Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-022

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 December 28, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Lorne Spooner, Director, Correctional Services

DOC Women's Prison Division

- Deborah Jo Wofford, Deputy Assistant Secretary
- Paul Clark, Health Services Manager 3

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary

DOC Community Corrections Division

- Mac Pevey, Assistant Secretary
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1954 (69-years-old)

Date of Incarceration: October 1997

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 bladder cancer. The manner of death was natural.

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

Months prior to death	Event
March 2021 - August 2022	• The incarcerated individual complained of urinary symptoms including intermittent blood in his urine. • Treatment provided by primary care practitioner for his symptoms.
September 2022 - October 2022	• Seen for initial consult with urologist who requested advanced diagnostic testing.
January 2023	• Neurology found bladder mass and recommended surgery to remove tumor.
February 2023	• He started complaining of back pain.
March 2023	• He underwent surgery. • Was diagnosed with bladder cancer. • Was advised the tumor was not completely removed. • Urologist recommended additional biopsies in 6 weeks.
April 2023 - July 2023	• Symptomatic treatment for back pain continued including medication and X-ray ordered.
Mid-June 2023	• Second biopsy was conducted through urology. • Results showed the spread of cancer.
Mid-July 2023	• Followed up with Urologist and advised cancer had spread. • Bladder removal was recommended.

Days prior to death	Event
55 days	• Xray completed and showed possible cancer spread to spine. • He was seen in follow-up for backpain. • Diagnosed with spinal cord impingement. • Sent to ER and admitted for treatment including surgery to stabilize spine.
28 days	• Sent to Local ER for worsening condition. • Found to be septic. • Transferred to larger hospital for higher level of care.
Day 27 – Day 1	• Hospital provided treatment. • Condition continued to deteriorate. • Healthcare DPOA consulted by hospital staff. • DPOA elected to transition him to comfort care.
Day of death	• Incarcerated individual died at the community hospital.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the 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. In addition to the community specialty consultants, the incarcerated individual was under the care of multiple DOC staff and contracted primary care providers in the last 12 -18 months of his life.

      b. DOC staff and contracted primary care providers focused on the diagnoses of benign prostate enlargement and chronic back pain leading to delayed workup for the continued presence of blood in his urine and the ultimate diagnosis of bladder cancer.

      c. The DOC staff and the contracted primary care providers failed to document, in the paper health record, the bladder cancer diagnosis and the severity of the cancer, which delayed the diagnosis of metastatic spread.

      d. Lack of access to X-ray imaging on site caused care delay.

      e. The lack of an electronic health record delays receiving results, makes it difficult to locate consult reports in the chart, and to comprehensively review and trend results to see the holistic picture.

   2. The Mortality Review Committee recommended:

      a. A referral to the Unexpected Fatality Committee.

b. A retrospective clinical care review by the Facility Medical Director (FMD).

c. A discussion with statewide FMDs regarding when an advanced practitioner should involve the FMD and the care management nurse in patient care.

B. The Department of Health (DOH) representative expressed appreciation of DOC's deep analysis of the gaps that occurred in this case and asked if there are problems system-wide with the continuity of care and what recommendations could the committee propose to help improve continuity.

Note: The lack of continuity of care is endemic in the US and not just DOC. In terms of collaboration, DOC must urgently obtain an electronic health record and eliminate the reliance on paper medical files. DOC is a member of the Enterprise Planning Committee formed in spring of 2023. This committee is tasked with creating a common technology solution for electronic health records across the Health and Human Service Coalition agencies.

In addition, DOC, as a system, has not been funded to have physicians as primary care providers. The advanced practitioners who act as the front-line primary care providers do not have the same level of training in differential diagnostic decision making.

The DOH representative stated support of DOC EHR implementation and will offer support during the legislative session on bills that will assist DOC with obtaining an electronic health record (EHR).

C. The Health Care Authority (HCA) representative asked what formal process DOC has to provide feedback to a practitioner who didn't understand the need for additional diagnostic workup, and also asked if there is a system in place for practitioners to ask for help when they are unsure about the next treatment steps.

Note: Each facility has an assigned FMD whose main job is to provide clinical oversight and feedback on an ongoing basis. Most FMDs have daily patient rounding with the advanced practitioners. In addition to the FMD, practitioners also have virtual resources available. DOC Health Services is working on implementing grand rounds and a peer review program. The majority of this individual's diagnostic course occurred during the COVID-19 pandemic. The facility was experiencing extreme staffing shortages for both advanced practitioners and physicians. The vacancies were being filled with contract staff that changed every three months. The Chief Medial Offer and the Deputy Chief Medical Officer were providing support remotely in addition to an FMD from another facility coming onsite every other week. The facility currently has a permanent FMD and Physician 3 as well as several advanced practitioners.

D. The Office of the Corrections Ombuds (OCO) representative asked if there are options to get individuals x-rays when the local x-ray machine is down, and asked if DOC could confirm the x-ray machine at this facility has been repaired.

Note: DOC always has an option to send incarcerated individuals offsite to a community facility for imaging when necessary. DOC has confirmed the x-ray machine has been repaired.

The OCO representative asked if this individual was included on the DOC Cancer Care Tracker.

Note: DOC does not currently flag blood in the urine (hematuria) for inclusion on the Cancer Care Tracker. The members of the DOC Clinical Services Board will be discussing whether it should be included going forward.

The OCO representative asked about the patient's extraordinary medical placement (EMP) request.

Note: The extraordinary medical placement referral was requested eight days before his death. All documents were received, and the packet was sent for review the day before his death. He died before the request could be reviewed and approved.

The OCO representative asked if there were opportunities to catch the spinal infection sooner.

Note: There were opportunities for nursing to advocate for this incarcerated individual to make his end-of-life more comfortable. DOC Health Services has added nursing leadership as members of the mortality review committee going forward to augment the care reviews with a nursing perspective.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was metastatic bladder cancer.

Committee Recommendations

1. DOC Health Services should determine if the diagnosis of blood in the urine should be added to the DOC Cancer Care tracker.
2. DOC should develop general guidance for when an advanced practitioner should involve the facility medical director and the care management nurse in patient care.

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 files and allow interface with community health systems.
2. DOC should pursue implementation of clinical grand rounds and a peer review program in the coming year.