Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-25-006

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 29, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Penny Bhagia, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Shane Evans, Administrator
- Dr. Rae Simpson, Director - Quality Systems
- Mary Beth Flygare, Health Services Project Manager

DOC Men's Prisons Division

- James Key, Deputy Assistant Secretary
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Director
- Ollie Webb, Assistant Corrections Ombuds - Investigations

Department of Health (DOH)

- Karen Pastori, Health Services Consultant – Prevention and Community Health

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1931 (93-years-old)

Date of Incarceration: February 2000

Date of Death: February 2025

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

His cause of death was due to multi-organ system failure and advanced kidney disease. The manner of his death was natural.

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

Days Prior to Death	Event
Day 12	• The incarcerated individual was transported to the local community hospital for care.
Day 3	• His condition worsened, and per family wishes he was transitioned to comfort care.
Day 0	• He was pronounced deceased by hospital staff.

UFR Committee Discussion

Upon the 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 members 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 antecedent care provided by DOC and previous hospitalizations. They did not identify any additional recommendations to prevent a similar fatality in the future.

    1. The committee found:

        a. The incarcerated individual was an elderly gentleman being treated for several serious medical conditions.

        b. After returning from the hospital, the incarcerated individual was erroneously

administered medications. A clinical review determined the error was not a causal factor for his death, but did identify staff reliance on care coordination via telephone may increase miscommunications and errors.

c. Prior to his final hospital admission, he was receiving supportive care in the facility infirmary due to his chronic health concerns.

d. His portable orders for life sustaining treatment form had not been updated since 2013.

e. At the wishes of his family, he was transitioned to comfort care at the hospital and passed away.

2. The committee supports:

a. Advancing the efforts of the DOC Hospice and Palliative Care Workgroup to facilitate the normalization of discussions surrounding end-of-life care between DOC staff and incarcerated individuals.

b. Reviewing and revising clinical protocols and processes to provide clear guidance and facilitate accurate care planning documentation.

The MR 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 discussed the following.

1. Fatality reviews.

a. DOC reviews the death of every incarcerated individual through the Mortality and Critical Incident Review processes. Deaths that meet the RCW definition of an unexpected fatality are then referred for review by the interagency UFR Committee.

2. Housing options for elderly incarcerated individuals in DOC prison facilities.

a. Many incarcerated individuals prefer to remain in their unit with their community as long as possible. DOC works to support this wish and is implementing changes to infirmary operations to allow more peer interaction and support once they require infirmary support.

3. Care transitions.

    a. Committee members discussed the care transition and communication challenges faced by DOC staff after an individual receives care in the community, acknowledging a non-contributory medication error that occurred weeks prior to this patient's death as an important safety gap.

    b. Members discussed DOC's lack of an electronic health record (EHR), the use of contracted nurses to maintain staffing levels and the need to ensure essential onboarding for each of these temporary staff, and transitions of care from community hospitals back to DOC being key gaps for intervention.

    c. Members support DOC Health Services' plan to continue expansion of the Patient Centered Medical Home, augment and standardize the current on-boarding process for contract nursing staff, revise protocols and templates to facilitate accurate care planning documentation and continue the pursuit of an Electronic Health Record.

Committee Findings

The incarcerated individual died as a result of multi-organ system failure and advanced kidney disease. The manner of death was natural.

Committee Recommendations

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