Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-037

Report to the Legislature

As required by RCW 72.09.770

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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. 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 9, 2023.

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr, Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Director Health Services
- Dr. Janell Simpkins, Facility Medical Director
- Paul Clark, Administrator
- Rae Simpson, Director – Quality Systems
- Nancy Fernelius, Chief Nursing Officer
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Reentry Administrator
- Mary Beth Flygare, Program Manager – Quality Improvement
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Eric Jackson, Deputy Director
- Deborah Wofford, Deputy Assistant Secretary
- Ronald Haynes, Superintendent

DOC Reentry Centers

- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator
- Carrie Stanley, Administrator

DOC Graduated Reentry – Community Corrections

- Danielle Armbruster, Assistant Secretary
- Kelly Miller, Administrator
- Donta, Harper, Regional Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

- Tyler McCoy, Health Services 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

Date of Birth: May 1968 (54 years old)

Date of Incarceration: December 2019

Date of Death: December 2022

This case was referred for an unexpected fatality review after the DOC Mortality Review Committee determined the cause of death for this individual met the statutory definition of unexpected (not the result of a documented terminal illness or other debilitating or deteriorating condition).

The incarcerated individual was a 54-year-old man who had been incarcerated since December 2019. During his incarceration, he was employed as a food preparation worker. He had a history of high blood pressure and successfully treated prostate cancer. He died while being treated in a community hospital as a result of pneumonia and SARS COVID – 19. The manner of his death was natural.

A brief timeline of the incarcerated individual's final illness:

Day(s)	Event
Day 1	• During formal count, a medical emergency was initiated by custody officers when the incarcerated individual was found unresponsive. He was transported by ambulance to the local hospital.
Days 2 – 3	• He was admitted to the community hospital and diagnosed with COVID – 19.
Day 4	• He was transferred via Life Flight from the community hospital to University of Washington Medical Center (UWMC) after his condition worsened.
Days 4 – 9	• He remained hospitalized and receiving ongoing care. ○ Despite treatment, his breathing continued to deteriorate, and he required mechanical ventilation.
Day 10	• His family was able to visit him in the hospital. ○ After consultation with the hospital medical staff, his family chose to discontinue life support and transition to comfort care. ○ He was pronounced deceased a few hours later.

Committee Discussion

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

   1. The incarcerated individual was diagnosed with COVID and likely acquired pneumonia during his final hospitalization resulting in septic shock and acute respiratory distress syndrome which ultimately caused his death.

   2. His course of care for the prostate cancer was in accordance with established standards of care and successful.

   3. He chose to prioritize transfer to another facility resulting in a delay to evaluate new symptoms and finding of a mass in his skull that was thought to be a secondary site related to his prostate cancer.

   4. His care was also complicated by what appeared to be a longstanding undiagnosed monoclonal gammopathy (a precancerous condition of blood cells) that was likely the source of the mass in his skull.

   5. DOC Mortality Review Committee (MRC) members voted to refer this case for an unexpected fatality review because acquiring an infection that does not respond to treatment is unexpected.

   6. DOC Patient Services Representatives statewide have been provided education regarding when and how to place a medical hold to prevent facility transfers when needed.

   7. DOC MRC members did not identify any recommendations to prevent a similar fatality in the future. The medical care provided to this individual for this event appeared to be timely and appropriate.

B. Independent of the mortality review, the DOC conducted a fact-finding to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

   1. The review did not identify any opportunities for system improvements.

C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and asked for additional information regarding the following:

   1. In this case, several of the incarcerated individual's family were able to visit him in the hospital. Does DOC allow family to visit those that are near death in facilities?

      DOC Response: We do our best to allow families to visit when an incarcerated individual is identified as being seriously ill. Each request is handled on a case-by-case basis. If a group is too

large, they will rotate family members in and out of the room for the visit. We encourage all incarcerated individuals to have their family members approved for visitation which facilitates approval for end-of-life visits.

2. Further discussion occurred about allowing visits from other incarcerated individuals when someone is on comfort care to both support the needs of the dying individual and the needs of their friends in the incarcerated population who will be impacted by their death. At this time, all visits are handled on a case-by case basis.

3. The OCO recommends DOC explore a modification of the policy that governs death bed visits with the goals of increasing the number of people allowed in the facility to be present when someone dies and to better support incarcerated individuals on end-of-life care and their friends.

D. The Health Care Authority (HCA) and the Department of Health (DOH) representatives concurred with the findings and did not offer additional recommendations.

Committee Findings

1. The incarcerated individual died as a result of pneumonia and SARS COVID – 19.

2. He chose to prioritize transfer to a different facility and wait for continued diagnostic testing and treatment for a skull mass which was thought to be a recurrence of his prostate cancer.

3. The medical care provided during this event was timely and appropriate. His family was able to be present and involved in his end-of-life decision making.

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 DOC explore a modification of the policy that governs death bed visits (DOC 450.300 Visits for Incarcerated Individuals) with the goals of increasing the number of people (family and other incarcerated individuals) allowed to visit in the facility and to be present when someone dies and to better support incarcerated individuals receiving end-of-life care.