



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-030 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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UFR-22-030 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. 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 December 8, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Mark Eliason, Deputy Director Health Services
- Ronna Cole, Deputy Director Health Services
- Paul Clark, Administrator
- Rae Simpson, Director of Quality Systems
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary

DOC Reentry Centers

- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator

DOC Graduated Reentry – Community Corrections

- Kristine Skipworth, Regional Administrator – East Region
- Steven Johnson, Regional Administrator – Southwest Region
- Jennie Fitzpatrick, Programs Administrator – Family/Offender Sentencing Alternative
- Autumn Witten, Administrator

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. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: 1983 (39-years-old)

Date of Incarceration: April 2022

Date of Death: August 2022

The incarcerated individual was a 39-year-old man who had been involved with Washington DOC since 2013. He was readmitted to prison in April 2022. While at the prison facility, he worked in food services and had requested to participate in several vocational training programs. During his semi-annual classification review, he was noted to be doing well. He requested to be transferred to a reentry center when he became eligible for a custody promotion. After serving four months of his sentence, he received a custody promotion and was transferred to a reentry center. Five days after arriving at the reentry center he was found unresponsive in his room by another resident. An emergency was announced, and staff called 911. Reentry center staff administered Narcan and provided CPR until emergency medical services (EMS) staff arrived. At this time, the autopsy and toxicology reports are pending. Per the county coroner, his cause of death was lack of oxygen to his brain, presumed to be from a fentanyl overdose. The manner of his death is presumed to be accidental.

A brief timeline of the incarcerated individual’s medical emergency and hospitalization:

| Day 1 | Event |
|------------|--|
| 2310 hours | Correctional Officer (CO) observes the incarcerated individual walking up the stairs toward his dorm room. |
| 2324 hours | The CO is contacted by a facility resident informing him the incarcerated individual is on the ground and unresponsive in his room. The CO enters the dorm room and confirms he is unresponsive. |
| 2325 hours | The CO makes an emergency radio call for assistance. A second CO calls 911. |
| 2326 hours | The Supervisor enters the room and administers one dose of Narcan. A blue substance starts coming from his nose. They initiated chest compressions when no pulse is detected. |
| 2330 hours | The second CO brings the AED from the officers’ station. The AED fails to power on. |
| 2334 hours | Community EMS from the local fire department arrive on scene and took over resuscitation efforts. They were able to regain a pulse. |
| Day 2 | Event |
| 0015 hours | Ambulance departs the facility with the incarcerated individual. |

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|--------------|---|
| 0102 hours | The incarcerated individual is admitted to the hospital and furlough paperwork is provided to the hospital. |
| Day 3 | Event |
| 1609 hours | The hospital notifies DOC that the incarcerated individual was declared deceased. |

Committee Discussion

- A. The DOC Mortality Review Committee reviewed his health record, the circumstances of his death and presented the following topics for discussion and UFR committee consideration:
1. The incarcerated individual had a history of post-traumatic stress disorder, anti-social personality disorder, benign prostate enlargement, hypertension, and previous foot and spine surgery for injuries received in a motor vehicle accident. He had no history of substance use disorder and had never had a positive urine drug screen.
 2. After finding the incarcerated individual, the reentry center staff rendered emergency aid including administration of Narcan and CPR. EMS personnel pursued advanced cardiac life support.
 - a. The individual received 3 doses of Narcan and was defibrillated three times.
 3. He regained a pulse without regaining consciousness. He arrived at hospital in multiorgan failure secondary to the lack of oxygen and circulation. The plan was to attempt to stabilize him for 72 hours and then reassess.
 4. After admission to the intensive care unit, he was assessed, and it was determined he had suffered an irreversible brain injury due to lack of oxygen and had no brain stem function.
 5. His father, mother and sister were involved in the decision to withdraw life support. He was pronounced deceased a few minutes later.
 6. The incarcerated individual died from a suspected fentanyl overdose without an established pattern of drug use, abuse, or suicidal intention.
- B. The committee discussed the availability of fentanyl and the ability to incorporate it into other substances without users being aware it was added. No opportunities for improvement were identified.
- 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. The CIR found:
1. The incarcerated individual had not left the reentry center property since his arrival.

