Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-010

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, 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 October 19, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Brooke Amyx, Health Services Reentry Administrator
- Dawn Williams, Program Administrator, Substance Abuse Recovery Unit
- Tiffany Bibeau, Health Services Credentialing Manager
- Deborah Roberts, Program Manager
- Ashley Ayers, Executive Secretary

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Community Corrections Division

- Dell-Autumn Witten, Community Corrections Administrator
- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Centers

- Danielle Armbruster, Assistant Secretary - Reentry
- Scott Russell, Deputy Assistant Secretary - Reentry
- Susan Leavell, Senior Administrator
- Carrie Stanley, Administrator

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Hannah Carmichael, Health Services Consultant 3, 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: 1989 (34 years-old)

Date of Incarceration: May 2023

Date of Death: July 2023

At the time of his death, this incarcerated individual was housed in a Reentry Center operated by a contracted vendor. The cause of death was the result of acute drug intoxication including fentanyl. The manner of death was accident.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Weeks prior to death	Event
11 weeks	• Readmitted to prison.
8 weeks	• Transferred to parent facility.
6 weeks	• Transferred to reentry center.
2 weeks	• Started a job in the community.
Days prior to death	**Event**
1 day prior to death	• Incarcerated individual was showing signs of concerning behavior prior to entering his room at 21:52 hours.
Day of death	• He did not leave the facility for work and contract employees did not verify his status. • At 13:05 hours, he was found deceased.

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 members considered the information from both reviews in formulating recommendations for corrective action.

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 incarcerated individual was diagnosed with methamphetamine, opioid, and alcohol use disorder.

b. He was cared for briefly by DOC Health Services while in the violator unit, which provides problem focused care. Records from the violator units are not part of the

central medical file.

c. He died of a fentanyl overdose while living at a reentry center.

d. He was not in substance use treatment or receiving medications for opioid use disorder.

e. He did not report a need for help to DOC Health Services regarding substance use or mental health.

f. A review of his community hospital admissions after his death showed, he had previous hospital admissions for mental health treatment and a history of substance use.

2. The MRC recommended:

a. Discussing the role of DOC, HCA and DOH for individuals in similar situations during the UFR Committee meeting to determine what additional resources might have helped this individual.

b. DOC continue to pursue an electronic health record (EHR) to interface with community health systems.

c. DOC explore options for obtaining community care information using a health information exchange like One-Health port.

d. DOC explore the possibility of integrating violator health records and assessments into the permanent medical file to support care needs.

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.

1. The CIR found:

a. The incarcerated individual was housed in a reentry center, operated by a contracted vendor to provide the daily operations and custody of individuals within facility.

b. He was not referred for substance use disorder (SUD) treatment, as required.

c. There is no documentation that he was pat searched per DOC Reentry Center established procedures.

d. The contractor did not conduct training per DOC Reentry Center established procedures, although contract employees did complete the 40-hour on-the-job training checklist.

e. Contract employees and other incarcerated individuals in the reentry center did not report concerns or attempt to intervene and offer assistance when he began to exhibit unusual behavior.

f. The contracted vendor's staffing issues included not being able to employ enough people to adequately staff the facility. The facility census was reduced to mitigate staffing concerns as well as DOC providing staff to fill vacant shifts identified by the vendor.

g. There were no male contract employees available to conduct urinalysis for drug screening. Due to this concern, DOC provided an alternate drug testing method with oral swabs. Use of the oral swabs did delay results being communicated back to the facility.

h. Facility counts were not conducted per DOC Reentry Center established procedures.

2. The CIR recommended:

a. Ensure contract staff are fully trained prior to assuming independent completion of duties.

b. DOC update Reentry Center procedures for pat searches, room searches, counts, inside security checks, drug testing, and area searches within 90 days.

c. DOC work on statewide reentry center operational memorandum/procedures for counts and security checks and work towards inclusion in DOC Policy 420.150 Counts, which currently applies only to prisons.

C. The Department of Health (DOH) representative supported the recommendations. DOH also asked how we can help foster an environment so incarcerated individuals will report when someone may need support? Is there any way to take away the fear of getting in trouble?

Note: DOC is fostering an environment of support for incarcerated individuals in reentry centers which includes orientation and discussion around the importance of reporting when they have concerns for another resident's safety. Reentry is actively trying to break down these barriers to help people succeed. Additionally, the vendor has returned the contract and at this time all residents have been moved out of the building and transferred to another reentry center.

D. The Health Care Authority (HCA) Representative asked about existing agreements between HCA and DOC regarding Medicaid and Medicare benefits.

Note: DOC would welcome exploring the expansion of partnership with HCA. An electronic health record that has the ability to retrieve community health records could have made a difference in this case.

E. The Office of the Corrections Ombuds (OCO) submitted the following for UFR committee discussion:

1. The OCO asked what is in place to identify patients in need of treatment when they inaccurately self-report.

Note: DOC screens for follow-up care needs. This incarcerated individual declined services. DOC also partners with the assigned managed care organization (MCO) by providing a care report identifying care needs. The MCO case manager offers support and access to care following reentry.

2. The OCO stated that self-reported assessments have limitations and gaps and asked if there was some way to supplement the assessment.

Note: DOC offers services to those who self-report as well as those identified by DOC.

Kiosks are available for the incarcerated individuals in reentry centers and can be used anytime to request care or change an assessment response. Additionally, case managers are a resource and support to incarcerated individuals in reentry.

3. The OCO asked if there are differences in health care between a regular prison unit and a violator unit.

   Note: Violator units are typically a short-term setting which provides problem focused medical care, mental health support and medication assisted treatment. Sanctions for violating community supervision are typically 15 days or less, limiting what care DOC can provide in this timeframe.

4. The OCO asked how DOC is improving overdose education at re-entry centers. Is there regular education or events around Narcan use and signs of overdose for the residents and staff?

   Note: DOC has signage in the facilities and accessible emergency Narcan stations. A Health Care Authority video is played at orientation, pamphlets are provided, and contactors provide a verbal training. Each contract staff member is provided a required training on Narcan and opioid overdose education.

Committee Findings

The manner of the incarcerated individual's death was accident. The cause of death was acute drug intoxication including fentanyl.

Committee Recommendations

1. DOC update statewide Reentry Center procedures for:
   a. searches,
   b. counts,
   c. drug testing,
   d. facility security,
   e. orientation and training, and
   f. substance use assessment referral.

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

A. The UFR Committee recommended DOC explore the possibility of reviewing violator records and assessments to integrate into the central medical file to support care needs.

B. The committee recommended DOC continue to pursue an electronic health record (EHR) to interface with community health systems when funding becomes available.

C. The committee recommended DOC explore options for obtaining community care information using a health information exchange like One-Health port.