Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-033

Report to the Legislature

As required by RCW 72.09.770

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Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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

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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, 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 February 14, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Janell Simpkins, Facility Medical Director
- Mark Eliason, Deputy Director Health Services
- Rae Simpson, Chief Quality Officer
- James Rogers, Clinical Nurse Educator
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary – Men's Prison Division
- Jeannie Darneille, Assistant Secretary – Women's Prison Division
- Ronald Haynes, Superintendent – Airway Heights Corrections Center

DOC Reentry Centers

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

DOC Graduated Reentry – Community Corrections

- Steven Johnson, Regional Administrator
- Kristine Skipworth, Regional Administrator
- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator – Community Corrections

DOC Risk Management

- Michael Pettersen, Director of Risk Mitigation

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. 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: October 2022

Date of Death: October 2022

Place of Death: Contracted Community Jail

The incarcerated individual was a 27-year-old male who had been involved with the criminal justice system since 2014 for both felony and misdemeanor convictions. He was never sentenced to prison incarceration and served his periods of confinement in community jails. He had a long history of illicit substance use and was homeless during his final period of community supervision by DOC. There was an active Secretary's Warrant for his arrest due to his failure to comply with his release conditions that required him to meet with his assigned Community Corrections Officer (CCO). He was arrested by community law enforcement and placed in a contracted community jail for his supervision hearing. He was found unresponsive in his cell three days after his arrest by jail staff. Resuscitative efforts were unsuccessful. His cause of death was acute methamphetamine and fentanyl intoxication.

A review of his final term of community custody supervision documented:

1. In 2018 he was sentenced to six months of confinement followed by 12 months of community custody supervision by DOC.
2. He released from the community jail in September 2018 after being given expectations of when and where he was to meet with his CCO to begin his period of community supervision.
3. Between September 2018 and October 2022, he never reported for his scheduled supervision meetings.
4. He was arrested and appropriately sanctioned on fifteen separate occasions due to his failure to meet with his CCO.
5. A final Secretary's Warrant was issue in August 2022, and he was arrested by city police officers in October 2022.

Committee Discussion

A. The DOC Mortality Review Committee (MRC) reviewed his available health record from the jail and the circumstances of his death. They presented the following topics for discussion and UFR Committee consideration:

   1. The incarcerated individual was a 27 y/o male with a long history of SUD and OUD with progressively worsening opioid withdrawals, who passed away unexpectedly in October 2022

after being found unresponsive without a heartbeat.

2. He had no court ordered conditions for substance use treatment.
3. He was housed at the same contracted community jail fifteen times for failing to meet with his CCO.
   a. During these brief incarcerations, his medical care was delivered by an outside agency that is contracted by the contracted community jail system and operates on its own policies and procedures which are not dictated by DOC.
   b. During each of these incarcerations, he underwent a receiving screening, and either was immediately started on the clinical opioid withdrawal protocol (COWS) or was started within two days of his admission.
   c. His screening forms consistently documented SUD, tobacco use, one suicide attempt, and a history of being prescribed medication for anxiety and depression that were stopped in 2018.
   d. The COWS opioid withdrawal protocol used by the contracted medical agency that he was placed on routinely consisted of nursing COWS assessments every 8 hours, starting non-opiate medication for symptom relief, and offering Gatorade.
   e. The incarcerated individual tolerated this protocol well from 2019 until early 2022 without significant medical issues, however in 2022 he started requiring more interventions during his withdrawals. He required transportation to the Emergency Room (ER) during two separate withdrawal episodes.
   f. Despite buprenorphine treatment being referenced in their COWS form and his COWS scores being consistent with its use, the contracted medical agency providers never prescribed opiate medication.
   g. Their protocol states requirements of when a health care provider needs to be contacted. The provided record does not document adherence to the referral requirements of their protocol.
4. The ordered COWS protocol was not followed explicitly, specifically not performing nursing checks every eight hours and not contacting a health care provider when the initial COWS score was greater than eight for a medication assessment.
5. The resuscitative efforts were done in a timely and appropriate manner but were unsuccessful.
6. There were some minor documentation deficiencies noted and due to this it is unclear when his last assessment was done by nursing before he was found unresponsive.
7. Due to his recent history of multiple complex withdrawals, it would have been appropriate to monitor him more closely during his withdrawal and consider additional medication treatment.
8. He would have also benefited from medication assisted treatment (MAT) for his chronic OUD illness and with his frequent admission to the jail complex there were multiple opportunities to

help assist in coordinating this care. For example:

- Prior to his initial release from jail,
- During stay at a DOC facility by the health services staff,
- During his DOC hearings,
- By the emergency room staff directly to the community,
- By contracted community jail staff via DOC or directly to the community.

Further communication and involvement with the community jails, DOC health services, and community custody officers can be one way that the DOC can help facilitate this key step in the future.

9. The MRC recommends a debrief with the community jail custody and their contracted medical staff to discuss the noted documentation deficiencies, the COWS protocol and the assistance DOC can provide to assist incarcerated individuals needing connected to MAT.

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 while the individual was under community supervision. The CIR scope included the timeframe from February through October 2022. The CIR found:

1. The incarcerated individual never reported for his scheduled supervision meetings therefore his Community Corrections Officer (CCO) was unable to complete the required supervision activities.
2. The only contacts DOC community corrections staff had with the incarcerated individual was during one transport from the emergency room and during administrative hearings to address his failure to report to supervision meetings.
3. For the months reviewed, he had five Secretary's Warrants (SW) issued and negotiated sanction hearings.
4. The CIR recommendations were administrative in nature and did not directly correlate to the death. They will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

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

1. The OCO Director recently visited this community jail and shared that the jail's contract medical provider is starting a Medication Assisted Treatment (MAT) program to further support incarcerated individuals experiencing opioid withdrawal symptoms.
2. This jail's contract is coming up for renewal and due to the noted documentation deficiencies, the OCO Director recommends the DOC contract administration staff provide a briefing to the UFR Committee regarding the department's contract review and renewal process for jails contracted to house individuals who have been arrested on a Secretary's Warrant.

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

Committee Findings

1. This individual would have benefited from long-term medication assisted treatment (MAT) for his chronic Opioid Use Disorder (OUD). While he never reported to scheduled meetings with his CCO, his frequent admission to the contracted community jail complex afforded multiple opportunities to help assist in coordinating this care.
2. While being housed in a contracted community jail, the incarcerated individual died of a combined methamphetamine and fentanyl overdose.

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. A debrief with the contracted community jail custody and their medical staff to discuss the noted documentation deficiencies, the clinical opiate withdrawal scale (COWS) protocol, and the assistance DOC can provide to assist incarcerated individuals needing connected to medication assisted treatment (MAT).

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

1. DOC contract administration staff provide a briefing to the UFR Committee regarding the department's contract review and renewal process for jails contracted to house individuals who have been arrested on a Secretary's Warrant (SW).

2. DOC should continue to explore ways to enhance communication with community jails to facilitate connecting incarcerated individuals with Opioid Use Disorder (OUD) with a Medication Assisted Treatment (MAT) program in their community prior to their release from DOC sanction. DOC Community Custody Division staff will coordinate with the DOC Nurse Desk as required.