Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-024

Report to the Legislature

As required by RCW 72.09.770

November 17, 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.

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 October 20, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Ronna Cole, Deputy Director
- Mark Eliason, Deputy Director
- Paul Clark, Administrator
- Rae Simpson, Director Quality Systems
- Nancy Fernelius, Chief Nursing Officer
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Director

DOC Community Corrections

- Steven Johnson, Regional Administrator, SW Region
- Donta Harper, Regional Administrator, NW Region
- Kristine Skipworth, Regional Administrator, East Region
- Autumn Dell-Witten, Administrator

Office of the Corrections Ombuds

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Policy Advisor

Department of Health

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

Health Care Authority

- Dr. Emily Transue, Associate Medical Director

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

Fatality Summary

Date of Birth: 1948 (74-years-old)

Date of Incarceration: July 2022

Date of Death: July 2022

The incarcerated individual was a 74-year-old man who was incarcerated for the first time in July 2022. At the time of his death, he was being housed under Washington State DOC COVID-19 Screening, Testing, and Infection Control Guideline (V.32) for intake separation. This guideline required cohort separation of 10 to 14 days while testing negative for COVID-19 infection before being eligible for the initial DOC physical exam.

His cause of death was severe cardiovascular disease with acute blood clot. Contributing factors were an enlarged heart and diabetes. The manner of his death was natural.

Brief Timeline of the incarcerated individual's medical emergency:

1552 hours – the incarcerated individual was observed sitting on his bunk during formal count

1631 hours – the cellmate notified the control booth officer that the incarcerated individual was unwell (i.e., making weird noises)

1634 hours – the responding officer makes a medical emergency radio call from the incarcerated individual's cell, indicating he was experiencing breathing distress and had urinated on himself

1637 hours – Basic Life Support CPR initiated by additional responding officers

1638 hours – RN arrives on the unit to assist with the medical emergency

1646 hours – Emergency Medical Services (EMS) ambulance crew # 1 arrived on unit and utilized "LUCAS" device for CPR compressions

1648 hours – AED utilized for the first time and advises no shock x 2

1654 hours – EMS ambulance crew # 2 arrived on unit - Advanced Cardiac Life Support (ACLS) initiated and appropriate medications administered

1703 hours – Using ACLS protocols, EMS was able to briefly reestablish his pulse

1714 hours – The ambulance transporting the incarcerated individual departs the facility

1729 hours – The community hospital emergency room physician pronounced his death

Committee Discussion

A. The DOC mortality review committee reviewed his health record and the circumstances of his death and presented the following.

    1. On the day of his arrival, the nursing intake screening documented his chronic medical conditions.
        a. His vital signs were within normal limits.
        b. His medications were appropriately continued.
        c. He tested negative for COVID-19 infection twice and had been vaccinated prior to incarceration.
        d. He was educated on how to access care and appeared stable.
    2. He had completed the required intake separation four days prior to his death, the fact that he had not yet received a full intake physical exam is not unusual or unexpected.
    3. The medical emergency response by DOC staff was found to be insufficient.

B. Independent of the mortality review, the 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. The CIR found:

    1. Initial response from the unit officer was approximately 2 minutes and 45 seconds after they were notified of a possible medical emergency.
    2. Narcan was not administered per "Nasal Narcan Protocol for Staff."
    3. The emergency response vehicle was not used by responding medical staff.
    4. An AED was not initially brought to the emergency by custody or medical staff.
    5. Custody officers providing CPR had lapsed CPR certification.
    6. The initial responding nurse did not follow DOC nursing protocols and their emergency response training had lapsed.

C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

    1. When staff determined CPR was necessary, an AED should have been available and immediately used as part of the emergency response.

D. The Health Care Authority (HCA) and the Department of Health (DOH) representatives concurred with findings and did not offer additional recommendations.

Committee Findings

1. An AED was not initially brought to the emergency.
2. An AED was not readily available for use on the unit.
3. The roles, expectations, and coordination of staff response during a medical emergency are unclear.
4. The facility emergency response vehicle is not reliably used when responding to a medical emergency.
5. The responding nurse's emergency response training had lapsed due to suspension of training during the COVID-19 pandemic response.
6. The CPR certification of the custody officers had lapsed due to suspension of training during the COVID-19 pandemic response.

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. Inform staff an AED should be brought to a medical emergency response and identify which staff members are responsible to transport an AED to the scene.
2. DOC should expand the availability of and access to AEDs in their facilities.
3. Update DOC Policy 890.620 Emergency Medical Treatment to require periodic emergency response drills that include health service staff, custody staff, and the use of the emergency response vehicle.
4. Offer training opportunities to all employees to maintain CPR certification as required for their position per DOC Policy 890.620 Emergency Medical Treatment.
5. DOC Health Services should resume annual emergency response training as mandated by DOC Policy 890.620 Emergency Medical Treatment.
6. DOC should ensure emergency response vehicles are ready and capable to meet the need statewide.