Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-035

Report to the Legislature

As required by RCW 72.09.770

March 9, 2023

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 February 9, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Areig Awad, Deputy Chief Medical Officer
- Dr. Zainab Ghazal, Administrator
- Mark Eliason, Deputy Director Health Services
- Rae Simpson, Director Quality Systems
- Nancy Fernelius, Clinical Nurse Educator
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director

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: 1948 (74-years-old)

Date of Incarceration: October 2009

Date of Death: November 2022

This case was referred for an unexpected fatality review after the DOC Mortality Review Committee determined the cause of death for this individual met the statutory definition of unexpected (not the result of a documented terminal illness or other debilitating or deteriorating condition).

The incarcerated individual was a 74-year-old man who has been incarcerated since October 2009. During his incarceration, he worked as custodian and library assistant. He had a history of multiple chronic medical conditions including an abdominal aortic aneurysm (bulging of the lower part of the aorta which could be life threatening if ruptured) which was repaired with a surgical graft procedure in 2020. His graft repair became infected which is an uncommon event and unfortunately did not respond to treatment. His cause of death was sepsis (an infection of the blood stream). The manner of his death was natural.

A brief timeline of the incarcerated individual's final illness:

Day(s)	Event
Days 1 –14	The incarcerated individual was sent out to the local hospital after being evaluated for a fever and confusion. He was admitted for treatment.
Day 14	A seriously ill notification was made to his next of kin.
Day 19	The hospital consulted physicians from the University of Washington, who determined there were no additional surgical options available and the only treatment option was continued use of antibiotics to suppress the infection.
Day 24	He is sent to the local hospital for evaluation of worsening abdominal pain. Hospital staff determined no further treatment is available and discharge him back to the facility infirmary.
Days 25 - 29	Facility medical staff continue to provide supportive treatment and the incarcerated individual discusses transitioning to comfort care with his family.
Days 30 - 37	The incarcerated individual requested comfort care with no further hospitalizations. Facility medical staff consulted local hospice provider and appropriate end-of-life care was provided.
Day 38	The incarcerated individual was pronounced deceased at 18:28 hours.

Committee Discussion

A. The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:

   1. In 2020 the incarcerated individual was appropriately referred for abdominal aortic aneurysm screening based on his smoking history which was positive for an aneurysm that required surgical repair.

   2. He had the aneurysm repaired with a graft to reinforce the wall of the blood vessel and prevent it from rupturing.

   3. In addition to the infection of his surgical graft, he had a history of significant high blood pressure, high cholesterol, heart disease, chronic lung disease, low thyroid, degenerative spine disease, and experienced shortness of breath and dizziness with exertion.

   4. Based on this information the consulting physician from the University of Washington determined he was medically fragile and would not survive a surgical procedure to remove and repair the infected graft. It was determined the only possible treatment option was continued antibiotics.

   5. When his condition continued to deteriorate, the individual with the support of his family chose to transition to comfort care. The facility medical staff consulted with local hospice providers and provided appropriate end of life care until his death.

   6. The DOC Mortality Review Committee (MRC) members voted to refer this case for unexpected fatality review because it is unexpected for the cause of death to be an infection that did not respond to treatment.

   7. DOC MRC members did not identify any recommendations to prevent a similar fatality in the future. Medical care provided to this individual for this event appeared to be appropriate and timely.

B. Independent of the mortality review, the DOC conducted a fact-finding review to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures.

   1. The review did not identify any opportunities for system improvements.

C. The Office of the Corrections Ombuds (OCO), Department of Health (DOH), and Health Care Authority (HCA) concurred with the findings and did not offer additional discussion or recommendations.

Committee Findings

1. The incarcerated individual died from sepsis due to an infection that did not respond to appropriate medical treatment.
2. With the input and support of his family, he was transitioned to comfort care for his end-of-life support.

Committee Recommendations

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