OFFICE OF THE
CORRECTIONS
OMBUDS

Person-Centered Prevention and Management of Infectious Diseases Recommendations

February 15, 2023

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The Office of the Corrections Ombuds is established in Chapter 43.06C RCW. Duties of the office include investigations into complaints regarding the health, safety, welfare, and rights of incarcerated individuals in the Washington Department of Corrections. The investigations and underlying records are confidential pursuant to RCW 43.06C.040 and 43.06C.060. This report has been edited to protect confidential information.

Summary

This report identifies the COVID-19 related deaths of 20 people under the care and custody of the Washington Department of Corrections during the period June 2020 through December 2022 and discusses factors contributing to these infectious disease-related mortalities within the state's prison system. Studies show that the conditions of confinement in prisons contribute to the amplification of infectious diseases within people who are incarcerated.[1] While Washington state has one of the lowest COVID-19 death rates in the nation,[2] COVID-19 remains a concern to the state and to those who live and work in our state's prison system.

In September 2021, the previous Director of the Office of the Corrections Ombuds forwarded a preliminary investigative report to the Department of Corrections. The Office of the Corrections Ombuds (OCO) then consulted with Department of Corrections (DOC) Health Services leadership to discuss the OCO's preliminary findings and recommendations. The OCO considered information and feedback provided by the DOC during these consultations. While the previous leadership considered the publication final (see Appendix A), no report was issued. New OCO leadership determined that the draft report needed additional preparation prior to publication.

The OCO again discussed the preliminary findings and recommendations with the DOC Health Services leadership and consulted with the Chief Medical Officer, Assistant Secretary – Health Services Division, and the Deputy Assistant Secretary – Health Services Division about the six COVID-19 attributed deaths that occurred after the initial conversations in 2021. As a result of this work, the OCO made recommendations based on four themes to the DOC: (1) Patient-Centered Care Model; (2) Supporting Informed End-of-Life Decisions; (3) Patient Autonomy and Choice; and (4) Alternative Care Spaces. The four themes, along with their supporting recommendations, are intended to assist the DOC in establishing and delivering person-centered prevention and management of infectious diseases and correctional medicine excellence.

The OCO acknowledges that the already demanding work performed by the DOC staff became significantly more challenging during the COVID-19 pandemic. Further, the OCO recognizes that the DOC's management of the COVID-19 pandemic contributed to the relatively low mortality rate in comparison to other states. The OCO continues to receive complaints related to infectious diseases and considers this report a critical self-advocacy tool for all people impacted by incarceration in Washington state.

[1]Examples of two studies are: (1.) Bosworth, R.J., Borschmann, R., Altice, FL., Kinner, S.A., Dolan, K. & Farrell, M. (2022) "HIV/AIDS, hepatitis and tuberculosis-related mortality among incarcerated people: a global scoping review", *International Journal of Prisoner Health,* 18(1), 66-82. (2.) Kamarulzaman A., Reid S.E., Schwitters A., Wiessing, L., El-Bassel, N., Dolan K., Moazen B., Wirtz, A. L., Verster, A. & Altice, F.L. (2016), "Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners", *The Lancet*, 388(10049), 1115–1126.

[2] Centers for Disease Control and Prevention, September 2022

Recommendations

The American College of Physicians (ACP) suggests that public health priorities in prisons requires correctional medicine excellence. In 2022, the ACP proposed 22 position recommendations, including suggestions about engagement, administration, infectious diseases, and treating aging incarcerated patients and those living with life-limiting illnesses with respect.[3] The following four themes, along with their supporting recommendations, are ways in which the DOC can demonstrate a commitment to correctional medicine excellence.

Patient-Centered Care Model

1. As the DOC develops a patient-centered care model, it is vital to ensure a minimum competency around whole-person care, health efficacy, and appropriate diagnostic capability on each DOC campus.

2. Each facility should proactively prioritize connections to the community hospitals to ensure vital partnerships are in place and remain healthy. At a minimum, each FMD and RN4 group should connect quarterly with local community hospitals.

Supporting Informed End-of-Life Decisions

1. DOC health services should establish a system of end-of-life decision support, including effective patient counseling, operationalizing patient-driven orders for end-of-life care such as Physician Orders for Life-Sustaining Therapies (POLST) forms, proxy decision maker instructions that represent the patient's wishes, and the use of orders such as "do not attempt resuscitation" and even "do not hospitalize" for persons carrying a known life-limiting illness and in the terminal phase who wish not to die in a hospital setting. There should be a regular review and renewal cycle and processes to keep the patient's wishes updated and actionable by staff. To the greatest extent possible, the end-of-life wishes should be truly portable: following the patient in transitions from intake to their living unit to inpatient care to community care and reentry phases.

2. Vital signs must be included in all assessments except when evaluating patients whose illness has progressed beyond the utility of vital signs and care is targeted to comfort. In this case, vitals are only needed if they add to the ability to monitor comfort measures.

3. Build staff competence around proxy decision-making to enhance patient autonomy, patient experience, and quality of care. DOC health services should commit to all appropriately transparent communication with community partners as well as the persons the patient defines as their personal support team, such as family.

[3] Kendig, N.E., Butkus, R., Mathew, S., & Hilden, D. (2022) "Health care during incarceration: A policy position paper from the American college of physicians", *Annals of Internal Medicine*, 175(12), 1742-1745.

4. Develop hospice and palliative care models. With the acknowledgement that additional resources will likely be needed, the OCO encourages the DOC to seek these resources.

5. Increase nurse staffing levels consistent with strong end-of-life care. Consider nursing hours per patient day (NHPPD) staffing model.

6. Improve the flow of communication with families and loved ones at the end-of-life as early as feasible. Discuss with custody partners how to value the end-of-life concerns versus security concerns and determine the primary versus secondary factors in communication.

Patient Autonomy and Choice

1. As DOC health services moves to a culture of ownership and patient-centered behavior, they should target the development of a framework to expect and enable informed decision-making and enable patient autonomy and choice.

2. Replace antagonistic sounding terms with pro-patient language like "patient chooses" rather than "patient refuses" care.

3. Ongoing improvement of effective triage and response to better anticipate the known contributing factor that patients may not report symptoms early for their reasons.

Alternative Care Spaces

1. Augment resources and staffing, especially in the alternative care spaces such as the Regional Care Facilities (RCFs), the Rapid Deployment Care Facilities (RDCFs), and the Extended Family Visit trailers (EFVs). Reiterate that when patients are housed in alternative care spaces, all documentation (health services and custody) should be immediate.

2. Remove barriers to alternative housing placements (e.g., physical limitations of the RCF at WCC and AHCC contributed to the strain of patient management options).

