Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-22-032

Report to the Legislature

As required by RCW 72.09.770

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Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Legislative Directive and Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an unexpected fatality review (UFR) committee to review any case in which the death of an incarcerated individual was unexpected, or in any case identified by the Office of the Corrections Ombuds (OCO) for review.

The purpose of the unexpected fatality review is to develop recommendations for DOC and the legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for incarcerated individuals in DOC's custody.

This report describes the results of one such review and presents recommendations. Within ten days of the publication of this report, DOC must publish an associated corrective action plan. DOC will then have 120 days to implement that plan.

Disclosure of Protected Health Information

RCW 72.09.770 requires DOC to disclose protected health information - including mental health and sexually transmitted disease records - to UFR committee members. Under federal law, substance use information was not disclosed unless the next of kin authorized release.

UFR Committee Members

The following members attended the UFR Committee meeting held virtually on January 12, 2023:

<u>DOC Health Services</u>

- Dr. MaryAnn Curl, Chief Medical Officer
- Dr. Karie Rainer, Director of Mental Health
- Mark Eliason, Deputy Director Health Services
- Paul Clark, Administrator
- Nancy Fernelius, Chief Nursing Officer
- Mary Beth Flygare, Program Manager
- Keith Parris, Health Services Manager

<u>DOC Prisons Division</u>

- Jeff Uttecht – Deputy Assistant Secretary
- Eric Jackson – Deputy Director
- Ronald Haynes – Superintendent Clallam Bay Corrections Center

<u>DOC Risk Management</u>

- Michael Pettersen, Risk Mitigation Director

<u>Office of the Corrections Ombuds (OCO)</u>

- Dr. Caitlin Robertson, Director
- Elisabeth Kingsbury, Senior Corrections Ombuds – Policy

<u>Department of Health (DOH)</u>

- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities

<u>Health Care Authority (HCA)</u>

- Dr. Judy Zerzan, Medical Director

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

Fatality Summary

Date of Birth: 1996 (26-years-old)

Date of Incarceration: October 2022

Date of Death: October 2022

The incarcerated individual was a 26-year-old man who was first incarcerated by WA DOC on October 11, 2022. He was housed at the reception center for COVID-19 infection prevention intake separation and initial classification. He received standard nursing and mental health intake screenings on the day he arrived with no current mental health concerns noted. His initial cell assignment was with two other incarcerated individuals who had arrived on the same day and were also on COVID-19 infection prevention intake separation. Soon after his arrival in the cell, he made statements to custody staff indicating his intent to commit self-harm if he continued to be housed with others. After a nursing assessment and discussion with mental health and custody, he was moved to an unoccupied cell where he was housed until his death. He died five days later from diminished oxygen to the brain secondary to ligature hanging. The manner of his death was suicide.

A brief timeline of the incarcerated individual's prison incarceration:

Date (10/11/2022)	Event
1300 hours	The incarcerated individual's initial housing placement was as a "floor sleeper" with two additional incarcerated individuals who had already been assigned the upper and lower bunks for sleeping.
1400 hours	He was moved to an unoccupied cell after reporting he may harm himself if housed with others.
Dates (10/12 - 10/15/2022)	**Event**
	He continued to be housed by himself without concern.
Date (10/16/2022)	**Event**
1825 hours	An incarcerated individual housed in another cell reported seeing him at his window and stated he did not appear distressed.
1854 hours	A unit Correctional Officer (CO) was notified by an incarcerated individual housed in another cell that he was in distress.
1855 hours	The CO made a radio call for a medical emergency and entered the cell to remove the bed sheet from the incarcerated individual's neck which he had secured to the upper bunk. A second CO follows to assist. CPR was initiated after they lowered the incarcerated individual to the floor.

1900 hours	The first responding nurse arrived on the unit to assist with the response and directed custody staff to call 911 for a community emergency medical services (EMS) response. They then placed the AED, which advised no shockable rhythm.
1901 hours	The second nurse arrived on the unit to assist in the response and notified the on-call provider.
1915 hours	EMS staff and ambulance arrived on-site and continued resuscitation efforts.
1943 hours	EMS staff contacted the community hospital physician who pronounced the incarcerated individual deceased.

Committee Discussion

A. The DOC Mortality Review Committee reviewed his full jail and prison health record and the circumstances of his death and presented the following topics for discussion and UFR Committee consideration:

1) The incarcerated individual was in the county jail for five months prior to his prison incarceration, while there he reported:

    a) A significant history of illicit drug use in the community including IV heroin, smoking ten pills of fentanyl per day, and methamphetamine use (when he was unable to get fentanyl).

    b) He was screened with the Clinical Opiate Withdrawal Scale (COWS) and met the criteria for medication assistance to manage his withdrawal from the drugs and was prescribed buprenorphine. He was appropriately tapered off the medication prior to his transfer.

    c) He had dental concerns and was treated with antibiotics, antibacterial mouth rinse, and ibuprofen.

    d) He was placed on suicide watch several times after making statements of his intent to self-harm if he was housed with others, (jail staff documented they felt it was a form of manipulation for single-man cell housing placement).

    e) He tested positive for COVID-19 infection, was symptomatic and recovered prior to his transfer.

