Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-020

Report to the Legislature

As required by RCW 72.09.770

September 30, 2022

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.

An unexpected death is defined as any death for incarcerated individuals that was not the result of a diagnosed or documented terminal illness or other debilitation or deteriorating condition where the death was anticipated.

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 September 15, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Frank Longano, Deputy Chief Medical Officer
- Dr. Zainab Ghazal, Administrator - Command A
- Dawn Williams, Program Manager - Substance Abuse Recovery Unit
- Mark Eliason, Program Manager
- Mary Beth Flygare, Project Manager

DOC Women's Prisons Division

- Jeannie Darneille, Assistant Secretary

DOC Reentry Division

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

DOC Community Corrections Division

- Mac Pevey, Assistant Secretary
- Kristine Skipworth, Regional Administrator - East Region
- Steve Johnson, Regional Administrator - SW Region
- Donta Harper, Regional Administrator - NW Region
- Dell Autumn-Witten, Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Dr. Caitlin Robertson, Director

Department of Health (DOH)

- Katherine Shaler, Health Services Consultant - Healthy and Safe Communities
- Tyler McCoy, Health Services Consultant - Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director
- Dr. Emily Transue, Associate Medical Director

This death meets the statutory definition of unexpected for the purposes of this fatality review. This report includes a summary of the unexpected fatality, committee discussion, findings, and recommendations.

Fatality Summary

Date of Birth: 1961 (61-years-old)

Date of Incarceration: October 2018

Date of Death: June 2022

The incarcerated individual was a 61-year-old man who was incarcerated with DOC from October 2018 until the time of his death in June 2022. During that time, he worked as a clerk in the facility law library and as part of the general labor pool for his facility. While in the day room of his housing unit he collapsed and became non-responsive. He was evaluated by DOC medical staff and transported via ambulance to the local community hospital. Upon arrival it was determined he required a higher level of care than they were able to provide. He was transported to another hospital via Life Flight for specialized stroke treatment. He died two days later from the stroke. The manner of his death was natural.

Committee Discussion

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

    1. The incarcerated individual had a past medical history of high blood pressure and elevated cholesterol levels. He was on medication for his blood pressure, and it was reasonably controlled. He was on daily aspirin for stroke risk reduction and was on medication for his elevated cholesterol.

    2. His blood test results from December 2021 showed continued elevation of his cholesterol levels which indicated his medication dosage was suboptimal for stroke risk reduction. His primary care provider did not make any changes to his treatment. This highlights an opportunity for care improvement by maximizing medication management for individuals at increased risk of stroke.

B. DOC did not conduct a critical incident review (CIR) as the incarcerated individual died while being cared for in a community hospital and the manner of his death was natural.

C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and did not offer additional recommendations.

D. The Department of Health (DOH) representative did not offer additional recommendations.

E. The Health Care Authority (HCA) representative discussed their analysis of the case and determined

the following topic warranted further discussion

1. Stroke risk reduction is multifaceted, and management of cholesterol levels is one piece. For a 61-year-old male with similar health conditions, having optimal cholesterol levels reduces their risk of stroke from 16% to 12%. Optimal cholesterol levels may not have prevented a stroke for this individual.

Committee Findings

1. While in DOC custody, the incarcerated individual's blood test results from December 2021 showed continued elevation of his cholesterol levels which were not addressed by his primary care provider.
2. Many factors play a part in stroke risk. Optimal management of elevated cholesterol levels has health benefits but does not eliminate the risk of stroke entirely.

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. Educate DOC medical providers on accepted care pathways for stroke prevention.

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

1. Continue progress toward acquiring an electronic health record.
2. Improve management of chronic care through the continued development of the Patient Centered Medical Home care model.