OCO Investigative Actions

The Office of the Corrections Ombuds took the following actions in furtherance of this multi-case investigation:

Reviewed the following documents:

- Medical charts
- DOC Policy 600.000 Health Services Management
- DOC Policy 610.010 Offender Consent for Health Care
- DOC Policy 610.040 Health Screenings and Assessments
- DOC Policy 610.650 Outpatient Services
- DOC Policy 890.620 Emergency Medical Treatment
- Washington DOC Health Plan
- DOC Screening, Testing, and Infection Control Guideline
- Centers for Disease Control and Prevention (CDC) Interim Guidance on Management of Coronavirus Disease 2019 in Correctional and Detention Facilities

Interviewed:

- Key providers at each of the involved facilities

Patient Summaries

Summaries for Patients A-N incorporate reviews from the OCO and the DOC. Patients O-T are DOC summaries, as those deaths occurred after the initial OCO/DOC conversations in 2021.

Patient A

- Patient was in his 80s with increased risk of severe illness from COVID-19 due to age and multiple chronic health conditions.
- No documentation of any complaints consistent with possible COVID-19 until a nurse was called to assess him due to symptoms suspicious for COVID-19 infection.
- Reported to hospital staff that his symptoms had been present over the past week and had progressively worsened.
- DOC reported he was treated with Remdesivir and Regeneron.
- DOC reported that family consultation determined comfort care.
- DOC reported that it referred this case to QI to improve monitoring, emergency response, and referral processes.

Patient B

- Patient was in his 70s with increased risk of severe illness from COVID-19 due to age and lung disease.
- No documentation of complaints consistent with potential COVID-19 illness until patient declared a medical emergency and reported symptoms consistent with COVID-19.
- Patient reported to hospital staff that his symptoms had been present for four days.
- DOC reported he was treated with Remdesivir.

- DOC reported Patient had a POLST (Physician's Order for Life Sustaining Treatment) for non-invasive airway measures (Do Not Intubate).
- Patient died of pulmonary complications (pneumonia, acute respiratory distress syndrome).

Patient C

- Patient was in his 60s with increased risk of severe illness from COVID-19 due to age and the presence of multiple pre-existing medical conditions.
- Records noted a drop in Patient's oxygen saturation followed by fever and pain. No indication that treatment was provided.
- Patient transferred to facility's inpatient unit due to continued abnormal oxygenation levels.
- Within three days, records show Patient was slow to respond and then difficult to rouse and had developed a cough. Patient later transferred to hospital.
- Patient reported to hospital that he had been sick for about one week. Oxygen saturation remained abnormal, blood glucose was significantly low, and there was evidence of acute kidney injury secondary to dehydration.
- Patient died of pulmonary complications.
- The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected and noted "refusal of medical treatment" as a contributing cause.
- The patient had affirmed a Do Not Intubate status; however, clinic notes since February 2020 reflect Patient's overall willingness to work with assigned providers. There was no specific documentation of the patient's refusal of medical treatment in the records provided for review.
- DOC reported he had been treated with Remdesivir.
- DOC reported that it used this case at Morbidity & Mortality conference to brief on National Institutes of Health updates, use of Remdesivir, indications for anticoagulation. Revised seriously ill notification process as a result.

Patient D

- Patient had increased risk of severe illness from COVID-19 due to several chronic health conditions.
- Patient reported symptoms suspicious for COVID-19 and requested to be seen for sick call via Kite. Patient was not evaluated; the Kite response the following day stated that the patient felt better and did not need to be seen.
- Patient reported "dry heaving" and the need to use an inhaler for an "asthma attack;" again, this patient sent a Kite for a sick call appointment. However, a nurse saw the patient at cell front and advised the patient to journal the causes and effects of their thoughts, and to use word searches to "get mind off issues." There is no documentation of vital signs being taken or other evaluation being performed.

- Patient submitted another Kite reporting "bronchitis" and the desire to be seen at sick call. Patient's oxygen saturation was dangerously low and heart rate was elevated. He was sent to the hospital.
- Patient reported to hospital staff a two-week history of progressively worsening symptoms.
- DOC reported that patient elected Do Not Resuscitate/Do Not Intubate status and comfort care. Facility Medical Director facilitated communication and seriously ill notification was in place.
- DOC reported discussing identification of symptomatic individuals, ensuring excellent clinical COVID-19 care because of this case.
- DOC reported that patient was not treated with Remdesivir.

Patient E

- Patient was in his 60s with increased risk of severe illness from COVID-19 due to presence of multiple chronic conditions and immunosuppressive medications.
- Patient was placed on quarantine; at that time, records note the patient was afebrile and had a satisfactory oxygen saturation. (Subsequent documentation after the initial entry only denotes temperature, with no other vital signs reported; in addition, the majority were late entries, transferred onto the form two days after the patient had died.)
- Custody staff and a medical assistant reported Patient was "out of sorts." The facility Infection Control Nurse requested a full nursing assessment, but no assessment was performed.
- Infection Control Nurse again requested a nursing assessment; the patient was found slumped on the bed and appeared to be in respiratory distress.
- Patient reported to hospital staff that he had progressive symptoms consistent with COVID-19 for the past two weeks.
- DOC reported patient elected Do Not Resuscitate/Do Not Intubate status at local hospital.
- DOC reported augmentation of pulse oximeters and nursing staff at AHCC because of this case.
- DOC reported that patient was not on seriously ill notification but should have been.

Patient F

- Patient was at increased risk of severe illness from COVID-19 due to advanced age and metastatic cancer.
- Patient was first confirmed to have COVID-19 while hospitalized for an unrelated condition.
- Upon return to the facility over a week later, oxygen saturation was normal without need for supplemental oxygen.
- Patient had increased confusion and "slow and uncoordinated" movements; records note an intermittent cough. Despite these new symptoms, a note by the facility medical

director three days later described the patient as being in no acute distress, but there is no documentation that a physical examination was performed.

- Patient was found to have weak respirations and received supplemental oxygen. Nurse found the patient's oxygen saturation had dropped to low levels, and it dropped even further when he sat up to take his medications. Nurse waited for an hour and then performed a recheck; by that time, oxygen saturation had dropped to severely low levels.
- Patient was admitted to the hospital for COVID-19 pneumonia and later developed several additional medical complications.
- DOC reported holding discussion about managing kites and improving access, making consult process easier. DOC reported chronic care deficiency reported to Facility Medical Director.

Patient G

- Patient was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions.
- Records indicate that Patient had previously been placed in isolation for suspected COVID-19; oxygen saturation remained at satisfactory levels during that time.
- Patient sent a Kite reporting some concerning symptoms which were new, but not commonly associated with COVID-19. In Kite response, medical staff stated that they could not see Patient that day because they had no provider, but they would try to have him seen three days later. No chart note indicates Patient G was evaluated for those new complaints.
- Patient sent another Kite, reporting common COVID-19 symptoms; the patient additionally reporting taking excessive nitroglycerin pills for his heart condition.
- Patient was evaluated two days later, but the note only reflects an evaluation for chest pain, with no mention of the other symptoms reported in the previous Kites.
- The Influenza-Like Illness Assessment form indicates that Patient G was afebrile but had a rapid heart rate and a severely low oxygen saturation. Nurse indicated that "*heart – [oxygen saturation] runs very low." Testing was performed as part of the facility's mass testing program; it did not confirm COVID-19.
- Patient arrived at pill line complaining of difficulty breathing; oxygen saturation had dropped even further by this time.
- Patient transported to the hospital, where he reported a two-week history of progressively worsening shortness of breath and hypoxia. "Staff reports that he has been sick for the last 7 days."

