Unexpected Fatality Review Committee Report

Unexpected Fatality UFR-21-003

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

February 18, 2022

Unexpected Fatality Review Committee Report, Publication Number 600-SR001

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Table of Contents

Legislative Directive ... 1
Unexpected Fatality Review Governance ... 1
Disclosure of Protected Health Information ... 1
UFR Committee Meeting Information ... 2
Committee members in attendance ... 2
Patient Information ... 3
Incident overview ... 3
Discussion ... 4
Review Process ... 5
UFR Committee Recommendations ... 5
Table 1. Committee Recommendations for UFR 21-003 ... 6
DOC Corrective Action Plan ... 6

The Washington State Department of Corrections acknowledges that its facilities, offices, and operations are on the ancestral lands and customary territories of Indigenous Peoples,Tribes and Nations. Corrections is thankful to the Tribes for caring for these lands since time immemorial and honors its ongoing connection to these communities past, present and future. We welcome the opportunity to collaborate with the Indigenous populations and communities and strive to work without Tribal partners to improve the lives of Indigenous People and non-Indigenous neighbors throughout the state.

Learn more about Corrections' values

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UFR-21-003 Report to the Legislature –600-SR001

Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the office of the corrections ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Disclosure of Protected Health Information

As part of conducting a UFR, the assistant attorney general provided the opinion that the mandates in RCW 72.09.770 requires the department to disclose health information to the UFR committee members including mental health and sexually transmitted diseases. However, the state does not have the authority to supersede federal law prohibiting the disclosure of substance use information. Any information related to substance use has been excluded.

UFR Committee Meeting Information

Meeting date: February 15, 2022, via virtual conference

Committee members in attendance

DOC Health Services

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

DOC Office of the Deputy Secretary

- Tom Fithian, Senior Director of Correctional Operations

DOC Risk Management

- Michael Pettersen, Risk Mitigation Director

Office of the Correction Ombuds (OCO)

- Sonja Hallum, Interim Director
- Dr. Patricia David, Director of Patient 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

Patient Information

The patient was a 33-year-old male of Pacific Island descent who was incarcerated from July 2016 until the time of his death in September 2021. He did not have any major medical or mental health conditions. His death appeared to be suicide by ligature.

Incident overview

Two and a half months before his death, he was voluntarily placed into administrative restrictive housing due to personal safety concerns. His classification codes did not reflect serious mental illness and had the minimal code of (S1) for mental health at the time of his housing change.

He was screened by a nurse during intake for administrative restrictive housing. Three days later, he underwent a mental health screening by a psychology associate. He initially indicated a desire for anxiety support during the mental health screening. However, the following week, he declined a follow-up visit for anxiety support by a psychology associate.

A week later, a member of the patient's family called the facility with concerns that he was suicidal. A psychology associate tried to meet with the patient. Although the patient declined to meet, he did respond to questions. He denied thoughts of self-harm and shared he wanted to wait to meet with a therapist who was more familiar to him.

The following day, the patient's preferred psychology associate met with him in person. Additionally, a Psychiatry Advanced Registered Nurse Practitioner met with the patient for a crisis appointment. Antidepressants and antipsychotic medications were prescribed for symptoms of hearing voices and lack of sleep.

A follow up appointment was indicated for four weeks, or as needed by the patient. His S code was changed to reflect a change in mental health status. No diagnosis was conferred but a "rule out" designation for psychotic disorders was noted.

The psychology associate checked in on subsequent days and the patient declined appointments, reporting "I'm fine," "not always on edge," giving a "thumbs up sign", and appearing to the practitioner to be more relaxed.

Three weeks following medication initiation, the patient sent a kite (medical written request) to ask if it was safe to stop one of the medications. The patient noted he wished to discontinue the medication due to effects he was experiencing, including sleeping a lot and "feeling less stable." He was advised it would be better to have an appointment to better answer this question, and that an appointment would be scheduled. The record indicates that the psychiatrist renewed his prescriptions the following week.

The psychology associate noted at one check in that the patient had appeared unkempt and unbathed. The psychology associate check that indicated the unkempt concern was thirty-six days prior to his death.

At a subsequent cell-front check, twenty-three days prior to his death, the psychology associate documented that the patient declined to be seen for a MH appointment. The patient gave "thumbs up" and appeared "relaxed" based on the notes in the documented check-in.

Ten days before his death, the patient sent a kite for a medical visit. He was seen two days later at a cell front visit by medical staff. He voiced urinary concerns. As a result of his concerns, nursing assistants started recording his daily vital signs two days later and suspended daily checks two days before his death.

