Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-023

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.

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 October 20, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Ronna Cole, Deputy Director
- Mark Eliason, Deputy Director
- Paul Clark, Administrator
- Rae Simpson, Director Quality Systems
- Nancy Fernelius, Chief Nursing Officer
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Jeffrey Uttecht – Deputy Assistant Secretary
- Eric Jackson – Deputy Director

DOC Community Corrections

- Steven Johnson, Regional Administrator, SW Region
- Donta Harper, Regional Administrator, NW Region
- Kristine Skipworth, Regional Administrator, East Region
- Autumn Dell-Witten, Administrator

Office of the Corrections Ombuds

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

Department of Health

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

Health Care Authority

- 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: 1985 (37-years-old)

Date of Incarceration: August 2021

Date of Death: July 2022

The incarcerated individual was a 37-year-old man who has been involved with the Washington State Corrections system since 2005. He had a history of substance use disorder (SUD) since his teen years that led to multiple incarcerations. After transferring from the intake facility in April 2022, he met with his classification counselor to complete his risk and needs assessment and was appropriately classified. Based on the results, he agreed to program referrals for Narcotics Anonymous, Thinking for a Change, Digital Design, Automotive Services, the Flagging Program, and was added to the Associate of Arts Program waiting list.

On the morning of his death, he was found lying on his bunk unresponsive by his cellmate prior to leaving for the morning meal. His cellmate notified unit correctional officers who responded to his cell and radioed for a medical emergency response. The first responding nurse was unable to find a pulse, documented his skin was cold to the touch, and signs of rigor mortis were present. The nurse had custody officers assist with moving the individual off his bunk to provide access for CPR. CPR, AED, and rescue breathing were continued for approximately 20 minutes. The AED did not recommend a shock during that time. A responding advanced practitioner directed CPR continue until Emergency Medical Services personnel arrived. Resuscitation efforts by staff were unsuccessful. His cause of death was toxic effects of buprenorphine (an opioid medication). The manner of his death was accidental.

Committee Discussion

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

   1. He was found deceased in his cell from an overdose of buprenorphine that he was not prescribed. A psychological autopsy was conducted and found no significant factors that would support his death being anything other than an accidental overdose related to ingestion of a contraband drug.

   2. He was diagnosed with depression, anxiety and substance use disorder and had no history of opioid use disorder. Historically, his drugs of abuse were methamphetamine and marijuana.

   3. In 2019, during a previous incarceration, he successfully completed a residential SUD treatment

program for severe methamphetamine dependence and participated in outpatient treatment after he released to the community.

4. During his intake physical exam, his vital signs were within normal limits. On the Opioid Screening Questionnaire, he reported using opioids in the six months prior to his incarceration, but indicated that he never had withdrawal symptoms, did not have problems stopping their use, and had never experienced an opioid overdose. Covid-19 testing was negative. No medical concerns were identified.

5. He continued receiving mental health treatment and was prescribed medication to assist with management of his depression and anxiety which he did report to be helpful.

6. The committee discussed the potential impact of a referral for SUD treatment and the benefit he may have gained from treatment during his most recent incarceration. The committee discussed current resource limitations of available DOC SUD treatment options and the plan to expand treatment capacity in the future for incarcerated individuals.

7. During this incarceration, he did not request, nor did DOC staff identify him for SUD treatment.

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 risk assessments, classification review, and custody facility plan were completed within the guidelines of department policy.

2. DOC staff incident response complied with policy requirements to include crime scene handling and required notifications.

3. The Critical Incident Stress Management (CISM) team was deployed for staff support after this incident, however:

   a. Not all staff were available during the time CISM was at the facility,

   b. Not all staff were offered CISM services, and/or

   c. Not all staff received promised follow up.

4. The nursing pill line radio did not beep to warn of low battery. Nursing staff could hear radio transmissions about the incident but could not transmit.

5. The incarcerated individual did not attend pill line to receive his mental health medication on three different occasions during July. There was no documentation found that the prescriber was notified of missed doses as required per nursing protocol N-306 Medication Management.

6. During the incident response, multiple staff members noted signs of rigor mortis and expressed concerns with having to conduct CPR per DOC Policy 600.620 - Emergency Medical Response until the incarcerated individual was declared deceased.

CIR Recommendations did not directly correlate to the 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 asked for additional information regarding the following:

1. Incarcerated individuals are asked to complete an Opioid Screening Questionnaire at DOC intake. The OCO representative asked if the questionnaire is evidence-based and what is its purpose?

   DOC Response: The Opioid Screening Questionnaire used at the reception centers is used to determine if the incarcerated individual may benefit from an assessment by the Substance Abuse Recovery Unit (SARU). It is designed utilizing the validated Global Appraisal of Individual Needs – short screener format. The purpose of this abbreviated tool is to quickly identify individuals who may have opioid use disorder and need a comprehensive substance use assessment. The responses provided by the incarcerated individual did not indicate he had a need for an opioid dependence assessment.

2. How does the department intend to address individuals who report a history of SUD?

   DOC Response: On September 30, the DOC Deputy Secretary issued a memo directing staff to encourage incarcerated individuals with a history of substance use to prioritize and participate in SARU programming to give them the best chance of success in maintaining sobriety. Incarcerated individuals who choose to participate in SARU programming will be offered a person-centered sobriety support plan.

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

Committee Findings

1. The incarcerated individual died as a result of an accidental overdose from ingesting contraband opioid drugs.

2. He had not been diagnosed with opioid use disorder and had not requested SUD treatment during this incarceration.

3. Current DOC resources do not support the current level of need for SUD treatment. A request for funding has been made to support the expansion of the SUD treatment program in all DOC facilities.

4. DOC staff complied with policy requirements regarding classification, medical emergency response, and the death of an incarcerated individual.

Committee Recommendations

1. The UFR Committee members 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. UFR committee identified conflict in policy language between DOC 620.200 – Death of an Incarcerated Individual that allows advanced practitioners to pronounce a death, while DOC 890.620 - Emergency Medical Treatment requires resuscitation efforts to continue until otherwise directed by a physician unless a “Do Not Resuscitate” advanced directive is in place. Recommend DOC 890.620 – Emergency Medical Treatment be updated to reflect authority of advanced practitioners to direct discontinuation of resuscitation efforts and pronounce a death.