Unexpected Fatality Review Committee Report

2021 Unexpected Fatality UFR-21-002

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

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Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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The Washington State Department of Corrections acknowledges that its facilities, offices and operations are on the ancestral lands and customary territories of Indigenous Peoples, Tribes and Nations. Corrections is thankful to the Tribes for caring for these lands since time immemorial and honors its ongoing connection to these communities past, present and future. We welcome the opportunity to collaborate with the Indigenous populations and communities and strive to work without Tribal partners to improve the lives of Indigenous People and non-Indigenous neighbors throughout the state.

Learn more about Corrections' values

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Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the Office of the Corrections Ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Disclosure of Protected Health Information

As part of conducting a UFR, the assistant attorney general provided the opinion that the mandates in RCW 72.09.770 requires the department to disclose health information to the UFR committee members including mental health and sexually transmitted diseases. However, the state does not have the authority to supersede federal law prohibiting the disclosure of substance use information. Any information related to substance use has been excluded.

UFR Committee Meeting Information

Meeting date: November 17, 2021 via virtual

conference

Committee members in attendance

DOC Health Services

- Dr. Sara Kariko, Chief Medical Officer
- Dr. Lisa Anderson-Longano, Chief Quality Officer
- Dr. Karie Rainer, Director of Mental Health
- Scott Russell, Deputy Assistant Secretary
- Kathy Reninger, Health Services Administrator, Command B
- Debra Dobson, Executive Assistant (UFR meeting notetaker)

DOC Office of the Deputy Secretary

- Tom Fithian, Senior Director of Correctional Operations

DOC Risk Management

- Inger Brinck, Director (UFR meeting facilitator)
- Pamela Yates, Management Analyst

Office of the Correction Ombuds

- Joanna Carns, Executive Director
- Dr. Patricia David, Director of Patient Safety & Performance Review

Department of Health

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

Patient Information

The patient was a 61-year-old male with a history of diabetes, heart disease, chronic lung disease and mental illness. He began his period of incarceration in February 2009 and died in August 2021. Per the death certificate, the cause of death was chronic hypertensive cardiovascular disease. Other conditions that contributed to his death were blunt injury of the left leg with thigh hematoma, and diabetes.

Incident overview

Two days prior to this individual's death, a DOC nurse noted that the patient appeared very pale and demonstrated an unsteady gait. She assessed the patient and reported that his skin was very cool and clammy, and his speech was slurred and incoherent. The patient reported that he fell and struck the left side of his head. A fall was not witnessed. The patient stated he was very tired but did not report any pain. The nurse reported findings to the DOC provider who ordered the patient be sent to the EvergreenHealth Emergency Department via 911. The patient was subsequently admitted to EvergreenHealth.

In the hospital, signs of trauma to the left thigh were noted on exam and advanced imaging revealed a large hematoma. The patient was treated with IV fluids, antibiotics, and surgical evacuation of the deep hematoma.

In the early morning hours on the day of death, the DOC Corrections Officer on hospital watch observed the patient becoming agitated and unable to sleep. He alerted hospital nursing staff. The patient became unresponsive, and a medical code was called. EvergreenHealth medical staff attempted life-savings measures that were unsuccessful, and the time of death was called at 0411.

Discussion

At the UFR meeting on November 17, 2021, DOC staff first presented their findings of the department's Critical Incident Review. The department found that staff responded to the incident according to DOC policies and protocols and did not identify any corrective actions.

The department then presented findings of its clinical mortality review. The review noted that the patient was being evaluated for ongoing heart issues by his primary care advanced practitioner and was seen by cardiology via telehealth in the same month of his death. The review noted that the individual had been a long-term resident of a mental health residential treatment unit within a major prison, where he had routine contact with nursing staff three times per day during medication administration rounds. He did not report a leg injury to staff.

Following the department's presentations, the Office of Corrections Ombuds shared findings of their review. The OCO observed that the patient's medical records suggest he had changed medications three times in the two weeks prior to his death, which could have increased his fall risk. The primary care provider also had noted that the patient seemed unsteady at times.

The committee discussed:

- The potential for severe mental illness to create barriers to chronic care
- Potential risks of polypharmacy including fall risk, especially among older patients
- Fall risk identification
- Notification of primary care providers of falls
- Next of Kin contact information was not promptly accessible for death notification
- How deaths are identified as expected versus unexpected in Washington prisons
- Team-based healthcare delivery
- Legibility of handwriting in paper-based medical records (note-the department was previously aware of instances of illegible chart entries, and has planned corrective action as per UFR-21-001)

UFR Committee Recommendations

Due to the patient's medical conditions and health history, the committee did not identify recommendations that could have prevented the patient's death. However, as noted above, the department's CIR and CMR and the OCO's review outlined several areas for improvement that could enhance patient safety and mitigate fatality risk. The recommendations identified by the committee are provided in Appendix 1.

DOC Corrective Action Plan

The statute requires DOC to develop and publish an associated Corrective Action Plan within ten days of publication of this report. The CAP will be published by the statutory deadline.

Appendix 1

Unexpected Fatality Review Committee Recommendations

Committee Recommendations
1. Consistently categorize deaths as expected or unexpected.
2. Improve educational efforts on the risks of polypharmacy.
3. Conduct routine fall risk assessments for high-risk patients.
4. Improve access to health care services for severely mentally ill patients.
5. Establish team-based care staffing and processes as the standard approach to overall patient care.
6. Improve reliability of primary care provider notification after a fall.