Patient H

- Patient was not of advanced age and had only a few chronic non-terminal medical conditions. He had mobility limitations.
- Patient declared a medical emergency for shortness of breath; reported being sick for two weeks and described a two-day history of COVID-19 symptoms.

- ER physician noted that the patient had not been tested for SARS-CoV-2 and was not in isolation. Testing confirmed COVID-19.
- Upon return to facility, patient was admitted to the inpatient unit.
- Patient was not evaluated by a clinician upon return to the facility, but nursing assessments described the patient as being very short of breath. Oxygen saturation remained at satisfactory levels on supplemental oxygen, but Patient continued to complain of difficulty breathing.
- Patient was found to have decreased oxygen saturation and a persistent fever despite medication; Patient was transferred back to the hospital, where he was found to have developed additional COVID-19 symptoms. Repeat testing confirmed COVID-19.
- DOC reported that patient did not receive Remdesivir.
- Patient died days later of COVID-19 and pneumonia/acute respiratory distress syndrome.
- DOC reported that Facility Medical Director thought regional care facility (RCF) would have been a better placement than inpatient unit, but Patient was not accepted at RCF due to mobility concerns.
- DOC reported discussing how case might have been escalated from facility inpatient unit to community hospital.
- DOC reported that Patient's rapid respiratory decline was discussed in Morbidity & Mortality conference.

Patient I

- Patient was at increased risk of severe illness from COVID-19 due to age and multiple chronic medical conditions. Facility's serial testing program confirmed COVID-19.
- Results were not returned to the facility until six days later, at which time Patient was placed in isolation; at cell front, Patient denied symptoms of COVID-19. No vital signs (e.g., temperature, oxygen saturation, etc.) were recorded; the plan was to monitor.
- Patient was found to have a severely low oxygen saturation and symptoms consistent with COVID-19. Providers gave supplemental oxygen but were unsuccessful in improving the oxygen saturation. Patient was transported to hospital for an evaluation.
- The ER note indicates that Patient had been feeling unwell for two weeks, with COVID-19 symptoms that had become acutely worse the night prior.
- DOC reported that patient elected Do Not Resuscitate status.
- Patient died of COVID Acute Respiratory Distress Syndrome.
- DOC reported that, because of patient's incarcerated status, the nearby hospital staff asked the Facility Medical Director to function as a communication intermediary from hospital to patient's family.

Patient J

- Patient was at increased risk of severe illness due to COVID-19 due to age and the presence of multiple comorbid medical conditions.

- Patient placed in quarantine and tested positive for SARS-CoV-2; initially asymptomatic.
- Oxygen saturation was low; no indication of any action or intervention in response.
- Five hours after identifying low oxygen saturation, nurse found Patient to be lethargic, fatigued, short of breath, and coughing; oxygen saturation was again low.
- Staff called on-call clinician and the patient was then airlifted to hospital.
- ER note indicates that it was Patient's eighth day in quarantine; symptoms were consistent with COVID-19, and oxygen saturation was low.
- Additional studies in the ER revealed blood clots within the lungs as well as other diagnoses.
- The patient was treated with several medications, but the regimen did not include a COVID-19 antiviral.
- Patient died of COVID acute respiratory distress syndrome.
- DOC reported that it was not involved in end-of-life decision-making to help surrogate decision maker; identified this as an area for improvement.

Patient K

- Patient was at increased risk of severe illness due to COVID-19 due to age and the presence of multiple comorbid conditions.
- Custody staff asked nursing to evaluate Patient for chest pain days after testing positive for COVID-19. At that assessment, Patient stated that nursing had visited the prior morning, but vital signs were not taken.
- The next day, Patient was found unresponsive in wheelchair; heart rate and blood pressure were low. Patient was transported to hospital.
- At the ER, the patient was believed to be dehydrated; treatment was provided, and the patient was returned to the facility later that same day.
- Patient sent a Kite reporting "a very difficult time breathing most <u>all</u> the time." The provider responded the next day, instructing the patient to use an inhaler.
- Patient then declared a medical emergency; the nurse's note states it was "due to him thinking he has pneumonia." Vital signs were within normal limits.
- Patient declared medical emergency for shortness of breath, chest pain, and cough. Patient was sent to the hospital and was admitted for COVID-19.
- Patient was treated with medications and oxygen supplementation; Patient returned to the facility with instructions to continue steroids and for future specialty follow-up.
- One month after the initial test, Patient was admitted to DOC Regional Care Facility. Records indicated that Patient had difficulty breathing but seemed to improve in the following days.
- Facility believed Patient had recovered from COVID-19.
- Patient was evaluated by DOC clinician who found an irregular heart rate; lungs were clear. Patient had a "list of health concerns" that were not specified in the note; the clinician referred Patient to the provider.

- Patient complained of shortness of breath and symptoms consistent with COVID-19; oxygen saturation was severely low.
- Patient was again sent to the emergency room and was admitted. The hospital note indicates difficulty breathing over the last six days. Oxygen saturation was below satisfactory levels even with supplemental oxygen.
- The hospital physician noted that Patient did not require oxygen before the COVID-19 diagnosis and suspected that Patient had experienced an improvement in lung function while on steroids, but now that the steroid course had ended the patient had still not recovered from the COVID-19 pneumonia.[14]
- DOC reported that patient had POLST/DNR/DNI from 2018.
- DOC reported computerized Tomography showed severe fibrosis. Seriously ill notification made.
- DOC reported that patient had been treated with Remdesivir and Regeneron.

Patient L

- Patient was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions.
- Records indicate Patient tested negative for SARS-CoV-2 several times over a period of months prior to the incidents below.
- Patient reported black stool, dizziness, and difficulty breathing; initially a FIT test was ordered "ASAP," but it was subsequently canceled with the reasoning that Patient had previously been negative a month earlier. Patient returned two days later with similar complaints; symptoms were attributed to use of Pepto-Bismol.
- Patient fell on the unit and was unable to get up; at hospital he was found to have sustained a right femur fracture. He was also noted to be symptomatic, and testing confirmed COVID-19. Discharge from the hospital was planned for the following day; however, it is not clear that the patient ever returned to the facility.
- Hospital notes indicate continued treatment; Patient ultimately passed at the hospital.
- DOC noted that COVID-19 appeared to be a contributing factor in Patient's death among multiple other factors.

Patient M

- Patient was at increased risk of severe illness due to COVID-19 due to advanced age and multiple pre-existing medical conditions. When Patient tested positive for COVID-19, oxygen saturation remained at satisfactory levels, and there was no fever. A note dated over two weeks later reflected a nursing follow-up for "significant symptoms reported during symptom check." Oxygen saturation was satisfactory, but the patient reported intermittent diarrhea.
- Nurse noted that Patient was having visibly labored breathing and had a one-week history of diarrhea; oxygen saturation dropped to a low level when climbing out of the stretcher.

