Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-022

Report to the Legislature

As required by RCW 72.09.770

August 29, 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 August 18, 2022:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Ronna Cole, Deputy Director Health Services
- Paul Clark, Administrator

DOC Prisons Division

- Donald Holbrook, Deputy Assistant Secretary

DOC Reentry Division

- Scott Russell, Deputy Assistant Secretary
- Dave Ganas, Administrator

DOC Community Corrections Division

- Mac Pevey, Assistant Secretary
- Kristine Skipworth, Regional Administrator East
- Dell-Autumn Witten, Administrator
- Donta Harper, Regional Administrator Northwest

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. Emily Transue, Associate Medical Director

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

Fatality Summary

Date of Birth: May, 1989 (33-years-old)

Date of Incarceration: July, 2020

Date of Death: May, 2022

The incarcerated individual was a 33-year-old male incarcerated with DOC from July 2020 to June 2021 at which time he was released on community custody supervision. There was an active Secretary's Warrant (SW) for his arrest due to his failure to comply with his release conditions that required him to meet with his assigned Community Corrections Officer (CCO). His death was caused from a brain stem herniation resulting from a bacterial abscess. The manner of his death was natural.

In April 2022, he was arrested by local law enforcement for new community charges and detained at a community jail. Upon his intake at the jail, a medical screening was completed. He did not report any health issues and medical staff did not identify any concerns.

A review of his activity log is as follows:

Seven days after his arrest, he participated in afternoon recreation. That evening he experienced a medical event and was assessed by jail nursing staff. The nurse noted he was sitting and appeared confused. During the assessment his condition improved and he was able to follow verbal prompts, and was oriented to place, time and self. His initial vital signs were within normal limits. They were taken two additional times during the shift and remained stable. The nurse did not witness a loss of consciousness or seizure type activity. Upon completion of the assessment he walked to an observation cell for on-going monitoring by jail custody staff.

On day eight, he spoke with his attorney. A DOC hearings officer attempted to meet in person with the incarcerated individual to discuss his violation for failing to report to his CCO as required. The hearings officer reported that he attempted to engage the incarcerated individual several times and did not receive a response. He left and returned a short while later with a second DOC hearings officer who could act as witness to the attempts to engage the incarcerated individual in the hearings process. They observed the incarcerated individual lying on his back with his eyes closed. He was breathing and appeared to be comfortable. Prior to leaving, the hearings officers said to the incarcerated individual that a full hearing would be scheduled to review his violation.

On day nine, jail documents note that he declined to shower and refused to participate in a medical "sick call." He received all three of the daily meals.

Ten days after his arrest, he showered and received a new uniform in the afternoon. He received all three of his meals. Later in the evening, a jail officer declared a medical emergency on his behalf. He was found on the floor and was unable to respond. His pupils were unequal, saliva was dripping from the left side of his mouth, his hands were "contracted," and his vital signs were abnormal. Jail staff called

emergency medical services and he was transported to a community hospital for evaluation and treatment.

At the community hospital he was diagnosed with a large brain abscess. He underwent emergency surgery to drain the abscess and relieve the pressure on his brain stem. He was also started on antibiotics to treat the infection. Despite treatment his brain continued to swell. After the surgery he never regained consciousness. The hospital spoke with his family regarding his condition and his inability to recover. His family alongside the treatment team made the determination not to pursue additional surgical options and ultimately to remove him from life support.

Committee Discussion

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

During the time of his prison incarceration, he did not request or receive medical, mental health, or dental services other than the required screening exams.

1. In July 2020, DOC intake physical determined that he was healthy and had no medical diagnoses requiring ongoing care.
2. In July 2020, DOC intake dental exam showed two of his top teeth were non-restorable and four bottom teeth were decayed to or below the gums. The dental exam findings were reviewed with him at the time of the appointment. He signed the intake screening form indicating that he had been informed of and understood the findings of the examination and recommended treatment.
3. The committee discussed the possible bacterial source for the development of a brain abscess.
    a. There was no evidence found that the incarcerated individual was injecting drugs which could have introduced the bacteria into his system.
    b. There is a possibility the bacteria entered his system through decay in his teeth. There was no information available for review regarding any dental care he may have received while residing in the community during the twelve months prior to his death.
    c. At the time of his DOC intake dental screening, there was nothing charted indicating that he was at a high risk of suffering a fatal event due to his oral health.
4. The mortality review did not identify any definitive DOC care gaps that may have contributed to the brain abscess that caused the incarcerated individual's death.
5. The committee recommended a retrospective quality assurance audit of records for DOC violators housed at the community jail to ensure contract requirements have been met.

Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the

facts surrounding the unexpected out of custody fatality and to evaluate compliance with DOC policies and operational procedures while the individual was incarcerated. DOC does not have any jurisdiction to review the operations or procedures of the contracted community jail.

The CIR found:

1. The supervised individual released from his final prison facility to the community in June 2021. After his release to the community, he failed to report for supervision as required.
2. His community supervision intake was not completed due to his failure to report for meetings with his Community Corrections Officer (CCO) and a Secretary's Warrant was appropriately issued.
3. Due to his failure to report for supervision, the CCO was not able to have any face-to-face contacts or perform required drug testing with the supervised individual.
4. The supervised individual was not involved in any known programming during his time in the community.
5. CIR recommendations were administrative in nature and did not directly correlate to the cause of death. They will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and recommended the following:

1. DOC conduct a review of the community jail's records to verify contract compliance.

The Department of Health and Health Care Authority representatives participated in the committee discussion and did not offer additional recommendations.

Committee Findings

1. While incarcerated in a DOC facility, the incarcerated individual was informed of his serious dental decay and possible health impacts. Despite this information the incarcerated individual did not request nor receive dental or medical care during his incarceration. There was no information available for review to determine if he sought or received care in the community.
2. While out of department custody and on warrant status, the incarcerated individual developed a bacterial brain abscess causing brain stem herniation leading to his death.

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***
A retrospective quality assurance audit of records for DOC violators housed at the community jail where the incarcerated individual was housed to ensure contract requirements have been met.

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

- Community jail leadership requested DOC conduct a UFR debrief with community jail custody and medical leadership.