



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-006

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. Federal law, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying substance use 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 4, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, MSN - Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, MSN - Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- Charles Anderson, Deputy Assistant Secretary
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men’s Prisons Project Manager

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, Nursing Consultant, Healthy and Safe Communities

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medical Director

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

Fatality Summary

Date of Birth: 1940 (83-years-old)

Date of DOC Incarceration: April 1994

Date of Death: January 2024

At the time of his death, the incarcerated individual was housed at a prison facility and was a federal boarder.

His cause of death was viral pneumonia secondary to co-infection with SARS COV-2 (COVID-19), human rhinovirus and enterovirus. The manner of his death was natural.

A brief timeline of events prior to the incarcerated individual’s death.

Prior to Death	Event
Day 1	<ul style="list-style-type: none">• Cellmate reported the incarcerated individual was having difficulty breathing and he was sent to medical.• He received a medical assessment and was encouraged to be admitted to the facility infirmary.• He declined infirmary care and was counselled to declare a medical emergency if anything changed.• He returned to his living unit against medical advice.
Day 0	<ul style="list-style-type: none">• Cellmate reports the incarcerated individual is unresponsive.• Officer responded.• CPR started and 911 called.• Emergency medical services (EMS) arrived and assumed care.• EMS pronounced him deceased.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR committee considered the information from the review in formulating recommendations for corrective action.

1. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered, and provided the following findings. The committee found:

- a. The incarcerated individual had several chronic medical conditions that placed him at high risk for a poor outcome from a COVID-19 infection.
- b. He received his last COVID-19 vaccination in April 2021 and received an influenza vaccine in the fall of 2023.
- c. He was not screened for respiratory infections when seen for shortness of breath.
- d. He declined admission to the facility infirmary.

2. The committee did not identify any additional recommendations to prevent a similar fatality in the future.

B. The committee reviewed the unexpected fatality, and the following topics were discussed.

1. COVID screening and protocols in the facilities:

The committee discussed the DOC COVID infection prevention guidelines, which align with the Centers for Disease Control recommendations. DOC described the current process for respiratory illness screening and notification of incarcerated individuals when there are active cases in the facility. Mass COVID testing is no longer recommended, and many incarcerated individuals choose not to be tested when there has been a possible exposure. DOC has reinforced with health services staff the requirement for testing when an incarcerated individual is showing symptoms. DOC continues to provide appropriate personal protective equipment for use by incarcerated individuals and staff.

COVID vaccines are offered to all incarcerated individuals and information on vaccines and clinics are posted in the units. Vaccine education is provided through infection prevention and primary care staff.

2. Facility infirmaries and declination of care:

In the hours before his death, this individual was assessed by nursing, and was encouraged to admit to the facility infirmary. He declined admission, was counselled to declare a medical emergency if his condition worsened, and then returned to his unit. This death highlights how quickly an individual can be overwhelmed by a COVID infection. DOC nursing leadership plans to provide additional training on performing respiratory evaluations, and clinical monitoring. The committee supports the additional training.

DOC described the process when an incarcerated individual declines care. In this case, the documentation did not fully describe the reason for admission to the infirmary and why he

declined. The committee recommends staff clearly document in the health record the information and guidance provided to the incarcerated individual when there is a care declination.

The incarcerated individual's medical record documented intervals of frustration with care provision and periods of disengaging from care during his lengthy incarceration. The committee discussed the value of maintaining a therapeutic relationship with incarcerated individuals who have care needs, even when they become frustrated and disengaged.

The committee discussed facility infirmaries and what level of medical care and treatment an incarcerated individual may receive. DOC infirmaries provide skilled care (e.g. focused nursing/complex wound care/intravenous antibiotics/post-surgical recovery). Incarcerated individuals requiring a higher level of care are transferred to a community hospital for care.

The committee also discussed the facility infirmary setting and why an incarcerated individual might decline admission. DOC reported some of the reasons including boredom, not being allowed to have their normal personal property, and less freedom of movement than their regular unit. DOC is looking at options for safely allowing some personal property in the infirmary.

Committee Findings

The incarcerated individual died as a result of viral pneumonia secondary to co-infection with SARS COV-2 (COVID-19), human rhinovirus and enterovirus. The manner of his death was natural.

Committee Recommendations

The UFR committee did not identify any recommendations to prevent a similar fatality in the future.

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

1. DOC nursing leadership should provide additional training on performing respiratory evaluations and clinical monitoring.
2. DOC Health Services should consider gathering information on the number of individuals declining facility infirmary admission and the reason for the declination, with the goal of decreasing declination rates.
3. DOC Health Services should continue implementation of the Patient Centered Medical Home model and include proactive outreach to individuals with known care needs who are not engaged.
4. The committee recommends staff clearly document in the health record the information and

guidance provided to the incarcerated individual when there is a care declination.