Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-015

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, 42 CFR 2.53 subsection (g) authorizes the sharing of patient identifying information to state, federal, or local agencies in the course of conducting audits or evaluations mandated by statute or regulation.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on January 11, 2024:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Arieg Awad, Deputy Chief Medical Officer
- Dr. Zain Ghazal, Administrator
- Patty Paterson, Director of Nursing
- Mark Eliason, Deputy Assistant Secretary
- Rae Simpson, Director – Quality Systems
- Deborah Roberts, Program Manager
- Mary Beth Flygare, Project Manager

DOC Office of the Secretary

- Megan Pirie, Director – Person Centered Services

DOC Prisons Division

- Jeffrey Uttecht, Deputy Assistant Secretary
- James Key, Deputy Assistant Secretary
- Lorne Spooner, Correctional Operations Program Manager

DOC Women's Prison Division

- Deborah Jo Wofford, Deputy Assistant Secretary
- Paul Clark, Health Services Manager 3

DOC Risk Mitigation

- Mick Pettersen, Director

DOC Reentry Division (Reentry Centers)

- Danielle Armbruster, Assistant Secretary
- Scott Russell, Deputy Assistant Secretary
- Susan Leavell, Senior Administrator – Reentry
- Michelle Eller-Doughty, Corrections Specialist 4

DOC Community Corrections Division

- Kelly Miller, Administrator – Graduated Reentry
- Dell-Autumn Witten, Administrator

Office of the Corrections Ombuds (OCO)

- Dr. Caitlin Robertson, Director, Office of the Corrections Ombuds
- Elisabeth Kingsbury, Senior Corrections Ombuds - Policy
- EV Webb, Assistant Corrections Ombuds – Investigations

Department of Health (DOH)

- Brittany Tybo, Deputy Director, Office of Nutrition Services

Health Care Authority (HCA)

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Year of Birth: 1946 (77-years-old)

Date of Incarceration: April 2023

Date of Death: October 2023

At the time of death, this incarcerated individual was housed in a prison facility. The cause of death was end-stage renal disease. The manner of death was natural.

Below is a brief timeline of events leading up to the incarcerated individual's death:

Days prior to death	Event
120 days - 7 days	• This incarcerated individual had specialty medical appointments in the community several times a month and then returned to the prison facility the same day.
2 days	• He was transferred to a new prison facility so he could access the dialysis unit. • During transport, his wheelchair tipped backwards in transport van. He complained of back and neck pain. • Transport staff brought him to the nearest hospital emergency room where he was evaluated and discharged with no urgent medical issues noted related to his wheelchair tipping over.
Day of death	**Event**
Day 0	• Incarcerated individual found deceased in his cell.

UFR Committee Discussion

The UFR Committee met to discuss the findings and recommendations from the DOC Mortality Review Committee. The UFR Committee members considered the information from the review in formulating recommendations for corrective action.

A. The DOC Mortality Review Committee (MRC) reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

a. The incarcerated individual had end stage renal disease being treated with peritoneal dialysis.

b. A community nephrologist recommended that he transition from peritoneal dialysis to

hemodialysis within seven days of his visit because he was not thriving on the peritoneal dialysis and was not adhering to the treatment regime.

c. There were no community hemodialysis beds available near the facility where the incarcerated individual was housed necessitating a facility transfer.

d. There was a care hand-off between the medical providers at the sending and receiving facilities and from the community nephrologist to the nephrologist that manages the DOC hemodialysis unit.

    i. Discussion included timing of treatment, and

    ii. The need for peritoneal treatment prior to transfer to accommodate the transfer and timelines exceeding the original seven-day recommendation.

e. Individual completed transfer to the inpatient unit that supports the DOC hemodialysis unit.

    i. He was assessed multiple times by medical staff and found to be stable at baseline.

f. The care transition was not coordinated seamlessly between the clinical disciplines.

2. The Mortality Review Committee recommended.

    a. A root cause analysis with formal recommendations be completed to support incarcerated individual's care and prevent similar incidents in the future.

B. Independent of the mortality review, 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 Unexpected Fatality Committee reviewed the findings and recommendations of the critical incident review and have considered this information in formulating the recommendations for corrective action.

1. The CIR found that custody staff documented tier checks and nursing staff documented assessments that were not supported by video evidence. DOC leadership will remediate per Article 8 of the Teamsters 117 Collective Bargaining Agreement.

2. Additional findings and recommendations did not directly correlate to the cause of death and have been remediated per DOC policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Department of Health (DOH) representative agreed with the recommendation and asked how DOC handles coordination of care and the care handoff when there are transitions.

Note: The DOC holds a weekly Medical Transfer Conference which is a case coordination and care conference. In this case, there were several care providers involved including community consultants which made the hand-off more complex. The Mortality Review Committee members were unable to identify specific corrective actions that would prevent a similar situation in the future. A Root Cause Analysis (RCA) was requested to get a deeper look and to determine if there are improvements DOC can make as a care delivery system.

D. The Health Care Authority (HCA) representative offered that it appears the incarcerated individual was not interested in transitioning to hemodialysis prior to his incarceration and chose to continue peritoneal dialysis. Based on his history, his death would have probably still occurred even if he was residing in the community. The HCA representative asked if DOC has enough capacity for an urgent hemodialysis start.

   Note: The DOC is able to send incarcerated individuals to the community hospital when they need urgent hemodialysis and DOC does this when needed.

E. The Office of the Corrections Ombuds (OCO) said they appreciated the ongoing discussion and raised concerns around the documentation of tier checks that could not be validated through video review. The OCO recommends DOC change the terminology used from "tier-check" to "wellness-check" to reinforce the purpose of these checks is to ensure appropriate behavior and wellbeing of the incarcerated individual.

   The OCO asked why DOC has chosen to conduct a Failure Modes Effect Analysis (FMEA) instead of the recommended RCA and whether a final report or a corrective action plan will be shared. Additionally, the OCO asked why this incarcerated individual was denied for Extraordinary Medial Placement (EMP) by the Community Custody Board (CCB) and whether CCB includes clinical representation.

   Note: The DOC has chosen to conduct an FMEA, which expands the RCA to a comprehensive, system-wide examination that will help identify areas for systemic improvement. The findings from the analysis will be shared with the members of the UFR committee.
   At the time of the application, the incarcerated individual did not meet the criteria to participate in EMP. The criterion for participation is determined by the court and the Community Custody Board, whose chair and members are appointed by the governor in accordance with RCW 9.95.003.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was end-stage renal disease.

Committee Recommendations

1. DOC should conduct a root cause analysis with formal recommendations to support incarcerated individual's care and prevent similar incidents in the future.
2. Tier checks should be completed and documented in accordance with post orders and align with the conditions of confinement.
3. Nursing assessments should be completed and documented in accordance with DOC procedures and nursing standards of practice.

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

1. The DOC should consider changing the name of "tier-checks" to "wellness-checks" to reinforce the purpose of the checks are to ensure appropriate behavior and wellbeing of the incarcerated

individual.

2. The DOC has initiated a structured training program for transport officers, focusing on the proper securing of wheelchairs during transport. This training will be maintained on a continuous basis.