# Unexpected Fatality Review Committee Report

## Unexpected Fatality UFR-24-003

## 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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UFR-24-003 Report to the Legislature–600-SR001

## 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 July 25, 2024:

DOC Health Services

- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Lorne Spooner, Director for Correctional Services
- Page Perkinson, Correctional Operations Program Manager

DOC Community Corrections Division

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

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

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: 1964 (59-years-old)

Date of Incarceration: November 2021

Date of Death: January 2024

At the time of his death, this incarcerated individual had been held for approximately thirteen (13) months in a county jail awaiting trial on new felony charges. Prior to his final arrest, he was a participant of the DOC Graduated Reentry program and was on unauthorized leave. The county jail is required to complete an independent fatality review of events for the time this incarcerated individual was housed in their facility. The DOC UFR Committee reviewed his DOC records for this report.

His cause of death was acute fentanyl intoxication. The manner of his death was accident.

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

| Prior to Death | Event |
|---|---|
| 20 months – 13 months prior | • He transferred from a DOC prison facility directly to inpatient substance use treatment as a participant of the Graduated Reentry (GRE) program.<br>• After successfully completing treatment, he resided in his private residence on electronic home monitoring for one (1) week prior to taking unauthorized leave.<br>• He did not respond to attempts to contact him and DOC staff were unable to locate him.<br>• A DOC Secretary's warrant was issued.<br>• He was arrested by the county sheriff's department and was housed at the county jail while awaiting trial for new charges. |
| **Day of Death** | **Event** |
| Day 0 | • He was found deceased in his cell at community jail. |

## 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 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 Mortality Review committee found no care gaps while he was incarcerated in a DOC facility.

    2. The Mortality Review committee did not identify any additional 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 DOC staff followed policy and operated within DOC guidelines.

C. The committee reviewed the unexpected fatality, discussed the DOC process for screening incarcerated individuals for substance use disorder, the benefit of record sharing with community care providers, and the importance of providing Narcan kits and overdose prevention training to DOC staff and incarcerated individuals reentering the community. Additionally, the committee was not provided jail records for review but confirmed that the county jail is required by law to complete an Unexpected Fatality Review for individuals housed in one of their facilities.

## Committee Findings

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

## Committee Recommendations

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

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

1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper files and allow interface with community care providers.