Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-015

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 December 19, 2024:

<u>DOC Health Services</u>

- Dr. MaryAnn Curl, Chief Medical Officer
- Shane Evans, Administrator
- Mark Eliason, Deputy Assistant Secretary
- Patricia Paterson, Chief of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

<u>DOC Prisons Division</u>

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Rochelle Stephens, Men's Prisons project Manager

<u>DOC Risk Mitigation</u>

- Michael Pettersen, Director

<u>Office of the Corrections Ombuds (OCO)</u>

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

<u>Department of Health (DOH)</u>

- Karen Pastori, Health Services Consultant, Prevention and Community Health

<u>Health Care Authority (HCA)</u>

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1982 (42-years-old)

Date of Incarceration: March 2019

Date of Death: September 2024

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

His cause of death was cardiac dysrhythmia due to dilated cardiomyopathy. The manner of his death was natural.

A brief summary of events on the day of the incarcerated individual's death:

Events on Day of Death
• The incarcerated individual is observed leaving his cell and entering the shower room. • Other incarcerated individuals enter the shower room bathroom and heard an unusual noise coming from the deceased individual's shower stall. • An incarcerated individual who heard the noise knocks on the shower stall door and receives no response twice. He then notified a custody officer of his concern. • The custody officer made a radio call for assistance and entered the bathroom with a second officer and found the deceased incarcerated individual unresponsive. • The officers removed him from the shower stall and administered aid. • Medical staff arrived and assumed care. • Community emergency medical services arrived, assumed care and transported him to the community hospital. • He was pronounced deceased by the community hospital.

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 committee found:

    a. He received recommended health screenings and immunizations.

    b. He was seen for problem focused medical care and no care gaps were identified.

    c. His symptoms and care needs were addressed, and he did not present with symptoms of heart failure.

    d. He may have had an unknown inherited condition/genetic predisposition that led to his heart enlargement found during the autopsy.

2. The committee recommended:

    a. A referral to the Unexpected Fatality Review committee.

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. The red emergency response bag was used for emergency response training earlier in the day and was not inventoried and restocked prior to being placed back in use which violates DOC Policy 890.620 Emergency Medical Treatment and DOC Nursing Protocol N-3100 Red Emergency Response Bag.

2. A root cause analysis (RCA) was conducted for the findings of the CIR and determined:

    a. The findings did not directly 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, and the following topics were discussed.

1. Red Emergency Response Bags (Red Bags):

    Committee members expressed concern that the red bag was not restocked after use earlier in the day. DOC Health Services currently has a nursing protocol directing red bags be restocked and sealed after each use, inventoried monthly, and a log be maintained to document compliance. While it is not contributory to this death, committee members agree it is essential to have necessary supplies available during an emergency medical response. The committee recommends Health Services review and update the current protocol and educate staff to increase compliance.

2. Genetic conditions:

    This sudden death may have been related to a heritable genetic condition. DOC Health Services

has provided information to the family about how to request genetic testing.

Committee Findings

The incarcerated individual died as a result of cardiac dysrhythmia due to dilated cardiomyopathy. The manner of death was natural.

Committee Recommendations

The committee did not offer any 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:

1. The committee recommends Health Services review and update the current red bag nursing protocol to ensure restocking the red bag is completed following emergency drills and educate staff to increase compliance.