Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-009

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 July 25, 2024:

DOC Health Services

- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Dr. Rae Simpson, Director – Quality Systems
- Mark Eliason, Deputy Assistant Secretary
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Lorne Spooner, Director for Correctional Services
- Page Perkinson, Correctional Operations Program Manager

DOC Community Corrections Division

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

Office of the Corrections Ombuds (OCO)

- Elisabeth Kingsbury, Deputy 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. Heather Schultz, Associate Medical Director

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

Fatality Summary

Date of Birth: 1985 (39-years-old)

Date of Incarceration: March 2023

Date of Death: May 2024

At the time of this death, the incarcerated individual was participating in the DOC Graduated Reentry (GRE) program and living in a community transition house.

The death was due to sudden cardiac death with underlying end stage liver disease including cirrhosis. The manner of death was natural.

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

Days Prior to Death	Event
90 days prior	• The incarcerated individual directly transferred from a prison facility to community inpatient substance use treatment as a requirement of GRE participation.
24 days – 18 days prior	• After successfully completing treatment, they transferred to their DOC approved residence. • Had two in person meetings with their DOC case manager and two (2) negative drug screens during this timeframe.
Day of Death	**Event**
Day 0	• Another resident found them deceased in the transitional house in the afternoon. • The house manager did not notify DOC of the death in a timely manner.

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 Mortality Review committee found:

    a. The incarcerated individual did not report any concerning symptoms and stated they had been sober for three (3) years.

    b. Intake laboratory testing showed a mildly elevated bilirubin level. All other results were within normal limits. There was no documented care plan to follow-up on the elevated result.

    c. Committee members concurred there was a low index of suspicion for serious illness based on exam findings and reported symptoms.

2. The Mortality Review committee recommended:

    a. A referral to the Unexpected Fatality Committee for 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 GRE staff inconsistently followed DOC policy and procedures regarding documentation and recordkeeping.

    2. The findings were administrative in nature and did not correlate to the cause of death. Findings will be remediated per DOC Policy 400.110 Critical Incidents Reviews.

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

    1. The DOC process for follow-up on abnormal test results; and

    2. Transitional housing staff reporting emergencies to DOC.

Committee Findings

The incarcerated individual died as a result of sudden cardiac death with underlying end stage liver disease including cirrhosis. The manner of their death was natural.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.

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 provide education to staff on the importance documenting a care plan for follow-up of abnormal lab results.