



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-008

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, substance use information was not disclosed unless the next of kin authorized release.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on May 4, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zainab Ghazal, Administrator - Health Services - Command A
- Ken Taylor, Deputy Director
- Ronna Cole, Administrator - Health Services - Command
- Rae Simpson, Chief Nursing Officer
- Candy Tribbett, Project Manager (Facilitator of UFR)
- Mark Eliason, Program Manager (Facilitator Support)
- Mary Flygare, Project Manager (Facilitator support)
- Shawn Pritchard, Project Manager (Facilitator Support)

DOC Prisons Division

- Michael Obenland, Assistant Secretary
- Eric Jackson, Deputy Director, Prisons – Command A

Office of the Correction Ombuds (OCO)

- Chase Rapach, Ombuds

Department of Health (DOH)

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Charissa Fotinos, Associate Director, Medical Services

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

Fatality Summary

Date of Birth: 1958 (63 years old)

Date of Incarceration: February 2017

Date of Death: February 5, 2022

The incarcerated individual had a history of coronary artery disease with multiple heart attacks and stent placement in his left main coronary artery in 2011. He had hypertension, high cholesterol, acid reflux, a seizure disorder, mental health concerns, and had his gall bladder removed in the remote past. In the month prior to his death, he was COVID positive but is thought to have been without concerning symptoms and did not require additional medical care at that time. Orders for routine lab work were documented in his chart, but notes indicate that he had a fear of needles and refused to have blood drawn. No recent blood test results were found in the laboratory record.

His last scheduled healthcare visit was with a mental health provider 32 days prior to his death.

On the day of his death, he was found by his cellmate during daytime hours to be unresponsive after reportedly laying down for a rest. Emergency response by DOC staff ensued including cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED), which analyzed his heart rhythm. The AED did not detect a heart rhythm that would be corrected with an electrical shock. Community emergency medical staff (EMS) responded and initiated advanced cardiac life support protocols including obtaining an advanced airway and intraosseous access for cardiac medication administration. These efforts were suspended after consultation with the emergency department physician approximately 55 minutes after the initial emergency call and the patient was pronounced deceased.

The cause of death was determined to be ischemic heart disease (aka coronary artery disease) with hypertension as a significant condition contributing to his death. The autopsy result did not find COVID to be a contributor to death. The manner of death was natural.

Committee Discussion

The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:

1. DOC does not have standardized guidance for the management of chronic cardiac conditions and seizure disorders while incarcerated.
2. Documentation of declinations for care was inconsistent.
3. Clinical documentation of emergency response was inadequate.

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. The CIR included the following recommendations for UFR consideration:

1. Critical Incident Management Staff were not able to meet with all staff involved in this incident.
2. Policy requiring count to be a standing count was not followed.
3. Emergency responders were not aware of incarcerated individuals' Do Not Resuscitate (DNR) status.

The Office of Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. The absence of policy and formal protocol to address when patients are not consenting to chronic care diagnostics.
2. Medication management issues including communication between providers and nurses as well as quality control in the pill line.
3. The need for additional processes to ensure patients with health conditions receive appropriate care, including when their conditions may put them at higher risk of complications due to COVID-19.
4. Documentation around emergency response and patient education.

The Health Care Authority (HCA) and the Department of Health (DOH) representative did not offer additional recommendations.

Committee Findings

While in the custody of the DOC, this individual died of natural causes.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. UFR Committee Recommendations
<ol style="list-style-type: none">1. Educate health services staff on accepted care pathways for cardiac and seizure disorders to ensure that patients receive care according to best practices of evidence-based medicine.2. Ensure that appropriate clinical follow-up occurs with incarcerated individuals when they have declined recommended care. Policy/protocol should:<ol style="list-style-type: none">a. Formalize a process for follow-up with incarcerated individuals who have missed, cancelled, or declined appointments, tests/procedures, or generally decline care,b. Give tangible guidance to staff integrating an assessment of the acuity of the patient's clinical condition to determine the frequency and insistence to be used for follow-up after

<ul style="list-style-type: none"> care refusals and,
<ul style="list-style-type: none"> c. Provide an acceptable “off ramp” for patients who have life-limiting illness to decline routine medical care and opt toward comfort-based care.
<ul style="list-style-type: none"> 3. Require facility custody leadership to observe a standing count at least once per week to ensure compliance with policy requirements.
<ul style="list-style-type: none"> 4. Ensure policies and procedures regarding medication management are followed by staff including guidance on: <ul style="list-style-type: none"> a. Medications required to be administered via “pill line” versus those available as “keep on person,” b. Expectations for nursing and/or pharmacy staff to alert the prescribing provider that a “keep on person” medication has not been ordered in the appropriate timeframe by the patient so that the provider can have compliance conversations with the patient, and c. Quality assurance procedures to ensure that medications are in stock as needed. Consider establishing PAR levels of commonly needed medications in facility pharmacy stock.
<ul style="list-style-type: none"> 5. Ensure that incarcerated individuals with health conditions that may place them at higher risk of COVID-related complications receive appropriate care when diagnosed with COVID-19.

Consultative remarks that do not directly correlate to cause of death, but should be considered for review by DOC

- A. The review committee felt the clinical documentation of emergency response could have been more robust in the sense that not all responders provided documentation of their role.
- B. Critical Incident Management Staff (CISM) were not able to meet with all staff involved in a critical incident after it occurred to provide support, a finding that was discussed to involve staffing levels of the CISM team.
- C. DOC staff responding to emergency did not know that incarcerated individual had a “Do Not Resuscitate” (DNR) order in place and began CPR.