Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-011

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 September 11, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Zainab Ghazal, Administrator
- Rae Simpson, Director - Quality Systems
- Patty Paterson, Director of Nursing
- Brooke Amyx, Health Services Reentry Administrator
- Deborah Roberts, Program Manager
- MaryBeth Flygare, Project Manager

DOC Prisons Division

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

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry

DOC Reentry Centers

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

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- 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. Judy Zerzan, 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: April 2023

Date of Death: July 2023

At the time of his death, this incarcerated individual was in prison. The cause of death was due to toxic effects of methamphetamine. The manner of death was accident.

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

Day of death	Event
13:10 – 19:53 hours	• Incarcerated individual meets with visitors. • Visitors exit. • Incarcerated individual is searched.
20:01 – 20:23 hours	• Incarcerated individual enters the unit dayroom. • He receives a cup from another incarcerated individual. • He leaves the dayroom and returns to his cell.
20:24 – 21:21 hours	• Several incarcerated individuals visit his cell.
21:29 hours	• Emergency lights flash for his cell.
21:32 hours	• Staff arrive and begin rendering aid, including Narcan administration. • Incarcerated individual was not responsive but had a pulse and was breathing on his own.
21:49 hours	• Community Emergency Medical Services arrive on scene and assume care.
21:56 hours	• Incarcerated Individual becomes pulseless and stops breathing. • CPR is initiated.
22:36 hours	• Emergency medical services call time of death.

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. This 34-year-old male died after resuscitation attempts by staff and emergency medical services.
    b. The decedent was noted to have altered conscious state in his shared cell. His clinical state worsened, and he became unresponsive, with resuscitative measures unsuccessful.
    c. Restraints were placed to protect staff from being struck when the incarcerated individual was unable to control his movements and were removed as soon as he became unresponsive.
    d. At autopsy, multiple small packages were identified in the small intestine, including one ruptured package.
    e. The cause of death was due to methamphetamine intoxication.
    f. From review of the medical record, the emergency response by the medical staff was appropriate given the limited amount of information.
2. The DOC Mortality Review Committee members did not identify any additional care recommendations to prevent a similar fatality in the future.

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. The decedent was appropriately classified.
    2. Emergency response was within policy guidelines.
    3. No corrective action items were identified.

C. The Department of Health (DOH) representative offered resources for response to methamphetamine overdose. The DOH representative asked what system gaps were there that allowed him to ingest these objects.

    Note: DOC provided information about contact visits and how when these visits are in place there are opportunities for visitors to pass drugs. Drugs may also be introduced by DOC staff or through physical mail. Maintaining connections through physical mail and contact visitation support successful reentry into the community.

D. The Health Care Authority (HCA) Representative asked if DOC considered using other drugs after the administration of Narcan.

    Note: DOC starts basic life support until community emergency medical services (EMS) arrive to assume care. EMS can initiate advanced life support procedures including medication administration.

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

1. The OCO asked if the resuscitation attempts may have been impacted by restraints and what the impact might look like.

   Note: DOC indicated that the restraints were initially placed for staff safety to allow treatment without anyone being inadvertently injured by the incarcerated individual when he could not control his movements. The restraints were immediately removed when he became unresponsive.

2. The OCO discussed concerns with emergency red bags and supplies and asked if there were missing items and requested the current status of the red bags.

   Note: DOC nursing has been working on this statewide. DOC Health Services has a request out for a quote on new emergency bags that are smaller and easier to use. Items that are not used are being removed. Updated emergency response training for each facility has been scheduled and includes use of the red bag and its contents. The training will be conducted quarterly instead of annually and new staff will receive the training prior to starting patient care.

Committee Findings

The manner of the incarcerated individual's death was accidental. The cause of death was toxic effects of methamphetamine.

Committee Recommendations

The UFR Committee did not offer any recommendations for corrective action.