Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-24-004

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 July 11, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Patricia Paterson, Chief of Nursing
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Ryan Quirk, Director – Mental Health
- Mark Eliason, Deputy Assistant Secretary
- Dr. Rae Simpson, Director – Quality Systems
- Deborah Roberts, Sentinel Event Program Manager
- Mary Beth Flygare, Health Services Project Manager

DOC Prisons Division

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

DOC Risk Mitigation

- Michael Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Madison Vinson, Assistant Corrections Ombuds - Policy

Department of Health (DOH)

- Ellie Navidson, Nursing Consultant, 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: 1980 (43-years-old)

Date of Incarceration: January 2021

Date of Death: February 2024

At the time of death, this incarcerated individual was housed in a DOC prison facility.

His cause of death was due to dilated cardiomyopathy. The manner of his death was natural.

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

Day of Death	Event
1113 hours	• Custody staff found the incarcerated individual unresponsive in his cell and began lifesaving measures.
1114 hours	• Facility medical staff arrived and assumed care.
1126 hours	• Community Emergency Medical Services (EMS) arrived and assumed care.
1147 hours	• EMS pronounced death.

UFR Committee Discussion

The UFR committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the DOC Critical Incident Review. The UFR committee considered the information from both reviews 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 committee found:

      a. The incarcerated individual received episodic problem focused medical and ongoing behavioral health care. The committee identified an opportunity for an annual wellness exam.

      b. During his intake physical exam, he reported a history of an irregular heartbeat as a child. Clinical evaluation was completed at his parent facility, and he was advised to declare a medical emergency if he experienced additional symptoms.

c. He was prescribed medication to assist in managing his mental health symptoms and increasing daily dosages. He did not receive follow-up testing to monitor medication effects. An electronic health record would have provided automatic notifications for follow-up testing. The committee identified opportunities for multidisciplinary care planning that would augment current prescribing practices, including monitoring and management of prescribed medications.

2. The committee recommended:

   a. A referral to the Unexpected Fatality Review Committee.

   b. DOC clinical leadership provide education for safe prescribing and medication monitoring guidelines.

B. 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.

1. The CIR found:

   a. Some tier checks were not in compliance with DOC Policy 420.370 Security Inspections.

   b. Facility automated external defibrillators (AED) were being replaced and standardized and staff were not trained on all available models.

   c. Custody and medical staff could improve communication and collaboration when medical emergencies arise.

2. A Root Cause Analysis (RCA) was conducted for the findings of the CIR and determined the CIR findings did not directly correlate to the cause of death and will be remediated per DOC Policy 400.110 Critical Incident Reviews.

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

1. Clinical care and impacts of facility transfers:

   The committee members concurred with the mortality review findings and recommendations for improvement in clinical care and collaboration.

   The committee discussed facility transfers and the potential impact the moves may have had on building trusting care relationships. DOC offered information on the transfer and housing process and the Department's commitment to housing individuals in the least restrictive, most supportive, and appropriate environment. DOC Health Services has weekly medical and mental health transfer calls and care navigators that help coordinate and follow complex incarcerated

individuals to assist with their transitions. In addition, the DOC classification process is used to assign incarcerated individuals to the least restrictive custody designation that addresses programming and other needs while providing for the safety of personnel, the community, and incarcerated individuals.

2. Emergency response:

   The UFR committee discussed DOC's medical emergency response process including readiness drills. DOC staff are basic life support (BLS) responders and provide care until community emergency response services arrive. Members offered practices from the community for consideration by DOC including visual identification for medical team lead.

   DOC provided information on the updates to the Automated External Defibrillators (AEDs). The committee agreed that AEDs are designed to be used correctly by lay people and that standardization or model specific training is not required.

   DOC has also established a collaborative workgroup between the Prisons and Health Services divisions to review and make recommendations to improve current emergency medical response processes to ensure that Department staff are equipped with information, skills and equipment needed to effectively respond to medical emergencies.

3. Tier checks:

   The committee discussed the intent and timing of tier checks. Custody tier checks were not consistently completed or documented as required per policy. The committee members recommended changing the name of tier checks to clarify purpose and function.

   DOC has also established a collaborative workgroup between the Prisons and Health Services divisions to review and make recommendations to improve current emergency medical response processes to ensure that Department staff are equipped with information, skills and equipment needed to effectively respond to medical emergencies.

Committee Findings

The incarcerated individual died as a result of dilated cardiomyopathy. The manner of his 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. Until an electronic health record system is implemented, DOC should provide education and care management guidelines that augment current prescribing practices and facilitate medication monitoring.

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

1. DOC should develop a written guidelines for the tier check process that will clarify the purpose and function.
2. DOC Health Services should work toward proactively offering an annual wellness exam visit for each incarcerated individual housed in a prison facility.
3. DOC should continue to pursue an electronic health record when full legislative funding becomes available to support care delivery.