Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-21-004

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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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 16, 2022:

DOC Health Services

- David Flynn, Assistant Secretary, Health Services
- Scott Russell, Deputy Assistant Secretary
- Ken Taylor, Deputy Assistant Secretary
- Dr. Frank Longano, Acting Chief Medical Officer
- Dr. Lisa Anderson-Longano, Chief Quality Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Health Services Administrator, Command A
- Kathy Reninger, Health Services Administrator, Command B
- Ronna Cole, Health Services Administrator, Command C
- Rae Simpson, Director of Nursing
- Candy Tribbett, Project Manager (UFR Facilitator)
- Johanna Painter, Executive Assistant (UFR facilitation support)

DOC Prisons Division

- Michael Obenland, Assistant Secretary, Men's Prisons Division

DOC Office of the Deputy Secretary

- Tomas Fithian, Senior Director, Correctional Operations

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Sonja Hallum, Interim Director
- Dr. Patricia David, Director of Patient Safety & Performance Review

Department of Health (DOH)

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities
- Elizabeth Cayden, Unit Supervisor, Suicide Prevention Program

Health Care Authority (HCA)

- Charissa Fotinos, Associate Director, Medical Services

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

Fatality Summary

Date of Birth: 1951 (70 years old)

Date of Incarceration: May 2010

Date of Death: November 25, 2021

On November 23, 2021, at approximately 10:40 am, a medical emergency was announced in the assigned living unit. An incarcerated individual, while being assisted up from the commode by a nursing assistant, fell to the ground striking his head and facial area. Following immediate medical response, the individual was transferred and admitted to a community hospital. Providers at the hospital diagnosed the individual with facial fractures and bleeding in his brain. Following consultation with family members, his court-appointed guardian chose comfort care.

Two days later, on November 25, 2021, the individual was pronounced deceased by hospital providers. The cause of death was listed as respiratory failure and bleeding in the brain secondary to the fall. Nonverbal dementia was a contributing cause.

DOC interviews with the nursing assistant and the physician's assistant at the scene, during the emergency response, describe the fall as witnessed by the nursing assistant who had been pulling up the individual's underwear after he stood up from the toilet.

The individual had a history of high cholesterol, hypertension, seizures, anemia, chronic back pain, witnessed falls, and dementia. He took medications for mental health symptoms and seizure prevention. Due to his dementia, the patient was housed in a specialized unit with access to assistive care. He received help with daily hygiene tasks and a therapy aide accompanied him during walks.

Committee Discussion

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

1. Medication management in elderly patients,
2. Medical documentation,
3. Fall-risk management, and
4. Advanced dementia management.

The mortality review included a root cause analysis of the fall conducted by a multidisciplinary workgroup facilitated by nursing leadership. The root cause analysis identified a fall occurred in the bathroom of a specialized unit while the individual was being attended to by a certified nursing assistant

(CNA). Without warning, the individual had a seizure like event, and the CNA was unable to stop the fall. The individual was not wearing a gait belt because he walked independently. The root cause analysis underscored the need to increase employee awareness of fall prevention for patients at a heightened risk for falls.

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. The CIR included the following recommendations for UFR consideration:

1. Making clear, specific radio communications during emergencies,
2. Communicating to responders what is needed at the scene,
3. Reinforcing the importance of following clinical protocols, and
4. Reiterating expectations for what equipment should be brought to all medical emergencies.

The Office of Corrections Ombuds (OCO) discussed the absence of periodic formal fall risk assessments for this individual and the lack of a clinical evaluation and root cause analysis after previous documented falls by this individual. The OCO discussed the following recommendations for UFR consideration:

1. Improving the management of falls in older individuals by performing periodic rescreening and education on what constitutes a fall risk,
2. Building multidisciplinary fall-prevention teams that include a pharmacist, a dietician, a physical therapist, and a nurse,
3. Completing after-fall investigations that include injury assessment and root cause analysis,
4. Prompt replacement of broken clinical equipment (an otoscope was not working), and
5. Ensuring follow-up appointments after a course of treatment depending on the condition.

The Health Care Authority (HCA) representative further supported the OCO's recommendation to improve the DOC fall-prevention program and discussed the importance of supportive assistance to all employees including health services after a traumatic incident. DOC has these supports in place and employees have been referred to the DOC critical incident stress management process.

The Department of Health (DOH) representative offered no additional comments or recommendations.

Committee Findings

Due to an accidental, witnessed fall while in custody of the DOC, the individual died as the result of his injuries sustained.

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***
1. When a medical emergency occurs, reinforce the expectation for employees to describe the situation clearly so that the responders bring the necessary equipment.
2. Clarify the requirements for responders, including medical employees, to bring necessary equipment to avoid the potential for a delay of care.
3. Reinforce expectations for following emergency response practices and protocols.
4. Accurately identify older adults at risk for fall through periodic screening and improve employee knowledge on recognizing fall risks.
5. Reduce fall risks by involving an interdisciplinary team to address all aspects of fall prevention, which may include: a. Prescribers and/or nurses to conduct screenings and carry out post-fall assessments. b. Physical therapist(s) to assess function/mobility levels, determine need for assistive devices, and develop exercise program to improve balance and gait. c. Clinical pharmacist to review medication lists of patients at high risk and identify medications that may increase fall risks.
6. When an individual sustains a fall, even if the fall seems minor or is unwitnessed, the DOC should develop and implement a process to assess if there are injuries and the cause of the fall, including clinical evaluation to assess for injury and a root cause analysis to assess for cause.
7. Replace broken clinical equipment promptly.
8. Ensure follow-up appointments after a course of treatment is completed to improve individual outcomes.
9. Provide prompt referral to specialist when no improvement is noted or when progression of disease is observed that increases risk of injury or safety of a patient.