Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-003

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, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on April 20, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- Dr. Zainab Ghazal, Health Service Administrator
- Paul Clark, Health Service Administrator
- Dr. Karie Rainer, Director Mental Health
- Rae Simpson, Director Quality Systems
- Danielle Moe, Chief Nursing Officer
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- Eric Jackson, Deputy Assistant Secretary
- Melissa Andrewjeski, Superintendent
- Lorne Spooner, Program Manager

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Ombuds – Policy

Department of Health (DOH)

- Brittany Tybo, Director – Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Sophie Miller, Medical Officer

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

Fatality Summary

Date of Birth: 1971 (51-years-old)

Date of Incarceration: January 2021

Date of Death: January 2023

The incarcerated individual was a 51-year-old man who had been involved with the justice system since 1990. He was readmitted for his fifth prison incarceration in January 2021, with an anticipated release date of January 2033. Prior to his death, he worked as a dishwasher. Additionally, he was referred for substance abuse treatment, basic skills education, sex offender treatment, and the "Thinking for a Change" program. His goal was to complete his GED. It was determined his death was the result of heart disease. The manner of his death was natural.

Below is brief timeline of events leading up to his death.

Days Prior to Death	Event

232	• He declared a medical emergency for chest pain.
	  ○ He had a normal electrocardiogram (EKG) and was treated for acid reflux.
	  ○ He was referred to a gastroenterologist for evaluation.
	  ○ The testing from the specialist was normal.

228	• He was seen in follow-up by a physician.
	  ○ An EKG was repeated and was normal.
	  ○ He was started on an additional medication for his blood pressure and the medication to control his cholesterol level was increased.

200	• He experienced an episode of profuse sweating and swelling in his legs.
	  ○ A blood sugar check was done and was within normal limits.
	  ○ He was issued compression socks.

116	• He experienced a breathing issue and was evaluated by a physician.
	  ○ Labs and x-rays were ordered.
	  ○ He was provided an inhaler and a two-week follow-up was requested.

115	• His chest x-ray showed signs of pneumonia. ○ He was started on antibiotics and advised to follow-up in two weeks. • His lab work was within normal limits. • His scheduled follow-up appointment was cancelled.
88	• He sent a kite stating he had throat pain from coughing. ○ His inhaler was refilled, and he was scheduled for an appointment.

81	• He was seen in follow-up by a physician and diagnosed with an abnormal buildup of fluid in his lungs (pulmonary edema) that was not related to his heart function.
70	• He sent a kite stating he was experiencing chest pain mostly with eating. ○ The medical assistant responded that he was in the scheduling queue for follow-up.
68	• He transferred to his parent facility from the reception center.
52	• He sent a kite and was seen in sick call for difficulty breathing and prescribed an inhaler.
39	• He was seen by a medical provider for follow up.
33	• He again sent a kite stating he was experiencing chest pain with eating. ○ The medical assistant responded that he was in the scheduling queue.
17	• He was seen by a medical provider for follow up.
1	• He declared a medical emergency on a Sunday at 13:30 hours for chest pain with pain radiating down his harm. ○ He was seen by nursing, and EKG was done and reported as normal. ○ Blood work to measure heart inflammation was drawn and sent to the outside lab per the on-call provider's orders. ○ At 16:28 hours the blood work results were received and e-mailed to the on-call provider at 19:55 hours. ○ The provider was not called because the lab was not flagged as being critically elevated. ○ He was seen again at 19:06 hours for a repeat EKG which was reported as normal. ○ He stated he was continuing to experience chest pain. ○ He was directed to return to his cell and follow up with the medical clinic the following day.
0	• At 06:40 hours the incarcerated individual was found by his cellmate lying face down on his bunk non-responsive. • His skin was mottled and blue. He was cold to the touch.

Committee Discussion

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

1. The incarcerated individual had a history of obesity, high blood pressure, acid reflux, elevated cholesterol, sleep apnea, a long history of smoking, substance use disorder, pre-diabetes and was receiving treatment for his mental health symptoms.

   a) He was prescribed medication to treat high blood pressure, elevated cholesterol, and mental health symptoms.

2. He had multiple factors placing him at moderate risk of having heart disease (heart score of 5 from the "UpToDate" clinical decision support system).

    a) The day prior to his death, he described experiencing symptoms consistent with an acute heart attack. The protocol for patients experiencing the described symptoms is to order an emergency transport to a local hospital emergency room for higher level of care and evaluation. In this case, the provider ordered a blood draw which was sent community laboratory for processing, and the individual returned to his housing unit.

    b) He was never referred for an evaluation by a cardiologist for the episodes of shortness of breath and chest pain after a normal gastroenterology workup.

3. The nurse involved in his final episodes of care was new to DOC and was not familiar with the normal process for evaluating an individual with chest pain in the prison setting.

4. The final medical emergency occurred on a weekend when there were no medical practitioner staff on site.

5. A root cause analysis determined:

    a) There was a communication breakdown between the nursing staff and the on-call provider.

        i. There is not a consistent or standard reporting format for nurses to use when contacting the on-call provider to ensure adequate and appropriate information is shared.

    b) There were gaps in training for staff.

        i. Nursing and provider staff were not fully aware of the chest pain protocol.

    c) There were challenges with communication of medical information.

        i. DOC does not have an electronic health record which increases the risk of illegible documentation, misfiled or missing information, and limited record availability which can lead to incomplete information being conveyed in medical reports and care delays.

    d) Staffing challenges:
        i. An on-duty nurse was away from the facility to transport the blood specimens to a local diagnostic laboratory, and
        ii. The legislatively approved and funded medical staffing model does not include an on-site provider or nursing supervision after normal business hours, on weekends, or holidays.

