Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-016

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.

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 January 11, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Arieg Awad, Deputy Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Women's Prison Division

- Deborah Jo Wofford, Deputy Assistant Secretary
- Paul Clark, Health Services Manager 3

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry
- Michelle Eller-Doughty, Corrections Specialist 4

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1980 (43-years-old)

Date of Incarceration: December 2018

Date of Death: October 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was acute cardiorespiratory arrest, acute hypoxic respiratory failure, and severe rapidly progressive interstitial lung disease. The manner of death was natural.

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

Months/Weeks prior to death	Event
13 months - 9 months	• Initial treatment for shortness of breath. • Imaging and testing completed. • Referred to specialist. • Imaging and testing showed severe restrictive lung disease.
8 months	• Seen by community pulmonologist and formally diagnosed with interstitial lung disease and provided treatment.
7 months - 3 months	• Seen multiple times by primary care provider and pulmonologist for ongoing treatment and monitoring of his condition. • Lung disease progressed despite treatment.
2 months - 1 month	• Seen in follow-up with pulmonologist and admitted to community hospital for 15 days. • Discharged to DOC facility inpatient unit for continued treatment.
Final two weeks	• Increased shortness of breath. • He declined transport to emergency room. • Transferred back to home facility for end-of-life care. • During transport, his oxygen level decompensated, and he was transported back to community hospital and admitted. • He failed to improve with treatment.
Day of death	• Death pronounced in community hospital.

UFR Committee Discussion

Upon request of the Office of the Corrections Ombuds, the UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from the review 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 history of heavy smoking (tobacco and methamphetamine). He reported illicit substance use prior to age 14.
    b. He had no documented chronic medical issues and did not seek care prior to his final illness.
    c. He requested to be seen for shortness of breath and was subsequently diagnosed with severe interstitial lung disease.
    d. There was significant weight loss in the year prior to his death and there was no nutritional consult or definitive plan of care to address his weight loss.
    e. He requested to be transferred from the inpatient unit (IPU) to his home facility for end-of-life care where he had the support of friends. Prior to transfer, his condition deteriorated, and he declined an emergency room evaluation.
    f. His condition further deteriorated during transport to his home facility. Upon arrival, medical staff attempted treatment to improve his breathing. His condition did not significantly improve so he was transported via ambulance to the community hospital for stabilization.
    g. His condition continued to deteriorate, and he elected to switch to comfort care and died three days later.
    h. The cause of death was acute on chronic respiratory failure with severe interstitial lung disease.
    i. During one of his hospitalizations, the community hospitalist noted that he needed to be evaluated for a lung transplant after he releases from incarceration in 2025.

2. The Mortality Review Committee recommended:

    a. Conducting a fact finding on why the incarcerated individual was transferred to his home facility when he was clinically fragile.

    Note: DOC Clinical leadership looked into this case further and found the incarcerated individual wanted to return to the facility where his friends resided, and he had support. He was aware he was terminal and wanted to return to his home facility to die.

    b. Acknowledging an opportunity to educate community providers on DOC Health Services treatment levels vs community and that being incarcerated does not eliminate the possibility of being considered for an organ transplant.

B. The Department of Health (DOH) representative appreciates the thoughtful approach and acknowledgement of where the breakdowns occurred. DOH has several programs and wonders how they can support the DOC with their nutrition planning.

   Note: DOC has one statewide nutritionist that completes nutritional consults. DOC would welcome a partnership with DOH to support nutrition planning.

C. The Health Care Authority (HCA) representative stated they were not surprised by the weight loss as it is part of this disease. The HCA representative asks if incarcerated individuals are considered for transplant.

   Note: DOC will support an individual through the transplant process. There seems to be a misperception by community providers that DOC will not support the individual through the process. Community providers seem to believe that the transplant process will be too complex and difficult to manage during incarceration, placing the incarcerated individual at risk for organ failure. DOC sees that community providers often elect to wait until release for individual to be considered for transplant.

D. The Office of the Corrections Ombuds (OCO) asked if custody staff were advised this was a transport to support his end-of-life care wishes and recommends including custody partners in the handoff discussions, especially the unit supervisor. The OCO representative stated in their experience even when transplants are being considered and DOC does all the required steps, the transplants do not happen for incarcerated individuals. The OCO supports incarcerated individuals having the same access to care as individuals who reside in the community.

   Note: DOC is exploring the use of interdisciplinary or multidisciplinary care conferences that will include appropriate custody partners. DOC will continue to support incarcerated individuals needing an organ transplant.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was acute cardiorespiratory arrest, acute hypoxic respiratory failure, and severe rapidly progressive interstitial lung disease.

Committee Recommendations

The UFR Committee did not offer recommendations to prevent a similar fatality in the future.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should look for opportunities to educate community providers on the care and support DOC is able to provide for transplant recipients.
2. DOC should implement the use of interdisciplinary or multidisciplinary care conferences as part of their patient centered medical home model of care delivery.