- Patient sent to hospital and was admitted. Labs suggested blood clot in the lungs, but confirmatory test could not be performed due to his medical condition.
- At discharge, hospital provider suggested CT angiogram if Patient became symptomatic. Patient returned to the facility and was admitted to the IPU. Oxygen saturation was low, but this improved to satisfactory levels with supplemental oxygen.
- Facility medical director attempted several trials off oxygen, but these resulted in a drop in oxygen saturation to below satisfactory levels.
- Patient was noted to be very fatigued and complained of shortness of breath; Patient returned to the hospital, where tests confirmed a blood clot in the lungs as well as viral pneumonia.
- The patient's respiratory status continued to decline. Patient requested transition to comfort measures.
- Patient's death attributed to acute pulmonary embolism four weeks after COVID-19.
- DOC reported POLST was discussed but not executed.
- DOC reported discussion of possible age-related bias/halo effect that may have driven medical decision-making.

Patient N

- Patient was at increased risk of severe illness due to COVID-19 due to age and the presence of multiple chronic medical conditions.
- Patient was placed into isolation; at that evaluation, clinician noted mild symptoms but acknowledged Patient's age and outlined a plan to see him daily.
- Patient was seen by a different clinician, who noted additional symptoms not present the day prior. Despite the new symptoms, this new provider felt that Patient was "improving," and reduced the plan of care for nurse monitoring only, with provider evaluation only as needed.
- Two weeks after the initial test, symptoms again worsened; oxygen saturation was not recorded, and the provider commented that this was "because patient was cold and has underlying COPD." "Moderate" COVID-19 symptoms were documented; again, no oxygen saturation was recorded "due to cold hands." However, Influenza-Like Illness Assessment flow sheet indicated an oxygen saturation that was nearly 100%.
- Patient was transported to hospital; hospital records show severely low oxygen saturation. Patient reported that symptoms had never improved since the initial COVID-19 diagnosis.
- DOC reported patient had been treated with Remdesivir.
- Patient died of COVID acute respiratory distress syndrome.
- DOC noted concerns about end-of-life decision making and no next of kin. Staff educated on availability of monoclonal antibody therapy.

Patient O

Per DOC case review:

- Patient in his 80s was at increased risk of severe illness due to COVID-19 due to age and the presence of multiple chronic medical conditions.
- DOC's case review noted that Patient declined vaccinations and COVID-19 medications. Signed against medical advice and had Do Not Resuscitate POLST.
- Patient opted for comfort measures.
- Patient died of COVID pneumonia.

Patient P

Per DOC case review:

- Patient in his 80s was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions
- Treated with Remdesivir and Regeneron.
- DOC's case review noted that consultation with Patient's family determined comfort care.
- DOC staff facilitated end-of-life care and made it possible for family to visit at end of life.
- DOC discussed improving IPU staffing ratios to enable nursing to have additional time with patients.

Patient Q

Per DOC case review:

- Patient in his 70s was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions, including metastatic multiple myeloma.
- DOC's case review noted that Patient had three longstanding DNR/DNI POLST orders.
- Patient was not a candidate for Remdesivir and declined Regeneron.
- Patient ultimately chose comfort care and died of COVID.
- Discussion with the facility about how DOC might involve family earlier in the course of serious illness, but no corrective actions recommended related to death. Comfort care provided.

Patient R

Per DOC case review:

- Patient in his 70s was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions.
- Treated with Regeneron, Dexamethasone, and Remdesivir.

- DOC's case review noted that Patient developed acute respiratory distress syndrome; elected to receive comfort care measures only and died of COVID-19.
- DOC identified gaps in chronic care were not directly related to Patient's death. Communication barriers with family were noted when Patient was put on seriously ill notification.

Patient S

Per DOC case review:

- Patient in his 50s was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions.
- DOC's case review noted that Patient had been in isolation, transferred to hospital, returned to facility, and returned to hospital a week later with acute deterioration that evening.
- Patient died of septic shock with diabetic ketoacidosis, acute kidney injury, elevated transaminases, deep vein thrombosis, multiple other thromboses that may have been a complication of COVID-19.
- Patient was treated with Remdesivir, Regeneron, Dexamethasone.
- Outside hospital missed dose of Patient's chronic medications. DOC physician asked outside hospital ethicist for review. Appears hospital was reluctant to call Patient's daughter due to a "No Contact" order. DOC helped remedy this concern.

Patient T

Per DOC case review:

- Patient in his 50s was at increased risk of severe illness from COVID-19 due to age and the presence of multiple chronic medical conditions, including end-stage lung disease.
- DOC's case review noted that Patient died of COVID acute respiratory distress syndrome despite maximal treatment.
- DOC noted that future practice must ensure immunocompromised patients are offered initial and booster vaccine and education on risk.

Office of the Corrections Ombuds

Investigative Report: Analysis of COVID19 Deaths in the Washington Department of Corrections System

September 27, 2021

This report is provided pursuant to RCW 43.06C.040. This report has been edited to protect confidential information. OCO investigations are confidential pursuant to RCW 43.06C.040 and 43.06C.060.

Brief Summary of Issue

This report reviews the circumstances surrounding fourteen[1] COVID19-related deaths within the Washington Department of Corrections (DOC) from June 2020 through August 2021, examines factors affecting patient care, and describes opportunities for improvement. The purpose of this report is to assist DOC in identifying gaps in care and developing solutions to improve care quality. The report also includes ideas and recommendations for improving pandemic preparedness, which we believe can be successfully integrated into DOC's processes. The review focused solely on the care provided within DOC's system; it does not include an analysis of the care by community providers.

OCO acknowledges that the already demanding work performed by DOC became significantly more challenging during the COVID19 pandemic. OCO recognizes that the department has managed to maintain a relatively low mortality rate in comparison to other states – only four states reported lower COVID19 mortality rates in prisons according to data analyzed by The Marshall Project and The Associated Press.[2]

Executive Summary

Findings

- In five cases, patients reported having symptoms suspicious for COVID19 for up to two weeks prior to being seen by a DOC provider.

[1] One additional case was reviewed which DOC does not include in their list of COVID19-related deaths through August 2021. See footnote 13.
[2] https://data.world/associatedpress/marshall-project-covid-cases-in-prisons

- In six cases, patients were not adequately evaluated after they requested to be seen for symptoms.
- In five cases, a clinician was not contacted for an evaluation or for other recommendations, despite having symptoms of concern.
- In five cases, documentation processes were not followed, contributing to delays in evaluation.
- In four cases, positive COVID19 test results were not received for 3-6 days.
- In two cases, patients were evaluated by DOC clinicians and demonstrated worsening of their conditions but were not transferred to the ER until days later.
- In one case, a patient reported significant COVID19-like symptoms and requested an evaluation; although an appointment was made, the crucial information regarding symptoms was not passed on to the clinician.
- In one case, a clinician reduced an at-risk patient's plan of care, even though he had become more symptomatic.
- In all cases, there was no objective documentation of the Facility Medical Director's awareness / oversight of the care of these patients in the days leading up to the patient's transfer to the ER.

