



# Unexpected Fatality Review Committee Report

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## Unexpected Fatality UFR-22-014 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, 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 July 21, 2022:

### DOC Health Services

- Dr. Frank Longano, Deputy Chief Medical Officer
- Ken Taylor, Deputy Director
- Rae Simpson, Chief Quality Officer
- Brooke Amyx, Reentry Services Administrator
- Paul Clark, Administrator

### DOC Prisons Division

- Jeffrey Uttecht – Deputy Assistant Secretary

### 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 Administration (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

## Fatality Summary

Date of Birth: 1952 (69 years old)

Date of Incarceration: February 1991

Date of Death: April 2022

The incarcerated individual was a 69-year-old man who has been incarcerated from February 1991 until the time of his death in April 2022. He has a medical history of high blood pressure, heart disease (with a previous heart attack in 1998), increased cholesterol, anemia, an enlarged prostate, thyroid disease, Hepatitis C (treated in 2019), latent tuberculosis infection (treated in 2018), and polysubstance use (alcohol, cannabis, intravenous drug use, methamphetamines). His most recent visit with a primary care provider was in September 2020. He signed a Physician Order for Life Sustaining Treatment (POLST) form during that visit, requesting treatment including resuscitation in the event of a medical emergency. His cause of death was determined to be heart disease.

On the day of his death, he walked into the medical clinic and stated he did not feel well. He then collapsed. Emergency Medical Services (EMS) was immediately called. He was transported via gurney to an exam room. An electrocardiogram showed a slow heart rate and evidence of a heart attack. Approximately one minute later his breathing stopped, and no heartbeat was identifiable. Cardiopulmonary resuscitation (CPR) was immediately initiated. An automated external defibrillator (AED) was placed, and no shock was advised. EMS arrived at the facility and assumed care. They continued CPR and AED monitoring during transport to a community hospital where the incarcerated individual was declared deceased.

A review of his medical records showed that in September 2020, his blood sugar levels began to trend up beyond normal limits and there was no follow-up. His cholesterol was also above normal limits which should have been addressed with medication and diet. Of note, the incarcerated individual refused a modification to his diet. His thyroid disease was undertreated, and appropriate medication adjustments were not made. He also completed a cardiac stress test with results being within normal limits.

His primary care provider left DOC in November of 2020 and his care was not assigned to another provider for ongoing management. In January 2021 the incarcerated individual submitted a written inquiry to the medical department stating that he knew his primary care provider was no longer at the facility and that he would like to know who his provider was currently. He received a response that assignment of primary care providers was “in flux” and that he should submit a written request for a medical appointment if needed. There is no record that the incarcerated individual requested an appointment after receiving this direction.

## Committee Discussion

- A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:
  - 1. The incarcerated individual was not scheduled for the follow up visit recommended by his primary care provider during their visit in September 2020.
  - 2. Opportunities for medication adjustments were identified during the review to help manage his thyroid disease, cholesterol, and blood sugar levels.
  - 3. Instead of relying on the incarcerated individual to request an appointment, he may have benefitted from proactive primary care follow up including lab work and medication management.
- B. DOC did not conduct a critical incident review (CIR) as the incarcerated individual’s manner of death was natural.
- C. The Office of the Corrections Ombuds (OCO) representative participated in the committee discussion and did not offer additional recommendations.
- D. The Health Care Authority (HCA) and the Department of Health (DOH) representatives participated in the committee discussion and did not offer additional recommendations.

## Committee Findings

- 1. While in DOC custody, the incarcerated individual died from heart disease. The manner of his death was natural.
- 2. The incarcerated individual did not request or receive follow up care for his chronic medical conditions after his primary care provider left the facility.

## 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.

<b>Table 1. UFR Committee Recommendations</b>
1. Ensure incarcerated individuals receiving ongoing medical treatment are assigned to a primary care provider.

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

1. Improve management of chronic care through the continued development of the Patient Centered Medical Home care model.
2. Develop a protocol for the management of medical care provided to incarcerated individuals identified with chronic disease, other significant health conditions, and disabilities.