# Unexpected Fatality Review Committee Report

## Unexpected Fatality UFR-23-017

## 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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UFR-23-017 Report to the Legislature–600-SR001

## 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: 1953 (70-years-old)

Date of Incarceration: November 2004

Date of Death: October 2023

At the time of his death, this incarcerated individual was housed in a prison facility. The cause of death was metastatic renal cell carcinoma. 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 |
|---|---|
| 1805 hours | • Cellmate reported concerns for the incarcerated individual. |
| 1806 hours | • Priority radio call was initiated for shortness of breath. |
| 1809 hours | • Staff retrieved AED and Narcan before entering the cell.<br>• Incarcerated individual was found unresponsive on his bed.<br>• Custody transferred him to the ground in preparation for aid. |
| 1810 hours | • Facility medical staff arrived on scene and began rendering aid including Narcan administration and CPR. |
| 1832 hours | • Community emergency medical services arrived and assumed responsibility for care. |
| 1847 hours | • Incarcerated individual was declared deceased by EMS personnel. |

## UFR Committee Discussion

Upon request of the Office of the Corrections Ombuds (OCO), the Unexpected Fatality Review (UFR) Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR Committee members 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 did not have an advanced directive or physician orders for life sustaining treatment form on file to document his goals of care wishes.

      b. Lack of an electronic health record creates barriers for care coordination.

c. Care coordination could be improved with primary care staff calling the specialists to discuss treatment.

2. The committee recommended:

   a. DOC Health Services end-of-life care committee create a documentation tool or decision-making matrix for goals of care discussions.

   b. DOC Health Services will work on communication strategies with community care partners as part of their strategic goals for 2024.

   c. Explore opportunities for DOC Health Services to participate in the Washington State Health Information Exchange initiative.

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. The medical response was within policy and procedural framework for a medical emergency response.

      b. The custody response was within policy and procedural guidelines.

      c. The manual suction device in the red bag was not effective. Alternative methods were appropriately employed.

   2. The CIR did not recommend corrective actions.

C. The Department of Health (DOH) representative asked if there is a standard procedure for testing medical equipment including tracking and trending equipment failures. They wanted to know if a community 911 response can be initiated prior to medical staff arrival at the emergency. They also requested information regarding the DOC standard for Physician Orders for Life-Sustaining Treatment (POLST) discussions.

   *Note: DOC Health Services tests medical equipment routinely. The Clinical Services Board evaluates the effectiveness and appropriateness of medical equipment used. Clinical leadership is currently conducting a review of medical emergency response equipment and procedures. Concerns that are noted more than one time are tracked and evaluated for needs to change. When the need is obvious, custody staff call 911 prior to medical staff arrival. DOC is in process of launching an end-of-life care committee, as part of their work, this committee will propose establishment of DOC standards for POLST discussions.*

D. The Health Care Authority (HCA) representative asked what supports are available to individuals with a terminal diagnosis like cancer.

   *Note: End-of-life care patients are generally managed by a physician in the facility inpatient unit (IPU). Some facilities already have contracts with community hospice providers. The new end of life care committee is in process of establishing a palliative care program to further support the wishes and care for incarcerated individuals with a terminal diagnosis.*

E. The Office of the Corrections Ombuds representative (OCO) appreciated the conversation and asked if he was being considered for the DOC's Sage unit which is equipped to provide care services for an aging and ill population. The OCO representative asked to hear more about the development of the end-of-life care plan.

   *Note: His primary care providers had discussions with the individual about transferring to Sage. However, he felt his current living unit was home, and he did not want to move. The facility Care Management Nurse visited with him in his cell and confirmed that he had everything in place to manage his current needs.*

   *The DOC end-of-life committee is in its early stages and is currently focused on standardizing the palliative and hospice level of care being provided.*

### Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was metastatic renal cell carcinoma.

### Committee Recommendations

The UFR committee did not identify any recommendations for corrective action.

### 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 implementing the end-of-life care program.