Key Recommendations

- Improve screening process to encourage reporting by symptomatic patients.
- Remind patients how to seek care for acute conditions so that there is no delay.
- Reinforce the need for thorough evaluation of patients exhibiting symptoms and provide sufficient screening equipment.
- Refer to a clinician for guidance when worsening symptoms are identified.
- Utilize a lab that provides the shortest time for receipt of abnormal test results.
- Ensure that critical Kite information is passed to clinicians when appointments are made.
- Transfer promptly for higher level of care when there is evidence of deterioration.
- Require daily case review with responsible physician(s).
- Build a quality assurance process into pandemic preparedness.

Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.
- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

Investigative Actions

For this multi-case investigation, OCO reviewed the following documents:

- Medical charts
- DOC Policies 600.000 Health Services Management
- 610.010 Offender Consent for Health Care
- 610.040 Health Screenings and Assessments
- 610.650 Outpatient Services
- 890.620 Emergency Medical Treatment
- Washington DOC Health Plan (a.k.a. Offender Health Plan)
- DOC Screening, Testing, and Infection Control Guideline
- Centers for Disease Control and Prevention (CDC) Interim Guidance on Management of Coronavirus Disease 2019 in Correctional and Detention Facilities

Additional information was obtained through interviews of key providers at each of the involved facilities.

OCO also spoke with the family member of one individual, who alleged a denial of care occurring over several years while under DOC jurisdiction. However, dates and circumstances around this care denial were not provided, and therefore the allegations could not be sufficiently investigated.

At the conclusion of this investigation, OCO forwarded the confidential preliminary investigative report to DOC in September 2021. OCO then hosted consultation with DOC Health Services leadership to discuss OCO's preliminary findings and recommendations. Information and feedback provided by DOC during these consultations were considered by OCO prior to publication of the final report.

Findings

Cases[3] were reviewed for the following factors, to identify opportunities for improvement:

- Quality of triage and delays in evaluation
- Timeliness of access to care once an evaluation occurred
- Documented involvement of Facility Medical Director (FMD) in care
- Timing and quality of emergency response

Quality of triage and delays in evaluation

In five cases, patients reported having symptoms suspicious for COVID19 for up to two weeks prior to being seen by a DOC provider. On interview, a provider stated that this happened often at their facility, explaining that patients denied symptoms during screening but would later admit to a longer duration of symptoms once those symptoms became intolerable.

Table 1.	Symptoms	Time to Evaluation
Patient A	Progressive shortness of breath	1 week
Patient B	Diarrhea / fever	4 days / 1 day
Patient E	Progressive difficulty breathing, body aches, cough with bloody sputum, lack of taste and smell	2 weeks
Patient H	"Sick" / vomiting / cough	2 weeks / 1 week / 2 days
Patient I	"Unwell"	2 weeks

In six cases, patients were not adequately evaluated (twice in one case):

Table 2.	Signs / Symptoms	To Hospital ER
Patient D	Requested to be seen for "dry heaving" and "asthma attack," but not evaluated; told to journal his thoughts and get mind off issues	4 days later
Patient E	Infection Control Nurse requested a nursing evaluation due to concerns that he was off baseline; no evaluation was performed	1 day later
Patient G	Reported shortness of breath and loose stool, but not evaluated for those symptoms	7 days later
Patient I	Placed in isolation but no vital signs recorded	1 day later
Patient K	In isolation; seen by nursing, but no vital signs recorded	2 days later
Patient K	Reported having near constant difficulty breathing, but not evaluated; told to use rescue inhaler	8 days later
Patient N	Although symptoms were worsening, oxygen saturation not performed	1 day later

[3] See Appendix 1 for Case Summaries.

In five cases, a clinician was not contacted for an evaluation or other recommendations despite having concerning symptoms.

Table 3.	Signs / Symptoms	To Hospital ER
Patient C	Worsening symptoms, slow to respond, difficult to rouse	4 hours later
Patient F	Weak respirations, oxygen saturation dropped significantly and did not recover to acceptable levels	Over 1 hour later
Patient G	Significantly low oxygen saturation but nurse appeared to imply that this was normal for his heart condition	1 day later
Patient H	Returned to facility after ER evaluation and was still short of breath and complained of difficulty breathing	1 day later
Patient J	Low oxygen saturation but no action taken until found to be lethargic, fatigued, with further drop in oxygen saturation	5 hours later

Documentation processes were not followed in five cases (twice in two cases).

Table 4.	
Patient D	Utilized Kite system[4] to request sick call evaluation for difficulty breathing
Patient D	Utilized Kite system to report “dry heaving” and “asthma attack”
Patient E	Influenza-Like Illness Assessment forms not consistently utilized for recording screenings; vital signs were incomplete; entries were made into forms two days after death
Patient G	Utilized Kite system to report near loss of consciousness, no control of balance
Patient G	Utilized Kite system to report shortness of breath, loose stool
Patient K	Utilized Kite system to report near-constant difficulty breathing
Patient N	Vital signs were incomplete; one entry conflicted with other documentation on the same day

Patients who had SARS-CoV-2 tests performed at the hospital received results the same day. However, when testing was performed at the facility, results were most often delayed. On interview, providers reported that long delays were the norm for one of the lab companies used for testing; time to notification improved when the agency changed to a different lab company.

Table 5.	Time to receipt of test results
Patient I	6 days
Patient J	3 days
Patient K	3 days
Patient N	4 days

[4] The medical Kite is a handwritten correspondence intended to schedule more routine medical, mental health, or dental needs; responses to medical Kites can take up to 14 days.

Timeliness of access to care

In two cases, patients were evaluated by DOC clinicians but not felt to require a higher level of care despite evidence of worsening or decompensation. In a third case, the DOC clinician did not review recent Kites sent by the patient, and therefore the clinician was unaware of the patient's COVID-like symptoms.

Table 6.	Signs / Symptoms	To Hospital ER
Patient C	Had repeat oxygen saturations lower than normal baseline as well as high fever	2 days later
Patient G	Reported near loss of consciousness, shortness of breath, loose stool via Kite	7 days later
Patient N	Clinician reduced plan of care to be seen only as needed, even though high-risk patient had become more symptomatic (note that a day earlier, a different clinician had planned on evaluating him daily given his age)	9 days later

Documented involvement of Facility Medical Director (FMD) in care

In all cases, there was no documentation of FMD awareness / oversight of the care of these patients in the days leading up to the patient's transfer to the hospital.

For those cases where the patients were returned from the hospital back to the facility and remained in the IPU for more than one day, FMD involvement was present.

Timing and quality of emergency response

For all cases, the emergency response was satisfactory once a medical emergency was correctly identified.

Additional finding

When a death occurs within DOC, a DOC provider completes a *DOC Medical Reporting of Patient Death* form which requires a determination of whether the patient's death is expected versus unexpected. In the 14 cases reviewed, half were marked as unexpected, and half were marked as expected. Although this has no direct bearing on the care given to the patient and did not impact death, it demonstrates inconsistency and lack of standardization. Review of DOC policies and protocols did not reveal any specific guidance for providers as to how deaths should be determined as expected or unexpected.

