Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-23-018

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 December 14, 2023:

DOC Health Services

- Dr. MaryAnn Curl, Chief Medical Officer
- Mark Eliason, Deputy Assistant Secretary
- 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 Reentry Division (Reentry Centers)

- Susan Leavell, Senior Administrator – Reentry

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. Heather Schultz, Associate Medical Director

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

Fatality Summary

Year of Birth: 1953 (70-years-old)

Date of Incarceration: October 2023

Date of Death: October 2023

This incarcerated individual was transferred to DOC custody from a county jail significantly ill. He died two weeks later while being cared for in a community hospital. The cause of his death was congestive heart failure, arteriosclerotic cardiovascular disease, and chronic lung disease with pneumonia. 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
14 days	• Readmitted to prison • Transported to local community hospital for medical needs
8 days	• Returned from the community hospital
7 days	• Transported to larger community hospital for advanced care
Day of death	• The incarcerated individual died at the community hospital.

UFR Committee Discussion

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

A. The MRC reviewed the medical record, the care delivered and provided the following findings and recommendations.

1. The committee found:

a. The incarcerated individual was significantly ill when he arrived at the reception center from the county jail.

b. DOC was not forewarned about his condition prior to his transfer.

c. He spent less than a total of 24 hours at the DOC facility.

d. He was discharged from the local community hospital back to the prison without warning after DOC health services staff advised they were unable provide the level of care necessary.

e. His hospital treatment was complicated by his age and his existing chronic conditions.

f. His condition continued to deteriorate, and his family chose to switch his treatment to comfort care.
g. DOC health care staff responded appropriately when confronted with a seriously ill incarcerated individual upon arrival.
h. DOC does not have a system to communicate regularly with all of the county jails and other detention centers that regularly send people to the reception centers.

2. The Mortality Review Committee recommended exploring opportunities to discuss medical hand-off of significantly ill individuals with county jails beginning with the county responsible for this incarcerated individual.

B. The Department of Health (DOH) representative agreed that an improvement in communications when an individual is being transferred to a DOC facility is needed. If DOC knew in advance this individual was significantly ill, there could have been a different and quicker response and treatment. The DOH representative acknowledged that the UFR Committee's scope is limited to care provided by DOC and asked what options DOC has for addressing outside medical providers when their care has not met clinical standards.

Note: When an issue occurs, DOC leadership meets with the transferring entity to discuss the specific case to offer an opportunity for improvement and the resetting of expectations. This is an ongoing need and when DOC notices a pattern, we are able to file a report with the appropriate licensing board.

C. The Health Care Authority (HCA) representative stated they disagreed with the decision of the local hospital to discharge the incarcerated individual when DOC clearly advised that there were not appropriate resources to care for him in their infirmary. The HCA representative concurs that continuing education and improving communication with community caregivers is an important focus for DOC.

D. The Office of the Corrections Ombuds (OCO) representative agreed with DOC's concerns regarding not receiving notification from the county jail prior to the individual's transfer. OCO recommends DOC explore a formal process for transferring seriously ill individuals into DOC from county jails.

Note: The DOC Chief Medical Officer (CMO) met with the county jail involved in this individual's care to discuss the case and identify opportunities for improvement. DOC is working to improve care handoffs and communication with community partners.

The OCO representative also expressed concerns about the individual being inappropriately discharged back to DOC and asked if there has been a conversation with the community hospital.

Note: The DOC CMO discussed this situation with the community hospital leadership. Most DOC facilities meet routinely with their community hospitals, and DOC intends to formalize this process for all facilities. This DOC facility will continue to reach out to their local hospital to educate and reinforce realistic expectations regarding the level of care DOC can provide.

Committee Findings

The manner of the incarcerated individual's death was natural. The cause of death was congestive heart failure, arteriosclerotic cardiovascular disease, and chronic lung disease with pneumonia.

Committee Recommendations

1. DOC Health Services should improve communication and care handoffs with their local community hospitals.
2. DOC Health Services should improve communications and care handoffs between transferring facilities and DOC health services.