

This draft report was sent to the Department of Corrections under a previous director of the OCO. Review by subsequent OCO leadership determined that this draft was not ready for publication. The current OCO Director and the DOC Secretary have agreed that the OCO and the DOC will participate in a facilitated conversation about the contributing factors that lead to these deaths.

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 fourteen¹ 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

Cases³ 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.* An 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 noted⁶, 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 mandatory⁷, 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 A⁹

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 B¹⁰

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 cancer¹²; 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 weeks¹³, 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 age¹⁵ 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.