Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-005

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 both May 16, 2024, and June 6, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patty Paterson, MSN, Director of Nursing
- Dr. Eric Dant, Facility Medical Director
- Dr Frank Longano, Chief Medical Information Officer
- Darren Chlipala, Administrator
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Charles Anderson, Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy
- EV Webb, Assistant Corrections Ombuds – Investigations
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant Institutional, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

Date of Birth: 1978 (45-years-old)

Date of Incarceration: January 2021

Date of Death: February 2024

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

His cause of death was severe atherosclerotic coronary vascular disease. The manner of his death was natural.

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

Day of Death	Event
0755 hours - 0758 hours	• The incarcerated individual was found unresponsive in his bunk. • A medical emergency was initiated, and lifesaving efforts started.
0818 hours	• Community emergency medical services arrived and assumed care.
0843 hours	• Death was pronounced by a DOC physician assistant.

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 and recommendations.

    1. The MRC committee found:

        a. There was no indication of acute illness.

        b. His high blood pressure was not well controlled, and treatment was complicated by his reluctance to take medications.

        c. There was no clear indication for additional medication management and nothing in medical history suggesting a full cardiac work up was necessary.

2. The MRC committee recommended:

    a. A referral to the UFR committee

    b. Continuing to support the current DOC Health Services hypertension management efforts.

    c. All individuals should have routine follow-up for chronic care management. If they decline to participate, reattempt engagement and provide chronic care education during urgent care appointments.

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. DOC policies and procedures were followed, and no recommendations were identified to prevent a similar fatality in the future.

C. The UFR committee reviewed the work of the Mortality Review committee and the Critical Incident Review and discussed the following topics:

1. Emergency response:

    The DOC emergency response was acknowledged by committee members for the quick action by custody staff including the administration of Naloxone, placing the AED and initiating CPR prior to the arrival of medical staff. Per DOC policy and training, custody staff administer appropriate first aid and medical staff assume care when they arrive on scene.

    Discussed community emergency services (EMS) response and whether DOC can call 911 without the authorization of medical staff. DOC explained that custody officers are authorized and encouraged to activate 911 if they are aware the situation is life-threatening. The Chief Nursing Officer (CNO) shared that the response time was appropriate, and EMS arrival often depends on the facility location and how quickly custody is able to secure the scene.

    Discussed DOC emergency response equipment, including portable oxygen tanks. CNO explained that portable oxygen tanks are not currently required as part of the response equipment due to their weight and how quickly they drain during an emergency. DOC nurse leadership is currently reviewing the emergency response equipment and updating the emergency response protocol.

2. Hypertension treatment:

    The incarcerated individual was appropriately offered additional medication to assist with controlling his blood pressure during a primary care visit. He declined additional medications. Incarcerated individuals do not always agree with the recommended treatment plan and have the right to decline treatments. DOC providers meet them where they are in that moment and provide appropriate treatments that they are willing to accept. They do provide encouragement, education and attempt to reengage them during future visits.

The updated DOC hypertension treatment protocol is now in place and medical staff have been trained. In addition, the protocol includes guidance on patient education and engagement. The DOC Chief Medical Office shared Panel Management Dashboard which is a case management tool used to coordinate and monitor care needs for incarcerated individuals identified with certain chronic medical conditions such as hypertension and diabetes. This dashboard is being developed to support clinical care and positively impact the health of our population until an electronic health record that supports panel management has been implemented.

3. Electronic Health Records.

   An electronic health record (EHR) will allow tracking and trending of vital signs and lab results to support clinical care for incarcerated individuals. The EHR is at least one year out from implementation.

Committee Findings

The incarcerated individual died as a result of atherosclerotic coronary vascular disease. The manner of death was natural.

Committee Recommendations

The committee did not offer recommendations for corrective action to prevent a similar fatality in the future.

Consultative remarks that do not directly correlate to cause of death, but may be considered for review by the Department of Corrections:

DOC should continue to pursue an electronic health record when full legislative funding becomes available.