Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-017

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. 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
- Dr. Rae Simpson, Director - Quality Systems
- Patricia Paterson, Chief of Nursing
- 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: 1990 (33-years-old)

Date of Incarceration: October 2022

Date of Death: October 2024

At the time of death, the incarcerated individual was in a community hospital after being transferred for medical care from a contracted community jail.

His cause of death was due to a low grade glioneuronal tumor consistent with ganglioglioma. His manner of death was natural.

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

Weeks Prior to Death	Event
19 weeks	• The incarcerated individual began his community supervision.
7 weeks	• He failed to report for supervision and a DOC Secretary's warrant was issued for his arrest. • He was arrested and incarcerated in Oregon on new charges.
6 weeks	• WA DOC was notified of the incarcerated individual's arrest and requested extradition from Oregon.
1 week	• The incarcerated individual waived extradition and was transported to a community jail in Washington on behalf of the department.
Days Prior to Death	**Event**
6 days	• The incarcerated individual waived extradition and was transported to a community jail in Washington on behalf of the department.
2 days	• The incarcerated individual experienced a medical emergency and was transported to a community hospital for treatment.
1 day	• DOC authorized a conditional release from confinement.
0 day	• The incarcerated individual was pronounced 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 and offered no 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 was exhibiting signs of a serious illness, and his care needs were unmet during his final incarceration in the community.

        b. The medical information relayed from the community jail to the DOC Utilization and Management Nurse Desk staff was incomplete and did not accurately reflect the seriousness of the individual's condition.

    2. The committee recommended:

        a. The WA DOC Chief Medical Officer (CMO) report the missed care opportunities to the CMO of the Oregon jail and the CMO of the DOC contracted community jail where the individual was incarcerated in the weeks prior to his death.

        b. Health Services explore how unmet care needs can be highlighted when a person is transferring from another correctional health care system into DOC 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. A root cause analysis was conducted and did not identify any operational issues that caused or contributed to the incarcerated individual's death.

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

    1. Health information sharing between DOC and other care systems.

        a. Committee members noted DOC's lack of an electronic health record creates barriers to information sharing and care transitions.

        b. The Health Care Authority provided information regarding the upcoming pilot launch of a statewide electronic health information exchange.

Committee Findings

The incarcerated individual died as a result complications from a brain tumor. His manner of death was natural.

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:

DOC should continue work with the Washington Association of Sheriffs and Police Chiefs (WASPC) to develop agreements with all county jurisdictions to develop and implement a more thorough interfacility transfer document that highlights areas of clinical concern and considers use of a standardized reporting format to ensure that all pertinent medical information is conveyed in the referral.