



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-006 Report to the Legislature

As required by RCW 72.09.770

April 25, 2022

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 March 3, 2022:

DOC Health Services

- Dr. Frank Longano, Acting Chief Medical Officer
- Dr. Lisa Anderson, Chief Quality Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Health Services - Command A
- David Flynn, Assistant Secretary
- Scott Russell, Deputy Director
- Ken Taylor, Deputy Director
- Ronna Cole, Health Care Administrator Command C
- Rae Simpson, Chief Nursing Officer
- Candy Tribbett, Project Manager (Facilitator of UFR)
- Johanna Painter, Executive Assistant (Facilitator support)

DOC Prisons Division

- Jeffery Uttecht, Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Sonja Hallum, Interim Director
- Dr. Patricia David, Director of Patient Safety & Performance Review

Department of Health (DOH)

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

Health Care Authority (HCA)

- Charissa Fotinos, Associate Director, Medical Services

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

Fatality Summary

Date of Birth: 1970 (51 years old)

Date of Incarceration: July 2021

Date of Death: December 27, 2021

This review examines the case of a 51-year-old black male who was incarcerated from July 2021 until the time of his death in December 2021. The cause of his death was reported to be heart disease.

A summary of his prior care in the jail was provided to the DOC reception center at the time he was transferred. He had been diagnosed with diabetes, chronic lung disease, high cholesterol, seizure disorder, and high blood pressure. His prescriptions included self-administered insulin injections. He was screened by a nurse upon arrival. He was provided a blood sugar meter and supplies to monitor his blood sugar and prescribed insulin injections.

Prior to receiving his intake physical, he experienced several episodes of high blood sugar. The Advanced Registered Nurse Practitioner (ARNP) documented an intake history and physical two weeks after his arrival. Notes from that visit reflected the plan to request medical records from community providers he had seen for care, including specialists in endocrinology, ear nose and throat, and pulmonology. His insulin doses were adjusted, and his plan included “get approval for insulin pump.” At a follow up visit with a third ARNP, a note indicated that his insulin pump was “not here”, and an e-mail prompt was sent. The patient reported he sent his pump home from the county jail because the jail did not allow him to have it. Insulin doses were adjusted.

The next week the patient transferred to another prison. Three weeks after his transfer he was treated for a low blood sugar episode. A physician’s assistant adjusted his insulin. The patient was seen in follow up by his intake ARNP, who completed paperwork for permission to use his insulin pump. Medication records indicate the insulin pump was received and was in use for the next 27 days until supplies for the pump ran out. The patient restarted insulin by injections. The insulin pump supplies had been ordered but were not yet available when the patient suddenly lost consciousness in a common area just after dinner hour.

Health care staff responding rendered aid, including treatment of low blood sugar with medications and intravenous dextrose. He quickly became pulseless during this care and was unable to be resuscitated by the team or by EMS personnel who also responded. Death was pronounced by the community ER physician at the request of EMS staff at 18:48 in the evening. Later fact finding revealed he had not attended the medication line for his pre-dinner insulin dose or his dinnertime meal.

Cause of death was hypertensive cardiovascular disease, with diabetes, chronic lung disease, and obesity as contributory conditions. The manner of death was natural.

Committee Discussion

The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:

1. Documentation of self-administered insulin,
2. Care planning at reception facility,
3. Diabetes care during incarceration including insulin pump and continuous blood glucose monitoring,
4. Code response, and
5. Empanelment and team-based care delivery.

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. The CIR found:

1. A contract nurse had not been oriented to emergency response procedures and equipment,
2. A suction and oxygen saturation medical devices did not function correctly, and
3. Some DOC staff did not have a current documented CPR training certification.

The Office of Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. Improve diabetes management and recommended a care pathway including consultations,
2. Ensure patients with diabetes have access to prescribed equipment, medical supplies, medications, and clinical support necessary to manage their blood sugar level, and
3. Improve communication between clinical and administrative staff when responding to patient inquiries (i.e., kites and resolution requests).

The Health Care Authority (HCA) and Department of Health (DOH) representatives did not offer additional recommendations.

Committee Findings

While in the custody of the DOC, this individual died of natural causes.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop and publish an associated corrective action plan within 10 days of the publication date of this report. The corrective action plan will

be implemented within 120 days of its publication.

Table 1. UFR Committee Recommendations
1. Clarify protocol for medical staff members to educate, monitor and provide feedback to patients regarding dosing and documentation of self-administered medications.
2. Improve coordination of care through a team-based model of care delivery. Improve communication between clinical and administrative staff when responding to patient inquiries (i.e., kites and resolution requests).
3. Advance education, protocols, and guidance to support excellence in diabetes care within the DOC. This should include: <ul style="list-style-type: none">• having access to prescribed equipment, medical supplies, medications, and clinical support necessary to manage their blood sugar level and,• developing a care pathway that identifies when a specialist should be consulted for treatment recommendations.
4. Ensure a responsible doctor or advanced practitioner is assigned to each patient through a team-based model of care delivery.
5. Establish a quality assurance process to ensure red medical response bags are stocked, inventoried, and items are in working order per established protocols.
6. Establish consistent onboarding procedures and new employee orientation training for medical staff, including contractors, for basic life support response and red bag use to ensure all personnel are prepared to respond effectively in the event of a medical emergency.

Consultative remarks that do not directly correlate to causes of death, but should be considered for review by DOC:

While non-contributory to this death, it was noted that members of the DOC staff who responded to the emergency had lapsed Basic Life Support Certification cards. It is inherent on all supervisors to assure 100% compliance with this policy standard.