Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-021

Report to the Legislature

As required by RCW 72.09.770

October 17, 2022

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Table of Contents

Unexpected Fatality Review Committee Report

UFR-22-021 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 September 29, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Frank Longano, Deputy Chief Medical Officer
- Dr. Zainab Ghazal, Administrator - Command B
- Paul Clark, Administrator – Command A
- Ronna Cole, Deputy Director
- Dr. Karie Rainer, Director Mental Health
- Rae Simpson, Director Quality Systems
- Mark Eliason, Program Manager
- Mary Beth Flygare, Project Manager

DOC Women's Prisons Division

- Jeannie Darneille, Assistant Secretary

DOC Reentry Division

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator
- Dave Ganas, Administrator
- Amanda Lease, Community Corrections Supervisor
- Randi Unfred, Field Administrator

DOC Community Corrections Division

- Steve Johnson, Regional Administrator - SW Region
- Donta Harper, Regional Administrator - NW Region
- Dell Autumn-Witten, Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

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

Department of Health (DOH)

- Katherine Shaler, Health Services Consultant - Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Date of Birth: 1995 (27-years-old)

Date of Incarceration: December 2021

Date of Death: June 2022

The incarcerated individual was a 27-year-old man who was involved with the Washington State corrections system since 2019. Between April 2019 and December 2021, he was detained multiple times for violating the conditions of his community supervision and/or being arrested for new criminal charges. His first prison incarceration occurred in December 2021. Five weeks prior to his death, he transferred to the Graduated Reentry Program (GRE) and was placed in a transitional sober living house on electronic ankle monitoring. His death was a result of fentanyl intoxication. 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. His medical and dental intake screening exams were unremarkable and documented he had a history of opioid use disorder (OUD) and mental illness.

      i. His reported drugs of abuse included heroin, fentanyl, and methamphetamine saying he last used opiates in November 2021.

      ii. He had been prescribed suboxone for OUD in the past and would like to start again after his release to the community.

   2. His mental health intake documented a history of mental illness that included self-harm events, medication for symptom management, and a mental health hospitalization.

      i. During his follow-up mental health assessment, he indicated that his mental health symptoms were stable, and he currently did not need mental health medications.

   3. He did not request a Health Services appointment during the time he was housed in a prison facility.

   4. Prior to his GRE transfer he was given a Narcan kit and provided overdose education.

   5. Due to his earned release date (ERD) being listed as November 2022 on the Reentry Care

Navigator April eligibility report, he was not connected to community chemical dependency treatment services prior to his GRE transfer in May 2022. As a result:

i. DOC Policy 350.200 – Transition and Release was revised 9/1/22 to establish expectations for coordination of reentry planning with appropriate employees, contract staff, tribes, and/or community-based services including medical, mental health, substance use disorder, education, employment or vocational training.

ii. The Reentry Navigator program eligibility report was revised in July 2022 to include incarcerated individuals approved for GRE transfer and not just those scheduled for release.

iii. The Reentry Division has updated their screening form to include previous use of medication to treat opioid use disorder (MOUD). When need for MOUD is identified, the individual can be directly connected to the Health Services Care Navigator Team for assistance with accessing community services.

iv. In October 2022 DOC added an additional Health Services Reentry Care Navigator to support incarcerated individuals transferring to GRE and other partial confinement settings.

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:

Day 1 - The incarcerated individual transferred into the GRE program, met with his assigned Correctional Specialist (CS) and completed his orientation of GRE expectations. The CS collected an oral swab for drug screening.

Day 7 - Drug screen results from day one came back negative.

Day 10 - DOC Reentry Navigator called for a check-in. The incarcerated individual reported he was doing well, applying for jobs and indicated his roommates were friendly and focused on maintaining sobriety. He stated he would reach out if he needed assistance with anything.

Day 16 - The incarcerated individual was admitted to the hospital for a non-opioid drug overdose.

