Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-018

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.

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 May 5, 2025:

DOC Health Services

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

DOC Men's Prison Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Community Reentry Division

- Sara Sytsma, Deputy Assistant Secretary
- Carrie Stanley, Reentry Center Administrator
- Michelle Eller-Doughty, Reentry Center Operations Administrator

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1988 (36-years-old)

Date of Incarceration: August 2023

Date of Death: October 2024

At the time of death, this incarcerated individual was housed in a DOC contracted community reentry center (RC) and was receiving medication-assisted treatment (MAT) from a community treatment provider.

His cause of death was due to infection with SARSCoV-2 (COVID-19). The manner of his death was natural.

Prior to his death, the incarcerated individual did not show the usual signs or symptoms of COVID-19 infection. The Committee discussed the possible side-effects he may have been experiencing from MAT and identified opportunities to support individuals with opioid use disorder (OUD) reentering the community.

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

Days Prior to Death	Event
4 days	• The incarcerated individual was seen for an intake exam by a community opioid treatment program and began medication-assisted treatment (MAT) to help support his sobriety.
3 days	• He received a dose of medication at the treatment center.
2 days	• Missed dose of medication.
1 day	• He was seen at the treatment center where the dose of his medication was increased. • He was provided with two individual doses for the weekend. • He turned in the weekend doses to RC staff which were secured.
Day of Death	**Event**
02:50 hours 05:30 hours 10:30 hours 13:20 – 14:15 hours	• He requested and took his daily dose of medication. • He was observed doing laundry at the facility and missed breakfast. • RC staff checked on him in his room where he was sleeping but able to awaken. • Another resident informed RC staff, the incarcerated individual was not looking well. • 911 was called and first aid including CPR and Narcan were administered.

	• The incarcerated individual was declared deceased by emergency medical personnel.

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 opioid use disorder and was receiving medication-assisted treatment (MAT) from a community treatment center. Records from the community provider were not available for review.

      b. Available records indicate the incarcerated individual had not used illicit narcotics or been prescribed MAT for approximately one year prior to his death lessening his tolerance to opiates.

      c. The strength of medication provided by the community treatment provider is recommended for individuals currently consuming opiates and the incarcerated individual may have experienced unwanted side-effects including slow and ineffective breathing.

   2. The committee recommended:

      a. Referral to the UFR Committee for review.

      b. The DOC Director of Addiction Medicine provide education on MAT to reentry center staff.

      c. Inform the State Opioid Treatment Authority of the mortality review committee findings and request a review of the treatment provided to the incarcerated individual by the community clinic.

      d. Remove this treatment provider from the community treatment resource list provided to the incarcerated individual pending the outcome of the State Opioid Treatment Authority review.

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. While residing at the RC, the incarcerated individual was working, completed chemical dependency treatment and had negative urine drug screens.

b. RC staff noted the incarcerated individual appeared off his baseline after starting MAT and assumed his behavior was medication related.

2. The CIR recommended:

a. Provide education on MAT and common side effects for all RC staff.

b. Provide written education to all RC residents upon intake related to MAT and common side effects.

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

1. Infection prevention including COVID vaccination in reentry centers –

a. RC residents are provided with cleaning and disinfection supplies.

b. Residents are encouraged to lay-in and not attend work or socialize when feeling unwell.

c. Reentry centers do not have a process to promote vaccinations for residents.

2. Overdose/Harm Reduction strategies –

a. DOC Addiction Medicine Team completed reentry center staff member training regarding medication-assisted treatment.

b. Residents are provided with personal Narcan kits and education during intake with additional kits available throughout the facility.

c. Staff are trained in emergency response and use of Narcan.

d. Residents with a history of substance use are referred for assessment and chemical dependency treatment. DOC provides contact information for providers to the incarcerated individual.

Committee Findings

The incarcerated individual died as a result of infection with SARSCoV-2 (COVID-19). The manner of his death was natural.

Committee Recommendations

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