



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-023 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 March 7, 2024, and March 13, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zain Ghazal, Administrator – Health Services
- Rae Simpson, MSN, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Page Perkinson, Correctional Operations Program Manager

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Deputy Director
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Ellie Navidson, MSN, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Christopher Chen, Associate Medical Director

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

Fatality Summary

Year of Birth: 1954 (69-years-old)

Year of Incarceration: 1992

Date of Death: December 2023

During his incarceration, he was housed in a prison facility and died while being cared for in a community hospital. The cause of death was hypoxic respiratory failure, post obstructive pneumonia, and metastatic lung cancer. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual’s death:

Days prior to death	Event
10 days prior	<ul style="list-style-type: none"> • The incarcerated individual began coughing up blood at work and a medical emergency response was requested. • 911 was called. • Community emergency medical services (EMS) arrived and assumed care and transported him to the community hospital. • Testing at the hospital showed a large bleeding mass in his left lung.
8 days prior	<ul style="list-style-type: none"> • Procedure performed to reduce the size of the lung mass and stabilize the airway passage. • Pathologic testing confirmed the mass was cancerous.
7 days prior – 1 day prior	<ul style="list-style-type: none"> • DOC Seriously Ill Notification process was initiated. • DOC and community hospital’s attempts to reach next of kin were unsuccessful. • His condition continued to deteriorate. • He was not able to discuss his wishes regarding care. • Community hospital ethics, hospitalist, oncology, and palliative care teams concurred that he would not benefit from further aggressive treatment and would suffer undue harm. • Community hospital provided updates to the facility medical director who assented to the hospital’s decision to remove him from the ventilator.
Day of death	<ul style="list-style-type: none"> • He was removed from the ventilator, and he passed away at the community hospital.

UFR Committee Discussion

The UFR Committee met on two occasions to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from

the review in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The MRC found:

- a. The incarcerated individual was not a frequent utilizer of medical services. His last visit with a primary care provider was August of 2021.
- b. He was from Africa and English was his second language. It was not documented whether he was able to effectively communicate and discuss his care needs without translation although medical notes indicated he was able to participate in decision-making for previous medical care and at the beginning of this hospitalization.
- c. He was a former smoker but there is no clear documentation of when he stopped smoking, though DOC banned smoking in 2004.
- d. Based on effective date for the DOC smoking ban and the current U.S. Preventative Services Task Force (USPSTF) recommendations he would not be eligible for lung cancer screening by a low dose chest CT screening.
- e. He received mental health treatment until February of 2016. At the time of his death, he had a long history of needing minimal support services and was on no medication for his mental health symptoms.
- f. He had no Portable Order for Life Sustaining Treatment (POLST) or advanced directive on file and the emergency contact information he had listed was out of date.

2. The MRC committee recommended:

- a. Referral to the UFR committee for review.
- b. DOC include advanced care planning as part of the health services intake process.
- c. DOC request the Patient Centered Medical Home (PCMH) steering committee prioritize a process for an annual visit with the primary care team in 2024.

B. The UFR committee had a robust conversation on several topics related to this unexpected fatality.

1. Topic: DOC's process for scheduling follow-up appointments and documentation of cancellations.

In the months before his death, the incarcerated individual had a nursing sick call visit for symptoms of all over body pain and skin dryness that worsened with cold weather. He was evaluated and scheduled follow-up appointment with his primary care provider. The schedule shows the follow-up appointment was cancelled but staff did not document the reason for the cancellation. The committee discussed the importance of documentation in the health record when recommended care visits are not completed as scheduled.

Note: DOC has existing procedures that require documentation of cancelled appointments which was not followed by staff. DOC Health Services (HS) does not have an electronic health record or scheduling system that provides notification when a follow-up appointment has

been cancelled and not rescheduled. HS is continuing to explore options to ensure necessary follow-up occurs.

2. Topic: DOC's role in community hospital end-of-life care decisions.

The committee reviewed the records and discussed the end-of life-care for the incarcerated individual. The committee asked about DOC's role in community hospital end-of-life care and whether advanced directives are provided by DOC to community care providers.

Note: Incarcerated individuals have autonomy to make their own care decisions and DOC staff members do not hold surrogate decision-making capacity. If an incarcerated individual is unable to make decisions and there is no next of kin or an established surrogate decision maker, the hospital will follow their established process for medical decision-making. DOC works with the community hospital by sharing health information and advanced directives, attempting to reach next of kin, and providing support for transfer of care when needed.

The committee recommended DOC connect with the DOH POLST registry to explore options to include DOC Health Services as part of the registry.

The committee reviewed the community hospital records which documented the process to have a guardian appointed and the care decisions made with support of their ethics committee. The committee recommended DOC provide the community hospital ethics department information regarding DOC's role in care decision-making. The committee noted the lack of guardianship resources statewide and guardians frequently cannot be appointed timely to provide care decision support.

The committee discussed the impacts of cultural and religious preferences in relation to end-of-life care and final wishes and concurred that this is part of holistic, person-centered medical care. The group recommends DOC document religious preferences and final wishes as part of their intake process and provide this information to community hospitals as part of sharing advanced directive information.

3. Topic: Language and translation services.

The committee discussed language services for individuals with limited English proficiency in DOC health services. Discussion revolved around how incarcerated individuals know language services are available, how they obtain and decline care, and how informed consent is ensured. The committee recommended improvements for incarcerated individuals who have limited or no English proficiency.

Note: DOC provides oral interpretation and written translation services at all facilities and DOC Health Services uses certified contracted medical interpreters. DOC is working on more avenues to request care. The patient education committee is working on documentation and forms including opportunities to improve primary language services.

The committee recommends printing and distributing the "Point to Your Language" posters. Additionally, the committee recommends DOC explore options to make written information available in additional languages.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was acute hypoxic respiratory failure, post obstructive pneumonia, and metastatic lung cancer.

Committee Recommendations

The committee did not offer any recommendations for corrective action to prevent a similar fatality in the future.

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

1. DOC should review current religious and person-centered practices regarding end-of-life care and final wishes for their body after death.
2. DOC should explore options to expand access to written material and language translation services for non-English speakers including translating the statewide orientation handbook.
3. DOC should explore options for chaplain resources in multiple language and religions.
4. DOC HS should provide feedback to the community hospital regarding end-of-life decision making for DOC patients.
5. DOC should contact the DOH POLST registry program to explore options for DOH inclusion.
6. DOC should continue to request resources for an electronic health record that supports documentation, scheduling, and electronic communication with community care providers.
7. DOC should develop an informational brochure for community care providers regarding incarcerated individuals' right to direct care decisions.
8. The committee requests the report highlight the need for guardianship resources for Washington state residents and processes/guidelines for individual cases to be expedited.