Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-21-005

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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Table of Contents

Table of Contents 1
Legislative Directive and Governance 2
Disclosure of Protected Health Information 2
UFR Committee Members 3
Fatality Summary 4
Committee Discussion 4
Committee Findings 6
Committee Recommendations 6

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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 February 24, 2022:

DOC Health Services
- Dr. Frank Longano, Acting Chief Medical Officer
- Dr. Lisa Anderson, Chief Quality Officer
- Dr. Karie Rainer, Director of Mental Health
- Dr. Zainab Ghazal, Administrator - Health Services - Command A
- Kathleen Reninger, Administrator - Health Services – Command B
- David Flynn, Assistant Secretary
- Scott Russell, Deputy Director
- Ken Taylor, Deputy Director
- Rae Simpson, Chief Nursing Officer
- Candy Tribbett, Project Manager (Facilitator of UFR)
- Johanna Painter, Executive Assistant (Facilitator support)

DOC Prisons Division
- Michael Obenland, Assistant Secretary

DOC Risk Management
- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)
- Sonja Hallum, Interim Director
- Dr. Patricia David, Director of Individual Safety & Performance Review

Department of Health (DOH)
- Tyler McCoy, Health Services Consultant, Healthy and Safe Communities
- Elizabeth Cayden, Suicide Prevention Program Unit Supervisor

Health Care Authority (HCA)
- Charissa Fotinos, Associate Director, Medical Services
- Emily Transue, Associate Medical Director for Clinical Quality and Care Transformation

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

Fatality Summary

Date of Birth: 1978 (43 years old)

Date of Incarceration: July 2021

Date of Death: July 23, 2021

The individual was a 43-year-old male who was in the community in a Graduated Reentry program (GRE). On July 22, 2021, he cut off his ankle monitor, and an escape warrant was issued for his arrest. He later returned to his home and contacted DOC by phone to let them know he had returned. He explained that he felt like a spiritual entity had been following him and that neighbors, his bracelet, and phone had been surveilling him as reasons for his escape. DOC confirmed with his family that they felt safe having him remain in the house until he could be picked up by DOC in the morning.

On the morning of 7/23/2021, he was apprehended and returned to a DOC correctional facility. Upon intake, he denied suicidal ideation or any thoughts of self-harm. He stated he did not wish to speak with mental health staff and was referred for a visit with an Advanced Registered Nurse Practitioner that same day.

At 13:30, an Advanced Registered Nurse Practitioner (ARNP) talked with the individual. He stated, “I’m okay” and “There’s nothing wrong, I’m fine, really.” He reported that he had a lot on his mind and declined a referral to meet with a mental health provider. He again denied feeling suicidal and let the ARNP know that he was aware of how to request mental health or emergency service if he had any urgent needs. A urine toxicology screen was negative. He was then placed individually in a cell with a solid door for separation from others per COVID-19 protocols for newly arrived individuals.

At 16:41 a medical emergency was called for an individual found unresponsive due to self-harm. Unit staff entered the cell and removed a sheet obscuring the view of the individual, which revealed that he had tied a shoelace around his neck and to the ladder of his bunk. The ligature was freed, CPR was initiated, an AED was placed, and 911 was called. Community emergency medical services staff arrived at the scene at 16:57.

Medics contacted a community hospital physician, who pronounced the individual’s death at 17:08 after receiving the telephonic report from the medics on scene.

Committee Discussion

The DOC mortality review conducted determined the following topics warranted further discussion and UFR committee consideration:

1. The effectiveness of the escalation process when there are patient care or safety concerns.
2. The practice of conducting medical assessments in non-confidential areas.
3. The need to clarify the process for contacting an on-call provider when needed and ensure providers can reliably be contacted.
4. The possibility of issuing shoes without laces to individuals returned to custody (GRE Termination or Violator) or initially at the reception centers.
5. Explore the possibility of including the DOC Nurse Desk for placement of individuals terminated from partial confinement by Community Corrections Specialists.
6. Lack of interdisciplinary team communication due to mental health staff not being included in the morning huddle.

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. The policy regarding mental health services and health screening and assessments was not followed, and,
2. There were no previous completed suicides in which shoelaces had been utilized.

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

1. The need for mental health screenings be performed on all new intakes,
2. The lack of written request for mental health evaluation of this individual despite the medical staff's concern,
3. The need for contact information and availability of mental health staff for reporting concerns,
4. Staff did not have easy access to keys for the emergency vehicle and the electric gurney's battery was not charged,
5. The need for outreach to the individual's family after a completed suicide.

The Health Care Authority (HCA) representative discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. Recommend raising awareness that point-of-care drug screens may not detect synthetic substances.
2. The need for a culture shift to adjust the sense of responsibility for following up on mental health concerns, along with the processes to escalate these concerns.

The Department of Health (DOH) representative discussed their analysis of the case and submitted the following recommendations for UFR committee discussion:

1. Continued collaboration between DOH and DOC for providing "Excellence in suicide prevention"

training which had been recommended for action on a prior UFR case.
2. There is a high-risk period for suicide attempts 24-48 hours after intake to prison, which is compounded by isolation.
3. This individual had no history of self-harm which would indicate less risk for a suicide attempt.

Committee Findings

The individual died while in the custody of DOC due to a completed suicide.

Committee Recommendations

Table 1 presents the UFR Committee's recommendations to further strengthen safety and health protections for incarcerated individuals. As required, the DOC will develop and publish an associated corrective action plan within 10 days of the publication date of this report. The corrective action plan will be implemented within 120 days of its publication.

Table 1. ***UFR Committee Recommendations***
1. Reinforce the importance of handoff communication with community staff and ensure staff understands how to escalate individual care and safety concerns.
2. Review the process for Community Corrections Specialists to have health needs reviewed prior to return from partial confinement in the community.
3. Ensure mental health screening upon intake, regardless of category of custody, in accordance with DOC Policy 630.500.
4. Re-evaluate what is generally issued to the newly incarcerated individuals for potential hazards that could enable self-harm and update policies to reflect approved changes.
5. Ensure nursing staff appropriately escalate needs to on call providers. Enforce the expectation that on call providers respond in a timely fashion. Ensure staff know how to escalate needs up the supervisory chain until the patient care need is satisfied. Health Services will ensure that those who are in on-call status answer their phones when called.
6. Ensure equipment is accessible and in working order.
7. Ensure outreach to family and/or emergency contact after the death of an incarcerated individual.
8. Review policies that pertain to the care of persons deemed at risk of self-harm and assure they are consistent with best standards of practice; update if needed.

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

1. Consider whether it would be of benefit for mental health providers to attend morning team huddles.

2. In this case, it appears that an assumption of safety was made because the patient had a negative urine drug screen. Consider a leadership discussion to share this lesson learned and discuss the limitations of urine toxicology screening, in this case, as part of the evaluation of new intake patients.
3. As with most cases, team communication and the dynamics that promote “see something – say something” safety culture appeared to have been suboptimal in this team. DOC should continue to promote a culture of safety.