



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-025 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 March 12, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Patty Paterson, MSN, Director of Nursing
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Risk Mitigation

- Michael Pettersen, Director

DOC Prisons Division

- Jeffrey Perkins, Superintendent
- Lorne Spooner, Director for Correctional Services
- Paige Perkinson, Correctional Operations Program Manager
- Rochelle Stephens, Men’s Prison Project Manager

Office of the Corrections Ombuds (OCO)

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

Department of Health (DOH)

- Ellie Navidson, RN Nursing Consultant Institutional, 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

Year of Birth: 1952 (71-years-old)

Date of Incarceration: August 1995

Date of Death: December 2023

At the time of his death, this incarcerated individual was housed in a prison special needs unit.

His cause of death was due to complications of chronic kidney and bladder infection from kidney stones leading to hemorrhagic bladder rupture. The manner of his death was natural.

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

Weeks before death	Event
1 week prior	<ul style="list-style-type: none">The incarcerated individual transferred from a prison inpatient unit to a prison special needs unit.
Day of Death	Event
1127 hours	<ul style="list-style-type: none">He was eating lunch in the unit day room when he became unresponsive.911 called.CPR was initiated.
1142 hours	<ul style="list-style-type: none">Community emergency medical services (EMS) arrived on grounds.
1221 hours	<ul style="list-style-type: none">Community EMS pronounced his death.

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 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.

1. The MRC found:

a. The incarcerated individual with a history of calculi-associated kidney and bladder inflammation died of an extremely dilated urinary bladder leading to

hemorrhagic bladder rupture.

- b. He carried serious chronic medical and mental health conditions, then experienced increased frailty and dependence for activities of daily living which necessitated a transfer from his residential care housing unit to the special needs unit. The referral specifically referenced the need for toileting support.
- c. The review demonstrated that this individual experienced negative symptoms of schizophrenia and depression and had a history of frequent declinations of care. Staff did not document assessment of the incarcerated individual's decisional capacity to decline care during the transfer nor on arrival to the special housing needs unit. The committee discussed transitions of care creating higher vulnerability for persons with cognitive and receptive differences.
- d. There was no documentation of multidisciplinary team meetings regarding his care management and the minutes of the Facility Medical Director transfer call indicate that his case was not managed via this care coordination venue.
- e. He had an indwelling urinary catheter with a leg collection device that was covered by clothing. The Root Cause Analysis performed by nursing revealed that the absence of a plan for catheter care contributed to his death. Prior to this review, there existed no "nursing home like" intake process to systematically ensure urinary catheter and collection device care in the special needs unit.
- f. For years to his final illness, he was housed in residential treatment unit with little interaction with other incarcerated individuals. He was transferred to an inpatient unit for several months, then to a dormitory setting in the special needs unit. These transfers may have exacerbated his lack of coping mechanisms for which the support in the residential treatment unit may have mitigated. The transfers themselves may have had a negative impact on his mental health symptoms. His interactions with health services staff remained consistent with little interaction and care declinations.

B. The MRC recommended:

- 1. Referring to the Unexpected Fatality Review Committee.
- 2. Additional Root Cause Analysis (RCA) with resultant action items by nursing leadership to examine and improve the following aspects of nursing care in special needs unit:
 - a. Orientation to staff and patients for individuals transferring from a residential treatment unit to special needs unit housing.

- b. Educating nursing staff on need to chart elements of the evaluation that were completed and not just note “wellness check”.
 - c. Requiring nursing assistants to document care provided in the health record.
 - d. Development of treatment planning that more closely emulates “nursing home level” of care in the special care unit.
- 3. Providing education to DOC Health Services staff regarding the process to evaluate decisional capacity.
- 4. Encouraging the use of multidisciplinary care team meetings that include primary care, nursing, and behavioral health team members for individuals with complex needs.
- C. The DOC discussed an additional finding out of the initial nursing RCA was that the certified nursing assistant (CNA) documentation was recorded on a log that is not part of the health record. The DOC Chief Nursing Officer (CNO) will be working with the facility to ensure all care is appropriately recorded in the health record. Additionally, the CNO will be educating staff regarding supporting incarcerated individuals that experience persistent mental health illness.
- D. The Department of Health (DOH) representative offered that in healthcare, if “something is not documented in the health record, it did not happen”. The DOH representative recommends that an accountability process be established, as education is not enough to address the documentation deficiencies. The DOH representative also recommends a formal process to determine if an incarcerated individual’s care needs can be met in their current housing setting. The DOH representative asked when multidisciplinary teams occur and recommends a formal process for when they are mandated.