Recommendations

Many experts agree that there will be another pandemic in the coming years. As a result, on both the national and international level, most agree on a drastic shift for pandemic preparedness – focusing on a proactive, coordinated strategy rather than remaining in a reactive response mode. Based on the findings from this multi-case review, OCO recommends incorporating the following in future pandemic planning, as well as in current pandemic efforts:

1. *Improve the screening process*

   A. *Encourage reporting by symptomatic patients.* This is a multifactorial problem that could be addressed, in part, via multiple solutions:

   - According to the providers we interviewed, patients were fearful of the conditions in isolation and therefore would hide their symptoms until they became unbearable. As recommended in a prior OCO publication,[5] creating a nurturing environment conducive to healthy recovery could improve reporting – which would result in earlier care for the patient, as well as earlier removal from the general population. OCO acknowledges that DOC has taken strides in improving isolation by ensuring access to personal belongings, etc. However, ongoing work is needed to ensure that conditions in isolation and quarantine are not just humane but desirable, to better enable staff to stop the spread of disease and prevent potential deaths.
   - One provider reported that screenings were performed on the quarantined population only twice daily, and that some staff were more thorough than others; indeed, screening forms were not properly completed in two of the COVID19 deaths. Incorporating a quality assurance process for these screening forms will help ensure that the necessary objective findings are recorded, and more frequent screenings by trained staff from different disciplines may yield more responses from symptomatic patients.
   - DOC previously developed brochures outlining what to expect when in quarantine or isolation. Continuing to address circulating misinformation quickly can help the population make evidence-based decisions, and communicating directly with the population may help build trust with DOC medical staff.

   B. *Remind patients when medical Kites should be used vs. signing up for sick call or declaring a medical emergency.* Responses to Kites may take up to ten days, per

[5] OCO Investigation of COVID19 Mortalities at CRCC, published 11/16/2020.

DOC policy; therefore, the Kite is not an appropriate method for requesting an evaluation for symptoms in the setting of a pandemic.

2. *Improve triage*

   A. *Reinforce need for thorough evaluation of patients exhibiting symptoms*
      - In the setting of a pandemic, an evaluation of all patients who report symptoms is prudent, regardless of whether they subsequently deny the need for an evaluation.
      - Engineer into the evaluation process the specific information that must be collected when patients are reporting symptoms.
        - Reinforce the requirement that proper forms be utilized to document information collected from patients, so that necessary objective information is recorded.
      - Provide staff with sufficient equipment (e.g., pulse oximeters, touchless thermometers, N95 masks).

   B. *Build into protocol an immediate outreach to a clinician as soon as worsening symptoms are identified.* This includes those patients who have just returned to the facility from the hospital emergency department but continue to be symptomatic.

   C. *Seek the shortest time for receipt of test results.* During a pandemic, time is of the essence in shared housing settings such as correctional facilities. Rapid identification of individuals infected with a highly transmissible disease not only allows them to receive care more quickly, but also allows them to be removed from the general population to minimize disease spread. OCO recognizes that delays in COVID19 test results were multifactorial and often beyond the control of DOC (attributed to staff shortages at the labs and delays in specimen transportation); nevertheless, this remains included as a recommendation for future pandemics since the most rapid receipt of test results is imperative.

   D. *Ensure that critical Kite information is passed to clinicians when an appointment is made. A*n electronic health record will make it much easier to incorporate this information into a scheduled appointment, but until one is in place there must be a process within the current paper chart system that allows for seamless flow of information.

3. *Refer promptly for higher level of care.* As one DOC clinician noted[6], patients who are more likely to get severely ill should receive a higher level of monitoring, to allow for careful monitoring of any changes. In addition, rapid referral to the ER – or, at a minimum, consultation with FMD for guidance (see #4) – should occur when there is evidence of deterioration.

4. *Require case review with the Facility Medical Director (FMD).* It would be challenging for one FMD to have full knowledge of every patient at a facility. However, supervision of a physician assistant's practice activities is mandatory[7], and in no situation is it more mandatory than when a patient is deteriorating. In the setting of a pandemic, daily team meetings to discuss symptomatic at-risk individuals with the FMD are critical to ensure that care decisions are appropriate and timely. Note that OCO issued this recommendation for stronger oversight by the responsible physician(s) in a prior OCO publication documenting DOC healthcare shortfalls.[8]

5. *Embed a quality assurance process to monitor compliance with protocols.* An early, data-driven, systematic assessment of current performance identifies shortfalls and solutions sooner rather than later, so that improvements to public health emergency processes can be quickly implemented.

6. *Review the current process for completing the DOC Medical Reporting of Patient Death form.* Although not causally related to the cases reviewed, the inconsistencies in the way these forms were completed (specifically to the unexpected vs. expected terminology) does not yield reliable data for DOC, and is another demonstration of the lack of quality control by Health Services leadership. If the determination of unexpected vs. expected remains in the existing form, providers need solid guidance on DOC's definition of these terms and how to complete this form correctly.

[6] See Appendix, Patient N.
[7] RCW 18.71A.120(2)(b)
[8] OCO Investigation of Delayed Cancer Diagnosis & Management, published 3/29/2021.

Appendix: Case Summaries

Patient A[9]

Patient A was at increased risk of severe illness from COVID19 based on age and multiple chronic health conditions. There is no documentation of any complaints consistent with possible COVID19 until a nurse was called to assess Patient A due to symptoms suspicious for COVID19 infection. Patient A was sent to the ER via ambulance.

At the hospital, Patient A reported that symptoms had been present over the past week, and progressively worsened. Patient A worked in food service at the facility, and a co-worker had confirmed COVID19 infection. Tests confirmed the diagnosis of COVID19.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.

Patient B[10]

Patient B was at higher risk of severe illness due to COVID19 based on age. The records do not demonstrate any complaints indicating potential COVID19 illness until the Patient B declared a medical emergency and reported symptoms consistent with COVID19. Patient B was transported to the ER.

Upon arrival at the hospital, Patient B reported that symptoms had been present for four days. Tests confirmed the diagnosis of COVID19.

The patient ultimately passed. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected.

Patient C

Patient C was at increased risk of severe illness from COVID19, based on age and the presence of multiple pre-existing medical conditions. The records noted an initial drop in Patient C's oxygen saturation to an abnormal level; the following day, Patient C developed a fever and complained of pain, but there is no indication that any treatment was given. Oxygen saturation remained abnormal, and Patient C was transferred to the facility's IPU. Three days later, Patient C was described as being slow to respond; by that afternoon, Patient C was difficult to rouse and had had developed a cough. Four hours later, Patient C triggered the call light, but

[9] This case was previously reviewed; a summary is included here for completeness in addressing all COVID19 deaths from June 2020 through August 2021.
[10] This case was also previously reviewed; a summary is included here for completeness in addressing all COVID19 deaths from June 2020 through August 2021.

the IPU nurse could not understand what Patient C was saying. Oxygen saturation remained abnormal despite supplemental oxygen. Patient C was transferred to the emergency room.