Medical records show, on the day of death, the patient was discovered with a sheet tied around his neck. An emergency response was initiated to the medical emergency. Medical staff arrived promptly to the scene. Cardiopulmonary Resuscitation (CPR) was in progress and continued until emergency medical services arrived and pronounced death at 2:44 PM.

Discussion

At the UFR meeting on February 15, 2021, the department shared results of an examination of the death of the incarcerated individual. The examination was conducted by a Mortality Review Committee composed of clinicians within the DOC, as well as a representative from the Health Care Authority.

This committee produced recommendations regarding areas to target for health care quality improvement. A critical incident review (CIR) was completed to evaluate the department's policy compliance and operational performance related to specific critical incidents identified in DOC policy.

The Mortality Review Committee representative provided a review of the information on the case. The Mortality Review Committee recommendations included improving capacity for scheduled psychiatric care visits to match demand at facilities and develop scheduling processes that allow for same day or soon day scheduling when needed at all facilities.

The CIR Committee representative provided a review of the information on the case from their perspective. Their recommendations included clarifying rounds and tier checks as purposes change for housing tiers, reviewing the codes across databases that indicate medication or level of care, and possibly working on a notification process to Health Services to prompt a review of medical needs prior to transfer of a patient.

Part of these findings were based on information that the individual's transfer to a lower custody facility had been delayed due to a medical code designation. The medical code was related to his medications, which had not been reviewed and updated by health services staff.

The OCO presented their findings of the case. The OCO concerns centered on the patient declining doses of his medications as well as refusing several times to meet with the mental health provider in an appointment. The primary issues put forward as recommendations were

described as concerns for treatment non-adherence, inconsistent scheduling of follow up appointments, and gaps in communication.

Through discussion it was shared that psychiatry or other treatment providers could have been notified upon an escalation of patient needs. The discussion noted that if notification occurred it would initiate a possible medication review.

It was noted that the patient declined therapy sessions and there was not clear notification to other providers within the healthcare team. The discussion included recommendations for the healthcare team to further collaborate on care, which may have initiated a reevaluation by psychiatry. In this case a psychiatric prescriber and psychiatrist were responsible for medication management, but a psychology professional was performing intermittent encounters.

The Department of Health representative offered evidence-based methods for training correctional staff ("gatekeeper training"), to provide them with the best tools to reduce suicide risk. DOC offers suicide prevention training at onboarding and annually but has not previously collaborated with DOH regarding this format.

The Health Care Authority representative pointed out the need for an electronic health record to facilitate communications across space and time and suggested considering infrastructure requirements for consolidating electronic systems which share information such as medication handling specifications.

Review Process

The OCO, DOH, HCA, and DOC met to review and apply a risk assessment to system and process concerns based on the case review. The committee then discussed recommendations to address each of the identified concerns and applied selection criteria. Selection criteria was based on the impact of the recommendation and the effort required to implement.

Eight of the eleven recommendations reviewed were selected for implementation.

UFR Committee Recommendations

The recommendations identified in Table 1 were presented during the meeting and are within the scope of the UFR and will be pursued by the Department.

Table 1. Committee Recommendations for UFR 21-003

Committee Recommendations
1. Improve capacity for scheduled psychiatric care visits at the facility under discussion (to match demand for appointments) so that follow up appointments are not missed, and backlogs are rectified.
2. Develop a scheduling process which allows for same day or soon day scheduling when an appointment is needed.
3. Clarify Post Orders for Units as purposes change for multi-purpose tiers.
4. Develop a notification process to HS when a transfer is in process to prompt review of medical needs.
5. Establish a clear policy to ensure there is follow up with the patient to be sure they understand the treatment being prescribed and the risks, as well as to discuss alternatives. This policy may include: • Notification to the FMD and assigned provider promptly of all missed and canceled appointments, tests, procedures. • Formalize a process for follow-up with patients who have missed or canceled appointments, tests, or procedures. • Process should include recognition of the nature and severity of the patient's clinical condition, to determine how vigorous follow up should be.
6. Develop and consistently implement structured, codified communication practices (e.g., morning huddles, afternoon check-outs) that include MH and psychiatry (as well as other disciplines), with the goal of sharing patient information and collaborating on plan of care.
7. Enhance suicide prevention training for corrections officers and correctional facility staff members with ongoing dedicated gatekeeper training.
8. Pursue implementation of an Electronic Health Record

DOC Corrective Action Plan

The statute requires DOC to develop and publish an associated Corrective Action Plan (CAP) within tendays of publication of this report. The CAP will be published by the statutory deadline.