2) During his nursing intake screening at the prison reception center, he was provided antibiotics and an antibacterial mouth rinse for his dental concerns. An urgent dental referral was placed. No other concerns were noted.

3) During his mental health intake screening he reported:

    a) A history of emotional, physical, and sexual abuse as a child.

    b) A history of depression, anxiety, schizophrenia, and attention deficit disorder.

    c) A history of prescribed psychiatric medication and not taking anything for the last year.

    d) A history of substance abuse with past chemical dependency treatment.

    e) He denied any history of self-harm or suicide attempts.

    f) He denied any current thoughts of suicide or self-harm.

g) He denied a need for mental health services at the time of the intake.

4) Later that day he was assessed by nursing staff for a "mental health emergency."

   a) He informed the nurse that he was concerned about being housed with others due to bad breath from his dental issues. He stated he would not harm himself if housed alone.

   b) After he was placed in a cell by himself, the nurse submitted a "Request for Mental Health Assessment" DOC form 13-420.

   c) A mental health clinician reviewed the incarcerated individual's information and determined a follow-up by mental health staff was not necessary as the Mental Health Duty Officer had been consulted prior to the request being submitted and felt the issue was resolved with a custody housing move requested by the incarcerated individual.

5) A Psychological Autopsy was conducted to review his suicide risk and protective factors:

   a) Suicidal Desire – It appears the incarcerated individual had a desire to die, and that his desire to be housed alone would provide him with an opportunity to act without interference.

   b) Static and Dynamic Risk Factors – He was a 26-year-old male which tends to place him at higher risk. He had a history of criminal activity and polysubstance dependence, which may have contributed to tooth decay and associated pain.

   c) Protective Factors – He appeared to have outside support from his mother and sister. Other incarcerated individuals reported liking him and being concerned about him. Medical, mental health, and dental services were available to assist with management of his health needs.

   d) Intent - His suicidal intent appears to have been rather high as he had tried for some time to be housed alone, while also denying any suicidal ideation (other than to obtain a single cell). When asked about suicide risk several times while at the reception center, by medical and mental health staff, he denied any suicide risk.

6) A copy of the individual's full medical file from the jail was not received at the reception center.

   a) The jail's health provider "Release Summary" only identified dental concerns and associated prescriptions.

   b) No other issues, including mental health concerns were documented.

7) The intake screening location available for use by the Mental Health Team during reception intake is not optimal for privacy and meeting with incarcerated individuals.

8) The resuscitation efforts by DOC staff appear to have been timely and appropriate, but unsuccessful.

9) His cause of death was diminished oxygen to the brain (cerebral anoxia) secondary to ligature hanging. Bleeding in the stomach was noted as a contributing factor in the cause of the incarcerated individual's death.

   a) While the bleeding in his stomach was listed as contributing to his death, the autopsy confirms it was not the cause.

   b) During his nursing intake screening he did not disclose any history of stomach issues and did not request any care for stomach or abdominal symptoms.

c) There was also nothing related to stomach pain or bleeding included in the "Release Summary" that accompanied the patient from the jail.

10) The DOC Mortality Review Committee members recommended working with the medical and mental health staff from the jail to increase communication regarding patient history and treatments as incarcerated individuals transfer between facilities.

B. Independent of the mortality review, the DOC conducted a critical incident review (CIR) to determine the facts surrounding the unexpected fatality and to evaluate compliance with DOC policies and operational procedures. The CIR found:

