Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-021

Report to the Legislature

As required by RCW 72.09.770

March 19, 2024

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

Cheryl Strange, Secretary
cheryl.strange@doc.wa.gov

Table of Contents

Unexpected Fatality Review Committee Report

UFR-23-021 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 February 8, 2024:

DOC Health Services

- Dr. Frank Longano, Chief Medical Information Officer representing the Chief Medical Officer
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Prisons Division

- James Key, Deputy Assistant Secretary

DOC Risk Mitigation

- Mick Pettersen, Director

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services
- Ellie Navidson, Nursing Consultant Institutional, Health and Safe Communities

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1959 (64-years-old)

Date of Incarceration: 2008

Date of Death: November 2023

At the time of his death, the incarcerated individual was housed in a prison facility. His cause of death was metastatic liver cancer. The manner of death was natural.

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

Approximate Months prior to death	Event
18 months prior	• Incarcerated individual was seen by his primary provider for weight loss, low energy, and abdominal pain. • An urgent referral was submitted to community gastroenterology and hematology for diagnostic consultation.
17 months prior	• Specialty medical consults occurred. • Additional diagnostic testing requested by specialty consultants.
15 months prior	• Abdominal ultrasound demonstrated abnormal findings. • Radiologist recommended a dedicated liver CT scan to evaluate further. • No documentation that this abnormal finding was received or reviewed by the requesting community consultant or by his DOC provider.
13 months prior	• Seen for follow-up at the request of the incarcerated individual to discuss ultrasound results, ongoing symptoms, and new swelling in neck. • No documentation that the abnormal ultrasound was discussed or further work-up of weight loss or dizziness was considered.
12 months prior	• The incarcerated individual was sent to a community hospital for abdominal pain and weight loss. • In the hospital, an abdominal ultrasound was performed, but it did not show the abnormal findings seen in the prior ultrasound. The quality of the ultrasound result was documented as "poor". • In the documentation, the emergency department provider noted the original abnormal ultrasound result and determined an additional CT scan was recommended and to follow-up on an outpatient basis.

	• Neither the community specialist nor DOC providers ordered the recommended CT scan.
9 months prior	• Diagnostic testing was completed by the community gastroenterologist. • Results indicated inflammation but no malignancy in the intestinal track.
8 months prior	• Follow up appointment with hematologist/oncologist who recommended a liver CT scan based on the original abnormal ultrasound findings. • Urgent CT scan ordered and scheduled. • Results revealed a large mass with possible metastatic growth in the liver. • Biopsy positive for liver cancer. • Follow-up and treatment with oncologist scheduled.
6-7 months prior	• Chemotherapy treatment initiated. • Second chemotherapy treatment was complicated by infection requiring hospitalization. • He declined further chemotherapy treatment due to side effect concerns which he felt would interfere with his family visits. He was counseled by DOC staff and signed an informed declination of care.
3- 5 months prior	• He continued to be monitored by his oncologist. • Follow-up CT scan indicated metastatic spread. • He elected to begin palliative treatment and supportive care.
2 months	• Multiple visits to the emergency room for symptom management. • Seriously ill notification initiated. • Extraordinary medial placement (EMP) was requested.
1 month	• Incarcerated individual requested full treatment and full code response. • EMP request passed clinical screening and was advanced to next step.
Final month	• The incarcerated individual updated his Physician Order for Life Sustaining Treatment (POLST) order to Do Not Resuscitate (DNR) and elected for comfort focused care. • His health continued to deteriorate. • The EMP process was stopped at the request of his family and care team due to concerns that transfer would cause more harm than benefit.
Day of death	**Event**
Day of death	• The incarcerated individual died while being cared for in the facility IPU.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from the review 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 CT scan recommended in the abnormal ultrasound report was not ordered resulting in a delay in care.
        b. The possible causes for the unintentional weight loss experienced by the incarcerated individual were not explored by the DOC primary care provider.
        c. The Department of Corrections lacks a standard process for receiving and reviewing consult reports and test results.

