Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-010

Report to the Legislature

As required by RCW 72.09.770

November 15, 2024

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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 October 3, 2024, and October 17, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director – Quality Systems
- Paul French, Administrator – Substance Abuse
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary of Prisons – East Division
- Deborah (Jo) Wofford, Deputy Assistant Secretary – Women's Prison Division

DOC Community Corrections Division

- Kristine Skipworth, Administrator – East Region
- Kelly Miller, Administrator – Graduated Reentry

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1993 (30-years-old)

Date of Incarceration: April 2023

Date of Death: June 2024

At the time of death, this incarcerated individual was participating in Graduated Reentry program while residing in a community sober living house.

His cause of death was due to acute fentanyl intoxication. The manner of his death was accidental.

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

XX Days Prior to Death	Event
38 days – 3 days prior	• He was transferred to the Graduated Reentry (GRE) program. • Narcan was provided to him. • He was participating in substance use treatment, as required. • All drug screenings were negative. • He was attending approved social visits with his family and had obtained employment.
2 days prior	• The house manager received third party information that he deviated from his approved schedule
Day of Death	**Event**
0 days	• He was found non-responsive by a housemate. • Housemate called 911 and performed CPR until EMS arrived and assumed care. • He was declared deceased by EMS.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews in formulating recommendations.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

   1. The committee found:

      a. The individual received substance use disorder (SUD) treatment while incarcerated which was continued after his transfer into the GRE program.

      b. Prior to his DOC admission he was not prescribed medication for opioid use disorder (MOUD) and requested to begin treatment. He did not meet treatment eligibility criteria at the time of his request.

      c. He was transferred to his parent facility and enrolled in a therapeutic community as part of his SUD treatment plan.

      d. During his incarceration, he required dental treatment. The facility where he was housed did not have on-site dental services and he was transferred for care.

      e. He was transferred to the Graduated Reentry program from a facility that does not offer MOUD inductions.

      f. He was scheduled for an appointment in the community to discuss available MOUD treatment options. He opted to not participate in the MOUD program.

   2. The committee recommended:

      a. DOC continue to pursue necessary resources and partnerships to expand the use of medications for opioid use disorder (MOUD) treatment to ensure each individual who needs care has access.

      b. DOC continue implementation of a mobile self-contained dental clinic to support facilities that currently do not have on-site dental services.

      c. DOC Health Services continue to review and update process to maximize access to MOUD treatment for incarcerated individuals.

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 findings were administrative in nature, did not correlate to the cause of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The UFR committee reviewed the work of the Mortality Review committee and the Critical

Incident Review and discussed the following topic.

Current State of Medications for Opioid Use Disorder Treatment in DOC Facilities:

Committee members agreed that this individual could have benefitted from medication assisted treatment for opioid use disorder (OUD) and discussed the importance of providing treatment when requested by incarcerated individuals as the window for treatment acceptance is often small.

DOC currently has one addiction medication physician who acts as a consultant to maintain individuals on medication assisted treatment after they are admitted to a DOC when their sentence is six months or less. If an individual is serving a sentence longer than six months, they are weaned off medication. Incarcerated individuals may request a transfer to a facility that does offer inductions prior to community reentry if they reside in one that does not offer this.

Committee members verified that DOC has requested resources to support expansion of their MOUD treatment program while the Health Services division is working to improve current processes to maximize medication assisted treatment program access.

Committee Findings

The incarcerated individual died as a result of acute fentanyl intoxication. The manner of death was accident.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.

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

DOC should continue to advocate for resources to expand Medication Assisted Treatment.