



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-026

Report to the Legislature

As required by RCW 72.09.770

April 29, 2024

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 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. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 5, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Dr. Karie Rainer, Director Behavioral of Health
- Dr. Zain Ghazal, Administrator
- Patty Paterson, MSN, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, MSN, Director of Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men's Prisons Project Manager

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Ellie Navidson, MSN, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

Year of Birth: 1986 (37-years-old)

Year of Incarceration: 2023

Date of Death: December 2023

At the time of his death, the incarcerated individual was housed in a prison facility. His cause of death was asphyxia due to strangulation. The manner of his death was suicide.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Day of death	Event
0543 hours	<ul style="list-style-type: none">• A tier check was conducted at his cell and no concerns were noted.
0625 hours - 0642 hours	<ul style="list-style-type: none">• Custody officers found the incarcerated individual hanging.• They removed the ligature and lowered him to the floor.• Emergency response and CPR was initiated.• Community 911 response requested and assumed care upon their arrival.
0655 hours	<ul style="list-style-type: none">• Community EMS pronounced time of death.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and Critical Incident Review. The UFR Committee members considered the information from the 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. There were no gaps in care identified.
- b. The incarcerated individual reported a suicide attempt within the last year during the intake screening process and was not flagged for further mental health evaluation because he denied current suicidal thoughts or ideations.
- c. The incarcerated individual did not request medical or mental health services during his incarceration.

2. The Mortality Review Committee recommended:
 - a. A referral to the UFR committee.
 - b. Scheduling a mental health appraisal for further evaluation of suicide risk when an incarcerated individual reports a suicide attempt within one year.
- B. Independent of the mortality review, 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. Medical and mental health intake screenings were conducted according to policy.
 - b. He reported a history of suicidal behaviors and denied current suicidal thoughts during intake screening.
 - c. He was not referred or scheduled for follow-up with mental health.
 - d. He did not request mental health treatment.
 - e. Emergency response and treatment was conducted according to policy.
 - f. He used the shelf in his cell to anchor the ligature.
 - g. The hand-held video of the incident response was not retained.
 2. The CIR recommended the DOC behavioral health department review criteria for scheduling mental health appraisals on intake when an incarcerated individual reports previous suicidal thoughts or actions.
- C. The UFR committee reviewed the unexpected fatality and discussed the following topics related to the death:

1. DOC Intake process:

The intake process is designed to be completed in a short timeframe to maintain bed space and allow individuals to transfer from the reception center to their parent facility where they can access programming supports. The reception center receives 400 to 500 individuals every month from county jails. DOC does not always receive health information from transferring facilities which can make identifying needs difficult.

The committee discussed the mental health intake process for incarcerated individuals and how individuals are assessed for mental health and suicidality. Individuals are briefly screened by a mental health professional. Those identified as needing mental health services or higher risk for suicide are scheduled for a mental health appraisal for additional needs evaluation.

The committee discussed the medical intake process. Incarcerated individuals are briefly screened by the nurse for any concerns that need to be addressed immediately, if no urgent needs identified they are scheduled for the routine intake physical. The intake

physical documented no chronic medical conditions, and he was on no medication prior to incarceration. He did report a history of mental health symptoms and had not found previous treatment helpful.

This individual disclosed a previous suicide attempt within the last year but when asked he repeatedly denied current thoughts of suicide. The committee concurred that DOC should automatically target an individual reporting a recent suicide attempt for further evaluation.

2. Transfer to parent facility and housing assignments:

The committee discussed the process of classification and housing determination in prison facilities. Based on his sentence, this individual was required to reside in a close custody unit for at least one year. A close custody unit provides a higher level of security, provides more supervision, less freedom of movement and has stricter limits on property and programming.

This incarcerated was approved to be housed with another but at the time of his death he was housed without a cellmate. Cell assignments are determined at the unit level and many factors are considered.

The committee also discussed the environment of close custody at the prison and what a day may like for an incarcerated individual living there.

Committee Findings

The manner of the incarcerated individual's death was suicide. The cause of death was asphyxia due to strangulation.

Committee Recommendations

DOC should update the mental health intake process to ensure an incarcerated individual has a mental health appraisal for further evaluation if they report a suicide attempt within the last year.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should expedite the release of the new Critical Incident Review Policy to support the critical incident review teams.
2. DOC should continue to advocate for an electronic health record to facilitate communicate with community and jail providers.
3. DOC should retain hand-held incident response video per the department's record retention schedule.