



Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-012 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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Table of Contents

Table of Contents	1
Legislative Directive and Governance.....	2
Disclosure of Protected Health Information.....	2
UFR Committee Members	3
Fatality Summary.....	4
Committee Discussion	5
Committee Findings.....	5
Committee Recommendations	5

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UFR-22-015 Report to the Legislature—600-SR001

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 June 9, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Command A
- David Flynn, Assistant Secretary
- Ken Taylor, Deputy Director Health Services
- Rae Simpson, Director of Nursing Services
- Dawn Williams, Program Manager – Substance Abuse Recovery Unit
- Brooke Amyx, Psychiatric Social Worker 4

DOC Prisons Division

- Tom Fithian – Senior Director – Correctional Operations
- Jeffrey Uttecht – Deputy Assistant Secretary of Prisons

DOC Reentry Division

- Susan Leavell, Senior Administrator
- Dave Ganas, Administrator

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Caitlin Robertson, Director

Department of Health (DOH)

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

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

Fatality Summary

Date of Birth: 1954 (67 years old)

Date of Incarceration: June 1982

Date of Death: February 2022

This review examines the case of a 67-year-old male incarcerated from June 1982 until the time of his death in February 2022. The incarcerated individual died during a medical procedure while in a community hospital. The cause of death was reported to be cardiovascular collapse due to complications of anesthetic administration.

The individual had multiple chronic conditions including chronic kidney disease, heart failure, mitral valve replacement, high blood pressure, and diabetes. He received treatment for a hepatitis infection in 2018 but had liver scarring that remained.

On February 11, 2022, he developed acute back pain and met with a registered nurse at the facility infirmary who recommended that he be treated with a short course of non-steroidal anti-inflammatory (NSAID) medication and ice. He returned to the infirmary on February 14, 2022, as his pain had not improved. He was assessed by an Advance Registered Nurse Practitioner (ARNP) and was started on a muscle relaxant in addition to the NSAID. The ARNP reassessed him on February 15, 2022. His back-pain had improved, but he reported that when he awoke in the morning, he continued to have spasms in his lower back. The ARNP provided him with his muscle relaxant medication dose, a water bottle and Lidoderm topical pain relief patch. That evening, a medical emergency was called for the individual as he was complaining of pain on his right side that radiated to the left side of his lower back. He also now needed assistance with transfers. The after-hours on-call practitioner was contacted who provided orders for him to be taken to the hospital for evaluation.

The incarcerated individual was admitted to the hospital on the evening of February 15, 2022, with back pain and an elevated white blood count. No signs of abscess appeared on the MRI performed at the hospital. Neurosurgery reviewed the findings and recommended no surgical intervention on imaging findings. He was treated with fluids for low sodium. While in-patient at the hospital, he received consults from nephrology, cardiology, and infectious disease services. On February 24, 2022, he was taken for a transesophageal echo (TEE), when he died unexpectedly. During the procedure, he stopped breathing and experienced cardiac arrest. The hospital attempted to revive him for over an hour. A return of pulse was achieved briefly twice with an unsuccessful attempt at using an external pacemaker for his heart.

Committee Discussion

- A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:
 - 1. Improved surveillance tools are needed to reliably track incarcerated individuals who have liver disease.
 - 2. Improved reliability of scheduling for follow-up appointments is needed on the part of schedulers and clinical staff.
- B. The DOC did not conduct a critical incident review (CIR) as the incarcerated individual's death occurred in a community hospital.
- C. The Office of the Corrections Ombuds (OCO) representative participated in the committee discussion and did not offer additional recommendations.
- D. The Department of Health (DOH) representative participated in the committee discussion and did not offer additional recommendations.

Committee Findings

While in the custody of DOC, this individual was admitted to the hospital and died during a medical procedure.

Committee Recommendations

The UFR committee did not offer any recommendations for corrective action.

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

- 1. Manage liver disease according to best practices, using DOC tools (form and guideline) and clinical decision support or specialty consultation when needed.
- 2. Improve reliability of scheduling follow-up on the part of schedulers and clinical staff.