# Unexpected Fatality Review Committee Report

## Unexpected Fatality UFR-22-029

## Report to the Legislature

*As required by RCW 72.09.770*

December 15, 2022

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

## Table of Contents

Table of Contents ..... 1
Legislative Directive and Governance ..... 2
Disclosure of Protected Health Information ..... 2
UFR Committee Members ..... 3
Fatality Summary ..... 4
Committee Discussion ..... 5
Committee Findings ..... 7
Committee Recommendations ..... 8
Consultative remarks that do not directly correlate to cause of death, but should be considered for review by the Department of Corrections: ..... 8

# Unexpected Fatality Review Committee Report

UFR-22-029 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, 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 November 17, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Director Health Services
- Rae Simpson, Chief Quality Officer
- Richard Fall, Corrections Specialist - Substance Abuse Recovery Unit
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Don Holbrook, Assistant Secretary
- Eric Jackson, Deputy Director
- Jeri Boe, Superintendent - CBCC

DOC Reentry Centers

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

DOC Graduated Reentry – Community Corrections

- Kristine Skipworth, Regional Administrator – East Region
- Steven Johnson, Regional Administrator – Southwest Region

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

## Fatality Summary

Date of Birth: 1980 (41-years-old)

Date of Incarceration: November 2016

Date of Death: August 2022

The incarcerated individual was a 41-year-old man who was incarcerated for the first time in November 2016. He had been diagnosed and was receiving treatment for several chronic medical conditions. On the day of his death, a medical emergency was called on his behalf and he was evaluated by facility medical staff for shortness of breath and chest pain. He was transferred to the hospital by ambulance and died later that day. His cause of death was acute heart failure and heart attack. The manner of his death was natural.

During his incarceration he completed the “Life Skills Computing,” “Non-Violent Communication” and “Redemption” courses. He had been employed as a custodian, therapy aide, and most recently an office clerk.

A brief timeline of the incarcerated individual’s medical emergency and hospitalization:

| Time | Event |
|---|---|
| 0756 hours | A Correctional Officer called a medical emergency for the incarcerated individual who was “in distress” and complaining of chest pain, breathing issues, and blood in his sputum. |
| 0758 hours | Nursing staff arrived, evaluated him, and determined he needed additional care. He refused to be carried from the upper tier and was assisted down the stairs and transported via gurney to the facility medical department. |
| 0800 - 0815 hours | He was evaluated by a practitioner, started on oxygen, and sent to the community hospital via ambulance. |
| 0831 hours | Community emergency medical services arrived and transported him to the hospital. |
| 1335 hours | While being evaluated in the emergency room his condition worsened. He was intubated and sent to the critical care unit for monitoring and additional treatment. |
| 2231 hours | He experienced a cardiac arrest. Hospital staff continued resuscitation efforts for 20 minutes without response. |
| 2251 hours | He was declared deceased by hospital staff. |

## Committee Discussion

A. The DOC Mortality Review Committee reviewed his health record and the circumstances of his death and presented the following topics for discussion and UFR committee consideration:

   1. The incarcerated individual had a history of chronic neck and headache pain, substance use disorder (IV methamphetamines), diabetes, high blood pressure, obstructive sleep apnea, recurrent major depression, social phobia, and morbid obesity.

   2. He was under the care of the Mental Health team for counselling and psychiatric medication.

   3. His last visit with his primary care practitioner was in May 2022.

      a. His diabetes was poorly controlled and adding a new medication was to improve control was discussed.

      b. His medication to control his elevated cholesterol was continued, but additional heart attack/stroke risk reduction was not directly addressed.

      c. He was not prescribed daily aspirin for heart attack/stroke risk reduction, and he had not purchased aspiring from the commissary.

      d. He was taking a non-steroidal anti-inflammatory drug (NSAID) for arthritis pain.

      e. Blood tests were done to evaluate possible inflammatory causes for his neck pain.

   4. He had elevated risk factors for having a heart attack or stroke due to his family history, smoking history, simulant use history, diabetes, high blood pressure, elevated cholesterol, obesity, obstructive sleep apnea, prolonged use of NSAIDs, and a sedentary lifestyle

      a. His blood pressure was well controlled.

      b. His diabetes (high blood sugar) and high cholesterol were poorly controlled.

      c. He was using a C-Pap machine for sleep apnea treatment.

      d. Causes for his chronic pain and different treatment options were being considered.

      e. He was at elevated risk for having a heart attack or stroke and did not have a documented risk reduction plan in his health record.