1. On the day of his arrival at the reception facility he declared a "mental health emergency" and nursing staff responded and assessed him.
    a. He informed the nurse that he was concerned about being housed with others due to his dental issues that were causing bad breath and stated he would not harm himself if he was housed alone.
    b. The nurse discussed his request to be housed alone with the unit custody staff who stated they could accommodate the request. She then contacted the on-call Mental Health Duty Officer (MHDO) for consultation and submitted a "Request for Mental Health Assessment" DOC form 13-420.
    c. The MHDO concurred with the plan and noted that mental health staff did not request the single cell assignment but felt it was an appropriate solution to resolve the housing request.
    d. He was then moved to a cell that had no other occupants.
    e. The clinician who reviewed the request for a mental health assessment form felt the issue was housing related and had been resolved so no follow up from mental health was necessary.
2. Only a medical information summary problem list was received from the jail and did not include any mental health history or self-harm history.
3. The DOC male reception facility lacks a dedicated confidential space for intake screenings to occur.
4. Staff were unaware that the incarcerated individual asked another incarcerated individual to call a CO for him. It was discovered during an interview with the individual he requested assistance from was interviewed.
5. There is no way for an incarcerated individual to directly summon staff if they are secured in their cell. Cells should be equipped with a system that enables the incarcerated individuals to contact staff for emergencies.
6. Tier checks were logged as being completed. A video review demonstrated the tier checks for that shift were not completed according to policy standard.
7. A review of DOC Policy 630.500 Mental Health Services and provide further clarification on the standard for processing "Request for Mental Health Assessment" DOC form 13-420.
8. Additional findings and recommendations did not directly correlate to the cause of death and will be remediated per DOC Policy 400.110 Reporting and Reviewing Critical Incidents.

C. The Office of the Corrections Ombuds (OCO) discussed their analysis of the case and submitted the following to the UFR committee members for discussion:

   1. The OCO Director observed the CIR for this case and recommends that members of this committee have the opportunity to observe the CIR in cases of suicide to gain a better understanding.
   2. The male reception facility standard housing model allows for three incarcerated individuals to be housed in each room, two in bunks and one on the floor. The OCO believes that assigning this individual to a bed on the floor may have contributed to his request not to be housed with others. The OCO recommends changing this model to utilize all beds prior to the enacting the contingency plan of housing someone on the floor. The OCO considers the option of housing someone on the floor unacceptable and is hopeful that the Department will eliminate this option in its standard housing model.
   3. DOC Policy 420.140 Cell/Room Assignment allows for an individual to be placed in a single-man cell during an emergency as a time-limited exception. The higher level of review that is required by policy to maintain an individual in a single-man cell did not occur in this case.
   4. The OCO concurs that tier checks were not conducted per policy. They recommend that staff should not only walk the tier but look in all cell windows to ensure the safety of incarcerated individuals. Then the tier check should be documented in the unit logbook.
   5. DOC should look at increasing the staff resources available at the male reception facility to include a dedicated nurse to collaborate with community jails to increase communication for incarcerated individuals' care needs.
   6. For traumatic events, DOC should ensure follow up support is provided for staff and incarcerated individuals with the appropriate support staff (Critical Incident Stress Management team, Staff Psychologists, and the Mental Health Team).

D. The Department of Health (DOH) representative concurred with the discussion and recommendations. They emphasized the importance of suicide risk reduction through staff training.

E. The Health Care Authority (HCA) representative concurred with the discussion and did not offer additional recommendations.

Committee Findings

1. A summary of current medical treatment information is all the DOC reception center staff received for this individual when he transferred from a community jail. The summary did not include his mental health status while in jail.
2. The custody tier checks conducted during this incident were out of compliance with DOC policy requirements.
3. There is no private and confidential clinical setting for medical and mental health screenings and assessments at the male reception facility.
4. There is no way for an incarcerated individual to directly summon staff if they are secured in their cell at the male reception facility.
5. Mental health staff reviewed the "Request for Mental Health Assessment" form 13-420 and

determined follow up with the incarcerated individual was not necessary.

6. DOC Policy 420.140 Cell/Room Assignment was not followed when the incarcerated individual remained housed in a single-man cell after the initial emergency without the required higher levels of review.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to prevent similar fatalities and further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop, publish, and implement an associated corrective action plan within 10 days following the publishing of this report.

Table 1. ***UFR Committee Recommendations***
1. Ensure tier checks and observations are done according to DOC policy and the operational memorandum of the unit.
2. Ensure DOC policy is followed when an individual is assigned single-man cell housing.
3. Develop a process for incarcerated individuals to be able to notify staff in an emergency.
4. Review DOC Policy 630.500 Mental Health Services and provide additional direction for the completion and resolution of the "Request for Mental Health Assessment" form 13-420.

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

1. DOC should evaluate the current mental health team staffing model to address case load volume and investigate the possibility of job-related fatigue.
2. DOC should evaluate the process for timing and the need for a follow up a mental health visit when there is an after-hours call to the MHDO.
3. Evaluate the infrastructure needs to have a dedicated private and confidential space for medical and mental health intake screenings.
4. Evaluate the infrastructure needs to equip all cells at the male reception center with an electronic emergency notification system.
5. DOC should evaluate the staff resources available at the male reception facility to include a dedicated Health Services staff to collaborate with community jails to increase communication for incarcerated individuals' care needs.
6. For traumatic events, DOC should ensure follow up support is provided for staff and incarcerated individuals with the appropriate support staff (Critical Incident Stress Management team, Staff Psychologists, and the Mental Health Team).