Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-002

Report to the Legislature

As required by RCW 72.09.770

August 3, 2023

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. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 20, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary Health Services
- Rae Simpson, Quality Systems Director
- Paul Clark, Health Services Administrator
- Mary Beth Flygare, Project Manager
- Deborah Roberts, Program Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy

Department of Health (DOH)

- Brittany Tybo, Director – Healthy and Safe Communities

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

Fatality Summary

Date of Birth: 1978 (44-years-old)

Date of Incarceration: August 2011

Date of Death: January 2023

At the time of his death, this incarcerated individual was housed in the Intensive Management Unit pending a serious infraction hearing.

His death was the result of hemorrhagic pulmonary consolidation (bleeding into lung tissue filling the small air sacs of the lungs) most likely from a viral infection. The manner of his death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death.

Days Prior to Death	Event
13	• The incarcerated individual was placed in the Intensive Management Unit pending a serious infraction hearing.

0	• He had several interactions with staff members throughout the day and did not express any health concerns.
	  ○ A nurse conducted a wellness check.
	  ○ He received his breakfast.
	  ○ He met with a mental health staff member.
	  ○ He met with his classification counselor.
	  ○ A formal standing count was conducted.
	• He was found unresponsive by a custody officer when his evening meal was being delivered.
	• Resuscitation efforts were unsuccessful, and he was pronounced deceased by community Emergency Medical Services.

Committee Discussion

A. The DOC mortality review committee evaluated the care the incarcerated individual received during their incarceration, found no care gaps, and offered no recommendations to prevent similar fatalities in the future.

B. Independent from 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 no deviations from policy or operational procedures and determined the medical emergency response to be appropriate for both the custody and health services staff.
2. The CIR recommendations did not directly correlate with the cause of death and will be remediated per DOC Policy 400.100 Reporting and Reviewing Critical Incidents.

C. The Office of the Corrections Ombuds (OCO) offered the following information and input:
   1. The OCO representative had no concerns about the care provided by DOC.
   2. They discussed requesting an extension for this review from the governor due to the delay in receiving the autopsy report and cause of death. They asked how they can help DOC obtain results in the future, so extensions are not necessary.
      a) The Washington state forensic lab is backlogged and receiving lab results may exceed the statutory timeframe for the UFR committee to issue a report requiring an extension request.
      b) This laboratory backlog impacts forensic results statewide.

D. The Department of Health (DOH) representative requested additional information and offered the following:
   1. How frequently are incarcerated individuals seen for routine preventative care appointments?
      a) The current funded staffing model does not support proactively scheduling annual preventative visits for every incarcerated individual. DOC does cover preventative care appointments per the US Preventative Services Task Force Grade A and B recommendations and does proactively schedule periodic visits for incarcerated individuals receiving treatment for chronic medical conditions.
      b) The department is moving toward the Patient Centered Medical Home model which emphasizes prevention and comprehensive care.
   2. The DOH representative also asked how they can help support the patient centered care model.
      a) DOH could consider partnering with DOC to provide audits to help identify system gaps.

Committee Findings

Despite resuscitation efforts, the incarcerated individual died of natural causes from hemorrhagic pulmonary consolidation most likely from a viral infection.

Committee Recommendations

The UFR Committee members did not identify any recommendations for corrective action.