested to enter treatment. She was taken into custody for her safety until a bed became available in the treatment program.
119	• She was admitted to an in-patient substance abuse treatment program in the community.
81	• She is discharged from the in-patient substance abuse treatment program and returns to the sober living house. • The CS confirmed that she was enrolled in after-care treatment and received a "suboxone" injection prior to discharge.
73	• The CS confirms she is in mental health treatment and receiving after-care from the substance abuse treatment program.

67	• She obtained employment at a local fast-food restaurant.
36	• She met with her CS and reported that she stopped taking her mental health medications and is feeling overwhelmed but not close to a relapse. • The CS advised her to contact her mental health provider.
4	• She met with her assigned CS and an oral swab (drug test) is collected (results returned negative). • She reported that she "loves" her work and a "big boss" came to her location and presented her a pin for being an exemplary employee. She also reported being excited about being close to completing her sentence.
0	• She is found unresponsive by another resident and pronounced deceased by community emergency responders at the transitional sober living house.

Committee Discussion

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

1. The incarcerated individual had a past medical history of asthma, migraines, post-traumatic stress disorder and substance use disorder (methamphetamines, heroin, fentanyl, and alcohol).

2. She did not admit to opiate use during her needs assessment with her classification counselor but did admit to using opiates on the nursing intake screening questionnaire. Both questionnaires require the incarcerated individual to self-report.

3. During a medical appointment in June, she requested to be started on suboxone prior to her transfer to the GRE program.

    a. She was advised she would need a definite transfer date prior to starting suboxone and she could be referred to a community medication-assisted treatment provider if she could not get a final transfer date or if she transfers quickly.

    b. A referral to the DOC Substance Abuse Recovery Unit (SARU) was submitted. SARU staff confirmed they did not have enough time to complete the assessment prior to the incarcerated individual's transfer.

    c. The Health Services Reentry Navigator was unable to meet with her to arrange services in the community prior to her transfer.

4. She received appropriate support from the Corrections Specialist and Reentry Navigator assigned to her case.

5. When she relapsed, she was quickly referred for in-patient treatment and was receiving after-care post discharge from the program.

6. There was no evidence of another relapse prior to her death.

7. DOC SARU staff do not receive information on individual's who receive a Residential DOSA sentence and services in the community due to federal confidentiality laws which prevent sharing of substance abuse information.

8. There was a missed opportunity for DOC Health Services to schedule an intake appointment for the incarcerated individual with a community medication-assisted treatment provider prior to her transfer.

    a. The Health Services Reentry Navigators can schedule a next day appointment for incarcerated individuals transitioning back into the community.

    b. Since the time of this death, their process has been updated to include continuing to reach out to incarcerated individuals post transfer until contact has been made and services are offered.

9. Mortality Review Committee members recommended that DOC explore the possibility of providing information to all incarcerated individuals transferring or releasing to a community setting for community-based medication-assisted treatment providers and support.

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. All requirements for orientation to the GRE Electronic Home Monitoring were completed.

2. Drug testing and monitoring were conducted within the parameters of the GRE program.

3. The Corrections Specialist and Reentry Navigator made frequent contact with the incarcerated individual to provide support, ensure she enrolled in substance abuse treatment and participated in mental health counselling.

4. The critical incident review recommendations were administrative in nature and did not directly correlate with the cause of death. They will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

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

1. The OCO asked why the incarcerated individual was not directly referred to inpatient treatment

when she transferred to the reentry center?

   a. During her reentry team meeting the incarcerated individual denied she had any current medical or mental health needs and treatment participation is voluntary.

   b. As soon as she let the Corrections Specialist know that she wanted treatment they found a bed for her in an inpatient treatment program.

2. The OCO asked why the incarcerated individual was not transferred to a DOC Reentry Center instead of being placed in the community with an electronic home monitor?

   a. To qualify for placement in a Reentry Center an incarcerated individual must have at least twelve months left on their sentence. She did not have enough time remaining to serve on her sentence to qualify for placement.

3. The OCO recommends DOC classification explore a centralized screening process for Graduated Reentry (electronic home monitoring) and Reentry Centers.

D. The Health Care Authority (HCA) and the Department of Health (DOH) representative concurred with the committee discussion and did not offer additional recommendations.

Committee Findings

1. DOC Health Services missed an opportunity to connect the incarcerated individual with a community-based medication-assisted treatment program prior to her transfer.
2. The current DOC screening process does not include verification of the substance abuse treatment level needed for incarcerated individuals transferring from a prison facility into a DOC reentry partial confinement program (DOC Reentry Center or Graduated Reentry).
3. She was provided appropriate support from the Corrections Specialist and Community Reentry Navigator assigned to her case and was immediately referred for inpatient substance abuse treatment when she experienced a relapse.
4. While participating in the Graduated Reentry Program on electronic home monitoring she died as a result of the toxic effects of fentanyl.

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. DOC should develop a process as part of the reentry partial confinement program eligibility screening with the Substance Abuse Recovery Unit to verify the incarcerated individual's substance use disorder

assessment and treatment needs prior to approval for transfer.