   5. Just prior to his death, he was seen for consideration of adding Jardiance which is a medication to improve blood sugar control and reduce the risk of cardiac related death, non-fatal heart attack/stroke, and decrease hospitalization for heart failure.

      a. The medication was approved for the incarcerated individual and he started taking it in

June 2022. This was a well selected therapy for his conditions but did not seem to influence his outcome.

   b. Jardiance is currently a non-formulary medication in DOC and the Diabetic Workgroup has recommended inclusion in the formulary treatment options.

6. Recently DOC sponsored a five-part clinical medical education series for the "Management and Prevention of Cardiovascular Disease" that was presented by specialists from Virginia Mason Medical Center for DOC primary care practitioners. The topics included:

   a. Management of High Blood Pressure (August 2022)

   b. Management of Atrial Fibrillation (September 2022)

   c. Prevention and Management of Heart Disease (October 2022)

   d. Prevention and Management of High Cholesterol (November 2022)

   e. Outpatient Management of Congestive Heart Failure (November 2022)

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. DOC policy and procedure was followed during this incident.

   2. After a review of the incident and interviews with staff who participated in the medical emergency response and care of the incarcerated individual there were no opportunities for improvement identified.

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

   1. The OCO has received complaints from this facility that diabetes management is inadequate.

      a. DOC providers work with their patients to create individually tailored care plans for individuals with chronic medical conditions including diabetes.

      b. Health Services leadership is aware of the concerns and have confirmed that they are related to individuals experiencing low blood sugar episodes and not high blood sugar. Facility providers are working with the individuals expressing concerns to refine their care plans.

      c. DOC Diabetes Workgroup have drafted treatment protocols that mirror the University of Washington current evidence-based recommendations.

d. The Department is currently not funded to implement the new protocols and is working on a funding request ($4 million) to be able to start implementation if approved.

2. At the time of this death, the facility had no permanent facility medical director (FMD), what steps is DOC taking to improve staffing?

   a. There was a physician covering the FMD duties, and they were actively involved in the care of this individual. Additionally, the Department is actively recruiting physicians to fill these vacancies.

   b. The recruitment efforts include:

      i. In-person participation in three conferences and one medical career fair between July and November 2022.

      ii. Virtual participation in four medical career fairs in August.

      iii. Advertising and resume searches on professional career sites.

   c. The facility currently has an Acting Facility Medical Director which has been there for several months.

   d. There is an Internal Medicine physician who is coming to the facility weekly to provide care consults.

   e. A Chronic Care Management Nurse has been hired for the facility which creates the opportunity for individuals to have additional one-to-one support for reaching their health goals.

D. The Health Care Authority (HCA) representative discussed their analysis of the case and proposed the following for UFR Committee discussion.

   1. DOC primary care practitioners should consider a specialty consultation for patients who continue to experience high blood sugars with treatment.

E. The Department of Health (DOH) representatives agreed with the committee findings and did not offer additional recommendations.

## Committee Findings

1. The individual was at elevated risk for heart disease and did not have a documented risk reduction plan.

2. The individual had poorly controlled diabetes with continued blood sugar elevation.

3. The individual was not prescribed a daily aspirin.

## 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. The DOC diabetes workgroup should create a "Diabetes Care Pathway" that identifies when a specialist should be consulted, including a presentation of the case to Rubicon MD requesting treatment recommendations when an individual presents with poorly controlled blood sugar. If the virtual consult recommendations are not effective, consider an in-person appointment with an Endocrinologist. |
| 2. DOC should educate Health Services clinical staff on accepted care pathways for the prevention and treatment of cardiac disorders to ensure that incarcerated individuals receive care according to the best practices of evidence-based medicine. |
| 3. DOC practitioners should issue a prescription for aspirin when it is medically indicated. |

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

1. The US Preventative Services Task Force has specific recommendations for preventative care services that have a proven high or moderate net benefit for patients. DOC should consider revising the DOC formulary to align with the medication recommendations.