Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-012

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. Under federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 January 25, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Melissa Freeman, Registered Nurse 3
- Dawn Williams, Program Administrator – Substance Abuse Recovery unit
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager
- Rochelle Stephens, Project Manager

DOC Women's Prison Division

- Melissa Andrewjeski, Assistant Secretary
- Deborah Jo Wofford, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services
- Ellie Navidson, Nursing Consultant Institutional, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1958 (64-years-old)

Date of Incarceration: January 2018

Date of Death: August 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was hypertensive cardiovascular disease. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Day of death	Event
0550 hours	• Alert button in the incarcerated individual's cell was activated. • Custody officer checked on him in cell and noticed he appeared to have mobility issues and was holding the wall for stability. • The custody officer reported the incarcerated individual stated multiple times that he must have accidently pressed the button and advised the officer he was not declaring a medical emergency.
0618 hours	• Tier check completed.
0717 hours	• Tier check completed.
0750 hours	• Custody officers were advised by another resident from his unit to check on the incarcerated individual. • Custody staff found him nonresponsive, radioed for a medical emergency, and began life saving measures.
0751 hours	• DOC Health Services staff arrived and assumed responsibility for aid.
0758 hours	• EMS arrived and assumed care.
0826 hours	• EMS pronounced the incarcerated individual deceased.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered information from the review 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. The incarcerated individual's high blood pressure management was complicated by his

lung disease and his blood pressure control was not optimal.

b. A medication previously discontinued by the consulting cardiologist was restarted by the DOC primary care provider because the provider thought it had dropped off the active medication list during one of his hospitalizations.
c. The primary care provider ordered monitoring of his blood pressure with a follow-up visit with them scheduled in two months. Documentation does not show the primary care provider received and acted on results of the blood pressure monitoring prior to the scheduled follow-up visit.
d. DOC's paper health record makes trending vital signs hard to follow over time and makes medication reconciliation between multiple care venues more difficult.

2. The Mortality Review Committee recommended:
    a. A referral to the Unexpected Fatality Review Committee.
    b. DOC Health Services should monitor the effectiveness of blood pressure treatment.
    c. DOC Health Services should identify a process to support the management of patients with high blood pressure while using a paper health record.

B. Independent of the mortality review, 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. DOC unit post orders were not clear regarding logging an alert call button activation nor conducting a tier check.
2. The CIR recommended updating the unit post orders.

C. The Department of Health (DOH) representative agreed with the proposed recommendations and emphasized the need for an electronic health record (EHR). The representative acknowledged the difficulty of tracking continuity of care for multiple doctors without an EHR. The DOH representative asked how DOC coordinates when there are multiple providers. DOH encourages DOC Health Services to continue identifying processes to support use of a paper health record until DOC implements an EHR.

Note: Historically the DOC primary care provider was responsible for care coordination. As DOC continues to implement the Patient Centered Medical Home model of care, incarcerated individuals are supported by an integrated care team who work together to support care coordination.

D. The Health Care Authority (HCA) representative was present for the discussion and did not offer additional recommendations for improvement.

E. The Office of the Corrections Ombuds (OCO) representative asked about whether tier checks were correctly conducted and asked for a description of the response process when an individual hits

the “emergency” button in their cell.

The OCO representative would like to see improvements to documentation of “emergency” call button response and clear guidance for clinical assessments/notification. If a call button is accidentally pressed, is there a way to document the accident along with a patient signature.

The representative also recommended again to change the name of the tier check to a “wellness check” and asked what actions DOC can take when tier checks are conducted incorrectly. The OCO also asked if the concept of “wellness checks” can be part of all trainings.

Note: DOC responded that the tier checks had been conducted as logged but were not as thorough as desired. Custody officers respond immediately to an alert button activation to assess the individual’s need. If there had been a medical emergency, the custody officer would initiate a medical response via radio. In this case, the custody officer reported the individual stated multiple times that he was not having a medical emergency, he pressed the button accidentally and did not need any assistance.

DOC agrees that an entry should have been made in the unit logbook documenting the use of the in-cell alert button and the response. Corrective actions have been put in place to address staff training for maintaining unit logbooks. DOC has provided system wide training on the process for conducting tier checks. When tier checks are not conducted correctly, DOC will utilize the just cause process to hold individual staff members responsible.

Committee Findings

The manner of the incarcerated individual’s death was natural. The cause of death was hypertensive cardiovascular disease.

Committee Recommendations

1. DOC Health Services should update the performance metrics to monitor the effectiveness of blood pressure treatment.
2. DOC Health Services should adopt a statewide standard system to support the effective management of high blood pressure.

Consultative remarks that do not correlate to the cause of death but should be considered for review by the Department of Corrections

1. DOC should continue to pursue funding for an electronic health record (EHR) to replace paper health records and to support interface with community health systems.
2. DOC should ensure required tasks are completed and documented in accordance with policy and unit post orders.
3. DOC should review the process to improve paper record processes while awaiting an EHR.
4. DOC should review the process for documenting alert button activation including when an incarcerated individual declines services after activating the alert button.
5. The OCO requests DOC consider changing the name of “tier-checks” to “wellness-checks” to reinforce the purpose of the checks to ensure appropriate behavior and wellbeing of the incarcerated individual.