7. Members of the Mortality Review Committee recommend:

    a) DOC consider adopting the SBAR (Situation-Background-Assessment-Recommendation) reporting template as a standard communication tool for nursing telephone communication with on-call providers.

    b) Standardizing the onboarding, orientation, annual and just-in-time trainings for Health Services (HS) staff, which was impeded during the COVID-19 Pandemic.

    c) Further educate staff on access to and content of nursing protocols.

    d) Continue the implementation of the Patient Centered Medical Home (PCMH) model of care in DOC facilities to foster stronger care teams and improve communication.

    e) Develop a legislative request to fund additional positions to support staffing an on-site provider 24/7 at major facilities.

    f) Explore adding additional communication options for nursing and on-call providers to utilize for after-hours communications.

    g) Facility leadership establish routine unit/department meetings, implement daily huddles, and leadership rounding to encourage and support team communication.

    h) Conduct an education conference (M&M) for clinical decision making in patients with chest pain.

8. Corrective actions already taken by HS leadership include:

    a) A communication from the Chief Medical Officer providing care directives when there is an individual experiencing acute chest pain (do not order urgent labs and monitor, send the individual to the emergency room).

    b) A facility team debrief of events and a root cause analysis was conducted with the involved staff.

    c) HS nurse leadership has communicated the expectation of not using e-mail to communicate urgent lab results and to clearly document the notification in the individual's health record.

    d) HS nurse leadership has reinforced the expectation for nurses to utilize protocols and associated forms when responding to a patient emergency.

    e) The Facility Medical Director has had coaching conversations with the involved staff and will pursue additional clinical oversight to ensure improvement.

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. Facility nursing staff were not using the correct/updated chest pain assessment form (DOC 13-467) which is designed to screen for critical symptoms of a heart attack.

    a) Recommend ensuring that facility nursing staff have access to and are using the current nursing assessment protocols and forms.

2. Additional CIR findings and recommendations were administrative in nature and did not directly correlate with the incarcerated individual's cause of death. They will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The representative from the Health Care Authority (HCA) discussed the importance of fostering a "culture of safety" that empowers staff to put an individual's safety first. A safety culture encourages people across ranks to raise concerns.

1. Some diagnoses should automatically be an escalation of care (emergency room/hospital).

    a) They recommend educating clinical staff regarding when an automatic care escalation is necessary.

2. The DOC Health Plan currently grants authority to any DOC "Provider" for activating 911 in the event of a life-threatening emergency.

    a) Committee members felt the designation of "DOC Provider" is unclear and does not support a safety culture. They recommend updating the DOC Health Plan to grant authority to any DOC staff member, contractor, or volunteer to activate a community 911 response in the event of a life-threatening emergency.

D. The representative from the Department of Health (DOH) discussed the importance of prevention for heart disease and inquired how DOH can partner with DOC to provide health education (tobacco cessation, healthy eating, and increasing activity) to the incarcerated population.

    i. Committee members discussed the possibility of utilizing the incarcerated individual's Securus tablets to publish the educational information.

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

1. To increase access for incarcerated individuals, the OCO offered to help facilitate uploading the DOH health education materials onto the Securus tablets.

2. The OCO representative appreciated the thoroughness of the DOC review including the in-depth root cause analysis with the limited resources that are available. They recommend that Health Services develop a matrix or rubric to define when the circumstance of an incident requires this level of review (sentinel event) and consider what level of staffing would be needed to support this level of review on an ongoing basis.

Committee Findings

1. The incarcerated individual died due to long-standing heart disease.
2. The day prior to his death, he was experiencing symptoms of an acute heart attack and was not referred for a higher level of care in the community.
3. The DOC Health Plan is not clear on who has authority to initiate a 911 community response.
4. The UFR Committee Members concurred with the findings described in the root cause analysis.

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. DOC Health Services (HS) should consider adopting the SBAR (Situation-Background-Assessment-Recommendation) reporting template as a standard communication tool for nursing telephone communication with on-call providers.
2. HS should make nursing protocols easier for the staff to find, ensure staff are educated on their contents, and appropriately using the associated assessment forms.
3. HS should reinvigorate the onboarding, orientation, annual, and just-in-time trainings for their staff.
4. Facility HS leadership should establish routine unit/department meetings, implement daily huddles, and leadership rounding to encourage and support team communication.
5. HS leadership should educate clinical staff regarding when an automatic care escalation is necessary.

6. DOC should update the Health Plan language to clearly grant authority to any DOC staff member, contractor, or volunteer to activate a community 911 response in the event of a life-threatening emergency.

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

1. DOC should continue the implementation of the Patient Centered Medical Home (PCMH) model of care in all DOC facilities.
2. DOC should explore adding or augmenting options for nursing and on-call providers to utilize for after-hours communications.
3. DOC should explore the possibility of having an on-site provider 24/7 at major facilities.
4. DOC should explore the possibility of utilizing the Securus tablets to disseminate health education material from the Department of Health to the incarcerated individuals.
5. DOC should consider developing a matrix or rubric to define when the circumstance of an event (sentinel event) triggers a full root cause analysis and determine what level of staffing would be needed to support this level of review on an ongoing basis.