Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-021

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.

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 May 1, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief Nursing Officer
- Dr. Eric Rainey-Gibson, Director – Behavioral Health
- Dr. Ashley Espitia, Psychologist 4
- Dr. Rae Simpson, Director – Quality Systems
- Shane Evans, Administrator
- Mary Beth Flygare, Health Services Project Manager

DOC Men's Prisons Division

- James Key, Deputy Assistant Secretary
- Chuck Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Director
- 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, and findings.

Fatality Summary

Year of Birth: 1965 (59-years-old)

Date of Incarceration: November 1981

Date of Death: December 2024

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

His cause of death was due to a pulmonary embolism. The manner of his death was natural.

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

Days Prior to Death	Event
15 - 0 Days	• The incarcerated individual was receiving care in a community hospital.
0 Days	• He experienced a medical emergency in his cell, was transported via ambulance to the community hospital where he was pronounced deceased.

UFR Committee Discussion

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, and the care delivered. They did not identify any additional recommendations to prevent a similar fatality in the future.

   1. The committee found:

      a. The incarcerated individual received comprehensive care from his DOC primary care team and community specialists.

      b. Upon return to the facility after an extended hospital stay, he unfortunately developed complications from a blood clot in his lung and passed away.

   2. The committee members did not identify any 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 fatality, evaluate compliance with DOC policies and operational procedures. The CIR did not identify any operational issues that caused or contributed to the incarcerated individual's death.

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

1. Extraordinary Medical Placement:

   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 incarcerated individual did not meet the medical eligibility criteria prior to his death.

2. Medical care provided:

   Committee members concurred the incarcerated individual's medical needs were complex. The care provided and coordinated by DOC staff with community specialists was appropriate.

Committee Findings

The incarcerated individual died as a result of a pulmonary embolism. The manner of death was natural.

Committee Recommendations

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