



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-011 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, 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 July 7, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Paul Clark, Health services Administrator - Command B
- Ronna Cole, Deputy Director Health Services
- Ken Taylor, Deputy Director Health Services
- Rae Simpson, Chief Quality Officer
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit

DOC Office of Correctional Operations

- Tom Fithian – Senior Director – Correctional Operations

DOC Prisons Division

- Mike Obenland – Assistant Secretary
- Jeffrey Uttecht – Deputy Assistant Secretary

DOC Reentry Division

- Scott Russell – Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

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. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: 1985 (36-years-old)

Date of Incarceration: August 2021

Date of Death: March 2022

This individual was a 36-year-old otherwise healthy man with a history of substance use disorder. He was incarcerated from August 2021 until his transfer to the Graduated Reentry Program (GRE) in February 2022. He was living in a Department of Corrections (DOC) reentry center facility at the time of his death. The cause of death for this individual was acute combined drug intoxication including fentanyl and ethanol. He had a blood alcohol concentration of 0.180 (g/100 ml) and 4.5 (ng/ml) of fentanyl in his system. The manner of his death was accidental.

A review of the reentry center security video from the date of the incarcerated individual's death and relevant documents showed:

- At 1140, the incarcerated individual returned to the facility from an approved outing. A facility contract staff person conducted a search of his backpack but did not complete a pat search. The incarcerated individual was then observed walking up the stairs to his room. He was holding his backpack with his left hand and appeared to be holding something inside the bottom portion of his sweatshirt near his groin. He is then seen exiting and entering his room several times between the hours of 1149 and 1318.
- At 1318, he exited his room and bumped into the wall across from the doorway. He then continued down the stairs. During the descent, he is seen leaning against and running into the wall on one of the stairwell landings. He returned to his room at 1325.
- At 1343, a contract staff person entered the individual's room to conduct count. During their interview the staff person reported that the incarcerated individual was observed sitting on his bed, eating and talking on his cell phone.
- At 1450, a contract staff person is seen conducting the hourly facility safety and security walk-through. During their interview the staff person reported they do not enter individual rooms when conducting a walk-through. Per the facility procedure manual, visualizing each incarcerated individual present in the facility occurs during the count procedure which happens ten times per day.
- At 1524, the incarcerated individual's roommate returns to the facility from an approved outing and heads to their shared room. The roommate stated the incarcerated individual appeared to be asleep when he entered. The roommate is seen entering and exiting the room multiple times. During this time the roommate contacted a third incarcerated individual who lives on the same floor. They are then seen entering the roommate's shared room together.

- At 1535, the third incarcerated individual went downstairs and summoned staff for assistance after he and the roommate attempted to engage the incarcerated individual lying on the bed in the room after he did not respond.
- At 1536, two contract staff people arrived and began resuscitation efforts to include administration of two doses of Narcan and CPR. They also requested community Emergency Medical Services (911) respond.
- At 1537, two DOC staff arrived and took over resuscitation efforts. Two additional Narcan kits were requested and administered. The incarcerated individual did not respond to continued CPR and Narcan administration.
- At 1543, Emergency Medical Services arrived and assumed resuscitation efforts. The incarcerated individual did not respond to these efforts, had no pulse and was declared deceased. The police and medical examiner were contacted and took over the scene upon their arrival.
- During a subsequent search of the deceased incarcerated individual’s room by DOC staff, an empty 750 ml whiskey bottle was discovered in his nightstand.

Committee Discussion and Findings

- A. The DOC mortality review determined the following topics warranted further discussion and UFR committee consideration:
1. The incarcerated individual did not seek medical care during his prison incarceration. He did not have a primary medical care provider in the community. He also did not seek medical care after his transfer to the reentry center.
 2. His classification review indicated “low” risk for substance use treatment needs and the Health Services Reentry Team was not aware of any healthcare needs prior to his transfer.
 3. Based on his sentence length, his eligibility for transfer to the reentry center happened within 6 months of his prison incarceration.
- 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. Facility staff did not conduct a pat search when the deceased incarcerated individual returned to the facility after an approved outing.
 2. The incarcerated individual was not tested for fentanyl during urine drug screening, as this is not a drug that could be detected by the opiate assay used by the Graduated Reentry program.
 3. Staff at the reentry center are not required to enter an incarcerated individual’s room when conducting a safety and security walk-through.

- C. The Office of the Corrections Ombuds (OCO) representative discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:
 - 1. At the time of this incarcerated individual’s death, the reentry center staff were not conducting pat or area searches as required per policy even though reentry center staff were notified May 4, 2021, that searches were to resume utilizing appropriate COVID-19 guidelines for personal protective equipment requirements.
- D. The Department of Health (DOH) representative participated in the committee discussion and did not offer additional recommendations.

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. Ensure reentry staff are conducting required searches.
2. Test for fentanyl during all drug screens.

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

- 1. Consider providing education to reentry center incarcerated individuals and staff regarding the dangers of fentanyl.