The ER note indicates that Patient C had been sick for about a week. Upon arrival at the hospital, oxygen saturation was abnormal, blood glucose was significantly low, and there was evidence of acute kidney injury secondary to dehydration. He was given IV fluids and admitted.

The patient ultimately passed. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected, and noted "refusal of medical treatment" as a contributing cause. The patient had indeed affirmed a Do Not Intubate status; however, clinic notes since February 2020 reflect Patient C's overall willingness to work with assigned providers, although there was difficulty controlling some of the chronic conditions and adjustments to medications were needed. There was no specific documentation of the patient's refusal of medical treatment in the records provided for review.

Patient D

Patient D was at increased risk of severe illness from COVID19 due to several chronic health conditions. This patient reported symptoms suspicious for COVID19, and requested to be seen for sick call via Kite. However, Patient D was not evaluated; the Kite response the following day stated that the patient felt better and did not need to be seen.[11]

A week later, Patient D reported "dry heaving" and the need to use an inhaler for an "asthma attack;" again, this patient sent a Kite for a sick call appointment. However, a nurse saw the patient at cell front and advised the patient to journal the causes and effects of their thoughts, and to use word searches to "get mind off issues." There is no documentation of any vital signs being taken, or other evaluation being performed.

Over a week later, Patient D submitted another Kite reporting "bronchitis" and the desire to be seen at the next sick call. By this time, Patient D's oxygen saturation was dangerously low, and heart rate was elevated and he was sent to the hospital. Upon arrival at the hospital, Patient D reported a two-week history of progressively worsening symptoms; COVID19 test was positive.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.

Patient E

[11] On interview, a provider stated that this was not consistent with protocol, and that the patient should have been evaluated based on the prior symptoms even if believed to have improved.

Patient E was at increased risk of severe illness from COVID19, based on the presence of multiple chronic conditions and immunosuppressive medications.

Patient E was placed on quarantine; at that time, an Influenza-Like Illness Assessment form indicates the patient was afebrile and had a satisfactory oxygen saturation. Subsequent documentation after the initial entry only denotes temperature, with no other vital signs reported; in addition, the majority were late entries, transferred onto the form two days after the patient had already died.

Almost two weeks later, custody staff and a medical assistant reported Patient E as being "out of sorts." The facility Infection Control Nurse requested a full nursing assessment, but no assessment was performed. The next day, the Infection Control Nurse again requested a nursing assessment; the patient was found slumped on the bed and appeared to be in respiratory distress. When the ambulance arrived, the DOC nurse asked that he be sent to a specific hospital under the direction of the facility medical director, but the ambulance staff felt he should be taken to the closest ER.

At the ER, the patient reported progressive symptoms consistent with COVID19 for the past two weeks. Testing confirmed the diagnosis of COVID19, and Patient E was treated.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected.

Patient F

Patient F was an elderly person who had been diagnosed with metastatic cancer[12]; both this diagnosis and the advanced age placed the patient at increased risk for severe illness due to COVID19.

Patient F was first confirmed to have COVID19 while hospitalized for an unrelated condition. Upon return to the facility over a week later, oxygen saturation was normal without need for supplemental oxygen.

Four days later, Patient F had increased confusion and "slow and uncoordinated" movements; an intermittent cough was noted the following day. Despite these new symptoms, a note by the facility medical director three days later described the patient as being in no acute distress, but there is no documentation that a physical examination was performed. An hour later, Patient F was found to have weak respirations, and supplemental oxygen was given. Shortly before midnight, another nurse found the patient's oxygen saturation had dropped to low levels, and it dropped even further when he sat up to take his medications. The nurse waited

[12] Although the cancer diagnosis is not the focus of this report, OCO found that this patient experienced a delay in diagnosis of his cancer, as well as a subsequent delay in initiation of treatment.

for a little more than an hour and then performed a recheck; by that time, oxygen saturation had dropped to severely low levels. 911 was called.

Patient F was admitted to the hospital for COVID19 pneumonia, and later developed several additional medical complications.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected.

Patient G

Patient G was at increased risk of severe illness from COVID19, due to age and the presence of multiple chronic medical conditions. The records indicate that the patient had previously been placed in isolation for suspected COVID19; oxygen saturation remained at satisfactory levels during that time.

Patient G sent a Kite reporting some concerning symptoms which were new, but not commonly associated with COVID19. In a Kite response, medical staff stated that they could not see the patient that day because they had no provider, but they would try to have the patient seen three days later. However, there is no chart note that indicates Patient G was evaluated for those new complaints.

Four days after the first kite, Patient G sent another Kite, now reporting some common COVID19 symptoms; the patient additionally reporting taking excessive nitroglycerin pills for his heart condition. Patient G was evaluated two days later, but the note only reflects an evaluation for chest pain, with no mention of the other symptoms reported in the previous Kites.

Almost a week afterwards, the Influenza-Like Illness Assessment form indicates that Patient G was afebrile but had a rapid heart rate and a severely low oxygen saturation. The nurse appears to dismiss the low oxygen saturation, writing in the Comments section: "*heart – [oxygen saturation] runs very low." Testing was performed as part of the facility's mass testing program; it did not confirm COVID19. The next day, Patient G arrived at pill line complaining of difficulty breathing; oxygen saturation had dropped even further by this time. The patient was transported to the ER.

At the hospital, Patient G reported a two-week history of progressively worsening shortness of breath and hypoxia. "Staff reports that he has been sick for the last 7 days." Testing confirmed COVID19.

The patient ultimately passed. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected.

Patient H

Patient H was not of advanced age, and had only a few chronic non-terminal medical conditions which appeared to be in good control. The patient declared a medical emergency for shortness of breath; Patient H reported being sick for two weeks[13], and described a two-day history of COVID19 symptoms. The patient was transported to the emergency room, and the ER physician noted that the patient had not been tested for SARS-CoV-2 and was not in isolation. Testing confirmed COVID19; medication was prescribed, and the patient was returned to the facility.

Upon arrival back to the facility, the patient was admitted to the IPU. Patient H was not evaluated by a clinician upon return to the facility, but nursing assessments described the patient as being very short of breath. The remainder of that day, oxygen saturation remained at satisfactory levels on supplemental oxygen, but Patient H continued to complain of difficulty breathing.

The following day, Patient H was found to have decreased oxygen saturation and a persistent fever despite medication; the patient returned to the hospital, where he was found to have developed additional COVID19 symptoms. Repeat testing confirmed COVID19.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.

Patient I

Patient I was at increased risk for severe illness with COVID19 based on age and multiple chronic medical conditions. Testing as part of the facility's serial testing program confirmed COVID19. Results were not returned to the facility until six days later, at which time Patient I was placed in isolation; at cell front, the patient reportedly denied any symptoms of COVID19. No vital signs (e.g. temperature, oxygen saturation, etc.) were recorded, and the plan was to monitor.

