Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-020

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.

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 February 20, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Rae Simpson, Director – Quality Systems
- 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
- Paige Perkinson, Correctional Operations Program Manager

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

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: 1961 (63-years-old)

Date of Incarceration: August 2023

Date of Death: December 2024

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

His cause of death was hepatocellular carcinoma. The manner of his death was natural.

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

Months Prior to Death	Event
7 months	• He received a serious medical diagnosis
6 months	• He began testing and specialty treatment after initial diagnosis.
5 months	• He did not meet DOC Extraordinary Medical Program (EMP) medical eligibility criteria as it was not clear that his life expectancy was less than 6 months, and he did not meet the physical debilitation thresholds.
4 months	• Second request for EMP review. He did not meet medical eligibility criteria for the same reasons as the prior review.
1.5 months	• He was placed on seriously ill status by the Facility Medical Director.
1 month	• Admission to the facility infirmary. • EMP participation approved. • Transition plan developed.
0 month	• He updated his Physician Orders for Life-Sustaining Treatment (POLST) form from full treatment to comfort care, no resuscitation (DNR). • Virtual and in-person visits with family and friends in the infirmary until the time of his death.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombuds, the UFR committee met to discuss the findings from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews and offered no recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and did not identify any additional recommendations to prevent a similar fatality in the future.

   1. The committee found:

      a. He was appropriately referred for advanced imaging and specialty treatment.

      b. He was approved for participation in the Extraordinary Medical Placement (EMP) when he met criteria, however DOC was unable to find a placement that could support his end-of-life care needs.

      c. The Facility Medical Director initiated a seriously ill notification (SIN) when the incarcerated individual became critically ill.

      d. End-of-life care planning and family communication were ongoing, supported his goal to remain in his housing unit as long as possible, and allowed him to specify the types of medical treatment he wished to receive.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the fatality and to evaluate compliance with DOC policies and operational procedures. A Root Cause analysis was conducted and did not identify any operational issues that caused or contributed to the incarcerated individual's death.

C. The committee reviewed the fatality, and the following topics were discussed.

   1. Seriously Ill Notification:

      The SIN is a process used by DOC to ensure appropriate staff and the incarcerated individual's family have been informed when they have become critically ill or injured.

      A SIN is not required to allow special family visitation. DOC considers each request on a case-by-case basis.

   2. Extraordinary Medical Placement:

      The EMP program allows incarcerated individuals who meet specific criteria to serve the remainder of their sentence in home confinement, monitored electronically.

      DOC follows RCW 9.94A.728 criteria when determining eligibility for EMP participation and internal policy 350.270 Extraordinary Medical Placement for program administration.

      The approval process and placement criteria consider public safety risk and ensure the incarcerated individual has a suitable and safe community placement that can meet their care needs.

Committee Findings

The incarcerated individual died as a result of hepatocellular carcinoma. The manner of his death was natural.

Committee Recommendations

The UFR committee members did not offer any recommendations for corrective action.