Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-014

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. 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 November 14, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

Year of Birth: 1965 (58-years-old)

Date of Incarceration: February 2007

Date of Death: August 2024

At the time of death, this incarcerated individual was housed in a DOC prison facility.

His cause of death was end-stage liver disease. The manner of his death was natural.

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

Events Prior to Death	Event
3 months prior	• He was placed on seriously ill status per DOC Policy 610.600 (Infirmary/Special Needs Unit Care) and appropriate notifications were made.
1 day prior	• He was taken to a community hospital for care that could not be provided by the facility.
Day of Death	**Event**
0 days	• He returned from the community hospital for end-of-life comfort care/palliative care. • He passed away at 0831 hours.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombud, 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 did not identify any findings or recommendations to prevent a similar fatality in the future.

B. Independent of the mortality review, the DOC conducted a fact-finding to determine the facts surrounding the unexpected fatality. The fact-finding did not identify findings or recommendations which correlated to the cause of death.

C. The UFR committee reviewed the Mortality Review Committee and the fact-finding reports. The

members did not offer recommendations to prevent a similar fatality in the future. The committee discussed:

1. End-of-Life support –

   The committee discussed the benefit of having multidisciplinary teams (MDT) involved in supporting incarcerated individuals with end-of-life support. An MDT may have helped address the psychosocial barriers that contributed to this incarcerated individual declining to move to the inpatient medical unit for supportive care earlier. The Health Services Chief Medical Officer discussed the robust body of correctional literature identifying the stigma associated with dying in prison, and the need to have intentional conversations with incarcerated individuals diagnosed with a terminal illness.

2. Community hospital care –

   The incarcerated individual was sent to a community hospital for care that could not be provided at the facility. He was discharged from the community hospital and returned to the prison inpatient unit to continue comfort care. He died a few hours later. The committee discussed the value and methods of working with community hospitals regarding caring for incarcerated individuals.

Committee Findings

The incarcerated individual died as a result of end-stage liver disease. The manner of death was natural.

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 may be considered for review by the Department of Corrections:

1. DOC should continue exploring ways to work with community hospitals to support incarcerated individuals.