Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-013

Report to the Legislature

As required by RCW 72.09.770

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Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Tim Lang, Secretary
tim.lang@doc1.wa.gov

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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. 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 April 17, 2025:

DOC Health Services

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

DOC Men's Prison Division

- James Key, Deputy Assistant Secretary
- Eric Jackson, 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
- Ollie 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. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1992 (32-years-old)

Date of Incarceration: April 2014

Date of Death: July 2024

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

The cause of death was asphyxia due to hanging. The manner of death was suicide.

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

Days Prior to Death	Event
3 days	• A routine tier check was completed. • Approximately 10 minutes later, another resident notified custody staff the incarcerated individual needed aid. • Custody and medical staff responded, called 911 and rendered medical aid. • Community Emergency Medical Services transported the incarcerated individual to the hospital via ambulance.
0 days	• The incarcerated individual was declared deceased by hospital staff.

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 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. The incarcerated individual had a past medical history of gender dysphoria, PTSD, depression, substance use disorder, asthma, seizure disorder and previous suicide attempts while a teen.

b. She was being seen by her primary care, mental health and gender affirming (GA) care teams for management of her needs.

c. She did not express to staff any desire to die by suicide in the weeks or months before her death but did express frustration with the DOC GA care process.

2. The committee supports:

a. Referral to the UFR Committee for review.

b. Continuing the work of the DOC Suicide Risk Reduction workgroup.

c. GA care team in ensuring timely care without delays.

The committee members 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.

1. The CIR found:

a. That custody staff did not consistently follow safety inspection procedures when conducting tier checks on the day of the incident, including failing to look into the cell. This was identified as a concern and not a causal factor for the death. This concern is being administratively remediated at the facility level.

The CIR team did not identify any recommendations to prevent a similar fatality in the future.

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

1. Consistency of Tier Checks:

a. Members noted tier checks not being completed and documented consistently as a repeat concern.

b. Members support DOC explore options to improve the consistency and quality of tier checks.

2. Housing, support and care for transgender individuals:

a. A transgender incarcerated individual may be housed in a facility that does not align with their identified gender. They may also experience an increased sense of isolation and vulnerability during incarceration.

1. DOC staff follow policy 490.700 Transgender, Intersex, and/or Non-Binary Individuals to ensure equitable treatment when determining housing, classification, and programming needs for transgender individuals.

2. Committee members support reestablishing facility LGBTQI peer support groups that were suspended during the pandemic.

b. A representative from OCO stated transgender incarcerated individuals have contacted their office with concerns that legislative changes may result in changes to gender affirming care coverage in DOC.

    1. The DOC health plan coverage aligns with the Washington Apple Health Transhealth Program.

    2. Committee members support a communication be sent to incarcerated individuals providing reassurance that no reduction for covered gender affirming care is planned.

Committee Findings

The incarcerated individual died as a result of asphyxia due to hanging. The manner of death was suicide.

Committee Recommendations

The UFR committee did not identify any recommendations to prevent a similar fatality in the future.

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

a. DOC should explore options to improve the consistency and quality of tier checks.

b. DOC leadership should send a communication to incarcerated individuals providing reassurance that no reduction for covered gender affirming care is planned.