Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-031

Report to the Legislature

As required by RCW 72.09.770

January 23, 2023

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 December 22, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Frank Longano, Deputy Chief Medical Officer
- Mark Eliason, Deputy Director Health Services
- Brooke Amyx, Reentry Administrator
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager
- Ashley Ayers, Executive Secretary

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Ramona Cravens, Executive Assistant

DOC Reentry Centers

- Scott Russell, Deputy Assistant Secretary

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

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 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: October 1965 (57-years-old)

Date of Incarceration: June 1998

Date of Death: September 2022

The incarcerated individual was a 57-year-old man who had been involved with the Washington corrections system beginning in 1998. He was released from prison in September 2006 and had been residing in the community. He was readmitted to prison in March 2022 with an earned release date of October 2022. In September he was found unresponsive in his cell by a correctional officer performing a tier check. Medical emergency treatment was provided and he was transported to a community hospital via ambulance. Hospital staff determined he had suffered a stroke and he was admitted to the intensive care unit on life support. After 13 days of treatment, his condition did not improve. The hospital consulted with his family, he was removed from life support, and was pronounced deceased. His cause of death was acute cerebral hemorrhage (stroke). The manner of his death was natural.

During his final incarceration, his risk and needs assessments were completed correctly with educational and substance abuse being the focus of his programming. He was participating in the "Basic Skills" course and had been referred for a custodian or groundskeeper job.

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

Day & Time	Event
Day 1 0955 hours	Tier check completed
1116 hours	Tier check completed – after unit Place Safety Muster
1205 hours	The Correctional Officer (CO) noticed the incarcerated individual lying in the same position as he had been in during the two previous tier checks. He knocked on the door and entered the cell where he found the incarcerated individual was breathing but unresponsive. He immediately radioed for a medical emergency.
1212 hours	Nursing staff respond to the unit and initiated emergency medical treatment.
1224 hours	The RN requested a 911 call and the incarcerated individual was transported to health services by gurney.
1242 hours	The ambulance arrives at the facility.

1259 hours	The ambulance transporting him departs the facility.
1315 hours	He was admitted to a community hospital.
Days 2 - 12	He received treatment in the community hospital intensive care unit.
Day 13	With family agreement, he was removed from life support and pronounced deceased.

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:

    a. Polysubstance abuse most recently used methamphetamines and cocaine.

    b. Significant traumatic brain injuries from accidents in 1983 and 2022.

    c. Epilepsy in the mid-2000s but reported he had been seizure free for two years.

    d. Bipolar disorder requiring hospitalization, not currently under treatment.

    e. Testing positive for Hepatitis C during incarcerations in 2004 and 2006. He was not eligible for treatment by DOC either time based on his release dates. He was counselled and provided information regarding community treatment options.

2. During his most recent incarceration, he chose not to pursue recommended preventative health screenings, medication to manage his high blood pressure, and mental health support.

    a. His reasons for declining care were not well documented in his health record.

    b. He was offered appropriate treatment for high blood pressure and preventative care (colon and lung cancer screening, routine blood tests and infectious disease testing).

    c. DOC is making improvements based on a previous corrective action associated with UFR-22-008 to address documentation of medical care declinations, “Develop and implement policy / protocol to ensure that documented follow-up occurs with incarcerated individuals when they have declined recommended care to help promote improved understanding of the rationale, alternative options that might be available, and risks associated with declining care.”

3. The medical emergency response appeared to be appropriate, with nursing staff reinforcing the use of Narcan with participating custody staff.

4. The DOC Mortality Review Committee members did not identify any recommendations to prevent a similar fatality in the future.

B. Independent of the mortality review, the DOC conducted fact-finding review to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operation procedures.

   1. The review did not identify any opportunities for system improvements.

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

   1. What is the process and timing for Extraordinary Medical Placement (EMP) after receiving approval from the Chief (CMO) or Deputy Chief Medical Officer (DCMO) regarding an incarcerated individual's medical condition, and how quickly can it occur?

      a. The DOC Headquarters Community Screening Committee meets every Thursday to review cases unless an ad hoc meeting is requested for an earlier review.

      b. In addition to the serious medical condition of the incarcerated individual being approved by the CMO/DCMO, the committee reviews whether the individual poses a low risk to the community and will granting the EMP will result in cost saving to the State.

      c. A viable plan for housing placement also impacts the expediency of a case being presented. An individual needs either family support for housing or a referral to the Department of Social and Health Services (DSHS) for placement in the community. DSHS can take up to 45 days to confirm financial availability for placement.

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

Committee Findings

1. The incarcerated individual died from the effects of a stroke.

2. He declined recommended medical care and screenings during his final incarceration.

3. He was medically approved to participate in the DOC Extraordinary Medical Placement process but died prior to the process being completed.

Committee Recommendations

1. The UFR Committee members did not offer any recommendations for corrective action.