



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-016

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, 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 August 4, 2022:

DOC Health Services

- Dr. Frank Longano, Deputy Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Command A
- Ken Taylor, Deputy Director Health Services
- Rae Simpson, Director of Nursing Services

DOC Prisons Division

- Mike Obenland – Assistant Secretary
- Jeffrey Uttecht – Assistant Deputy Director – East Command
- Eric Jackson – Assistant Deputy Director – West Command

DOC Reentry Division

- Susan Leavell, Senior Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: 1959 (62-years-old)

Date of Incarceration: March 1998

Date of Death: May 2022

The incarcerated individual was a 62-year-old male who was incarcerated on three separate occasions. His final incarceration began in March 1998 when he was sentenced to life without parole. He resided at the same facility for the entire period of his final incarceration. A review of his medical records showed he had a complex medical and mental health history with multiple chronic diseases in variable states of control, including major depression, diabetes, episodic blood pressure elevations, chronic anemia, heart failure, unspecified heart disease, and a painful foot deformity which severely limited his mobility.

At the end of April 2022, he elected to have a below the knee amputation on his right leg to treat his painful foot deformity with the goal of improving his mobility. After his discharge from the community hospital, he was admitted to the facility in-patient unit (IPU) for postoperative care, pain management, and recovery support. Nursing staff performed assessments every shift and documented the care provided. Medical practitioners conducted rounds to monitor his recovery and wound healing. His dressing was changed every three days per the recommendations of the surgeon. Throughout this time his vital signs remained stable. On the sixth day after his surgery, at approximately 1:30 a.m. the nurse came in to draw his blood for scheduled lab work. He appeared drowsy and was cooperative. The nurse performed the requested testing and noted the results were out of the normal range. Approximately ten minutes later, the nurse returned to his room to conduct an assessment in preparation for contacting the on-call practitioner and found him unresponsive and without a pulse. Nursing staff immediately summoned additional help and started CPR. Community emergency medical services (EMS) were called. Despite these efforts, attempts at resuscitation were unsuccessful and he was pronounced dead by the community EMS.

The cause of his death was sepsis most likely secondary to the amputation. The manner of the death was natural.

Committee Discussion

- A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:
1. The incarcerated individual was not on blood thinning medication while he was being cared for in a DOC IPU, though he was at increased risk for forming blood clots during his post-operative period.
 2. He had chronic anemia for many years that worsened suddenly on the day of his death.
 3. Given the preponderance of medical evidence, a blood clot was a possible contributing cause of

death. This presents the opportunity for DOC to explore the formal use of blood thinning medication for incarcerated individuals being cared for in an IPU setting.

- B. There was no CIR conducted and the fact finding did not identify any gaps in process or procedure followed by DOC staff.
- C. The Office of the Corrections Ombuds (OCO), Department of Health (DOH), and Health Care Authority (HCA) representatives participated in the UFR discussion and did not offer additional recommendations.

Committee Findings

1. The incarcerated individual was not on blood thinning medication while he was being cared for in a DOC IPU though he was at increased risk for forming blood clots during his post-operative period.
2. DOC has no protocol or guidance for medical staff to follow regarding blood clot prevention for incarcerated individuals being cared for in a DOC IPU.

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
1. Create and implement a protocol for prevention of blood clots in incarcerated individuals being cared for in a DOC IPU.