Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-019

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 January 16, 2025:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Frank Longano, Chief Medical Information Officer
- Patricia Paterson, Chief of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director - Quality Systems
- Shane Evans, Administrator
- Nancy Fernelius, Clinical Nurse Specialist
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC 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 Risk Mitigation

- Michael Pettersen, Director

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: 1957 (67-years-old)

Date of Incarceration: October 2023

Date of Death: October 2024

At the time of death, this incarcerated individual was housed in a prison facility. He died while receiving care in a community hospital after admission for a planned surgical procedure.

The cause was brain death due to subdural and subarachnoid hemorrhage. The manner of his death was natural.

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

Days Prior to Death	Event
51 days prior	• Admitted to local community hospital for scheduled surgical procedure and post-operative care.
45 days prior - 3 days prior	• Care provided at community hospital for post-operative complications. • Seriously ill notification completed.
2 days prior	• Transferred to another community hospital for higher level of care.
0 days prior	• He was pronounced deceased at the 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.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, and the care delivered. The MRC committee did not identify any additional 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 unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The CIR did not identify factors within the scope of the critical incident review that contributed to the death of this individual. No recommendations were identified to prevent a similar fatality in the future.

C. The committee reviewed the unexpected fatality due to medical complications following surgery and discussed the following topics:

1. Expedited care referrals:

   The committee discussed processes in place to expedite urgent care referrals including an electronic tracking report which provides target dates to obtain consultations and appointments. The report is updated weekly and allows care teams to know which incarcerated individuals have referrals nearing or past target date. The report supports additional care planning and necessary coordination.

2. Advance Directives:

   The committee members noted that the incarcerated individual did not have an advance directive for health care at the time of his hospitalization. The committee supports having advanced directive conversations as part of care planning when the incarcerated individual has a serious health condition.

Committee Findings

The incarcerated individual died as a result of brain death due to subdural and subarachnoid hemorrhage. The manner of death was natural.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.