Day 18 - The CS met with the incarcerated individual at the hospital. The incarcerated individual told the CS he had obtained and ingested Xanax. The CS escorted him home from the hospital, restricted his movements to the sober living house and collected an oral swab for drug screening.

Day 19 - The CS met with the incarcerated individual at the sober living house to complete a stipulated agreement for his admission of using non-prescribed medications. As part of the agreement, he agreed to complete a chemical dependency assessment within two weeks and obtain a mental health assessment within three weeks.

Day 21 - The drug screen results collected on day 18 came back negative. The CS met the incarcerated individual at the sober living house for short and long-term goal setting and to collect an

oral swab for drug screening. He provided the incarcerated individual with a Narcan kit. The incarcerated individual stated he didn't want the kit but agreed to keep it.

Day 25 - The Reentry Navigator called the incarcerated individual for a check-in and the CS visited the sober living house and checked his living space. No visible concerns were noted. The CS collected an oral swab for drug screening.

Day 27 - The drug screen collected on day 21 was positive for fentanyl. The result was posted in the lab portal and available for the CS to review.

Day 28 - The CS had telephone contact with the incarcerated individual to address him returning to his residence 15 minutes late without notification to the CS. The CS gave him a verbal warning.

Day 33 - The Reentry Navigator received a call from the incarcerated individual who needed transportation to attend a job interview and he had forgotten to request a bus pass. The Reentry Navigator delivered bus passes to his residence later the same day.

Day 34 - The incarcerated individual called the Reentry Navigator to report he would be late getting home due to his job interview running long. He reported that he was offered the job and would start the following week.

Day 35 - The CS received a text message from the incarcerated individual confirming he had a chemical dependency assessment scheduled for the following week.

Day 37 - The incarcerated individual was found unresponsive by his roommate who called 911. He was pronounced deceased at the scene by emergency medical services personnel.

Day 39 - The CS reviewed his text messages and voicemails from the previous holiday weekend. He returned the call from the coroner's office and was informed the incarcerated individual was found deceased with drugs on his person and a box of Narcan next to him. The CS checked drug screen results on lab portal and noted the drug screen from day 21 was positive for fentanyl.

After the incarcerated individual's death, the GRE supervisor noted the CS had not checked the lab portal for almost two weeks and had missed the positive drug screen result that was available for review on day 27. In response to this finding the supervisor implemented the following:

1. The CS must check the lab portal weekly at a minimum.
2. If an incarcerated individual has a positive oral swab result, they are to be placed on urine sample testing which provide instant results.
3. If an incarcerated individual tests positive for fentanyl they are required to seek inpatient substance use treatment.

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

1. DOC Reentry does not have a process in place to track receipt of oral swab drug testing results.

2. Recommends providing staff guidance and training to Reentry staff members on how to configure the lab portal to send an email notification to staff members when their results are ready for review.
3. Recommends Reentry staff be required to check the lab portal every business day for results and document the check.

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

Committee Findings

A. The incarcerated individual was not on medication assisted treatment for OUD prior to his death. Currently, DOC facilities are not funded to support medication assisted treatment and DOC staff are unaware of available community-based OUD treatment options for incarcerated individuals who are transferring to GRE or releasing to the community.

B. DOC 420.380 Policy – Drug/Alcohol Testing does not include expectations for monitoring and documenting receipt of drug screen results that are sent to a contracted lab.

C. Not all Reentry staff are aware the lab portal can be configured to send an email notification when drug screen results are ready for review.

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. Explore expansion of treatment options for incarcerated individuals diagnosed with opioid use disorder.
2. Develop and implement a formal process for tracking and documenting drug screening results for individuals in the GRE program.
3. Provide staff guidance and training on how to configure the lab portal to send email notifications when drug screen results are ready for review.

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

1. Offer incarcerated individuals overdose harm reduction training prior to their reentry into the community.

2. Update DOC 420.380 Policy – Drug/Alcohol Testing to clarify expectations for monitoring and documenting drug screening results when the test is sent to a contract lab.