Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-025

Report to the Legislature

As required by RCW 72.09.770

November 10, 2022

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 November 10, 2022:

DOC Health Services

- Dr. Frank Longano, Deputy Chief Medical Officer
- Dr. Kasey Gregory, Facility Medical Director CBCC
- Mark Eliason, Deputy Director Health Services
- Rae Simpson, Director Quality Systems
- Mary Beth Flygare, Program Manager
- Keith Parris, Project Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Jeri Boe, Superintendent CBCC

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Policy Advisor

Department of Health (DOH)

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

Health Care Authority (HCA)

- Dr. Charissa Fotinos, Medicaid Director

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

Fatality Summary

Date of Birth: December 1985 (36-years-old)

Date of Incarceration: May 2016

Date of Death: August 2022

The incarcerated individual was a 36-year-old man who was involved with the Washington State Corrections system since 2007. Shortly before his death, he was seen for what was believed to be an infected spider bite. He was treated with antibiotics. Although the spider bite was improving, he then developed the symptoms of Stevens-Johnson Syndrome/toxic epidermal necrolysis (SJS/TEN). This is an unpredictable, rare, serious, and potentially fatal skin and mucous membrane condition that occurs as a reaction to certain medications or infections. He was transferred to a community hospital where the diagnosis of SJS/TEN was confirmed. He died several days later as a result of a large blood clot (embolism) in his lungs secondary to being immobilized on a ventilator while undergoing treatment for SJS/TEN. The manner of his death was natural.

During his most recent incarceration, he completed the Roots of Success, Beekeeping, Partners in Parenting, Lean Basics, and Correctional Industries Worker Safety Training programs. He was known as a musician and an artist. He was a facilitator for the Black Prisoners' Caucus Liberation Arts program and a volunteer for the beekeeping class.

A brief timeline of the incarcerated individual's illness:

Day	Event
Day 1	He was seen and treated for what he believed was an infected spider bite on his abdomen.
Day 2	During a follow-up visit for dressing change, he reported feeling worse and was sent to the local emergency room for evaluation. The hospital physician noted the medical actions taken at the facility were appropriate.
Day 3	The incarcerated individual returned to the facility from the hospital emergency room and reported feeling better. The care plan was to continue daily dressing changes with nursing and finish the prescribed medications. A follow-up appointment with a provider was scheduled for five days later.
Day 7	He had a follow-up visit with a provider. He reported improvement. There were no changes made to his care plan. He was scheduled for follow-up with a provider in seven days.
Day 14	At his follow-up visit with the provider, he reported eye redness/soreness, lip swelling, and trouble swallowing. He was initially admitted to the facility in-patient unit for observation and IV fluids. After the ARNP consulted with the physician on duty, he was transferred to the local hospital for the suspected diagnosis of SJS/TEN.

Day 14 (cont.)	The hospital physician agreed with the SJS/TEN diagnosis and consulted a dermatologist at the Harborview burn unit who recommended a treatment plan and stated the incarcerated individual did not currently meet criteria for transfer to Harborview. He was admitted to the local hospital for treatment.
Day 17	His SJS/TEN symptoms were progressing. He was intubated and placed on a ventilator for airway protection. The hospital again consulted with Harborview burn unit who agreed to accept him for transfer.
Day 22	He was airlifted to Harborview and admitted to the burn ICU for care.
Day 25	He died as a result of a large blood clot (embolism) in his lungs secondary to being immobilized while on a ventilator during his treatment for SJS/TEN.

Committee Discussion

A. The DOC mortality review committee reviewed his health record, the circumstances of his death and presented the following for discussion:

1. Throughout his hospital stay, the DOC facility medical staff continued to monitor his progress and document his status.
2. He had no known medication allergies.
3. Once he presented with signs of SJS/TEN, the danger was immediately recognized and reviewed collaboratively with a physician. He was urgently referred to a higher level of care and admitted to the hospital without delay.
4. The medical treatment chosen by the facility team appears to have been appropriate and timely.
5. The mortality review committee was unable to identify areas for improvement with the care provided by DOC personnel.

B. Independent of the mortality review committee, 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. The initial kite sent by the incarcerated individual requesting to be seen by medical staff and the wound care flowsheets could not be located at the time of the critical incident review.
2. Signature stamps are not being utilized on medical chart entries. Per DOC protocol, all medical chart entries should be stamped or have a printed name and title.
3. The entries in the Incident Management Reporting System documenting movements of the incarcerated individual were not updated appropriately when he returned from the initial emergency room visit and when he was airlifted to Harborview.

4. The Facility Religious Coordinator did not make rounds in the incarcerated individual's unit after his death, nor was a memorial service offered to the incarcerated population.

5. The DOC critical incident stress management team was not deployed for staff support after the incarcerated individual's death.

The CIR recommendations did not directly correlate to the incarcerated individual's cause of death and will be remediated per DOC Policy 400.110 – Reporting and Reviewing Critical Incidents.

C. The Office of the Corrections Ombuds, the Health Care Authority and the Department of Health representatives concurred with the findings and did not offer additional recommendations.

Committee Findings

1. The incarcerated individual died as a result of a large blood clot (embolism) in his lungs secondary to being immobilized on a ventilator while undergoing treatment for Stevens-Johnson Syndrome/toxic epidermal necrolysis.

2. The medical treatment chosen by the facility team appears to have been appropriate and timely.

Committee Recommendations

1. The UFR Committee members did not offer any recommendations for corrective action.