# Unexpected Fatality Review Committee Report

## Unexpected Fatality UFR-24-023

## 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
- Patricia Paterson, Chief of Nursing
- Dr. Rae Simpson, Director - Quality Systems
- 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
- Ollie 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:** 1962 (62-years-old)

**Date of Incarceration:** June 2024

**Date of Death:** November 2024

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

His cause of death was atherosclerotic and hypertensive cardiovascular disease. The manner of his death was natural.

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

| Day of Death | Event |
|---|---|
| 1230 hours | • Tier check completed. |
| 1301 hours<br>-<br>1314 hours | • He is found unresponsive by a custody officer during a routine tier check.<br>• Radio call for medical emergency response including 911 requested.<br>• Lifesaving efforts provided by DOC staff.<br>• Emergency medical services (EMS) enter the cell and assume lifesaving efforts. |
| 1315 hours | • He was pronounced deceased by EMS. |

## 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 committee found:

      a. He had been prescribed medication to treat his elevated blood pressure and had not requested a refill.

b. His last blood pressure reading during a nursing chronic care management appointment was at goal and a follow-up nursing visit in six (6) months was planned.

c. He had not requested a medical appointment nor been seen by his primary care provider after transfer to parent facility.

d. Substance use disorder assessment and treatment records were not included in the incarcerated individual's DOC health record.

2. The committee recommended:

a. Referral to the UFR committee for review.

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 safety inspections standards were not consistently followed by custody staff when documenting and conducting unit tier checks on the day of the incident. The CIR team recommended the facility utilize supervisors (Sergeants and Correctional Unit Supervisors) to ensure DOC safety inspection standards are followed.

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

1. Substance use disorder (SUD) and medical records:

DOC kept substance use assessment and treatment records confidential and restricted access to SUD treatment providers. Inclusion in the medical record required written consent from the incarcerated individual. In 2024, federal law (42 CFR Part 2) changed to allow for the integration of SUD records for care coordination. DOC confirmed that they are taking steps to integrate substance use records into the medical record.

2. Prescription Refills:

Incarcerated individuals have autonomy to manage prescribed medications that are designated for self-administration including requesting refills, as in the community. For unknown reasons, this incarcerated individual did not request a refill of the medication to treat his elevated blood pressure. Lack of an electronic health record increases the difficulty for primary providers to monitor patient engagement with the recommended treatment plan. The committee acknowledges the community also face similar challenges. DOC is continuing to pursue an electronic health record, and in the interim is building strategies to identify and engage incarcerated individuals.

3. Missed tier checks:

The critical incident review noted that staff were not in compliance with DOC policy 420.370 *Security Inspections*. Staff failed to conduct or document the required 60-minute tier checks earlier in the shift.

## Committee Findings

The incarcerated individual died as a result of atherosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

## Committee Recommendations

The UFR committee did not identify any recommendations to prevent a similar fatality in the future.