Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-016

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 April 3, 2025:

DOC Health Services

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

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, 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

DOC Community Corrections Division

- Kristine Skipworth, Administrator – East Region
- Kelly Miller, Administrator – Graduated Reentry

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Director
- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

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: 1986 (38-years-old)

Date of Incarceration: October 2018

Date of Death: September 2024

At the time of death, this incarcerated individual was housed in a DOC prison facility.

His cause of death was methamphetamine toxicity. The manner of his death was accident.

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

Day of Death	Event
0457 hours	• The incarcerated individual exited his cell. • Officers observed him acting erratically (off his baseline) and sweating profusely. He stated he had a "really hard leg day" workout. • He agreed to see medical, and a radio call was made for medical to come to the unit.
0504 hours - 0545 hours	• The nurse examines him briefly and determines he needs to go to Health Services (HS) for further evaluation. • After completing the evaluation, a report is phoned to the on-call provider who was on the way to the facility. • The provider ordered IV fluids and repeat vital signs.
0546 hours - 0606 hours	• Nurse continues to provide treatment. • The incarcerated individual's level of consciousness declined, and additional care was provided including Narcan administration and oxygen therapy.
0607 hours - 0618 hours	• The on-call provider arrived in HS. • He continued to decline and lost consciousness. • Community EMS called. • AED requested to treatment room.
0619 hours	• The incarcerated individual became pulseless, and CPR initiated.
0624 hours	• Community EMS arrived and assumed care.
0657 hours	• 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 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 did not disclose he had ingested large amounts of methamphetamine.

        b. Nursing staff did not recognize his level of intoxication was life-threatening until he became non-responsive.

        c. Community EMS request was not made until his condition deteriorated.

        d. There is not a nursing protocol for suspected stimulant intoxication.

    2. The committee recommended:

        a. Nursing leadership review and update protocols and forms to include stimulant intoxication and guidelines for clinical instability.

        b. Facility leaders conduct drills and post-action emergency response debriefs to improve communication including the process of obtaining and interacting with community EMS.

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, and the following topics were discussed.

    1. Contraband management in DOC facilities:

        a. Contraband reduction is part of DOC's strategic plan. The presence of contraband, including illegal drugs, leads to a less safe environment for those in our custody and staff.

        b. The Department takes a multipronged approach to prevent contraband, for example; education for staff and incarcerated individuals, substance use treatment, support programs, security inspections, and searches (electronic, incoming mail, pat, canine).

2. Status of DOC's plan to expand the addiction medicine program and availability of medication for opioid use disorder (MOUD) treatment:

    a. The state budget has not been finalized. DOC is continuing to move forward to align policy and protocol for more effective utilization of existing resources and optimize available treatment.

3. Processes in place to aid in the prevention of overdose deaths in DOC facilities:

    a. Launch of an interagency Fentanyl taskforce.

    b. Screen all individuals are for substance use during intake.

    c. Offer evidence-based programming and treatment to assist individuals to maintain their sobriety.

Committee Findings

The incarcerated individual died as a result of methamphetamine toxicity. His manner of death was accident.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. DOC Health Services should review and update nursing protocols and forms to include stimulant intoxication and guidelines for clinical instability.

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

1. DOC should explore ways to improve communication during a medical emergency including the process of obtaining and interacting with community EMS.