Note: DOC currently has an established process for multidisciplinary team meetings. These meetings may include representatives from custody, primary care, nursing, and behavioral health. In this case, he was presented on the behavioral health transfer call. The discussion occurred several weeks prior to the individual transferring and a medical status update care handoff was not provided prior to his transfer.

- E. The Health Care Authority (HCA) representative asked about the protocol for monitoring external medical devices and the definition of a “wellness check” in the setting. The HCA representative supports expanded decisional capacity discussions.

Note: DOC stated that nursing orders and a care plan are developed for the management of medical devices like urinary catheters and are implemented. DOC acknowledged that wellness checks are not adequate documentation of care that is being provided.

- F. The Office of the Correctional Ombuds (OCO) representative shares the concerns of the other

representatives that the lack of documentation does not allow for a thorough care review and acknowledges that recommendations will be based on the information available. The OCO representative asks what support for activities of daily living (ADL) the incarcerated individual required when he was transferred.

Note: DOC stated that his needs for support with activities of daily living included day-to-day grooming like prompts for face washing and shaving, help with toileting, and some assistance with dressing. He was able to complete these tasks independently once prompted. He was assessed as being frail and a fall risk.

The OCO representative stated there is an opportunity to look at how transfer discussions and transfer decisions happen. The representative recommends expanding the transfer calls to include anyone transferring from a residential treatment level of care to both the behavioral health and medical transfer calls. The OCO representative asks how care managers are being used and whether one was used in this case.

The OCO representative stated that the incarcerated individual was transferred due to need for care and does not believe the transfer was completed timely. The OCO representative requests that UFR discussions lead to actionable recommendations coming from the committee. The OCO highlighted that some records identified as being necessary in this UFR, including nursing encounters and nursing records, were not available. The OCO representative recommended that nursing staff document in the health record and have a clear transfer process with written protocols.

Note: DOC is currently working on a system redesign for the medical transfer call to create a more interdisciplinary and systematic process to ensure the appropriateness of transfer. This individual was transferred to a facility staffed to provide more nursing care support and passed away suddenly. Electronic transfer orders show there was a medical hold in place preventing a transfer until necessary care was completed. The individual was transferred the date the hold expired.

The way the special needs unit was documenting care is no longer occurring and records regarding care and assessments will be kept in the health record. DOC agrees there should always be care needs hand off communication, so staff are aware of mental health and medical conditions.

The OCO representative discussed how reevaluating decisional capacity is necessary, and continuity of care should be consistent. The representative asked the UFR committee to make a recommendation to the residential treatment unit workgroup to require a multidisciplinary team that includes members of the medical team when transferring an individual with mental health needs to another facility.

Committee Findings

The incarcerated individual died from complications of calculi-associated pyelonephritis and cystitis,

including hemorrhagic bladder rupture. The manner of death was natural.

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 should provide education to DOC Health Services facility staff on the process to evaluate decisional capacity.
2. DOC Health Services should use a multidisciplinary care team meeting that includes primary care, nursing, and behavioral health team members for individuals with complex medical and mental health needs.
3. DOC ensure appropriate catheter care is being provided to all incarcerated individuals housed in prison facilities.
4. DOC should ensure that all nursing documentation is contained in the health record.

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 request the residential treatment unit workgroup require a multidisciplinary team when transferring an individual and develop an orientation and training to address impacts of transfer to other settings.
2. DOC should continue to pursue an electronic health record to support care transitions.