



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-007 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, 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 March 10, 2022:

DOC Health Services

- Dr. Lisa Anderson, Chief Quality Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Health Services - Command A
- Kathleen Reninger, Administrator - Health Services - Command B
- David Flynn, Assistant Secretary
- Scott Russell, Deputy Director
- Ken Taylor, Deputy Director
- Ronna Cole, Administrator - Health Services - Command
- Rae Simpson, Chief Nursing Officer
- Candy Tribbett, Project Manager (Facilitator of UFR)
- Johanna Painter, Executive Assistant (Facilitator support)

DOC Prisons Division

- Michael Obenland, Assistant Secretary
- Tom Fithian, Senior Director Correctional Operations

Office of the Correction Ombuds (OCO)

- Sonja Hallum, Interim Director
- Dr. Patricia David, Director of Patient Safety & Performance Review
- Chase Rapach, Early Resolution Specialist

Department of Health (DOH)

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

Health Care Authority (HCA)

- Charissa Fotinos, Associate Director, Medical Services

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

Fatality Summary

Date of Birth: 1949 (72 years old)

Date of Incarceration: June 2004

Date of Death: December 30, 2021

This review involves a 72-year-old White male incarcerated from 2004 until the time of his death in December 2021. The cause of his death was cardiac disease.

This individual had multiple chronic conditions including cancer of the mouth, cardiac disease, and lung disease. He had completed treatment for his mouth cancer years prior. In 2020, he had multiple pre-cancerous skin lesions evaluated including removal of a few of these which had become cancerous. Over recent years he had voiced mixed feelings about engaging in recommended health care.

In 2019, he declined testing recommended by the cardiologist. Notes in the medical chart reflect that he stated “no reason. I’m just not going.” In January of 2020 he was encouraged to restart one of his cardiac medications. On February 6, 2020, the patient wrote a kite (Communication form) stating that he was voluntarily declining to take his prescribed cardiac medications stating that there was “No change or notable positive benefits.” In April of that year the cardiologist who saw him noted he was “refusing all testing.” The cardiologist recommended a follow up visit in one year’s time.

In June 2020, this patient was encouraged to visit with mental health staff by his primary care provider and agreed. The psychology associate he saw documented that he “feels pretty hopeless about his future and stated that he doesn’t even make goals anymore.”

In March 2021, the patient was referred to a cardiologist for follow up of his heart rhythm disorder and increasing symptoms.

On March 11, 2021, the patient signed a refusal of Medical, Dental, Mental Health and/or surgical Treatment release form pertaining to future prostate and bowel cancer screening, and cardiology care. He stated, “after carefully reconsidering my previous decision I’ve decided against pursuing anymore heart related tests-have no desire to prolong a life dictated by poor health.” He asked for any appointments to be canceled.

In June 2021, after an admission to the facility’s inpatient unit, the patient maintained that he was still not willing to restart taking his medications

In July 2021 another referral to cardiology was placed. The patient had stopped taking medications but agreed to have a conversation with the cardiologist about treatment options to improve his quality of

life.

He saw his cardiologist in October 2021, who made recommendations for testing, medication management, and follow up after two to three months. The cardiologist described in the chart note that the patient was not willing to take a blood thinner medication. An alternative recommendation was made to take daily aspirin. This is available at no cost in the facility store, but the patient did not request a supply.

On the date of his death, the patient was found unresponsive in his cell. Emergency aid was rendered, including multiple rounds of Narcan, CPR, and shocks from the AED when indicated. The local fire department arrived in 23 minutes to participate in rescue measures, which were unsuccessful.

Cardiac ventricular arrhythmia was the immediate cause of death. Other significant conditions noted were history of cancer of the mouth apparently in remission, history of a cardiac arrhythmia, and a heart valve disorder.

Committee Discussion

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

1. Pharmacy not supplying over-the-counter aspirin for medically necessary conditions,
2. Follow-up on care refusal needs policy or protocol created.

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. Delay in custody staff providing immediate life-saving measures when responding, medical staff were not able to use the emergency response vehicle as it had not yet been equipped to carry a gurney for use in transport.

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

1. Need to improve the health services' response when a patient does not adhere to treatment plans,
2. Made note of staff uncertainty as to when they should initiate CPR,
3. Ensure medical equipment is accessible and in working order for emergency response.

The Health Care Authority (HCA) representative discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. Language be modified from use of the words adherence and refusal when describing an incarcerated

individual's acceptance of care plans in the medical record. Adherence and refusal imply they are required to do what a medical provider recommends, whereas incarcerated individuals have choices regarding their care.

The Department of Health (DOH) representative offered no additional discussion or recommendations.

What is the language in our current medical plan, should we add this, or the legal language that patients have the right to refuse treatment?

Committee Findings

The individual died while in the custody of DOC due to natural causes.

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. Provide aspirin as a prescription medication for medically necessary treatment.
2. Establish a process for tracking incarcerated individuals with a cancer diagnosis for necessary surveillance after treatment is completed.
3. Reinforce the expectations for custody staff to immediately initiate life-savings measures when it is safe to do and provide necessary training.
4. Modify the medical emergency response vehicle to carry emergency medical equipment.
5. Incorporate Mental Health expertise in assessing incarcerated individuals when they refuse care, to ensure they have capacity to make an informed decision about their medical care.

Consultative remarks that do not directly correlate to causes of death, but should be considered for review by DOC:

Remission care in coordination with follow-up care after treatment of oral cancers.