Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-008

Report to the Legislature

As required by RCW 72.09.770

August 22, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

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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 August 2, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Rae Simpson, Director – Quality Systems
- Eileen Krembs, Registered Nurse 4, Addiction Medicine Team
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations
- 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: 1998 (25-years-old)

Date of Incarceration: June 2023

Date of Death: April 2024

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

His cause of death was acute cardiogenic shock, bacterial endocarditis of the aortic valve, acute toxic encephalopathy, and septic shock. The manner of his death was natural.

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

Days Prior to Death	Event
49 days prior	• Began the medication for opioid use disorder program per DOC protocol (MOUD) treatment in preparation for release to the community.
27 days prior	• During planned unit search, the incarcerated individual surrendered a homemade syringe and needle to a custody officer and reported he was using it to inject narcotics. • Possession of drug paraphernalia while incarcerated is categorized as a serious violation of Washington Administrative Code 137-25-030. • The incarcerated individual received an infraction.
17 days prior	• He reported to nurse during pill line that he was not feeling well. • The nurse did a brief assessment and scheduled him for the next day.
16 days prior	• He was evaluated and treated in clinic by provider.
14 days prior	• During the disciplinary hearing, he was found guilty and received a mandatory sanction causing custody demotion. • He was placed in administrative segregation pending new housing assignment. • He declined vital signs during the nursing assessment prior to placement.
13 days to 7 days prior	• Nursing wellness checks completed on 5 of 7 days he was housed in administrative segregation. • He intermittently showered and went to the yard. • He was seen one (1) time for a requested medical appointment.

6 days	• He declined to attend the administrative segregation review. • Nursing wellness check completed; he declined shower.
5 days	• Nursing wellness check completed. • Staff incident report documents that he declined scheduled lab testing appointment. • Custody staff spoke to him at cell-front, he said he would call his wife, and assured staff he was fine.
4 days	• He declined medication during pill line.
3 days	• He was unable to attend scheduled family visit due to feeling unwell. • Transported to Health Services for evaluation and treatment. • Transferred to local community hospital for higher level of care.
2 days	• Transferred from local hospital to multi-specialty hospital for higher level of care.
Day 0	• Despite treatment, he passed away at the community hospital with his family at his bedside.

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. Mortality Review committee found:

      a. Care provided in community hospitals appeared to be appropriate.

      b. There were missed opportunities for earlier intervention by DOC clinical staff.

      c. The individual had two positive clinical toxicology screens as part of Medication for Opioid Use Disorder (MOUD) treatment.

      d. Nursing wellness checks are not documented in the health record.

   2. The committee recommended:

      a. A referral to the Unexpected Fatality Review committee.

      b. The facility clinical team and nursing leadership review of this case to identify possible opportunities for improvement.

c. DOC should provide direction on how to perform and document a wellness check for incarcerated individuals in a restricted housing unit.

d. DOC should provide additional direction for clinical staff when a participant has a positive clinical toxicology screen for a non-prescribed substance.

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 identified these concerns:

    a. Wellness checks for the incarcerated individual were not consistently documented, as required by policy, while in administrative segregation.

    b. There was no communication between custody staff and Health Services after the incarcerated individual was found with a syringe. The incarcerated individual did not receive a urinalysis nor a medical evaluation after being found with drug paraphernalia and self-reporting drug use.

2. The CIR recommended:

    a. Developing a process to ensure the incarcerated individuals receive a urinalysis and/or medical evaluation if drugs or paraphernalia are located on them.

    b. Other recommendations were administrative in nature and did not correlate to the cause of death and will be remediated per DOC Policy 400.110 Critical Incident Reviews.

C. The committee reviewed the unexpected fatality, discussed the course of the incarcerated individual's illness, and the clinical care provided.

The committee discussed the difficulty of diagnosing bacterial endocarditis in a primary care setting. Research shows approximately 54% of individuals were not diagnosed prior to hospital admission and specialty testing. Committee members were concerned that health services staff did not utilize appropriate diagnostic curiosity or recognize the increased infection risk for an incarcerated individual using home-made syringes.

The primary care clinical team and nursing leadership did an in-depth review of this case to identify gaps and opportunities for care improvement. The identified clinical interventions were focused on treating withdrawal symptoms and failed to consider a possible infection. The clinical reviewers identified intervention opportunities to engage and evaluate incarcerated individuals more thoroughly by utilizing nursing wellness checks, MOUD appointments, pill line medication administrations, and follow up after care declinations. The committee agrees with the care gaps

identified by DOC and members recommend clinical education for recognizing signs and symptoms of sepsis and how to engage with incarcerated individuals at increased risk for using illicit drugs to effectively care plan.

Additionally, the Health Services Addiction Medicine team is updating the MOUD protocol to provide clarification and give clear direction to clinical staff when an incarcerated individual tests positive for a non-prescribed substance.

Committee members discussed the current DOC MOUD program parameters and encouraged DOC to continue expanding medication assisted treatment.

Committee Findings

The incarcerated individual died as a result of acute cardiogenic shock, bacterial endocarditis of the aortic valve, acute toxic encephalopathy, and septic shock. His manner of 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 provide direction regarding nursing restrictive housing assessments.
2. DOC should update nursing protocol to direct a scheduled nurse visit when there is a missed dose of MOUD medication.
3. DOC Health Services should propagate a culture of heightened diagnostic curiosity and effective clinical decision making when faced with patients whose vital signs, labs, or symptoms are not completely explained by the working diagnostic hypothesis; further, a culture of shared responsibility where teams actively discuss patients is highly recommended.
4. DOC should update the MOUD protocol to include recommended clinical responses when there is a positive toxicology result, provide education to staff on the changes to protocol and offer ideas for engaging incarcerated individuals diagnosed with substance use disorder in their care planning.
5. DOC should provide clear direction on how to perform and document a wellness check for incarcerated individuals in a restricted housing unit.

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 continue to expand MOUD treatment as resources are available.
2. DOC should explore opportunities for facility clinical leaders to utilize the electronic incident management reporting system to identify incarcerated individuals that may need care or additional support due to illicit drug use.
3. DOC should explore a process to ensure incarcerated individuals receive a urinalysis and /or medical evaluation if drugs or paraphernalia are located on them.