Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-001

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 May 30th, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Patricia Paterson, Chief Nursing Officer
- Dr Frank Longano, Chief Medical Information Officer
- Dr. Zainab Ghazal, Administrator
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director – Quality Systems
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director- Correctional Services
- Paige Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Mick Petterson, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, Healthy and Safe Communities

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: 1977 (46-years-old)

Date of Incarceration: September 2023

Date of Death: January 2024

At the time of his death, this incarcerated individual was housed in a Department of Corrections prison facility.

His cause of death was bilateral pneumonia and atherosclerotic cardiovascular disease. The manner of his death was natural.

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

Day Prior to Death	Event
1200 hours	• He was seen on the unit for nursing sick call.
1830 hours	• He was seen on the unit for pill line.
Day of Death	**Event**
0600 hours (approximate)	• Custody officer reported during the shift pass-down report, oncoming staff were informed that the incarcerated individual would not be reporting to work due to illness.
0620 hours	• Custody officer observed him in his bunk.
0700 hours – 1047 hours	• All tier checks were completed and documented.
1114 hours	• Another incarcerated individual brought a lunch tray to the incarcerated individual's cell and found him unresponsive. • Custody officers were notified.
1115 hours – 1131 hours	• Custody officers respond and enter cell. • Medical emergency declared, 911 called, and emergency medical treatment was initiated. • Facility medical arrive.
1131 hours – 1134 hours	• EMS arrive and pronounce death.

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.

    1. The committee found:

        a. There was no documentation of appropriate diagnostic curiosity or treatment planning for the documented increased heart rate, low oxygen level and wheezing during the nursing visit.

        b. The committee was unable to determine if the nurse who evaluated the incarcerated individual informed the on-call provider that he complained of shortness of breath and had abnormal physical exam findings.

        c. The evaluating nurse did not recognize clinical signs of a serious illness and did not act on abnormal physical exam findings.

        d. There is no advanced practitioner physically present on-site evenings, weekends, and holiday in DOC prison facilities. Delivery of care is dependent on excellent nursing skills.

    2. The committee recommended:

        a. A referral to the UFR committee.

        b. Providing nursing education on physical assessment skills to include full person assessment, treating vital signs as “vital”, assessing musculoskeletal abnormalities, cardiac signs, and lung sounds.

        c. Reinforcing the use of situation, background, assessment, and recommendation (SBAR) format for charting and reports out to on-call practitioner. The expectations for reporting and documentation of on-call practitioner communication are essential.

        d. DOC consider expanding availability of on-site practitioner staff.

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:

a. Required follow-up by custody staff did not occur when the incarcerated individual did not report to work.

b. Respiratory symptoms were not addressed by the nurse during sick call.

2. The CIR recommended:

a. Requiring custody staff to verify the location and condition of the incarcerated individual if they do not report for work.

b. Additional training for nurses to improve emergent and urgent triage and evaluate all abnormal findings.

c. Remediating administrative findings per DOC Policy 400.110 – Reporting and Reviewing Critical Incidents.

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

1. Clinical care and training:

   The committee discussed the examination and care provided to the incarcerated individual during the nursing sick call. The committee agrees with the care gaps identified by the DOC MRC. Members recommended clinical education for nurses and practitioners include skill assessments and written materials be augmented with hands-on simulations.

2. The committee members encourage DOC to explore options for increasing availability of on-site practitioner coverage in their prison facilities.

Committee Findings

The incarcerated individual died as a result of bilateral pneumonia and atherosclerotic cardiovascular disease. The manner of his death was natural.

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. DOC should conduct physical assessment training for nurses and practitioners to include simulations.

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 explore and when possible, increase the availability of on-site advanced practitioner coverage in their prison facilities.