2. The Sergeant's office was identified as a Narcan storage location, but responding staff were unable to find it in the emergency.
 3. When Narcan was brought to the scene, responding staff were unaware of how to administer it expelling some of the container's contents attempting to understand how to administer the substance.
 4. The first floor AED did not work as designed.
 - a. The staff had not replaced the training pads.
 - b. The battery was not charged.
 - c. The AED was identified as nonfunctional during the August safety inspection which was provided to the facility safety office and then filed with other safety paperwork.
 5. The second floor AED was found after the arrival of community EMS.
 - a. There was no signage indicating AED locations.
 - b. Responding staff were unaware there was a second AED in the facility.
- D. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following for UFR committee discussion:
1. What are DOC's requirements for conducting searches at the reentry center?
 - a. At the time of the fatality, searches were conducted for cause per the COVID-19 Guidelines. A memo was sent out in September 2022 informing reentry center staff that the search requirements in place prior to the pandemic had resumed.
 - b. Bag searches are conducted each time a resident enters the facility, and the residents are pat searched randomly. Search randomizers have been installed for resident pat searches.
 - c. Rooms are searched on a random basis at least once per month.
 - d. Urine drug screens are conducted for cause or at least once per month on a random basis.
 2. They also asked if drug detection canines are used to search reentry facilities and if there is a drug related fatality can the reentry center policy or protocol be updated to include the requirement for the facility to be searched by a drug detection canine?
 - a. The reentry center administration is investigating the feasibility of being able to:
 - i. Conduct canine searches after a drug related fatality and

- ii. Develop a rotational schedule for routine canine searches of reentry center facilities.
- 3. They recommend DOC consider referring any incarcerated individual with a substance abuse history and a positive urine drug screen to a therapeutic community (TC).
 - a. Reentry center administration is currently discussing with the Substance Abuse and Recovery staff members what the pathway should be for referral and approval of enrollment into a TC.
 - b. Health services reentry staff are expanding their capacity to connect incarcerated individuals with community services prior to their transfer to a reentry center.
- D. The Health Care Authority (HCA) representative presented their analysis of the case and submitted the following for UFR Committee discussion:
 - 1. Due to the potency of fentanyl being found in the community, using a single dose of Narcan is inadequate. Current community recommendation is to administer 3 – 4 doses two to three minutes apart while continuing CPR.
 - i. DOC should consider increasing the amount of Narcan available for staff use and consider updating their Staff Narcan Administration protocol and education so staff are aware of the changes.
 - 2. The current fentanyl availability has caused a community crisis. It is frequently blue in color, and it is assumed to be oxycodone. Due to the potency, individuals are overdosing with just one use. It can be ingested in various ways including pill form or powdered for inhalation.
 - i. Dr. Fotinos volunteered to act as a resource to DOC reentry center administration regarding fentanyl and Narcan education.
- E. The Department of Health (DOH) representative concurred with the findings and did not offer additional recommendations.

Committee Findings

- 1. The incarcerated individual died as a result of lack of oxygen to his brain from a presumed fentanyl overdose.
- 2. He had no history of opioid use, or any substance use disorder.
- 3. Reentry center staff were not able to easily access or administer Narcan.
- 4. The AED brought to the incident was not functional.

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 |
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| 1. All reentry center staff should be trained and up to date on First Aid/CPR as well as “hands on” training with Narcan administration. |
| 2. All reentry center staff should be trained on the location of Narcan and AEDs and aware of how to access them during an emergency. |
| 3. All reentry center emergency response equipment should be functional and routinely checked per DOC policy 890.620 Emergency Medical Treatment including the AEDs. |
| 4. Safety equipment issues in the reentry center should be immediately reported and a backup plan communicated to all staff members. |

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

1. Due to potency of fentanyl, DOC should investigate the feasibility of increasing the amount of Narcan supplies available for use by staff and for distribution to incarcerated individuals entering the community.