



Unexpected Fatality Review Committee Report

2021 Unexpected Fatality UFR-21-001 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.

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2021 UFR-21-001 Report to the Legislature – 600-SR001

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 4, 2021 via virtual conference

Committee members in attendance

DOC Health Services

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

DOC Men's Prisons Division

- Mike Obenland, Assistant Secretary

DOC Office of the Deputy Secretary

- Tom Fithian, Senior Director of Correctional Operations

DOC Risk Management

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

Office of Corrections Ombuds (OCO)

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

Department of Health

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

Patient Information

The patient was a 77-year-old white male who was incarcerated from January 2004 until the time of his death in August 2021. The patient had an extensive history of cardiac disease including coronary artery stents, reduced heart function, and a history of arrhythmia. Per the death certificate, the cause of death was deemed to be acute on chronic heart failure.

Incident overview

The day prior to death, priority traffic was called at 2153 regarding the patient having difficulty breathing. Medical directed that the patient would be admitted to the In-Patient Unit (IPU) where he received initial care.

On the day of death, at 0000, a DOC nurse observed the patient experiencing increased difficulty with breathing and lower oxygen saturation levels. At 0047, Emergency Medical Services (EMS) and DOC custody staff departed the facility with the patient. At Deaconess Medical Center (DMC), the patient was intubated at 0129, Cardio-Pulmonary Resuscitation was performed at 0214 and, at 0300, the patient was pronounced deceased by the DMC provider.

Discussion

At the UFR meeting on November 4, 2021, the department shared results of its critical incident review (CIR) which was completed on September 9, 2021. The CIR is intended to examine the department's policy compliance and operational performance related to specific critical incidents identified in DOC policy. The UFR also incorporates findings from the DOC clinical mortality review (CMR) which was conducted on August 21, 2021. The CMR is a committee of clinicians including a representative from the Health Care Authority that reviews clinical aspects of all fatalities of incarcerated individuals.

The CIR reports typically include recommendations, which may be included in a companion corrective action plan. For the CIR related to this patient's death, the corrective action plan (CAP) indicated the following areas for improvement:

- The department's Critical Incident Stress Management (CISM) team was notified of the patient's death; however not all responding staff were contacted by CISM for follow-up support. Ensure that CISM follow-up with all staff involved in critical incidents.
- The acting facility medical director (FMD) was not reachable by facility staff during the incident. Ensure duty officers are aware of and fulfill their obligation to be reachable during their assignments.
- The incident reports did not record all staff involved, as required per DOC policy. Ensure supervisors understand the expectations for completing IMRS reports.

- Not all employees involved in the incident completed the required incident reports to document their involvement, as required per DOC policy. Ensure employees and supervisors are reminded of the policy requirements to complete incident reports when they are involved in an incident.

The CMR noted the patient was prescribed appropriate medications including blood thinners, aspirin, cardiac medications, and an inhaler, and while the patient was in the IPU he was given oxygen and medications. The oxygen was reduced when the patient showed improvement with medications, but subsequently the patient again experienced breathing difficulties and 911 was initiated. The care handoff between nurses was completed appropriately, but there were no notes in the medical chart about the hand-off. The CMR identified the following areas for improvement:

- Staff understanding of their level of authority for authorizing medically necessary care
- Patient care handoffs between clinicians (shift-to-shift or nurse-to-practitioner)
- Staff understanding and practice of documenting care handoffs
- Staff understanding and practice of on-call protocol and expectations
- Updates to call schedules with correct phone numbers for care escalations
- Situation, Background, Assessment, Recommendation (SBAR) communication pilot for shift-to-shift reports

The OCO also presented findings from their review, which were largely in line with the findings from the CMR. Additionally, the OCO noted that an off-site cardiologist documented that the patient was not compliant with his cardiac medications and that DOC should more closely monitor and address medication non-compliance with patients.

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. Evaluate ways to follow higher-risk patients more closely as part of a chronic care management program.
2. Address decision-making considerations regarding medical site of care for patient evaluation and monitoring depending on facility capacity and resources.
3. Educate staff on medical practitioner on-call protocol and expectations (“on-call escalation”) that were updated in 2020.
4. Reduce barriers to prompt emergency room referrals.
5. Improve reliability of primary care provider notification and follow-up after medical emergency.
6. Consider ways to better educate and engage patients in medication compliance and self-care.
7. Promote standardized clinical communication tools for patient care handoff.
8. Improve medical record documentation quality including ensuring legibility of handwriting.