



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-018

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 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, substance use information was not disclosed unless the next of kin authorized release.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on July 7, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Paul Clark, Health services Administrator
- Ronna Cole, Deputy Director Health Services
- Ken Taylor, Deputy Director Health Services
- Rae Simpson, Chief Quality Officer
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit

DOC Office of Correctional Operations

- Tom Fithian – Senior Director – Correctional Operations

DOC Prisons Division

- Mike Obenland – Assistant Secretary
- Jeffrey Uttecht – Deputy Assistant Secretary

DOC Reentry Division

- Scott Russell – Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: 1968 (53-years-old)

Date of Incarceration: February 2016

Date of Death: March 2022

This incarcerated individual was a 53-year-old man living in the community as a participant of the Graduated Reentry (GRE) program from February 2022 until the time of his arrest by community law enforcement on new felony charges for two counts of murder in the first degree. While residing in the community he was gainfully employed, all requirements for GRE participation were completed and urine drug screens were negative for any prohibited substances. It appears the possibility that he would be found guilty and returned to prison for the rest of his life prompted his decision to attempt suicide. His cause of death was asphyxiation by hanging, and the manner was suicide.

During his DOC intake he disclosed a history of illicit drug use. In 2017, he received substance use disorder treatment. Upon discharge from the treatment program, he stated he did not believe drug use was the primary source for his problems. He was diagnosed with benign prostate enlargement and gastric reflux. A review of primary care records for the two years prior to his death reveal reasonable continuity of care given the absence of serious medical problems. Lab results showed a pattern of three elevated blood sugars that did not appear to be addressed, which represent a missed primary care opportunity.

A review of his mental health records showed no history of suicidal ideation or previous suicide attempts. His mental health needs were adequately assessed and managed while residing in a DOC facility including a brief period of treatment for depression and anxiety. He chose to end treatment and declined further mental health visits. During this time there is no evidence that he presented as a suicide risk. There was no indication that he sought mental health treatment while residing in the community and there was no evidence of any suicide risk or mental health concerns prior to his arrest.

Committee Discussion

- A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:
 1. This death occurred while the incarcerated individual was in the custody of a community law enforcement agency. However, this case highlights an opportunity within the DOC system to investigate ways to offer support and services to incarcerated individuals who experience a major life event (i.e., new charges, Dear John/Jane letter, lost appeal, family death, etc.).

- Currently mental health staff rely on incarcerated individuals to reach out for support.
2. There was a missed opportunity for primary care intervention in response to elevated blood sugars.
 3. There was a missed opportunity for mental health follow up after a declination of care.
- 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 found:
1. The GRE staff followed all department policies and procedures while this incarcerated individual was participating in the program.
 2. DOC staff worked in partnership with county and FBI officials to successfully plan and carry out an arrest of an incarcerated individual with a new arrest warrant.
 3. DOC interviews with community jail staff confirmed that a suicide risk assessment was completed during the intake at the jail. The incarcerated individual denied any suicidal thoughts or intent to commit self-harm.
- C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following for UFR committee discussion:
1. DOC has a process in place for staff, family, or friends of an incarcerated individual to request mental health services when they have concerns. A request for mental health services does not have to come directly from the impacted incarcerated individual.
- D. The Health Care Authority (HCA) and the Department of Health (DOH) representatives did not offer additional recommendations.

Committee Findings

It appears that the precipitating event for the death of this incarcerated individual was the information he received during his arraignment regarding the new felony charges. This occurred after he was in the custody of community law enforcement. DOC was able to confirm a suicide risk assessment was conducted by the community jail during his intake with no concerns identified.

Committee Recommendations

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

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

1. DOC should ensure that incarcerated individuals are offered an opportunity to reengage after a care declination.

2. DOC should consider ways to provide additional support when an incarcerated individual experiences a major life event.
3. DOC Health Services should ensure that elevated blood sugars are appropriately addressed by primary care providers. This will be addressed in the Patient Centered Medical Home model of care being implemented by DOC.