The following day, Patient I was found to have a severely low oxygen saturation and symptoms consistent with COVID19. The providers gave supplemental oxygen, but were unsuccessful in improving the oxygen saturation. As a result, the patient was transported to the emergency room for an evaluation. The ER note indicates that Patient I had been feeling unwell for two weeks, with COVID19 symptoms that had become acutely worse the night prior.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.

[13] On interview, the provider confirmed that he was not in quarantine or isolation during this two-week time frame.

Patient J

Patient J was at increased risk for developing severe illness due to COVID19, based on age and the presence of multiple comorbid medical conditions. Patient J was placed in quarantine and tested. Testing was positive for SARS-CoV-2, and the patient was initially asymptomatic.

Two days later, a nurse found Patient J's oxygen saturation to be low; there is no indication of any action or intervention in response to this low oxygen saturation. Five hours later, a nurse found Patient J to be lethargic, fatigued, short of breath, and coughing; oxygen saturation was again low. The on-call clinician was contacted, and the patient was transported to the local emergency room.

The ER note indicates that it was Patient J's 8th day in quarantine; symptoms were consistent with COVID19, and oxygen saturation was low. Additional studies in the ER revealed blood clots within the lungs. The patient was treated with several medications, but the regimen did not include a COVID19 antiviral.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.

Patient K

Patient K was at increased risk of developing severe illness due to COVID19, based on age and the presence of multiple comorbid conditions. Patient K was given a test that confirmed COVID19.

Four days later, custody staff asked nursing to evaluate Patient K for chest pain. At that assessment, the patient stated that nursing had visited the prior morning, but vital signs were not taken. The next day, Patient K was found unresponsive in the wheelchair; heart rate and blood pressure were low. At the ER, the patient was believed to be dehydrated; treatment was provided, and the patient was returned to the facility later that same day.

Two weeks after the initial test, Patient K sent a Kite reporting "a very difficult time breathing most all the time." The provider responded the next day, instructing the patient to use an inhaler. Patient K then declared a medical emergency; the nurse note states it was "due to him thinking he has pneumonia." Vital signs were within normal limits.

Another week passed; Patient K declared a medical emergency for shortness of breath, chest pain, and cough. The patient was sent to the emergency room and was subsequently hospitalized for COVID19. The patient was treated with medications and oxygen supplementation; Patient K returned to the facility with instructions to continue steroids for five days and for future specialty follow-up.

One month after the initial test, Patient K was admitted to the DOC Regional Care Facility. At that time, the patient was described as having difficulty breathing, but seemed to improve in the following days. The facility believed Patient K had recovered from COVID19.

Two weeks later, Patient K was evaluated by a DOC clinician who found an irregular heart rate; lungs were clear. The patient had a "list of health concerns" that were not specified in the note; the clinician referred Patient K to the provider. Later that day, the patient complained of shortness of breath and symptoms consistent with COVID19; oxygen saturation was severely low. Patient K was again sent to the emergency room and was admitted.

The hospital note indicates difficulty breathing over the last six days. Oxygen saturation was below satisfactory levels even with supplemental oxygen. The hospital physician noted that Patient K did not require oxygen before the COVID19 diagnosis, and suspected that Patient K had experienced an improvement in lung function while on steroids, but now that the steroid course had ended the patient had still not recovered from the COVID19 pneumonia.[14]

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected.

Patient L

Patient L was at increased risk of severe illness from COVID19, based on age and the presence of multiple chronic medical conditions. The records indicate that testing was negative for SARS-CoV-2 several times over a period of months prior to the incidents below.

Patient L reported black stool for four days, along with dizziness and difficulty breathing; initially a FIT test was ordered "ASAP," but it was subsequently cancelled with the reasoning that he had previously been negative a month earlier. The patient returned two days later with similar complaints, and symptoms were attributed to the use of Pepto-Bismol. Two days after that, the patient fell on the unit and was unable to get up; at the emergency room, where he was found to have sustained a right femur fracture. He was also noted to be symptomatic, and testing confirmed COVID19.

Discharge from the hospital was planned for the following day; however, it is not clear that the patient ever returned to the facility. Hospital notes indicate continued treatment and the patient ultimately passed at the hospital.

The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.

[14] DOC does not include Patient K in its list of COVID19-related deaths; however, OCO has included Patient K in this report because of the hospital physician's opinion that he had not recovered from COVID19 pneumonia.

Patient M

Patient M was at increased risk for severe illness due to COVID19, based on advanced age and multiple pre-existing medical conditions. Testing confirmed COVID19; at that time, oxygen saturation remained at satisfactory levels, and there was no fever.

A note dated over two weeks later reflected a nursing follow-up for "significant symptoms reported during symptom check." Oxygen saturation was satisfactory, but the patient reported intermittent diarrhea. The following day, another nurse noted that Patient M was having visibly labored breathing and had a one-week history of diarrhea; oxygen saturation dropped to a low level when climbing out of the stretcher. Patient M was sent to the ER and was admitted unrelated medical conditions. Labs were additionally suggestive of blood clot in the lungs, but a confirmatory test could not be performed due to his medical condition. Patient M was discharged from the hospital; the hospital provider suggested a CT angiogram if the patient became symptomatic.

Patient M returned to the facility and was admitted to the IPU. Oxygen saturation was low, but this improved to satisfactory levels with supplemental oxygen. The facility medical director attempted several trials off oxygen, but these resulted in a drop in oxygen saturation to below satisfactory levels. Patient M was noted to be very fatigued and complained of shortness of breath; the patient returned to the hospital, where tests confirmed a blood clot in the lungs as well as viral pneumonia. The patient's respiratory status continued to decline, and Patient M requested a transition to comfort measures.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as expected.

Patient N

Patient N was at increased risk for severe illness due to COVID19, based on age and the presence of multiple chronic medical conditions. Testing confirmed COVID19. Four days later, Patient N was placed into isolation; at that evaluation, the clinician noted mild symptoms, but acknowledged Patient N's age[15] and outlined a plan to see him daily.

The following day, Patient N was seen by a different clinician, who noted the presence of more symptoms that were not present the day prior. Despite the new symptoms, this new provider felt that the patient was "improving," and reduced the plan of care for nurse monitoring only, with provider evaluation only as needed.

Two weeks after the initial test, symptoms again worsened; oxygen saturation was not recorded, and the provider commented that this was "because patient was cold and has

[15] Per the CDC, older adults are more likely to get severely ill from COVID-19; more than 80% of COVID-19 deaths occur in people over age 65, and more than 95% of COVID-19 deaths occur in people older than 45.

underlying COPD." "Moderate" COVID19 symptoms were documented; again, no oxygen saturation was recorded "due to cold hands." However, a separate entry in the Influenza-Like Illness Assessment flow sheet indicates an oxygen saturation that was nearly 100%. Patient N was transported to the local hospital.

At the hospital, Patient N had a severely low oxygen saturation; the patient reported that symptoms never improved since the initial COVID19 diagnosis.

The patient ultimately passed at the hospital. The provider who signed the DOC Medical Reporting of Patient Death form marked this death as unexpected.