Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-004

Report to the Legislature

As required by RCW 72.09.770

May 23, 2025

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
tim.lang@doc1.wa.gov

Table of Contents

Unexpected Fatality Review Committee Report

UFR-25-004 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 April 17, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Dr. Eric Rainey-Gibson, Director - Behavioral Health
- Shane Evans, Administrator
- Dr. Rae Simpson, Director - Quality Systems
- Dr. Ashley Espitia, Psychologist
- Mary Beth Flygare, Health Services Project Manager

DOC Men's Prisons Division

- James Key, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons project Manager

DOC Reentry Division

- Sarah Sytsma, Deputy Assistant Secretary

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, 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. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1958 (66-years-old)

Date of Incarceration: September 2024

Date of Death: January 2025

At the time of death, the incarcerated individual was receiving care in a community hospital after being transferred for medical care from a DOC prison facility.

His cause of death was due to myocardial infarction, atherosclerotic and hypertensive cardiovascular disease. The manner of death was natural.

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

Days Prior to Death	Event
5 days	• The incarcerated individual was emergently seen and treated for symptoms of a chronic lung condition.
3 days	• He reported increasing shortness of breath to staff. • He was assessed by nursing staff and treatment was provided. • His condition worsened and 911 was called. • Staff continued to provide medical treatment until the incarcerated individual was transported by ambulance to a community hospital.
0 days	• He was pronounced deceased in the community hospital.

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. The incarcerated individual had a past medical history of chronic lung disease, high blood

pressure and heart disease.

b. He was not prescribed a cholesterol lowering medication.

c. During his initial exam, he reported experiencing daily trouble breathing which worsened with activity.

d. Nursing staff did not recognize his symptoms were life-threatening, and a request for community EMS was not made until his condition deteriorated.

e. The current DOC Medical Emergency Response Form 13-440 does not include guidelines for clinical instability.

2. The committee recommended:

a. Referral to UFR Committee.

b. Nursing leadership review and update medical emergency response form, DOC 13-440 to include guidelines for clinical instability.

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.

1. The CIR found:

a. There was a delay in requesting a community EMS response.

2. The CIR recommended:

a. Ensure Health Services Emergency Response training includes signs of clinical instability and reinforces when to request a community EMS response.

b. Facility leaders conduct drills and post-action emergency response debriefs to improve communication including the process of obtaining and interacting with community EMS.

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

1. Emergency Response:

The UFR committee discussed DOC's medical emergency response process including readiness drills.

Health Services is working to incorporate visual cues into our process that include guidelines for clinical instability and red flag prompts for requesting community EMS response.

DOC has also established a collaborative workgroup between the Prisons and Health Services divisions to review and make recommendations to improve current emergency medical response processes to ensure that Department staff are equipped with information, skills and equipment needed to effectively respond to medical emergencies.

2. Care for individuals with chronic medical conditions.

   Health Services continues to expand the Patient Centered Medical Home to support individuals with chronic medical conditions utilizing a team-based care approach.

   There are quality measures in place that include heart disease.

   - The focused work has been on management of diabetes and high blood pressure.
   - The next target area is heart disease.

   The goal is development of an electronic patient dashboard for the care team to easily visualize an individual's status and care needs.

Committee Findings

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

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. Nursing leadership review and update medical emergency response form, DOC 13-440 to include guidelines for clinical instability.
2. Ensure Health Services Emergency Response training includes signs of clinical instability and reinforces when to request a community EMS response.
3. Facility leaders should conduct drills and post-action emergency response debriefs to improve communication including the process of obtaining and interacting with community EMS.