    2. The Mortality Review Committee recommended.

        a. A referral to the UFR committee.
        b. A multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) be conducted to look at the identified care delays related to system failures.
        c. DOC explore development of a statewide tracking tool to ensure that results are received and appropriately managed.

B. The Department of Health (DOH) representative discussed the large gaps in time between care and acknowledged the impact not having an electronic health record has on care delivery. The DOH representative asked that the gaps in care be explained and addressed.

    Note: DOC explained that currently there is no standard process for obtaining results from offsite visits which contributed to gaps in care. Ultimately it is the responsibility of all providers to follow-up on care requests and results. DOC Health Services is exploring options to improve care coordination with community consultants including obtaining results and reports from offsite care.

    The DOH representative asked DOC to describe the seriously ill notification process. DOH also asked why the incarcerated individual was found ineligible for Extraordinary Medical Placement (EMP) the first two times they applied and after he was approved by health services the process stopped.

    Note: The seriously ill notification is a status determined by clinicians when an incarcerated individual is significantly ill and has the potential to decline. This notification is a way for Health Services to notify custody, religious coordinators, and other partners of the incarcerated individual's status. This supports flexible visitation and facilitates provider communication with next of kin.

    At the time of his initial application, the Extraordinary Medical Placement (EMP) law required an individual to be physically incapacitated in order to qualify. In 2023, the law changed to allow

eligible incarcerated individuals, who have prognosis of six months or less to live, to transition into an appropriate community setting. In addition to the medical criteria, approval to participate in the EMP program requires meeting custody and community safety criteria.

Once he was approved for EMP, the family requested to stop the placement process as it may do more harm than good to move him away from his care team. This request was supported by his care team.

The DOH representative was concerned that the incarcerated individual declined his third chemotherapy treatment to not miss an opportunity to visit with his family. The DOH representative asked if there is an option to extend family visits due to end-of-life care to avoid having to choose between care and visitation with loved ones.

Note: DOC shared that the incarcerated individual was experiencing side effects from the chemotherapy. He indicated he was too tired after treatment and chose to stop so he would feel well enough to visit with his daughter.

DOH would like to see the term "Offender" removed from the DOC electronic death report.

Note: DOC will explore the ability to change name of the death report in the software.

C. The Health Care Authority (HCA) representative asked if the incarcerated individual was tested for Hepatitis C.

Note: DOC stated that he was tested in 2022 and was positive for Hepatitis C antibodies with no evidence of active infection requiring treatment. DOC currently treats individuals with active Hepatitis C infections.

D. The Office of the Corrections Ombuds (OCO) supports the committee recommendations including the exploration of the development of a statewide tracking tool for test results and recommends including tracking of nutritional status and weight loss. The OCO representative asked if DOC is working on a corrective action plan to address monitoring nutritional status and weight loss.

Note: DOC has one dietician for the state. The CMO and dietician have discussed development of a support tool but no specific timeline for deployment. DOH representatives met with the DOC nutritionist and provided resources and tools available through DOH to support incarcerated individuals experiencing unintended weight loss.

The OCO representative reported they had received concerns from this family related to delays in his care and were able to elevate the concern to DOC Health Services. OCO wants to make sure that the provider investigation led to results within DOC.

Note: DOC investigated the reported concern, and the concern was appropriately addressed with the provider.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was metastatic liver cancer.

Committee Recommendations

1. DOC should conduct a multi-disciplinary Healthcare Failure Mode and Effect Analysis (H-FMEA) to look at this case in addition to two other cases previously identified with care delays.
2. DOC should explore the development of a tracking tool for external provider consult reports and test results.

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

1. DOC should look for opportunities to continue partnering with DOH on nutrition and unintended weight loss support resources.
2. DOC should continue to implement the Patient Centered Medical Home model of care to offer multidisciplinary team support and care planning for individuals with nutritional and weight related challenges.
3. DOC should explore removing the word "offender" from the DOC electronic death report.