



# Unexpected Fatality Review Committee Report

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## Unexpected Fatality UFR-23-019 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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UFR-23-019 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, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying 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 May 16, 2024:

### DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer for the Chief Medical Officer
- Dr. Eric Dant, Facility Medical Director – Airway Heights
- Dr. Rae Simpson, Director – Quality Systems
- Patricia Paterson, Chief of Nursing
- Darren Chlipala, Administrator
- 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
- Rochelle Stephens, Men’s Prisons Project Manager

### DOC Risk Mitigation

- Mick Pettersen, Director

### Office of the Corrections Ombuds (OCO)

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

### Department of Health (DOH)

- Ellie Navidson, Nursing Consultant Institutional, Healthy and Safe Communities

### Health Care Authority (HCA)

- Dr. Sophie Miller, Associate Medical Director

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

## Fatality Summary

Year of Birth: 1967 (56-years-old)

Date of Incarceration: April 2002

Date of Death: November 2023

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

The cause of death was arteriosclerotic and hypertensive cardiovascular disease. The manner of death was undetermined.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Day of Death	Event
0639 hours	<ul style="list-style-type: none"><li>• Tier check completed at his cell front.</li></ul>
0655 hours – 0711 hours	<ul style="list-style-type: none"><li>• He was found unresponsive.</li><li>• Medical response requested and aid rendered.</li></ul>
0714 hours - 0747 hours	<ul style="list-style-type: none"><li>• Community Emergency Medical Services (EMS) arrived and took over life saving measures.</li><li>• He was pronounced deceased by EMS.</li></ul>

## UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee and the Critical Incident Review. The UFR Committee members 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 death was unexpected.
- b. He had a history of significant traumatic brain injury with seizure-like events. He was followed by a neurologist and taking seizure prevention medication.
- c. There were no red flags that he was at high risk for sudden cardiac death.
- d. His cardiovascular risk score was below the recommended level for treatment with a cholesterol lowering medication.
- e. At times, his blood pressure was not optimally controlled. On several occasions he

declined to take medication for lowering his blood pressure.

- f. DOC's paper health record makes trending and monitoring changes in vital signs hard to assess over time.

2. The Mortality Review Committee recommended.

- a. A referral to the UFR committee.
- b. DOC Health Services (HS) should identify a process to support the monitoring and management of individuals with chronic medical conditions while using a paper health record.
- c. DOC should continue to support current high blood pressure management work.

- 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. There were missed tier checks that were logged as completed in the logbook. The missed tier checks were not communicated with the booth officer.
- b. The medical emergency response kit was missing items, and the manual suction device was ineffective.

2. The CIR recommended:

- a. Forming a DOC workgroup with the specific aim of designing and executing a strategy to enhance compliance with tier checks and red bag inventory; and
- b. Conducting an evaluation of portable suction devices by the Health Services leadership team.

- C. The UFR committee reviewed the unexpected fatality and discussed the following topics.

1. Medical care and emergency response.

Committee members noted CPR was provided quickly and Narcan was deployed.

The incarcerated individual had appropriate work-up for reported shortness of breath and cardiovascular risk. Treatment options for blood pressure control were discussed and offered to him. He was involved in his care planning with his providers and due to perceived side effects, he inconsistently took his prescribed blood pressure medication.

DOC Health Services clinical leadership is planning to replace current manual portable suction device with a battery powered unit.

## Committee Findings

The manner of the incarcerated individual's death was undetermined. The cause of death was arteriosclerotic and hypertensive cardiovascular disease.

### **Committee Recommendations**

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

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

1. DOC should continue to pursue an electronic health record when full legislative funding becomes available.